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LOOK WHO'S TALKING:

LONG TERM CARE FROM THE STANDPOINT OF THE NURSING ASSISTANT,
A FEMINIST ANALYSIS

BY

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ABSTRACT

This research presents a feminist analysis of the work carried out by Nursing Assistants in the context of facility based extended care for elderly people within the current, rapidly evolving long term care system in British Columbia.


Institutional ethnography, a non positivist method, is used to examine the problem of rigid and routine methods associated with Nursing Assistants' work. Management and professional staff have criticized Nursing Assistants for adhering to inflexible care giving routines which impede quality nursing care.

The starting point for exploring this problem is the everyday work experience of Nursing Assistants. A typical day is described based on the researcher and participants experiences. The study proposes that inflexibility is organized into Nursing Assistants' work through methods designed by management and professional staff to standardize the work and thereby assure a high quality of care. Further, it is argued that the top down approach to planning and organizing the work creates contradictions in the quality of the care. Nursing Assistants are expected to follow the standard directives of their superiors while feeling the pressure to offer the individual care which residents indicate they need. This study shows that Nursing Assistants succeed in offering flexible resident care;


however, their lack of authority and heavy workload presents them with many challenges in doing so.

The author contends that the top down manner of arranging Nursing Assistants' work contributes to lack of understanding between management and professional staff at the top of the organization and Nursing Assistants located at the bottom. The contribution Nursing Assistants' knowledge and experience makes to the facility remains undervalued and invisible. The invisible and skilled aspects of Nursing Assistants' work are illuminated as are emerging pressures they must cope with related to the changing long term care environment.


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CHAPTER ONE

INTRODUCTION

This study developed out of the timely convergence of two significant sets of circumstances: my introduction to the non positivist way of thinking and my growing concern with nursing care in the field of long term care.

The opportunity to gain awareness and knowledge of non positivist thinking has been and continues to be one of my most profound learning experiences. I can describe it only as a long closed door in my brain finally being opened. The opening of this door has allowed me to view the world through "new eyes" in a way that, on the one hand, is very different from what I have been taught to see in the past, yet, on the other hand, it is very familiar. Non positivist thinking is very new and different to me. It does not ask me to remove myself from my world, to stand back, and adopt someone else's conception as a legitimate way to gain knowledge. Such a stance is expected of positivist reasoning, and effectively makes me a stranger in my own world. At best, the positivist position has made me feel very awkward; at worst it has distorted the knowledge I have of my world. The familiarity comes from the level of comfort the non positivist view affords me. For the first time, I have the opportunity to see, to explore and to understand the world in which I live and work, as I know it,

and as I experience it. Non positivism acknowledges that it is impossible to remove ourselves from the world we inhabit, that we are an integral part of making it what it is. Thus, non positivism has opened up the unique yet familiar possibility of learning about the world from our position in it.

The non positivist view has had a strong influence on all aspects of my life; however, it is particularly relevant here in terms of my research. It offers me a way to inquire into the growing concerns about the quality of my work and that of other team members within long term care without removing myself from the picture.

The facet of long term care with which I am concerned here is extended care, specifically as it is provided to elderly people within the institutional setting. Extended care is the highest classification within the long term care continuum, offering services to those elderly persons judged as requiring the most extensive level of care in terms of care giver time.

My experience with the extended care environment has spanned approximately twelve years and has been in the capacity of Registered Nurse. Four of these years were spent working in a privately owned facility in Montreal during the mid 1970's. For the past eight years I have been employed in a government funded extended care institution in Victoria, British Columbia where this study takes place. My

role within this institution is that of a Care Coordinator which is a front line position involving a combination of care giving and supervising activities. As a care giver, my time is primarily taken up with giving medications, doing treatments, making assessments of residents' health and care needs as well as documenting care. The role of supervisor, involves serving as a resource person for, and monitoring as well as directing the work of, Nursing Assistants who provide most of the hands-on care for the residents. Nursing Assistants are in continuous close contact with the residents, tending to their most intimate needs for help with, functions such as washing, dressing, getting out of bed, using the toilet and even eating. Care Coordinators' duties involve the more "complex" and medically oriented work of dressings, assessments and treatments whereas Nursing Assistants carry out the "basic" care of meeting personal needs. Initially, I accepted this method of organizing the work as sensible, but over time I became uncomfortable based on what I had witnessed and experienced.

In some ways, my role as a Care Coordinator with the "expert" knowledge directing the work of Nursing Assistants with the "non expert" knowledge seemed reasonable, but in many ways it raised concerns for me. Although I had the knowledge, for instance, to know how to correctly change a Foley catheter which had blocked, I encountered many circumstances when my "expert" information was inadequate

for the situation. One such incident involved my attempt to transfer a resident onto the toilet using the method approved for this person, a one person pivot. After one failed effort, when I managed to lift the resident about twelve inches off the wheelchair only to have her sink back down again she advised me to "get someone who knows how to do it". The "someone who knew" was a Nursing Assistant who explained that this resident was a difficult transfer and could only be done by those who knew exactly what to do. I began to understand that Nursing Assistants carry a lot of "knowing exactly what to do" kinds of knowledge necessary to getting the work done safely and quickly.

Nursing Assistant's knowledge, however, is not accorded the same respect as that held by Care Coordinators. This was apparent in an incident where I witnessed a Nursing Assistant report to the Care Coordinator that one of her residents looked unusually pale and tired and probably should be left in bed. The Care Coordinator, based on her documentary information, insisted the resident be up. No sooner was the resident in the chair then she fainted. My point is not to suggest this particular Care Coordinator made a poor decision. Most Care Coordinators are extremely skilled and conscientious. Rather, I want to draw attention to the authority granted the Care Coordinator's decision. The Nursing Assistant was expected to follow this directive even though her own experience told her this was not best

for the resident. There is an assumption underlying this perspective that the "expert" knowledge lies only with the professional and if Nursing Assistants follow instructions given by professionals the right care will be provided. Over time, I began to experience more of these discrepancies between the instructions that are supposed to direct the delivery of excellent care and my observations of what Nursing Assistants *did* to take good care of the residents. All of my concerns about work relations in extended care have been exacerbated by the recent trend that sees the typical resident increasingly frail and requiring a great deal more of all facets of nursing care, that offered by Care Coordinators and that provided by Nursing Assistants. Without due recognition of what is happening, extended care of elderly people relies more and more on the work and the knowledge of Nursing Assistants.

In this context, one of the discrepancies has been particularly troubling to me and forms the primary basis for my inquiry. Over the past two to three years, on many occasions I have heard professional and management staff complain that rather than follow the professional directives given and therefore do their work right, Nursing Assistants are adhering rigidly to their own routines. This is troubling to management staff because Nursing Assistants' reluctance to alter their work habits prevents the introduction of new techniques to offer the best quality of

care, a high priority for the institution. My experience over the past eight years of working with Nursing Assistants has shown me that the pressures of their daily work have increased remarkably, and they adapt to the new demands incredibly well. On the one hand, they are seen by some as rigid in their conformity to "routines", on the other hand, as remarkably adaptive. My research seeks to explore this seeming contradiction. The inquiry begins with participant observation of Nursing Assistants' work, examining their daily activities as the first step to increased understanding of the routines they use.

This study is presented in seven chapters. Chapter two reviews the literature related to long term care and to Nursing Assistants' work within this field. Studies of their work in long term care are characterized predominantly by research which identifies and measures attributes of Nursing Assistants and their work that may affect the quality of care. Dissatisfied with the results reported, I note several promising studies that have situated Nursing Assistants' work in their social context.

In chapter three, I describe the methodology used in this study, outlining both the non positivist view and the institutional ethnographic method which it supports. I have taken care to identify and discuss the differences between my choice of a feminist methodology and the more traditional, mainstream procedures.

I see this study as a feminist undertaking, even though I have not begun, either with feminist theory, or pursued topics normally constituting feminist research. My study embraces the standpoint of Nursing Assistants who are primarily women and whose work is systematically controlled by management and professional practice. Dorothy Smith (1990) holds that, "... the standpoint of women has been essential to the method used (p.9). Smith continues, "The standpoint of women... (has emerged) at a point in women's contemporary struggles when we had to place a radical reliance on our experience in learning with each other how to speak together as women. The method of experience returns us always to the subject active in the remembering, in finding out how to speak from the actualities of her life, bringing forward... a speaking for which she is the only authority. It is a method that feminists have taken up in a variety of ways" (pp. 4-5).

I have learned through my inquiry into the work lives of Nursing Assistants how to see and show the relations of ruling that silence and subordinate them. Giving them back their voice through this analysis is, I claim, feminist work.

Chapter four is largely descriptive, showing Nursing Assistants' work as it happens and with a beginning analysis of the structure of their activities. I recreate the events of a typical day shift, weaving in direct quotations from

various participants to support and illuminate particular aspects of their work.

In chapter five, I propose the top down approach is the overall structure which organizes Nursing Assistants' experience and this frames my analysis. I then present two parts of my three part argument. First, I demonstrate how 'quality' is maintained through documentary control of Nursing Assistants' work which embeds the management and professional perspective. Next, I argue that contradictions in care result from the inflexibility which is inadvertently built into Nursing Assistants' work through mechanisms intended to promote quality.

In chapter six, I offer the third part of my argument, contending that the top down method has contributed to the construction of a barrier between those at the top and those at the bottom of the organization. I discuss the realities of Nursing Assistants' work, given their isolation at the bottom of the hierarchy, and in light of the current changes in the long term care industry.

Chapter seven concludes with a brief summary and offers reflections on changes that are necessary in planning and delivering extended care for elderly.

CHAPTER TWO

The long term care system in British Columbia depends on the labour of Nursing Assistants. This group of caregivers provides 70% to 90% of all direct, 'hands-on' personal care received by frail elderly people who reside in nursing homes (Waxman, Carner and Berkenstock, 1984., Wright, 1988., Diamond, 1986., Feldt and Ryden, 1992., Novak and Chappel, in press). Recent trends in long term care policy have had a profound influence not only on how service to the frail elderly population is structured but also on how nursing care within institutions is organized.

Long term care in British Columbia is currently in a phase of rapid development as it responds to changes in the structure of the population, to shifts in funding for health care and to emerging philosophic approaches to health care. Population aging is a well documented national phenomena; however, it is most pronounced in the province of British Columbia which attracts a large number of retirees. People over the age of 65 now comprise 12.5% of the total population in this province and this is expected to increase to 14.5% over the next twenty years (Ministry of Health, 1989). The fastest growing segment of the elderly population is the 85 and over age group, often referred to as the old - old. It is estimated people in this age category will increase by 51% between the years 1990 and

2000 (Royal Commission on Health Care and Costs, 1991). It is widely acknowledged that the increase in the proportion of older people in the population, particularly those over the age of 85, will lead to greater need and increased expenditure for health and social services (Connidis, 1987., Denton, Li and Spencer, 1987., Roos, Shapiro and Roos, 1987., Ministry of Social Services and Housing, 1991). Shapiro and Roos (1987) studied nursing home utilization and found the greatest risk for placement in an institution was advanced age. Angus (1985) suggests most elderly people remain in good health and are able to live independent, active lives and it is a only small proportion of about 5% who require extensive short and long term care. Support for this view is offered by Roos, Shapiro and Roos (1987) who analyzed data from two ongoing studies in Manitoba and concluded that a small number of elderly people account for high rates of hospital and nursing home use. Connidis (1987) identified a similar pattern in her examination of the use of community services by elderly people living in their homes in London, Ontario. She found only 7% of the sample of 400 individuals were using formal community services.

Population aging therefore means an increase, not only in well elderly persons, but also in those older people who will need extensive service and care. Thus, Nursing Assistants, as the main providers of the hands-on care in

the institutional setting will be caring for people who are primarily 85 years of age and older who require complex and comprehensive care.

The focus of health care funding is shifting from institutional to community care as the province accommodates demographic changes, escalating costs and an economic environment of recession. Institutional care for the elderly in British Columbia consumes 75% of the resources allocated to the elderly (British Columbia Ministry of Health, 1989). Evans (1987) argues that institutionalization of frail elderly people is not only costly but also inappropriate as it does not meet many of their needs. He proposes that elderly people can be better cared for if resources are allocated independent of the health care system (Evans, 1987, p.622). The slow economic growth of the past ten years, in concert with rising expenditure, has resulted in health care consuming an ever increasing percentage of the gross national product, from 5.5% in 1960 to 8.8% in 1985 (Fulton and Sutherland, 1988). Burgeoning health costs during the 1970's led the federal government, in 1977, to limit the transfer of funds to the provinces with the Established Programs Financing Act (EPF). Bill C69 continued this trend of reducing transfer payments. Prior to that, and with the advent of medicare, 50% of all health costs were paid by the federal government (Taylor, 1987). The challenge, then, for British Columbia is to

provide the health care required by an aging population with limited funds. The dilemma is being addressed by a policy of capped global budgets for long term care institutions and increased funding for community services to enable frail elderly people to remain in their homes.

The shift toward community care in conjunction with capped funding on institutions is placing a great deal of pressure on the existing resources of these facilities. Only the most frail and the very old people who require extensive and complex physical, emotional and social care are being admitted to long term care facilities (Mantle, 1988., Royal Commission on Health Care and Costs, 1991). Long term care institutions have not received enhanced funding to compensate for the increased need (British Columbia Royal Commission on Health Care and Costs, 1991). Indeed, the institution in which this study was carried out operates in an uncertain financial environment in which the amount of funding provided by the Ministry of Health is never known until it arrives. A former senior executive of the facility refers to this as "surprise funding" and acknowledges the difficulties it presents to management.

The growth of community services reflects the government's attempt to contain health spending by giving some of the responsibility for health back to the community and the individual. This philosophy was introduced by Lalonde (1974) in his "health field concept" which defined

health as being composed of four factors, human biology, environment, lifestyle and the organization of health care. The notion that lifestyle influenced health placed some of the onus for one's well being with the individual and this began a move away from the paternalism of the more traditional approach. This idea was further developed by Epp (1986, p.9) in his call for public participation in health issues to "... channel the energy, skills and creativity of community members into the national effort to achieve health".

In response to this environment of consumer participation, elderly people and their advocates have become more vocal in defining the services required to promote their well being. The needs they have identified include programs to enable them to remain at home as long as possible and institutions which provide a more homelike living environment offering the personal choice and control indicative of a home (B.C. Ministry of Health 1989., Royal Commission on Health Care and Costs, 1991). The result is that institutions are now struggling, with limited resources, to implement homelike environments for a client population with more complex care needs. The solution to this dilemma in long term care tends to be to look to the front line workers. Nursing Assistants in particular are experiencing a dramatic change in the demands on their time and on how they do their work. A great deal of management

attention is being directed toward Nursing Assistants in an attempt to carry out the new policies without increasing expenditure.

LONG TERM CARE

Long term care is a concept for which there is no single, consistent definition; however, there appears to be consensus that it involves a continuum of services; is provided primarily to elderly people; is dominated by the medical model and institutional care, but is beginning to shift toward more community based programs (Sutherland and Fulton, 1988., Swenger, 1987., Brody, 1977., McDaniel, 1986., Ministry of Health, 1989., British Columbia Royal Commission on Health Care and Costs, 1991). The notion of health promotion as a component of long term care is less widely accepted; however, it is emerging and gaining momentum as having the potential to make an important contribution to long term care for elderly people (Rapelje, 1986, in Baumgart and Larsen, 1988., Mantle, 1988., B.C. Ministry of Health, 1989). Long term care has been discussed from the perspective of a number of stakeholders including academics, health professionals, government agencies and the elderly themselves.

According to Sutherland and Fulton (1988) who carried out a description and analysis of the Canadian health care

system, long term care in Canada is a dynamic process that has responded to social and historical events. Sutherland and Fulton (1988, p.268) view long term care as an evolutionary process and describe three developmental phases. Phase one, labelled "social disinterest" occurred prior to 1960 and was characterized by minimal government involvement in care for elderly people. Care giving was left to the family and charitable organizations which held the philosophy that frail older persons were like children who were best cared for away from the rest of society. Phase two, referred to as "benevolent paternalism", took hold in the 1960's with increased government support for services for elderly people in need. The services were organized primarily around institutionalization with medical care administered by professionals. The guiding principle behind this approach was protection of elderly persons in care; however, this was often at the expense of their quality of life. Phase three or "contemporary" long term care is now emerging, supported by a philosophy that frail elderly people should be regarded and treated as adults. According to Sutherland and Fulton (1988, p. 269) contemporary long term care is becoming very complex and they propose one or more but never all of the following ten goals to guide current long term care:

- to prolong life and maintain health
- to improve the quality of life of the LTC recipient
- to support household care givers and protect their quality

- of life
- to reduce agency or program cost
 - to reduce total system cost
 - to reduce departmental cost
 - to reduce user and household cost
 - to protect acute treatment hospital beds from 'bed-blockers'
 - to make a profit
 - to be cost-effective compared to other sources of similar care.

Swenger (1987) describes long term care in Canada as being in a state of chaos, characterized by fragmentation, competition and lack of adequate information at the local, provincial and federal levels. He suggests excellent systems of long term care exist in this country but there is a tendency to ignore these in favour of looking for solutions outside Canada. Swenger (1987 p.512) argues that competition between the medical model which is declining and the social model of care which is gaining acceptance is destructive. He advocates for the "Manitoba model" of long term care to be initiated throughout Canada. This approach to long term care coordinates institutional with home care and decreases physician influence to concentrate on meeting social needs.

Brody (1977) who writes from an American experience strongly supports this view. She proposes there are two factors which determine the need for long term care, social and functional disability. In her view, long term care requires a spectrum of social and medical programs and physicians should not be the gatekeepers to these services.

In Victoria a continuum of long term care is available ranging from personal care which is the lowest level of care through three levels of intermediate care to extended care, the highest level available. Included in this series of programs is short term crisis support, arranged by the Quick Response Team to assist with temporary problems (Continuing Care Division, Ministry of Health, 1991., National Advisory Council, 1992). Services which are available to assist individuals to remain at home include Homemakers, Meals on Wheels, Adult Day Care, Physiotherapy, and Home Nursing. All are available on a short or long term basis.

Gubrium (1991) argues that defining and organizing long term care primarily as a continuum of services is oriented to an administrative need to plan interventions and does not take into account the real life situation of care receivers and their families. According to Gubrium (1991, p.20), "... care giving is a dynamic interplay of troubles, ties and traditions and the professional caregiver needs to understand, not predefine, the meaning of problems." The adoption of a strictly linear perspective limits the ability of professionals to recognize the complex and discontinuous nature of problems facing the elderly and their families. Gubrium proposes another perspective of long term care which he refers to as a "mosaic" of care. In this multi-faceted, view the professional acknowledges the diversity of care giving problems, understands the meanings of these problems

to families and is, therefore, more able to design interventions "...to facilitate the recovery of troubled lives, not preplan for them" (Gubrium, 1991,p.19).

Long term care is often described as a tertiary level of care necessary to compensate for functional losses already suffered (Sutherland and Fulton, 1988). Rapelje (1986, in Baumgart and Larsen, 1988) advances the notion that long term care should expand to include health promotion, life enrichment and wellness programs. Evaluation of a three year health promotion program for frail elderly people in New Westminster, British Columbia suggests health promotion interventions reduced institutionalization by 15% (Hall et al, 1992).

Mantle (1988), speaking from the perspective of a Clinical Nurse Specialist in geriatrics, views the practice of nursing in long term care as complex and challenging. She calls for educational preparation of beginning level nurses to include more knowledge of aging and health so they will have the necessary clinical skills to enter this field. According to Mantle (1988, p.116), Clinical Nurse Specialists can make a valuable contribution to long term care by acting as role models, serving as consultants, participating in research and promoting front line concerns at the organizational level.

Buzzell (1992, p.13) another health professional, who refers to long term care as "life care" identifies three

critical ways in which it differs from acute care: it is life, not illness focused, the individual and the family, rather than professionals, dominate decision making and personhood is more at risk in long term care and needs to be acknowledged. To provide "life care" demands new ways of helping which involve " ... human to human relationships with the person in care, his family and health professionals" (Buzzell, 1992, p.13).

Elderly people themselves are speaking out and helping to shape long term care policy. Through the Seniors Advisory Committee, submissions to task forces and Royal Commissions, they have described their view of long term care as requiring both community and institutional services. Elderly people have advocated for community services to enable them to die at home and to offer more support and respite for care givers in the home. Within institutions, the elderly want to be able to "age in place" and to be cared for in an environment which provides opportunity to make choices and maintain control of their situation (Ministry of Health, 1989., Seniors Advisory Council, 1991., Royal Commission on Health Care and Costs, 1991). Mead (1991), a senior citizen writes from his personal experience of fourteen years of living in nursing homes. Mead suggests that residents are the low point on the institutional totem pole. He proposes this is related to the business approach to managing nursing homes which dominates the industry in

the United States. Residents are regarded as "cases" or "units" and staff direct most of their attention to the executives who hire, supervise and pay them (Mead, 1991, p.9). The result, according to Mead (1991, p. 11), is medically oriented care which ignores social and psychological needs of the residents who are relegated to live a "colorless" existence. What is needed is an organization which will enable staff to understand, "...the aspirations and anxieties of each heart and mind, emotions not usually entered in the record volumes in the medical office" (Mead, 1991, p. 10). According to Sutherland and Fulton (1988), reform such as that advocated by Mead is being delayed by long term care legislation, institutions' and professional groups' failure to adapt. Yet an evolution is underway. The adoption of the new philosophy of consumer involvement and personal choice in service planning is creating pressure to change the way service is organized and delivered. Contradictions currently exist within institutions. Elderly people are encouraged to look on the facility as their home and to take part in identifying their care needs; however, the funding and the organizational structure to support such an approach are not in place. Front-line workers appear to be caught in the middle.

NURSING ASSISTANTS

In long term care facilities, the largest group of

front line workers is referred to by a number of names including Nursing Assistant, Nursing Aide, Long Term Care Aide, Resident Care Attendant, and Health Care Aide. This diversity of titles reflects the preference of specific institutions, the dynamic role of these workers within the long term care industry as well as the lack of mandatory educational standards and licensing. The term Nursing Assistant will be used here to refer to those support workers who have received some formal education in geriatric care but who, generally, have no credential in nursing.

The concept of support worker in health care denotes a care provider at the front line who works under the supervision of a professional. According to Lemieux-Charles (1990, p.2), "a key premise is that the professional has overall responsibility for the care which is delivered" by the support worker. This suggests close supervision of Nursing Assistants by professionals; however, studies on the use of these employees suggest this supervision is often more theoretical than it is practical (Manthey, 1989., Hardie, 1989).

Currently no mandatory legislation governs the education of Nursing Assistants in British Columbia. Community colleges throughout this province have been offering diverse training programs which vary in length from 13 to 20 weeks of full-time study (Ferguson, 1991). A standard five month educational program for Nursing

Assistants has recently been developed and is currently being implemented on a voluntary basis, in community colleges throughout British Columbia (Ferguson, 1991). This project was undertaken in response to a growing need for well prepared workers, prospective employers requesting consistent education and concern related to the proliferation of private training programs (Ferguson, 1991). Graduates of this revised and updated program will receive the designation of resident care attendant and will be qualified to work in all levels of institutional care as well as adult day care. The adoption of a uniform curriculum for Nursing Assistants by community colleges is considered to be an initial move toward a legislated educational standard (personal communication with Faye Ferguson, 1992).

Most of the research related to the work of Nursing Assistants in nursing homes originates in the United States. In Canada, health care is funded and structured differently and higher wages are paid to nursing assistants. The American research is useful, however, because of the similarities between the countries with regard to who the workers are, what their work involves and how it is organized. Interestingly, salaries for Nursing Assistants in the United States remain low at near minimum wage level, yet they are required to meet a legislated educational standard of 75 hours of training (Hayes and Irby, 1990.,

Hare, 1988). This differs significantly from the situation in Canada where Nursing Assistants generally earn more than double the minimum wage, are not required to meet legislated educational standards, yet would have difficulty finding employment without having successfully completed a formal training program.

Historically, these employees were women who were recruited for their homemaking skills to work in old folks homes (Barney, 1983). Following World War II, homes for the aged evolved into nursing homes providing medical care, and the work these women performed became subordinate to that offered by professionals such as registered nurses and physicians (Barney, 1983). Today, their position remains unchanged; however, the legislation of minimum educational requirements in the United States and the implementation of a uniform education program in British Columbia suggests a move toward professionalization (Hayes and Irby, 1991., Hare et al., 1988., Ferguson, 1991). In a paper which remains timely Hyerstay (1978) proposes the professionalization of nursing assistants will have political and economic ramifications for the nursing home industry in the USA. She suggests that as Nursing Assistants become better educated, they will press for improvements in the quality of nursing care and they will demand higher wages. According to Hyerstay, (1978) the USA nursing home industry would then be faced with a dilemma as to how they can make a profit yet

still offer humanitarian care. This mirrors what is happening in Canada today. Long term care institutions are coping with economic restraint, higher wages negotiated by the unions and heavier workload along with the pressure for more homelike care and resident autonomy. Nursing Assistants, by virtue of their close association with the elderly residents, occupy a pivotal position between quality of care on the one hand and cost effectiveness on the other.

A profile of the typical Nursing Assistant today, based on data from the United States, is one of being female, a single parent, very often foreign born and having high school education or less (Garland et al., 1988., Wright, 1988). The recent Royal Commission on Health Care and Costs (1991) indicates Nursing Assistants employed in nursing homes in British Columbia may be overworked as a result of chronic understaffing. Support for this view is provided by Chappell and Novak (in press) who conducted a study of Nursing Assistants caring for frail elderly people in long term care institutions in Winnipeg, Manitoba. They suggest a decrease or change in workload is necessary to alleviate burnout in Nursing Assistants.

Formal care giving, such as Nursing Assistants do, has been viewed as an extension of the work women have traditionally done in the home (Baines 1991). Abel and Nelson (1990, P 13) suggest that the movement of women into the role of formal, paid care giver has created problems for

these employees. Formal care givers are not only regulated by bureaucratic rules which apply standardized techniques to a process which is inherently unpredictable, but they also work in an environment where the emphasis is on medical care which devalues the non medical work these women do.

Moreover, measures used to evaluate the care capture neither the complexity of the work nor the actual quality of the care (Abel & Nelson, 1990).

The significance of the unrecognized aspects of the work front-line care givers do is acknowledged. In her analysis of health care workers at the bottom of the hierarchy, Sacks (1991, P.191) argues that the unrecognized work such as emotional care and coordinating activities routinely performed by non professional staff are increasingly important for successful health care. Further, Sacks suggests the subordinate role of these employees places them in a position such that they cannot use all of their knowledge. According to Sacks, (1990, P.194) front-line workers are, " information keepers and integrators ...they are in contact with all parties; they are a captive source of information held responsible for drawing conclusions from it but denied authority to make the decisions that stem from putting two and two together." Sacks (1990) calls for the unions to address the issues of invisible work and proposes their failure to do so in the past has made these employees vulnerable to bearing the

brunt of the restructuring currently taking place in the health care system (P.189).

These arguments reflect my experience with Nursing Assistants' work in extended care. Although their unrecognized work and experiential knowledge is essential to being able to provide good nursing care, such duties and knowledge often conflict with the management idea of what constitutes 'real' work and 'quality' care.

QUALITY OF CARE

In a review and analysis of nursing home quality, Davis (1991, p.130) proposes that quality of care is "...an elusive concept which is value based and which emerges from ... the preferences of policy makers, health care professionals, administrators, owners, investors, third party insurers and consumers." Davis calls attention to the lack of resident involvement in defining and assessing quality of care and relates it to resident fear of speaking out or mental impairment which interferes with participation. He contends that quality can be achieved by consultation between all stakeholders to identify areas of agreement. Parker (1991) introduces further complexity into the notion of quality by suggesting variation in values exist not only between stakeholder groups but also within these groups. She proposes that "because we have different

cultural and life values, quality of life will be different for each individual" (Parker, 1991, p.2). In a survey of residents living in an intermediate care facility in Victoria, British Columbia, Parker (1991, p.3) identified several aspects of quality which residents valued. These included: security, a safe environment and twenty four hour care, good nutrition and meals being prepared, socialization and overcoming loneliness and closer health care supervision than at home was highly valued.

Donabedian (1982) states quality consists of the three dimensions: structure, process and outcome. He proposes a framework for assessing quality by examining these three components and the interaction among them. According to Donabedian (1982, p.359), 'structure' refers to the more stable physical attributes such as size of the organization and the human resources. 'Process' involves how the care is delivered including, "preventative, intervention and remedial actions" and 'outcome' denotes the actual result of the care giving activities. The literature related to the quality of care provided by nursing assistants falls generally into these three categories suggested by Donabedian.

QUALITY AND THE DIMENSION OF 'STRUCTURE'

Turnover, training and attitudes of Nursing Assistants are considered to be structural indicators of quality

(Donabedian, 1982). These characteristics have received a great deal of attention from researchers.

Estimates of job turnover among Nursing Assistants varies from 40% to 117% annually; it has been suggested this leads to decreased quality, quantity and efficiency of care (Waxman et al., 1984., Wagnild and Manning, 1986., Irby and Hayes, 1990., and Reagan, 1986). An exploratory study conducted by Garland, Oyabu and Gipson (1989) examined turnover to determine if there were differences between seventy nine Nursing Assistants who were known as "stayers" and thirty five who were classified as "leavers". Stayers had worked in the same nursing home for ten years or more, whereas leavers had resigned within the first six months. Results indicate that leavers were younger, better educated and single. In comparison, the stayers placed greater value on pay and benefits. These findings are supported by a number of other studies (Caudill and Patrick, 1989., Wagnild and Manning, 1986) including Reagan (1986) who recommends that turnover be managed by carefully screening staff to exclude younger persons who are more likely to resign. This technique is not prohibited by law in the United States. In that country, protection from discrimination based on age is afforded only to those persons aged 40 to 70 years (Reagan, 1986). In Canada, such a practice would be considered discriminatory under the Charter of Human Rights and Freedoms which does not allow exclusion based on race,

religion, sex and age. The principle behind the recommendation for age screening appears to be that turnover is a problem rooted in the characteristics of the Nursing Assistants and will be solved if the right employees are selected.

The training of Nursing Assistants has also been the focus of research examining quality of care. A group of researchers (Block, Boczkowski, Hansen, and Vanderbeck, 1987) developed an in-service education program in consultation with Nursing Assistants to help them cope with aggressive residents. Following four weeks of intervention, residents were found to exhibit substantially improved behaviour suggesting a better quality of care and Nursing Assistants expressed satisfaction with the training. The researchers proposed that the staff's familiarity with the residents enabled them to be involved in both the planning and implementation of the program. A study conducted by Linn, Linn, Stein and Stein (1989) found a positive relationship between training given Nursing Assistants about care of the dying and increased resident satisfaction and decreased depression. The Nursing Assistants in this study had expressed an interest in education on this topic. This suggests an assessment of learning needs may be important to successful training.

Research which examines quality of care in light of the training given to Nursing Assistants suggests these

caregivers are largely responsible for the care giving process. This perspective is useful in that it recognizes education as one of influences on Nursing Assistants' work; however, it ignores the overall context which organizes and shapes what these trained employees can and cannot do.

Research carried out by Schnelle, Newman, and Fogarty (1990) found that in service training on urinary incontinence did not result in improved quality of care because Nursing Assistants did not maintain the two hourly toileting protocol. Campbell, Knight, Benson and Colling (1991) carried out a similar study offering more extensive training on urinary incontinence for the Nursing Assistants and found a compliance rate of 72% for toileting residents. Campbell et al. (1991) examined the reasons for noncompliance and proposed the sociocultural environment of the nursing home which emphasized custodial care was possibly the strongest influence on Nursing Assistant behaviour. In this environment, changing residents when they were wet was seen as the most efficient use of time by the Nursing Assistants. This study draws attention to the organizational context, in particular, the custodial approach, as an influence on behaviour. The research suggests that quality of care is related to the overall sociocultural environment in which care giving occurs. Within this context Nursing Assistants' knowledge is only one aspect which influences their behaviour.

Attitudes of nursing assistants have been examined extensively as indicators of quality of care. Surveys of the attitudes of Nursing Assistants have yielded varying results including positive feelings toward their job (Cohen - Mansfield, 1989), low levels of empathy, negative attitudes toward the elderly residents, a custodial approach to care giving (Bagshaw and Adams, 1986), and positive feelings during interaction with residents (Fisk, 1982). These studies focus on the Nursing Assistant with the apparent assumption that attitudes are generated solely from within the individual. Quality of care then depends on finding the person with the right attitude. Tellis-Nayak and Tellis- Nayak (1989) connect the sociocultural environment outside of the nursing home to the milieu within the institution. They suggest Nursing Assistants come from disadvantaged and troubled backgrounds, a situation which is perpetuated in the nursing home where these employees are given little respect, are treated harshly and receive no support. The researchers propose that a vicious circle is created in which the negative attitudes these nursing assistants feel about themselves and bring to their work are reinforced in the institution. The outcome is compromised quality of care.

Nursing Assistants may be more vulnerable to burnout than other nursing home staff because of their close and prolonged contact with frail elderly residents. Hare and

Pratt (1988) examined differences in burnout by occupation and work environment with a sample of 312 professional and paraprofessionals in acute and long term care facilities. They found paraprofessionals measured significantly higher on emotional exhaustion and depersonalization than professional nurses working in long term care facilities. This finding is supported by research conducted in Sweden which suggested that Nursing Assistants working with demented elderly residents were more at risk of burnout than either R.N.'s or LPN's (Astrom, Nilsson, Norberg, Sandman, and Winblad, 1991). Chappell and Novak (in press) examined the relationship between social support and stress with a random sample of 245 Nursing Assistants employed in long term care facilities in Winnipeg. Their findings suggest workload is the main predictor of burden, burnout and perceived job pressure. This study acknowledges that stress is related to the context in which the work is carried out and points to the need for organizational changes to reduce work related stress.

QUALITY AND THE DIMENSION OF 'PROCESS'

Assessing quality by examining process criteria or how the care is delivered is considered a more accurate measure of quality than structural indicators (Donabedian, 1982., Wright. 1988., Davis, 1991). A number of studies have suggested that care giving activities of Nursing Assistants

are hampered by a custodial approach to care and the use of rigid work routines (Bagshaw and Adams, 1986., Cox, Kaeser, Montgomery, and Marion, 1991., Ullmann, 1990., Brannon et al., 1988). In a study conducted by Schnelle et al.(1990) which investigates urinary incontinence in elderly residents it is suggested that Nursing Assistants perpetuated the rigid and routine approach to their work. The researchers observed that Nursing Assistants were not following the recommended two hourly toileting protocol and linked this to their adherence to an established routine and to time management problems. This study did not explore either how the routines came to be adopted or how they enabled the Nursing Assistants to do all of their work.

The concept of routine has been described as, "fixity in timing, place and sequence" (Albert, 1990, p.27). As a result of qualitative research of informal caregivers in the home, Albert (1990) proposes that a routine has a value to the caregiver. Individuals employed in human service work are well aware of the endless needs to be met. According to Albert (1990), a routine provides a border, or a beginning and an end by which caregivers measure their work and their mastery of the tasks. This is helpful in limiting the disruptiveness of the work to the household. Albert (1990, p.28) suggests routines sometime take on a "life of their own" and become more "ceremony" or "ritual" with the result that the routines are often more disruptive and oppressive

than helpful. When this occurs it may be difficult for the caregiver to see what has happened and an outside perspective is required.

Researchers have recognized the significance of the relationship between the resident and the Nursing Assistant, not only to resident satisfaction and the quality of care, but also to Nursing Assistants' satisfaction with their work life (Burgio and Burgio, 1990., Erikson, 1987., Garland, Oyabu and Gipson, 1988., Larsson and Starrin, 1990). Researchers have examined ways to influence the Nursing Assistants' interaction with the residents in order to improve the quality of the care. Pietrukowicz and Johnson (1991) tested the effect of using resident life histories and found that Nursing Assistants perceived residents as more autonomous and instrumental when life histories were available. Heiselman and Noelker (1991) developed in-service sessions for the Nursing Assistants to alleviate problems of mutual disrespect in the nurse-resident-family relationship. These studies were useful in promoting better understanding among care givers and care receivers. However, they do not help us to understand how the relationships between nursing assistants, residents and families were influenced by the other aspects of the organizational context in which these people lived and or worked. Diamond (1986) conducted a three year ethnographic study of nursing homes exploring the lives of residents and staff. He

contends that what happens at the bedside is influenced by broad political and organizational forces which are difficult to see because they are a taken for granted part of the context of the nursing home. Diamond proposes that to understand events in the nursing home, for example, the "routine" work of Nursing Assistants one must make visible the invisible, contextual forces which shape their work.

QUALITY AND THE DIMENSION OF 'OUTCOME'

Evaluation of quality of Nursing Assistant care by examining resident outcomes is considered the most accurate measure of quality and is closely related to the process of care giving (Donabedian, 1982., Davis, 1991). Learman, Avorn, Everitt and Rosenthal (1990) tested the effect of caregiver expectations on resident outcomes using a random sample. Nursing staff were told that certain residents were expected to do very well and these residents were assessed on a weekly basis. After ten weeks, it was found that residents assigned to the high expectancy group experienced decreased physical function but had fewer depressive symptoms and higher mental performance than the control group, suggesting that the staff's expectations had influenced them to act differently with these residents.

Cox et al. (1991) measured resident response to a new approach to nursing care which emphasized resident autonomy. The method involved the introduction of new policies at the

unit level to promote resident control. The study involved the development and implementation of a new care giving model in conjunction with the residents, different levels of nursing staff and the unit administrator. According to the findings, residents in the experimental group reported significant increases in their sense of well being and in the degree of choice in their lives as compared to the control group. This demonstrates that resident outcomes are related to how the care was organized at the unit level, a point taken up later, in the discussion of this literature.

QUALITY OF WORK LIFE

Nursing Assistants have long recognized the relative lack of quality of their work life. This is perhaps best demonstrated in their high turnover rates and the attention given by researchers to the phenomena of burnout. Studies using ethnographic data suggest why the turnover may be so high. Gale (1981, p.104), a Registered Nurse who worked as a Nursing Assistant, described how she developed, " a sense of uselessness, a feeling that good work went unrecognized, a notion that one did not need to display much intelligence, a sense of powerlessness, and anxiety about patients..." . Diamond (1986, 1992) identified low pay, the invisibility of the caring aspect of his work, and a subordinate position as significant characteristics of his two years' work as a Nursing Assistant. Other research suggests the work of the

Nursing Assistant offers low prestige and little respect, it is physically and mentally demanding with no opportunity to advance (Chenitz, 1983., Reagan, 1986).

'Quality of work life' is regarded as both a management problem and as a management tool. The assumption underlying this concept is that employees who are content in their jobs will provide a better quality of work. The most prominent approach to the issue of quality of work life of Nursing Assistants is one which offers some benefits for the staff but does not alter how their work is organized. Research on job turnover has identified rewards and personal recognition as needs expressed by Nursing Assistants (Garland et al. 1988., Caudill and Patrick, 1989., Grau, Chandler, Burton and Kolditz 1991). The suggestion was made by Garland et al. (1989, p. 379) that in return for an engraved plaque or a certificate of appreciation, the nursing home could have more satisfied employees and therefore enhanced quality of care.

Training is seen as a way to make the Nursing Assistant feel more valued; however, Wagnild and Manning (1986) advise caution as too much education results in ambitious Nursing Assistants who seek more challenging work. Several studies recommend that management provide support for the Nursing Assistants through such activities as employee councils, quality circles, and self-growth programs (Deckard et al. 1988., Goodwan and Trocchio, 1987., Erickson, 1987). These

are methods commonly used by management to help staff feel good about their work, to foster a group identity and to neutralize criticism (Parker, 1985).

A second and less prominent approach to quality of work life of Nursing Assistants calls for shifts in the organizational structure. Carter, Kooperman and Clare (1988, p.13) propose, "It is no longer cost efficient to view the nursing home aides position as a dead end job," and they recommend the adoption of career ladders. This view is supported by Reagan (1986) who contends that nursing home management need to provide opportunities for advancement for Nursing Assistants. Erickson (1987) suggests that because quality of work life when used as a management tool requires change at all levels, a move away from the traditional organizational structure to one which gives more authority and responsibility to Nursing Assistants is necessary.

'Quality of work life' is a management tool which is often attractive to Nursing Assistants because it meets their needs for such things as continued learning, personal recognition and a sense of belonging. At the same time, it is an effective method of soliciting employee cooperation in carrying out nursing home goals to achieve the best quality of nursing care (Erickson, 1987). The Nursing Assistant who, on having received a certificate of merit or a paid trip to attend a conference, considers she/he is obligated

to repay this reward with high quality of care even if it means self sacrifice and eventual burnout. Both management and Nursing Assistants may find it difficult to see the how 'quality of work life' strategies organize the work experience. The benefits of such management strategies for the Nursing Assistant are usually quite obvious. What is not clear to either the management or the Nursing Assistants are the problems inherent in using 'Quality of work life' strategies while not recognizing and addressing work issues. This suggests the usefulness of bringing the organizational context into view.

QUALITY AND THE ORGANIZATIONAL CONTEXT

The quality of care provided by Nursing Assistants has generally been examined in isolation of the organizational context in which their work is carried out. Some research, however, has pointed to the significance of the sociocultural environment as an influence on Nursing Assistants' activities and is, therefore, related to the quality of their work (Campbell, Knight, Benson & Colling, 1991; Tellis-Nayak & Tellis-Nayak, 1989; Chappell & Novak, in press). Golden, (1992, p.5) proposes culture is, "...not the cause of action but rather the context which predisposes humans to take or not to take certain action". From this perspective, the organizational context or culture will influence certain Nursing Assistant behaviors. Smith (1987,

p.183) views the context as, "... the generalizing social organization ...in which particular experiences are embedded". According to Smith (1987,p. 183), the social organization consists of a web of social relations "...in which what people do is already organized as it takes up from what precedes and projects its organization into what follows". Jackson (1984, p.8) describes these preceding or prior social relations as, "...the product of interactions that have gone before any particular individuals and which they inherit as the circumstances of their world". Social relations are often difficult to see because they are such a taken for granted part of the environment and because they are obscured by ideological procedures such as professional discourse (Jackson, 1984., Smith, 1987). To make social relations visible the researcher begins with the everyday experiences and traces these to back to the social and historical processes from which they emerge (Jackson, 1984., Smith, 1987).

In his exploration of life in nursing homes, Diamond (1986) links the experience of being a Nursing Assistant to social and economic policies. He suggests the nursing home environments are dominated by medical and business discourse which defines the work of Nursing Assistants in an objective, task-centered way. This leaves the real caring work they do unnamed and invisible because it does not fit into the language of business and medicine (Diamond, 1986).

According to Diamond (1990, p.1292), the real caring work includes the following, "...a special knowledge and skill and begins with being in touch with someone else's body, the emotional work of holding, cuddling, calming and grieving and the thought work of tending to one patient while thinking of another." Prior (1989, p.134) argues these social relationships are conflicting and antagonistic, reflecting the opposing social interests inherent in the organized production of labour. Thus, the activities of Nursing Assistants are organized by how they interpret these diverse demands on their time.

A dominant theme in long term care is the call for facilities with a homelike atmosphere which promote personal choice for the residents (British Columbia Royal Commission on Health Care and Costs, 1991., Seniors Advisory Council, 1991., Williams, 1990., News and Views, Juan de Fuca Hospital, 1992). Because of the extreme frailty of most individuals residing in extended care facilities, their ability to exercise choice often depends on the assistance of their caregivers. The Nursing Assistant becomes an extension of elderly people, enabling them to lie down for a rest, go to the toilet, or even complete such a simple act as getting a drink of water. The emphasis on personal choice as a criteria of quality of care in conjunction with the increased frailty of elderly persons admitted to long term care institutions means that Nursing Assistants must be

more productive to meet these additional needs. The need for a faster pace to complete the work is not immediately apparent as the nurse/resident ratio has not changed. When individual resident needs are not being met, it is often related to the Nursing Assistants' rigid routines and the custodial approach to their work which, it is suggested, can be corrected through training, changing their attitudes or better supervision (Bagshaw and Adams, 1989., Williams, 1989). Hinkley (1990, p. 16) argues that such corrective methods are doomed to failure because they assume that Nursing Assistants exist in a " performance vacuum". She proposes the entire nursing home system must be looked at including, "... staffing, supervision, peer pressure and management philosophy (Hinkley, 1990,p.16). Hinkley's comments suggest the actions of Nursing Assistants are shaped by a number of factors some of which are beyond their own responsibility. The quality of care then is influenced by the context in which Nursing Assistants work. By exploring the organizational context, it is possible to gain a better understanding of how Nursing Assistants come to act as they do in their daily practices.

DISCUSSION OF LITERATURE ON QUALITY OF CARE

Literature related to the quality of care and Nursing Assistants' work is dominated by research which examines Nursing Assistants' activities in isolation from the context

in which they occur. Regardless as to whether the research uses structural, process or outcome indicators to evaluate the quality of care the focus is on the behavior of nursing assistants. Their rate of turnover, their attitudes, degree of burnout, and training were examined with a goal to explain and improve the nursing care. This approach has met with limited success as evident in the studies of urinary incontinence. The conclusions in these studies suggest that the rigid work habits of Nursing Assistants, characterized by their refusal to assist residents to the toilet when scheduled, interfered with the quality of the nursing care. Schnelle et al.(1990) proposed the Nursing Assistants themselves imposed the routines. In contrast, Campbell et al.(1991) suggested factors in the sociocultural environment of the nursing home contributed to the development of the rigid approach. What is clear from my review of the literature which examines Nursing Assistants' work is that they are thinking people who plan how to organize their work, and who make choices as to which routines they will use. At the same time, there are multiple demands on their time which must be incorporated into their work activities and these demands structure and constrain Nursing Assistants' behaviour.

A number of other studies drew attention to the sociocultural environment both inside and outside of the nursing home as being salient to the quality of nursing care

and called for further study in this direction (Tellis - Nayak and Tellis -Nayak, 1989., Wright, 1988., Diamond, 1986., Grau et al., 1991). This research which recognizes the significance of the sociocultural environment represents an emerging view that Nursing Assistants' decisions do not occur in isolation of broader social, political and economic context. From this perspective the current environment of fiscal restraint in health care, the move to offer more long term care in the home and the increasing numbers of people over the age of 85 will influence how care is provided by the hands-on care giver. Research which explores the connection between Nursing Assistants "local" world and the "extra-local" world of legislation, policy and delivery systems will offer another way of knowing about the quality of care.

The notion of quality of worklife provides a way to think about the environment in which Nursing Assistants work. Much of the research concerning quality of work life suggested techniques such as recognition certificates and length of service awards as being successful in improving staff morale and therefore the quality of the care. Such methods do not consider the structural features of the work environment which affect the quality of the care. The significance of making substantive changes to the quality of Nursing Assistants work life by altering the organization of their work was recognized by Novak and Chappell (unpublished

manuscript) who proposed that workload be decreased. Other researchers suggest career ladders (Carter et al., 1988) and increased authority for Nursing Assistants (Erikson, 1987) as ways to improve the quality of their work life. What has not been explored is how 'quality of work life' techniques are interpreted by Nursing Assistants and how this shapes their work. Given that quality of nursing care remains an issue of concern even after many years of work life programs and after a great deal of research which focuses narrowly on Nursing Assistants' activities it seems that a different approach should be tried. Non positivist research, done from the standpoint of Nursing Assistants could shed light on the multiple forces which shape their work and the quality of care. Such an approach could help us to understand how it is that Nursing Assistants' work comes to be carried out in the rigid way that it has been described.

The problem of inflexible nursing care has not, to my knowledge, been explored using an approach which emphasizes the context of the work of Nursing Assistants. It appears that an inquiry which shows their work within its organizational structure may provide the most satisfactory way to understand the care giving process and how it is arranged within an extended care institution. The purpose of this research is to illuminate the forces which influence the decisions Nursing Assistants make, to explore the context in which they carry out their work. In this way,

insight will be gained into how it is that Nursing Assistants do and do not take certain actions. An understanding of the work Nursing Assistants do, from their standpoint, will offer valuable information regarding the organization which underlies the care they provide.

To research the problem of routine and rigid nursing care I would pose the question, "How do the activities of Nursing Assistants become structured into an inflexible routine and how do Nursing Assistants use routines to make practical sense of the demands of their work day?" The rationale for conducting such an inquiry is the potential to improve the quality of care if we can really understand how the problem comes about. My observations will include a detailed view of Nursing Assistants and their work activities. I will show how their work experiences are actively shaped by the background or context in which they take place and to which they are articulated. My purpose here is to present Nursing Assistants' work as it really is for them and to reveal the connections between the decisions they make in the course of doing their job and the multiple facets of the context of their work.

CHAPTER THREE

METHODOLOGY

This study was carried out using institutional ethnography a relatively recent addition to the field of research methodology (D. Smith, 1987., Campbell and Jackson, 1992., P. Boston, 1993). It is an approach which seeks to understand human behavior within the larger context in which it is embedded and in which it occurs. The primary goal of this method is to illuminate contextual features and show how they shape people's actions. This approach does not assume that humans are puppets acting without careful thought, rather, it holds that people respond intelligently to the complex of influences in their immediate and in their distant environment.

According to Dorothy Smith, (1987) who developed this method, the term institutional refers to the complex of social relations that make up the governing practices. Ethnography is the exploration, description and analysis of such a complex of relations (p.160).

Key to this method is the idea that everyday experiences are organized by governing practices, what Smith, (1987) refers to as "the ruling apparatus" (p.153). Smith describes the ruling apparatus as, "... consisting of varieties of administration, management and professional organization, interwoven by the multiple forms of textually

mediated discourse" (1987, p. 153).

The concept of social relations is central to institutional ethnography. According to Smith, social relations are the ongoing orchestration of everyday actions (1987, p.183). Everyday activities are organized by what has preceded them and, they project their organizing influence into the actions which follow (Smith, 1987, p.183). In addition to being a way of thinking about daily experiences, social relations is also a procedure for analyzing everyday activities as they are determined by the generalized and generalizing governing practices (Smith, 1987, p.160). (Also see G. Smith, 1990)

Institutional ethnography is non positivist or interpretive in nature. This means that it has as its underlying premise, "...that the social world has no existence independent of the activities and understandings of social actors, including the understanding and activities of the researcher" (Jackson, 1991, p.1). From this perspective, a primary participant in the investigation is the researcher who cannot be distanced from the research process. Rather than confound the data as would be the case in positivist methods, this interpretive technique depends on the active involvement of the researcher and acknowledges that her presence both alters the context and is in turn altered by it. This is reflexive understanding which both promotes and is necessary to the analysis (Hammersley and

Atkinson, 1983).

The researcher using the interpretive method seeks to make visible the ruling relations and the meanings people make of them in their day to day work. Groups of people organized for a specific purpose, such as Nursing Assistants, will adopt a set of social behaviors which are generated from their interpretation, and the meaning they make, of institutional rules. The researcher must become familiar with these behaviors, then look to the context for the rules and then back to the member's meanings to understand how the social behaviors came about. According to Rosen (1991), "The purpose of ethnography in general is to decode, translate, and interpret the behaviors and attached meaning systems of those occupying and creating the social system being studied" (p.12).

Traditionally, ethnographic research sought to explore and understand general forms of organization in foreign cultures. Now ethnography is used in many different ways and in Western industrial societies. Institutional ethnography's goal according to Smith (1987) is, "to explicate the actual social processes and practices organizing people's everyday world" (151). This research originates neither with the literature, nor a theoretical framework, rather, it starts with the every day experiences in the real world. In the case of this particular study, the starting point is the real work experiences of Nursing

Assistants employed within an extended care facility.

According to Rosen, (1991) who uses organizational ethnography as an adjunct to management, organizational ethnography differs from traditional ethnography in that it is often carried out by researchers who are themselves a part of the organization being studied. This applies to the study presented here. During the time I conducted the study I was employed with the organization in which the research was carried out. Although this offers some insider information it can also serve to constrain the researcher who may be denied access to certain information, may not be trusted by members who see the researcher as aligned with other groups in the organization, and who must be able to switch roles from co-worker to researcher (Rosen, 1991, p, 14).

I chose to use this research method for a number of reasons. First, the premise underlying institutional ethnography fits with my personal philosophy of the social world. According to Moccia (1989, p.3), "...it remains for nurse scientists to ensure that their scholarship and their activities as researchers reflect their philosophies and world views". Second, this method supports the purpose of my research which is not to control and predict what Nursing Assistants do, rather it is to construct an interpretation of their activities which accounts for how they conduct their work the way they do. To accomplish this I need to

pay attention to the social context in which Nursing Assistants work and the interpretive paradigm allows me to do this. Third, my study will be carried out from the standpoint of the Nursing Assistants, beginning with their experience, an approach to research that arises from the feminist critique of standard scientific positivist method (D. Smith, 1991). My analysis does not focus on feminist implications; however, it is important to see that my research is feminist in origin. This study is based on the view that knowledge building should begin with people's experience, a view which stands behind feminist research.

The qualitative research method which I have chosen differs significantly from mainstream scientific inquiry and should be evaluated differently. In quantitative research, validity is said to be achieved if certain criteria are upheld, for example, if the study shows that it measures the defined variables and if a representative sample is used. Validity is evaluated somewhat differently within the interpretive paradigm. Findings are considered valid if they account for the data in a plausible manner and if the research participants recognize their experiences in the analysis (Rosen, 1991). Guba and Lincoln (1981, in Sandelowski, 1986) refer to this as "credibility" and they suggest other readers of the research should also be able to recognize the experience when confronted with it. The notion of "fittingness" is proposed by Guba and Lincoln

(1981, in Sandelowski, 1986) as a way to assess whether qualitative research is generalizable. Study results are said to "fit" other settings, "... when the audience views the research findings as meaningful and applicable in terms of their own experiences" (Guba and Lincoln, 1981 in Sandelowski, 1986, p.36).

Reliability in quantitative research accepts that findings can be replicated by other researchers using the same methods and this is promoted as a way to feel confident about the validity of the findings. In non positivist qualitative research the emphasis is on variation in human experience and studies seek not to repeat previous work but to describe and account for different human conditions. While validity is not assessed in the traditional sense, another researcher given the data, perspective and situation should arrive at a similar conclusion for qualitative findings to be considered valid (Sandelowski, 1986,p.33).

The notion of objectivity which underlies quantitative data collection and analysis rests on the positivist perspective that the world exists as an objective reality. The goal of research supported by this assumption is to explain and predict behaviour; the researcher is interested in explaining theorized causal relations. It is important in this approach for the researcher to distance themselves from the phenomena being studied to avoid the researcher influencing the data. This contrasts with the qualitative,

interpretive perspective which views objectivity as a social construction. The goal of interpretive research is to understand the meaning of human events and how they come to be the way they are. This requires and depends on a closeness between participants and the researcher who must absorb their subjective meanings and learn, not only to make sense of them as the participants have done, but also to explicate the social organization of this "making of meanings".

THE SETTING

This study was conducted at a large extended care facility for frail elderly people, located in Victoria, British Columbia. I will refer to this extended care facility as Arbutus Manor. Arbutus Manor is a multi-site institution with four geographic locations. It has the capacity to care for 512 residents and employs a large number of Nursing Assistants who provide much of the direct care. Nursing Assistants are support staff who work in conjunction with a range of professional staff including: social workers, physiotherapists, occupational therapists, physicians, registered nurses, nutritionists, the chaplain and directors of nursing. Nursing Assistants also work in connection with many non professional staff such as dietary aides, housekeepers, reactivation aides, volunteers, paid companions, maintenance staff and resident's family members

and friends.

Arbutus Manor has a reputation both nationally and internationally as a geriatric center that offers excellent and progressive care. I was employed by this organization for eight years as a Care Coordinator so was known to many of the caregivers and administrative staff. My work experience in this organization provided me with insider knowledge of the policies, procedures, language and ways of doing things which enabled me to take better advantage of my researcher/participant activities. During the course of this research I carried out my scheduled work as a Care Coordinator, and collected data on my scheduled days off.

I communicated clearly to all of my co-workers when I was at the hospital in the capacity of a paid employee and when I was there as a researcher/participant. Although my research received official approval from the President of the institution and from the Research Committee I was prepared for some staff distrust of my activities during data collection. On only one occasion did I sense suspicion. My approach to this was to respect the person's feelings and opinions, to be open and honest with them about the research and my goals for it.

PARTICIPANTS

I refer to the members contributing to my research as "participants" as this reflects the active role they took in

this study. Participants include: ten Nursing Assistants, three Care Coordinators, two Directors of Nursing and myself as researcher. Each of the fifteen participants were informed about the study verbally and in writing, they volunteered to take part and each signed a consent. (see appendix one)

Confidentiality and anonymity has been promoted through the use of numerical codes on field notes, interviews and transcriptions of the interviews. The raw coded data has been available to only myself and my thesis committee members. At no time did I or will I discuss particular observations with other participants or non participants. In the writing of this thesis I have used pseudonyms to protect both the identities of the participants and of the residents with whom Nursing Assistants work.

The interactive nature of Nursing Assistants' work created a situation where non participants could not be totally isolated from the research, whether they were staff or residents. I was sensitive to this situation and have attempted to respect their need for privacy to the greatest extent possible. As in other feminist inspired work, the very act of paying respectful attention to traditional womens's work was also a powerful mechanism for easing my entry into this setting.

DATA COLLECTION

Data were collected through participant observation from a number of sources using active participation, observation and interviews. These sources include:

- 1) Nursing assistants. I worked as a Nursing Assistant, sharing the workload of eight of the participating Nursing Assistants. This enabled me to gain insight into what it means to do their work, to learn what is behind their activities and how they account for what they do. I also observed Nursing Assistants during their working hours and conducted in depth audio taped interviews with nine of them on their off duty time. Each interview lasted approximately one hour. Questions were exploratory and open ended to elicit their feelings, meanings and nuances about their work. (see appendix two)
- 2) Care Coordinators. I observed three Care Coordinators as they carried out their duties and as they interacted with and supervised Nursing Assistants. In depth audio taped interviews lasting approximately one hour were carried out with two Care Coordinators on their off duty time. Questions were exploratory in nature and related to their work of coordinating the duties of Nursing Assistants and their interactions with Nursing Assistants. (see appendix two)
- 3) Directors of Nursing. Audio taped interviews were conducted to learn their expectations and concerns about

Nursing Assistants and Care Coordinators. (see appendix two)

4) Documents. This refers to documents which guide the work of Nursing Assistants and Care Coordinators, in particular, records and lists which are required by the hospital to be maintained by the staff. These include the following: bath, float and bowel lists, shift routines, nourishment lists, dining room duties routines, the bowel and treatment records, nursing care plans, living care plans, communication books, anecdotal notes, incident reports, progress notes and performance appraisals.

5) Field notes. Throughout my participant observation I maintained field notes. Following each shift of either working as a Nursing Assistant or observing Care Coordinators I made notes about my activities, observations, feelings and about the talk I had engaged in. The field notes included comments and experiences volunteered by people within Arbutus Manor, primarily Nursing Assistants who, on hearing of my research were eager to share their stories and who were willing to have me use the information.

The data were not collected in the systematic way it has been presented here. I moved from one data source to another and back again to clarify information and follow up on hunches and nuances to "... 'see' organization in people's talk, and in the text of institutional documents" (G. Smith, 1990, p.644). The use of diverse sources over the period of several months enabled me to see the social relations which

organize the Nursing Assistant's everyday work. According to Rosen (1991) ethnographic data is longitudinal in nature and provides more than a snapshot view, "...it is a method of seeing the components of social structure and the processes through which they interact" (p.13).

SAMPLE

Sampling in qualitative research requires that attention be paid to the setting, the case and within cases, to the dimension of time, people and context (Hammersley and Atkinson, 1983).

My research was conducted at an extended care facility with four geographic locations within one city. Initially I planned to limit my data collection to one site to simplify the details of arranging for and carrying out the research. My reason for this was that, although each location appears unique in character, they are actually very similar, with the same type of work organization. While this remained the case, in the early stage of information gathering I became aware of emerging pressure points in Nursing Assistants' work world, specifically racial tensions and union activism. To obtain the most useful data I approached participants working at different sites where these trends appeared to be most established. When I completed my data collection the sample included participants from each of the four geographic locations.

The dimension of time in terms of the sample alerted me to be aware of the different activities, feelings and pressures experienced by staff at various time periods during their work. Data were collected for three months in 1992, throughout the months of August, September and October. While this time period fit my schedule it was also selected to capture the usual episodes of short staffing which occur during the summer months and the return to normal staffing which usually takes place in the early fall. According to Hammersley and Atkinson (1983) the researcher needs to observe the usual and the routine in order to obtain a sample that is representative of the work experiences.

The conditions of short staffing which commonly are limited to the summer months and weekends persisted throughout the time that I was gathering data. While this was an unusual situation, during only two of the eight shifts which I worked as a Nursing Assistant were we operating with less than a usual complement of staff. Thus, when I describe the activities I experienced and observed Nursing Assistants managing, it represents a typical workload.

Participants represent full time, part time and casual staff working days, evening and night shifts. When I was working as a Nursing Assistant, I worked three day shifts, four evening shifts and half of one night shift to gain an

understanding of their experience.

The people dimension directed me to include as many of the diverse characteristics of participants in the sample as possible. I obtained a mix of people in my sample to represent the diverse attributes of sex, age, race, length of service and experience among the population of Nursing Assistants. This made it possible to understand the multiple interpretations which emanate from the similarly organized work environments.

Morse (1986) describes three techniques for acquiring participants, the "volunteer", the "snowball" who is referred by a volunteer and the purposeful participant who is selected by the researcher. I have used each of these three methods in obtaining the sample. On hearing of my proposed research several nursing assistants volunteered to take part. Of those who volunteered some suggested other Nursing Assistants who would be helpful as they offered different perspectives such as being a fairly new employee or having a very long history with the facility. In addition, I approached certain participants and asked if they would take part in order to obtain participants representing the Care Coordinator and Director of Nursing roles within the organization, the diverse ethnic mix of staff, interest in union activities and varied length of service.

Morse (1983) proposes evaluating qualitative samples

according to their "appropriateness and adequacy". Appropriateness refers to the, " degree to which the sample fits the purpose of the study and adequacy means the completeness and amount of information contributed by informants" (Morse, 1983,p.184). Based on these criteria my sample was complete when I had sufficient data to answer my research question. In comparison to quantitative studies which often use large and random samples, the sample I used was small and purposeful. A small sample is necessary to gather data that is sufficiently in depth to enable me to explicate the social context.

The small samples used in qualitative research have been criticized for not being generalizable to a larger population. This reflects the statistical methods of generalizing used in the positivist approach to research. In choosing participants I was looking for people who could "represent" the experience of the work and the setting adequately from their own position in it. I was not attempting to aggregate opinions, to arrive at a statistically sound general account, as in positivist research. Rather, the purpose of this research, within the non positivist, interpretive paradigm is to understand behavior and to make visible the social context which influences it. Institutional ethnography views the embedded social relations which organize the everyday activities or the routine behaviors as the generalizing force (Smith,

1987). What is representative in this study then, is not the sample, but, the "...institutional relations which bring to light not only common bases of experience but also bases of experience that are not in common but are grounded in the same set of social relations" (D. Smith, 1987, p.176). My analysis uncovers and bring to light the invisible and taken for granted structures which organize Nursing Assistant's activities.

CHAPTER FOUR

NURSING ASSISTANTS' WORK: PARTICIPANT OBSERVATION

The intent of this chapter is to show what Nursing Assistants (NAs) in this organization really do. To provide a feel for their work and their work world I will recreate a typical day drawing on my own experience working as a NA and on a compilation of observations and conversations with the other participants. I am presenting an account from the standpoint of NAs, telling their story the way I have seen it, heard it and lived it. This chapter chronicles events on the day shift; however, it reflects a pace of work, lack of authority and structure which I experienced on each of the three shifts.

DEADLINE DERBY

One of the outstanding characteristics of NAs work is the degree to which their activities are scheduled. It is possible to know what duties NAs will be engaged in on any shift and on any unit, simply by knowing what time of day it is. This aspect of NA's work is related to organizational structures which have been developed over time to promote the smooth and efficient delivery of service; however, they also create a series of deadlines for NAs to meet: I present an outline of the main features of

the structure.

0700 - 0715 Sign in. Get report/instructions from CC.
0715 - 0845 Morning care. Get residents up.
0845 - 1000 Breakfast. Dining room duties. 1st and 2nd
coffee breaks for NAs (15 minutes each).
1000 - 1100 Bowel care and toileting residents.
Planned social events for residents.
1100 - 1200 1st and 2nd lunch for NAs (30 minutes)
Dining room duties.
1200 - 1245 Assist residents to eat. Dining room
duties.
1245 - 1315 Toilet residents and lay them down for a
rest.
1315 - 1330 Do charting and give report to CC.
1330 - 1400 1st and 2nd coffee break for NAs. Prepare
nourishment carts.
1400 - 1500 Do nourishments. Get residents up from their
rest.

It is 0655 hours on a mid summer morning as I walk onto the unit to begin another shift as a NA. This is my second day working as a NA and already the routine is becoming apparent. Paula, the NA whose work I will share, stands at the desk with several of her colleagues waiting their turn to sign in for the shift. Getting paid is a priority so signing in on the form used by the timekeepers to track the hours worked is the first order of the day. Paula tells me the first thing she does after signing in is check the bowel order list to see if any of her residents are scheduled for bowel care. It is the NAs' job on day shift to administer the suppositories and enemas ordered by the Care Coordinator (CC) as part of the bowel program. The bowel program is a protocol developed to manage constipation, a problem

frequently experienced by the elderly people residing in this institution. I observe how important it is for NAs, not only to check the bowel list, but also to give the prescribed treatment and to chart it. Bowel care is one of the rare aspects of NA's work which must be documented and it is monitored closely. CCs order the bowel care each day based on the information NAs document on the bowel record.

Enemas and suppositories are not usually given until after breakfast; however, Paula tells me she likes to know first thing in the morning which of her residents are scheduled for them because this allows her to think about how she will integrate these treatments with the rest of her work. It also enables her to use the knowledge she has of each resident's personal habits, likes and dislikes to their best advantage. For instance, Paula knows that one resident who is scheduled for bowel care does not like the procedure, and is usually able to move her bowels without treatment, so first thing in the morning as she helps this resident onto the commode, Paula suggests to her that she try and have a bowel movement. NAs also look at the bowel list first thing in the morning as a quick way to assess and plan for the type of day they will have. If enemas or suppositories have been ordered for two or more of their residents NAs know they are in for a hectic or heavy day. Sarah, another NA I worked with, told how bowel care can make for a difficult shift:

...If I see more than three bowel cares on my chart well, I'm going to have a hard day. I just know that my day is not going to be easy... It's easy to do three bowel cares but these residents are going to ooze stool all day, they are not going to eliminate everything... And so you are going to be busy cleaning stool all day.

Sarah has not elaborated on what is involved in cleaning up the results of bowel care. The words "picker" and "painter" have a unique meaning for NAs, referring to the habit some confused residents have of putting their hands into their stool, picking at it and smearing it on anything within reach, including their body, their hair, the furniture and the walls. It falls to the NAs to deal with this situation and leave a clean resident.

Paula and I smile when we note that only one of our residents is scheduled for bowel care; our day is off to a good start. Our mood changes suddenly when the CC tells us that Jill, another NA, has called in sick and a replacement has not yet been found. There is a collective groan among the NAs standing around the nursing station and I hear one say, "Not another day of working short." Working short means that NAs must look after the needs not of only their own residents but also "pick up" some of the residents of the NA who is absent. This increases their workload by two or three residents. The problem of short staffing typically occurs during the peak of summer holidays; however, this summer it has been particularly troublesome for a prolonged period of time and staff are becoming tired

and frustrated. Paula tells me of the negative attitude which immediately envelops her when the unit is short staffed and how she has to talk herself out of feeling this way. She describes a day recently when the unit was not only short staffed but she was the only regular or permanent NA on duty; the rest of the staff were on-call NAs. Paula was left to care for twelve residents, received no thanks or extra pay, and commented, "I felt like quitting that day".

Getting the laundry we will need for our days' work is our next activity. We gather all the clean linen needed for our entire shift, piling it on a trolley which we take from room to room, along with a hamper for soiled laundry which contains various bags to sort the dirty items into. The laundry at Arbutus Manor goes to various locations for cleaning and it is up to the NAs to sort and separate the items so they will be sent to the correct place. For instance, residents' personal clothing is usually washed at the hospital so these items are collected in one bag. There are exceptions to this as some residents' families or friends wish to wash the clothing at home, in which case they provide a hamper of some kind at the bedside. Another laundry bag is needed for towels and face cloths. All other linen can be placed in one bag except for the reusable incontinent pads which are collected in plastic bags. This makes for a confusing array of four laundry bags and a time consuming task of sorting the items correctly.

While collecting our linen Paula spotted a brightly coloured new bed quilt which she quickly takes because as she said, "it will make the room look pretty". Making each residents personal space look attractive and tidy is a habit shared by NAs and stands out as part of the work culture. Keeping a neat working area is also one of the criteria on the performance appraisal form used by the CCs to assess the quality of NA's work. When we have gathered all the necessary linen, plus a laundry hamper and the bags for soiled items we head for our section to start morning care.

On this particular unit there is no formal report for the NAs; only the CCs listen to the taped report and pass pertinent information on to the NAs. According to Paula, NAs used to listen to report but it was discontinued when it began to interfere with NAs getting their resident care finished in time to be in the dining room to start their breakfast duties. Getting to the dining room on time is uppermost in NA's minds as they do morning care. It is crucial to meet this deadline because their work involves not only assisting residents to eat, but also preparation and distribution of much of the food. The residents' meal depends largely on the NAs being there.

Some NAs miss having the report with all of the staff at change of shift and feel it was stopped because CCs did not like NAs drinking coffee while report was in progress. Other NAs are relieved they do not have to waste time

listening to information about doctors' calls and medications which they feel is meaningless to their work. On other units where I work as a NA, report is handled in different ways but in all cases there is an awareness of NA's use of time being critical. I was soon to gain first hand knowledge of the reason for this.

It is approaching 0715 hours as we enter the first room in our section. On day shift the seventy five residents on each unit are divided into sections consisting of six or seven residents with one NA assigned to each section. This level of staffing changes at 1300 hours when lunch is finished (on some units the change occurs at 1100 hours). Then two NAs, referred to as "floats" because they do not work a full shift and may move between sections, leave. The remaining NAs each pick up two or three more residents.

Paula tells me that we are in a section which is considered "light". "Light" refers to the workload and means the residents are not overly demanding or aggressive people, they do not all require a mechanical lift or two staff to transfer them and they are probably women. Men are generally considered "heavy" in terms of workload because of their larger size which makes transferring or positioning them physically more difficult. Also if they are inclined to be aggressive, they tend to, "pack a bigger wallop". Sarah describes what is meant by "heavy" workload:

Heavy means weight, time, lifting. They are very heavy

residents; they are combative residents; they will strike you. Instead of taking ten or fifteen minutes for you to wash up they will take fifteen to twenty because they are so combative. Plus you have to stop working, leave them alone for awhile, go on to someone else and then come back and try again, so they are hard on you in the way that they wear your patience down...

Whether assigned to a "heavy" or "light" section NAs work is physically demanding. As one DNU acknowledged "NAs can do up to forty lifts and transfers in one shift." Using a conservative estimate of each resident weighing 120 pounds, when a NA bears half of that weight forty times per day she is carrying one ton of weight in the course of doing her day's work. This does not take into consideration the strain of turning and positioning residents either in bed or in their wheelchairs. NAs at Arbutus Manor have the highest rate of Workers Compensation Claims within extended care facilities in the province.

Paula informs me that we have to be finished our resident care by 0845 hours to begin our assigned duties in the dining room. This gives us ninety minutes to complete morning care for the six residents in this section. I divide the six residents into the ninety allotted minutes and calculate this gives me approximately 16 minutes with each person. NAs who are in the sections with seven residents will have less than fifteen minutes to give morning care to each person and I wonder aloud to my partner how it is possible to accomplish the work in this time. Paula acknowledges it is a challenge and comments, "Just

think how long it takes you to get yourself organized in the morning, well I have to get six people who are old and slow, up and ready to face the day in one and a half hours - no wonder they feel rushed!"

The first room we enter has four residents and Paula tells me she usually begins with those who are able to move from their bed to a chair with the help of one person. Then she does the residents assessed as a two person transfer or lift and gets them all ready so she only has to interrupt another NA once to ask for help with transferring. A constant feature of resident care is that it is fragmented either by NAs having to assist each other with lifts or transfers or to search the unit for the appropriate mechanical lift. A frequently heard call in the corridors is the phrase, "can I get a lift?" *

NAs organize their work to minimize the comings and goings. Careful planning of how to do the work saves time for Paula and her colleagues. This is essential because assisting each other with lifts, transfers and positioning comes out of the sixteen minutes allotted each resident. Jessica, a NA who works evenings describes how giving lifts

* Since this research was carried out new electric lifts, the Sara and Maxi have been introduced. Although helpful, because they usually only require one person to operate, NAs must search for these lifts and wait until they are free. Now, instead of hearing the phrase, "Can I get a lift?", being called out by NAs, what is heard is the call, "Does anyone know where Sara is?"

increases her work and her stress:

You've got people always coming in asking for lifts which is part of the job and you've got to go and do but the pressure is always there to get everybody done and do the best job you can and let's not have any wet beds.

We begin morning care and follow Paula's usual approach of assisting residents who are one person transfers. This morning all of the residents are awake which saves time. If they are sleeping Paula tries to waken them gradually by making noise, and turning on the lights. In this way the residents have time to orientate themselves which tends to prevent the fear residents experience when wakened suddenly with someone touching them. I begin to "do" one woman, Mrs Astor. "Doing" a resident in the morning involves brushing their teeth or putting their dentures in, washing their face, hands, underarms, under the breasts (in the case of females), their perineal area and their buttocks. It also includes any treatment such as application of ointments or splints, dressing the person, assisting them onto the toilet and then onto their particular chair and finally, the finishing touch of combing their hair and making them look neat and well put together. I get a basin of water and offer Mrs Astor a face cloth so she can wash her face and hands. She is able to do this but her movements are very slow. While she is drying her face I wash under her breasts

and her underarms, then dry carefully. Next I wash her perineum area as she has been incontinent of urine and she smells from lying on large absorbent pads that are soaked with urine. I then turn her onto her side so I can wash her buttocks to remove the stagnant urine smell. It is a struggle to fold the soiled pads she is lying on in such a way as to avoid her rolling back onto the dirty part. This is difficult because I am holding her body into position on her side with one hand which leaves me only one hand with which to fold the pad. I can feel the strain on my arm and upper body as I bear the weight of Mrs Astor's body. This is a strain which I am to feel many times as I turn and position people in their beds, many of whom are very stiff, resistive or unable to assist in any way.

When I have finished washing Mrs Astor I partially dress her while she is lying in bed. I then bring a commode to the bedside and transfer her from the bed to the commode using a one person pivot method as stated on the living care plan which hangs at her bedside. While Mrs Astor is sitting on the commode I comb her hair, give her mouth care by wiping the inside of her mouth with a small disposable swab, put her dentures into her mouth, fasten her clothing, insert her hearing aid and put her sweater on her. Hearing aids come in a variety of styles and models and determining how each of them is worn and operates requires knowledge and skill. I say a silent prayer of thanks to the person who

created geriatric clothing as this makes it so quick and simple to dress the resident. Geriatric clothing is designed in such a way that it is split right down the middle at the back and has Velcro fasteners. A dress, skirt, pants or shirt can be put on easily from the front, without the resident having to stand or bend and stretch their arms, and it is then fastened easily at the back. The sweater is another matter. Mrs Astors stiff shoulder and elbow joints, combined with her mental confusion makes getting her arms into the sweater sleeves very difficult and I worry about hurting her arms.

The work is a painstakingly slow process and I am aware of the minutes ticking away. I am gaining insight into the frustration and resistance on the part of NAs when told by CCs or family members to dress a resident in regular clothing. When Mrs Astor is fully dressed and seems finished using the commode I transfer her into her wheelchair. It becomes clear that I need an extra arm if I am to wipe her perineal area because I need both arms to support her to stand during the transfer into her wheelchair. This is one of many times while working as a NA that I needed a third or fourth arm to do the job properly. Fortunately this resident is confused and does not notice I have been unable to wipe her perineal area. She is unable either to complain about what I have failed to do or insist I get help to wipe her bottom. In this way residents who

are confused can be easier to care for.

I now need to put the foot rests on the wheelchair as these are removed during transfer to provide more room to maneuver and to prevent injury. It is tricky to figure out which pedal fits on which side of the chair and how to lock them in place without hurting Mrs Astor's legs. I am bent over at an awkward angle struggling with the pedals and am beginning to perspire. It occurs to me this is what another NA meant when she compared "doing a resident" to having a 20 minute workout. I am aware that I have observed NAs doing this on many occasions in a seeming effortless manner. Throughout the shifts when I work as a NA I am struck by how difficult the work is physically and emotionally. It proves to be a greater challenge than I was prepared for because NAs make the work look so easy. Eventually I have the wheelchair legs in place and I cover the residents legs with a lap blanket, sort the soiled linen and empty the basin and put it away. I check my watch and see that I have used twenty two minutes to do one person, six minutes more than I am allowed and I have not made her bed. Mrs Astor is an easy resident who is pleasant, cooperative and does not have any special needs. At this rate I will never get through six residents in time to be in the dining room for 0845.

I approach my next resident, Mrs Black, determined to work more quickly. This resident has been quite ill and is remaining in bed on the instruction of the CC. I breath a

sigh of relief as this is one less person to get up and dressed. Washing and changing her gown goes smoothly, then I bring a commode over to the bedside and enlist Paula's help to transfer Mrs Black onto it. It would be easier and faster for me to give her a bedpan but Mrs Black refuses. She is adamant that she never has and never will be able to use a bedpan so we lift her onto the commode. As it turns out she is not able to use a commode either and as soon as we lift her back into the bed she soaks the linen I have just changed. I quickly change the incontinent pads again, turning her from side to side because she is too weak to turn herself. As I finish, Paula asks for my help with a lift and I check my watch and note that I have made the sixteen minute deadline but only because I did not wash Mrs Black again after she was incontinent. Also, I have had the benefit of Paula being in the room so did not lose time asking for and then waiting for a lift.

The resident I assist Paula to move is very awkward because she is bottom heavy, is limp on one side from a stroke and is being lifted into a large and cumbersome geriatric chair. We use a lifting sling which we hold under her buttocks with one hand while supporting her back with our other arm. Paula knows precisely how this lift works and has positioned the chair and given me and the resident instructions so everything goes very smoothly. I realize that if I was alone in this section without the benefit of

her knowledge and experience it would be impossible for me to complete the work in time. Being able to do the work quickly and efficiently depends on extensive knowledge of the residents and the equipment. When the resident is seated in the geriatric chair Paula pulls a foot rest into position so quickly that I am not able to follow her movements. Geriatric chairs come in an array of models with an assortment of options to meet individual resident needs. I am beginning to appreciate how much knowledge and experience NAs need to be able to competently assemble and operate them.

When the resident is settled in her chair I collect the soiled linen and Paula arranges the residents' personal belongings on the bedside dressers so they look attractive and neat. While she is doing this she comments that this is their home and she likes to keep the room looking as nice as possible. We have now finished in this room, with the exception of making the beds. Paula has done two residents while I was doing two. As we leave she checks her watch, notes that it is 0800 and tells me that we are ahead of schedule. All I can think of is that it has taken me 45 minutes to do two people and I feel like I have been going at a breakneck pace. Working by myself I would be lucky to get out of this room by 0845.

We make our way down to the far end of the corridor where we have a two bed room. As I enter the room it

becomes clear why this is considered a "light" section. One of the two women is already up sitting in her chair so this is one less person to do. This resident, Mrs Clark likes to get up very early, as soon as she wakens, so the night staff assist her. Each resident, like Mrs Clark, brings with them when they move into the institution, a life long pattern of habits, routines and preferences which they expect to be met because this is their home. In many cases these routines which seem simple and ordinary from the perspective of the resident are time consuming for the NA to accommodate, and conflict with the habits and preferences of the other residents in the NAs care. It is common for residents with time consuming habits to be labeled as "demanding" by the staff, yet the resident themselves do not feel they are asking for very much. For instance, one resident has a routine at bedtime that involves a series of simple things such applying lotions, putting on particular clothing, and positioning items in specific places which takes about thirty five minutes for the NA to complete. The resident talked to me about feeling rushed at times by NAs and she cannot understand why because she feels her needs involve only ordinary, everyday things and as she said, " It's not as if I ask for a lot". Brooke, a NA who works the 3 to 11 shift, describes the difficulty of caring for residents whose needs do not fit into the standard time available for them:

...Some residents need more time, or some residents simply need a slower, more gentle approach. There are some residents whose care is very straightforward and you can do them in fifteen minutes. The allotted time is supposed to be twenty minutes but that is very vague in reality because you have to go per resident. There are some who are very demanding and can take half an hour and there is no way out of it. If you don't take your half an hour with an ultra demanding patient you pay for it later on in the shift... because the person won't be comfortable, or they won't have all their fiddley little details looked after. You just end up going back every half hour or so when that person will ring and remembers, "Oh this little detail was forgotten or that little detail wasn't done right". So in that way you have to spend the time.

In my observation of NAs I noted they continuously use their knowledge of each resident's personal habits and needs to organize their work in such a way to best promote the happiness and satisfaction of each resident and their family members. Keeping residents content or putting a smile on their faces is important to NAs as Paula explains:

I know this is their last home or their last place and I feel like if I can make them smile or comfortable or just relaxed in any type of way that makes me feel happy and I know that I have accomplished something.

Paula sits down to communicate with Mrs Clark and must write everything as this resident is totally deaf. I approach the resident in the next bed, Mrs Durk, note that she is awake and make small talk with her while I arrange the supplies to begin her care. All is fine until I fold her blankets down. At this point she begins a caustic verbal attack on me which continues throughout her morning care. Mrs Durk's comments are clearly articulated in a precise and measured voice and focus on my lack of

intelligence and despicable character. One of her comments delivered in a pensive manner while I was scratching her back as she requested was, " I wonder why the almighty lets anyone as stupid as you continue to live." This is a side of Mrs Durk which I had never experienced in my capacity as a CC and I was taken by surprise because she has always been friendly, humorous and easy to please. I maintained a slow pace throughout her care knowing that I had the time and thinking that she must be in pain although she answered my question about pain with a verbal tirade against my intellect. Each time I had to move her or even touch her she launched a new verbal attack and I began to wonder what anyone within hearing distance must be thinking about my nursing abilities.

My experience with Mrs Durk is not an isolated instance. I observed both verbal and physical abuse directed against NAs on a daily basis. They talked about this being one of the most difficult aspects of their work to tolerate emotionally. The abuse is so common place that in many cases it is taken for granted as "just part of the job". As one CC commented, "It happens so frequently that if a NA tells me that so and so hit her or whatever I just kind of ignore it"

Finally I am ready to transfer Mrs Durk into her chair but I need help as I expect she might not cooperate. This places both of us at risk for injury. The room I am working

in is at the far end of one corridor isolated from other rooms and there is no NA in the vicinity so I locate Paula in the dining room. I am beginning to learn that looking for, and waiting for lifting partners is a large and time consuming part of NAs' work.

Paula and I transfer Mrs Durk into her wheelchair with no difficulty. Mrs Durk then seems to relax and she stops the verbal abuse. Paula informs me that verbal hostility from this resident is common during morning care and sometimes is accompanied by hitting, scratching and kicking. When this happens Paula asks the CC if she can leave Mrs Durk in bed. Paula, like all NAs, works under the authority of CCs whose instructions she is expected to follow. This means NAs must generally obtain approval from the CC for any changes to the usual or routine nursing care their residents receive. NAs expressed frustration at having to carry out nursing care which they know is not in the best interest of their residents. Karmen questions the rationale for pushing activation of these very old people:

I'm in this area everyday. I'm getting them up. Why can't I decide when they should get up? ...it's like we are here to save the patient... to rehabilitate and make them better and get them up every day and make them eat. I find with a lot of old school RNs that is their main motivation. Lighten up. They don't want to eat, just leave them alone, they don't want to get up just let them stay in bed. This gear to get everybody up and dressed in their monthly suits, what are we doing here...that's frustrating. CCs have authority over this. I know we want to promote independence but at 101 years old, give the woman a break. I feel like saying to this person, if this was you would you want

someone saying to you to get up and wheel yourself to the dining room? ...As a NA how much authority do we have to say no? I hate making them get up when they don't want to. I hate it.

It is now 0835 and Mrs Durk is sitting quietly in her wheelchair but there is the matter of her hair. She has very long hair which is looking extremely unkempt. I have no experience with long hair but fortunately Paula is here and within five minutes she has brushed and braided Mrs Durk's so it looks very tidy and attractive. By the time I sort the soiled linen and put away the basin and other supplies it is almost time to begin work in the dining room. I have done three residents in the time NAs must do either six or seven people. I feel that I have been going at a very fast pace and have hurried the residents as much as possible. It is apparent that if I am to get six people up and ready by 0845 I will have to work twice as fast. The pressures and frustrations of "working short" are beginning to take on a whole new meaning. I realize that under these circumstances I would have to care for eight or nine people. Given the time needed to assist other NAs with lifts and going to ask for a lift myself I would have less than ten minutes to get each of these eight or nine elderly people ready for breakfast. Paula told me of how stressed she feels when she is "working short". Under these circumstances she has to cut down on her care to the point where she is waking residents and within five minutes she

has them up in their chairs. This is also very stressful for the residents. Both quality of care and quality of work life suffer.

It is 0840 when I enter the dining room where residents are sitting and waiting for their breakfast. The dining room plays a large part in organizing the work NAs do because dining room duties consume so much of their time. The dining schedule stipulates where they must be several times throughout the day and evening. One NA described her job as being, "half waitress and half nurse". Without exception those interviewed found this aspect of their job the least satisfying. Another NA in discussing dining room duties commented, "Everything that no other department will do is dumped on us and is justified by saying it falls under 'related duties' in the job description."

The dining room duties are particularly important at breakfast when NAs are expected not only to feed residents, but also to prepare food. The hot cereal, bacon and eggs are cooked by kitchen staff. It is up to the NAs to set the tables (this is done by night staff for breakfast) to make the toast, the tea and coffee, pour the fruit juice, dish out the prunes, pass out the special meal supplements sent down from the kitchen and add milk and sugar to the porridge according to residents preferences. NAs hand out all of these items to each resident and then assist and feed those residents who require help. In addition, there are fifteen

to twenty residents who remain in bed for breakfast and their trays, which come from the kitchen only partly prepared, must be completed, then delivered and the residents fed if necessary. On several units it is the CCs who set up the dining rooms for breakfast. NAs must still meet the 0845 hour deadline to be able to complete the many tasks in the dining room. When the meal is over NAs clear and wash the tables and scrape and stack the dishes which are taken away and washed by the kitchen staff. Residents are then moved out of the dining room by the NAs.

While observing NAs doing their work in the dining room it is clear they are using a wealth of stored knowledge. Long term NAs know what has to be done and they are aware of each resident's preferences and habits along with successful strategies to enable or encourage them to eat. The NAs move quickly, from one piece of work to another. There is no need to stop and ask questions or to consult the various written routines, posted throughout the dining-room, which outline what has to be done. Each NA knows what the other person is doing and can tell what else needs to be done just by looking around the room. This is the kind of information and experience which contributes to a breakfast that runs smoothly, on schedule and leaves residents and staff feeling content. NAs who work regularly as opposed to 'casual' staff know how to make the meals run smoothly. Casual NAs, particularly those who are new employees, rely on the

regular NAs to explain what needs to be done and to answer their questions about written instructions and procedures. It takes time not only for the regular NAs to coach and teach the casual staff what to do but also for the casual NAs to learn. While the casual NA is learning the ropes and working in a tentative way, the regular NAs have to work faster to make up for this. Paula discusses the pressure she feels when working with a casual NA:

...It feels like you have more of a workload because you don't want to leave them sort of off on their own. I know what it's like to be casual, it's a scary feeling not knowing your residents. I just feel like I've got almost double the workload because you've got to get your work done and you have to be free for them to say, "what's this" or "what's that" and that takes a lot of time.

On this particular day I am assigned to deliver trays to residents remaining in bed and feed those unable to eat independently. Usually each NA assigned to trays feeds three or four residents between about 0845 and 0930. At that time they are expected to be back in the dining-room to help with the work there and to cover for NAs going to first coffee. This allows 10 minutes to feed each person, a very short time given the physical and mental frailty of many residents. The first person I assist is coping with advanced dementia and swallows very slowly and at sporadic intervals. Feeding him is a process which seems to take forever even using the techniques suggested by one of the NAs of putting something sweet on each spoonful to encourage

swallowing or giving him a small drink following each spoonful. NAs use a number of strategies to help residents such as this to eat safely, some based on personal knowledge of the individuals' habits, others based on what has worked well in the past with similar residents. After fifteen minutes I stop feeding this resident, leaving the remaining juice at his bedside before taking the tray away. I am aware that I have two more people to feed and only fifteen minutes left before I need to be in the dining-room again. Fortunately these two residents are in the same room so I can feed them together giving one a spoonful and while she is swallowing move to the other resident and give her a spoonful. In this way the work goes much more quickly and I do not feel like I am wasting time while waiting for one person to swallow. Feeding two or more residents simultaneously is normal practice particularly in the dining room where they sit in close proximity. NAs often position themselves between two residents who need to be fed and offer a spoonful of food alternately to one and the other, allowing each time to swallow. At the same time the NA would be supervising and coaxing other residents in the vicinity who need assistance. This way of assisting people to eat is how the work of serving meals to seventy five people and feeding those who need help is accomplished. Under conditions of short staffing NAs told me they cut corners by not taking the time to coax residents to eat,

giving less fluids and trying to rush residents by feeding them quickly.

It is 0915 when I finish feeding residents who received a tray and I enter the dining room where breakfast is in full swing. Approximately fifty residents and six staff are crowded into a room which looks spacious when empty. Residents are positioned in such close quarters that if one wishes to leave it is either difficult or impossible to maneuver past others.

I sit down beside a resident who has all of her breakfast in front of her and begin feeding her. While helping her to eat I make small talk with her and our conversation contributes to the noise level that seems to be reaching a crescendo. The room is filled with the hubbub of multiple conversations as residents and staff communicate with and between each other. Voices are raised for hard of hearing people. Instructions and questions are shouted across the room by staff who are busy feeding residents. NAs who are sitting close to each other discuss personal matters while coaxing and encouraging residents to eat. One NA asks a hearing impaired resident if she has had enough to eat and another resident two tables away answers the question. As NAs finish feeding people they begin clearing the dishes away so the sound of scraping and stacking of dishes is added to the din.

It is important for the dining room duties to be

completed by 1000 hours because NA's lunch breaks begin at 1100 hours and this gives them only one hour in which to do bowel care, toileting and an assortment of other duties. In most cases NAs focus on finishing in the dining room before going on to their other work. It is not uncommon to hear a NA respond to a resident who asks to go to the bathroom during a meal with the comment, "You will have to wait until I'm finished in the dining room". NAs know from experience that almost all residents want to go to the toilet immediately following breakfast; however, taking only one resident leaves many others in need. Leaving the dining room to toilet someone also means one less person available to help with the feeding and cleaning up when staff are already stretched thin. Toileting one resident during a meal may be at the expense of another being fed and this is not seen as fair. Finishing in the dining room is also important because this room is used for recreational activities and a gathering place for residents after meals so it must be cleared of dirty dishes. NAs who leave the dining room to tend to their residents before the room is clean are sometimes seen by their colleagues as not doing their share and getting a head start on their other work. CCs pay attention to NAs ability to organize their work to include the dining-room duties as this is necessary for the unit to run smoothly. They also monitor the number of NAs in the dining room for reasons of resident safety. Leaving

residents unattended while they are eating has serious consequences for potential choking and CCs will speak to NAs to correct this problem.

The dining room work must articulate with the schedule of the kitchen staff and NAs work to accomplish this. If employees from the kitchen come to collect the dirty dishes and find they are not stacked and ready it is difficult for them to get the dishes washed in time for lunch. NAs know this means they will not have enough clean dishes when it is time for them to set up the tables for the noon meal. NAs orient their activities in the dining room to ideas of fairness and efficiency and to their attention as a scarce resource.

At 0930 Paula tells me it is time for our coffee break. I have not finished feeding the resident but Paula tells me someone else will take over. We are assigned to first break which is from 0930 to 0945 hours and it is vital that we leave on time so we can be back to relieve those on second break. In my experience of working as a NA there is little flexibility as to when coffee or meal breaks can be taken. NAs for the most part adhere very closely to the assigned times and arrange their work to fit around their scheduled breaks.

By 0930 I am more than ready for a cup of coffee. I have been working non stop at high speed since 0700 attending to the most personal needs of six elderly people

and sharing in the work of feeding seventy five people. I have only put in two and one half hours but my body feels like I have done a full days work. When I comment on how I feel NAs confide that they go to bed with sore backs and shoulders and wake up with the same pain as a result of the heavy physical labour they do day in and day out.

We return from coffee at 0945 and finish cleaning the dining room and move residents back to their rooms. A reactivation aide passes us and reminds us that one of our residents is going out on the bus at 1030 and needs to be ready. While I continue with dining room duties Paula finds the resident, toilets her, fixes her up with the appropriate clothing and leaves her sitting by the elevator convenient for the reactivation aide. Getting residents ready to go on outings is part of the NAs work which they must coordinate with their other activities. It may only involve making sure the person has been to the bathroom but in many cases includes transferring residents into wheelchairs acceptable to public handicapped transportation, application of a lap restraint or assisting a resident into or out of a family vehicle. When residents return from outings NAs again attend to their needs.

The hour between 1000 and 1100 we are busy doing bowel care, toileting residents, and making the beds. In other "heavier" sections NAs are also laying residents down for a morning rest or getting up those who have remained in bed

for breakfast. Working as a NA means you are constantly getting people up or putting them to bed. I experienced this jack-in-the-box feeling when I worked a day shift on a different unit in a section considered to be an average workload. My partner and I helped four of our six residents up for breakfast. We put one of these people back to bed right after breakfast for the rest of the day, and another of the residents who had been in bed for breakfast was assisted into her chair with a Hoyer lift, a mechanical lifting device, for lunch. After lunch we put two of our residents who had been up for breakfast and lunch into bed for the rest of the day and the woman we had just lifted up for lunch using the Hoyer lift, was also assisted back into bed. Yet a different resident was laid down just for an afternoon rest and assisted up again later. Throughout the day, the NA in this section was also doing other lifts with colleagues who needed help.

Between the hour of 1000 and 1100 there are six or seven residents to be toileted, lifted out of bed or back into bed and this allows NAs ten minutes or less in which to see to the needs of each of her assigned residents. The fast pace is relentless and I wonder how it is possible to maintain a positive attitude day in and day out. NAs, CCs and DNU's are unanimous in valuing the quality of a cheerful disposition in NAs. It is an important part of the work culture for NAs, not only to wear a smile but also to put a

smile on their residents' faces. Paula discusses this:

...I always feel no matter how much stress you feel inside you never show it to these people because I don't think they deserve that. This is their home... I feel like it's important to me to give them a positive attitude.

Stress at work is a topic that every NA raised as an issue influencing how they feel about and how they do their job. Workload, working short and tense relationships with other team members have a powerful effect on NAs attitudes, and their success in presenting a relaxed and cheerful demeanor. As my experience illustrates, NAs must work collaboratively; however, good working relationships do not magically happen when people are put in close proximity. This is apparent in Leslie's comments, a NA who is non Caucasian and from a distant country. She must learn not only how to work in a different culture but also how to cope with racist team members:

... And there are people here who can't even work next to me. And if I happened to work next to them for two days I think I would give up. That's how I feel. It might not be that bad but I'm scared of them some times, really scared. The way they talk. The way they pass you in the halls, it just makes me scared...

It is now 1030 hours and Paula's resiliently positive outlook is evident as she goes about administering bowel care to one of our residents, Mrs Green, who is resistive to the idea. Mrs Green does not want to have the suppository prescribed by the CC, believing she does not need it. She does not even want to sit on the toilet to see if her bowels

will move without the suppository. Paula is able to soothe and coax Mrs Green with gentle, comforting words. During the next twenty minutes, between seeing to the needs of her other residents, Paula is able to transfer a reluctant but no longer resistive Mrs Green, onto the toilet, then off again, move her to the bed, transfer her onto the bed and give her a suppository, assist her up again and help her onto a commode and later help her off the commode. Paula's experience and skill in communicating, transferring, administering a suppository, and coordinating these activities with her other residents' needs results in a content resident who received the prescribed bowel care and had good results. Paula reports to the CC that, "Mrs Green had a suppository with three cups soft formed stool" and she documents on the bowel care record the time the suppository was given, the results in quantity and consistency and then she initials the record. Neither Paula's good humour, her physical effort respectful manner, nor any of the body of accumulated knowledge she used to accomplish "bowel care" is apparent in her verbal or written report.

On this occasion Paula was able to take more time to coax Mrs Green out of her resistive mood because she had the benefit of me sharing her work load. Normally she is under a time constraint which means she has to rush her residents to be finished by 1100 hours when she is scheduled to go for lunch. Paula and other NAs assigned to first lunch must get

away at 1100 hours so they will return at 1130 hours, to relieve NAs on second lunch. The NAs' lunch breaks must be finished by noon for them to be available in the dining room to serve and feed lunch which arrives at 1200 hours.

It is now 1100 hours and we leave the unit for our thirty minute lunch break. If any of our six residents need anything while we are gone it will be up to the remaining NAs to do the work. We return from lunch at 1130 and again begin dining room duties. The work at lunch is very similar to what we did at breakfast except there is less preparation of food for NAs to do.

At 1245 hours residents have been fed and the dining room is clean. We then go to our section and begin preparing our residents for an afternoon rest. This involves toileting the residents, then transferring them onto their beds. If possible, residents are positioned on their sides to give their buttocks a rest. NAs must be alert to the condition of residents' skin and prevent breakdown, an ever present danger for people who spend long periods sitting in one position.

NAs are supposed to follow certain protocols of care for example routine toileting of residents when they are assisted up and then after meals and after rest period. NAs claim to have little discretion over nursing decisions yet toileting is one protocol honored mainly in it's breach. As one NA remarked, "If I put each of my residents on the

toilet before and after breakfast and lunch I would be doing nothing all day but toileting". I gained first hand knowledge of what this NA meant when I worked an evening shift. My partner Brooke was assigned to a section with thirteen residents. Between the hours of 1500 and 1630 when trays arrived we assisted seven of the residents onto the toilet. Of the other six residents one was able to go to the toilet independently and the other five we checked and then changed them if necessary. Brooke focused on helping those residents to the toilet whom she knew to be continent most of the time. Residents who are generally wet are changed without taking the time to put them onto the toilet. Two of residents assigned to Brooke required two staff to assist onto and off the toilet, a very time consuming process. One resident asked me repeatedly to be taken to the toilet continuing the request even after she had been lifted on and off the toilet. Initially I explained to her that she had just been on the toilet and would have to wait until after supper. When the meal trays came I ignored her requests in order to feed residents their supper. Given their tightly scheduled time it is impossible for NAs to meet each residents request without taking away from the care another resident needs. They exercise knowledgeable judgment about following the policy of toileting residents before and after meals.

The work of toileting people is one of several aspects

of NAs duties that are physically strenuous. As an extra person on day shift with Paula I provide an additional pair of hands to help her. Paula comments on how nice it is to have me close at hand to help, not only with the lifts and transfers onto the commodes and toilets, but also with the positioning of residents. She describes how it feels to do the physical aspect of her job:

Your body gets really worn out...especially your back. It's a lot of heavy lifting and just wear and tear. Over time it gets to you and you feel like you are elderly yourself some days.

Physical labour permeated almost every minute of my day as a NA, often in unexpected ways. After a morning of very strenuous work it seemed a relief to be assigned to trays, a simple matter of feeding residents who remained in bed. While it was not as physically demanding it also did not provide the rest I anticipated. Before I could begin feeding a resident I had to move them into a position so they could eat safely. This involved putting my arms under the person and with my now tired body shifting them into proper alignment on their beds. Then I had to crank up the head of the bed. This meant crouching down and turning the crank with one arm if I was lucky, more often the crank was so stiff it was necessary to use both arms, increasing the strain I felt on my shoulders, back and upper arms. While assisting each person to eat I usually had to reposition them once, residents have a way of slipping and turning.

When I finished doing the trays I entered the dining room and began to help there. Sitting between two residents and helping them to eat simultaneously, required a constant motion of twisting and turning that I could feel in my back. While not painful, it was a reminder that even assisting people to eat necessitates physical labour.

NAs attempt to minimize the effect of the heavy physical labour yet still remain on schedule. They ask for assistance to move residents who are aggressive or have been assessed as a two person transfer. This accounts for the frequently heard phrase, "can I get a lift?" NAs are less willing to help with a resident who is known to be a one person transfer unless there are unusual circumstances. The person who has asked for help will likely be told the resident is a one person transfer or help will be offered grudgingly so the message is clear. This way of managing the physical work is more stringently applied during the peak rush periods when all NAs are under a great deal of time pressure. Amy talks about arranging her heavy work and negotiating for help:

...If my partner is in the room with me I'll try to do all my two person lifts first because otherwise she is going to leave and I don't want to call her back. We try to save time for both of us. Even for bed patients it's great if someone is in the room with you. If someone is there I'll say okay I'll help you with that person and can you give me help just to boost a resident up in bed? If I'm by myself I wouldn't get help for little things but they do count with your back and things. Sometimes you do take risks when there is nobody in the room. It's not risk but you do more and

you use your body more ...we know everybody is busy so if we can manage by ourselves, we know it is going to be hard, but we do it. Like if somebody is really sliding down in bed and I need a boost I'll try and do as much as I can and then later on I'll go back when somebody is there to give me a hand. So it's not like it's just me, others do the same thing.

It is now 1315 hours and we have finished settling our residents for their afternoon rest. The NAs who work until 1300 hours (known as floats) have now left so Paula "picks up" three more residents which means that from 1300 to 1500 hours she has nine residents to care for.

Once the residents have been settled after lunch, NAs "do their books" and give report to the CCs. "Doing the books" refers to the charting NAs are required to do on each shift. Resident care provided by NAs is documented on three pages, the bowel record, the treatment sheet and a general comments section. These documents are not located in the resident's chart, rather they are isolated into binders known as books. Each book has the records of six or seven residents, corresponding to the work sections of NAs on day shift. To chart, the NA takes her book and initials all treatments she has administered, initials the bowel record, recording all bowel care or bowel movements, then writes any pertinent details on the general comments page. The treatment and bowel record become part of the residents' permanent record but the general comments section is discarded at the end of each week. According to the residents' charts, the work Paula and I have been doing for

the past six hours consists simply of bowel care and the application of ointments to the skin of some of the residents.

After lunch the pace of work slows dramatically and I feel much less tension and pressure in the atmosphere. During this time NAs can often be seen spending some time with residents who do not lie down or chatting with each other while they sit and do their books. It takes very little however, to quicken the pace. If a new resident has been admitted, if one resident is sick or incontinent the high pressure persists throughout the shift. This feeling is intensified on days when NAs are coping with being short staffed.

At 1330 hours we leave the unit for our fifteen minute coffee break. On returning we prepare trolleys with the afternoon refreshments and about 1400 hours we begin to "do the nourishments". This involves the NAs on each corridor serving drinks and special supplements to their twenty five residents. The NAs work together moving from room to room offering fluids and assisting those who need help to eat and drink. At this time residents remaining in bed are repositioned and changed while those who were put to bed for a rest are assisted to get up, use the commode if necessary, and then transferred into their wheel chairs. On another unit, nourishments are given by the evening NAs who come on duty at 1400 hours. On yet another unit the evening NAs get

residents up from their afternoon rest. These differences between units represent individual strategies to manage a workload which I experienced as consistently heavy across the organization.

We finish nourishments at 1445 and for the last 15 minutes of the shift we clean up the supplies and leftovers refreshments, do last minute charting of recent bowel movements, report new observation to the CC and leave the unit precisely at 1500 hours. As suddenly as the hectic, fast paced day had begun, it now ends.

CONCLUSION

This chapter illustrates NAs' work. It shows their work to be fast paced and tightly controlled by an organizational plan of events which continuously directs NAs' actions.

I have identified knowledge, skill and experience used by NAs to competently accomplish their duties. These qualities which NAs apply in the normal course of doing their job identify a level of unique expertise which is not commonly associated with their duties. The notion that NAs' work involves expertise runs counter to the position they hold within the organization as care givers who provide the "basic" care. Understanding NAs' work as requiring unique expertise accounts for my struggle to do their work. My competence as a CC did not equip me with all of the skills

necessary to perform NAs' work proficiently. Thus, NAs have unique care giving expertise which is very valuable to the organization.

In this chapter I have also shown the lack of control NAs have over their work. NAs' duties are directed by the professional or management staff who hold the decision making authority. I will refer to the external control of NAs' activities as the top down method. This is a term which has been used by researchers to analyze how policies are implemented within organizations (Linder and Peters, 1987). I have chosen to use the concept of top down because it offers a broad framework for understanding how NAs' work is arranged. It encompasses, not only the flow of information from the top of the organization to the bottom but also, the distance between management situated at the top of the hierarchy and NAs located at the bottom. Top down provides a way to see the processes that control NAs work which I will discuss in later chapters.

CHAPTER FIVE

"A STRICT ROUTINE WITH LOTS OF FLEXIBILITY"

The description of NAs' work, presented in the previous chapter illuminates three dominant structures which influence NAs' work. These structures are the organizational schedule (outlined on p. 61), the authority of the professional model of care giving and the heavy workload NAs manage. In this chapter, I propose that inflexibility is built into NAs' work by these three structural features. The pressures exerted by the organizational schedule, the professional authority and their heavy workload constrains NAs' capacity to accommodate the many changes currently taking place within long term care. My argument will explore how it is that NAs come to be perceived by professional and management staff as resistant to changes they recommend, as rigid and as stuck in routines considered to be of their own making.

NA's work at Arbutus Manor will be analyzed in three parts in this and the next chapter. First, I will show documentary control of NAs work. Second, I will illustrate how inflexibility is built into NAs' activities through the structural features and indicate how this contributes to contradictions in the quality of care. In the next chapter I will discuss the barriers to mutual understanding created by the top down process and outline some troubles this has

created for the organization.

DOCUMENTARY CONTROL

The work NAs do is structured and managed, to a great extent, by documents. This is documentary control (Campbell, 1984). A variety of work routines, schedules and protocols comprise the documents which define the work NAs must do during the course of each shift. These documents reflect the management and professional standpoint, serving as vehicles through which to direct NAs' activities and to maintain control over NAs' work. They also serve to order NAs' work in a way that is not readily apparent to those people outside of the world NAs occupy. Over time, the ordering of the work routines which flow from the documents become internalized by NAs and other staff as, "the way we do things". The connection to the management and professional perspectives becomes less clear. What remains clearly visible are the work routines NAs follow and these come to be viewed as freely chosen, even personal characteristics of individuals.

Documentary control of front line workers is characteristic of a top down approach to organizing work and managing quality. This method has a long history within acute care hospitals and other human service organizations and now permeates long term care. (Campbell, 1984, 1992) Such a one dimensional and one directional method of

structuring care giving has profound implications not only for those people located at the bottom of the hierarchy but also for those persons situated at the top. A barrier is created between the professionals at the top of the organization who have the "expert knowledge" and the non professionals with "basic skills" at the bottom. The isolation between the groups contributes to a lack of understanding of how policies initiated from above are played out at the bedside. When quality is determined by the "expert" professionals, quality as defined by the "non expert" residents or NAs is excluded. As shown, in chapter four (see page 79) and later in this chapter, (see page 114) there is a discrepancy between quality determined by management and professional staff and how it is defined from the residents' perspective. It falls to the NAs to make sense of such conflicting demands and balance the needs of the organization with the needs of the individual resident.

"I JUST KNOW WHAT HAS TO BE DONE"

(THE INSIDER)

Most of the NAs who participated in this study had been employed with Arbutus Manor for one year or more. In doing their work and in observing them it was difficult for me to see tangible evidence of how these NAs knew what they had to do during their shifts. They came on duty and carried out their tasks in what appeared to be, on first glance, an

independent fashion. These were NAs familiar with Arbutus Manor, who could easily tell me *what* they had to do; however, they had difficulty in identifying *how* they knew what they had to do. In response to my questions related to this they would hesitate and answer, "Well I've been here so long" or "I learned on the job".

NAs familiar with Arbutus Manor seem to "just know" what to do. Their work experience has provided them with "insider" knowledge so it is no longer easy to reference the policies, rules and protocols which outline their work. The defining features have either faded, almost invisible, into the background or they are so much a part of the daily scene they are taken for granted. NAs' tasks then become isolated from the external structures which shape them and the routine in which they are "stuck" is viewed as being of their own making.

As a CC employed for several years with Arbutus Manor, I shared much of the insider knowledge and its taken for granted character. This challenged me, in my capacity as researcher, to see the link between NAs' activities and the outside forces which mold them. Newly hired, on-call NAs provided me with the means to understand the connection.

"WHERE SHOULD I BE AND WHAT SHOULD I BE DOING?"

(THE OUTSIDER)

Recently employed NAs have an entirely different way of

knowing what it is they are supposed to do. In many ways they do NOT know their work; they are "outsiders" engaged in the process of gaining "insider" knowledge. Observing this learning process illuminates how NAs' work is not only directed, but also organized by documents which embody the professional and management standpoint. Within this standpoint is a professional conception of quality which NAs implement. The authority of this perspective is maintained through documents. This will be illustrated through the experience of Nicci, an on-call NA, who is working her first evening shift (taken from my field notes and interview with Nicci).

Nicci, a newly hired NA walks onto the unit at 1440 hours to start her 1500 to 2300 hour shift. She has been employed with Arbutus Manor for less than a month and is feeling nervous. Nicci wants to do a good job and earn the respect of her supervisors and fellow NAs; however, she has experienced difficulty in completing all of her work. This evening she is assigned to a unit she has not worked on before so she arrives early to gain a head start. Nicci realizes that she does not know where she should be or what she should be doing so she stands awkwardly beside the vacant nursing station waiting for someone she can ask. A NA who is working day shift notices Nicci and suggests she join the other evening NAs who are sitting outside having coffee prior to starting work.

Based on my interviews (see Paula's comments on p.73) and observations I know that Nicci's arrival at the coffee table will be greeted with both relief and regret on the part of full time NAs. They will feel relief because they will not have to "work short" and regret because of the added pressure it places on them to work with an on call NA. Nicci's lack of insider knowledge means that she will work at a slower pace. In addition she will need to be taught the intricacies of the job. Both of these factors increase their workload.

At 1500 hours Nicci and her fellow NAs gather at the nursing station where they receive a brief report from the CC. Nicci remembers little of what she heard as she does not know any of the residents so there is no familiar name or face to which she can attach the information. Nicci is at a disadvantage in being able to do the job because she is not familiar with the residents, the staff or her duties.

Following the general report Nicci meets with the CC. who identifies twelve residents assigned to Nicci and gives her a report specific to these people. Nicci is informed as to who to leave in bed for supper, who to get up and which of her residents may be aggressive. Included in this report is the information that one of her residents, Irene Luke is going out for supper to her daughter's home and must be ready to be picked up by the Handy dart bus at 1600 hours. Nicci is also alerted to the fact that another of her

residents, Muriel Jonas, has a severe swallowing problem and must be fed slowly and only receive fluids that have been thickened. The CC reminds Nicci to chart the treatments and bowel movements for her residents at the end of the shift. Nicci feels overwhelmed with the amount of information she must remember to do her work. She writes her residents names, their room numbers and the special instructions given by the CC on a piece of paper which she carries with her.

The CC then instructs Nicci to read the shift routine which outlines her duties for the evening. Nicci learns from the shift routine the sequence of the tasks assigned to her for the evening. Her schedule is as follows:

1500 - 1510	report with the CC.
1510 - 1630	toilet residents, prepare them for supper and assist them to the dining-room.
1600 - 1615	coffee break.
1630 - 1730	dining room duties.
1730 - 1800	start evening care.
1800 - 1830	supper break.
1830 - 2130	evening care, when finished place soiled linen for pickup, chart, report to CC.
2130 - 2145	coffee break.
2200 - 2245	final rounds.
2245 - 2300	chart and report as necessary, answer call bells.

Another NA, Treena who is working in the section next to Nicci this evening shows her the bath and float lists. The bath list identifies residents who are scheduled to receive a baths during the evening, a duty performed by the bath NA. This alerts Nicci to have the resident ready for their bath and also means she will not have to wash them.

The float list informs Nicci that two of her residents will be settled to bed by the float NA who works until 2000 hours. This means that although she is responsible for twelve residents she will provide evening care for nine of those people. Nicci adds this information to the piece of paper she carries with her.

The one NA to twelve resident ratio is based on funding from the Ministry of Health which provides for 2.5 hours of personal attention for each resident per twenty four hours. The funding policy reflects an objective calculation of "need" not necessarily what either the NAs or the residents experience as needed and necessary. Nicci's time then becomes a scarce resource which she must divide fairly between her twelve residents and her assigned duties in a way that makes sense to herself, to her residents, and/or to their families and to the CC. The standard funding also assumes that all NAs have uniform skills and that all residents have identical care needs. This does not take into consideration Nicci's beginner status. She is expected to be as competent and productive as any other NA on the unit this evening. The reality is that she is not yet as capable so both the residents and her fellow NAs must absorb the difference. Added pressure and stress is placed on her colleagues who must help her complete her work and on the residents who will not have their usual care needs attended to.

It is 1530 before Nicci has received her report, gathered her supplies and located her section. She knows from the shift routine that she has one hour until supper trays arrive. In that time she must collect the clean linen she will use during the shift, check, change and toilet her twelve residents and prepare each of them for supper, have Irene Luke ready for the Handy Dart bus, take her fifteen minute coffee break and respond to any unscheduled resident needs.

Nicci first finds Irene Luke and takes her to her room to toilet her. In consulting the bedside care plan Nicci sees that she must use a two person transfer to assist Irene Luke on and off the toilet. Nicci locates her colleague Treena who comes to help her. While doing the transfer Nicci comments that she will never get all the toileting finished by 1630 when supper arrives. Treena advises her only to toilet those residents who are continent and names five of Nicci's residents who will need to be assisted to use the toilet, other residents will only be checked and changed if wet. Treena also gives her other helpful hints such as how to position a cumbersome Broda chair for easier transfer and how to cope with a resident who constantly follows Nicci seeking attention. This kind of experiential knowledge, which Treena as an insider has acquired, is essential to enable Nicci to be finished her toileting work in time to be available to assist residents to eat. Ability

to maintain the rapid pace established in NA's work by the scheduling of their tasks depends on Nicci knowing and remembering a great deal of information.

At supper time Nicci refers to the dining room duty list to learn her responsibilities. She is assigned to feed and supervise residents in the dining room and clean up after supper. Nicci does not know the residents, their diets, their individual capabilities or needs so she must continuously ask her colleagues for the information she needs to enable her to carry out her assigned tasks. Later in the evening Nicci refers to the nourishment list which informs her as to which snacks to give to her residents.

As a casual NA, new to Arbutus Manor, Nicci does not have the knowledge to simply step in and do the work. She has entered into a work world with well established work methods which she must learn. She does so by consulting an assortment of lists, written routines and staff members. In this way her activities are controlled throughout the shift and brought into compliance with the organizational rules.

As a NA, regardless of how long she has been employed, Nicci does not have the authority to decide her work, this is done for her by professional and management staff. The documents which she consult represent the knowledge and authority of a diverse group of professional staff whose authority direct and shape NAs work. These include management staff who allocate funds for nursing which

determines the number of residents Nicci must care for and who make organizational decisions such as the time for supper to be served; nutritionists who choose the diet residents will eat; physiotherapists who assess the method of transfer and the type of wheelchair to be used; clinical nurse specialists who develop procedures to deal with specific resident problems like anxiety or aggression; physicians who order treatments such as topical creams which fall into NAs domain and CCs who determine many of residents daily activities and to whom NAs are directly accountable. It is apparent that Nicci's tasks are largely prescribed by professional staff. These prescriptions are evident in the documents which Nicci refers to throughout the evening.

Nicci's experience illustrates how NAs' activities are structured for them. The link between the documents and how they define Nicci's work is very visible because she has not yet mastered the knowledge. It is possible to see her work organized by these documents into a routine that is so tightly scheduled Nicci has difficulty getting through them. To get back on schedule she leaves some of her tasks undone. When Nicci has acquired all of the insider knowledge she will no longer need to refer to many of the lists. The lists, but not the prescribed activities and schedules, will fade, forgotten into the background. Like other NAs familiar with Arbutus Manor she will have difficulty articulating how she knows what to do. As the documents

that direct her activities fade it will appear the routine she follows originates with Nicci. The link to management and professional control will be lost. The question will be asked of Nicci "Why is she so stuck in her routine, why is she so resistant to change?" The problem of being stuck in a routine becomes constructed as lying primarily with the NA. This is the problematic I am exploring in this study.

The fading of the written information into the background is not all that blurs the connection between the documents that define NAs tasks and the management and professional control. In most cases NAs themselves participate in developing, updating and revising the documents. The bath and float schedules, for instance, are continuously being changed on the advice of NAs. Their involvement, however, in the ongoing revision of "their" lists is seen by managers, supervisors and even by some NAs as an indication of NAs having authority over their work.

NAs use creative strategies to adapt the lists to accommodate changing resident needs and to divide the workload equitably. Their involvement in planning and organizing their assigned tasks should not be confused with having the authority to determine such work. NAs have no voice in deciding either the number of residents or the degree of frailty of the residents they will care for. Decisions of this nature are determined by higher level rules, policies and processes such as admission guidelines

and Ministry funding policies. It is up to NAs to cope with the workload given to them.

NAs demonstrate flexibility and creativity in coping with a workload they have no authority to define. They participate in rearranging the contents of the various documents which organize their work. For example, the section assignment list is revised periodically, such that the best use is made of their limited time for the benefit of the residents. This continuous juggling of the resident assignment to optimize their time is an instance of NAs' flexibility. What is not flexible is the boundary which restricts NAs' authority. NAs are allowed to participate in the revision the documents; however, this simply shifts their work, much like someone carrying a heavy parcel will move it from one arm to the other to relieve the pressure. It gives them no say in how much of a workload they must carry. In that regard, NAs' voices in defining quality of resident care are as silenced as are the residents' voices. Management and professional control stands intact behind the documents.

"IT'S THE SAME OLD THING DAY IN AND DAY OUT"

By the end of the second day of working as a NA I recognized a repetitive rhythm to my assigned duties. Paula, who was my partner for that day advised me, as had

her counterpart the day before, "the first thing we do is check the bowel list, then we'll get our linen and start morning care". We proceeded to carry out a series of activities which were almost identical to the previous day and indistinguishable from those that followed, irrespective of the particular unit on which I was working.

The repetitive nature to NAs' duties is related to the structure (presented in chapter 4) which organizes their work into a set of tasks. A series of documents then orchestrates these tasks to follow an established format. This is what Alexi, a NA, was referring to when she cautioned me to be prepared for, "the same old thing day in and day out". It is also what I heard reflected in the answers to my question when I asked NAs to describe a typical shift. NAs responded by taking a deep breath and reciting their daily routine in a monotone voice reminiscent of meaningless nursery rhymes chanted in childhood. Later I came to understand there is a strong parallel between youngsters singing nursery rhymes which do not express their childhood and NAs reciting a list of daily tasks that do not capture their work.

The repetitive rhythm which I experienced in doing NA's work and which is evident in their talk represents the tasks assigned to them via the documents described earlier. The tasks follow a format which does not vary from day to day and this accounts for the routinization of their work. The

routine can quite accurately be described as rigid and NAs can indeed be found to be "stuck" in it.

It is my contention that inflexibility is organized into NA's work by the controlling mechanisms intended to assure quality resident care. The contradictory outcome of arranging care that is standard and professional is that resident's unique, day to day needs receive less priority. Routines developed to assure a good standard of care interfere with NAs using their discretion to offer "homelike care" (see page 128). NAs' time is taken with implementing the directives of professional staff. As their workload has increased over the past four years there is less and less discretionary time available for NAs to respond to the human needs expressed by residents. This has implications for the quality of resident care and the quality of work life of NAs.

The documents which regulate NAs work originate from a mosaic of policies, protocols, rules and established ways of doing things. The entire mosaic of protocols and policies when taken together, make up an organizational plan which represents the standpoint of management and professional practice. This reflects the top down approach to conceptualizing, implementing and evaluating the quality of the service, a traditional method characteristic of bureaucratic organizations. The top down approach relies on mechanisms developed from the top of the organization to

structure and control the employee and the work at the bottom. In the case of NAs, control is maintained through routinization and professional monitoring of their work. The outcome, in theory, is quality that is standard and equitable for all residents. In practice, neither the residents with their diverse needs, nor NAs with their varied capabilities, fit easily into the preformed mold which results from the top down approach. In reality, the outcome becomes quality defined, for instance, as sixteen minutes per resident for morning care and ten minutes for feeding a resident. I refer to this as cookie cutter care, a method which requires that all residents and all NAs conform to a standard.

Assuring a high standard of quality is important and is a goal which the management of Arbutus Manor work diligently toward. Organizing quality from the perspective of the expert manager and professional excludes other expertise. NAs and residents hold expert knowledge in the day to day and minute by minute human needs some of which do and some of which do not fall into the professional category. Excluding the experts at the bottom of the organization in defining and arranging quality results in contradictions in the quality of care.

"NO ONE LISTENS TO US"

The concepts of control, compliance and measurement are

key to the top down approach to delivery of service. The use of routines offers a systematic way to control NAs work. Compliance to the routines is monitored by CCs, DNU's and CNSs (clinical nurse specialists). Quality is measured by NAs' compliance to the directives contained in the routines. On the one hand, deviation from the routine is considered by managers to decrease the quality of the care, on the other hand, managers want NAs to meet residents' individual and unique needs. NAs are caught in the middle of this contradiction. They are sandwiched between the routine imposed by the organizational plan and managerial authority from above and the diverse needs expressed by their residents which the routine does not acknowledge. It falls to the NAs to make sense of this discrepancy, to weave residents' fluid and individual needs into the rigid fabric of the organizational plan. This is what Brooke was alluding to when she described her work as involving, "a strict routine with lots of flexibility". Paradoxically, it is the flexibility on the part of NAs which results in care that meets individual resident and family needs. This is quality of care from the perspective of the care receiver. Accomplishing the flexible work necessary to deliver care from the perspective of the individual resident and family is difficult because it means going against the authority and the routine established by the top down approach. NAs vary individually in their ability to successfully weave

residents needs into the organizational fabric.

The following vignette is compiled from field notes and interviews and recreates a typical evening shift. It illustrates how NAs address the demand for flexibility in their work in the face of the structure imposed on their activities by the organizational schedule, their subordinate position within the organization and their workload. The workload refers to the number of residents assigned to each NA and to the unique needs and expectations of each resident and/or their family. The structures described above, that is, the scheduling of their work, NAs lack of authority and the heavy workload are an integral part of the daily experience of NAs, continuously acting and interacting to influence their behaviour. These structures shape NAs work in ways that are not readily apparent to the onlooker who observes a NA interact with one resident in isolation of their other work. This story will show how these structures control NAs work to such a degree there is little leeway for them to accommodate unscheduled needs. NAs must struggle to fit unpredictable events into their tightly scheduled day.

Jeff, a full time NA working the evening shift comes on duty at 1500 hours. He receives a brief report from the CC and is told there is nothing new about the twelve residents he is assigned to care for. He notes that two of his assigned residents will be settled to bed later in the evening by the float NA. He notes also that one of his

residents is receiving a bath at 1530 and will be put right into bed for supper. This means he is left with nine residents to give evening care to and settle into bed after supper.

Jeff next collects the linen he will need for the evening, loading it on a cart he takes with him from room to room. He has been working with this particular group of residents for three weeks so he has learned what linen he will require. At 1520 Jeff enters his section and begins to toilet the residents, transferring each person whom he knows has bladder control, on and off either the toilet or the commode. At the same time Jeff prepares the residents' beds for evening care. This involves turning the covers down, and placing the appropriate incontinent pads in the proper position so the bed will remain dry and clean if the resident should be incontinent of either urine or stool. Jeff is so familiar with the personal habits of the residents in his care that he knows, for instance, when and how much each person is likely to void. This is the type of intimate knowledge NAs acquire in the course of their close contact with residents. It is this information which Jeff uses in deciding where, how many and what kind of incontinent pads to place on each bed to contain the urine or stool and prevent soiled beds. Each bed is padded differently depending on the habits and needs of each person. This is contrary to the recommended padding routine

which suggests that a single method and a single pad is effective for all but a few residents. Intermittently, NAs will be reproached for their distinctive approach to the use of incontinent pads as being too costly to the organization.

Arbutus Manor is charged for the laundering of the incontinent pads according to the weight of the pads sent for cleaning. It is therefore possible for management to note a sudden variation in use and in cost based on the rise or fall of the weight of the soiled pads. During episodes of cost increase, NAs' padding methods come under closer scrutiny by CCs who are advised by their supervisors to monitor NAs more carefully. In addition, NAs are instructed by managers or a representative from the company which provides the pads how to pad properly for more efficient use. NAs, like Jeff, express frustration at being expected to follow standard padding guidelines which they know do not meet individual residents needs. The result for residents is lying in beds with soaked linen. The outcome for Jeff and other NAs is they must either do total linen changes on beds that are soaked or they must surreptitiously use pads the way they know is effective and more efficient. Here we see that being flexible means going against the established method and taking the risk of being reprimanded for not doing the work properly.

Jeff moves quickly from room to room, toileting some residents, checking and changing others, preparing the beds

for evening care. At the same time he is chatting with the residents and responding to a number of different requests. While busy with this work, he is approached by the husband of one his residents, Kate Jacobs who has just had a tub bath and has been put to bed by the bath NA. Mr Jacobs has come to have supper with his wife and is surprised she is in bed. He visits Monday, Wednesday and Friday and knows that her bath day is on Tuesday. He asks Jeff to get his wife up in her chair so they can sit together in the dining room. Jeff explains to Mr Jacobs why Mrs Jacob received a bath today instead of tomorrow her usual bath day. Her assigned bath time for the next day has been switched on this occasion with another resident Edna Windsor, to enable her to have a bath prior to her sixtieth wedding anniversary celebration planned for the next day. After offering the explanation Jeff suggests that instead of getting Kate up he will bring their meals to the room. Mr Jacobs is not happy with this idea. He finds the CC and talks to her about the situation with the result that Jeff is instructed by the CC to get Mrs Jacobs up.

Getting Kate Jacobs up changes Jeff's work in a significant way. Not only is getting her up an addition to his early evening work but now he will have ten residents to put to bed rather than nine. He knows that most of the residents in his section are exhausted soon after supper, including Kate Jacobs. Several residents vie with each

other for Jeff's attention wanting to be put to bed first because they are so exhausted. Now Kate will be added to this group of residents who jockey for Jeff's attention. She will be up for supper but the cost to her will be a tiring wait for help to get into bed. There is also a cost to Jeff. It will take all of his emotional and physical energy and skill to balance these competing resident needs. This is Jeff's sixth consecutive shift without a day off and he also is tired.

Jeff's workload on the evening shift is no less demanding than is the workload of NAs working the day shift. Under normal circumstances he will assist nine residents to bed between 1800 and 2100 hours when he is scheduled for his last coffee break. Discounting thirty minutes for his supper break, and dividing his time equally between the residents this gives him about sixteen minutes with each person. As shown in chapter four, the sixteen minutes must accommodate other aspects of NAs work such as assisting other NAs as needed, locating and operating equipment and finding necessary supplies. Jeff, like other NAs, knows well that the sixteen minutes must stretch to meet, not only the needs of his residents, but also the needs of their families. Edna Windsor's family has requested that she be bathed prior to her anniversary celebration and Mr Jacobs insists that his wife be up for supper. These simple needs expressed by family members demand that Jeff be flexible.

As a NA, Jeff is not a free agent who can choose to be either flexible or rigid. His time is so programmed by the schedule of events and consumed by the extensive resident needs that his degree of choice is limited. Getting Kate Jacobs up and putting her to bed again after supper will impinge on the care of his other residents. Their sixteen minutes of care will be further reduced, a point of contention for NAs who wish to be fair to all of their residents. Jeff's reluctance to get Kate Jacobs up is understood by the CC and by Mr Jacobs as Jeff being rigid. The influence on Jeff, his other residents and Mrs Jacob herself is not readily apparent to either the CC or Mr Jacobs.

It is 1615 hours when Jeff enters his last room. He must be finished checking and toileting residents and preparing the beds by 1630 hours at which time the supper trays arrive. Most residents receiving trays need to be fed and it is important to start on time so as to be available in the dining room at 1700 hours for the serving of supper to residents who are up. On entering the room Jeff notes that another of his residents, Mrs Stark, who is usually sitting in her wheelchair is lying on top of her bed fully dressed and sleeping soundly. Usually the day NA in this section gets Mrs Stark and other residents up from their afternoon rest. On occasion, when a resident is exceptionally tired like Mrs Stark appears to be today, she

will be left sleeping with the understanding the evening staff will assist her up for supper. Such is the case today. However, Mrs Stark is still sleeping and rouses only briefly when Jeff calls to her and says, "time to get up Desi". Noting Mrs Stark's fatigue and taking into consideration the fact that she is a heavy two person lift and that he already has nine people to put to bed after supper Jeff decides it would be best to tuck her into bed for the evening and bring her a tray at supper. This is a decision which Jeff as a NA does not have the authority to make. Desi Stark's bedside care plan notes that she is "up" for supper so Jeff must have any changes approved by the CC. He approaches the CC and explains the situation and asks if it is okay to put Desi right into bed. The CC advises Jeff to wake Mrs Stark and get her up for supper to provide her with social stimulation and to prevent her being awake all night. Jeff finds his partner Jamie and together they reluctantly lift Desi into her wheelchair where she sits like a limp flower.

Characteristics of the standard of quality care offered at Arbutus Manor are that residents are not left in bed unless a medical condition warrants it and they are provided with social stimulation. A culture has developed which views leaving residents in bed as being indicative of poor nursing care and laziness whereas quality care is assumed when residents are out of bed. The CC has followed these

criteria in directing the NA. From Jeff's standpoint, at the bedside with Desi Stark, quality on this occasion would have been achieved by leaving her in bed for supper. But, as a NA, he is expected to carry out the directions of the CC. Jeff's freedom to plan or alter his work and make decisions about the care is very limited.

This vignette shows how NAs become "stuck" in a routine, and paradoxically, how they create degrees of freedom in order to act flexibly. The routine is constructed by the organizational schedule to which their activities are tied, by their lack of time as a resource and by their lack of authority to make decisions. These features govern NAs work on a minute by minute basis, continually controlling their activities and their relations with residents and with other staff. NAs and their residents become mired in a regimen of care from which they must struggle to extricate themselves. Often, to do so, they must act illegitimately.

As non professionals near the bottom of the organizational hierarchy (second only to the residents) NAs wield little power. Neither does their knowledge and skill command great value or credibility in the decision making process within Arbutus Manor. Many NAs do not struggle against the organizational plan because to do so means getting in trouble. Refusing to follow the instructions of their supervisors is cause for either verbal or written

reprimand. According to Jeff, "Its the age old story, you never buck the boss."

Jeff's efforts to be flexible and offer individualized care were stifled. Leaving Desi Stark in bed is what she wants and what she needs at this moment. It reflects quality of care from her perspective but it does not fall into the organizational and professional plan for quality. Jeff is in a position with little authority so he must comply with and enforce the standard concept of quality of being up for supper. This is the right way to "do" quality according to the organizational plan and professional guidelines.

NAs experience a great deal of frustration and stress in having to adhere to this standard when they know it does not promote quality for their residents. Their close contact with the residents offer NAs a unique and extensive body of knowledge of the residents' most intimate behaviors, moods, likes and dislikes and changes. It is based on this kind of knowledge of Desi Stark that Jeff wants to tuck her into bed and bring her a supper tray.

The top down method of conceptualizing and planning quality does not readily accommodate NAs knowledge. NAs' voices at the bottom of the organization are largely ignored. As Sonia, a NA with many years of experience in geriatrics comments, "No on listens to us." The cost of not listening can be seen in NAs' stress, their frustration and

even boredom at having to do "the same old thing day in and day out". The quality of their work life is compromised by the stifling of their knowledge and abilities. Restricting NAs to following professional and management instructions by rote contributes to a limited definition of quality that does not readily accommodate either the NAs or the residents perspective.

The cost of the top down approach can be seen in Desi Stark, asleep in her wheelchair, her head resting on her lap. She provides a living portrait of the discrepancy between quality as it is understood and planned for by the professionals extra-locally and quality as it is expressed and experienced locally by residents and their care givers. Jeff's ability to respond to Desi's need to stay in bed, is constrained by his lack of authority. Desi and Jeff share a subordinate position at the bottom of the organizational hierarchy which is inextricably linked by their lack of professional or managerial power. Residents' individual needs and NAs' capacity to adapt their work to respond to such needs are stifled.

CHAPTER SIX

"NO ONE REALLY KNOWS WHAT WE ARE UP AGAINST"

The top down approach to organizing service delivery relies on the organizational scheduling of events, on documentary control, and on the assumption that professional knowledge can be tied to routines to assure that NAs provide quality care. As shown in chapter five, such a method impedes flexible care giving processes which diminish NAs' capacity to use their judgment in responding to unplanned, fluid resident needs. Such a process also contributes to the development of a barrier between management at the top of the organization and those employees at the bottom. This barrier seriously limits the understanding which management and professional staff have of the troubles NAs face in their day to day work.

This chapter explores the troubles experienced by NAs which I propose arise out of the interaction between the traditional way their work is structured and today's evolving long term care environment. Understanding the difficulties NAs face is the first step toward making meaningful changes to the quality of their care and the quality of their work life.

The section "Tale of Two Worlds" presents the problems which grow out of NAs' isolation and powerlessness at the bottom of the hierarchy. Under the heading, "It's No Longer

Grandma and Grandpa Coming to the Nursing Home With Their Walkers" the troubles NAs experience related to the changing long term care policies are addressed.

"TALE OF TWO WORLDS"

One of the most surprising revelations while working as a NA was the isolation I felt from other employees, particularly professional staff. My duties as a NA were carried out in a world that proved to be very removed from the one I occupied as a CC. Indeed, I was hardly aware of the presence of CCs or other professional staff when I was working as a NA. With the exception of brief moments at the beginning and the end of the shifts, or when a CC asked me for information, my path as a NA would rarely cross that of the CC. I wondered why CCs were so invisible to me while I was a NA because, in the capacity of a CC, I had always felt very present to NAs. NAs explanation for this was, "They have their work to do and we have ours."

"Their work" and "our work" represents the division of formal care giving into the categories of professional and non professional. The separation of the professional and the non professional duties is so well defined CCs and NAs operate like distinct societies. Although they work in close proximity each group providing resident care, they move in parallel paths which rarely cross. The isolation between these two groups of care givers is so complete they

know very little of each others' work. This leads to such comments from NAs as, "CCs do nothing but give pills" and from CCs, "NAs waste a lot of time standing around talking." The rigid division of labour creates an immense barrier to an open exchange of knowledge between NAs and CCs and to an understanding of each others' work. The barrier looms even larger for management who are further removed from the day to day events of NAs. This means the work NAs do is not well understood within the organization.

The separation of care giving work into professional and non professional categories promotes an image of NAs' work as being basic and simple. The performance of NAs' tasks is perceived by professional and management staff as an easy matter of following the instructions set out by the professionals. NAs themselves accept the view of their work as being less valuable than that of professional staff. This is apparent in the frequently heard comment, "I'm only a NA." The perspective that NAs' work is rudimentary develops out of the division of labour and does not fit with what I learned that NAs actually do. As shown in chapter four it requires skill on the part of the NA, Paula, to communicate with a confused resident in a sensitive manner, enabling her to administer bowel care. Experience is needed by NAs to assist residents with swallowing difficulties to eat safely. In addition, operating the myriad pieces of geriatric equipment competently and quickly requires

proficiency. The skill and experience necessary to carry out these activities competently is neither simple nor basic; it is expert knowledge.

The labeling of NAs' work as non professional obscures the complex activities they engage in to provide resident care. The distance between NAs and CCs further supports the assumption that NAs' work is limited to performing the tasks assigned to them. It was only in getting close to and doing NAs' work that I began to see the knowledge and skill they exercise routinely to accomplish their duties. I have given the names of "team work", "body work", "emotional work" and "intellectual work" to some of these unrecognized aspects of NAs' work which they perform as a matter of course. Below, I briefly indicate how I saw these kinds of work, not as basic, but as different sorts of expertise.

NAs cannot carry out their work effectively without good relationships with their colleagues, the residents, their families and the other staff at Arbutus Manor. Positive healthy relationships with these groups of people is at the heart of the hands on care giving work which NAs perform. Such alliances form the basis for enabling good resident care. Developing these relationships involves interpersonal and communication skill on the part of NAs, what I call "team work". The heavy physical labour NAs must perform contributes to a cumulative wear and tear on their bodies and accompanying fatigue which I refer to as "body

work". People must know how to use their bodies effectively to get the work done and to remain healthy. "Emotional work" is necessary to enable NAs to cope with the stress of their workload, aggressive or irritable residents as well as to enable them to present the cheerful disposition they feel residents deserve. NAs' activities depend on their "intellectual work". They routinely conduct very skilled intuitive communication with people who have difficulty verbalizing their needs. NAs coordinate residents' needs with organizational demands, continuously weaving one in with the other. They plan their work to make the most efficient use of their limited time, to "make time" that really is not available to respond to unpredictable events. NAs learn from experience how to manage all this. This is "intellectual work" which NAs perform on a daily basis.

The knowledge and skill identified in these four areas of work is essential for NAs to perform their assigned tasks. It is also key to enabling NAs to respond to unique individual residents' needs, that is, offering flexible care. The quality of resident care is therefore conditional upon NAs' success in completing this invisible work. NAs know this and struggle to fit the work into their schedule. Failure to acknowledge these aspects of NAs' work and to provide organizational support for them compromises the quality of care. It also contributes to strained relations between NAs, their supervisors and management.

Problems arise for NAs as a result of the lack of understanding on the part of professional staff of both the recognized or assigned part of NAs' work and their unrecognized work. NAs' non professional status and position at the lower end of the organizational hierarchy affords them little power to define or control their work. NAs are accountable to professional staff who plan and monitor their tasks yet do not comprehend much of the work NAs do. This places additional stress and pressure on NAs who must balance the expectations placed on them by their superiors with the work they themselves know is necessary to provide quality care. As I have argued, NAs are experts in doing their job; however, their expertise remains undervalued, carries little authority and is underutilized in planning and organizing care. The rapid transition taking place in long term care is demanding new approaches, including looking to NAs for higher commitment to the organization.

**"IT'S NO LONGER GRANDMA AND GRANDPA COMING TO THE
NURSING HOME WITH THEIR WALKERS"**

In this section, I will illuminate recent changes in NAs' work related to the evolving long term care environment. I will show that NAs have adapted and continue to adapt to dramatic changes in their work. The purpose is to show how the challenges facing Arbutus Manor cannot be resolved by efforts to more successfully control and

structure NAs' work.

Arbutus Manor operates within a long term care environment which is changing rapidly. The new policy focus on home care, increasing fiscal restraint, the philosophy of homelike care in the institution and an increasingly frail clientele is placing the organization under enormous pressure. Not only must management accommodate to the changes but they are required to do so with unpredictable government funding. Senior management is charged with providing a quality service with "surprise funding" (described on p. 4) and doing so for a clientele whose needs have dramatically increased.

The solution to this dilemma within a top down model is to focus on the care givers. The assumption is that quality can be maintained or enhanced by increasing their education, better supervision, direction and improved work methods. (see for instance, Block et al., 1987., Campbell et al., 1991., Cox et al., 1991., & Linn et al., 1989.) This thinking is apparent in the recent increase in NAs' formal education through the community colleges from three months to five and in the in-service education provided to NAs at Arbutus Manor. It can also be seen in the workshops offered to CCs in the past year to increase their leadership and supervisory skills. It is my contention that while ongoing education and learning are necessary for NAs, these measures alone do not provide solutions to the problems. Rather, by

placing the onus for change on the care givers they add to the troubles NAs are experiencing. The need for systemic changes to support NAs in their work goes unheeded.

The pressures felt by management are also being experienced by NAs. Perhaps no one understands the implications of the changing long term care industry better than the hand-on care givers. As has been argued earlier, the top down approach to organizing care isolates management and professional staff from meaningful understanding of the NA's experience. This impedes the ability of management to see what recent policy shifts mean to NAs' work and quality of care. As the largest group of formal, hands on care givers in the long term care industry, NAs make a significant contribution to the quality of care. To be successful, organizational planning to promote continued quality of nursing care in the face of the policy changes must consider the reality of NAs work and how it is being altered.

It will come as no surprise to anyone associated with long term care that the acuity level of the residents classified as extended care has been dramatically transformed in the past few years. This was expressed succinctly by Karmen, a NA who commented, "It's no longer Grandma and Grandpa coming to the nursing home with their walkers". Karmen's remark carries with it many implications that are not immediately apparent. Residents currently

being admitted to Arbutus Manor are much more alike in their level of dependency than they used to be. Whereas five years ago a NA's assignment would include a mix of residents with two or three who were fairly independent and three or four requiring more help, now all residents have very extensive care needs. It is now very rare for a resident at Arbutus Manor to be able to transfer from bed to chair or from chair to toilet independently. Many residents require either two NAs to transfer them or a mechanical lift. This adds to the workload in that it consumes the time of two NAs or time must be spent by one person to locate the mechanical lift, then attach and detach it from the resident. Special geriatric chairs are now used frequently to enable very frail residents and those with particular needs to sit safely. These chairs are large and cumbersome to work with. It takes time and skill to maneuver them in the confined spaces resident rooms, their bathrooms and the dining rooms which were designed with the typical grandparent in mind rather than the typical resident. The advanced mental and physical frailty of the typical resident means many cannot feed themselves and experience swallowing difficulties. Assisting these elderly people to eat safely is a slow process requiring expertise and time. Nursing time is something which has not been increased. Job satisfaction is on the decrease and burnout is on the increase.

While care needs of residents have expanded, the ratio

of NA to resident has remained constant. Nicole, a CC, remarks on this, "...in eleven years the workload has increased tremendously. The aides' workload, with their charting and you know...I can remember when half the residents on the unit used to do a lot for themselves. Staff numbers have not changed." NAs have adapted to this change in their workload in a number of ways. They are working faster, at a pace which I experienced as breakneck and which allows little opportunity to communicate with the residents. As Jessica, a NA told me, "I come on duty and its just go, go, go the whole shift... there's no time to listen to residents...I have to tell them in mid sentence that I have to leave." NAs cut corners by toileting only those residents they know to be continent. Although there is no formal toileting program there are toileting times scheduled into the shift routines of before and after meals. There is also an expectation that NAs will toilet residents on demand. Neither of these rules specify they apply only those residents who have consistently demonstrated continence. This is an interpretation NAs make to manage an unmanageable workload. To conserve time NAs will take risks of lifting residents without using a mechanical lift and positioning residents without assistance. Some NAs are cutting short or missing their rest breaks to complete essential duties. It is common for NAs to provide extra nursing care on days off. NAs do shopping for residents,

provide the comfort of a favorite home cooked food, purchase small treats which they know residents will enjoy and take them on outings all on their own time. This is luxury nursing care for which there is no time in NAs' schedule.

UNION ACTIVISM

My field work indicated that NAs are increasingly turning to their collective agreement to gain some control over what they are experiencing as an out of control situation. As discussed in chapter four, NAs' workload has intensified dramatically and they must manage very heavy work demands. NA's experience of this work and their expertise in coping with the demands receives minimal attention from management as illustrated by the comment made by a NA that, "No one listens to us". The union, on the other hand, pays close attention to NAs' interests.

The Hospital Employees Union serves as a resource to which NAs can turn. The union organization attends to NAs' concerns and advocates strongly for its members. This support contributes to NAs feeling they are valued.

NAs' rights as Hospital Employee Union members are documented and legally recognized. This affords NAs a source of power within the organization which must be respected. Some NAs are using their union status to try to cope with the problems of increasing workload, criticism of the quality of their work, short staffing and violence.

Union activists among NAs now commonly lodge formal grievances in response to these occurrences. The target of many of these grievances are CCs. For instance, under conditions of short staffing, the CC may have a grievance filed against her if she fails to reorganize and decrease the work NAs are expected to do and communicate this to them. The result is a confrontational NA and CC relationship which dramatically increases the stress of an already stressful environment.

The strategies being used by union activists do not have the support of all union members. This means that not only are NAs being pitted against CCs, NAs are also pitted against each other. These groups remain embroiled in bitter clashes using their energy and resources while the issues of concern go unresolved.

Senior management is largely isolated from the reality underlying both NAs' concerns and their union activities. Their remote position impedes their understanding of NAs' work and of the issues of concern to NAs. Thus NAs and NAs' work as well as their knowledge remains undervalued within the organization. This interferes with the underlying problems being effectively addressed and the development of smoother union-management relations.

My analysis indicates that union activists are using strategies with a very narrow focus. The HEU actions are targeting the internal relations with professional and

management staff at Arbutus Manor. Union activities which are directed exclusively within Arbutus Manor fail to communicate their concerns to the Ministry of Health. As the body which allocates funding to Arbutus Manor, the Ministry of Health needs to be aware of NAs' contribution to long term care and of their concerns.

RACISM

Leslie, a non Caucasian NA explained to me that she was fearful at work, afraid of the hostile looks her colleagues gave her as they passed her in the corridors. Amy, also a non Caucasian NA, described the emotional pain she felt when residents told her they did not want her looking after them. Another non Caucasian NA is a specific target of a resident's planned physical attacks. These are harsh instances of the growing problem of racism within the work world of NAs.

The nature of NAs' work is such that there is an ongoing turnover of people necessitating an almost continuous need for new employees. Increasingly, immigrants to this country are filling this need. The community college actively recruits immigrants to enter the NA training program by offering a special "English as a Second Language" course for the program. The current economic recession makes this offer attractive to newcomers who often are unable to find employment in their own field of work. Once they have completed the course they are almost assured

of full time employment in the long term care industry. The outcome is evident at Arbutus Manor where there is a diversity of NAs who represent a variety of cultures and languages. As my data suggests, the diversity creates tensions in the workplace.

The inter cultural tensions among NAs and between NAs and the residents is a problem in itself but it also leads to even more troubles. NAs who are the targets of racism must learn how to cope with the prejudice. Amy commented that some non Caucasians attempt to disguise their ethnic origin while she relies on her self confidence and pride in her culture. In either case, emotional work is required to be able to cope. This means additional emotional work for non Caucasian NAs who must deal, not only with the usual pressures of the job, but also with the stress of racism. Putting on a happy face for the benefit of the residents can be doubly difficult for these NAs.

The diversity of ethnicity and language among NAs brings with it a challenge to verbal communication. NAs' work depends on talk and listening. NAs talk with residents and their families giving explanations and direction or asking questions. They talk with other NAs to share information, offer or ask for help and engage in friendly conversation. NAs talk with CCs and other staff listening to instructions or new information and giving report. Multiple languages can make verbal communication more

complicated and time consuming. The work process is also more difficult if information or instruction is not understood and errors are made. For instance, a NA fluent in English called across the dining room to ask a NA whose English was limited, "Did you make the tea?" The response from the NA with limited English was "yes" but when another NA was ready to pour tea it was discovered none had been made because the question had not been understood. Although NAs experience frustration with the language barrier they also develop methods to overcome it and avoid mistakes. Following the incident described above, NAs with fluent English became more aware of the speed with which they spoke and the noise level which interfered with understanding. They also gained insight into the pressures felt by some foreign born NAs to learn the language quickly or in some cases pretend to comprehend English out of fear of losing their job. This has led NAs to develop strategies for easier communication where a language barrier exists. NAs make the effort to speak more slowly, to move closer to the person they are addressing, to make eye contact and to wait for confirmation that the message was heard correctly. These strategies, while effective, increase the work NAs must do.

"I'M PAID TO GET BEAT UP"

Physical and verbal abuse are two very distressing troubles NAs encounter on a daily basis. The abuse ranges

from very violent physical attacks to verbal insults. NAs have been punched, kicked, slapped, bitten, held in vice like grips and suffered repeated verbal ridicule by being called, for instance, ugly, fat and stupid. I experienced the feeling of being jeered at for being stupid and was surprised at my own response. Although the comments were made by a resident coping with dementia, the insults were so persistent, loud and articulately spoken that I began to wonder what other people within hearing distance were thinking about my competence. It is not always possible to simply laugh off such hurtful remarks, a frequently used coping mechanism. It takes the emotional work of talking it over with colleagues and being listened to, of sharing feelings and experiences and offering helpful strategies to be able to fight the mental wear and tear of frequent verbal abuse.

Residents who are physically violent require that NAs be on their guard at all times. NAs must remain alert to sudden changes in behavior and be able to respond quickly and appropriately to prevent injury while performing their other duties, be they washing, dressing or lifting a resident. This is work which demands NAs have infinite energy, two pair of hands and eyes in the back of their head. It also demands courage. NAs attend to the most personal needs of residents whom they have been injured by and whom they fear.

The abuse NAs experience takes a physical and mental toll on their well being. This interferes with the quality of their own life and the quality of their work. While physical harm is usually quite visible and easy to track in terms of sick time and cost to the organization, emotional pain is less apparent. Though NAs are questioned as to whether the physical injury was related to carelessness, such as letting their guard down for a moment, it is none the less respected as a legitimate problem. Emotional injury does not receive the same respect. It is more difficult to recognize but possibly no less costly. Lena, a NA who suffered a severe physical trauma recovered quickly from the physical damage but has been left with lingering emotional wounds. She described how she could not stop thinking about the incident, how she felt like crying all the time and how she was having difficulty sleeping many weeks after the event. Lena felt victimized by the organization which, rather than offering support, suggested her problem was related to her home life. Lena knows that it is her family members who have enabled her to handle the situation so she can tolerate being at work. NAs use a variety of methods to cope with work related emotional stress, one of them is to stay away when the pressure is intolerable. Physical and verbal abuse is costly to the individual and to the organization. A NA who told me, "I get paid to be beat up" is alluding to both the frequency of

the problem and the prevailing attitude that defusing and tolerating aggression is a part of NAs' job.

"IT'S TRUE, THERE REALLY IS NO PLACE LIKE HOME"

Arbutus Manor, like most long term care facilities, is implementing a policy to provide a homelike environment. This is an aspect of quality which seniors groups themselves have identified as important to their long term care needs. It is also a quality which Arbutus Manor has successfully met because residents do view Arbutus Manor as home. One resident on returning from several days stay in hospital made the comment, "Thank goodness I'm home. There really is no place like home." While NAs recognize the value of this policy they also know the trouble it creates for them.

The success which has been achieved in presenting a home like appearance is apparent as you walk through the units of Arbutus Manor. The long corridors typical of many institutions have been softened with the addition of attractive pictures. Small sitting areas are tastefully decorated with comfortable furniture and curtained windows to remind one of home. Animals come to work with their staff member owners and are welcome visitors. Also cats, birds and turtles live on various units as residents pets. Uniforms are rarely worn by staff, instead you see casual, varied and colorful clothing. The residents also are dressed in everyday clothing, not unlike what they might

wear at home though alterations may have been made to accommodate easy dressing and undressing. The homelike atmosphere is promoted by the presence of personal items that residents have brought with them. Pictures, small pieces of furniture and an assortment of belongings contribute to the homey atmosphere.

The concept of "homelike" is significant in terms of the physical environment; however, it also has important implications for what happens between the care givers and the residents. When residents make their "home" at Arbutus Manor it is with the expectation they will have the opportunity for personal choice and the individualized care indicative of being at home. As the employees with the most direct contact with the residents, NAs are in the position of knowing what it means when residents expect homelike care. Claire, a NA described the "twenty minute workout" which she goes through to dress a very rigid and resistant resident in dress shirt and trousers. This is how his wife has been used to seeing him at home and she insists he continue to wear regular as opposed to geriatric clothing which would make dressing him easier. It is not only family members but residents themselves and CCs who identify homelike qualities. Jeff talked of the frustration of being directed by the CC to leave a resident up until 2200 hours because this is the resident's home. This means Jeff is

putting the resident to bed at the end of the shift when he is most tired and when he must fit this work in with the final round of checking, changing, toileting and turning residents which is scheduled at that time. It falls to NAs to do the work of carrying out multiple interpretations of home.

Homelike care increase NAs' work and competes with their scheduled tasks for time. On the one hand NAs' work is routinized to promote quality from a professional perspective; on the other hand NAs are expected to meet fluid needs. These are contradictions which Zoe, a DNU describes:

"...So I feel the NAs have really been regimented by their routines and they have been measured as to how well and how quickly and how many or whatever and they have not legally been allowed by their supervisors or their peers to sway from that very much. Often you find that you are beating your head against the routine versus the resident care. ...how do you change their routine that has been built to get so much work in it in such and such time without changing the workload? How can you do that?"

CHAPTER SEVEN

"WHAT WILL WE DO IF WE NO LONGER HAVE TO TELL PEOPLE WHAT TO DO?"

(REFLECTIONS FOR CHANGE)

I began this study with a question about professionals' perception of NAs being "stuck in routines". Through an exploration of NAs' work I have reconceptualized the whole idea of "routines", how they arise and what they mean for the organization and for NAs. Beyond that, I have come to see the ideas of change, contradiction, authority as well as the isolation of non professional care givers from professional and management staff as central to this analysis.

Change is evident across the long term care industry as restructuring in response to diverse pressures gains momentum. As I have shown through the description of NA's experience the restructuring is having profound effects at the bedside in the institution I studied. By virtue of their position as the principal hands-on care givers NAs have a unique understanding of what this restructuring means for resident care. NA's position places them at the forefront of the restructuring where they are adapting to dramatic changes in the demands of their job. I have argued they are doing so in an environment in which much of their work, though essential to the care giving process, is poorly

recognized. In addition, the work environment is organized such that NAs must follow rigidly structured procedures. It is within this context that NAs have been criticized for being resistant to change and therefore impeding optimum quality of care. The contradictions evident here are frustrating for all stakeholders in the long term care industry. Although change is a dominant theme it must become much more pervasive at all levels of long term care in order to eliminate the contradictions.

Within Arbutus Manor, the view of quality which is most credible is care that is carefully programmed. The planning is done primarily by people at the top of the organization's hierarchy. The unique and fortuitous aspects of quality which arise at the bottom of the hierarchy with the resident are given less credit. NAs hold the precarious position of being pulled in two directions at once; toward the demands of the organization, and toward the individual needs of the residents. Given NA's lack of authority, a common outcome is care that is contradictory to resident's wants and needs while care that individual residents request is difficult to provide. The programming of NA's time and work results in a system which tries to standardize care. This inhibits NAs ability to offer individualized, flexible care which falls outside of the standard. Thus it is common to hear a NA respond to a resident's request for assistance when it is not time for that activity with the words, "You will have to

wait."

Programming and routinization of work is typical of bureaucracies. It often promotes efficiency, enabling the processing of large amounts of work and offering a way to predetermine quality. Ursula Franklin (1990, p. 24) refers to this way of arranging work as, "prescriptive technologies" and suggests such a method should not be used for any tasks that involve caring. Franklin (1990, p. 24) describes a culture of compliance and a pervasive acceptance of there being only one right way to do the work, as a social cost being paid for the rampant spread of such technologies. Further, she suggests the outcome of the widespread adoption of this technology has been, "...a move from ordering at work and the ordering of work to the prescriptive ordering of people in a wide variety of social situations" (Franklin, 1990, p. 24). This result is apparent in observing both residents and staff at Arbutus Manor as they follow a routine which allows for little diversity from day to day. According to Franklin (1990, p.61) "...we are at the end of a historical period in which processes and approaches that initially had been exceedingly constructive and helpful have run their course and are now in many ways counterproductive."

I have shown that as non professionals NAs have little control over their work. They are bound to a schedule and to the authority of management and professional staff.

According to Sheila Neysmith (1991, p. 291) authoritative relationships are inherent in Western models of professionalism." Neysmith (1991, p.290) argues that the benefits awarded to the professions has resulted in "turf guarding" which, "...is an obstacle to ...planning a more egalitarian and collective approach to caring for others". Such is the case at Arbutus Manor where NAs, with no source of legitimate power, are largely excluded from the planning of the care giving process. Excluding NAs means valuable experience and information has been lost. Swenger (1987) has argued that long term care is in a state of chaos with inadequate information at the local, provincial and federal levels. Utilizing NA's knowledge would provide a view of long term care which has been missing. A move away from controlling mechanisms to a collaborative approach which includes NAs would promote optimum quality of care with the available resources.

NA's lack of power continues to impede their capacity to incorporate their experience into the organization of their work. Karmen, a NA who participated in this study, described the frustration she felt at being instructed to get residents up and out of bed when they had indicated to her their wish to sleep. Structural changes are necessary to incorporate this information which is significant to the quality of care. Abel and Nelson (1990, p. 13) define care giving as "intrinsically unpredictable" and argue that,

"...hierarchical structures of bureaucracies separates conception from execution, thus, staff are prevented from applying personal knowledge about the needs of their clients or drawing on their own experience". Franklin (1990) sees part of the solution as including different perspectives when developing plans. She proposes that, "...contradictory demands could be balanced through appropriate democratic planning processes" (Franklin, 1990, p.82). The move to a more democratic and less authoritarian organizational structure of care giving receives wide support (Erikson, 1987; Buzzell, 1991; Davis, 1991; Diamond, 1992; Sacks, 1990).

The top down method of organizing care promotes a division of labour which I have illustrated acts as a barrier to understanding between professional and non professional groups. This point was driven home to me, a registered nurse and an experienced CC when I began to work as a NA. I discovered that I had entered a world which I knew very little about. It was necessary to learn how to do the work which has looked so easy and which it is assumed within the organization that any CC is able to do.

The knowledge I acquired of NA's' work conflicted with the commonly accepted view of their role within the organization. The work of resident care is arranged into three broad spheres of management, professional care giving and non professional care giving practice. The categorizing

of work is accompanied by value labels. Management and professional practice is labeled as skilled work based on unique bodies of knowledge and levels of education. The non professional work performed by NAs is designated as simple, derived from less valuable, "basic" knowledge. This socially constructed understanding does not reflect the complexity which I experienced as a NA and which I observed in NA's everyday work.

The top down process obscures the reality of NA's work. This creates troubles for management located at the top of the hierarchy and for NAs and residents located at the bottom. These troubles are not clearly evident to those outside the specific sphere of work until it reaches crisis proportions. The stringent division of labor into professional and non professional classifications acts to isolate each group from the other. The division of labour is itself difficult to see because of its taken for granted nature. To this point, NA's situation and their work thus remains poorly understood within the organization; however, this is open to change.

The management of Arbutus Manor has realized that failure to understand the circumstances of NAs as the largest group of care givers within Arbutus Manor will impinge on the facility's capacity to make the changes necessary to remain viable in the evolving long term care environment. New initiatives to alter the traditional top

down method of organizing care giving are being envisioned. My study suggests that such changes must include structural revision to promote a shift in authority to accommodate NAs' expertise which is currently unrecognized and underutilized in defining and delivering quality care. As part of any such effort, it will be necessary for management and professional staff to examine their authoritative stance and develop collaborative methods to support the work of NAs rather than control it. This will require a different way of thinking about how the organization might operate and how work can be accomplished. The comment made by a senior executive, "What will we do if we no longer have to tell people what to do" is evidence that such reasoning is already underway. According to Neysmith, (1991, p. 296) "Thinking about something in a different way *is* change - it is a necessary step to action".

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APPENDIX ONE



CONSENT TO PARTICIPATE: NURSING ASSISTANT

This research is being undertaken as part of a graduate level thesis at the University of Victoria. The purpose is to understand the work you, as a Nurse Assistant do, from your point of view.

If you agree to participate in this study I would work with you for a few hours over the course of two or three shifts. This would involve me sharing your work, and observing your activities. I would also need to interview you concerning your work, on one occasion. No questions of a personal or private nature will be asked. I will not be evaluating your work, my goal is to learn about your experience of being a Nurse Assistant.

The interviews will last approximately one and one half hours and will be arranged to take place when you are off - duty, at a time and location convenient for you. I will tape the interviews and provide you with a transcript for your verification. All information you give me will be kept strictly confidential and your name will never be used.

If you choose to participate in the study, you may withdraw at any time. Should you have a complaint about any aspect of the research, at local has agreed to provide assistance in resolving the problem. If you have any questions or need to contact me I can be reached at

Your signature below will indicate that you understand and agree to the terms of participation in the study. Please sign two copies and keep one.

NAME..... SIGNATURE.....

DATE..... WITNESS.....

CONSENT TO PARTICIPATE - CARE COORDINATORS

This research is being undertaken as part of a graduate level thesis at the University of Victoria. The purpose is to understand the work which Nurse Assistants do from their point of view.

If you agree to participate I would like to observe your work as you interact with Nurse Assistants. I would also need to interview you on one occasion. All interviews will focus on your role as supervisor of Nurse Assistants. No questions of a personal or private nature will be asked.

The interview will be approximately one hour in length and will take place when you are off-duty at a time and place of your choice. I will tape the interview and provide you with a transcript for your verification. All information given to me will be kept strictly confidential and your name will never be used.

If you choose to participate you may withdraw at any time. Should you have a complaint about any aspect of the research,.....at localhas agreed to provide assistance in resolving the problem. If you have any questions or need to contact me, my home telephone number is

Your signature below will indicate that you understand and agree to the terms of participation in the study. Please sign two copies and keep one.

NAME..... SIGNATURE.....

DATE..... WITNESS.....

CONSENT TO PARTICIPATE: DIRECTOR OF NURSING

This research is being conducted as part of a graduate level thesis at the University of Victoria. The purpose is to understand the work performed by the Nurse Assistants, from their point of view.

If you agree to participate in this study I would like to interview you regarding the types of interactions you have with Nurse Assistants and the expectations you have of their work. No questions of a personal or private nature will be asked.

The interview will last approximately one hour and will be arranged for a time and location convenient for you. I would like to tape the interview and I will provide you with a transcript for your verification. All information you give me will be kept strictly confidential and your name will never be used.

If you choose to participate in the study, you may withdraw at any time. Should you have a complaint about any aspect of the research,..... at local.....has agreed to provide assistance in resolving the problem.

Your signature below will indicate that you understand and agree to the terms of participation in the study. Please sign two copies and keep one.

NAME..... SIGNATURE.....

DATE..... WITNESS.....

This research is being conducted by Minna Aitken. If you have any questions or need to contact me, my home telephone number is

APPENDIX TWO

QUESTIONS FOR NURSE ASSISTANTS:

- 1) Tell me about a typical shift, describing your activities from the time you start work until you are finished.
- 2) How do you know where to start your work that is, which resident to go to first at the beginning of your shift?
- 3) How do you decide when to assist each of your other residents?
- 4) What kinds of things or events make your work easier or help your shift to go smoothly?
- 5) What kinds of things complicate or interfere with your work and make for a difficult day? Could you give an example of an event that resulted in a difficult day.
- 6) What aspects of your work do you like the most? Why?
- 7) What aspects of your work do you like the least? Why?
- 8) How do you know that you have done a good job or a poor job? What happens to let you know this?
- 9) What problems do you have to deal with during the course of your day and how do you decide what to do?
- 10) How would you describe your work in relation to that performed by the care coordinators and the director of nursing?
- 11) What makes your relationships with the care coordinators and the director of nursing comfortable and difficult?
- 12) Would you describe briefly what it feels like to be a nurse assistant? Is it what you expected it to be?

QUESTIONS FOR CARE COORDINATORS:

- 1) Tell me about a typical day describing your activities from the beginning of the shift to the end.
- 2) How would you describe your work in relation to that of the Nurse Assistants?
- 3) What instructions do you feel are important to convey to the Nurse Assistants working with you? Why? How do you communicate these instructions to the Nurse Assistants?
- 4) How would you describe the activities performed by the Nurse Assistants?
- 5) What characteristics of Nurse Assistants do you value most and least? Why?
- 6) How do you know that a Nurse Assistant has done a good job? Could you give an example of work that was well done.
- 7) What makes your relationship with Nurse Assistants comfortable? Why?
- 8) What kinds of things make your relationship with Nurse Assistants tense? Why?
- 9) What kinds of problems do the Nurse Assistants report to you? Which problems do you see as most important?
- 10) How is distribution of the work reorganized when the unit is short staffed? How frequently would you estimate that the unit is short staffed? What is the effect on the Nurse Assistants?

VITA

Surname: Aitken

Given Names: Minna Uldall

Place of birth: Denmark

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Title of Thesis: LOOK WHO'S TALKING: LONG TERM CARE FROM THE STANDPOINT OF NURSING ASSISTANTS, A FEMINIST ANALYSIS.

Author



(Signature)

MINNA U AITKEN

(Name in Block Letter)

SEPTEMBER 29, 1993

(Date)