THE DESIGN AND CONTENT OF
PERSONAL SUPPORT WORKER TRAINING
PROGRAMS

by

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ABSTRACT

Problem Statement: Despite increased reliance on PSW certificate programs to standardize the workforce, and the introduction of a common training standard in 2015, there is limited research available on PSW certificate programs. This study adds to knowledge regarding PSW certificates, which can be applied to decisions regarding the future direction of PSW education.

Methods: This is an intrinsic case study of PSW certificate programs in Ontario. The research methods were document analysis, and key informant interviews.

Results: Informants perceived a PSW certificate as necessary to adequate performance of the PSW role. Informants perceived challenges in the areas of interprofessional teamwork, assessments, helping-relationships, client-centred care, medications, and abuse.

Conclusions: The role of the PSW has changed significantly over the last decade, and it is now commonplace for PSWs to be assigned nursing tasks. Further research should evaluate whether the new standard is being successfully implemented, and meeting sector needs.
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CHAPTER 1: INTRODUCTION

1.1 Problem Definition

Personal Support Workers (PSWs) provide services to people (usually those with disabilities or chronic illness) who require help with their daily needs, with an ultimate goal of improving quality of life. While tending to a person’s physical needs, PSWs also relieve loneliness, provide comfort, encourage independence, and promote the person’s self-respect (Ontario Personal Support Worker Association, 2016; Sorrentino, Remmert, Wilk, & Newmaster, 2014). In Ontario, PSWs are unregulated health care providers, and may work in private and publicly funded health care settings, including hospitals, long-term care homes, and home and community care (Church, Diamond, & Voronka, 2004a; Sethna, 2013). While similar care activities occur in all jurisdictions, the name by which the workers who provide such care are known varies, as do policies and legislation regarding their regulation, scope of practice, and education requirements (Sorrentino, Remmert, Wilk, & Newmaster, 2014). The objective of the study was to add to knowledge regarding the design and content of PSW certificate programs, and perceptions of program quality.

In Ontario, PSW certificate programs were introduced at the end of the 1990s (Kelly & Bourgeault, 2015). In this province, PSWs are unregulated and do not practice under a legislative framework (Church, Diamond, & Voronka, 2004a; Kelly & Bourgeault, 2015; Sethna, 2013). A legislative framework, such as the one which governs nurses and physicians, among other things sets out entry to practice requirements, including graduation from a profession-specific program. A legislative framework for professions may also confer “protection of title” meaning that only those who have met the entry to practice requirements and are registered in good standing with the relevant regulatory body can refer to themselves as members of that profession (Government of Ontario, 1991a, 1991b, 1991c). In the absence of a legislative framework, individuals with and without certificates can refer to themselves as “Personal Support Workers”. Despite the lack of legislative framework for PSWs, graduation from a PSW certificate program has become a typical employer requirement in many health care settings in Ontario. There is limited research available on how PSW certificate programs are designed, what they teach, and perceptions of program quality on the part of PSWs, PSW supervisors, and service users. This study seeks to
add to employer, educator, and policy maker’s knowledge regarding PSW education, which can be applied to decision making regarding the future direction of PSW education.

1.2 Research Goals and Questions: Exploring the Design and Content of PSW Certificate Programs

The objective of this study was to explore the design and content of PSW certificate programs, and perceptions of program quality. This study grows out of the findings of researchers exploring the nature of the role and scope of the PSW in Ontario who have observed that while there are a number of PSW certificate programs in existence, little is known about the content of such programs, or exactly how they prepare PSWs to fulfill the role (Church, Diamond, & Voronka, 2004b; Sethna, 2013). The findings of other researchers in this field are summarized in the literature review in the following chapter (chapter 2).

In the interest of meeting the research goals, three central questions, with related sub-questions were posed:

1. How is the PSW education system in Ontario designed?
   i. What types of institutions offer PSW programs and how many are there?
   ii. What are the application and admission requirements?
   iii. How are program standards set and evaluated?
   iv. What are the similarities and differences among the programs?

2. What is the content of PSW certificate programs?
   i. What are the competencies expected of graduates, and how are they covered by the programs and training materials?
   ii. What are the topics that are included in the PSW certificate programs?

3. What are key informant perceptions of the education programs?
   i. What are key informant perceptions of similarities and differences between the programs?
   ii. What are key informant perceptions of the relevance, comprehensiveness, and quality of program content, and the necessity of formal education?

The findings pertaining to question 1 are presented in chapter 4, the findings pertaining to question 2 are presented in chapter 5, and the findings pertaining to question 3 are presented in
chapter 6. As will be explained in depth in the following chapters, the study found while there are a number of factors that lead to significant similarity in the content of programs, there is significant variation in the design of the different institution types that offer PSW programs, and variation in perceptions of program quality. Additionally, while the data (documents and key informant interviews, described in detail in Chapter 3) suggested the programs were strong in covering the aspects of the role that are vocational and task oriented, they appeared weaker at covering the aspects of the role that most intersect with concept-oriented dimensions of the role (or “soft-skills”).

1.3 Chapter Guide

Chapter 2 of the thesis is a literature review that provides an overview of the design of Ontario’s health care system and the role of the PSW within it, as well as summary of current scholarship regarding PSWs. The chapter also describes theories of professionalism, which were applied as a theoretical framework for the study. Chapter 3 presents the study design and methods. Chapter 4 presents results regarding the design of the PSW education system, and Chapter 5 present results regarding the content of the PSW education system. Chapter 6 presents results regarding key informant perceptions of program quality. Chapter 6 contains the summary and conclusions.
2.1 Introduction

This chapter summarizes available literature on PSWs to provide a history of the role in the context of Ontario’s health care system and discusses the research challenges presented by the fact that there is no legislated definition of the term “PSW”. This study also applied theories of professionalism to provide a framework for understanding and analysing the role of the PSW and design of the education system. This chapter summarizes theories of professionalism and how they can be applied to understand and guide research regarding the nature of the PSW occupation. As will be described in detail below, theories of professionalism are relevant to inquiry regarding PSW certificate programs because much of the rationale for the lack of legislative framework for personal support work, including the educational requirements, stems from the belief that PSW is not a “profession” (Health Professions Regulatory Advisory Council, 2006).

Additional sources that provided information and discussion related to PSWs in Ontario were found through key word searches in relevant databases, including PubMed, Google Scholar and J-Store. Search terms were: personal, AND support AND worker AND Ontario. The bibliographies of results yielded by these searches were reviewed and additional sources were identified. Existing sources regarding PSWs are a mix of scholarly articles, institution and organization reports, and dissertations. Themes explored included role definition, clinical practice, health HR, and accountability.

2.2 Ontario’s Health Care System

This thesis focuses on the Canadian province of Ontario. It is located in East central Canada and with a population of approximately 12.8 million, it is the country’s most populous province, with approximately one third of the nation living there (Ewen, 2015).

Canada’s constitution places responsibility for health care services at the level of the provinces/territories. The federal government provides some funding to the provinces/territories under the Canada Health Transfer; to receive these revenues, the provinces/territories must comply with the terms of the federal Canada Health Act. One of the principles is the principle of comprehensiveness. This principle states that all “insured services” must be fully covered for all
“insured people” (legal residents of that province/territory). Like all Canadian provinces, Ontario accordingly has a single-payer system of universal coverage for these insured services. For historical reasons, the definition of insured services is fairly narrow, based both on whether these are deemed medically necessary and on where they are provided (in a hospital or by a physician). Provinces/territories can insure beyond this minimum should they wish to do so, but are not required to (Deber, Gamble, & Mah, 2012). Among the services falling outside of this required minimum are: prescription and non-prescription drugs and medical devices delivered outside hospitals; rehabilitation services delivered outside hospitals; long-term care; and home care and social support. In Ontario, the provincial government elects to pay for some of these additional services for some potential recipients.

Most health care in Ontario is privately delivered; funding is a mix of public and private funding, which varies with the service, and with the population being served. As noted above, the Canada Health Act requires that medically necessary services provided to insured people in a hospital or by a physician must be publicly funded. In Ontario, the province also funds a portion of the costs for long-term care costs, and home care services, for some people. Most other types of health care, such as outpatient prescription drugs, dentistry, and optometry, must be paid for privately (through a mix of private insurance and out-of-pocket payments), although some government programs exist to serve low income people or those on social assistance.

2.3 PSW Role and Activities

The term “Personal Support Worker” came into common use in the Ontario health care system in the late 1990s. In 1997 the Ontario Ministry of Health and Long Term Care (MOHLTC) replaced a number of related job categories such as care aide, home support worker, attendant care worker and respite worker with the term PSW. MOHLTC worked with the Ontario Community Support Association to develop a curriculum and the first PSW certificate programs were introduced (Lilly, 2008).

PSWs are important because they promote client independence and facilitate aging at home, thereby reducing the need for more acute health care services (Berta, Laporte, Deber, Baumann, & Gamble, 2013; Brooks, Gibson, & DeMatteo, 2008; Lilly, 2008). There are approximately 90,000 in Ontario employed in a mix of institutional and home and community care settings and
their positions can be privately or publicly funded (Health Professions Regulatory Advisory Council, 2006; Laporte & Rudoler, 2013; Lilly, 2008; Lum, Sladek, & Ying, 2010).

As noted in chapter 1, PSWs provide services to people who require help with their daily needs, with an ultimate goal of improving quality of life. Sethna divides PSW activities into four categories: activities of daily living (i.e. eating, bathing, dressing, toileting), clinical care services (e.g. measuring a client’s pulse, temperature or blood pressure, collecting specimens), controlled acts as set out by the RHPA (e.g. administering a substance by injection or inhalation), and instrumental activities of daily living (e.g. menu planning, meal preparation, shopping, transportation). IADL support is only considered to be part of the PSW role if the tasks are carried out in conjunction with tasks from one of the other three categories.

Other sources define the role by listing tasks that PSWs carry out such as housecleaning, meal preparation, laundry, and personal care such as toileting, bathing, and dressing. PSWs are unregulated care providers, and as such must work under the direction and supervision of a regulated health professional, most typically a nurse. More medical tasks carried out by PSWs can include wound care, medication administration, and ventilator support (Berta, Laporte, Deber, Baumann, & Gamble, 2013; Health Professions Regulatory Advisory Council, 2006; Keefe, Knight, Martin-Matthews, & Légaré, 2011; Lum, 2013; Lum, Sladek, & Ying, 2010; Sethna, 2013; Teplitsky, 2002).

2.3.1 Regulated Health Professionals (RHPs)

Health care and support services in Ontario are provided by a mix of regulated and unregulated care providers. Regulated professions are those which are governed under the Regulated Health Professions Act (RHPA). The RHPA sets out 14 controlled acts that can only be performed by members of specific professions, with certain exceptions (e.g. an emergency, or a family member is providing care). A complete list of controlled acts can be found in Appendix F. The profession-specific subsections specify which of the controlled acts can be performed by that profession. Controlled acts legislation contains a provision that allows regulated professionals to delegate a controlled act that is within their scope to someone who is not a member of that profession. Delegation can occur in situations where the provider is supervised by the RHP and has been shown how to perform the task for that client, the act constitutes an activity of daily
living for the client wherein the outcomes are predictable and stable, and it is in the client’s best interests that the task be delegated (College of Nurses of Ontario, 2013, 2014b).

There are a total of 26 regulated health professions in Ontario, including physicians and nurses. Appendix A provides a complete list of health professionals regulated under the RHPA. The Act contains subsections specific to each profession. The profession specific subsections, among other things, contain a scope of practice statement for that profession. The scope of practice statement describes in a general way what the profession does and the methods it uses. The RHPA recognizes that the scope of the various professions may overlap (College of Nurses of Ontario, 2014b). The RHPA was enacted in 1991 and a number of professions have been added since that time.

Each regulated profession is required by the RHPA to establish a regulatory College which is responsible for ensuring that its members are maintaining the standard of practice for that profession. To that end, the Colleges publish and revise professional standards, set and administer entry to practice regulations, implement quality assurance strategies and mechanism, and investigate allegations of professional misconduct. Regulated health professionals must register with their College and renew their registration annually to practice legally in Ontario.

2.3.1 PSWs and Nurses

Nurses have the ability to delegate or assign tasks from within their scope of practice to family caregivers or PSWs they are supervising (Health Professions Regulatory Advisory Council, 2006; Lum, 2013; Lum, Sladek, & Ying, 2010; Sethna, 2013).

The following scope of practice statement applies to all nurses:

The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function (College of Nurses of Ontario, 2014a, 2016).

The controlled acts that fall within all nurses’ scope are:

1. Performing a prescribed procedure below the dermis or mucous membrane
2. Administering a substance by injection or inhalation, and
3. Putting an instrument, hand or finger:
   
   i. beyond the external ear canal
   
   ii. beyond the point in the nasal passages where they normally narrow
   
   iii. beyond the larynx
   
   iv. beyond the opening of the urethra
   
   v. beyond the labia majora
   
   vi. beyond the anal verge, or
   
   vii. into an artificial opening in the body (College of Nurses of Ontario, 2014a)

There are two categories of nurses in Ontario: Registered Practical Nurses (RPNs), and Registered Nurses (RNs). Within the registered nursing category, nurses with specialized advanced training can be registered in the extended class and are known as Nurse Practitioners (NPs) (College of Nurses of Ontario, 2014a, 2016; Government of Ontario, 1991b).

While RN and RPNs study from the same body of nursing knowledge, RNs study for a longer period of time, allowing for greater foundational depth in areas such as clinical decision making, research utilization, and leadership. As a result, RNs have more authority to initiate controlled acts that fall within nursing’s scope.

Nurse Practitioners are RNs with graduate education that expands on the nursing scope to allow them to diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals, and perform procedures. In addition to the three controlled acts that fall within the scope of all nurses, NPs can perform the following 4 additional controlled acts:

1) Communicating to a client, or a client’s representative, a diagnosis made by the NP identifying as the cause of the client’s symptoms, a disease or disorder.

2) Applying or ordering the application of a prescribed form of energy

3) Setting or casting a fracture of a bone or dislocation of a joint.

4) Prescribing, dispensing, selling or compounding a drug in accordance with the regulation.

Nurse Practitioners cannot delegate these four additional controlled acts to other providers (College of Nurses of Ontario, 2016).
In the College of Nurses of Ontario’s reference document entitled “RHPA: Scope of Practice, Controlled Acts Model” delegation is defined as:

“a formal process by which a regulated health professional, who is authorized and competent to perform a procedure under one of the controlled acts, delegates the performance of that procedure to someone, regulated or unregulated, who is not authorized by legislation to perform it.” (College of Nurses of Ontario, 2014b)

2.3.2 PSWs and Delegation

The College’s practice guideline entitled “Working with Unregulated Care Providers (UCPs)” outlines considerations and provides guidelines on the delegation of the three types of controlled acts which are authorized to all nurses (College of Nurses of Ontario, 2013).

The document goes on to explain that as per the provisions of the RHPA, controlled acts can only be delegated by exception, or where the controlled act constitutes an activity of daily living for the client, of which the outcomes are clearly defined and predictable. The document also provides guidance on the teaching, assigning, and supervision responsibilities of nurses, and provides a decision tree for determining what activities can be assigned and taught to UCPs. The document explains assigning in this manner:

“Assigning is the act of determining or allocating responsibility for particular aspects of care to another individual. This includes assigning procedures that may or may not be a controlled act. Ideally, a range of care needs, rather than specific procedures, are assigned. Depending on the nature and responsibilities of their positions, nurses with the necessary knowledge and judgment may assign care to a UCP”. (College of Nurses of Ontario, 2013)

Fact sheets and practice standards produced by Ontario Personal Support Worker Association and the Personal Support Network of Ontario clarified that while the legislation only regulates a narrow range of activities, a greater number of activities may be regulated by employer policies. Key informants interviewed by this study provided substantial information as to how and which tasks are assigned and delegated to PSWs in home care, and how they are trained on the tasks. This information is presented in chapter 6.
2.4 PSW Employment Settings

As noted above, PSWs in Ontario are employed in a range of different settings. The two most common settings in which PSWs are employed are long-term care and home and community care. Primary data collection for this study focused on those two settings. The sources did not provide substantial details on the role of the PSW and the type of work PSWs conduct in these setting. This curtailed the researcher’s ability to develop a thorough understanding of the role in different settings, which constitutes a limitation of the research. Below is a brief description of how PSWs are employed in each setting.

2.4.1 PSWs in LTC

Long-term care homes are designed for “people who need twenty-four hour nursing care and supervision, in a safe, homelike environment. They differ from other residential care settings, such as retirement homes, in that all of the clients require a high level of care (Sethna, 2013). In the province of Ontario, the Ministry of Health and Long-Term Care (MOHLTC) “provides overall direction and leadership for the system, focusing on planning, and on guiding resources to bring value to the health system” (Ministry of Health and Long-Term Care, 2015). In addition to funding the medically necessary physician and hospital services stipulated by the Canada Health Act, Ontario also provides some public funding for long-term care homes. Local Health Integration Networks “plan, integrate and fund local health care” (Local Health Integration Networks, 2014), including long-term care. The LHINs operate using a catchment-based model. The costs of residing in a long-term care home are divided between the public and the resident, with the public paying for medical care, approximately two thirds of the cost, and the resident paying for room and board costs.

Of the approximately 90,000 PSWs in Ontario, 57,000 are employed in long-term care. 26,000 are employed in home care through community health agencies, and 7,000 are employed in hospitals. PSWs working in hospitals are often referred to as Health Care Aids and provide support with rehabilitation or complex continuing care. PSWs help with ADLs and activation activities that help people with injuries, aging, or illness. PSWs working in hospital are usually supervised by nurses, but may also take direction from other providers such as physicians and occupational therapists (Sethna, 2013).
There are approximately 633 LTC homes in Ontario, housing approximately 76,000 residents. As noted, the majority of PSWs in Ontario are employed in LTC. PSWs comprise 75% of the staff in LTC homes, although organizations such as the Registered Nurses Association of Ontario is of the opinion that the proportion should be closer to 55%, with the remainder of the client care provided by nurses to improve client safety. LTC homes are governed by the *Long-Term Care Act* (Government of Ontario, 2007). The average age of residents is 83, and only 6% of the 70,000 patients in LTC are under the age 65. 85% of the residents are described as having high care needs and requiring assistance with at least one activity of daily living. Clients in LTC enquire a high level of care, including constant supervision in some cases. Seventy-three percent of residents are experiencing some form of cognitive impairment (Sethna, 2013).

Changes to the LTC act were made in 2007 to require PSWs working in LTC to hold a PSW certificate. The legislation recognizes certificates from three different types of programs, which will be described in depth below and in Chapter 5. The legislation also states that 3 years of experience as a PSW, or nursing education are also acceptable qualifications (Government of Ontario, 2007; Kelly & Bourgeault, 2015). The LTC act also places further restrictions on the ability to delegate controlled acts to PSWs. These restrictions do not apply to workers in other settings.

The general trend of wages in LTC is higher than in home care (Lilly, 2008). Lilly provides a theoretical analysis of the wage disparity between PSWs in home versus institutional care settings; arguing that PSWs are compensated more highly in institutional settings because medical settings are attributed with higher status than domestic settings. According to Lilly, this privileging of medical spaces is rooted in the historical gendering of institutional, medical settings as male spaces and domestic settings as female spaces (Lilly, 2008). Her analysis does not address the specifics of PSW activities in LTC.

Over the last 20 years, most LTCs in North America have introduced the use of Resident Assessment Instrument – Minimum Data Set (RAI/MDS). RAI/MDS is an “interdisciplinary, standardized process” that allows regulated health professionals to collaborate on assessing a client’s care needs; designed to ensure that each client is assessed in the same manner. Although PSWs respond to the vast majority of a client’s quotidian care needs, and are uniquely situated to gather biographical information about the client, they are not included in the RAI/MDS process.
It has been suggested that PSWs rely heavily upon their observations of a client to determine the efficacy of care plan interventions, and adjust their care accordingly. RAI/MDS does not capture the richness of these observations, and does not use them to develop and adjust the care plan. As a result, the standardized RAI/MDS process may worsen care by not effectively capturing patient history, nor the efficacy of care plan interventions (Kontos, Miller, & Mitchell, 2009).

2.4.2 PSWs in Home and Community Care

Ontario also provides some funding for home and community care. Since the 1980s, hospital reorganization and advancements in medical technology have resulted in a significant amount of acute care shifting from the hospital to the home (Sethna, 2013). As noted above, the provinces are not required to pay for home care services. This often means that as more acute care services are transferred from the hospital to the community, more of the cost becomes assumed by service users and their families, rather than the government. Publicly funded home care in Ontario is administered by regional bodies known as Community Care Access Centres (CCACs), which like the LHINs, coordinate services for a catchment area. Ontario uses a system known as managed competition wherein private or non-profit agencies submitted proposals in a bid to CCAC to provide home care services. The agency that presented a proposal that delivers quality care for the lowest cost is granted a multi-year contract to provide care to a certain area (Denton, Zeytinoglu, Davies, & Hunter, 2006). Currently CCAC has frozen bidding, and the agencies that receive contracts are fixed. According to MOHLTC’s website, one of the responsibilities of the CCACs is to employ case managers who assess client eligibility for publicly funded visiting health and support services, develop, monitor, and adjust service plans as required, and authorize services. They also connect people who do not qualify for public funding, or those who wish to pay for additional hours, with private providers. Home care funding is predicated on the assumption that some care will be provided by family or friends. If a client’s care needs exceed the number of hours they are deemed eligible for and they do not have any or sufficient informal caregivers, clients must pay for additional care hours out of pocket if they are able to do so. PSWs working in home care are either employed through an agency to deliver CCAC funded care, employed through an agency that has been retained by the client directly, or employed by the client directly (Denton, Zeytinoglu, Davies, & Hunter, 2006; Sethna, 2013).
In addition to home care agencies, PSWs may also be employed by retirement homes, group homes, or community support agencies serving elderly people or people with disabilities. The exact job description for the PSW depends on the mandate of the organization and the needs of the individual clients they are caring for. As noted above, PSWs do for the client what they would do for themselves were they able. The client profile in home and community care is extremely varied, and as a result so is the work of the PSW (Sethna, 2013).

The 2011 paper by Keefe et al. uses the title home support worker (HSW) and is a synthesis of research on recruitment and retention challenges for HSWs in Canada (Keefe, Knight, Martin-Matthews, & Légaré, 2011). The paper identifies four key human resources issues faced by HSWs: compensation, education and education, quality assurance, and working conditions. With regards to education they note that while many jurisdictions in Canada now require formal education, not all do and the education requirements are not standardized across jurisdictions. They also suggest that education programs may not be adapting to the changing needs of the workforce quickly enough.

2.5 Regulation and Accountability Mechanisms for PSWs

The Health Professions Regulatory Advisory Council (HPRAC) is a publicly funded, non-governmental organization that “provides independent policy advice to the Minister of Health and Long-Term Care on matters related to the regulation of health professions in Ontario” (Health Professions Regulatory Advisory Council, 2012). In 2006, MOHLTC asked (HPRAC) to provide them with advice as to whether PSWs should be regulated under the RHPA. In their report they state that there is no uniformly accepted definition of a personal support worker. The report then provides two general definitions of the term, which are:

1. Personal Support Workers deliver quality care, assistance and support services to people in their own homes during times of need. The duties of home support workers vary according to the situation

2. Personal Support Workers provide long-term care and support to patients and clients. Work responsibilities include personal care, housekeeping duties, shopping and
companionship. The abilities of the Personal Support Worker are critical to the wellbeing comfort and safety and health of the people they support.

The first defines PSWs exclusively in the context of home care, despite the fact that the majority of PSWs work in LTC and some work in hospitals and other community settings such as group homes. The second provides a list of tasks that personal support work can include; this list does not purport to be comprehensive (Health Professions Regulatory Advisory Council, 2006). Moreover, the second definition is focused on the impact of personal support work rather than the substance. Other sources outlined in the literature review below confirmed HPRAC’s assertion that no uniformly accepted definition exists.

As the first definition offered in HPRAC’s 2006 report demonstrates, the term PSW is often conflated or used interchangeably with other position titles. Other researchers in this area have noted that organizations, such as Health Canada, group personal support workers with other similar occupations, such as home support workers, when collecting data, meaning that accurate demographic data regarding the PSW occupation is difficult to acquire (Laporte & Rudoler, 2013; Lum, Sladek, & Ying, 2010).

HPRAC asked the College of Nurses of Ontario to provide an opinion as to whether PSWs should be regulated. As noted above, nurses are the RHPs who most frequently supervise PSWs and it is the RHP supervising the PSW who is legally accountable for PSW actions on the job. CNO was of the view that PSWs did not need to be regulated. Their rationale was that PSWs have no specific body of knowledge but rather carry out tasks that would be performed by the client were they able. PSWs are responsible for executing elements of a care plan that is developed by members of a regulated profession (Health Professions Regulatory Advisory Council, 2006).

HPRAC advised against regulating PSWs as a profession. As a result, there is no regulatory body that governs PSWs and supervision and oversight are provided by regulated health professionals (Brookman, 2007; Church, Diamond, & Voronka, 2004b; Health Professions Regulatory Advisory Council, 2006; Pan-Canadian Planning Committee on Unregulated Health Workers, 2008; Sethna, 2013). Despite its recommendation against regulation, the HPRAC report observed that some stakeholders they consulted indicated that supervision from regulated professionals is
not always sufficient, especially for PSWs in home care. While many aspects of the discussion on PSW regulation have been updated, HPRAC has not issued a revised report, and PSWs continues to be unregulated.

HPRAC also advised against the establishment of a registry that would maintain demographic information about PSWs in Ontario; however, MOHLTC elected to introduce one in 2012 (Laporte & Rudoler, 2013; Lum, 2013; Ontario Community Support Association, 2012; Sethna, 2013). The rationale for the establishment of the voluntary registry was that in the time since HPRACs 2006 report, the role of PSWs had increased significantly, especially in the home care sector, where most of the paid care is provided by PSWs. As a result of the aging population, the fact that most seniors prefer to be cared for in the community, and that home care is cost-saving for the government because it reduces hospitalization, the number of home care recipients in Canada has increased by 51% over the last decade (Laporte & Rudoler, 2013).

The objective of the registry was to recognize PSWs and gather information about the workforce. The registry collected limited demographic data about PSWs and registration was voluntary. The government planned to make registration mandatory for all PSWs in publicly funded positions, beginning with those employed in home care. The registry did not fulfill the role of investigating and addressing complaints from the public, the way the regulatory colleges do (Laporte & Rudoler, 2013).

The Ontario Community Support Association, an organization that represents home and community support agencies, was tasked with establishing and maintaining the registry. In January 2016, local media reported that the MOHLTC had decided to shut down the registry; with all traces of it to be removed from the internet by March 2016. The decision was made as a result of concerns that there were no criminal background checks for registrants and registration requirements were not stringent enough (Brennan, 2016).

While the registry was controversial, some felt it was an important measure for stabilizing the PSW workforce. The 2012 report to MOHLTC on aging well recommended that MOHLTC support the PSW workforce by strengthening the then-new PSW registry. The report recommended that registration be made mandatory, and that a complaints process be established to protect the public. The report also recommended that educational requirements and curriculum...
for a number of health professional educational program, including PSW, be standardized (Sinha, 2012).

2.6 PSW Education System

The first “Personal Support Worker Certificate” programs appeared in Ontario in 1997. Prior to that, there were health care aide and visiting homemaker programs. The curriculum for the original PSW program was developed through a consultation process that began in 1993 between the Ontario Community Support Association (OCSA), and the Ministry of Education. The document that resulted from the consultation process contained 14 learning modules. At that time, students had the option to complete a personal attendant program, requiring the completion of 11 out of 14 modules, or a personal support worker program, requiring the completion of all 14 modules. The personal attendant program has since been discontinued.

As mentioned in the introduction, PSW certificate programs are offered by three types of academic institutions in Ontario: 1) district school board continuing education programs, 2) community colleges of applied arts and technology, and 3) private career colleges. While they all base their curricula on the program that was developed by the OCSA and the Ministry of Education, until recently, each of the three academic institution types (school board, community college, and private career college), adhered to their own education standard. Each type of institution is regulated by a different government branch under its own legislation and quality assurance mechanisms. As a result, there is variation among the programs with regards to program duration, the number of hours devoted to theory or practicum, cost, and program standards (Brooks, Gibson, & DeMatteo, 2008; Kelly & Bourgeault, 2015; Sethna, 2013).

In June 2014, MOHLTC introduced a common education standard for PSW programs. Programs offered by all institution types were expected to comply with this standard by September 2015. The standard included 14 learning outcomes, essential employability skills, and an optional general education component. The common program standard was developed in response to health workforce issues, including a growing unregulated workforce dealing with increasingly complex clients in a climate of labour shortages and strained resources. Prior to the implementation of the common standard, there were three standards in use in Ontario: one was set by the Ministry of Training, Colleges, and Universities (MTCU), which community colleges
adhered to; a second was set by the National Association of Career Colleges (NACC), and applied to most private career colleges; and the third standard was developed by the Ontario Community Support Association (OCSA), and pertained to school board-based continuing education programs. The introduction of a common standard increases standardization in the workforce, while avoiding the cumbersome legislative framework that applies to other health professionals (Kelly & Bourgeault, 2015). Notwithstanding the introduction of the common standard, the different institution types are still governed by different ministries and must comply with different legislation. Participants in this study were asked their opinion about the differences between the different program types. Their responses suggested that differences in both design and content of the certificate programs existed, as will be discussed in Chapters 5 and 6 of this thesis.

2.7 Analysis and Discussion of PSW Registry Data

Canadian Research Network for Care in the Community (CRNCC) published data from the PSW registry in 2013. CRNCC used SPSS21 to analyse the 32,302 PSWs who are in the registry. The data is based on self-reported information. The sample size represents roughly 1/3 of the total estimated PSW population. As mentioned earlier in this chapter, registration was voluntary. Although the sample is biased for these reasons, the statistics were still useful for gathering demographic information about the workforce, and information about the type of work PSWs do, where they are employed, and how they are trained. A description and discussion of the data is provided below.

2.7.1 Demographic Characteristics

The variables analysed by CRNCC were sex, age, credentials, areas of specialization, employment setting, language, and number of years as PSW.

As shown in table 2.1, the CRNCC data found that Registered PSWs were overwhelmingly female (92%). The largest proportion of PSWs were between the ages of 40 and 49 (26.9%), followed closely by PSWs 50 to 59 years of age (26.2%). The next largest group were those aged 30 to 39 (21.5%). The remainder were 20 to 29 years of age (14.1%) or over 60 (10.7%). A very small minority (0.5 %) were 19 or under. When asked at what age they began working as PSWs the largest proportion were between 30 and 39 years of age (31%). The next largest group were
those between the ages of 40 to 49 when they began working. This proportion is similar to the proportion who were currently in this age group, which suggests that a sizeable proportion of the workforce comes to the occupation as a career change. The largest proportion of the registered population have been employed as PSWs for over 10 years (31.2%). The balance of the registered population had worked from 2 to 5 years (20.8%) or 5 to 10 years (22.1%). 17.1% of the population had worked as a PSW for less than a year and 8.8% had worked for 1 to 2 years.

In summary, registered PSWs were predominantly middle-aged, female workers who view being a PSW as long term employment.

The vast majority (92%) reported that they speak English fluently. Only 1% reported that they had weak English while 5% spoke English at an intermediate level.

Table 2.1

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>92%</td>
<td>8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>19 or Less</th>
<th>20 - 29</th>
<th>30 - 39</th>
<th>40 - 49</th>
<th>50 - 59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.5%</td>
<td>14.1%</td>
<td>21.5%</td>
<td>26.9%</td>
<td>26.2%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Began Working as PSW</th>
<th>17 - 19</th>
<th>20 - 29</th>
<th>30 -39</th>
<th>40 - 49</th>
<th>50 - 59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.4%</td>
<td>26.8%</td>
<td>31.0%</td>
<td>28.3%</td>
<td>10.6%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Years Worked as PSW</th>
<th>&lt; 1</th>
<th>1 - 2</th>
<th>2 - 5</th>
<th>5 – 10</th>
<th>&gt; 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17.1%</td>
<td>8.8%</td>
<td>20.8%</td>
<td>22.1%</td>
<td>31.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>English</th>
<th>Fluent</th>
<th>Intermediate</th>
<th>Weak</th>
<th>No/Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>92%</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Total = 32, 299
2.7.2 Specialized Expertise
The registry asks whether PSWs have specialized experience with each of a number of specified clinical areas. Respondents could select as many clinical areas as they believed appropriate. The report does not define specialization, so it is unclear whether this has to do with continuing education in the relevant area, or practice experience. The document analysis did reveal any specialization programs for PSWs, such as graduate certificate programs. As shown in table 2.2, the most prevalent area of specialization for registered PSWs identified in the CRNCC data was Alzheimer’s with 60.3% having specialized experience in this area. The next largest area of specialization was diabetes (47.2%) followed closely by behavioural disorders (40%). Approximately 1/3 have specialized experience with MS while roughly ¼ have non-verbal communication, mental illness, cancer, or cerebral palsy. Approximately 1/5 have experience with children with special needs, muscular dystrophy and cardiac conditions. Less than 1/5 have special experience with children with autism, Amyotrophic Lateral Sclerosis, HIV/AIDS, and Fetal Alcohol Syndrome.

Table 2.2

<table>
<thead>
<tr>
<th>Credential</th>
<th>Other</th>
<th>Home Care Aide Certificate</th>
<th>Personal Attendant Certificate</th>
<th>Home Support Worker 2</th>
<th>Home Support Worker 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW Certificate</td>
<td>89.2%</td>
<td>10.1%</td>
<td>8.2%</td>
<td>2.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>10.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Care Certificate</td>
<td></td>
<td>8.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Attendant Certificate</td>
<td></td>
<td></td>
<td>2.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Support Worker 2</td>
<td></td>
<td></td>
<td></td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Home Support Worker 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Employment Setting (reported as number, rather than percent)

<table>
<thead>
<tr>
<th>Employment Setting</th>
<th>LTC</th>
<th>Home Care</th>
<th>Community Support</th>
<th>Supportive Housing</th>
<th>Retirement Home</th>
<th>Hospital</th>
<th>Attendant Service</th>
<th>Day Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>5367</td>
<td>3703</td>
<td>1671</td>
<td>1669</td>
<td>1056</td>
<td>689</td>
<td>407</td>
<td>291</td>
<td></td>
</tr>
</tbody>
</table>

Hours Worked per week

<table>
<thead>
<tr>
<th>Hours Worked per week</th>
<th>1 – 10</th>
<th>10 - 20</th>
<th>20 - 30</th>
<th>30 - 40</th>
<th>40+</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>10%</td>
<td>25%</td>
<td>35%</td>
<td>27%</td>
<td></td>
</tr>
</tbody>
</table>

2.7.3 Where do Registered PSWs work?
The report gathered data on the employment settings where registered PSWs work. Respondents could choose multiple options from a list. The report gives information for 14853 PSWs, recognizing that people could work in multiple settings. The largest number reported working in long term care (5367). However, 3703 reported working in Home Care, and another 1671 in
Community Support. Other workplaces reported were Retirement Home (1056), Hospital (689), Attendant Service (407) and Day Program (291).

The study also gathered data on how many hours a week PSWs work. The largest group worked 30 to 40 hours a week (35%). The next largest groups worked more than 40 hours a week (27%), or 20-30 hours per week (25%). Ten percent worked 10 to 20 hours, and 3% worked 1 to 10 hours. The study did not report on how often the total number of hours represented multiple work places.

2.7.4 How Are They Trained?

The vast majority of registered PSWs possess a PSW certificate (89.2%). 10.1% indicated that they had “other” education that was not specific to being a PSW. A small proportion had other types of education such as Home Care Aide certificate (8.2%), Personal Attendance Certificate (2.7%), Home Support Worker 2 (2.5%) or Home Support Worker 3 (1.3%) certificates. Home Care Aide, Personal Attendant, and Home Support Worker 2 & 3 certificates are no longer offered in Ontario. Because people can hold multiple credentials, respondents were able to choose more than one option, so this data does not add up to 100%.

2.7.5 Discussion

The vast majority of the registered population holds a PSW certificate. This is probably because many of the same employment settings that require staff to register also require or strongly prefer a PSW certificate.

As discussed in section 2.7.2, the statistics also show that the two conditions with which PSWs are most likely to have specialized experience are Alzheimer’s and diabetes. Both conditions are chronic health conditions; however while Alzheimer’s is primarily a geriatric illness, diabetes can affect people of any age group. This data was used to guide the focus of recruitment activities for a client advocacy group representative. This, combined with the data from the document analysis led to the decision to prioritize obtaining an interview with a representative from an Alzheimer’s or diabetes group.

The statistics also do not reveal how specialization was acquired or clarify what was meant by specialization. As will be discussed in more detail in chapter 6, the PSW key informants receive on-the-job training regarding specific conditions and issues, such dementia or palliative care. The
certificate programs in the analysis did not offer courses specific to certain diseases, therefore it seems likely that PSWs acquire specialized experience on the job. The registry data, combined with the paucity of job postings for positions in hospitals identified during the document analysis, led to the decision to focus employer and PSW key informant recruitment efforts on home care and long-term care.

2.8 Theories of Professionalism Applied to the Personal Support Work Occupation

Theories of professionalism are relevant to understanding the PSW education system; the perception that PSWs are not truly “professionals” is part of why the system has not pursued formal regulation of the profession, choosing instead to ensure the quality of the workforce by initiatives such as standardizing education. One of the arguments against regulation is that PSWs lack a clear body of knowledge, which is one of the characteristics of a profession (Brooks, Gibson, & DeMatteo, 2008; Kelly & Bourgeault, 2015; Sethna, 2013).

There is some dispute among theorists as to exactly what defines a profession. “Most agree that they have the following four characteristics: a) they possess specialized knowledge, attained through established education programs, and attested to through certification procedures; b) they provide services to members of the public; c) there is a risk to the public if the services are not done properly; d) the clients who receive these services are often not in a position to judge quality, or even whether the services are necessary; accordingly, there is an agency relationship with the clients receiving the service (i.e. caveat emptor is not an appropriate way to manage the relationship)” (Deber & Mah, 2014). The fourth characteristic means that only members of that profession are in a position to assess competence, thus professions are usually self-regulating (Deber & Mah, 2014).

PSWs are not viewed as professionals or regulated as such, although they possess many of the four characteristics outlined above. The first characteristic (specialized knowledge attained through established education programs) is currently ambiguous for the PSW. The Ontario LTC Act requires that PSWs in that setting have obtained some kind of formal education, but this is not a legal requirement in other settings, such as home care. Nevertheless, as will be discussed in greater depth in chapters 5 and 6, the data collected for this study revealed that in Ontario most
home care agencies that receive public funding require their PSWs to have some type of formal education for that job.

The fourth characteristic, that the client is not in a position to judge if the services are needed or performed correctly, is the most complicated to apply to the PSW. As described above, the services they provide are those which clients would perform for themselves were they able. Whether or not a PSW client is able to judge if the services are needed or being performed correctly depends on why clients are unable to perform the task for themselves. If a PSW is performing the task because the client has dementia, cognitive impairment, or intellectual disability, such clients may not know why there is a need for the task or whether or not the task is being performed correctly. Other clients may be intimately aware of their care needs and how they wish care to be performed, viewing the PSW as their employee rather than caregiver (Brooks, Gibson, & DeMatteo, 2008; Loft, McWilliam, & Ward-Griffin, 2003). Even if the client does not know whether or not the services are being performed correctly, it cannot be said that only members of the PSW occupation can assess competence. The expectation is that nurses, who are members of a regulated profession, are teaching and evaluating PSW skills.

PSWs clearly meet the second criteria in that they provide services to the public. They also share the third characteristic in that if certain tasks that are often assigned or delegated to the PSW are not carried out correctly, adverse events could occur.

Several sources discuss PSWs in relation to professionalism and the implications of their lack of professional status (Aronson & Neysmith, 1996; Health Professions Regulatory Advisory Council, 2006; Lilly, 2008). According to Aronson and Neysmith, home care workers are “low-status, paraprofessional” workers. The intimate nature of the care they provide means that the boundaries of their labour are often blurred to encompass unpaid tasks, allowing their labour to be taken advantage of by clients or employers. Since PSWs carry out a mix of healthcare and personal care, maintaining work appropriate boundaries is challenging and PSWs may be asked to carry out work that falls outside of their scope, either in that it is highly medical or overly intimate (Aronson & Neysmith, 1996; Berta, Laporte, Deber, Baumann, & Gamble, 2013; Brooks, Gibson, & DeMatteo, 2008; Church, Diamond, & Voronka, 2004b; Health Professions Regulatory Advisory Council, 2006; Janes, 2006; Keefe, Knight, Martin-Matthews, & Légaré, 2011; Pan-Canadian Planning Committee on Unregulated Health Workers, 2008; Sethna, 2013).
PSWs employed in an institutional setting or by an agency are supervised by regulated providers, typically nurses, who determine the appropriate plan of care. PSWs are responsible for the day-to-day implementation of the care plan and are often the first people to notice if the care plan is no longer effective. While PSWs in home and long-term care in Ontario are supervised by regulated providers, supervision in home care is clearly much less direct, often consisting of chart audits and phone meetings (Health Professions Regulatory Advisory Council, 2006; Sethna, 2013). Moreover, PSWs who are employed directly by the client are supervised by that client or their family, and may have no oversight from an RHP such as a nurse. This means that PSWs have greater degrees of autonomy over their work in different settings. According to some theories of professionalism, professions establish bodies or associations that control admission to the profession and control the type of work that is performed. Two major mechanisms that can be used are the establishment of credentialing requirements and regulatory bodies; and specification of restricted tasks that can only be performed by members of that profession (Freidson, 1988). While Ontario PSWs currently have no such credentialing body, two organizations have appeared in Ontario that complicate the issue of professional membership and control. The first was the now defunct registry described earlier in the chapter. The second is the Ontario Personal Support Worker Association (OPSWA). Founded in 2007, OPSWA is a professional association that describes itself as a voice for PSWs in Ontario. The organization is led by PSWs and publishes a number of PSW practice standards. The association has approximately 30,000 members, conducts background checks on its members, and requires that members have a PSW certificate from a recognized program to join. Membership in the association is voluntary and they do not have a legal mandate to ensure that members are upholding the standards of practice.

Some theories of professionalism observe that careers commonly thought to be professions are based more heavily on abstract and theoretical knowledge, and instruction is typically provided by members of that profession in an institution of higher learning. In contrast, craft or vocational training can take place in a more applied institutional setting or on the job (Freidson, 1988). PSW programs in Ontario are offered at vocational schools such as publicly funded community colleges, school board continuing education programs, or private career colleges. Some RHPs train at universities (institutions of higher learning), while others train at vocational schools, such as community and private colleges. This distinction between professional and vocational
education presents a quandary for PSW programs. The current role requires PSWs to be knowledgeable in a number of conceptual domains that would usually be covered in greater depth in a theoretical program, such as a nursing program in a university.

The first characteristic of professionalism identified above is specialized knowledge requiring specific credentials. While a certificate is not a legal requirement of becoming a PSW, it is listed as a requirement for obtaining employment in almost every job posting collected for this study. This further suggests that personal support work exist in a gray area between being a profession and an occupation.

2.9 Summary

There are approximately 90,000 PSWs in Ontario. Their scope of practice is to do for a client that which they would do for themselves were they physically or cognitively able. They are of vital importance to the health care system because they decrease the need for acute care services and are less costly than regulated care providers such as nurses. Over the last two decades, the role of PSWs in Ontario’s health care system has grown as a result of more complex care needs being delivered at home, rather than in hospital settings, where public funding is guaranteed. PSWs deliver most of the care hours in long-term care homes, and provide most of the paid care in private homes. PSWs are low-wage unregulated healthcare workers who must be supervised by much more costly regulated health care professionals. Low cost PSW labour is especially beneficial to the managed competition system used to allocate publicly-financed home care funding in Ontario. Under this system, home care providers are incentivised to deliver care for the lowest cost possible, which makes it advantageous to hire the smallest number of regulated care providers possible and have most of the care delivered by PSWs. In Ontario, PSW supervision is most typically provided by registered nurses. Nurses have the authority to delegate or assign tasks from within their scope to PSWs under their supervision, and such delegation is especially prevalent in the home care setting. The delegation and assignment of nursing tasks means that they may be involved in significant care that is part of a profession’s scope.

PSW certificate programs appeared in Ontario in 1997, the same year in which managed competition was introduced. While completion of a certificate program is not a legal requirement of working as a PSW, PSWs in long-term care must have either completed a certificate program
or all or part of a nursing program. The PSW key informants confirmed that some of them had foreign nursing education and had not been able to register in Canada, or had not completed their nursing education in Canada and had elected to work as PSWs instead. Completion of such education is not a requirement of any other setting; however, employers in other settings, including those hiring a PSW directly through their own resources, are free to require this certification if they wish. It has become increasingly typical for employers to require a certificate, making it more and more difficult for PSWs with only on-the-job training to obtain work, especially in higher paid settings such as hospital and LTC homes.

A common standard for education programs was introduced in June 2014 and certificate programs were expected to comply with the standard by September 2015. Most of the data collection for this study was collected between those dates. Key informants provided information as to how various programs had updated their curriculum to comply with the new standard, which will be described in chapter 6. Prior to that, certificate programs offered by three different types of institutions each complied with their own standard. While all the programs are now required to adhere to the same standard, each institution type has its own system of governance and quality assurance, and each program sets its own curriculum. The common standard was developed in part as a result of the fact that role and scope of the PSW in Ontario’s health care system has increased significantly in the last decade and it is a challenge for certificate programs to keep pace with these shifts.
CHAPTER 3: RESEARCH DESIGN AND METHODS

3.1 Overview of Design and Methods

This study can be described as an intrinsic case study wherein PSW certificate programs in Ontario are the case (Baxter & Jack, 2008; Yazan, 2015). The research employed multiple methods of data collection, and occurred in two phases: document analysis, and key informant interviews. The research was approached from a pragmatic paradigm, which is typically associated with the mixed-methods literature (Creswell & Clark, 2007). While this study gathered and reported on some quantitative information such as the total number of programs and program duration, data collection involved two types of qualitative data, meaning that this research would not be formally classified as a mixed-methods study. The mixed-methods literature was still useful to decision-making regarding study design because it offered specific examples of research typologies that were consistent with a pragmatic approach. Qualitative literature regarding case study typologies, thematic analysis, and inductive coding were also relied upon to provide guidance regarding study design, data collection, and analytical methods.

Case studies allow researchers to explore and describe phenomena and their associated contexts; they are useful for answering “how” and “why” questions (Baxter & Jack, 2008; Yazan, 2015). “This approach is valuable for health science research to develop theory, evaluate programs, and develop interventions because of its flexibility and rigor” (Baxter & Jack, 2008). In an intrinsic study, the case itself is the central focus, and the purpose of the study is to understand the case itself, usually because it is entwined with an issue of relevance to the researcher (Baxter & Jack, 2008; Stake, 1995; Yazan, 2015). In this instance, the case is PSW education programs, and it is intrinsically relevant because of the reliance upon the standardization of educational programs as a mechanism for standardizing the workforce (Kelly & Bourgeault, 2015). An intrinsic case study was consistent with the goal of learning more about how PSW certificate programs are designed, what they teach, and perceptions of program quality and relevance.

Decisions regarding research methods were made within the context of a pragmatic paradigm. According to Creswell and Clark, a pragmatic world view is typically associated with mixed methods. They state that:

“[In the pragmatic world view] the focus is on the consequences of research, on the primary importance of the question asked rather than the methods, and on the use of
multiple methods of data collection to inform the problems under study. Thus it is pluralistic and oriented toward “what works” and practice” (Creswell & Clark, 2007). The research methods used to gather information regarding the design and content of educational resources for PSWs, and the strengths and weaknesses of program design and content, were document analysis and key informant interviews. The document analysis preceded the interview phase.

The reasons for using two qualitative methods were twofold. The first reason was triangulation. Greene and colleagues define triangulation as the use of multiple methods to increase the validity of the results. The rationale is that all methods have inherent biases and limitations; therefore, if the results of multiple methods converge, the validity of the findings is enhanced (Greene, Caracelli, & Graham, 1989). Information from the key informants confirmed information in the documents regarding the design the educational system and content of programs. The second reason was that the key informants provided details that were not covered in the documents, such as perceptions regarding program quality, and areas where programs could be improved. The use of multiple methods of data collection is typical in case studies for the reason outlined in this paragraph (Baxter & Jack, 2008; Stake, 1995; Yazan, 2015).

One of the drawbacks of case studies, is that the use of multiple methods can lead to an overwhelming amount of data, in which the researcher can get “lost” (Baxter & Jack, 2008). A computerized database is often needed to manage the volume of data. In this study, the qualitative research software NVivo was used to manage the data, as will be described in greater depth below.

The Canadian Research Network for Care in the Community (CRNCC) is an “affiliation of academic and community researchers, community service providers, consumers and policy makers. The CRNCC encourages collaborative, community-driven research and knowledge translation in home and community care, a crucial, yet under-active research field” (www.crncc.ca). The data from CRNCC 2013 report on the PSW Registry Data Analysis results provided some information about the demographics of the PSW population that are relevant to the study. Because it did not provide details regarding exactly what tasks are being carried out by PSWs by setting and how they are being trained to carry them out, it was supplemented by the document analysis and the key informant interviews. Additionally, registration was voluntary,
and was implemented in the home care sector first, which means that the sample is biased and data may not be generalizable to the entire workforce.

Phase one and phase two of the study are described in detail below.

3.2 Phase 1: Document Analysis

3.2.1 Objective and Rationale

The Objective of the document analysis was to learn about the type and quantity of program in existence, how they are governed, and what they teach. A wide range of source types relevant to ascertaining the nature of the different PSW certificate programs and their relationship to learning needs in different PSW labour contexts were included in the analysis. This table summarized the sources that were used to respond to each of the research questions:

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Corresponding Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How is the PSW education system in Ontario designed?</td>
<td>Government documents, key informants (PCC rep, educators, accreditation program, NACC), program websites</td>
</tr>
<tr>
<td>2. What is the content of PSW certificate programs?</td>
<td>MTCU standard, Mosby’s Canadian Text for the support worker, program websites and orientation materials</td>
</tr>
<tr>
<td>3. What are key informant perceptions of the education programs?</td>
<td>Interview Transcripts</td>
</tr>
</tbody>
</table>

There are a number of advantages to document analysis. According to Bowen, documents can provide background information and context, lead to additional questions to be asked, be a means of tracking changes in information over time and verify information from other sources (Bowen, 2009). As will be described further in chapters 4 through 7 (results), the documents were used for all of these purposes in this study. Additionally, document analysis was the primary research method for this study for the reasons of availability, cost-effectiveness and stability noted by Bowen. He also notes that the advantage of stability is that the researchers presence or observation does not alter the content being analysed (Bowen, 2009).
3.2.2 Sources and Data Collection

The researcher used information gathered during the literature review and phase 1 to identify document categories that would be likely to have information relevant to the central research questions. Documentation from government and accreditation bodies, PSW employers, certificate programs, and PSW and Client Associations were included in the analysis. The sample for each source type was acquired via key word searches. The researcher visited the website for each institution and collected data regarding a) whether or not the institution had a website, b) whether or not the website had course descriptions, c) program duration (months, weeks, or hours), d) practicum hours, e) admission requirements, f) program delivery options, and g) accreditation status. Given the relatively small sample size, the data was collected and analysed using MS Excel. The results of each variable by institution type are presented in Chapter 4.

The researcher identified 87 PCCs that offer a PSW program. This total was reached by comparing the programs listed on NACC’s website as having purchased the PSW program to the list of institutions that are registered to offer the PSW program on Service Canada’s private career college search site. Four programs listed on NACC’s website as having purchased the PSW curriculum did not appear to be registered with PCC Branch. An informant at PCC branch confirmed that three of the schools had shut down and NACC was either unaware, or had not yet had the opportunity to update the list. The informant advised that the fourth school operates under one name; however, it is registered with PCC under a different name. This information brought the total number of operating programs to 84. A Google search was conducted of each institution. Some of the institutions have multiple campus locations, so the program is offered at over a hundred sites.

Seventy-four of the schools had a website. Two institutions were listed as having purchased the PSW program from NACC and were registered with PCC branch, but not to deliver a PSW program. The websites of these schools did not make any mention of such a program. Two schools were listed as having purchased the program from NACC and were registered with PCC to deliver the program, but made no mention of a PSW program on their websites. Of the twelve programs not accredited by NACC, two purported to be accredited with NACC although they did not appear on NACCs list.
The vast majority of the data was collected using the “NCapture” feature of NVivo. Ncapture installs a button on the tool bar of the user’s web browser. By clicking on the NCapture button, the user can create a PDF of the web material, name the file in a manner that is appropriate to the project, and import it into NVivo. Sources that could not be collected in this manner were saved as PDF files on the researcher’s computer and subsequently imported into NVivo. NVivo documents the date on which the data was imported.

**System Design Documents**

A variety of document types were used to gain an understanding of the design of the PSW education system, including program standards, government policy documents and frameworks, legislation, and accreditation and quality assurance body websites.

As will be discussed in greater detail in chapter 5, the Ministry of Training, Colleges and Universities introduced a consolidated PSW program standard in July 2014, which the three institution types are expected to implement by September 2015. This new MTCU standard was a significant focus of the document analysis. The standard presents 14 learning outcomes that PSWs are expected to have mastered upon graduation. These were used to inform the document analysis and the sections in chapter 6 correspond to each domain of the standard. The 14 learning outcomes are presented in Appendix C. Prior to the introduction of this consolidated standard, each institution type adhered to its own standard.

The school board continuing education programs adhered to the earliest of the program standards which was developed jointly by the Ontario Community Support Association in 1997; this was included in the document analysis.

Most of the private career colleges adhered to program standard developed by the National Association of Career Colleges (NACC). NACC’s program standard is a proprietary document. In order to offer the program, institutions must purchase the rights to it from NACC. As a result, the researcher was not able to obtain the program standard. Information from NACCs website, and key informants as will be described later in the chapter were used to gather information regarding this program standard.

The CAAT’s adhered to the prior MTCU program standard, which was no longer available on their website during the timeframe of data collection. The researcher was not able to obtain a
copy of the outdated standard. The current standard, to which all the programs must now adhered, was used.

Government policy documents and legislation that regulate the various institution types were also collected and reviewed. Legislation included the *Colleges of Applied Arts and Technology Act* (Government of Ontario, 2002), the *Private Career Colleges Act* (Government of Ontario, 2005), the *Education Act* (Government of Ontario, 1990). Pursuant to the CAAT Act, the Minister for TCU developed a binding policy directive entitled “Framework for Programs of Instruction”. Appendix A to this directive is the Ontario Credentials Framework. This document was also an important source of information regarding the design of the CAAT system.

Legislation was also used to learn about the labour settings where PSWs are employed, namely the *Long-Term Care Homes Act* (Government of Ontario, 2007), the *Retirement Homes Act* (Government of Ontario, 2010), and the *Home Care Act*.

Each of the institution types have their own quality assurance mechanisms. Quality assurance for the CAATs is provided by the Ontario Colleges Quality Assurance Service. Information from their website (ocqas.org) was reviewed to learn about this aspect of the CAAT system.

The schoolboard-affiliated programs are accredited through the PSW Education Program Accreditation (PEPA). Documentation from their website (www.pswepa.ca) was used to gather information regarding the design of this education system and its standards.

**Employer Documentation**

Employer documents included job descriptions and postings, a training manual and sample care plans. Employer documentation was included in the analysis to learn about the PSW labour context and the learning needs and expectations of PSW employers. The PSW employer data was acquired using the key word searches “personal support worker jobs Ontario”, “PSW jobs Ontario”, “personal support worker jobs hospital”, and “personal support worker job description”. The data was collected in the order of the search results, excluding the results that appear at the top marked “ad” as a result of payments made directly to Google by the advertiser, but including those by employers seeking workers if those appeared in the search results. Sources that duplicated an employer already in the sample were also skipped. The sources were
filed according to employer type to allow for analysis of employers as a whole as well as by sector type.

**PSW Association Documents**
Association documents included practise standards, sample care plans, fact sheets, association descriptions, and certificate program tables and lists. Data from personal support worker associations and organizations was included to learn about the self-identified learning needs and professional practise standards of PSWs. Association data provided valuable information as to what PSWs are doing, the setting in which the work takes place, and how they are expected to acquire the skills to carry out their role.

The Ontario Personal Support Worker Association (OPSWA) publishes 23 practice standards. The standards were included in the analysis because they were a valuable source of information as to what PSWs are doing and how they are expected to learn the requisite skills. Adherence to legislated requirements regarding the provision of care also emerged as a significant component of the PSW’s role. As a result, several pieces of legislation were collected.

The association and organization sample was acquired using Google search terms “Personal Support Worker Association” and “Personal Support Worker Association Ontario”. A total of 6 personal support worker associations that are active in this jurisdiction were identified. Any information on their websites pertaining to the associations’ function, the role of the PSW, and education was collected. The documents collected via this sampling methodology included fact sheets, policy papers, articles, practise standards, program lists, and a certificate program table.

**Program Documents**
Since educational resources for PSWs are the central focus of the study, one of the objectives of gathering documents from this category was to determine the total number of programs operating in Ontario. This was determined by accessing lists of schools published by MTCU, PSW associations and the National Association of Career Colleges. Each school’s website was visited and variables about the school, such as program duration, admission requirements, other certification included in the course, and whether the program was available part-time were tracked using MS Excel.
Another objective of gathering documents from the certificate programs was to learn more about the program content, and the extent to which it is in keeping with the consolidated standard. To this end, the researcher collected course descriptions, course outlines, and program orientation materials, such as PowerPoint presentations.

Additionally, the document analysis and interviews with the PSW educators revealed that there is one textbook in use in the vast majority of PSW and similar programs in Canada: *Mosby’s Canadian Text for the Support Worker* (Kelly, Sorrentino, Wilk, Remmert, & Schuh, 2013). Given that this text is one of the most standardized features of PSW certificate programs, and is the most comprehensive and validated source as to what is considered the body of knowledge of PSWs, the researcher acquired the e-book version of the text (identical to the print version), and included it in the document analysis. Because it is a good indicator of program content across programs, this textbook was a significant document in the program content analysis (Chapter 5). The textbook’s Table of Contents is provided in Appendix D.

### 3.3 Phase 2: Key Informant Interviews

#### 3.3.1 Objective and Rationale

The objective of the interviews was to corroborate information gathered in the document analysis and to provide information regarding program design and content that was not provided by the documents. Moreover, participants were asked about their views on how well programs had done at preparing PSWs for the role, and the areas in which they could benefit from additional learning. These questions were related to the goal of learning about perceptions of program quality.

#### 3.2.3 Sources and Data Collection

The interviews were semi-structured. The pre-determined questions were approved by the university’s research ethics board. Approval to ask clarification questions was also sought and granted. The interview guide is provided in Appendix B. Recruitment of key informants for this study was purposive and used a maximal variation sampling procedure. In maximal variation sampling, diverse individuals who are expected to hold different perspectives on the central phenomenon are purposively sampled (Creswell & Clark, 2007). The researcher began by identifying stakeholder categories that were relevant to the research questions, namely, PSWs, PSW supervisors, program instructors, accreditation bodies, and client advocacy groups. Then,
organizations with potential key informants were identified, primarily from the document analysis, and also from contacts identified by the research team. The goal was to achieve a sample of at least one person for each stakeholder category, for a minimum total sample of 5. This goal was achieved, and considerably exceeded; and there are a number of reasons for this. Participation was voluntary and more people from some categories responded than others. Also, within each category, there were multiple sectors to consider. Where possible, more interviews were collected to gather more diverse perspectives. For example, the employer recruitment letter was sent to a number of homecare and LTC agencies. Two homecare agencies responded, whereas only one LTC did. One of the homecare agencies was willing to facilitate access to a large number of PSWs and RN supervisors throughout the province. This unexpected volume of respondents had advantages and disadvantages to the study. On the one hand, the large number of interviews gave the researcher the opportunity to gather more data regarding perceptions of program quality, from a greater variety of participants, with experience in a greater variety of geographic and practice settings. On the other hand, because the unexpected respondents came from a single homecare agency, this led to the homecare sector being overrepresented in the sample. The educator recruitment letter was sent to emails at all three institution types; however, only educators from one institution type responded. A table of key informants, their participant codes, and the total sample size for each stakeholder category follows.
Table 3.2: Table of Key Informants

<table>
<thead>
<tr>
<th>PSWs N=14</th>
<th>PSW Supervisors N=10</th>
<th>PSW Educators N=2</th>
<th>Government &amp; Accreditation Bodies N = 3</th>
<th>Client Advocacy N=1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PSW Association rep (PA1 &amp; PA2)</td>
<td>1 LTC supervisor (L1)</td>
<td>2 CAAT Instructors (T1 &amp; T2)</td>
<td>2 PCC Sector (N1 &amp; G1)</td>
<td>1 Alzheimer’s Association (C1)</td>
</tr>
<tr>
<td>13 HCC PSWs (PP1 – PP13)</td>
<td>9 HCC supervisors (E1, &amp; PE1-PE8)</td>
<td></td>
<td>1 SBCE Sector (A1)</td>
<td></td>
</tr>
</tbody>
</table>

The recruitment strategy involved dissemination of the study information letter as an attachment with a covering email that was customized to the recipient. The researcher followed up with prospective participants by phone a few days after the initial email was sent to answer any questions about the research and schedule interviews. Most interviews were conducted by phone because most of the participants were not in the researcher’s geographical area. Two interviews with individuals in the researcher’s community of residence were conducted in person.

A total of 31 interviews were conducted, with informants from various parts of Ontario. Of these, the first nine were individuals who had experience teaching, supervising, regulating or providing personal care, or who advocate for clients receiving personal care. Upon completion of these interviews, a sample of one to two had been reached for each of the stakeholder categories.

These interviews were exploratory in nature, and both corroborated information gathered from the documents, and added to the researcher’s knowledge regarding both education system design and content. During these interviews, all of the prepared questions were asked, and the respondents were asked a number of clarification questions.

The remaining twenty-one interviews were conducted with thirteen PSWs and eight PSW supervisors from a single, CCAC contracted home care agency that serves Ontario. When the first 9 interviews were conducted, the researcher had a clear understanding of the educational system design, and an orientation to the program content. As a result, for the following 21 interviews conducted in home care agency 2, the interview questions were narrowed to include only those questions related to practice, on-the-job earning activities, perceptions of program quality, and suggestions for program improvements.
QUALITY ASSURANCE REPRESENTATIVE
There are two organizations that form part of the quality assurance mechanism in place for PSW programs: the National Association of Career Colleges (NACC), and PSW Education Accreditation Program (PEPA). The former accredits most of the private career colleges, and the later accredits most of the school-board affiliated programs, as will be described in depth in the following chapter. The researcher secured interviews with representatives from NACC (N1) and PEPA (A1).

CLIENT ADVOCACY GROUP
Relevant client associations were identified in the document analysis by reviewing content about conditions commonly treated by PSWs. Agencies representing clients living with the most commonly treated conditions, with Alzheimer’s and diabetes being the two most frequently mentioned conditions. Since both conditions also emerged as a typical area of specialization in the Phase I descriptive data, the researcher prioritized obtaining interviews with organizations representing these client groups. An interview with a representative from a Toronto-based organization that does advocacy for people with Alzheimer’s and dementias was conducted (C1).

CERTIFICATE PROGRAM INSTRUCTORS
The largest public, private and board-affiliated programs were identified during the quantitative component of the document analysis and recruitment letters were sent to potential informants at each institution type. An interview was conducted with two instructors at a large Toronto-based College of Applied Arts and Technology (CAAT) in person (T1, T2). Both instructors were registered nurses. One Instructor also provided a tour of the hospital, LTC, and home care simulation laboratories.

PRIVATE CAREER COLLEGES BRANCH, MINISTRY OF TRAINING, COLLEGES, AND UNIVERSITIES
This branch within the Ministry of Training, Colleges and Universities is responsible for regulating the approximately 600 Private Career Colleges (PCCs) in the province of Ontario. Private Career Colleges are for-profit, vocational institutions. The 84 institutions in the analysis that offered a PSW program ranged from large, multi-campus corporations offering numerous programs in a range of disciplines, to small institutions offering a single program. In order to operate legally, they must be registered and in good standing with the PCC branch. The researcher sought and conducted an interview with a staff member at the Private Career Colleges Branch.
branch within the Ministry of Training, Colleges and Universities to provide information regarding the design of the private career college system and how compliance with standards is assured (G1). The informant was not a subject matter expert regarding the design and content of PSW programs specifically. Where the informant was unable to provide answers to specific questions regarding system design, the questions were forwarded to the informant’s colleagues within PCC branch via email; responses were provided to the researcher via email.

**PSW Employers**

The primary researcher’s supervisors identified a contact who had access to PSW employers in their capacity as the executive director of an organization that represents home care agencies. The researcher provided the contact with the study information letter, which she circulated to her contacts. This outreach strategy lead to conducting an interview with a PSW supervisor at a large home care agency (E1). In chapters 5 and 6, this agency will be known as “home care agency 1”.

The researcher also contacted an association representing LTCs and was connected with the Director of Care of an LTC who agreed to participate in the study (L1).

**PSW Association**

The primary researcher’s supervisors also identified the executive director of a PSW professional association as a potential informant. The informant is the graduate of a CAAT PSW certificate program. The association she directs advocates for professional recognition for PSWs, protection of title, and provides a range of services for member’s including practise standards, practice advice, and hosts conferences. To become of a member of the association, one must be a graduate of a PSW certificate program, as well as have a background check conducted by the external agency “Backcheck”. An interview was conducted with this informant who provided significant insight into the role and scope of PSWs, as well as their learning needs and education system issues (PA1).

During the interview, the respondent mentioned that a colleague within her association had recently reviewed the revised NACC curriculum. The researcher requested an interview with this individual because at the time, efforts to obtain an interview with someone within NACC were unsuccessful. Additionally, NACCs program standard is a propriety document, and was not available to the researcher. As a result, the PSW association staff member who had reviewed
NACC’s program was a knowledgeable and objective source of information regarding the contents of the NACC program (PA2).

**HOME CARE AGENCY 2**

The remainder of the interviews were conducted with 8 supervisors (PE1 – PE8) and 13 PSWs (PP1 – PP13) within a large home care agency serving the province of Ontario. In the presentation of results in chapters 5 and 6, this agency is referred to as home care agency 2. The researcher sent recruitment letters to the general email of several large, home care agencies serving Ontario. The email was forwarded to the clinical consultant within one agency, who contacted the researcher to learn more about the study. The researcher answered her questions and she agreed to disseminate the recruitment materials to PSW supervisors throughout the agency. The supervisor provided the lead researcher with the names of interested participants. The supervisors were from various regions in Ontario, including the greater Ottawa area, the greater London area, the greater Toronto area, North Bay, and Sudbury. When the interview with each supervisor was conducted, the researcher asked them to forward the recruitment letter to their PSW team and requested that interested participants contact the researcher directly. Like the supervisors, the PSWs were from various regions in the province.

**3.3 Data Analysis**

The general inductive approach was used for the data analysis. In an inductive approach, the researcher begins with an area of study, and reads the raw data in detail; interpreting it to derive themes, categories or models. The purpose of an inductive approach is to allow research findings to emerge from frequent, dominant, or significant themes and categories in the data. The general inductive approach is consistent with the pluralism of a pragmatic world view. The method provides a straightforward set of procedures to follow for analysing qualitative data that are not reliant on the researcher’s understanding of an underlying philosophy. A general inductive approach is often used in qualitative research, without being explicitly labeled as such in reports (Thomas, 2006).

The underlying principles of the general inductive approach are that the findings are shaped by the underlying assumptions and beliefs of the researcher. Data analysis is guided by the research objectives, but the objectives are not connected to any expectations concerning the findings. The
researcher must make decisions about what is important and what is not for the findings to be usable. Different researchers may have findings that are not identical; however, trustworthiness can be established using the same criteria used in other qualitative analysis approaches (Thomas, 2006).

The chief strategy of the general inductive approach is the identification of categories arising from the raw data. There are 5 procedures in the general inductive approach: 1) preparation of the raw data files, or “data cleaning”, 2) close reading of the text, 3) creation of categories, 4) overlapping coding and un-coded text, and 5) continuing revision and refinement of category system (Thomas, 2006).

During the data cleaning phase, the researcher prepares the data for analysis by ensuring it is all in the same format (Thomas, 2006). In this study, with the exception of Mosby’s Canadian Text for the Support Worker, the sources for the document analysis were acquired via the internet and data was collected between July, 2014 and August 2015. The sources gathered during the document analysis were all imported into and coded with qualitative analysis software NVivo. All of the interviews were recorded, with the respondents’ permission. The recordings were transcribed by a transcription service and also imported into NVivo. All of the data were grouped by source type as they were collected.

During close reading of the text, the researcher reads the raw data in detail to become familiar with its contents and determine key themes and events. In this study, the data was read as it was collected, and memos were created that reflected the researcher’s observations regarding emerging themes.

During the creation of categories, the researcher identifies and defines themes and categories. The broader themes are usually derived from the research objectives, while the more specific categories are drawn from multiple readings of the data, with codes derived from words or phrases in the text, known as in vivo coding (Thomas, 2006). In this study, the researcher began with an in vivo coding process where codes were created from text or phrases that appeared frequently in a line-by-line read of the sources. Text frequency searches were used to support the generation of categories. Text frequency queries in NVivo allow the user to see how often words

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1 The term “in vivo” used by (Thomas, 2006) is different from “NVivo” the software.
are used within a dataset. With the default settings, the program identifies any word that has been used more than three times in the data set, but this number can be changed by the user. In this study, the default number of 3 words was not changed, but filters were set to exclude words such as “and”, “but”, etc. The results of the query are displayed from most to least commonly used words, and can also be displayed as a word cloud. Passages of text were coded to categories as each source type was reviewed, starting with job descriptions, followed closely by program standards, including the revised MTCU standard, the OCSA standard, and publicly available information regarding the NACC curriculum. The rationale for beginning with job descriptions is that they were readily available, brief documents that provide the reader with a fast orientation to the kinds of activities PSWs are engaged in in different settings. Education program standards and curricula followed because they were germane to the objective of learning more about the content of PSW certificate programs. Data gathered from certificate program websites was coded next. Much of the text from the programs could be coded to categories that had already been identified, and any new categories were added to the coding structure. Legislation that was mentioned in other sources was reviewed and coded. Key informant interviews were conducted after the documents had been coded. A very low number of new categories emerged from the key informant interviews. The categories were ones that had not been addressed by the documents, such as “areas for program improvement” and “on-the-job training”. Mosby’s Canadian text for the support worker was coded last because key informants such as the program instructors and NACC representative mentioned the text’s importance in PSW programs, which triangulated the results from the document analysis. The textbook could not be imported into NVivo, so the researcher created an extensive memo about the textbook in NVivo, which was coded. The text search function of the eBook was also used to explore the textbooks coverage of subject matter identified by the MTCU standard.

In the overlapping coding and un-coded text procedure, the researcher reduces overlap and redundancy among the codes. Qualitative coding makes the assumption that one selection of text can be coded to multiple categories, while other portions of text may be un-coded because they are not relevant to the research objectives. In this study, categories that were deemed to be synonymous were merged into one another, and memos were created explaining the rationale for these grouping.
Lastly, during continuing revision and refinement of the category system, the researcher reviews the content of each category to identify subthemes, dissenting viewpoints, and new insights. The categories can also be grouped together under superordinate categories if they have similar meanings. In this study, as the number of categories was narrowed, relationships between the categories were identified and documented in memos. Based on these observations, specific categories were grouped under broader categories, in a hierarchical structure. Once the coding structure was reorganized, the contents of each code were reviewed to ensure that the content within each node was accurate and that the right unit of content was captured.

Analysis was also supported by the coding, and matrix coding queries in NVivo. Coding queries can be used to learn more about certain themes or content in a particular context. For example, the feature can be used to show all content coded to the theme of “safety” in the source type “public colleges”. Matrix coding queries can be used to see how content within a particular node compares across source types. This feature was especially useful for determining how PSW labour varies by sector. Matrix coding queries can be used to see how content coded to the node “safety” differs between home care and LTC. As more observations about the data were made, queries were also used to test hypotheses and confirm observations about the data as will be described in greater detail in the results section below.

NVivo was also used to track demographic information about the programs and informants, such as program type attended, graduation year and course offerings. This data was used to answer secondary research questions regarding the characteristics of the different programs and labour settings across type.

The intended outcome of the inductive coding process is a small number (usually 3-8) of summary codes. In this study, the coding process resulted in a total of 8 summary codes, three of which were primarily relevant to the design of PSW programs (Question 1), and 5 of which were primarily relevant to the content of PSW programs (Question 2). The summary codes in response to Question 1 were Admission Requirements, Program Characteristics, and Education System. The summary codes in response to Question 2 were Patient Profile, Qualities, Supporting Quality of Life, Knowledge & Tasks, and Labour. The coding scheme pertaining program design, is presented below in figure 2. The coding scheme pertaining to program content is presented in 3.3.1.
3.3.1: Coding Structure Re. Program Design

- Admission Requirement
  - CPR/First Aid
  - Mature Student Status
  - Criminal Record Check
  - English/French
  - Medical Clearance
  - Mask Fit Test
  - Ontario Secondary School Diploma

- Program Characteristics
  - Lab
  - Placement
  - Program Duration
  - RHP Instruction
  - RPN Transition
  - Consolidates HCA/HSW

- Education System
  - System Improvements
  - Standards and Accreditation
  - Teaching Methods
    - Preceptor/Clinical Instructor
    - Continuing Education
    - Labs
    - Lecture
    - On-the-job
    - Clinical placement
    - Text and Materials
    - Theory
3.3.2 Coding Structure Re Program Content and PSW competencies

- Program Content
  - Patients
    - Disability
    - Addictions-Mental Health
    - Palliative
    - Ill & Injured
    - Across Life Span
    - Responsive behaviours
    - Communication Disorders
    - Dementia
    - Acute
    - Vulnerable
  - Qualities
    - Accountable
    - Adaptable
    - Efficient
    - Physically Able
    - Respectful
    - Compassionate
    - Positive Attitude
  - Supporting Quality of Life
    - Comfort/Well-being
      - Dignity
      - Emotional
      - Social
    - Individual
      - Cultural
      - Families
      - Maintain roles, interests, relationships
      - spiritual
    - Optimal Functioning
      - Cognitive
      - Communication
      - Independence
      - mobility
  - Employment Setting and Labour
    - RHP Supervision
    - Home Care
    - LTC
  - Knowledge-Tasks
    - Interpersonal
• Team work
• Compassion
• Conflict Resolution
• Diversity
• Helping Relationships
• Resources
• Respite
• Teach

- Clinical
  - Anatomy
  - Body Mechanics
  - Care Plan
  - Conditions
  - Delegated
  - Devices, Supplies, and Equipment
  - Health Promotion
  - Monitoring, Documentation, Reporting
  - Medical Terminology
  - Medication
  - Treatment Options

- Professionalism
  - Boundaries
  - Confidentiality
  - Ethics
  - Quality
  - Regulations
  - Rights
  - Role Scope

- Personal Care
  - ADLs
  - IADLs
  - Client-Centred/Directed
  - Safety/Rehabilitation

3.3.3 Rigour and Trustworthiness

Referencing Lincoln and Guba (1985), the case study and qualitative analysis literature referenced above identifies four criteria for ensuring analytical rigor and trustworthiness: Credibility, dependability, confirmability, and transferability (Baxter & Jack, 2008; Yazan,
The study endeavoured to meet these criteria to the extent possible; however, there were a number of limitations.

The study used two methods of establishing credibility: 1) triangulation, and 2) member checking (Casey, Houghton, & Murphy, 2012). The information from the key informants was used to corroborate information from the documents. For example, the key informants confirmed that there were three types of educational institutions, that there was a recently introduced common certificate program standard, that programs covered the content outlined in the standard, and that the content was consistent with their activities in the workplace. The study used member checking in that key informants were sent the portions of the report where there data was used, and asked to provide feedback on whether the information was accurate and complete.

The study use two methods of establishing dependability and confirmability: 1) audit trail, and 2) reflexivity (Casey, Houghton, & Murphy, 2012), with a greater emphasis on the first method. Memos in NVivo were used throughout data collection and analysis to create an audit trail. The memos explained decisions regarding coding, identification of themes, the rationale for grouping certain codes into themes, as well as which database queries were run and why, and the outputs resulting from those queries. The researcher also made memos regarding my reactions to information and personal perspectives on issues that arose.

The study relied upon thick descriptions to address transferability. Thick descriptions are a detailed account of the context of the data that provide the reader with sufficient information to assess how transferable the information is to other contexts. It is not a requirement that the data be transferable (Casey, Houghton, & Murphy, 2012). Transferability is not the goal of intrinsic case studies (Baxter & Jack, 2008). The researcher endeavoured to insure that the source of documents, and the labour context of key informants, was clear in the reporting of results. In this case, the data are not likely to be transferable to contexts in which PSWs practice under a profession-specific, legislative framework, or where applicable legislation allows PSWs to practice to a broader or narrower scope. Moreover, while a sample of at least one was achieved for each area of the sampling matrix, a significantly greater number of interviews were conducted with RN supervisors and PSWs within one homecare agency. This means that the
perspectives of homecare employees regarding the strengths and weaknesses of the programs, and how they could be improved are overrepresented in the data.

3.4 Limitations

3.4.1 Document Analysis

Many of the limitations of document analysis described in Bowen (2009) apply to this study. The first limitation observed by Bowen is insufficient detail. Documents are created for a purpose other than research. In this study, many of the documents were created for the purpose of marketing either programs to prospective students or job opportunities to prospective workers. As such, any drawbacks to programs or adverse aspects of jobs were not highlighted. Additionally, different programs used different marketing strategies. While some focused on academic content, other programs focused on other desirable aspects of the program such as low tuition or a short program duration and details regarding course content were not provided. Bowen’s observation that the level of completeness of the data can be relevant to the outcomes of the study is applicable to this study. For example, CAATs were more likely to provide course descriptions than the other program types. The details regarding what proportion of each program type provided information such as course descriptions, admission requirements, and application process are presented in chapter 5.

Another limitation noted by Bowen that is relevant to this study is biased selectivity. Bowen describes this idea in the context of organizational documents that are likely to be aligned with the policies and agendas of the organization’s leadership. Biased selectivity is relevant to documents such as program course descriptions. Course descriptions are brief, and programs must select what content to highlight in the brief write up. As a result, one cannot assume that because a topic is not mentioned that it is not covered in the course. The same can be said for documents such as job descriptions. This limitation was addressed as well as possible by accessing documents from a diversity of sources.

Data collection ended in August 2015. Since this was before the programs were expected to implement the common standard, any changes after the end of data collection may not have been captured by this analysis.
3.4.2 Interviews

The most significant limitation of the interview phase was that the researcher was unable to obtain an interview from someone within the PCC sector who was also a subject matter expert regarding PCC PSW programs. The researcher’s recruitment letters and voicemails to instructors at PCCs received no response. As a result, most of the opinions in the analysis regarding the PCC system are from individuals affiliated with one of the other institution types, which are essentially in competition with the PCC system for students.

The other significant limitation of the interviews was that all of the PSWs interviewed are currently employed in the home care setting. Several of the PSWs had experience working in the long-term care setting and were able to provide their opinion on the differences between the two settings; however, many of this group had left the LTC setting intentionally, as a result of concerns that will be discussed in greater detail during the chapter on program content. As a result, it is unclear whether PSWs currently employed within LTC would echo their views regarding the sector.

While some of the documents suggested that there are PSWs working in Ontario who have partially completed Canadian nursing training, or completed Canadian or foreign nursing training, only one key informant with partially completed nursing training was interviewed in this study. As a result, not enough information was gathered on the impact of nursing education on the PSW labour sector to include this issue in the analysis.

The study is not transferrable in the sense that the results are not likely to be repeated in another jurisdiction. There is too much variation from jurisdiction to jurisdiction with regards to the titles used to refer to workers fulfilling the personal support role; whether or not certificate programs exists and how they are structured, and to what extent it is legally mandated; and whether or not and to what extent the work force is regulated to know if the discussion of program design and content is applicable to other settings. The results are relevant to other jurisdictions because they provide a detailed description of the design and content of PSW programs that can be used to support decision making for jurisdictions wishing to implement or standardized PSW education.
CHAPTER 4: THE DESIGN OF PSW CERTIFICATE PROGRAMS IN ONTARIO

4.1 Overview

This chapter drew upon information coded to the admission requirements, program characteristics, and education system summary categories (see 3.3.1) to answer Question 1. Some general information that pertains to all of the programs is given in sections 4.1.2 & 4.1.3, followed by results that are specific to each institution type in sections 4.2.1 to 4.2.3.

4.1.2 How are Program Standards Set and Evaluated: The Consolidated Standard

In June 2014, the Ontario Ministry of Training Colleges and Universities introduced a common standard for PSW programs. The analysis in this thesis focused on this new standard. Since the previous MTCU standard was not available online at the time that data collection began, key informants provided information as to how the new standard differed from the old one.

Prior to the introduction of this standard, each institution type adhered to its own program standard or curriculum. The Colleges of Applied Arts and Technology adhered to the version of the MTCU standard that existed prior to the introduction of the new, standardized version in 2014. Most of the private career colleges adhered to a curriculum established by the National Association of Career Colleges, which will be described in greater detail in the section on the private career college system (4.2.2). The school-board affiliated continuing education programs adhered to a standard established jointly by Ontario Community Support Association (OCSA) and MOHLTC in 1997. As mentioned in chapter 2, MOHLTC is the largest ministry of the government of Ontario, responsible for the planning, funding, and evaluation of health care services in the province. The OCSA/MOHLTC standard is the earliest PSW program standard and the one on which the NACC standard is based (Kelly & Bourgeault, 2015). As noted in Chapter 2 its introduction coincided with the introduction of managed competition for homecare services in Ontario.

The new, consolidated standard expresses the program standards as 14 vocational learning outcomes (Appendix C). The substance of each outcome and if and how it is covered by the different program types is described and analysed in depth in the chapter on certificate program content (chapter 6). According to the standard, the vocational learning outcomes “represent culminating demonstrations of learning and achievement” and “they describe performances that
demonstrate that significant integrated learning by graduates of the program has been achieved and verified”’. The preamble to the learning outcomes explains that the rationale for this approach is that it ensures a consistent outcome amongst graduates, while allowing each institution to set the particulars of the curriculum with respect to delivery methods and program design. Each outcome has an “Elements of the Performance” section that sets out how successful graduates will demonstrate that they have achieved the learning outcome. All of this must be conducted in accordance with relevant legislation, employer policies and the care plan (Ministry of Training Colleges and Universities, 2014).

Under the detailed description of each learning outcome, several “elements of the performance” are listed that set out what the PSW must be able to do to demonstrate the learning outcome. Under each performance element, several “performance objectives” are listed, which set out what the PSW must do or know to execute each element. This is followed by a glossary of terms. The standard then sets out the essential employability skills standard and the General Education Standard that applies to all MTCU program standards. All programs offered at Colleges of Applied Arts and Technology must meet the essential employability skills standard; which has six domains: communication, numeracy, critical thinking/problem solving, information management, interpersonal, and personal. The General Education standard applies to diploma programs (as defined under the credentialing framework that will be described in greater depth below) at CAATs, although CAAT certificate programs are also advised to adopt the standard. The General Education standards do not apply to PCCs or School Board Continuing Education Programs and there is no evidence that these program types offer general education courses.

The PSW program standard provides information as to what PSWs must do and what they need to know to do so, but does not provide specifics with regards to program hours, program duration, instructor qualifications, specific course offerings or content, instruction methods, or materials. These details are determined by the individual institutions; and their compliance with the consolidated standard is assessed by regulatory processes that are specific to each institution type, as discussed below (Ministry of Training Colleges and Universities, 2014).
4.1.3 What types of Institutions offer PSW programs and how many are there?

As mentioned in Chapter 2, there are three types of institutions offering a PSW program in Ontario (Kelly & Bourgeault, 2015). The first type are Colleges of Applied Arts and Technology (CAATs), commonly known as community colleges. CAATs were established by the province in 1965 to provide publicly-funded educational opportunities for individuals who were not university bound but wanted vocational or technical education. They replaced trade schools that used to offer apprenticeships. Like universities, students must pay tuition to attend, and CAATs are administered by the Ministry of Training, Colleges, and Universities (Panacci, 2014).

The second category are Private Career Colleges (PCCs). PCCs do not receive public funding. They are geared towards those interested in acquiring specific skills and offer programs in areas such as business, health services, human resources, applied arts, information technology, electronics, services and trades. Students pay a tuition fee set by the institution. These schools are regulated by a branch within MTCU (Kelly & Bourgeault, 2015).

The third category are adult education programs that are typically affiliated with district public school boards, and are publicly funded through the Ministry of Education (Kelly & Bourgeault, 2015). They will be referred to as schoolboard-affiliated programs. The programs are not part of high school, but are rather continuing education programs for members of the community who may have not completed high school.

In Ontario at the time of writing, there were 23 Colleges of Applied Arts and Technology programs), 21 Schoolboard-affiliated continuing education programs and 84 Private Career College 84 programs, for a total of 128 programs.

The total number of College of Applied Arts and Technology (CAAT) programs was determined by visiting the website for each of the 24 CAATs listed on the Ministry of Training, Colleges, and Universities’ website and searching the site for a PSW program. All but one school had a PSW program, bringing the total number of CAAT programs to 23.

The total number of Private Career Colleges (PCCs) was determined by conducting a search for PSW programs on the PCC search service on MTCU’s website. This search yielded 146 results; however, where institutions have multiple campus locations, each location is listed individually. When duplicates were eliminated from the list, the total number of institutions was 84.
The total number of schoolboard-affiliated programs was determined by using a list of 22 school boards offering PSW programs retrieved from a PSW association website, and visiting the website of each of the schoolboards mentioned. All but one board had evidence of a PSW program on its site, which brought the total for that institution type to 21.

Of the 23 CAAT programs, 21 provided course descriptions. The ontariocolleges.ca website provides a list of the 24 CAATs divided by region. The course description from one school from each list was collected and coded until saturation was reached. Saturation was defined as nothing new being added to the codebook from that program type. One of the CAAT’s provided the detailed course outline for each course on its website, all of which were included in the qualitative analysis.

Of the 21 schoolboard-affiliated programs, two provided course descriptions on their website. These were also collected for the qualitative document analysis of program content. The researcher was also able to locate PowerPoint presentations used at informational open-houses hosted by two schools, and the student orientation manual of another schoolboard-affiliated program.

PCC and SBCE programs offer the same 13 modules as will be described in greater detail in the following sections. Appendix E provides a list of the modules as well as available information as to the number of hours spent on each module.

4.2 Program Design, Admission Requirements, and Quality Assurance Methods by Institution Type

For each type of program, the following sections will indicate: the number of programs and how they are regulated, the program design, the admission requirements, and quality assurance mechanisms.

4.2.1 Colleges of Applied Art and Technology (CAATs)

There are 24 Colleges of Applied Arts and Technology in Ontario; they are regulated under the Colleges of Applied Arts and Technology Act (2002). Further provisions as to how they must operate are set out in a Framework for Programs of Instruction, issued by the Minister of Training, Colleges and Universities in 2003, and revised in 2007. The framework includes an
appendix entitled “Credentials Framework” which sets out the criteria for each of the six types of documents that the Colleges can award to students upon completion of a program of instruction: Certificate, Ontario College Certificate, Ontario College Diploma, Ontario College Advanced Diploma, Ontario College Graduate Certificate, and Applied Degree. Under this framework, graduates of the Personal Support Worker Program are awarded an Ontario College Certificate (Ministry of Training Colleges and Universities, 2005).

Conformity to the “Framework for Programs of Instruction” is ensured by the Credentials Validation Service, a division of the Ontario College Quality Assurance Service. This oversight body was created after the introduction of The Colleges of Applied Arts and Technology Act, which transferred the responsibility for program approval from the government to individual institutions. According to the organization’s website, the quality assurance service is owned operated and funded by the 24 CAATs, and while government mandated, is not government affiliated (Ontario College Quality Assurance Service, 2015).

CAAT PROGRAM DESIGN

Twenty-three of the CAATs offer the Personal Support Worker Program (21 English, 2 French). The program is offered over the course of one academic year (2 semesters) when taken full-time. Nine of the institutions also offer the program on a part-time basis. Students can enroll in the required courses individually through that College’s faculty of continuing education and take the course in a time frame that is convenient for them. Most of the institution websites did not specify how long students had to complete the program part-time. The one institution that did provide this information gave students up to 7 years to complete the program. Two of the institutions offer a program that allows students to update their now defunct Health Care Aide Certificate to a PSW Certificate. Health Care Aide certificates were eliminated when PSW certificate programs were introduced in 1997. Four of the schools offer a program that allows students to bridge to the school’s Practical Nursing program. Practical Nursing is the 3-year CAAT diploma program individuals wishing to register with the College of Nurses of Ontario as practical nurses must complete. Nursing is not taught at the other institution types. Where such a bridging program is offered, students are either guaranteed admission to the Practical Nursing program if they maintain a certain GPA, or they are given advanced standing in the practical nursing program.
Eight of the schools provided information on their websites regarding the total number of hours of instruction. For the schools where this information is available, the hours range from 667 to 866, with the mean number of hours being 734. The program standard does not require a clinical placement component; but according to their websites, the all 21 CAAT programs include this. Students attend usually 2, but in some cases 3, clinical placements, with at least one being in an institutional setting and the other being in a community setting. Typically, the first portion of the placement involves shadowing a clinical instructor, while in the second portion, the student takes on a case load and is supervised by a preceptor. Eleven of the programs provided information regarding the number of practicum hours on their websites. The range is from 190 to 315, with the average number of practicum hours being 265. Prior to commencing the clinical placements, students engage in hands on learning in a simulated lab environment. The remainder of the total program hours are spent on course work.

The program instructor informants, who teach at a large CAAT in Toronto, advised that based on the current culture within the CAATs regarding instructor qualifications, all instruction in the PSW program at their institution and most of the CAATs is provided by registered nurses who hold a BScN degree (T1 & T2).

CAAT Application and Admission Requirements

Students can apply and be admitted on the basis of a completed high-school diploma or under mature student status. In Ontario, high-school credits are offered at 4 levels in grade 11 and 12. From highest to lowest these are workplace preparation (W), college preparation (C), college/university preparation (M), and university preparation (U) (Independent Learning Centre, 2016). For students applying with a completed high-school diploma, all but 3 of the schools require at least Grade 12 English completed at the University, College or University/College level. Of the three that do not have this prerequisite, two require completion of an English assessment and the other accepts students who have completed grade 12 English at the workplace level. One of the schools requiring an English assessment in lieu of Grade 12 C, U or M English is a French school. Three schools additionally require the completion of Grade 10 or 11 math at the College, University or College/University preparation level. One school also requires the completion of Grade 11 biology at a College, University or College/University level and one school strongly recommends the completion of this course. In general, the admission
process at the CAATs is that applicants’ final grades from high school are assessed and the students with the highest marks are selected in instances where the program is competitive (i.e. the number of applicants exceeds the number of spaces in the program).

Students who completed high-school with credits at the workplace preparedness level are required to pass equivalency tests or successfully complete the CAAT’s academic upgrading programs, which are often free of charge. Students who have not completed high-school and will be 19 year of age or older on the first day of class can apply as mature students. These applicants must either demonstrate that they have completed the prerequisite courses at the C, U or M level or pass equivalency tests. Mature student admission is determined on a case by case basis.

Additionally, applicants must provide a clean criminal record check, confirming that they can work with vulnerable people. Students must also demonstrate that they have a current First Aid/CPR certificate at the health care provider level. Typically, this is a requirement on admission; however, two schools will accept this documentation later, as long as it is before the clinical placement component of the program. Students must also provide medical clearance confirming that they are in good enough physical health to meet the demands of the clinical placement and that their immunizations are up-to-date so that they can be in compliance with most employer policies during their clinical placements.

**CAAT Quality Assurance Mechanisms**

When the Colleges of Applied Arts and Technology Act was passed in 2002, the responsibility for program approval, i.e. ensuring compliance with the standard, was transferred from MTCU to the individual college. Following this decentralization of the program validation process, the Minister for TCU issued a binding policy directive entitled “Framework for Programs of Instruction” (Ministry of Training Colleges and Universities, 2005). Among other things, the directive stipulates that the Colleges must establish an advisory committee for each program of instruction comprised of a variety of external stakeholders. The key informants from the CAAT in Toronto, which offers one of the largest PSW programs in the province, confirmed that their institution has such a committee which meets annually and is comprised of program graduates, people from the business sector, and current PSWs (T1 and T2). The directive also stipulates that the Colleges must establish a system wide credential validation service that provides reasonable assurance that each program conforms to the credentials framework. MTCU is responsible for
working with the Colleges to ensure that their programs meet the standard (Ministry of Training Colleges and Universities, 2005).

4.2.2 Private Career Colleges (PCCs)

The majority of certificate programs in Ontario are offered through Private Career Colleges (PCCs). In Ontario, the Private Career Colleges (n=84) are governed by the Private Career Colleges Act of 2005. A staff member in the Private Career Colleges branch at MTCU advised that the PCC branch registers and regulates private colleges. They are also responsible for program approval; however, staff within the PCC unit are not subject matter experts on each of the programs that PCCs offer. Institutions must commission an external auditor, who meets the expert qualification requirements for the program, to review and approve the program before submitting it to PCC Branch for approval (G1).

All of the PCCs refer to the credential that is awarded upon graduation as a diploma. A key informant at MTCU, PCC branch was asked to explain why the PCCs refer to the credential as a diploma while the MTCU standard, the CAATs, and the school board continuing education programs refer to it as a certificate. The key informant advised that this is because the PCCs are not bound by a credentials framework. As a result, the PCCs can award credentials as they see fit; however, they cannot refer to the credential as a degree, because they are not degree granting institutions as set out by other legislation (G1). A document entitled “Ontario Qualifications Framework” is available on MTCUs website, and notes that the framework applies to all institution types; however the PCCs are not yet required to comply. The document is undated and does not specify when the PCCs will be required to conform to this framework (Ministry of Training Colleges and Universities). A staff member in PCC branch was asked to clarify when the document was created and the implementation timeframe. The contact advised via email that the “document is currently under development by MTCU’s policy division, and relates to the mapping out of qualifications for the purposes of credit transfers. The PCC sector is considered, and will be examined in time, although there is not a specific timeframe identified at the moment”.

PCCs are not part of the credit transfer system to which the Universities and CAATs belong, meaning that credits earned at a PCC cannot be applied towards a program at a CAAT or
University. As a staff Member in PCC branch noted, PCCs are best suited to students who wish to obtain vocational learning, but are not significantly interested in academic advancement (G1).

*PCC Program Design*

All of the NACC accredited programs state that they offer the 685 program hours that are currently required by NACC. That being said, there was significant variation in program duration. Twenty-three institutions provided information regarding the program duration in weeks, with the range being from 20 to 32 weeks, and the average being 25 weeks. Four of the unaccredited programs provided information regarding program duration. Of these, 2 were the ones that claim to be NACC accredited, although this is not supported by NACC’s information, and thus purport to offer the hours required by NACC. Of the remaining two programs, one delivers the program in 618 hours, and one delivers the program over 32 weeks. Six schools advised that they offered the program on a part-time basis; however many had options where the program could be taken full-time on evenings and weekends.

NACC’s website lists 13 topics that will be covered in the program: Individuality of the Person, Role of the Worker, Interpersonal Skills, Safety, Assisting with Mobility, Abuse, Household Management and Meal Preparation, Optimal Support and Care Planning — including an Introduction to Computerized Documentation, Assisting with Personal Hygiene, Cognitive Impairments and Mental Health Issues, Assisting with Ongoing Conditions, Assisting with Medications, and Assisting a Person Who is Dying.

Nine of the schools provided brief course descriptions on their website. The remainder of the schools that had websites advised that they covered the 13 topics in the NACC program listed above. This meant that while there were a greater number of PCCs in the analysis, fewer of them had available data that would allow the researcher to learn how programs interpreted the NACC program.
APPLICATION AND ADMISSION PROCESS

Like the CAATs, students can apply to PCCs on the basis of a high-school diploma or mature student status. None of the PCCs have specific prerequisites or require that high-school courses were completed at a C, M, or U level, meaning that students who completed high-school with workplace level credits are eligible to apply. Moreover, where the CAAT application process is remote and paper based, the PCC application process often requires an in person meeting with a recruitment representative. This is especially true of the large, corporate institutions in the analysis. For these PCCs, very little information about the program is provided on line and students wishing to know more are required to fill out an online form requesting more details. The researcher completed this form for two of the large, corporate schools. Completion of the form elicited calls from recruiters requesting that an appointment be scheduled to receive more information. Since ethics approval for the project had not been obtained as of the date on which the forms were filled, the researcher declined the appointments and requested that information be sent via mail or email. The recruiters advised that this was not possible and that information could only be given to prospective students in person. At this point, the researcher declined further contact with the programs; however, several additional calls were received from recruiters from one of the schools. An article on a PSW information site confirmed that this was a typical practice amongst the PCCs so the researcher did not submit additional information request forms (Personal Support Worker Headquarters). When ethics approval for the project was received, the researcher completed an additional form. When a recruiter responded to this request, the researcher explained that the information was being requested for research purposes. The recruiter was willing to provide the information via email. This documentation was included in the qualitative analysis of program content and design.

Like the CAATs, all programs require a clean criminal record check, as well as medical clearance and proof of current immunizations before attending the clinical placements. On the other hand, a First Aid Certificate is not typically an admission requirement of the PCCs. 23 of the PCCs provided information regarding the First Aid Certificate requirement. Of those, 16 of them include the First Aid Certificate as part of the program of instruction and reflected this in the tuition cost. In this case, the institution usually offered the First Aid course as an independent course offering as well.
PCC Quality Assurance

Programs have the option of becoming accredited through an external program. Most of the PCC’s are members of the National Association of Career Colleges (NACC). NACC develops four programs which their members can purchase; a personal support worker program is one of the offerings (National Association of Career Colleges, 2014). NACC has its program approved by the PCC Branch and any of the schools that have purchased their program can report that they are offering that program when they register with PCC branch (G1). According to the staff member at PCC branch, the program is provided to purchasing schools on CD ROM and the software, among other things, auto-fills some of the documentation that must be provided to PCC Branch. The staff member at PCC branch also advised that NACC is in the process of updating its program to comply with the revised standard (G1). Any PCCs wishing to offer the PSW program who do not want to purchase NACCs curriculum would have to have their programs approved individually by the Superintendent of Private Career Colleges within MTCU. The staff member in the PCC branch advised that this is rare. Typically, programs trying to submit programs that they have developed independently end up engaging in a protracted review and revision process with PCC branch and ultimately decide that it is easier to purchase NACCs program. Since NACC sells the curriculum to colleges, it is not publicly available, and thus not possible to review it for this analysis. There is a description of the curriculum on NACC’s website. According to the web information, the NACC curriculum was “originally based on the MOHLTC curriculum, [and] has evolved to keep pace with the needs of the clients and PSWs. The program is reviewed annually to ensure that it continues to be relevant”.

The information on NACCs website at the time of data collection stipulated that students must receive at least 685 hours of instruction, with 355 of those as clinical placement hours. The researcher conducted an interview with a staff member from NACC. She confirmed that the NACC curriculum had been updated recently to be in compliance with the revised standard. The curriculum was reviewed and revised by a volunteer panel of experts, some of whom have been involved in PSW program development since 1997. In the new curriculum, the total program hours have increased from 640 to 700 hours. Of those hours, 390 are in-class, 110 are community clinical placement, and the remaining 200 are facility placement (National Association of Career Colleges, 2014).
While legal oversight for all PCCs is provided by MTCU, NACC conducts additional quality assurance activities for its members. Site-inspectors conduct visits with new programs and audits are conducted while school is in session. Students are asked to provide feedback as to whether the program is meeting their expectations and if they have any concerns (N1).

NACC also administers a standardized exam that all students in PCC programs must pass to graduate. In NACC's view, this creates more confidence in the private sector because it demonstrates that their graduates have all received the same standard of education. Schools that do not pass their audits are prohibited from participating in the exam and are reported to PCC branch within MTCU (N1).

The PSW association staffer who had audited the NACC curriculum did not believe the exam was an effective quality assurance mechanism because in her view it is not sufficiently rigorous, and does not test the students’ ability to apply the clinical knowledge in practice. Two PCC websites claimed that passing the exam was a requirement of working as a PSW in Ontario; however, this is misleading because while it is a requirement of graduating from NACC member schools, it is not a requirement of obtaining work as a PSW in Ontario (PA2).

Some key informants outside of the PCC system expressed skepticism that PCC students were actually attending the 355 placement hours in the currently posted requirements. Some suggested that PCCs were defining “practicum” as clinical placement or lab hours. It is possible that this pending revision to the standard is being implemented to clarify the distinction between the two teaching techniques.

Of the 84 schools, one was accredited through the Personal Support Worker Accreditation Program (PEPA), which will be discussed further below. One program is a vocational program offered through a home care agency. Such programs constitute a fourth program type that is only open to existing employees of the home care agency. The PSW association documents indicated that there were other such programs in existence. Of the remaining 82 programs, 72 programs are accredited through NACC, while 10 programs have no external accreditation. Graduates of the programs that are not accredited have different employment options than graduates from accredited programs. As touched upon earlier in the chapter, the current PSW qualification provision of the LTC Act states that employees must have a certificate from a program adhering
to the MTCU standard, the NACC standard, or the OCSA/MOHLTC standard. Thus, as the Act is currently worded, graduates from one of the unaccredited programs cannot work in LTC on the basis of their certificate. Additionally, the registration requirements for the PSW registry are similar to the qualification requirements in the *LTC Act*, meaning that graduates of the unaccredited programs cannot register on the basis of their certificates. A staff member from the PSW registry emphasized that at the present time, registration is voluntary and they are asking employers not to make this a hiring requirement at the present time. Nevertheless, three home care job postings out of the twelve reviewed in the document analysis stated registration as a requirement. Information for employers on the PSW registry website advised that MOHLTC was in the process of developing a policy that would have required PSWs in publicly funded positions to be registered, beginning with home care. A timeline for implementation was not provided; however, the information stated that employers would be given advance notification when the policy was finalized (PSW Registry). It is possible that some employers believed this was already a requirement, or were stating it as a requirement in job postings in preparation for implementation. In any event, employment opportunities for graduates of the non-member PCCs are likely more limited since they cannot obtain LTC employment, and could not register, unlike their NACC member counterparts.

4.2.3 School Board Continuing Education Programs (SBCEs)
An online resource for PSWs notes that there are 21 School board affiliated PSW programs. The researcher could not find evidence of a PSW program on the websites of one of the school boards. The programs are regulated under the continuing education regulation of the *Education Act* (1990). Prior to the implementation of the consolidated standard, the programs used a standard developed jointly by the Ontario Community Support Association and the MOHLTC in 1997. This standard is the earliest of the program standards and NACC notes on its website that its PSW program was developed based on the OCSA standard (National Association of Career Colleges, 2014).

The OCSA standard begins with a series of “open letters” from PSW clients, outlining the importance of PSWs to their quality of life. A general overview of the role of the support worker is then provided. The program standards are then described in 5 categories: Individuality of the Client, Role of Support Workers, General Abilities, Assisting with Routine Activities of Living,
Assisting with Specific Activities. Specific standards and associated learning outcomes are listed under each category.

**SBCE Program Design**

Nine of the schools provided information regarding the total number of hours of instruction. The hours ranged from 600 to 1140, with the average number of hours being 742.2. Since the program with a total of 1140 hours was an outlier, the average was calculated again without this case, for a result of 692.5 hours. 7 of the schools provided information as to how many of the program hours were clinical placement. Placement hours ranged from 270 to 360 hours, with the average number of hours being 320.4. Some programs were delivered over the course of an entire high-school academic year (September to June), while others were delivered over the course of 5-6 months. The programs did not offer part-time options or bridging programs, but alternative delivery allowing students to take the classes on evening or weekends was sometimes available. Two programs provided information regarding the minimum grade required to graduate. In these cases it was 70%.

Only two of the schools provided course descriptions on their websites, which were included in the qualitative analysis of program content. The researcher was also able to locate power point presentations used at the open houses for two schools and a detailed program information manual for one. These resources were also included in the qualitative analysis of program content.

The credential awarded by the continuing education programs is called a “certificate”.

**Table 4.1 – Summary of Program Hours and Duration**

<table>
<thead>
<tr>
<th></th>
<th>Total Programs</th>
<th>Total Hours (range)</th>
<th>Total Hours (Mean)</th>
<th>Practicum Hours (range)</th>
<th>Practicum Hours (Mean)</th>
<th>Duration (range)</th>
<th>Duration (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAATs</td>
<td>23</td>
<td>667-866</td>
<td>734</td>
<td>190-315</td>
<td>8 months</td>
<td>8 months</td>
<td>--</td>
</tr>
<tr>
<td>NACC</td>
<td>84</td>
<td>700</td>
<td>--</td>
<td>310</td>
<td>--</td>
<td>4-8 months</td>
<td>6 months</td>
</tr>
<tr>
<td>PCCs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SBCEs</td>
<td>21</td>
<td>600-1140</td>
<td>692.5</td>
<td>270-360</td>
<td>320.4</td>
<td>5-10 months</td>
<td>--</td>
</tr>
</tbody>
</table>

**SBCE Application Process**

According to information on program websites, the SBCE programs host open houses for prospective students where they can learn more about the program and enroll if they have
brought the required documentation and the “materials fee”. The required documentation included a current police screening attesting suitability to work with vulnerable populations (i.e. children, elderly people, and people with disabilities). Prospective students must also provide medical clearance attesting to current vaccinations and fitness to carry out the physical requirements of the placement. Tuition fees are paid by the Ministry of Education, so students only pay a materials fee which is usually approximately one thousand dollars.

Nine programs provided information regarding the school’s policy on first aid certification. Of these, seven included the first aid certification with the program. The other two required that applicants show proof they had completed first aid training in the community as an admission requirement.

Students who are over the age of 19 and have not completed their Ontario Secondary School Diploma can use credits from the PSW course to earn anywhere from 6 to 9 credits towards the completion of this diploma; thus the programs are considered a good option for adult learners who wish to receive career training while completing their high-school education.

**SBCE Quality Assurance**

Of the 20 school board affiliated programs that had websites, all were accredited through the PSW Educational Program Accreditation (PEPA) (PSW Education Accreditation Program). According to a key informant from PEPA, to become accredited, schools must complete a workbook, and submit supporting documentation. Surveyors then contact them and go out to see classes. The surveyors also meet with future and existing students, teachers, advisory boards for the school, area employers, and the school's administration. In addition to curriculum, they also look at whether there are appropriate policies in place; for example, whether there are mechanisms in place to ensure student participation. They also assess suspension and expulsion policies.

The same key informant advised that teacher qualifications are also considered. Unlike the other program types, wherein all instruction is provided by registered nurses, PEPA requires that the mobility module be taught by an Occupation or Physical Therapist, or a Kinesiologist with an appropriate background to teach the mobility module. Instructors must have competency in the subject matter, as well as current practice experience, knowledge of the PSW role, and skills in adult education (A1).
4.3 Discussion: What are the Similarities and Differences between the programs?

While as of September 2015, all PSW programs were required to meet the same program standard, the standard is a broad document that does not make any stipulations as to program structure, content, delivery methods, instructor qualifications, clinical placement requirements, or program duration. While the common standard ensures that graduates are meeting the same outcomes, it does not eliminate variation in the design and oversight mechanism of programs.

4.3.1 Variations Regarding Program Design

CREDENTIAL

A significant program design difference is that the credential awarded by each institution type is somewhat different. PCCs refer to the credential that is awarded as a “diploma”, while the other institution types refer to it as a certificate, although only the CAATs can refer to it as an “Ontario College Certificate”. As outlined above, the PCCs are not bound by the “Ontario Credentials Framework”, and the “Qualifications Framework” that will apply to them has not yet been implemented. PCC Branch at MTCU was not able to provide an implementation timeframe for the “Qualifications Framework” and until the framework is implemented, PCCs are free to refer to the credential as a diploma. A diploma is widely understood to be a higher level of qualification than a certificate; and both the MTCU “Ontario Credentials Framework” and “Qualifications Framework” (under development) confirm this hierarchy. Therefore, it is possible that the practice amongst the PCCs of referring to the credential as a diploma may make it appear that a higher level of credential is being earned at these institutions when this is not the case since the programs are not meeting the requirements of a diploma under either framework.

ADMISSION REQUIREMENTS AND PROGRAM DURATION

Another notable program design difference is the variation in admission requirements. CAATs are only readily accessible to individuals who completed their high-school diploma with credits at a College, University or University/College level. Moreover, in instances where the institution receives more applications than there are placement opportunities, grades are assessed and students with the highest grades in the required courses are selected. This means that students who completed their credits at a workplace preparedness level or those who had low grades,
have a much better chance of being admitted to a PCC or school-board affiliated program than to a CAAT.

There is also considerable variation with regards to program hours and duration. The CAATs and school-board programs determine their own hours; however, most of the PCCs adhere to the number of hours stipulated by the NACC program, although some programs purport to deliver the hours in as little as 20 weeks (four months).

While the ostensible primary advantage of attending a CAAT is increased opportunities to advance one’s education, and by extension one’s career, the CAAT instructors indicated that uptake of options to transition into Practical Nursing was very low at their school. According to the instructors, at the start of the course, the majority of students indicate that they plan to continue on to nursing; however each year, only a handful actually pursue this option. Students tell them that because the PSW course was harder than they expected, they no longer wish to pursue nursing, fearing it will be too challenging (T1 & T2). Related to this, the accreditation program representative questioned why there is so much emphasis on moving on to nursing or another regulated profession as the ultimate goal for PSWs. The informant also had experience with program design and instruction and said that one of her main objectives in this capacity was to instill in PSW students the belief that support work is a valid, reputable and important profession (in her words) in its own right (A1).

4.4 Conclusion

While it is clear that the three program types are designed and governed in different ways, it is more challenging to determine conclusively if these systemic differences make a meaningful difference to learning outcomes.

The current certification model is complicated and places significant onus on the prospective student to know the labour market and the impact of their program choice. For example, students who elect to attend a PCC program that is not a NACC member school may not realize that this will create a barrier to registration or obtaining employment in a long-term care home. Moreover, since registration with PCC branch is mandatory, whereas membership with NACC is voluntary, the LTC Act and registry requirements that PCC graduates must have attended a NACC member program is worth further examination.
The implementation of a common program standard is a response to pressure to ensure that all PSW certificate programs are of equivalent quality. As noted earlier, the implementation of the common standard happened during the time frame of the project, but after the data was collected. The MTCU standard is coded to several times more categories than the OCSA document. The information from the documents suggested that the new standard is considerably more detailed than the previous OCSA standard (upon which the NACC curriculum was based). The following chapter presents information on the program content, in response to the second research question.
CHAPTER 5: THE CONTENT OF PSW CERTIFICATE PROGRAMS

This chapter presents the content of PSW certificate programs and resources as described by the consolidated standard, textbook, program documents and key informants, and discusses the extent to which the consolidated standard, the text, the program course descriptions and outlines, and informant opinions concur or diverge as to appropriate program content and where the content could be improved. The information is preceded by a brief description of how the results were drawn from the data.

As discussed in chapter 4, a common program standard for PSWs was introduced in 2014 and it identifies 14 learning outcomes; all PSW programs in Ontario were expected to be in compliance with this standard by September 2015. The 14 outcomes are: Role and Scope of the Worker, Accountability, Interprofessional Care Team, Client-Centredness & Directedness, Helping-Relationships, Assessment, Safety & Comfort, Activities of Daily Living, Medication, Instrument Activities of Daily Living, Respite, Abuse, Palliative & End of Life Care, Cognitive Impairment, and Mental Health Challenges, & Responsive Behaviours. Data in this chapter was gathered using queries of the data in the program content categories, relying heavily upon information in the knowledge-tasks category, and the professionalism category. The researcher made memos summarizing query outputs. The knowledge-tasks category and the professionalism category each had a number of subcategories, and each domain of the standard was represented among the subcategories. This stemmed from the fact that the standard was the first lengthy document coded, and generated a number of new categories. The categories that stemmed from the program standard were among the most densely populated in the analysis, so the standard’s learning outcomes were used as template for organizing the results in this chapter.

For each of the vocation learning outcomes, this chapter presents: 1) a summary of the standard; 2) a description of how that standard is covered by the textbook; 3) a description of how it is covered in the certificate programs; 4) comments from the key informants; and 5) a summary. The learning outcomes are presented in appendix C. The learning outcomes are 1) Role and Scope of the Worker (5.1), 2) Accountability (5.2), 3) Interprofessional Teamwork (5.3), 4) Client-Centredness and Directedness (5.4), 5) Helping Relationships (5.5), 6) Assessment (5.6), 7) Safety and Comfort (5.7), 8) Activities of Daily Living (5.8), 9) Medication (5.9), 10) Instrumental Activities of Daily Living (5.10), 11) Respite (5.11), 12) Abuse (5.12), 13)
Palliative Care and End-of-Life Care (5.13), and 14) Cognitive Impairment, Mental Health Challenges, and Responsive Behaviours (5.14).

5.1 The Role and Scope of the Worker

Information in this section was gathered by querying the sources for information coded to the “role-scope”. Role-scope was one of the most populated categories in the analysis, with 172 references from among 74 sources. NVivo was used to determine which other categories were coded most often to the information within role-scope. These were: “Ethics”, “RHP Supervision”, “delegated”, “ADLs”, “Medication”, “PSW Certificate” and “devices, supplies, and equipment”. A matrix query was conducted to see how each of these categories interacted with role and scope. A memo entitled “Role-Scope” was created from query outputs.

5.1.1 The Standard

Ontario’s Personal Support Worker Program Standard (Ministry of Training Colleges and Universities, 2014) defines the competency as being able to identify the PSW’s role in the provision of client-centred, client-directed care, and being able to compare this to the roles of other regulated health professionals. They are also expected to understand and be able to work in compliance with all applicable legislation and employer policies, with sensitivity to the nuances of the role by setting, including variations in the level of care. Additionally, they should be able to identify potential risks associated with performing outside the scope of the role (Ministry of Training Colleges and Universities, 2014).

5.1.2 The Textbook

The first chapter of the text is entitled “The Role of the Support Worker”. According to the text, “the ultimate goal of support work is to improve quality of life” and support workers “provide services to people who require help with their daily needs in the community or facilities”. The text is written from a national perspective and goes on to explain that support work and relevant legislation varies across the county, and that an instructor is required to clarify which elements of the text material are applicable in their jurisdiction.

The text also provides an overview of different settings where PSWs may work, and of care needs related to the setting. The text divides “setting” into the two categories of institutional and community.
The responsibilities of the worker are broken down into 5 categories: personal care, support for nurses and other health care professionals, family support, social support, and housekeeping or home management. The section on personal care defines activities of daily living (ADLs) as activities that a person must engage in daily to remain “independent and function effectively in society”, including eating, bathing, grooming, dressing, toileting, and mobility. The section notes that while PSWs are not responsible for making care decisions, they are expected to report any changes in the client’s condition, while promoting the client’s comfort and safety.

The PSW is also expected to assist nurses and other RHPs by carrying out the care plan directions for each client, and assisting with a range of clinical tasks and procedures, including sterilizing equipment, wound care, oxygen therapy and range of motion exercises. The section reiterates the importance of observing and reporting, and notes that PSWs may also have to consult with other professionals such as social workers and psychologists.

Examples given as to PSW responsibilities with regards to family support include: providing respite care for a sick family member in a home care setting, and providing orientation and supporting admission and discharge activities in facility settings.

PSWs may be responsible for providing social support in the form of scheduling and helping clients attend social activities, as well as teaching social skills such as cooking, cleaning, and shopping independently.

The chapter also describes the people that PSWs work with, including: older adults, people with disabilities, people with medical issues, people having surgery, people with mental health issues, people needing rehabilitation, children, mothers and newborns, and people requiring special care (e.g. patients of ICUs or burn units). The text notes that PSWs in certain parts of Canada are not allowed to provide care to individuals in unstable or critical conditions, such as patients in the special care units noted above. Information from the literature review for this study, which was confirmed by key informants (T1, T2, E1), indicates that Ontario would be one such jurisdiction since in this province, PSWs are only supposed to provide care to individuals who are clinically stable with predictable treatment outcomes.

The chapter also discusses the PSWs role in relation to other members of the care team. An explanation of the difference between regulated and unregulated providers is given. It notes that
unregulated providers have neither a regulatory college nor a code of ethics they are bound to. It also notes that there are no official requirements for educational programs; however, this is no longer true in the Province of Ontario as a result of the introduction of the common program standard in 2014. The text also observes that in the absence of regulations, PSWs are personally accountable to their employer, supervisor and clients.

The text does not define a PSW’s scope of practice because this varies from province to province. However, it does note that working within one’s scope involves not carrying out any tasks one has not been trained to do and cautions that serious harm could befall clients if PSWs practise outside their scope. It cites educational programs, employer policies, and supervisors as sources of information regarding PSW scope. The text also notes that having a clear understanding of one’s scope is essential since PSWs may be asked to do tasks that fall outside their scope. The text also notes that while PSWs are most often supervised by nurses, they may be supervised by other types of professionals, such as a social worker. The text also outlines a number of principles of professionalism, ranging from personal appearance and positive attitude to preserving confidentiality and maintaining work appropriate boundaries. The text’s usage of the term “professional” is vernacular, and not consistent with theories of professionalism as defined in chapter 2 of this thesis.

The acronym “DIPPS” (Dignity, Independence, Preferences, Privacy, and Safety) is provided to remind PSWs of the priorities of support work. The PSW instructor key informants confirmed that this acronym was a theme throughout the program in which they teach (T1, T2).

The chapter then provides guidance on decision making and notes that PSWs must consider the principles of support work (i.e. DIPPS is maintained), the client’s viewpoint, the scope of practice, and the supervisor’s viewpoint. The chapter stresses the importance of adhering to the client’s preferences throughout the chapter.

5.1.3 The Programs
A review of program data such as course descriptions, course outlines, and orientation materials revealed that all of the programs, across institution type, offer a course with a title like “Role of the Support Worker” or “Foundations of Support Work”. The course typically provides an overview of the PSW role, placing emphasis on the importance of being able to adapt to different
employment settings. Course descriptions often note that the role and scope of other healthcare team members, and supervision by regulated professionals will also be covered. The course also introduces students to relevant legislation, with Ontario’s *Regulated Health Professions Act* mentioned most frequently. Some course descriptions note that the role of the College of Nurses, and the relevance of its standards to support work would also be discussed. Some schools note that an overview of the history and design of Canada’s health care system will be given. The course also introduces students to the concept of professionalism, with the importance of professional boundaries, ethics, privacy, and confidentiality highlighted most often in the course descriptions. Many of the course descriptions also noted that the course would cover time and stress management skills.

The NACC member schools and School Board programs are of a modular design and the titles of the modules of the two program types are identical. The researcher observed that the course descriptions on several PCC and SBCE programs websites were identical. One PCC provided complete course outlines for its programs. The header of the outlines state that the information is “Excerpted from the Personal Support Worker Training: Outcomes and Module Outlines (with alterations by NACC) documents produced by the Ontario MOHLTC and published by the Ontario Community Support Association (OCSA)”. Several other programs provided course descriptions that were identical to theirs. It is possible that many of the NACC programs copy and paste the course descriptions from the NACC curriculum. One SBCE program provided a program information package on line. The course descriptions in this document were also identical to those provided by many of the PCCs. Because NACC acknowledges that its curriculum is an alteration of the one developed by OCSA/MOHLTC that is in use by the SBCE programs, it is unsurprising and appropriate that there is overlap among the course descriptions. Where course descriptions are identical and assumed to be copied from the NACC or OCSA/MOHLTC curricula, these are the versions that have been used for the analysis. The shared description for the “Role of the Worker” module is:

“In this module, students will be introduced to the role and scope of practice of workers providing support to clients and families in individual homes and long-term care facilities. The variety of settings, work relationships, level of supervision, the need to adapt to varying settings, as well as time and stress management will be covered. Finally the student must recognize that they cannot be all things to all people and the client must
not be exposed to unsafe practice. This module clearly outlines the scope of the Personal Support Worker’s role, including consequences for exceeding that scope. Students will be introduced to the Regulated Health Professions Act. The steps to be taken when the worker has concerns in these areas will be discussed.” (St. Albert Adult Learning Centre)

In contrast, each CAAT designs its own curriculum, and there is accordingly no standardization of course titles and descriptions in this sector. One CAAT described a similar course entitled “Foundations of Support Work” in this manner:

“In this course, the learner is introduced to the role of the Ontario Personal Support Worker (PSW) and the scope of practice for the PSW within the health care system. Through class discussion, seminars, lectures, the learner will explore confidentiality and privacy, client rights and boundaries, ethical issues, professional behavior, and legislation involving the health care system.” (Fanshaw College, 2014)

The two descriptions quoted above highlight a trend that was true throughout the program data. The CAAT course descriptions were more likely to emphasize, theoretical, concept-oriented learning. Note that the NACC/OCSA descriptions state that students will be introduced to information, whereas the CAAT descriptions note that students will explore concepts. This pattern was repeated throughout the program data.

5.2 Accountability

Information in this section was gathered by exploring the contents of the “accountable” category. This was also a very populous category in the analysis, with 120 references in 37 sources. Information in “accountable” was often also coded to the “LTC”, “Interprofessional Teamwork”, “Communication Interpersonal”, “vulnerable”, “role-scope”, and “safety” categories. The interaction between these categories was explored using a coding matrix query. A memo was created synthesizing the outputs of the various queries.

5.2.1 The Standard

The second learning outcome identified in the program standard is that graduates have the ability to “act responsibly and be accountable for own actions, while recognizing the boundaries of knowledge and skills within the support worker role that require collaboration with the client, family and supervisor and/or other members of the interprofessional care team.” The section
highlights the importance of admitting mistakes and accepting responsibility for them, and recognizing when care falls outside the scope of one’s knowledge and seeking appropriate guidance. The standard on accountability also notes that PSWs should be able to use systematic critical thinking to support decision making in care settings. Graduates are also expected to have the ability to identify gaps in their own knowledge and proactively seek guidance and continuing education resources to improve their skills. The section alludes to the potential for PSWs to have tasks delegated to them, in that they are expected to be able to identify when procedures were not part of their education and they may need to be trained on the procedure on a case by case basis (Ministry of Training Colleges and Universities, 2014).

5.2.2 The Textbook
The text defines accountability as “the willingness to accept responsibility and to explain your actions, inactions or omissions, intentions, and decisions. Accountability cannot be shared; it rests solely on an individual”. The text discusses accountability as a consideration in several areas. Most of the information is focused on providing guidance as to who is legally accountable in specific situations, with the general theme being that RHPs are accountable for the actions of PSWs. The first chapter of the textbook, which outlines the role of the worker, notes that in the absence of a college, PSWs are accountable to their supervisor, their employer and their clients.

Accountability is also discussed in the chapter five of the text, called “Working with Others”. The text notes that it is the team leader, usually a nurse, who has overall accountability for client care in the LTC setting. In community settings the accountable person is the supervisor, usually a nurse as well. In the section on delegation, the text explains that the delegating nurse is accountable for the outcome of delegated controlled acts. It goes on to note that PSWs are still accountable for their own actions and responsible for knowing the regulations for delegation in their jurisdiction and in the employment setting. They are also accountable for knowing how to perform the task correctly and safely, with the onus on them to agree or refuse to do the task. If they agree, they are accountable for asking for additional help if it is needed. In chapter 8 of the text readers are provided with guidance on PSW accountability with regards to documentation, noting that PSWs are legally responsible for the accuracy of their charting of care provided, and knowledge of any relevant electronic documentation systems.
5.2.3 The Programs
The subject of accountability or taking responsibility for one’s actions is not discussed significantly in the program course descriptions. There are no courses in the material reviewed specific to this topic and the only references to accountability in the program data were found in the two programs where full course outlines were available on the college’s public site. The CAAT program notes that accountability will be covered in a course called “Professional Issues” (George Brown College, 2014); however, most programs do not offer a course with this or a similar title.

The PCC program notes that accountability will be covered in the unit on legal issues in “The Role of the Worker” along with issues of professional conduct/misconduct and liability. The same program discusses accountability in the legal issues unit of the “Assisting with Medication” course. The same course outline notes that PSWs must be able to recognize “when they need guidance from the person responsible (case manager, physician, pharmacist, supervisor etc.) with regards to questions about storage and administration” (Cornwall Career College, 2015).

5.3 Interprofessional Care Team
Information in this section was gathered by reviewing content in the “Interprofessional Team Work” category. The category was also highly populated, with 119 references across 51 sources. Information in this category was often also coded to the “Safety”, “Regulations”, “Medication”, “Devices, Supplies, and Equipment”, “Optimal Functioning”, and “Care Plan” categories. The interaction between “interprofessional team work” and the other categories was explored using a coding matrix. The results of the various queries were summarized in a memo.

5.3.1 The Standard
The standard specifies that graduates should have reliably demonstrated the ability to “participate as a member of the interprofessional care/service team and maintain collaborative working relationships in the provision of supportive care within community, retirement homes, long-term care homes, and/or hospital care settings.”

To meet this learning outcome, graduates must be able to identify the role of the various members of the care team, including the client and family members and understand how the PSW role fits into the team. PSWs are also expected to develop and maintain positive
relationships between the various members of the care team. The outcome also highlights the importance of timely and ongoing reporting to other members of the team by PSWs, and also notes that they should promote the quality, efficacy and efficiency of care provided by the team. Related to the earlier discussion of accountability, PSWs are also expected to accept and act upon feedback from team members.

5.3.2. *The Textbook*

Most of the text’s discussion of interprofessional teamwork can be found in its Chapter 5: Working with Others: Teamwork, Supervision and Delegation. The chapter discusses the composition of care teams, noting that the exact membership of the team is dictated by the client’s needs and can include nurses, physicians, social workers, physical therapists, the client’s family, and the client. The chapter also discusses the benefits and challenges of working with a team and the importance of raising concerns and observations about the client’s status with the other members of the team. The text notes that PSWs may feel intimidated by the regulated members of the team and reluctant to give feedback as a result. The text assures students that their feedback is valued and important and that they should feel comfortable coming forward with their views. The chapter also discussed the composition and implications of team work in different employment settings, observing that teams in facility settings have many opportunities to meet face to face and work collaboratively, whereas in home care settings, teams meet less frequently and use remote means of communication such as phone and email, to discuss concerns.

The text chapter also introduces the concept of supervision and its importance in PSW work settings. It observes that the PSW’s supervisor is typically a nurse, but could be a different type of care provider, and notes that PSWs can also be employed by the client directly. When this is the case, the text advises that they enter into a contract with the family and should have the contract reviewed by a lawyer to ensure their rights are protected.

Finally, the chapter discusses delegation (*for definition see section 2.3.2*) in depth, giving an overview of relevant regulations in jurisdictions across Canada. It defines delegation as a process by which a nurse authorizes another health care provider to perform certain tasks, and explains the decision making process regarding delegation. The chapter notes that in Ontario, Alberta and British Columbia, tasks can be delegated to a PSW if they are a routine activity of daily living.
for the client. For example, administration of an enema to a paralyzed client who requires one on a regular basis as part of their care plan can be delegated; however, administration of an enema to a client who requires one post-operatively cannot be delegated. The text also discusses the impact of employment setting and employer policies on supervision and delegation.

5.3.3 The Programs

Since PSWs are never solo or primary care providers and are always working in the context of a care team, it is unsurprising that references to the importance of interactions with the care team appeared throughout the course descriptions in most courses or modules.

A few CAAT programs offer courses specific to interprofessional teamwork or professional growth issues. Where a specific course is offered, the stated aims are the acquisition of tools for working effectively as part of a team, including leadership skills, conflict resolution, and assertiveness training. Course descriptions also emphasized the importance of collaboration and cooperation. One school offers a simulation lab concurrent with the course on interprofessional practice where students have the opportunity to work with practical nursing students. Here is an example of a course description:

“Foundations of Interprofessional Care: In this course, students will be introduced to the concept of interprofessional collaboration. Students will examine the role of regulated and non-regulated health care professionals, the principles of interprofessional practice and the importance of a team-based approach to enhance care and job satisfaction. Emphasis will be placed on the importance of creating a supportive climate through effective communication, constructive conflict resolution and collaborative team dynamics. Via realistic work-related scenarios, students will gain practical experience, techniques and strategies necessary to build an environment of cooperative, collaborative care.” (Cambrian College)

Some of the CAAT programs offer courses specific to anatomy and physiology, and medical terminology. For such courses, the description noted that being able to communicate effectively with regulated members of the care team was one of the objectives. One CAAT program in the analysis offered a course on observation, reporting, and documentation. The course’s descriptions also emphasized the importance of effective communication with the care team.
Most of the course descriptions for practicums cited applying an understanding of interprofessional teamwork as one of the objectives of the practicum component.

In general, the subject of interprofessional teamwork, including the role of supervision by regulated staff, is highlighted in modules and courses on the role of the worker, communication and interpersonal skills, and assisting with medications.

5.4 Client-Centredness and Directedness

Information in this section was gathered from the “client-centred” and directed category. This category was also densely populated, with 101 references among 34 sources. Data in this category was also often coded to “Role-Scope”, “Dementia”, “Efficient”, “Care Plan”, “Adaptable”, and “Regulations”. Coding and coding matrix queries were used to explore the interaction between these codes. A memo entitled “Client-Centred and Directed” was created that summarized the results of the queries. The standard identifies advocacy, ethics, rights, dignity, and confidentiality as aspects of client-centredness. Due to the standard being one of the earliest documents reviewed, these were all categories in the analysis. Content in these categories was also reviewed. A memo entitled “client-centredness and directedness”.

5.4.1 The Standard

The fourth learning outcome states that graduates should be able to provide client-centred/directed care that is ethical and sensitive to diversity and family values, in accordance with the care plan. In the glossary that appears at the end of the standard, client-centredness is defined as “an approach to supportive care where clients are considered the brokers of care get what they ask for. This involves the clients taking an active role, controlling care delivery not just at the point of care, but in the broader healthcare system” (Ministry of Training Colleges and Universities, 2014). This involves advocacy, empowerment, an understanding of ethics and respecting clients’ rights to autonomy, dignity, privacy, and confidentiality. PSWs are also expected to promote the client’s independence, taking into consideration the impact of diversity and family values.

5.4.2 The Textbook

The text only uses the term “client-centred” on one occasion. It appears in its chapter 8, “Client Care: Planning, Processes, Reporting and Recording” and is described as a different approach to
assessment that is now in use in some facilities. The chapter does describe the planning process, including the development of the care plan, establishing priorities, goals, and treatment interventions. Even though the terms “client-centred or directed” are not used often in the text, many of the philosophical principles outlined by the standard are discussed in various chapters of the text. Health care ethics are outlined in its chapter 10. The text identifies 4 principles of health care ethics: Autonomy, justice, beneficence and non-maleficence. Autonomy is the principle that intersects with the concept of client-centred and directedness as defined by the standard. The text describes autonomy as having the freedom and independence to make decisions that affect one’s life. The text provides guidance on ethical dilemmas, gives some case studies of ethical dilemmas faced by PSWs, and works through the ethics-based decision making process. The text also devotes a chapter to culture and diversity (Chapter 12). This is a component of the philosophy of client-centred and directedness, in that support workers are expected to recognize the impact of culture and diversity on client decision-making regarding care and responses to treatment interventions. The text defines diversity as the state of different individuals and cultures coexisting and describes a respect for diversity as one of the most important values of a support worker. It defines culture as the characteristics of a group of people, including language, beliefs, values, habits, ways of life etc. The text identifies a number of identities that can impact culture, including race, ethnicity, sexual orientation, socio-economic status, religion, age, and disability. The effects of culture, as well as the definition and impact of stereotypes, prejudice, and cultural conflict are discussed. A number of case studies that elucidate the impact of culture and reactions to diversity are provided, (for example scenarios involving the use of alternative or religious remedies). Cultural attitudes that impact care provision are discussed, such as the reaction of different cultures to body language and physical or eye contact. The use of translators and interpreters is also covered. The text emphasizes the importance of providing care that is non-judgmental and tolerant, and revisits the DIPPS acronym discussed above. Unlike the common program standard, the text does not connect health ethics and diversity to a client-centred/directed care philosophy.

5.4.3 The Programs
Like in the text, the term “client-centred” was not used significantly in the program data. There was one reference in the course description for the PSW Foundations course in a CAAT
program, where the description notes that course will cover “relevant legislation, ethics, work environments, client-centred care, care plans, reporting and recording”.

The module offered by the SBCE and NACC programs that overlaps the most with the learning outcomes set out in the fourth domain of the standard is entitled “Individuality of the Person”.

Courses on individuality of the person focus on the importance of individual differences as defined by social identity (culture, ethnicity, religion, etc.) and personal beliefs on a client’s care needs. The course description that comes closest to the language of client-centred care is this one:

“The work of the personal support worker and the personal attendant is based upon the individuality of the consumer/client and her/his relationship with family, friends and others. Central to the personal support worker and the personal attendant's work is the importance of the consumer's/client's involvement in directing the assistance required, to the extent that the person wishes and is able to do so. This module introduces students to the concept of individuality of all persons, their experiences, rights, interests and needs. Students will be given the opportunity to identify and examine their own beliefs, values and attitudes about aging, disability, independence and interdependence” (St. Albert Adult Learning Centre).

Being able to define the concept of independence and interdependence was identified as a core competency for the course in several descriptions. The PCC that provided complete outlines online describe the competency in this way:

“Core Competency – 18. Recognize Concepts of Interdependence, Independence

1. Explain meaning of the concept of interdependence (the reliance upon cooperation/mutual support that all persons have on each other); relate to situations in one’s life & that of a consumer/client.

2. Demonstrate support of independence (ability to prioritize needs/set goals, take responsibility to make decisions, take required actions to attain goals despite ability to physically perform task w/out aid).
3. Explain the importance of attaining balance of power between consumer/client and worker; demonstrate application of this information appropriately to one’s work” (Cornwall Career College).

The same program identifies an understanding of client’s legal rights as the first competency of the course. The theme of client rights was echoed in several other course descriptions, as was the importance of reflection on one’s own beliefs. Some schools use the course as an opportunity to discuss discrimination and harassment.

The term client-directed is only used once in the CAAT’s course descriptions retrieved. The school’s outline for the community placement states that students will “Provide client centered and client directed care following established college and agency policies and procedures” (George Brown College). While various ideas related to the client-centred and directed care philosophy are touched upon in the program data, the patient or client is still framed primarily as the recipient of care whose opinions, culture, values, and preferences must be considered in the care process, rather than as the leader of the care team, which is the essence of the client-centred care philosophy. For example, one course on individuality notes that students will learn to provide care “in the least restrictive way possible, respecting client choice” (Cornwall Career College).

5.5 Helping Relationships

Much of the information for this section was gathered from the “helping relationships” (23 references in NVivo), compassion (21 references), respectful (39 references), “boundaries” (39 references), and “confidentiality” (40 references) categories. There were 23 references to the specific term “helping relationships” in the data, and it was not one of the more densely populated categories in the analysis. The standard identified boundaries, empathy, trust, respect, privacy, and confidentiality as characteristics of a helping relationship. The total number of references in all relevant categories was 162. Outputs from queries of the various categories was summarized in a memo entitled “helping-relationships”.
5.5.1 The Standard
The standard defines helping-relationships as “A professional relationship where clients’ needs are central to the relationship and the basis for supportive care provided. Helping relationships are client goal-directed and characterized by empathy, trust, respect and professional client-caregiver boundaries.” Program graduates must be able to establish and maintain such a relationship with clients and their families. The outcome focuses on the importance of professional boundaries and communication, including maintaining privacy and confidentiality, knowing relevant legislations, and using appropriate medical terminology. PSWs are expected to be able to tailor their communication style to the needs of diverse client populations. They are also asked to explore the impact of personal beliefs and values on non-verbal communications, and recognize the potential for and signs of abuse of power and unhealthy communication patterns. PSWs are also expected to know how to support the client to communicate, including through the use of assistive devices.

5.5.2 The Textbook
The subject of helping relationships is discussed in the 6th chapter of the textbook, entitled “Working with clients and their families”. Like the standard, the text defines a helping relationship as one that is established to benefit the client. It identifies and describes respect, empathy, compassion, sympathy, competence, and self-awareness as aspects of a helping relationship. The text offers failing to recognize a client’s need for privacy and independence as an example of failure to show respect. The text also elucidates the distinction between a helping relationship and a friendship, observing among other things that in a helping relationship one person takes responsibility for helping the other with specific goals in mind; whereas in a friendship, individuals are responsible for helping each other and the relationship is not goal directed. The text also defines the concepts of independence, dependence, and interdependence, describing them as integral to the concept of the professional helping relationship. The section on ethics also reminds PSWs to stay within the boundaries of a professional helping relationship. While the text does not make the connection to helping relationships, guidance that would be relevant to the subject of helping relationships as defined by the standard is also provided in the textbook’s chapter on diversity (Chapter 12), as outlined above, and in the chapter on interpersonal communication (Chapter 13). The interpersonal communication chapter discusses
the nuances of verbal and non-verbal communication, stressing the importance of courtesy and confidentiality and describing communication methods and barriers to communication.

5.5.3 The Programs

The term “helping relationships” is not used very often in the program data; however, most of the schools offer a course on the subject of relationships and communication. Typically course titles are “Interpersonal Communication Skills” or “Human Relationships”. Where programs do use the term “helping” or “therapeutic” relationships, this is usually in the context of courses on interpersonal communication, or foundations of support work. One program notes that the interpersonal relationships course will focus “on the importance of creating interdependent professional helping relationships that preserve client dignity, ethnicity, cultural diversity, independence, preferences, privacy, confidentiality and safety (Centennial College, 2015).”

Most of the time, course descriptions for this subject focus on general communication skills and building relationships with members of the care team as well as with clients and their families. For the most part, the subject of professional boundaries is not touched upon in the program data analyzed. It is only referenced twice, once in the course on interpersonal skills, once in a foundations course. As a result, it is not possible to know from this analysis if courses consistently cover the nuances of therapeutic relationships as outlined by the standard and the text, or if or how the maintenance of professional boundaries is covered. One program mentions that it will cover boundaries in the interpersonal communication course, noting that the College of Nurses standard on the Therapeutic Nurse Client Relationship will also be discussed.

One program notes that the interpersonal skills course will cover supporting clients with communication disorders; however, the subject of communication support is not covered otherwise in the program data.

5.6 Assessment

Data pertaining to PSW involvement in client assessments was stored in a category called “monitoring, documenting, and reporting”. Assessment, monitoring, documenting, and reporting were originally each their own categories, however an early review of the data revealed that very similar or related activities were captured in the respective nodes. For example, documentation was always mentioned together with observing and reporting, because PSWs are expected to
document their observations, report anything they deem to be significant, and document their observations. “Change in Status” was a subcategory of “monitoring, documenting, and reporting”, and captured references to expectations of the PSW with regards to recognizing changes in the client’s status. Since a number of reference to documenting and reporting mentioned that PSWs are expected to use appropriate medical terminology during these activities, the category “medical terminology” was also queried. A memo entitled “Assessment-MDR” summarizing the outputs from various queries of these categories was created.

5.6.1 The Standard

The next learning outcome sets out that PSWs should be able to conduct ongoing monitoring and assessment of a client’s status and document any relevant information appropriately in the client’s health record. This includes taking and recording the client’s pulse, respirations, electronic blood pressure, oxygen saturation, and temperature, height, and weight, with the ability to recognize any deviations from the client’s norms. This may also require knowledge of assessment instruments. Related to this, PSWs are expected to know when to report any changes in the client’s status to the appropriate person. They are also expected to be able to complete various types of health records accurately and in accordance with relevant legislation, using medical terminology.

5.6.2 The Textbook

While the text and the standard concur that PSWs must be able to make relevant observations about the clients’ condition, (including taking vital signs), document the observations and data appropriately, and report to the appropriate person, usually a nursing supervisor or case manager, the sources seem to differ as to whether this constitutes an assessment. The text defines assessments quite simply as “collecting information about the patient; a step in the care planning process” (p. 98). However, in the discussion of assessments in both the facility and community settings in the chapter on the care planning process (Chapter 8), assessments are described as the interpretation of the impact of multiple observations about the client’s status on care needs, and is situated within the scope of physicians, nurses, or social workers. According to the text, PSWs need to know how to make meaningful observations about the client’s status and report these to the appropriate member of the care team so the observations can be used by regulated professionals to make assessments of the client’s care needs, including potential changes to the
care plan. The text also notes that in the community setting, the PSW may be the only member of the care team who sees the client regularly for long periods of time; thus it is of the utmost importance that they are able to identify relevant information regarding the client’s status and report this appropriately in a timely fashion. In support of PSW knowledge requirements with regards to making, documenting and recording observations, the text contains chapters on: Medical terminology (Chapter 7), measuring height, weight, and vital signs (Chapter 41), and the client care planning process, including verbal reporting and charting (Chapter 8).

5.6.3 The Programs

There are no references to assessments in the program data, other than in passing to describe the activities of regulated health professionals. There are repeated references to the expectation that PSWs have the ability to identify relevant observations about the client and report and document these appropriately.

One CAAT program offers a course specific to this topic. It describes the course on observation thusly:

“This course introduces students to a variety of aspects of care to be considered when caring for clients, both in the clinical facility and in the community. This includes effective and safe care; knowledge of current concepts of health and wellness, as achieved in all stages of life; identification of common reactions to illness and disability; and concepts relating to promotion of client well-being. As well, students are introduced to the concepts of family violence and abuse, including its possible signs, as well as appropriate actions to be taken (including legal requirements) if abuse is suspected. Personal beliefs and attitudes about family violence and potential abuse of the worker are discussed. Utilizing medical terminology, the PSW observes, reports and records findings as an integral part of care. As such, this course describes common methods of interpreting information gathered and communicating this to the appropriate interprofessional team members” (George Brown College).

The final sentence of the description unites the ability to interpret the information with being able to communicate it appropriately.
The NACC and School board programs offer a module entitled “Providing Optimal Support and Care Planning”. This module introduce students to the concept of the care plan and its implementation. The most in-depth description, portions of which were excerpted by the other programs, is:

“Support of various types is the main function of the PSW. The word “support” appears in the program title. Yet, support is more than providing help- it relies on a number of factors, not the least of which are skill and sensitivity. Optimal support refers to the ability to provide sufficient materials presented in the introductory module “Interpersonal Skills”. It identifies the support to be provided and the significance of the support (and of the need for the support) to the client. Supporting the client to re-learn/regain routine abilities and issues of the rights of the client as a receiver of support will be presented.

The support/care plan or service contract is the framework within which the worker provides support to the client. The worker must know the purpose of planning, the ways in which planning is done, and the persons (client, support worker, caregivers, and professionals) who are involved. PSW’s will learn about implementing parts of the plan and communicating information accurately and without judgment, as members of the support team. These activities are conducted in accordance with the guidelines of the employer (agency or client)” (St. Albert Adult Learning Centre).

All of the programs refer to the expectations regarding observation, documentation, and reporting in the context of a number of courses. Courses on communication, medication administration, and care for the cognitively impaired or those with dementia appeared to contain the most substantive discussion of these topics. Most programs also note that one of the objectives of the practicum component is to become proficient at making and reporting observations. The references to observations in the course descriptions or program overviews centralize the importance of recognizing change in the client’s condition on any level. As one program outline puts it, a graduate “is able to recognize, report and document changes in the client’s physical, emotional, social, spiritual and mental needs.”
It is clear from the program materials that students are expected to graduate with the ability to understand and use appropriate medical terminology and abbreviations when documenting their observations. One CAAT program’s description of the institutional placement states:

“Students must be able to communicate, report and document (both written and oral form) by using appropriate abbreviations and medical terminology when communicating with the health care team throughout the clinical experience. Acceptable: The client had a cholecystectomy. Unacceptable: The client had their gall bladder out.” The description goes on to say that students must be “Able to verbally advocate for the client and/or client’s family by bringing forward their concerns and/or needs to the health care team” (George Brown College).

PSW involvement in providing feedback on the efficacy of the care plan interventions is often discussed alongside observation, documentation, and reporting.

5.7 Safety and Comfort

Data for this section stemmed from references in the “safety” category. With 208 references across 67 sources, this was the most densely populated category in the analysis. Some content was gathered from references in the “comfort-well-being category” (49 references, 25 sources). The categories to which data was coded most often in conjunction with safety were: “confidentiality”, “ADLs”, “Emergency Measures”, “Vulnerable”, “Care Plan”, and “MDR”. The content in these categories was also explored, and various queries were run exploring the relationship between the categories. A memo entitled “safety and comfort” was created summarizing the results.

5.7.1 The Standard

The standard expects PSWs to have the skills to maintain a safe and comfortable environment for clients. This includes the implementation of infection control and prevention measures, and knowledge of emergency first aid procedures. PSWs must become familiar with employer policies, including those related to the use of restraints, as well as legislation such as the Ontario Occupational Health and Safety Act. They must also be able to identify environmental risks and hazards and reduce or report them as appropriate. The outcome expects that PSWs are familiar with safety protocols related to all devices and potentially hazardous materials within the facility.
and have knowledge of incident reporting. Safety expectations also extend to knowledge of infection risks, infection control measures, emergency preparedness, and incident reporting. The standard does not elaborate upon what is meant by “comfortable environment”.

5.7.2 The Textbook

The text contains a chapter entitled “Safety” (Chapter 19). Infection risks and control measures are discussed separately in the following chapter (Chapter 20). The meaning of comfort and its relevance to a PSW’s role is covered in the text’s chapter on promoting client well-being. The chapter on safety describes it as a basic need and right, noting that there are physical and emotional dimensions to feelings of safety. The text goes on to discuss a number of factors that are relevant to safety risks, including impaired awareness or sensory perception resulting from a variety of conditions, age, and medication. Safety measures and strategies for preventing falls and injuries are also described. The use of restraints is discussed at length. PSWs are given guidance on the psychological impact for clients of being restrained, potential physical safety hazards, relevant legislation, and different types of restraints and when they can be appropriately used. The text stresses that the use of restraints is to be avoided if possible and provides alternative strategies. The text provides additional guidance on preventing a number of injuries and accidents, such as, poisoning, burns, suffocation, accidents with equipment, and fires. Emergency measures for all of these scenarios are described. PSWs are also reminded in this chapter to be aware of ensuring that they have correctly identified the client and cautioned that providing care to the wrong client can seriously threaten client health and safety. PSWs are also reminded to consider factors that affect their personal safety on the job, for example hazardous materials or harassment.

The chapter on infection control (Chapter 20) provides biological information on how different types of infections are spread and factors that increase risk of contracting an infection. Strategies for controlling the spread of infection are also covered, with significant emphasis placed on the importance of hand hygiene. The chapter also notes that maintaining the cleanliness of the physical environment is an important infection control strategy.

The textbook describes comfort as a “feeling of contentment. The client is not in any physical or emotional pain and is calm and at peace”. Several physical considerations with regards to comfort are described, namely temperature, ventilation, odours, noise, and lighting. The chapter
devotes significant attention to comfort in relation to pain assessment and management as well, with some attention given to common pain scales. The PSWs role in promoting comfortable sleep and rest is also described.

5.7.3 The Programs
The NACC member schools and the SBCE programs offer a module entitled “Safety”. One PCC specified that this was a 9 hour module. According to the course descriptions, upon completion of the course, students should be able to identify safety issues with equipment and in the environment, and describe the potential associated risks. Students are also expected to have the ability to understand and implement infection control measures. The importance of good body mechanics when supporting clients with transfers and lifts was another common theme in safety courses. More detailed descriptions noted that good body mechanics were important to the client’s comfort and safety, as well as the PSW’s back health. The safety module is also where accident and injury prevention strategies are covered. Some courses also referred to the safe handling of hazardous materials. The programs describe the module in this way:

“This module deals with aspects of safety as they relate to both the client and the worker. One of the fundamental activities of the PSW is assisting the client with routine activities of living. It is essential that the PSW provide assistance in a manner that is effective, safe, and provides for the client’s comfort. As part of this, the PSW must be aware of potential risks posed by unsafe equipment or settings and the appropriate actions to take if unsafe situations are identified.

Infection control methods will also be taught as infections can cause distress for both the client and the worker” (St. Albert Adult Learning Centre).

None of the CAAT programs in the qualitative analysis offered a course specific to the subject of safety. Instead, safety issues are addressed in a wide variety of courses, such as “Foundations of Support Work”, “Health Promotion”, “Optimal Care Planning”, and “Community Care Theory”. Descriptions of the care simulation labs indicate that students are given the opportunity to apply their understanding of safety considerations.

The NACC and School Board programs also incorporate discussions of safety into other courses, such as role of the worker, mobility, ongoing conditions, and household management and meal
preparation. The references to safety in these course descriptions are usually in the context of a list of topics.

Where comfort is mentioned, it is usually mentioned in passing along with safety. Little time is spent on defining what is meant by comfort and the focus of the materials is practical considerations regarding safety. The references to comfort describe it in relation to keeping the client’s home clean and tidy, and proper positioning, transfers and lifts.

5.8 Activities of Daily Living

The category “ADLs” was also one of the largest in the analysis, with 142 references from 77 sources. The categories coded most often along with “ADLs” were: “Nutrition”, “Conditions”, “Transfers-Lifts”, “Independence”, “Safety”, “Care Plan”. References within these categories were also reviewed, and relationships between the categories were explored using coding and matrix coding queries. Again, a memo was created summarizing the results.

5.8.1 The Standard

The standard defines ADLs as activities performed by a person in a normal day, and can include bathing, dressing, toileting, eating, and mobility. The standard notes that an ADL for one client may not be for another (e.g. taking a short term prescription versus an ongoing prescription). The goal of providing support with ADLs is to promote the client’s sense of health and wellbeing and facilitate their participation in social and productive activities. According to the learning outcome, to effectively support clients with ADLs, PSWs must take into consideration a client’s right to safety, dignity, autonomy, respect, privacy, and confidentiality. The provision of ADL support should also be provided in accordance with the client’s personal preferences. This applies to cultural preferences, as well as preferences regarding the pace of care and their living space. By extension, PSWs are expected to advise their supervisors if they cannot deliver care in the allocated time. The outcome states that PSWs must have a sound knowledge of human biology informing their provision of ADL support; including an understanding of the functioning of all the major systems of the body, human development across the lifespan, and alterations in functioning. PSWs are also involved in supporting clients’ optimal functioning through the use of rehabilitative, restorative, and convalescent care techniques. Health promotion and disease prevention best practises as they pertain to ADLs are also required knowledge. The ability to
provide nutritional support in accordance with the client’s dietary and cultural needs is also expected, including knowledge of enteral feeding methods and equipment, and potential complications. Knowledge of how to assist with hygiene and grooming, including hair and nail care, bathing, and dressing, is also an essential skill set. Support with toileting and continence extends to knowledge of how to provide ostomy care and clean technique for drainage of permanent catheters. The support expectations with regards to mobility extend to knowledge of devices used for transfers and lifts.

5.8.2 The Textbook

Given the centrality of ADL support in the PSW role, it is unsurprising that a significant proportion of the textbook is devoted to in-depth coverage of the various components of ADL support. The text and the standard concur as to PSW knowledge requirements regarding ADL support, and related knowledge of human biology and development.

A basic grounding in human biology and development is provided in the chapters on body structure and function (Chapter 14), growth and development (Chapter 14), caring for the young (Chapter 16), caring for older adults (Chapter 17), and common diseases and conditions (Chapter 18). Information relevant to the provision of ADL support is covered in the chapters on body mechanics, including transfers and lifts (Chapter 23), exercise and activity (Chapter 24), nutrition and fluids (Chapter 27), enteral nutrition and intravenous therapy (Chapter 28), personal hygiene (Chapter 29), grooming and dressing, urinary elimination (Chapter 31), and bowel elimination (Chapter 32), and oxygen therapy (Chapter 44). The text also contains a chapter on rehabilitative care (Chapter 33).

The chapter on body mechanics, positioning, transfers and lifts highlights the importance of good back care for PSWs when positioning and transferring clients. Different techniques for rolling, repositioning, transferring and moving the client are explained in depth. Some injuries that can result from repositioning the client and explains that mechanical lifts are used for clients who cannot participate in a transfer and notes that manual lifts are almost never allowed in facilities anymore because of the risk of injury to the workers. Strategies for avoiding them are discussed.

Guidance is provided on performing range of motion exercises with clients, noting that exercises involving the neck should only be performed if allowed by employer policy. The chapter also
provides detailed instructions on how to support clients with walking, fall prevention and how to catch falling clients.

The chapter on nutrition and fluids provides basic education regarding vitamins, minerals and other nutrients in food, the Canada food guide, and eating a balanced diet. Nutritional requirements at different developmental stages and for different conditions are also discussed. The text also reminds students to consider the impact of religion and culture on food choices and needs, noting that condition-specific diets must be designed to take cultural needs into consideration as well.

A further chapter is devoted to enteral nutrition (tube feeding) and intravenous (IV) therapy, either of which may be ADLs for some clients. The role of different members of the care team in the prescription and administration of enteral nutrition is outlined. The text explains that PSWs can never insert feeding tubes, test the position of the tube, or give the first dose of the feed. In some cases, PSWs can start feeding pumps and pour formula into bags or containers, but only if certain types of feeding tubes are being used. The text notes that this procedure must always be delegated by a nurse. As with all delegated tasks, the training must be provided on a client-by-client basis. Health risks and comfort measures for clients receiving tube feeds are also covered.

The chapter cautions that PSWs are never responsible for starting or maintaining IV therapy; however, they may be involved in supporting clients receiving ongoing IV therapy with their activity and hygiene needs, and as such must be aware of safety needs and precautions when caring for these clients. The text provides guidance on how to identify when there are complications from intravenous therapy, any of which should be reported to the supervisor.

The chapter on personal hygiene provides detailed directions on the proper procedure for providing all aspects of hygiene care, including baths, bed baths, oral hygiene, skin care, and perineal and menstrual care. The text provides guidance on addressing common problems that could arise in the bath or shower, such as hardened stool or secretions on the client’s body, the client developing an erection, or the client refusing the bath or shower as a result of dementia or mental health issues. The impact of diversity, such as bathing practices for practitioners of Islam, are touched upon.
The text describes procedures for hair care, nail care, shaving and dressing in detail in the chapter on grooming and dressing. Conditions affecting the hair and scalp are briefly outlined. As in all the chapters, guidance on safety is provided. For example, students are cautioned that they should never clip the nails of clients who have diabetes, take medication that affect blood clotting, have poor circulation to the legs and feet, or have thick or ingrown nails. The text notes that some employers do not allow PSWs to clip nails under any circumstances and that they should always be aware of employer policies before completing this type of care.

Urinary and bowel elimination are each covered in their own chapters. The text describes the use of devices such as bed pans and continence products. Different types of catheterization and the involvement of PSWs in the care of patients with indwelling catheters is discussed at length. While PSWs are typically never involved in inserting catheters, they are frequently involved in cleaning, draining, or measuring output from catheters, which requires the application of standard procedures regarding medical asepsis (sterile technique). The text also provides significant guidance on caring for clients whose urine output has been redirected through a stoma, a surgically created artificial opening in the body. Urine output drains into a bag, and PSWs must be proficient in sterile technique for draining the bag and cleaning the stoma, including being able to recognize symptoms of infection around the stoma. The chapter on bowel elimination provides an overview of normal bowel functioning and of common problems (such as constipation and diarrhea). Directions on how to give an enema are provided, noting that this is a delegated act. Again, care for clients whose stool has been diverted through a stoma into an ostomy bag is described, with attention given to sterile technique.

In the chapter on rehabilitative care, rehabilitation is described as “the process of restoring a person to the highest possible level of functioning through the use of therapy, exercise or other methods.” The text goes on to explain that rehabilitation may be short term, in response to an acute injury, or an ongoing component of treatment of a chronic illness. The chapter notes that in the home care setting, the PSWs is often the care provider who interacts with the client most frequently; therefore, their observations regarding the efficacy of rehabilitative strategies are important to report in a timely fashion. Common health problems requiring rehabilitation, such as acquired brain injury or addiction, are listed.
In the chapter on oxygen needs, the text describes the PSW’s role in caring for clients’ respiratory problems, including individuals who have had tracheostomies. The text explains that PSWs are never responsible for starting and maintaining oxygen therapy, but they are involved in providing safe care to clients receiving oxygen. PSWs are cautioned that they must ensure that the suctioning of airways is within their scope of practice in their jurisdiction. PSWs may also be asked to assist nurses with this procedure, which still requires knowledge of standard safety precautions. Manual ventilation, the use of a machine to move air in and out of the lungs, is also described. PSWs are also cautioned to ensure that assisting with this procedure is within the scope of practice for their province.

5.8.3 The Programs

Given the centrality of ADL support to the PSW role, it is unsurprising that there was no one course that addressed the subject of ADLs. The topic is covered throughout the courses; however, there are two modules in the NACC and OCSA curricula that specifically address ADLs: Assisting with Personal Hygiene, and Assisting with Mobility.

Hygiene modules typically covered the impact of disability and illness on a client’s hygiene needs. There was often a reference to the importance of supporting client control and choice in the provision of hygiene support. Upon completion, students are expected to understand the proper procedure for bathing, dressing, grooming, and providing oral care to dependent or independent clients. For example:

“The PSW is required to have knowledge, skills and sensitivity to provide appropriate assistance to another person, since a significant number of clients have disabilities that affect their ability to look after their personal hygiene. Sufficient knowledge about the structure, function, aging changes and common conditions of the skin is covered. The necessity of a positive attitude and sound interpersonal skills when working with clients experiencing a disability is discussed. The importance of supporting the client’s control over their own personal hygiene to the extent possible/desired is also covered, as is the need to respect the client’s right to make choices as to how they wish assistance to be given. Throughout the module, sensitivity and respect for the client’s dignity and privacy while providing assistance is stressed” (St. Albert Adult Learning Centre).
Modules on mobility typically covered supporting dependent and independent clients with ambulation, transfers and lifts, range of motion exercises and contractures. The descriptions identify the musculoskeletal system, body mechanics, and adaptive devices and prosthetics as subjects upon which PSWs must be knowledgeable in order to provide effective mobility support. One program describes the module this way:

“The personal support worker/personal attendant practices good body mechanics in many aspects of the work she/he performs to ensure safety and comfort for her/himself and the consumer/client. It is recognized that workers in this field are at risk for developing back injuries from improper use of body mechanics. Consistency in transferring, lifting techniques and the use of equipment increases safety and reduces consumer/client anxiety, confusion and dependency. This module also discusses promoting proper positioning in a bed or chair for the comfort and safety of the consumer/client. Personal support workers/personal attendants have the appropriate knowledge, skill and attitude to assist the consumer/client with routine activities of living. They recognize the importance of providing assistance, which supports the consumer/client's sense of self-determination and well-being in such a way that the consumer/client feels well served by their actions” (St. Albert Adult Learning Centre).

CAAT programs discuss ADLs in a number of courses, such as “Optimal support and Personal Care”, “Foundations of Support Work”, “Health and Wellness” and “Health Promotion” and “Clinical Practice”. All of the descriptions for the simulation labs identify practicing ADL provision, taking into consideration the principles of client rights, choice, safety, confidentiality and privacy, as the central objective of the lab. One CAAT program describe the lab as follows:

“Laboratory practice course is designed to introduce the basic skills involved with activities of daily living (ADLs). When taken concurrently with Clinical Practice I, the student is given an opportunity to practice in both clinical and laboratory settings. Throughout this course, emphasis is placed on respecting the client's need for privacy, as well as for dignity, preferences, safety and respect” (Fanshaw College, 2014).

5.9 Medication

The “Medication” category had 72 references in 44 sources. The categories that appeared most frequently alongside “Medication” were: “ADLs”, “Ethics”, “IADLs”, “RHP Supervision”,

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“Role-Scope”, and “Delegated”. The same procedures were used to explore and summarize the results.

5.9.1 The Standard
According to the standard, PSW accountabilities with regards to medication include understanding the relevant provisions of Ontario’s Regulated Health Professions Act, Long-Term Care Homes Act, and Retirement Homes Act. They must also be aware of the impact of employer policies on the scope of their role regarding medications in different settings. They are expected to have sufficient knowledge of mathematics to be able to accurately measure oral and topical medications, as well as the ability to appropriately observe, document and report any unexpected outcomes from medication therapy. Additionally, PSWs must have an understanding of the role of RHPs in the ongoing monitoring of medication treatment outcomes. Lastly, PSWs are expected to be proactive about seeking guidance from their supervisor regarding any questions or concerns about their role in assisting with medications.

5.9.2 The Textbook
The chapter on assisting with medication (Chapter 40) highlights the distinction between assistance and administering medications. According to the text, the administration of medication “involves measuring medications or getting them into the person’s body, and it requires special judgement and knowledge.” The text makes it clear that the administration of medication falls outside the scope of PSW practice and that they can only assist. This can involve reminding the client to take their medications, reaching the bottles or opening the packaging, steadying the client’s hand so they can self-administer, providing water and other fluids, and documenting medications that have been taken. The text provides best practices regarding assisting with medications. Additionally, PSWs can be assigned the administration of oral medication or eye drops, or delegated the administration of medication via injection (e.g. insulin) or inhalation if this constitutes an ADL for the client. Again, as with all delegated tasks, formal training must be provided on a client-by-client basis. Basic information regarding drug classifications, interactions, and side effects is provided.

5.9.3 The Programs
The NACC and OCSA curricula contain a module entitled “Assisting with Medications”. One program indicated this was a 12 hour module. As described by the course descriptions, the
module discusses topics such as the purpose of medication, the role of the pharmacist, interpreting information on prescriptions, and monitoring changes in the client’s condition. Several descriptions indicated that students are expected to demonstrate their ability to assist with oral, topical, inhaled, and transdermal medications upon completion of the course. One program described the course in this manner:

“The Personal Support Worker's (PSW) ability to assist a client with medication may be essential in supporting the client's independence, or in supporting a family caregiver to attend to tasks or take needed respite. Student will identify purposes of medication, required instruction/information about medications to be administered, and cautions with regard to medications. You will develop and demonstrate skill in reading and interpreting information in prescription containers, and demonstrate assistance with oral/topical medications as well as eye, ear, and nose drops. The importance of observation for both desired and undesired outcomes will be described. Finally, procedure to be followed in the event of concern about, or problems with medications will be discussed” (St. Albert Adult Learning Centre).

CAAT programs cover medications in courses specific to the design of their programs. Two CAAT programs offered a course on pharmacology for PSWs. One program described the course this way:

“This course will introduce students to the principles of pharmacology including the role medications play in restoring or maintaining health and provide the basic knowledge and skills required to safely administer medications in community workplaces. Given the ever expanding and changing nature of pharmaceuticals, only an overview of therapeutics will be presented. Emphasis will be placed on remaining current with medications and their actions and reactions in the body through life-long learning” (Northern College).

Four CAAT programs offer a course on math and measurement, with the stated aim of ensuring PSWs have the numeracy skills to assist with medications and other tasks. Medication may also be covered in courses on professional issues, ongoing conditions, or community care. None of the course descriptions discuss the distinction between assistance and administration. Moreover, the program referenced above states that the course prepares PSWs to administer medications in
the community. Likewise, the potential for PSWs to be assigned or delegated medication administration by nurses was not mentioned in the course descriptions.

5.10 Instrumental Activities of Daily Living (IADLs)

The IADLs category had 90 references in 48 sources. The codes that appeared most frequently alongside IADLs were: “Employment setting”, “safety”, “able”, “medication”, “conditions” and “nutrition”. The same procedures as above were used to explore and summarize the results.

5.10.1 The Standard

The Standard defines IADLs as “Activities related to clients’ independent living, involving interactions with the physical and social environment, which may include but are not limited to: preparing food, shopping, and cleaning”. According to the standard, PSWs must know about safety guidelines for household equipment and best practices with regards to controlling the presence and spread of microorganisms in the home. They are also expected to know how to support clients with preparing grocery lists that are consistent with the Canada Food Guide and which take into consideration the client’s budgetary, cultural, and dietary health needs. PSWs may also be expected to support clients with managing their finances in a responsible and ethical manner. The care should also be provided in a manner that empowers clients to make choices and respects their decisions, without exerting inappropriate control over the client’s life.

5.10.2 The Textbook

PSW responsibilities with regards to IADLs are covered in the chapter on home management (Chapter 25) and the chapter on bed making (Chapter 26). The home management chapter outlines the primary home management tasks PSWs will be involved in, which can be termed light housekeeping (washing dishes, vacuuming, cleaning bathrooms etc.), and provides detailed instructions on how to execute these tasks, including tips on making home-made cleansers and understanding laundry symbols. Since most hospitals and LTCs have housekeeping staff, the chapter focuses on the community setting. Guidance is provided on managing the client’s money, including ethical considerations related to this. Students are reminded to ensure their housekeeping practices control the spread of microorganisms. The chapter on bed making provides detailed instructions on how to make a bed such that skin integrity for the client is preserved.
5.10.3 The Programs
The NACC and OCSA curricula includes a module entitled “Household Management and Meal Preparation”. Descriptions typically highlight the importance of client preferences when providing IADL support. Descriptions also typically state that graduates should have an understanding of the impact of health conditions and culture on dietary needs. As one program puts it:

“Students will learn to assist the client with their nutritional needs, household activities and household management according to client preferences, comfort and safety, within employer guidelines as required. Nutritional needs include planning balanced nutritious menus, preparing shopping lists, shopping, handling of food, storage and specific cooking techniques. Special dietary needs of infants, pregnant and nursing mothers, persons with specific conditions such as diabetes, feeding tubes etc., as well as persons with specific cultural and religious preferences will be addressed. Students will have the opportunity to practice and demonstrate skills in a lab environment” (St. Albert Adult Learning Centre).

In the CAAT programs, there is no one course where the subject of IADLs is covered. The topic is referenced in courses such as “Foundation of Personal Support Work II”, “Caring for Clients in the Community”, and “Numeracy” or “Math and Measurement”. IADLs are mentioned in the courses on math and numeracy because PSWs need math skills for activities such as budgeting and cooking. The CAAT descriptions generally contained a list style reference to household management. The most detailed explanation as to how the topic would be covered was this:

“This course deals with aspects of safety, mobility and household management. Accident risk factors as well as safety measures are discussed. Infection control and the principles of good body mechanics are introduced. Client safety and comfort as it relates to positioning are emphasized. The concepts of rest and activity and how these two affect the client's well-being are also discussed. In addition this course enables students to develop and demonstrate skills related to assisting with household activities and household management. Planning and preparing nutritious and appealing meals are explored. Special diets, cultural and religious preferences are emphasized when discussing meal preparation” (Seneca College).
Four of the CAAT programs in the analysis offered a course on math and measurement or numeracy. IADL support was cited as one of the applications of mathematical knowledge. One program described the relationship in this way:

“This course provides an overview of fundamental mathematical skills required of a Personal Support Worker. Concepts covered include calculations with whole numbers, fractions, decimals, percentages, ratios and proportions as well as measurement principles relating to the Metric, Apothecary and Household Systems of Measurement. Applicable conversions between the different systems will be discussed. Application of these same principles as they relate to providing household management and personal care will also be discussed” (George Brown College).

Some programs indicated that the course would include a lab where students could practice meal preparation and household management skills; however, it is not clear whether this teaching method is used in all programs.

5.11 Respite

Information regarding respite care was coded to the category “Families”, which had 92 references in 42 sources. In the early phases of the analysis, respite was its own category, but was merged into “families” when the researcher observed that respite was always mentioned in conjunction with families. The categories that were coded alongside “Families” most often were “Nutrition”, “Addictions-Mental Health”, “Role-Scope”, “Pain Management”, and “Treatment Options”. Content in the categories was analysed as above.

5.11.1 The Standard

According to the standard, in order to provide effective respite care, PSWs must have an understanding of the role and significance of friends and family and respect for diversity and individual identity within families. They must also be familiar with conflict resolution processes and be able to describe conditions that affect caregivers, such as caregiver strain. As with many of the other outcomes, PSWs are expected to reflect on the impact of their personal values and how they impact their understanding of the role of family and friends. The learning outcome also expects graduates to understand and maintain professional boundaries. Since PSW responsibilities can include childcare, knowledge of child development is also expected.
5.11.2 The Textbook

The text defines respite care as “temporary care of a person who requires a high level of support, care and supervision that gives the person’s caregivers a break from their duties”. Respite care is mentioned throughout the book. The text notes that some hospitals and LTCs may have respite units wherein PSWs provide some of the care. In the chapter called “Working with Clients and their Families” (Chapter 6) the text discusses the interpersonal aspect of respite care, observing that a family member often becomes a person’s primary caregiver when that person become affected by an illness or disability. This changes the relationship; for example, the disabled person may resent needing care, while the care provider may feel the disabled family member is a burden. The passage also briefly outlines the process whereby health professionals support family members to assume care responsibilities (Textbook, p. 83). In the chapter on mental health disorders (Chapter 34), the authors note that parents of children with attention deficit and disruptive behaviour disorder may especially benefit from respite care because the child’s disruptive behaviour is more apt to be directed at parents and teachers. Respite care is also mentioned in the passage on clients with mild stage dementia in the chapter on concussion, delirium and dementia (Chapter 35). As mentioned above, each chapter of the text has a number of scenarios and in some scenarios, the context is respite care. The importance of breaks for those caring for individuals with developmental disabilities, dementia, and mental health issues is emphasized.

5.11.3 The Programs

The NACC and OCSA curricula includes a module called “Assisting the Family”. Three of the course descriptions mentioned respite. As discussed in the section on the role of the worker, several of the PCC programs provided the same description for modules verbatim. In this instance, three schools provided the following description for the “Assisting the Family” module:

“This module assists students to understand the characteristics of today's families in terms of structure, functions, roles, lifestyles and relationships. An understanding of the influence of cultural values, practices, religious beliefs as well as the effects of illness, stress, disability on family relationships will be emphasized as central to the PSW's ability to provide effective support. This module also explores the PSW’s role in providing respite to and assisting families/significant others and their children, including
those with special needs” (St. Albert Adult Learning Centre).

The term respite was not used in the CAAT data. One program provided a course on family support at levels 1 and 2. As seen below, the description alludes to respite in that it references caregiver stress, but does not purport to cover the PSWs role in caregiver relief:

“This course enables student to understand the effects of illness, stress and disability on today's families. The Personal Support Worker is required to provide personal hygiene to clients of all ages. Infection prevention is discussed as it relates to providing personal care and the integumentary, urinary, digestive and immune systems are briefly introduced to enhance learning” (Seneca College).

Otherwise, most of the references to family support in the CAAT data appeared in the context of a list of stakeholders the PSWs must interact with. Some courses indicated that conflict resolution strategies would be covered in courses on interpersonal skills; however, unlike the standard, this was not connected to respite care in the program data.

5.12 Abuse

Data for this section was primarily gathered from the “vulnerable” category, which contained 44 references in 25 sources. “Vulnerable” was one of the earliest categories created because it was often used in job postings to describe the client population the PSW would be working with. The separate category “abuse” was later merged into vulnerable because the world vulnerable almost always appeared in passages containing the word abuse. The categories that appeared most often in conjunction with “vulnerable” were: “care plan”, “communication interpersonal”, “emergency measures”, “communication interpersonal”, “emergency measures”, “confidentiality”, “change in status”, “MDR”, “Safety”. The same procedures were used to analyse and summarize the data.

5.12.1 The Standard

The standard expects that graduates will have the ability to recognize signs of abuse and neglect by family members or caregivers and document and report it in accordance with employer policies and legislation. This includes an understanding that physical, verbal, sexual, emotional and financial abuse are ways of exerting power and control over vulnerable people, including children, people with disabilities, elderly people, and people with mental health issues. They are
also expected to recognize situations that put the PSW at risk of abuse or harm, including workplace sexual harassment and bullying.

5.12.2 The Textbook
The text contains a chapter entitled “Abuse Awareness” (Chapter 21). It discusses abuse as a form of exerting power and control over another person and explains that children, elderly people, and individuals experiencing any form of social marginalization (i.e. poverty, mental health and addiction issues) are more at risk of abuse. The chapter describes different types of abuse, including physical, financial, sexual and emotional, and identifies warning signs that any of these forms of abuse are taking place. The potential for workers to be physically, emotionally, or sexually abused by clients, and strategies for addressing and preventing this are discussed. The chapter also provides legal information about the charter of rights and reporting obligations.

5.12.3 The Programs
The NACC and OCSA curricula contain a module entitled “Abuse”. The school board program that provided this information indicated this was a 15 hour module. The PCC program that provided course outlines indicated that the module works from the framework that abuse is a form of exerting power and control. The module covers different forms of abuse, how to recognize signs of abuse, and a PSW’s legal and ethical obligations with regards to reporting abuse. Most of the course descriptions also noted that PSWs may be the focus of abuse by clients and indicated that the module would cover strategies for addressing this. Some courses stated that students would also be asked to reflect upon their personal beliefs and attitudes regarding abuse and family violence. One example of a course description for the abuse module is this:

“Family violence (incorporating child, spousal, and elder abuse) is a significant aspect of current society. As well, research indicates an increased awareness among support workers of abusive behaviour toward consumer/clients. This module introduces students to the concepts of family violence and abuse, including its possible signs, as well as appropriate actions to be taken (including legal requirements) if abuse is suspected. Personal beliefs and attitudes about family violence and abuse are examined, as is the concept of worker abuse of the consumer/client. Finally, abuse of the worker is discussed. Personal support workers and personal attendants identify the concept of abuse and are able to recognize both causes and indicators. They are able to identify the requirements of
legislation and to respond in accordance with legislation, employer policy and provisions of the service contract or support plan. They recognize that personal support workers/personal attendants may also be the focus of abuse” (St. Albert Adult Learning Centre).

While the above description notes that abuse of clients by workers will be covered, this was not common. Only one other school board program’s course description mentioned this, and similar wording as the one above, although abbreviated.

CAAT programs covered the topic of abuse in courses on foundations of support work, community care, professional issues, interpersonal communication or family support. One of the more detailed descriptions of the coverage of abuse appears in the outline for a course on observing and reporting findings on the PSW client. The outline states that students will be expected to “Identify the concept of abuse, the possible signs of abuse, the worker’s reporting responsibility, and other appropriate actions in keeping with agency policy” (George Brown College). The outline indicates that abuse is covered in the 6th week of the course, as a continuation of the unit on safety. In the unit, students are expected to be able to: “Describe the types of abuse, Describe the cycle of abuse, Describe spousal abuse, child abuse and abuse of older adults, Describe how clients and health care workers can be abused, Explain what to do if you have an abusive client, Identify signs of abuse, and Explain your legal responsibilities when reporting abuse”.

The course outline indicates that Mosby’s text is supplemented with community resources regarding elder abuse and legal obligations.

5.13 Palliative Care and End-of-Life Care

Data from this section was gathered primarily from the category “palliative”, in the summary category “Clientele”. “Palliative” contained 56 references across 35 sources. The categories that appeared most often in conjunction with “palliative” were: “care plan”, “ADLs”, “emergency measures”, “comfort-wellbeing”, “safety”, “MDR”, “nutrition”. The same procedures as above were used to analyse and summarize the data.
5.13.1 The Standard

The standard notes that supporting clients and families in dealing with death and grief is also a key dimension of the PSW role. To provide effective support in this area, PSWs must understand that reactions to death and terminal illness are individual and impacted by culture and personal beliefs. Again, they are expected to reflect on their own values and beliefs with regards to death and dying and how this has the potential to impact care. They must also be able to discuss the distinction between sympathy and empathy, the role of advocacy, and the maintenance of helping relationships and professional boundaries. Graduates should be able to perform non-pharmacological comfort techniques, and appropriately document client vital signs, indications of pain, and comfort measures. They must be familiar with relevant legislation and regulations, including those concerning substitute decision makers and the role of the coroner in sudden death. Care should be provided in a manner that supports the client’s rights and autonomy.

5.13.2 The Textbook

The text contains a chapter entitled “Caring for a Client Who is Dying” (Chapter 47). The chapter discusses the impact of religion, culture and age on attitudes towards death and dying. It outlines different theories of grief, such as Kubler-Ross’s stages of grief and presents a brief history of palliative care and provides guidance on providing emotional, spiritual, social, intellectual, and physical support to dying clients and their families. The chapter also briefly outlines legal issues such as advance directives and do not resuscitate orders, and provides students with instructions on how to recognize the signs of death, and how to conduct post-mortem care of the body. The role of funeral directors in funeral planning is briefly touched upon.

5.13.3 The Programs

The NACC and OCSA curricula include a module entitled “Assisting the Person who is Dying”. The PCC that provided course outlines indicated that the module covers knowing one’s own reaction to death and dying, and the impact of life threatening illness on clients and families. Upon completion, students are expected to understand the process of dying, and have knowledge of and the ability to apply the concept of palliation, comfort measures, and pain relief techniques. They must also have an understanding of client needs at the time of death, and support them to deal with loss and uncertainty, with sensitivity to the impact of culture and religion.
Additionally, they must know the client’s right with regards to treatment decisions, living wills, do not resuscitate orders etc. The course also covers activities required at the time of death, and post mortem care of the deceased. These themes were repeated throughout the program data. The course description that was repeated most frequently was this one:

“This module allows students to discuss the concept of dying as a part of life and the possible impact of life-threatening illness on the person and their family. They will also have the opportunity to examine personal beliefs about life-threatening illness, dying and the provision of support to the dying person, his/her family and friends. Assisting the dying person to maintain a desired lifestyle and respecting his/her right to make decisions with regard to support is also discussed. Specific approaches within the scope of the support worker to reduce discomfort or pain (within the context of a plan of support or care) are covered. Care of the person at the time of death, care of the body after death, as well as any procedures which must be followed are discussed” (St. Albert Adult Learning Centre).

CAAT programs typically included a course on palliative care; however, in some programs, the subject of death, dying, and palliative care was subsumed in courses on interpersonal communication, life transitions, or developmental psychology. The CAAT program that provided a course outline indicated that Mosby’s text would be supplemented with a training package for PSWs developed by the Canadian Hospice Care Association.

5.14 Cognitive Impairment, Mental Health Challenges, Responsive Behaviours

Data for this section was gathered from the categories “addictions-mental health”, “dementia”, and “responsive behaviours” in the summary category “Clientele” and “cognitive” in the summary category “Supporting Quality of Life”. Each category was moderately populated, with 21 – 36 references. The categories were kept separate because they were not always mentioned together. However there was significant overlap between the categories, and the standard established a relationship between the categories. The researcher reviewed the contents of each category, and created a coding matrix to explore the interaction of the various categories. The same procedures as above were used to analyse and summarize the data.
5.14.1 The Standard
The Standard expects that graduates will have the ability to support clients experiencing cognitive impairment, mental health challenges, and related responsive behaviours. The standard defines responsive behaviours as behaviours “that indicate an unmet need in a person” or “a response to circumstances in the environment that may be frustrating, frightening, or confusing to a person”. The behaviours in question are often violent or aggressive, and pose a challenge for staff caring for people with dementia. Knowledge requirements under this domain include being able to recognize changes to the client’s motor skills, judgment, memory, perception, organization, and language that could signify cognitive impairment, mental illness, delirium or dementia, and acquired brain injuries including stroke. In addition to an awareness of treatment best practices for each condition, PSWs must also be aware of the impact of social stigma towards mental illness and cognitive impairment, including the impact of their own personal biases regarding issues such as suicide. Integral to this domain is the ability to use basic behavioural strategies to mitigate responsive behaviours.

5.14.2 The Textbook
PSW knowledge requirements with regards to cognitive impairment, mental health challenges and responsive behaviours are covered in the textbook’s chapters on mental health (Chapter 34), dementia, delirium (Chapter 35), and developmental disabilities (Chapter 39).

The chapter on mental health provides an overview of the causes and social impact of mental illness, a high-level description of the signs and symptoms of a number of mental illnesses, and divides them into broader categories. Illnesses described include acquired brain injuries, anxiety disorders, mood disorders, attention-deficit and disruptive-behaviour disorders, eating disorders, sleep disorders, schizophrenia, impulse-control disorders, substance dependence disorders, and personality disorders. Students are provided with a few strategies for providing support to clients in each disorder group. The text also discusses the impact of social stigma, as well as of culture, on mental illness. For example, the chapter includes a passage on mental health considerations that are specific to refugee populations.

In the chapter on confusion, delirium, and dementia, students learn to describe confusion and delirium and their causes, and differentiate between normal and abnormal age-related changes to mental functioning. The chapter provides a lengthy bulleted list of strategies for supporting
clients with dementia and provides an overview of different types of dementias (including Alzheimer’s and related dementias) and the characteristics of the three stages of dementia (mild, moderate, and severe). The chapter contains a passage on managing challenging responsive behaviours. The passage echoes the standard, noting that all behaviours have meaning and that clients are usually reacting to physical or emotional discomfort that they cannot communicate otherwise. The Gentle Persuasive Approach (GPA), is briefly described. The program data and the key informants concurred that GPA is a validated approach for working with clients with dementia. As noted above in the section on respite care, the chapter also covers the support needs of family caregivers.

The chapter entitled “Developmental Disabilities” provides a high-level description of a number of disorders, including Down syndrome, intellectual disabilities, and autism. Guidance is provided on the safety and compassionate care needs of clients with disabilities.

5.14.3 The Programs

The NACC and the OCSA curricula contain a module entitled “Cognitive Impairment and Mental Health”. The SBCE program for which a complete orientation manual was available described the course as follows:

“Personal Support Workers recognize that behaviours or changes in behaviour can be related to illness or other conditions such as cognitive impairment, substance abuse, or mental illness. They identify factors that can increase the risk of suicide and recognize signs of possible suicidal behaviour. They use approaches and techniques to assist clients with these changes or conditions in keeping with the care/support plan and report observations to the appropriate team member.

This module will introduce the student to common psychiatric conditions (affective disorders and schizophrenia), substance abuse, and cognitive impairment. The possibility of multiple conditions such as Alzheimer’s disease and depression will be discussed. The role of the family caregiver will be reviewed (Assisting the Family) as well as the importance of observation, documentation, and reporting (Interpersonal Skills)” (St. Albert Adult Learning Centre).
Several PCC programs used either the first or second paragraph as their course description. The term “responsive behaviours” was not used in the PCC or SBCE data.

Several CAAT programs also offered a course specific to cognitive impairment, mental health issues or dementia; however, the subject matter was sometimes subsumed in courses on client conditions and treatment interventions, abnormal psychology, and interpersonal and interprofessional relationships. Only one program used the term “responsive behaviours”; however, 3 others used the term “challenging behaviours” in this or similar contexts:

“This course is designed to provide a basic knowledge of mental health issues in today's society. Understanding and managing of challenging behaviours in the cognitively impaired person are discussed, along with strategies for working with these challenging behaviours. Students are encouraged to reflect on their personal feelings, experiences and reactions surrounding mental health” (Seneca College).

5.15 Summary of Chapter

This section summarizes the information with regards to program content. PSWs require knowledge and competency in a range of domains beyond the realm of common knowledge, and beyond that which could be acquired solely in an employer orientation of typical duration. The program standard with which institutional programs must comply was the outcome of extensive stakeholder consultation and appears to accurately identify the most relevant domains of PSW knowledge. The two staff members from the PSW association were of the view that the common standard is a high-level document that outlines the bare minimum knowledge requirement for PSWs and is not specific enough with regards to the required learning to ensure consistent and adequate quality among the programs. In the association director’s view, a standard curriculum is needed.

The researcher’s impression from the documents is that programs are strong in teaching the aspects of the PSW role that are vocational and skill-set based; however, they are less thorough at teaching the theoretical competencies for the role. This observation is most applicable to the modular design of the NACC and SBCE program, where each module identifies a skill set area. On the other hand, CAAT courses, are more likely to subsume teaching of specific skills under relevant theoretical knowledge areas such as “Professional Issues” or “Development across the
Lifespan”. The most significant theoretical areas where the comprehensiveness of current education could be further explored are abuse dynamics between provider and patient, professional boundaries, client-centred and directed philosophy of care.

The text does not use the client-centred and directed language very much, but does stress the importance of client preference, and also does touch upon professional boundaries. However, this is not situated in the context of power dynamics between care provider and client, and among members of the care team. The complex implications of power in the PSW-client relationship are central to the discussion of abuse, professional boundaries, and client-centredness since all three themes assume that the relationship between the client and the care provider cannot be conducted like other types of social relationships because of an imbalance of power.

One potential challenge for PSW educators with incorporating an analysis of power into educational resources is that the power dynamics of PSW-client relationships have more layers than that the RHP-client relationship. The PSW, largely as a result of having less formal education, has less social status than other members of the care team. This means that there is more potential for clients, especially in the home care setting, to see the PSW as a domestic labourer rather than health care expert. As discussed above, numerous informants and sources referenced the fact that PSWs are highly vulnerable to abuse, harassment, and violence on the job, especially in the home care context where care is delivered behind closed doors. On the other hand, the client is still reliant on the PSW for care; moreover, that care is potentially of a nature that has significant emotional and psychological meaning for the client due to the intimate and ongoing nature of the care and the fact that the client’s personal home becomes a care delivery site for clients in home care. As such, the power relationships are more challenging to define since there are tensions between the power imbalance that exists in the provider-patient relationship due to the patient’s reliance on the provider, and the power imbalance between the client and a worker who is of lower socioeconomic status than other members of the care team. In short, while PSWs are significantly more vulnerable to abuse than other care providers, they simultaneously have access to a myriad of ways to use power against the client.
CHAPTER 6: KEY INFORMANT PERCEPTIONS OF THE PROGRAMS

Key informants interviewed for this study included PSWs, RNs who supervise PSWs, RNs who educate PSWs, PSW association representatives, staff from a client advocacy groups, and staff from accreditation bodies. The various key informants were asked to identify the perceived strengths and weaknesses of the programs, and to identify areas where they believed PSWs could benefit from more training on the job. Key informant perceptions of the design and content of PSW educational programs are described below. Data was gathered from the same outcome specific categories and related categories as described in the preceding chapter. Information regarding how employers covered the topics on-the-job was gathered from data coded to the “on-the-job” category. Information regarding where PSWs felt training could be improved was gathered from the category “training improvements”.

6.1 Perceptions of the Education System

In general, the key informants expressed more negative attitudes towards the PCCs than the other institution types. In addition to concerns about the hours, two expressed doubt that all of the instruction was actually being provided by regulated health professionals. The NACC Auditor confirmed that the revised NACC program stipulates that instruction must be provided by registered nurses; however she did not believe that all of the instruction at all of the PCCs was actually being provided by nurses (PA2). This opinion was based on feedback from members of the PSW organization that she works for. This is possible because the Private Career Colleges Act states that up to 10% of the instruction can be provided by instructors who do not meet the qualification requirements if other criteria that demonstrate they have the skills to teach the course are met (Government of Ontario, 2005). The NACC auditor was also of the opinion that the NACC program was not significantly more comprehensive and in her words “regurgitates the MTCU” standard. In her view, the MTCU standard sets out the minimum knowledge requirement for PSWs and does not by itself ensure that programs are teaching students to meet the needs of the sector.

A PSW association staff member and former PSW (PA1) noted that the quality of education can vary significantly across the PCCs, since some are well-established, large scale corporations with state of the art facilities, while others are small, store-front operations with limited resources for
delivery methods such as lab simulations, which education experts agreed were essential preparation for clinical placements.

The same association staffer was asked whether employers in the sector had different opinions about the different program types. She stated that employers held CAAT graduates in higher regard than graduates from the other program types. She then relayed an anecdote to support this view. Shortly after she graduated from a CAAT program, she was offered a position by a large agency. A recent PCC graduate she knew was offered a position at the same agency for two dollars per hour less than the wage she was offered. She went on to say she was of the opinion that it was unlikely that any employers would admit to this practice (PA1).

Some key informants observed that there was instability in the PCC sector that affected the perception of schools, and cited the recent closure of Everest College by way of example (PA1, PA2, T1, T2). The closure of Everest was covered in media outlets such as the Toronto Star, CBC, and a number of others. These sources confirmed that this large, North America-wide, multi-campus institution, that offered numerous programs, was ordered to shut down while it filed for bankruptcy amidst reports that standards for various programs offered by the institution were not being met (Edwards, 2015; Evans, 2015). The “Notice of Proposal to Revoke Registration” regarding the school advises that the school continued to enroll as many as 20 students per day as late as February 2015 despite the fact that insolvency was imminent (Ministry of Training Colleges and Universities, 2015). This attitude among the key informants that the PCC sector was unstable was consistent with the findings from the document analysis. As the researcher reported above, three of the schools listed on NACCs website had closed down and NACC had not yet updated their list of schools authorized to offer the PSW program.

The data collected from the 8 supervisors and 13 PSWs within the home care agency painted a slightly different picture. Many of the supervisors only hired PSWs from one type of certificate program and as result were not able to provide an opinion on whether there was any difference between the graduates from different institution types. These were supervisors from smaller communities where virtually 100% of the graduates were from the only program available locally. The interviews with the PSWs confirmed that among this sample, the PSW program was not one that students typically relocated to attend and individuals had chosen their program based on proximity to their community of origin.
Most of the supervisors who had experience working with graduates from different program types worked in more populous regions and had experience with graduates from a maximum of 3 programs. While some of the supervisors who had experience with graduates from different institution types felt that their recent graduates had been well prepared by their certificate programs and did not observe any relevant differences in learning based on program types, two were strongly of the view that CAAT education was more rigorous and reputable than education received from the other institution types (PE3, PE8), and that new hires from CAAT programs were “better fits” (PE8). Meanwhile, the supervisor from a different home care agency was of the opinion that all of the program types were meeting the program standard (E1).

One supervisor (PE1) within the agency where multiple interviews were conducted, the LTC supervisor (L1) and the one supervisor from a different agency, indicated that when a PSW graduated made more of a difference to the type of education received than where the certificate was from. The perception of these informants was that the role of the PSW has become significantly more complex over the last fifteen years and programs have had to adapt to this change. As a result, recent graduates have received more education on clinical skills than graduates with older certificates (E1, PE1, L1).

Related to the perception that graduation year had an impact on depth of knowledge, the PSW association informant noted that she also does not believe that the school board programs are as good as the CAAT programs and cited the age of the OCSA/MOHLTC standard (1997) as one reason why this program type is not as good. By way of example, she relayed an anecdote wherein she was a participant in a conference and was shocked when some continuing education program graduates indicated they had never heard of C. Difficile. Clostridium (or C.) Difficile is a bacterial infection that can occur after treatment with antibiotics and which can cause severe, and potentially fatal diarrhea and inflammation of the colon (Surawicz, 2012). She was astonished since now, most PSWs are employed in the LTC setting and are definitely involved in providing care during epidemic or pandemic outbreaks and in her view, knowledge of infection control is essential for a PSW (PA1). Otherwise, most of the key informants had no opinion regarding the board-affiliated programs. The CAAT instructors did not believe there were any such programs still in existence, and were surprised to learn there were still over twenty of these programs in Ontario (T1 & T2). The client association representative could not recall having
worked with many graduates from school board affiliated programs at the professional
development course on caring for clients with Alzheimer’s and dementia that she facilitates (C1).

Some informants (A1, PA2, T1&T2, C1), observed that PSW programs are often funded by
reemployment programs offered through Service Canada or Ontario Works. Many people in such
programs are directed towards PSW courses because the demand for PSWs is increasing and the
program is fast and inexpensive. They are usually directed to study at a school-board based
program because these programs are the cheapest. The key informants expressed concerns that
this practise was leading to graduates who did not have the right characteristics to be PSWs,
regardless of how they are trained. Since the school-board affiliated programs are the least
expensive, this is often where reemployment program participants are sent.

Several key informants, including the program instructors, PSW association staff members, and
the accreditation body representative expressed skepticism that the programs claiming to offer
the program in four to five months were actually delivering the hours of instruction required by
NACC.

The PSW association staff member also noted that it is typical for the PCC students to complete
the clinical placement after they have completed all of the course work and no longer have the
opportunity to ask their instructors questions. Where program websites provided this data, they
confirmed this program structure. The CAAT instructors speculated that this was a cost saving
measure, because there is a period of time where students have still paid to attend the program,
but no onsite instruction is being provided, or paid for. They also noted that they had seen
instances where PCC students did not arrive with a preceptor during the portion of the placement
where they are expected to arrive with one.

The CAAT instructors advised that for the purposes of clinical placements, retirement homes are
considered a community setting. They explained that the distinction between the two settings
was that individuals living in an LTC require full support, whereas in a community setting such
as a retirement home, clients are still living more independently and do not require as much
support with activities of daily living (bathing, dressing, feeding, mobility etc.). The PSW
association staff member also did not believe that retirement homes provided sufficient contrast
to the long-term care setting to adequately prepare new graduates for the home care environment.
According to this informant, the home care setting was analogous to the “Wild West”, in that unlike institutional settings, PSWs cannot rely on support from nurses also working onsite, and are acting with significant autonomy (PA1). This is consistent with information provided by a home care employer who said that most new staff had no home care experience from their programs and were underprepared for the realities of this environment (E1). As a result of the fact that most placements take place in LTC or retirement homes, new graduates are better prepared for these settings, although a significant proportion of them end up employed in home care. Moreover, the home care employers and PSWs confirmed that currently care needs in home care can be quite advanced, with clients more and more frequently requiring significant support to carry out ADLs. PSWs have little day-to-day supervision in this setting (PA1, C1, E1).

It is important to note that not all of the negative perceptions regarding the PCCs were supported by any evidence. For example, it is only speculation that the programs offering the program over 20 weeks are not providing the number of hours required by NACC. When the key informant from NACC was asked about program hours, she explained that while CAAT programs offer the program over 2 semesters, students only attend class for a few hours each day and are expected to take general education courses. On the other hand, students in condensed PCC programs attend class for a full day each day and take only those courses that are required by the PSW program standard (N1). There is similarly no evidence that the primary instruction is not being provided by Registered Nurses as required by NACC. That being said, since negative attitudes towards PCCs were fairly common, it is entirely possible that this affects the employment opportunities offered to PCC graduate PSWs.

6.1.1 Views Towards the Consolidated Standard

The schools are required to implement the common standard by September 2015, which is after the timeframe of data collection for this study. The program instructors (T1 & T2), accreditation program rep (A1) and NACC program reviewer (PA2), and the NACC staff member (A2) were asked whether the revised standard would necessitate significant changes to the programs. The instructors from a large Toronto based CAAT said that their curriculum is reviewed regularly to ensure that it continues to meet the needs of the sector and that they did not believe that the revised standard would require changes to the program outside of the scope of their usual revision process. The representative from the accreditation body with which most of the board
affiliated programs are registered said that the new standard would more readily allow programs to cover assessment skills, which has previously been a somewhat controversial topic within PSW programs because assessment is seen as a nursing skill. According to the informant, this is in contrast to the fact that PSWs, especially in the home care setting, must make functional assessments on a regular basis. She also noted that they would be expanding the section on emergency preparedness under the Safety unit, but that the current curriculum was largely meeting the standard.

As mentioned above, the NACC curriculum was revised in order to be in compliance with the revised standard. The total program hours were increased from 640 to 700. Each module is now longer, and the curriculum now includes more content regarding anatomy and physiology, and abuse (N1).

According to the information on NACCs website, its current program was originally based on the OCSA standard, previously relied upon by the board-affiliated programs. Several key informants believed that, while the OCSA standard was a good reflection of the scope of the PSW at the end of the 1990s, it is no longer adequate to address the current breath of the role. The MTCU standard is a much longer, more comprehensive document which covers a number of topics that are relevant to the modern day PSW, including medication, pain management, body mechanics, medical terminology, devices and delegated tasks.

The program instructor, accreditation body and PSW association informants were strongly of the opinion that the common standard would not be adequate to ensure consistency in the education provided by the programs and that a common curriculum, with more stipulations with regards to delivery methods is what is actually needed. The instructors noted that as the standard is currently worded, there is nothing to prevent a program from offering the program exclusively on line, which in their opinion was wholly inappropriate for this program. They were of the belief that there was already a PCC offering the program in this manner; however, the researcher was not able to find evidence of this.

The accreditation body key informant made similar observations and expressed concerns that the PCCs in particular may cease to offer a practicum or clinical placement as part of their program since this is not stipulated by the standard. She was of the view that the CAATs would likely
continue to include clinical placements, and advised that they are still a requirement of her accreditation program. Meanwhile, the NACC key informant confirmed that clinical placements are still a requirement of that program as of the most recent revision.

6.2 Perceptions of Role Scope

The main theme that emerged from the informant data with regards to role and scope was that the scope of the PSW has expanded significantly in recent years, and programs have had to adapt to this. Related to this, PSWs are being increasingly asked to perform delegated controlled acts or assigned tasks that were formerly part of the nurse’s role (EI, PE7). Additionally, some informants identified that there is significant variation in the scope of the role depending on the employment setting and employer and supervisor policies (T1 & T2, E1, PA1, PA2, PP13). One informant stated that delegation is far more prevalent in home care and working independently can be challenging; however, the acuity of many of the clients is lower:

“There’s a lot of delegated tasks that you have in home care that you would not normally have in the long term care facility that’s for sure. Some of them would be a suppository. In a large care facility, there’s no way you’d be doing that. Home care is a little bit different. You have to because you have to help. Also, with home care, there’s lots of clients that need less. But, at a long term care facility, you have two people always mandatory all the time, which is very helpful. But in home care you only have one person and you’ve got to do everything yourself, which makes it a little bit difficult sometimes” (PP6)

Some informants felt that as a result of the variation in role based on the setting and individual client needs, significant confusion as to the scope of practice of the PSW exists in the healthcare sector and PSWs are frequently being asked to practice outside of their scope (T1 & T2, PA1, PA2).

They felt that more learning regarding the role and scope of practice for PSWs is needed, not only for PSWs, but for other members of the care team.

Two PSW key informants had been working in the supportive care field for over 20 years. According to their historical account, prior to the creation of the title “Personal Support Worker” in the late 1990s, and the coinciding development of the original PSW program developed by
OCSA and MOHLTC, all workers were what would now be considered Home Support Workers (HSWs), primarily providing household management services. When the PSW designation was created, their employer provided HSWs with the opportunity to take the PSW course, at the agencies’ expense, and to receive higher wages under the PSW designation once certified. A number of staff members took this option at that time (PP4, PP12).

According to a supervisor within the same agency, currently, the distinction between the two job titles is that PSWs can have nursing tasks assigned to them, whereas Home Support Workers cannot. The informant described the distinction between the roles in this manner:

“The only difference is HSW, there are certain delegated tasks that we're not allowed to delegate to them, such as [administering] any eye drops or medication. We definitely would want the PSW who has the certificate to do that” (PE1).

The informant went on to explain that within her agency, HSWs are primarily involved in providing support with IADLs, whereas PSW are more involved in personal care such as bathing, and assisting with medications.

Multiple informants concurred that during the time they have been in the workforce, the scope of the role has continued to expand. As one supervisor put it:

“The role of PSW five years ago or six years ago, they had much less responsibility. [They] could do personal care. Now [they’re doing] medication and catheterization, measuring the client’s urine, emptying the urine bags. So they’re taking a lot of responsibilities that require nursing responsibilities.” (PE7)

Another PSW supervisor cites an increase in delegated tasks as a key driver for the increase in scope:

“Well, there’s an increased need for delegations going on. So, the nurses are so busy and are off-loading duties that they would normally have done in the past. And now, we’re teaching them how to do G-tube feeds, and flushing, and the cleansing of the G-tube. We’re asking them to do catheter cleansing. We’re asking them to do intermittent catheter. We’re asking them to do a whole lot of things that previously have been nursing functions, and we’re downloading and off-loading onto these PSWs. They’re not getting paid for it, and there’s no official training programs or labs for them to go in and learn
how to do intermittent catheterization as a general skill that they can then take and be delegated off.” (PE3)

Since controlled acts are not part of the PSWs scope of practice, these skills are not taught in certificate programs. This means, that as noted by the informant quoted above, controlled acts must be taught on the job. The above informant was of the opinion that PSWs should receive some applied general education regarding these activities given the current labour environment.

Several informants expressed the view that PSWs are frequently asked to practice outside of their scope of practice. For example, the PSW association informant relayed a story in which a member called the association’s practice support line for guidance because her employer had asked her to administer flu shots (PA2). As noted in the section on delegation, a controlled act can only be delegated in circumstances where the act is a routine activity of daily living for the client, the client’s condition is stable, and the outcome of the intervention is predictable. As such, the administration of a vaccine cannot be delegated, and is a good example of a task that falls outside a PSW’s scope.

Another informant from the same association echoed similar concerns with regards to poor understanding of the PSW scope within the care sector as a whole. The informant had this to say:

“There’s such a vagueness around what is the actual role of the PSW etc. It is vague. It is very vague because they do not have a scope of practice. They do not have anything laid out saying, this is the scope that you can work within. And OPSWA being, Ontario Personal Support Workers Association, I did write a scope of practice for members so that it can number one, protect the public, and number two protect the member. Because right now because there is no real scope of practice and nobody to govern it, regulate it, uphold it. There are employers out there and family members out there asking PSWs to do things that they are not trained to do. So, that's why a scope is so important and, yet, there isn't one out there. Other than if you're a member of OPSWA. [PA2]

The association director was of the opinion that fear of reprisals in the work place was a factor in PSWs agreeing to perform activities outside of their scope:
“A lot of them fear for their jobs. So they do it. That's a very sad reality of it. Some of them even know that they shouldn't be doing certain things but they do it because they're afraid of losing their job.” [PA1]

The informant went on to observe that more training was needed among employers and regulated health professionals regarding PSW scope. In her words:

“It's not only teaching the PSWs or letting the PSWs know their scopes. Not only knowing the employers getting to know the scopes. It's other RHPs understanding their scope, right? Because there is a misunderstanding there, what they can and can't do.” [PA1]

The PSW educators in the CAAT system made similar reports of students being asked to practice outside of their scope during the practicum and indicated that they emphasize scope in their teaching because they are aware of this issue:

“They're expected to do more and more out there. But we're very cognizant of them not over stepping their bounds and going over the scope of practice, and that is a very strong message that our students get because they get a lot of pressure...to do stuff that they should not be doing like administering medications. They're only allowed to assist. But sometimes we get out there and ‘oh, can you just take this down to so and so?’ Yeah, so we really stress safety, and being mindful of what their limitations are.” [T1]

The key informant data revealed that there are some controversies in the sector as to exactly what PSWs should be doing. For example, the PSW educator referenced above was of the opinion that PSWs should not be involved in administering oral medications; however, this is not prohibited by the legislation, and many other individuals, including PSWs, were of the opinion that it was acceptable for PSWs to administer oral medication, provided they received the appropriate client-specific training (PE4, PE5). This and other differences of opinion regarding PSW scope will be described in greater detail in the sections on specific areas of PSW knowledge.

6.2.1 Discussion of Role and Scope

The standard, text, and certificate program material all identify a clear understanding of the nature and breath of the role, and how the role differs in different settings (i.e. community, LTC, retirement, hospital) as the first thing as PSW must know.
On the surface, the scope of the PSW is deceptively simple, in that they can carry out any task that is an ADL for the client, provided the client is stable, and the outcome of the task is predictable. However, by its very nature, the scope is so mutable that PSWs and other professionals in the health care system struggle to correctly interpret it. Using the administration of medication by injection as an example, a PSW can administer insulin to a client with stable blood sugars, but cannot if the client’s sugars are unstable. Also, while PSWs can administer medications such as insulin under the right circumstance, they can never administer a vaccine by injection because this is not an ADL. Another similar example given in Mosby’s text is that PSWs can administer an enema if it is on the client’s care plan to address routine constipation; however, they cannot give an enema to a pre or post-operative client if this is needed, since it is not an ADL in this instance.

Given the mutable nature of what PSWs can do, confusion in the sector was unsurprising. Moreover, there was a strong sense from the data that it would also be fair to describe the scope of the PSW as encompassing any care task for clients with high care needs that cannot or will not be carried out by RHPs due to understaffing due to the high cost of RHP labour, and more subtle intersections between certain care tasks and status. The CAAT instructors used the expression “too posh to wash” in their discussion of the impact of status on certain tasks. T1 observed that when she was studying to be an RN they were expected to do everything from the more advanced clinical care that is currently provided by nurses to tasks such as giving bed baths. She went on to observe that many of the younger members of the profession feel they are above providing care such as baths and expect that this work will be performed by PSWs. There is a benefit to the health care system if the exact scope of the PSW continues to be vague and informal because it makes it more possible to use the role to fill any identified gaps in care for chronically ill or disabled clients. The delegated tasks environment creates inevitable uncertainty with regards to the nature of the role, since PSWs can be involved in any activities of daily living and these can change for each client. OPSWA has created a scope of practice document to which it expects its members to abide; however, membership in the association is voluntary, and there is no mechanism for its enforcement.

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Due to the inevitable, and potentially intentional, ambiguity of the role, certificate programs alone do not prepare PSWs and substantial and ongoing, client specific training is provided on the job. That being said, all the key informants agreed that it would not be possible to carry out the role without having completed a certificate program.

6.3 Perceptions of Accountability

The PSW Association director, who is herself a PSW, and a graduate of a CAAT program, expressed grave concerns regarding the lack of formal accountability mechanisms for PSWs. She is strongly in favour of formal regulation of the profession. In her view, the lack of a regulatory body leaves clients at risk, especially in circumstances where the PSW is self-employed. In her words:

“PSWs are using their skills to abuse people. They go work one place, and then they abuse, and then they lose their job, and they go down the street and they get a job somewhere else, and they do that.”
“And out of all our PSWs, a lot of them have decided to just do away with the agency and work for themselves. Which in one aspect is a great idea, but in another aspect, there’s literally then no oversight on these individuals that are providing that care. You know they might have the best of means and the best education, But they might not have that practical end. (PA1)”

In the interests of improving accountability within the profession, her organization offers a complaint line to the public, investigates the complaints, and creates a “black list” of problematic PSWs.

“We have a complaints and discipline process. We have a blacklist, but that's only so good for our association and our corporate members.” (PA1)

When asked whether many employers were aware of their complaints process and black list, the response was:

“A lot of them. What happens is they call us. We don't believe in putting names out there like the registries do. Because you want information about somebody, call us. And we get that information back within a day as to whether or not they are on our phone registry. I mean for the most part employers love us.” (PA1)

Her organization has made a request that the government give them formal regulatory authority over PSWs, meaning that they would be required to become members of the association. At the time of writing, this request had been denied.

6.3.1 Discussion of Accountability

The program standard emphasizes the concept of accountability as a feeling of personal responsibility for one’s own actions, whereas the program data and text emphasized the formal, legal definition of the term accountability. Moreover, the text and program data elucidated a distinction between formal accountability and the taking of personal responsibility. Where accountability as such was mentioned in the text and the program data, it was usually to describe the accountability of other actors in the care setting. The documents were clear about the fact that there were limited formal accountability mechanisms for PSWs outside of employer policies. In the absence of formal accountability mechanisms, programs focus their efforts regarding accountability on instilling a sense of compassion and personal responsibility in the PSW,
primarily through the use of self-reflection exercises. If a mix of education and the person’s fundamental personality and belief system do not result in a strong sense of personal accountability, there are limited formal mechanism to address any resulting poor practice. It appeared from available documentation that programs are realistic in their approach to this topic.

6.4 Perceptions of Interdisciplinary Care Teams

While the standard, the text, and the program data described PSWs as members of an interdisciplinary care team, the key informants painted a slightly different picture. According to their composite account, PSWs are typically engaged in a professional relationship with nurses wherein nurses function as their supervisors. As will be discussed in greater depth in the section on assessment, several informants reported that although PSWs, especially in the home care setting, are often the care provider who interacts with the client the most, they felt nurses did not respect PSWs and PSW feedback (PP13, T1&T2, C1, PP10, PP9). Moreover, information from the key informants confirmed that learning, both in institutions and on the job, is rarely provided on an interprofessional basis. The CAAT program instructors advised that one of their simulation labs involved PSW and practical nursing students working collaboratively, and that PSWs frequently demonstrated superior observation skills with regards to safety as compared to practical nursing students (T1 & T2). No other opportunities for collaborative learning came to the researcher’s attention. PSW supervisors advised that on-the-job programs were usually geared to the specific position to ensure that the teaching was relevant and geared to the appropriate learning and language level, since a significant proportion of the PSW work force speaks English as a second language.

6.4.1 Discussion of Interdisciplinary Care Teams

The importance of knowing the role in the context of the other care team members, and knowing the scope of various allied health professionals with whom PSWs interact was discussed in all the sources. The responsibility of the PSW to report changes in the client’s condition to “the most responsible person”, often a nurse, was mentioned frequently in the documents. References to the role of nurses, especially in supervising PSWs, and the dynamics of that relationship were prevalent.
While PSWs often function as members of a care team, some informants indicated that PSWs are not viewed as peers on that team, a fact that is largely obscured in the program standard and downplayed in the text and program data. In fact, the text goes so far as to assure readers that their opinions will be taken seriously; however, several PSWs contradicted this. As noted above, several informants across stakeholder type reported that PSW input was not valued by regulated members of the care team, despite the fact that PSWs often spend more time with the client, especially in home care. In the researcher’s view, the tendency among regulated professionals to dismiss PSW feedback that the key informants identified may be related to the fact that there are limited opportunities for collaborative learning among the different types of care providers. Some of the segregation of learning may be related to the fact that education for health professionals does not take place at the same institutional sites. Practical nursing students and PSW students in CAAT programs do attend the same schools, but the program data suggested, and the CAAT instructors confirmed, that interaction between the two student populations is rare. One program examined does include one lab where PSW and practical nursing students work together. A supervisor advised that collaborative learning was relatively rare on the job as well, citing the fact that trainings were offered at a level that was tailored to the educational level and training needs of each worker population. That being said, it is possible that more opportunities for collaborative learning and discussion would alleviate some of the challenges with implementing PSW feedback, in that nurses may develop greater trust in the PSW’s skills and PSWs may learn more about nurses’ needs.

### 6.5 Perceptions of Client-Centred and Directed Care

The CAAT instructors advised that the client-centred and directed care philosophy is interwoven in all courses, and emphasized in the course on client conditions. On the other hand, the informant from the accreditation body was of the opinion that the rigid adherence to technique and care plan directives that is emphasized in certificate programs can be a barrier to practicing a client-centred and directed approach on the job. In her view, programs should focus more on supporting students to make good decisions and have effective communication with clients:

“That’s really, I think, what we miss a lot. It’s that sense that you’re not there to apply a technique to someone. A. K., who’s now with disabilities, was involved with the PSW development, says that when she has caregivers, in the first 60 seconds, she’ll say ‘I know
whether or not I'm a person that requires support, and I will have someone that will assist me, or whether or not I am an object of care. Something to whom or which something is done.’

And I think the emphasis we need is to be less on the ultimate procedure, and more on what are the key aspects of this? What are the key components of this? And where’s our wiggle room? Because we expect that there’s going to be wiggle room. My way of doing a bath may not be your way of doing a bath. My morning routine probably isn't your morning routine. How do we get to the PSW that sense that part of my role is doing an adaptation and drawing out for the client what would really make it sing for them?” [A1]

Several informants indicated there were a number of challenges with implementing the client-centred and directed care philosophy on the ground. Time constraints, lack of institutional support, and poor comprehension of the philosophy were cited as the most common concerns (PP13, PP2, C1, PP5). Adaptability was identified as a key quality that PSWs needs to deliver client-centred care (C1, A1).

The informant from the Alzheimer’s association observed that PSWs in home care are well placed to provide feedback regarding the client’s needs and the success of care plan interventions. She stated that in her experience, PSWs often have valuable information regarding client-centred strategies that are working for the client; however, they struggle to have their feedback taken seriously by employers. When PSWs repeatedly experience barriers with having the feedback incorporated into the care plan, they often end up applying client-centred approaches that work for them and the client, in contravention of the care plan. She also indicated that many PSW fear they will be in trouble for applying their judgement and critical thinking skills to support the client. She relayed an account wherein an employer was revamping their approach to make it more client-centred by giving PSWs more autonomy with decision making on a client-by-client basis. One PSW insisted that this be entrenched in employer policy because she feared reprisal for showing initiative. She also observed that many employers have few mechanisms in place to recognize PSW accomplishments. For example, if a PSW discovers a strategy for bathing a client who is usually resistant to personal care, they are not incentivised to share their technique with their colleagues, but rather to guard it as a personal secret since being known as the only PSW who can bathe that client is the only recognition they receive [C1].
Several PSWs cited time constraints as a barrier to providing client-centred, individualized care in a manner that treated the client with dignity. Several PSWs who had experience in home care and LTC stated that this was a particular problem in the LTC setting. One PSW had this to say about why she preferred working in home care:

“The quality of time you get to spend with the person is so much different. Like working at the manor, I would come home at night crying because there's not enough time to give these people the dignity and the respect they deserve.

So you're just so rushed, right? It just broke my heart. So in the community, at the end of the day, I feel good about myself. I feel like I've made a difference in the world, [LAUGH] and I'm happy when I come home, I don't cry.” [PP5]

One PSW felt the situation in home care was little better. According to her, a typical home care visit as stipulated by the client’s CCAC service contract is about 15 minutes:

“In that 15 minutes I'm supposed to give somebody a sponge bath and get them dressed.”

She went on to say that this left little time to interact with the client and that clients were often angry with them because they are being rushed:

“They're too pissed off at us to talk to us at that time. It's bad. Because you got to remember, you're waking up, you're stretching, you're rolling over, and we're yanking you. ‘Come on, let's go, let's go, come on. We only have 15 minutes honey'. Try to be as polite as you can in 15 minutes. They get so fed up they just look at you and say leave.” [PP2]

When the LTC director of care was asked what aspect of the role new graduates seemed underprepared for when they started the job, she said that they were underprepared for the workload and high client-to-caregiver ratios (L1). This was consistent with the feedback from the PSWs, who cited time constraints as the chief factor that made implementing client-centeredness difficult.

Some PSWs said they could benefit from additional on-the-job training as to how they can practice client-centred care, while meeting employer expectations with regards to caregiver-patient ratios.
One PSW advised that on-the-job trainings within her agency have addressed how to interpret the care philosophy in practical situations. She relayed a case study that was discussed in a workshop wherein a PSW had cut a client’s flowers without asking their permission because she knew the client was an avid gardener and thought they might enjoy some flowers from their garden to brighten up their home. The client on the other hand, was furious because the PSW had killed their flowers. The case study was used as an example of why it is important to never make assumptions about what the client wants, even if the intentions are good [PP5]. The same PSW observed that some of her colleagues will rearrange a client’s furniture, or make other changes to the client’s home, believing these to be in the client’s best interests. She indicated more training was needed to ensure that PSWs really understand the philosophy of client-centred and directed care.

Another PSW within home care agency 2 who had spent most of her career working in LTC homes stated that she found it especially challenging to implement the client-centred care philosophy when working with clients with dementia in the LTC setting. This was owing in part to the fact that there was little support from the employer or the client’s family to apply this care approach. When asked to elaborate upon her perspective, she relayed the following example:

“*When you come to someone with dementia and memory loss, you are looking at a person who, let’s say, is covered in feces and you know they need changing, but they don’t know it. To them, they’re perfectly fine. And I’m coming to you and I’m saying to you, ‘Cara, why don’t you come with me to the bathroom? Let’s see if we can get you changed. Your clothes need changing, or your underwear needs changing’ They’re looking at me, like I have two heads.*

*And you’re resisting from me. You’re telling me ‘no, I’m fine’ because in your mind you’re fine. Who am I to tell you what you think? And then all of a sudden [the client’s] son comes in [and says] ‘my mom is not being taken care of, she’s being neglected’, without even knowing what happened. And then my managers are putting me in a situation where they’re telling me, ‘you need to take this person and change them.’ But they know that, on a daily basis, a lot of these, a lot of it is being violated. So it's damned if you do, damned if you don’t.*” [PP13]
6.5.1 Discussion of Client-Centredness and Directedness

It was clear from the data that the ability to comprehend and apply the client-centred and directed philosophy of care was a relatively new expectation for PSWs. Much of the discourse in the teaching material focused on the impact of individuality and diversity on care needs, rather than centralizing the client as the primary actor and authority in their own care.

The general trend of feedback from the key informants was that implementation of the client-centred and directed care philosophy was easier said than done and this was an area where significant benefit could be derived from additional teaching, in programs and on the job.

The confusion expressed by the key informants regarding the terms “client-centred” and “client-directed” and how to implement these concepts does not appear to be confined to PSWs, nor the setting in which they work. The definition provided in the PSW program standard does not appear to be accurate or complete, in that it suggests that under a philosophy of client-directedness, any request made by the client will be executed, even if the request is dangerous or in contravention of the principles of medical ethics. Other scholarship on the subject revealed that this is not exactly what is meant by the term. Most of the scholarship that the researcher located was from a physician perspective and explored the current trend away from “paternalism” in physician practice, whereby the physician is seen as the expert who decides what is best for the patient, in favour of an approach that equalized power between the physician and the patient. As described by one author, the primary care physician becomes the “coach”, rather than the “gatekeeper” of the patient’s care; presenting them with information, answering their questions, thereby enabling the client to make informed decisions about their care. Patient-centred care is personalized, and in a patient-directed model, the patient is seen as the leader of the health-care team (Jayadevappa & Chhatre, 2011; Loignon & Boudreault-Fournier, 2012; Stange et al., 2010).

The literature referenced above grows out of the medical epistemology and is not well tailored to the PSW. PSWs are not usually included in care decision-making, and the history of power over the patient that applies to the physician does not translate well to the PSW. It does not appear that the spirit of this learning outcome of the standard is substantially different from the understanding of individuality and personal autonomy that PSWs were expected to have in the
prior version of the standard, even though the actual client-centered and directed philosophy of care is much more nuanced than this.

One of the challenges for programs in adequately covering this topic is that it is one of the more theoretical learning outcomes and the current design of PSW programs is largely vocational, with the emphasis on skills development rather than theoretical learning. This is especially true for the PCC and SBCE programs that use a modular design where the modules are defined by tasks, rather than concepts. Teaching about the client-directed philosophy is especially complicated in the context of a vocational program because total client-directedness may be in conflict with the principles of medical ethics if the client wants something that is bad for their health. Although the scenario is not presented in the context of the client-directed philosophy, the textbook does provide a very good example that explores this dilemma. In the scenario, a diabetic client wants to eat a piece of cake that a friend has provided for her birthday. The client’s care plan indicates that she is to have no sugar in her diet. The “correct” PSW response in the analysis is to remind the client that the decision is in opposition to doctor’s orders, but to not stop them from eating the cake (p. 143). The PSW in the scenario then monitors the client’s condition after they have eaten the cake, documents the consumption of the cake in the health record, and reports the incident to the supervisor.

Since Mosby’s Canadian text for the support worker essentially does not include this topic, the onus is on course instructors to supplement the resources for students in this area. One potential challenge is that virtually all instruction in PSW programs is provided by RNs. While the philosophy of care does not differ between the two types of providers, the circumstances under which RNs and PSWs would need to apply the philosophy are radically different. For the RN client-centredness and directedness means taking the client’s lead with regards to care plan goals and which interventions will best achieve those goals in accordance with the client’s personal values. For the PSW, client-centredness relates more to following the client’s direction as to the details of how specific interventions are carried out (such as bathing procedure); as well as supporting the client’s autonomy over their domestic space. For example, whereas a nurse might have to ensure that the care plan reflects the client’s directives as to their timeline for re-learning how to dress themselves, the PSW would have to follow the client’s direction as to what outfit they would like to wear that day. While actions such as cutting the client’s flowers without
asking, or picking out a blouse for their appointment without consulting them may appear trivial as compared to deciding on care plan interventions without sufficient patient input, the perspective from the key informants was that making such decisions on the client’s behalf has the potential to be extremely disempowering for the client. Moreover, there is every possibility that some clients might be more willing to accept RHPs such as physicians and nurses as an expert regarding treatment interventions than they would accept the PSW as an expert with regards to their own home or personal decisions (Loft, McWilliam, & Ward-Griffin, 2003). Thus in the home care setting especially, it seems imperative that PSWs have the ability to apply the philosophy to the type of scenarios they are likely to encounter.

6.6 Perceptions of Helping Relationships

The data from the key informants revealed that there are tensions for PSWs between the expectation that they provide companionship to clients and the maintenance of professional boundaries. Informants cited the intimate nature of the care provided by PSWs as a challenge to the maintenance of appropriate therapeutic relationships (PP8, PP12). Some informants were of the opinion that teaching with regards to communication and professional boundaries could be improved (PP5, PE2, PA1, A1, PE8). Others sited lack of compassion and empathy on the part of some PSWs as a concern (PP2, PP7).

Two PSWs observed that because PSWs spend more time with the client than many other members of the care team, a more intimate relationship is formed between the client and the worker [PP8, PP12]. A supervisor noted that the intimacy of the relationship can cause a number of issues on the job. When asked where educational resources for PSWs could be improved, she had this to say:

“Not completely understanding therapeutic boundaries, and that seems to be a huge issue. We have some PSWs who have borrowed money from clients, we've had PSWs that have used their phone for long distance phone calls. We've had people doing things for them that is not in the care plan. And it's such an obscure area, I think it's become a challenge for the best of us, for all of us, whether we're regulated or nonregulated. PSWs, because they're in the home, the same home every day, day after day potentially, and they get so close to the clients that they begin to believe that they're…like a family member.
Right, so a lot of times, I think, they seek out their supervisors or get the supervisor to kind of help them with the line. Because it will be, ‘well Mrs. Smith is wanting me to go to her daughter's whatever with her’, you know. And it's like, ‘no, you can't do that’, or they would like us to, I can't even think of what might be, like take their dog for a walk, I'll just use that for an example. It's like 'no, you're not there to take care of the home, or other children, or the animals, or the other children, or anything else like that, you're there specifically for that person to do a very specific role’. And you can sit and talk to them, but you have to be very careful about crossing the line into talking about personal things that benefit you. We've had situations where clients have called saying, ‘I'm so upset because you don't give the staff members their hours, and they can't buy shoes for their kids’. [PE2]

On the other hand, two PSWs were of the opinion that many of their colleagues did not spend sufficient time providing companionship to clients. In their view, some PSWs approach their work by crossing off the tasks on the care plan and then leaving, without engaging the client in any interaction while providing care, which in her view was inconsistent with the principle of patient dignity [PP2]. The informant from the accreditation body (A1) and another supervisor (PE8) were also of the opinion that PSWs needed more support regarding interpersonal skills and communication.

6.6.1 Discussion of Helping Relationships

While the standard unites the concepts of comfort and safety, the concept of comfort did not emerge strongly in the program or informant data. Conversely, the subject of client and worker safety was addressed substantially in these data sets and was clearly a significant subject in on-the-job and institutional programs. While it is true that the consequences of an unsafe environment are more serious than the consequences of an uncomfortable one, this does not fully explain the limited attention paid to the subject of comfort in the program materials. The prioritization of safety over comfort in the materials could be because comfort is conceptual, whereas safety is addressed exclusively in an applied manner in the materials. In general the program information is more detailed with regards to skills that will be developed rather than conceptual learning.
The home care setting presents particular challenges for workers with maintaining appropriate professional boundaries. Since visits can be lengthy and on-going and the care provided by PSWs is personal rather than medical, there is significant potential for the line between a helping relationship and friendship to be blurred. The rationale for professional standards on therapeutic boundaries is that there is an assumed power differential between the care provider and the client, with the provider having greater power. While this language of power is not usually applied to PSWs, the informant data confirmed that inappropriate boundaries between PSWs and clients can lead to the same concerns, such as clients feeling obliged to lend the worker money or advocate on the worker’s behalf.

Again, the emphasis on task-based rather than theoretical learning may be relevant to educational challenges in this area. In the researcher’s view, it is imperative that a mix of institutional and on-the-job training instill a thorough understanding of helping relationships in students since there are limited alternative mechanisms to address poor boundaries.

On the other hand, the sources were in agreement that it would be wrong for PSWs to provide intimate care such as bathing, feeding and dressing without engaging the client in a conversation; however, they must recognize that the conversation needs to be about the client, not themselves. This dynamic would be admittedly hard to maintain over the course of several years working with the same client. Again, more involvement in teaching by PSWs may improve training issues in this area. While the theory of the helping relationship is the same for nurses as PSWs, the scenarios in which this is likely to come up are different, most notably in home care. According to the key informants in home care, nursing visits are typically brief and the nurse is engaged in specific clinical care such as intravenous therapy or complex wound care and as such, has much more limited interactions with the client than the PSWs, whose visits to the home can last from 15 minutes to an hour, are more likely to be daily and involve more interaction with the client during the provision of personal care. The flip side to the fact that PSWs are only working with clients who are considered stable is that the majority of their clients are permanently disabled or chronically ill. As a result, the treatment relationship can continue for many years, often ending only upon the client’s death. This in turn means more opportunity for the line between the helping relationship and friendship to become blurred. PSW students may benefit from more
guidance with regards to how to navigate this reality from experienced PSWs during their certificate programs.

6.7 Perception of Assessments

Informant PA1 confirmed that the inclusion of assessments was part of the most recent revision of the standard. Prior to that, the expectation was that PSWs be able to recognize change in the client’s status and document and report this appropriately, but not to assess, as in make any decisions regarding their observations. In the informant’s view, this change to the standard is positive and necessary because making functional assessments has actually always been a part of the role. In her words:

“PSWs assess all the time. They’ll take a look at a client, and they’ll say, ‘today, she’s not following my communications as clearly or as quickly as she used to, as she did yesterday’. Or, ‘you know what, I’m watching her balance, and she’s not as steady on her feet. Maybe today is not the day that we do the bath’. Right? They’re doing that all the time. They don’t get credit for it, but they’re doing it all the time. Yes, they may report that to someone, and should, but they’re also making the decision at the time, so the classroom has to support that ability to critically think and to draw that out of people, also has to give them the opportunity to practice some of those different personal skills.”

(PA1)

Several informants reported that there was more onus on PSWs to make observations and in the moment decisions based on those observations, in the home care setting (PA1, C1, E1, PP9, PE3). The PSW supervisor from Home Care Agency 1 was of the view that programs could augment their teaching in this area:

“I think that the main difference is really that independent thinking and problem solving when they’re working in the independent practice setting as opposed to the long term care where there isn’t support there. One thing that we do notice is, and I think could be improved in the programs, is the PSWs’ recognition of problems and when to report. And maybe giving them the confidence to feel confident enough to report when there is something that just doesn’t seem quite right. We certainly try to foster that in our
employees through education. But I think if the actual program could start giving them those skills that would be really helpful for them once they get out into practice.” (E1)

An employer within home care agency 2 had a similar perspective:

“We certainly need to get our PSWs more skilled on making assessments, because they don’t report enough that they should be, for skin care and skin breakdown. Things can go from bad to worse with a nurse not even being informed of it, if there is a nurse in the home. And sometimes there’s just PSWs in the home, and there’s no nursing. I’ve had a situation like that last week, where I don’t have any contacts for this client. His pressure sore is getting worse and worse, and it’s just a shambles the way that we deal with these long-term care clients in the community.” [PE3]

Meanwhile, several informants, (namely 3 PSWs, the program instructors (T1&T2) and the informant from the Alzheimer’s advocacy agency (C1) stated that while many PSWs are skilled at making observations and assessments, they struggle to have their input taken seriously by regulated staff or administrators. The Alzheimer’s agency informant (C1) relayed an account wherein the PSW observed that a client with Alzheimer’s experienced less agitation and had better sleep when they were allowed to wander at night and sleep during the day (known as sun downing) and recommended that the client be able to do so and that the care plan be updated to reflect this. The employer advised the PSW that they would not implement the change because the night staff complained when the client did this. According to her, many PSWs who encounter such barriers respond by implementing interventions that they know work for the client, even if these are not reflected in the care plan. This in turn creates risk for the PSW, whose employment security could be threatened, and risk for the client because their official care plan is now no longer an accurate reflection of the treatment needed or received. As discussed above, this was intertwined with barriers that PSWs experienced with implementing the philosophy of client-centredness and directedness.

6.7.1 Discussion of Assessments

While it is obvious that PSWs have to make observations about their clients and report any relevant observations, thoughts differed significantly as to the appropriate extent of PSW involvement in interpreting their observations and making decisions based on them. PSWs in home care are more responsible than PSWs in other care settings for making observations
regarding the client and knowing when to report the observations to the supervisor. Although
PSWs do not assess in the sense that they do not analyse all available data regarding the client to
determine care plan goals and interventions, they do have to make decisions in the moment as to
whether or not the care plan interventions are effective or feasible in specific circumstances. The
collective opinion of the key informants was that PSWs cannot meet the expectations of their job
just by using the care plan like a check list. Thus, the tension that PSWs must navigate is
between following the plan and being adaptable to the patient’s needs.

The accreditation program director (A1) observed that care plan goals may not always be
consistent with the client’s priorities. She told a story wherein a client’s care plan specified that
the worker was supposed to be helping the client learn to dress themselves following a stroke.
When the worker tried to support the client in this, the client said “there is more to life than being
able to put my pants on by myself. I want to go back to my Euchre game”. There is a patent
benefit to the system in increased client independence, since as client independence increases,
worker hours can be decreased. In other words, there may be conflict between the care plan and
the principles of client-centredness and directedness. This in turn adds an additional layer to
assessment expectations for PSWs since they must be sensitive to the client’s willingness to
participate in activities stipulated by the plan if they wish to provide care in accordance with this
philosophy.

In environments where nurses and other RHPs who are working with them are not receptive to
PSW feedback, the question of how well PSWs are trained in this aspect of the role becomes
moot, since the feedback falls on deaf ears regardless of how well founded it is. As noted above,
this suggests that benefits could be derived from more collaborative learning opportunities so
that more trust could be built across the professions.

6.8 Perceptions of Safety and Comfort

The CAAT instructors (T1, T2) stated that safety was a significant theme in their program
throughout all the courses. Students are required to practice care skills in a simulation lab before
advancing to the clinical placement. Students are not allowed to move on to the clinical
placement if they do not demonstrate an adequate understanding of safety in the simulation lab,
for example, forgetting to lock the client’s wheelchair when stopped.
Supervisors and PSWs within both home care agencies and the LTC Director of Care all indicated that significant on-the-job training regarding safety is also provided that is tailored to the specific setting. When asked what aspects of the role new graduates were well or not well prepared for when they started the job, one supervisor observed that the safety considerations in home care were significantly different from the safety issues in retirement or long term care homes.

“I would say they are not well prepared for the safety aspects. So looking at client safety and staff safety are two of the things we really try to focus on when they first come on. It's very different working in the community than it is working in a retirement home or a hospital. They're sort of looking at each environment separately, each environment's so different. I mean, we have smokers, we have people with pets, we have people with mental health issues and hygiene issues. So I find the safety aspect as something we really are starting from scratch.” (PE4)

As discussed earlier in Chapter 4, most programs place students in retirement homes for their community placement.

Another supervisor noted that issues in home care could range from dealing with bed bugs, to how to provide safe care in an unhygienic home. In her view, new staff members were underprepared to provide care outside of an ideal clinical setting.

“Because a lot of times, particularly in our Toronto program, I mean, we've got a number of patients where there's bedbugs in the home, or other types of infestation. And I give the PSW amazing amount of credit because their job is not easy at all. And it's really hard both emotionally and physical.

It's physically hard caring for these people and helping them transfer and getting them in and out of a shower or a bathtub with the right bars and bath seats safely without having them fall. Yeah, it's a challenging job.” (E1)

Home care agency 2 provides significant on-the-job training with regards to safety, some of which is offered online. Safety modules include topics such as driving safety, how to avoid the spread of parasites such as bed bugs, back care for the worker, dealing with workplace
harassment and bullying, women’s safety issues, fall prevention, protective equipment. In one supervisor’s words:

“We actually provide an online training for safety called Safety 24/7. Which is something they log into themselves before they start seeing clients on their own. And they have to go through all the modules there and they have what are called training modules. So every three months they have a module where they have to read and then complete and exam and they get a score. And some of them, they get a certificate for. Such as then there’s also like an introduction to health and safety, there’s workplace hazards. There’s one on bullying as well and violence and harassment, which is something we touch on in the community as well with clients who are living in their own homes and having people come in. I believe we also have a driver's safety.” (PE4)

One PSW was of the opinion that staff could benefit from additional training on dealing with sexual harassment from the clients, which she said was commonplace, and which she attributed to the blurring of boundaries created by the intimacy of the care relationship (PP2).

None of the PSWs or supervisors indicated that there were gaps in PSW knowledge with regards to comfort.

6.8.1 Discussion of Safety and Comfort

While the standard unites the concepts of comfort and safety, the concept of comfort did not emerge strongly in the program or informant data. Conversely, the subject of client and worker safety was addressed substantially in these data sets and was clearly a significant subject in on-the-job and institutional programs. The supervisors and PSWs within agency 2, and the supervisor within Agency 1 told the researcher that staff were provided with significant on the job training with regards to safety.

6.9 Perceptions of Activities of Daily Living

The general trend of the feedback from the key informants was that programs do a very good job of teaching students the appropriate techniques and procedures for providing ADL support. PSWs explained that learning how to tailor their provision of ADL support to the individual client’s needs was an ongoing aspect of their work. Two PSWs observed that some workers more
so than others pride themselves on providing exceptional ADL support, and demonstrate differing levels of attention to detail, causing some clients to have preferences for specific workers. Informant PP2 was also of the opinion that some of her colleagues could benefit from additional training on how to properly support the client in the shower; as well as how to engage the client in a conversation and provide companionship while providing the care. PP5 felt that some of her colleagues could benefit from more training on how to provide an effective sponge bath (PP2, PP5).

PSWs and supervisors advised that range of motion exercises (PP7, PP8, PP9, PE2, PE4) and the use of mechanical lifts (PA2, E1, PA1, PP12, PP13, PP3, PP6, PP8, PP9, PE2) were nursing tasks that were frequently assigned to PSWs, and that delegation of the range of motion exercises is usually carried out by a physiotherapist. These tasks are supposed to be transferred in the manner outlined above; however one PSW stated that sometimes an experienced PSW may show a new PSW how to provide this type of care to a client. The informant seemed unaware that this was inconsistent with employer policy as explained by supervisors within the same agency.

PSWs also advised that they are rarely involved in meal preparation in the form of cooking, although those who had been in practice longer said that this used to be more commonplace. One PSW said that if they are involved in food preparation now, they are usually serving frozen dinners. She did note that she had observed some of her colleagues and clients improperly storing food and said that safe food handling was an area where more training could be helpful.

6.9.1 Discussion of Activities of Daily Living
The literature review emphasized, or in some instances solely addressed, the importance of activities of daily living (ADLs) when describing the role of the PSW. All of the sources concurred that supporting the client to carry out ADLs was an integral aspect of the role, and one that was significantly more nuanced than it would appear on the surface.

The general picture from the data is that institutional programs do a thorough job of teaching PSW students the correct procedures for carrying out ADL support and related safety considerations. Delegated controlled acts cannot be taught in institutional programs; however, students are oriented to commonly-assigned nursing tasks such as range of motion exercises, and mechanical lifts.
On the surface, the scope of the PSW seems simple; they can carry out any task that constitutes an ADL or IADL for the client, and they can be assigned any tasks within the scope of nursing related to ADL support, including the delegation of controlled acts, provided they are taught how to do the task by a regulated provider authorized to do the task. Beyond that, it is very difficult to outline with clarity the full scope of what PSWs are doing, since due to the varied nature of ADLs, their work varies from setting to setting and client to client. This creates certain contradictions and challenges for the educational environment. For example, while it was clear from the text book and program data that all programs train PSWs on clipping nails, and potential risks associated with this, the employer orientation manual that was included in the analysis states that PSW within their agency are not allowed to perform this task. On the other hand, programs cannot train PSW students on the controlled act of administering medication by injection, but as will be discussed in more depth in the following section, the key informants reported that PSWs are commonly involved in this type of administration, most typically for insulin dependent diabetics in the home care setting. The implications for new graduates in this significant variation in working environment is that individuals with the same education could end up in situations where the expectations are much lower or higher than what they were trained for. There were numerous references in the data, especially in the employer data, to the need for PSWs to be adaptable. The broad nature of ADLs provides further context for the emphasis on the characteristic of adaptability.

6.10 Perceptions of Medications

The CAAT instructors were of the opinion that the administration of medications falls outside a PSWs scope and that they should only be involved in assisting with medications. They acknowledge that PSWs are routinely asked to administer medications, in facilities and in the community, which in their view is inappropriate. Their program emphasizes the safety implications of administering medications and cautions students not to yield to pressure to exceed their scope. On the other hand, employers and PSWs attested to the fact that PSWs are very commonly involved in the administration of medications, although this is significantly more prevalent in home care. This is owing in part to the fact that there are additional restrictions on PSW involvement in the administration of medication set out in the Long Term Care Homes Act. Employer policies or CCAC contracts in home care typically set out additional protocols
regarding PSW involvement in medications, namely that the administration of medications is classed as a nursing task that can be transferred to the PSW via the appropriate mechanisms. The LTC director of care advised that in her facility the application of topical prescription creams was sometimes transferred to the PSW, but they were not usually involved in the administration of other types of medication. Meanwhile in home care, PSWs were frequently involved in the administration of oral and topical medications, and eye drops, as well as suppositories, injections, and inhaled medication which would be covered under the controlled acts legislation. There was some disagreement among the key informants who were supervisors within Home Care Agency 2 as to whether PSWs should be involved in the administration of insulin in particular. One supervisor was of the opinion that PSWs should never be involved in the administration of insulin since they did not have sufficient clinical education to appropriately monitor outcomes from this treatment. She attested to the fact that this never occurred and was under the impression that this was an agency-wide policy (PE5).

Conversely, another supervisor had this to say:

“If the client does not have family to do the medication and we are there specifically at the time they need their medication, we can administer medication. So we can either, even just providing them with the oral pills that they have to take, we go from that right till administration of insulin. We do a lot of insulin injections, so they check the blood sugar, and they do the insulin administration, let’s say every morning. And that again, would be a supervisor doing a one-on-one training in the client’s home, for each client.”

(PE4)

The supervisor from home care agency 1 (E1) had similar views, as did the representative from an Alzheimer’s organization (C1). C1 observed that when PSWs are delegated tasks such as insulin administration it provided better continuity of care for clients because clients can become insulin-dependent after many years of being supported by the same PSW and they may not want to change support providers.

PE5, a supervisor within home care agency 2 was also of the opinion that graduation year made a difference to how well-prepared new grads were for their medication administration responsibilities when they entered practice, with newer grads receiving more extensive education
on this aspect of the role. Their agency provides an online module to staff entitled “Medication Review”.

6.10.1 Discussion of Medication

While the sources concurred that assisting with medications was an important component of the PSW role, there was significant variation in attitudes toward the appropriate nature and extent of that involvement. This variation is partially accounted for by the fact that multiple pieces of legislation have provisions regarding this activity, some of which are only applicable to certain employment settings. Additionally, employers and CCACs create their own policies regarding the extent to which PSWs can be involved in medication administration.

The CAAT instructors were of the view that medication administration was categorically outside of a PSWs scope, but it is clear that it is commonplace for PSWs to be involved in administering medications in a variety of settings, with significant medication administration being provided by PSWs in home care. It is up to employers to ensure that there are appropriate policies in place to ensure client protection and that PSWs receive adequate training in this regard. The most concerning report of PSWs being asked to go outside of scope with regards to administration was the example provided by the PSW Association director wherein the PSW was asked to administer flu shots. This seems connected to the mutable nature of the PSWs’ scope with regards to medication administration. Regulated professionals know that PSWs can be delegated the administration of medication by injection in certain circumstances, but are potentially unclear as to how to interpret what constitutes an appropriate circumstance. In the example above, delegation is not appropriate because the flu vaccine is not an activity of daily living and the treatment can cause unpredictable adverse reactions. Even where medication administration did fall within a PSWs potential scope, this did not necessarily mean agreement among stakeholders as to what was appropriate. Most notably, one supervisor within agency 2 attested to the fact that PSWs on her team administered insulin, while another supervisor within the same agency said this was categorically prohibited within their agency and generally inappropriate.
6.11 Perceptions of Instrumental Activities of Daily Living

No training issues or needs with regards to IADLs were raised by the key informants. The PSWs within home care agency 2 advised that because the agency employs PSWs and Home Support Worker (HSWs), clients who exclusively require IADL support receive HSW care. One PSW identified a potential challenge with this division of labour. One of her clients has CREST syndrome, a rare multisystem connective tissue disorder. As a result of her condition, the client experiences severe challenges with carrying out IADLs such as housekeeping. The PSW stated she wanted to help the client with these tasks, but the client’s care plan does not allow her to do so, and the client does not have additional funding for support from an HSW. The PSW said she has asked her supervisor to speak with the client’s CCAC to change her service contract, but as of the date of the interview, CCAC had not responded (PP10). This seemed related to information that key informants provided that PSWs are not considered part of the care team. Based on the above account, it did not appear that PSWs were provided information regarding the impact of funding models, resulting in a lack of clarity regarding the rational for the care plan interventions.

6.11.1 Discussion of Instrumental Activities of Daily Living

Since the PSWs interviewed worked for an agency that employs a different type of labourer to provide much of the IADL support, they did not have significant feedback in this area. One PSW who had worked in the support sector for over 10 years said that when she started, it was fairly common for PSW to prepare meals for clients, now if they are involved in nutrition, it is usually by way of heating up frozen dinners (PP10). No gaps in knowledge were identified and the challenge that emerged seemed more related to health system design issues rather than learning needs.

6.12 Perceptions of Respite

One example relevant to the subject of respite emerged from the key informant data in the context of a discussion with a supervisor as to where educational resources for PSWs could be improved. As discussed above in the section on helping relationships, in her view PSWs could benefit from additional teaching with regards to the maintenance of professional boundaries. She cited instances where PSWs who are providing respite care for one child in a household have
been left to care for that child’s siblings as well, despite the fact that this is not documented in the care plan (PE2).

6.12.1 Discussion of Respite

In the researcher’s opinion, the textbook does a good job of ensuring that PSWs are aware that they will be involved in providing respite to family caregivers to alleviate caregiver stress. The programs did not provide enough information regarding respite specifically to determine exactly how this topic is covered. It did not seem that there were any technical or clinical skills specific to respite care that were different from the knowledge and skills required to care for any clients. It did appear than an understanding of family structures and dynamics and the role of family members on the care team would support the provision of effective respite care.

6.13 Perceptions of Abuse

While the potential for clients to be abused by support workers was not specifically addressed in the standard, text, or program material, it was discussed by the key informants. The PSW association director stated that this was one of her main reasons for advocating for the regulation of PSWs. In her words (also quoted on page 76):

“PSWs are using their skills to abuse people. They go work one place, and then they abuse, and then they lose their job, and then they go down the street and they get a job somewhere else, and they do that.

And so just that you're aware, we made a bid to that governing body. So we said to the government ‘listen, we don't want you to pay us’, you know what I mean? Nothing, just ‘give us the PSWs because it's mandatory, that's all we ask’. And they won't do it.” [PA1]

She also observed that behaviour that constitutes abuse in the therapeutic relationship may not meet the threshold for prosecution under criminal law. She told a story about an incident that took place in a facility that had been on the news:

“The PSWs were caught on video, by the family. Well basically what happened was is that abuse occurred on camera. And the police investigated it and didn't deem it a criminal act, because they say that the PSW was having a bad day.” (PA1)
One PSW’s interview highlighted the fact that abuse of clients by PSWs can take the form of neglect as well. She said that her clients often made reports of poor care to her, but were afraid to report this to the agency because they do not believe the agency will take action and this will lead to worse care by the PSW. She also said that she frequently provided support to clients who had obviously not been properly groomed by the previous care providers:

“I am tired of walking in a couple of days later and smelling urine on these people or smelling [faeces] on these people or seeing their faces still not shaved.” (PP2)

The same PSW echoed information in the program data and text that PSWs were also vulnerable to abuse by the client and she indicated she could especially benefit from more training on how to deal with sexual harassment by clients:

“They think they can touch you. They think they can touch your tits. They think they can touch your ass. And you're standing there, looking at them, saying, ‘excuse me, this is my body’. ‘But you just got done washing my body.’

‘Yeah, I washed your body, I'm not touching your body to get aroused and put a smile on my face.’” [PP2]

She also observed that the agency has declined the requests of female clients to only have care provided by female workers. Supervisors from agency 2 confirmed there was a module regarding abuse for staff.

6.13.1 Discussion of Abuse

All sources and stakeholders agreed that abuse was a relevant area in which PSWs required knowledge and education.

The minimal discussion of the potential for clients to be abused by health providers in the program standard, text and program data is significant because the regulations and professional standards governing regulated health professionals are clear about the fact that there are some specific ways in which clients can be abused by health professionals that may not constitute abuse in other types of relationships. For example, as discussed above, the PSW association director observed that conduct that constitutes physical abuse in the care setting may not amount
to assault in a criminal context. The presence of a criminal record is the only formal mechanism to prevent PSWs from obtaining further employment in the care sector.

Based on the regulations of the RHPA clients cannot consent to a sexual relationship with their health care provider because of the agreed upon power imbalance between provider and patient (Government of Ontario, 1991c). Therefore, even consensual relationships between patient and care provider can lead to allegations of sexual abuse before the provider’s regulatory body. However, this legislation does not apply to PSWs, and so PSWs are essentially on an “honour system” with regards to having sexual relationships with clients.

Given the potential for specific forms of abuse to manifest in the care context, a key question that training resources and programs for PSWs must consider is whether the same power imbalance that exists between RHPs and clients exists between PSWs and clients, and whether they should be ethically beholden to the same expectations regarding the maintenance of therapeutic boundaries that regulated providers are held to. When the supervisor referenced in the section on helping relationships who raised concerns with regards to the teaching PSWs received with regards to boundaries was asked whether she felt that PSWs should be held to the same expectations as nurses with regards to the maintenance of appropriate therapeutic boundaries she said “yes, absolutely”, observing that personal support work is a branch of nursing care and the same expectations with regards to professionalism apply. She confirmed that employer policies within her agency reflect this expectation. It is reasonable to assume that conduct such as commencing a sexual relationship with a client or hitting a client would result in a termination of employment; however, as observed by the PSW association director, if this conduct does not result in a criminal conviction, there are no barriers to obtaining further employment in the care field. The director explained that this scenario was a significant rationale for her advocacy work to regulate PSWs. Her agency recently responded to a complaint against a PSW that was reported on W5, a Canadian investigative journalism television program. The PSW had provided the client’s contact information to a collection agency as her own and the client began receiving calls from the collection agency seeking payment, asking for the PSW. When the client confronted the PSW, the PSW threatened to put her wheelchair out of reach and leave, so she would be effectively bedridden, if the client reported her to the employer. This case is an excellent example of how a provider can manipulate the nature of the care relationship and the
client’s dependence to abuse the client. The quote from the PSW above wherein she has returned to clients who smell of urine and feces is also an excellent example because it demonstrates that what could seem to be simply poor attention to detail, could actually be abuse in the form of neglect in the care context. In the absence of limited formal mechanisms with which to address this type of client abuse by PSWs, it is imperative that institutional and on-the-job training resources address provider-to-patient abuse and ethical obligations in this regard. No evidence emerged in the analysis to suggest that abuse in the context outlined above is discussed by the programs or on-the-job training.

There was some evidence to suggest that the abuse of PSWs by clients was mentioned; however, some PSWs were of the view that the education was not adequate at preparing them for what they identified as a prevalent problem, or providing sufficient concrete strategies for addressing this behaviour from clients. The picture from the standard, the text and the program material supported the view that while the topic was mentioned, coverage was minimal. It appears that the focus of the education with regards to abuse is on being able to recognize when the client is being abused, by conventional definitions, by other people; and the legal expectations with regards to reporting such observations. While this is undoubtedly important, this scenario seemed to account for a fraction of the ways in which abuse could manifest in the care setting. Whether and how teaching in this area for PSWs could be improved is an area that merits serious further exploration.

### 6.14 Perceptions of Palliative Care

According to supervisors and PSWs at home care agency 2, PSWs are offered extensive on-the-job training with regards to palliative care. One PSW described attending a mandatory 8 week course that was offered face to face and online. According to her:

“It was a very good course. I enjoyed it because it taught us a lot about the process that people have to go through if they have a serious life threatening condition and we know that they’re eventually going to pass on.

It also taught us a lot about how people go through the grieving process, which I found the most interesting. And it gave us an insight into the kinds of questions, the open ended
questions that we would ask our clients if they were approaching end of life, and how to assess their pain levels.” [PP8]

The director of the PSW association felt that PSWs could benefit from more clinical teaching with regards to end-of-life care. She elucidated her viewpoint with an example that had come to the association’s attention wherein a PSW reported to a client’s family that the client was sleeping when she had in fact been deceased for several hours and the PSW failed to recognize this. In her view, the education she received emphasized emotionally supporting the terminal client and providing bereavement support to the family, but did not sufficiently address the physiological process of death. Meanwhile, the CAAT instructors advised that this was an area of their curriculum that had been recently updated.

One PSW stated that end-of-life care was the aspect of the job she was least well prepared for when she started working. She observed that although her program had covered the topic, it was impossible to be emotionally prepared for what it was like the first time one of her clients passed away.

The client advocacy, program instructor and home care supervisors confirmed that clients are dying at home more and more frequently. That being said, the example described by the association director where the PSW failed to observe that a client had been dead for several hours is likely an anomaly. It appeared from the data that PSWs receive thorough education on checking vital signs and should be able to identify when a client is absent of essential vital signs. Moreover, many of the most clinical tasks related to end-of-life care would need to be taught on the job via the transfer process outlined above, regardless of whether certificate programs became more thorough. It appears from the data gathered that the institutional education regarding palliative care is strong, but substantial onus still rests with PSW employers in home care to ensure they receive adequate on-the-job training to meet the current scope of the role with regards to palliative and end-of-life care.

6.14.1 Discussion of Palliative Care
The data suggested that PSWs receive very thorough education on the relational aspect of death and dying with regards to supporting the client and their family through the grieving process. This is likely to be all the education that is needed for workers in the LTC setting where fewer
nursing tasks are assigned to PSWs and they are less responsible for making and reporting relevant observations.

6.15 Perception of Cognitive Impairment, Dementia

All the PSWs and supervisors confirmed that they receive extensive on-the-job training with regards to dementia care, especially the Gentle Persuasive Approach (GPA). Several PSWs were of the opinion that GPA training was very helpful to their work.

The key informant from the Alzheimer’s association explained that her agency offers a 6 hour training for PSWs on working with clients with dementia. Most of their participants are practising PSWs who are there because their employers have paid for staff to take the course. The course emphasizes the importance of creativity and adaptability when working with clients with dementia. According to the informant, if the care plan says “give the client a bath on Tuesday”, but every time you try to do so, the client slaps you in the face, you can’t keep trying to give the client a bath on Tuesday. She also observed that if the client does not recognize the worker when they arrive at the home, a creative PSW will work to jog the client’s memory with specific prompts about their life (e.g. “don’t you remember, I was here a few days ago, I fed your dog named”…), whereas a PSW lacking in creativity will simply call the agency and say the client did not let them in. Like the standard and the textbook, their course works from the perspective that all communication from clients with dementia has meaning, even if it is not apparent to the worker. She relayed an anecdote in which a client with dementia would become very agitated every time a certain worker came to home and would begin yelling and screaming at her. No one understood the client’s behaviour, until one day her daughter was also at the home and said “oh my god, that PSW looks exactly like a woman my dad had an affair with years ago”.

The PSW association director was of the opinion that PSWs could benefit from more education on how to work with clients exhibiting aggressive behaviours. In her view, programs need to augment their teaching in this regard since the majority of their clients with dementia exhibit aggressive behaviours.

Two PSWs observed that while they receive very thorough education on the appropriate techniques and procedures for providing ADL support, they do not receive adequate education
on engaging clients who are not interested in participating in ADLs or other activities as a result of mental health issues. As one of them put it:

“There are areas where I think we could benefit from more training. I think one important area that I find is a little bit difficult is how to engage the client into getting an interest in to doing things rather than just sitting around in their chair and watching TV. I find that sometimes just talking to them is okay, but they never seem to want to really do anything. A lot of the times, it's really upsetting just to see them sitting there. And even trying to get them to do leg exercises or something, while they're sitting in the chairs, can sometimes be very difficult.” [PP8]

The PSW association director echoed the opinion that the subject of mental health was not adequately covered in her CAAT program, given the prevalence of mental health issues in the field.

6.15.1 Discussion of Cognitive Impairment, Dementia

The observations regarding the program data on dementia and responsive behaviours strongly overlapped with the observations regarding the lack of discussion of client-centred and directed care in the program data. Where program materials touch upon the behaviour of clients with dementia, they are more likely to use the term “challenging” rather than “responsive” behaviour. The term “challenging” prioritizes the provider in the care relationship, since presumably the behaviour is challenging for the provider. The term “responsive” on the other hand centralizes the client, since it assumes that the client’s behaviour is a valid response to the client’s experience, even if this is not obvious to the provider. Because the term “responsive centralized the client, it is more consistent with the principles of client centred care.

This seems connected to the feedback from one PSW within home care agency 2 who had spent most of her career in LTC (PP13) that the client-directed care philosophy and client rights were more difficult to implement when working with clients with dementia, since they are more apt to refuse care that others would deem necessary.

There was strong evidence that the Gentle Persuasive Approach was taught to PSWs during their programs and on-the-job training. The informant from the Alzheimer’s association confirmed
that this was a well-validated approach for working with clients with dementia, although not the one in use in their training program.

The feedback from PSWs was that they could benefit from learning more practical strategies for engaging clients in their care and optional functioning (known as patient activation) that are specific to the needs of clients experiencing mental health issues such as depression. The essence of the feedback was that knowing the correct procedure for giving a bath or carrying out range-of-motion exercise is of little benefit to clients who are too depressed to want to engage in such activities. The PSW quoted above who found it challenging to motivate clients to engage in care activities went on to say that she would like more training regarding patient activation techniques. Some CAATs offer a graduate certificate program entitled “Activation Techniques in Gerontology” for PSW or registered practical nursing graduates that covers strategies for promoting optimal functioning in elderly clients; however, the course descriptions do not clarify if they address the impact of mental health on patient activation. Moreover it is not known what proportion of the PSW workforce pursues extended certification such as this.

The following and final chapter provides high level responses to each of the research questions, a general discussion of the data, and suggestions for further research.
CHAPTER 7: CONCLUSION
The goal of this study was to explore the design and content of PSW certificate programs, and perceptions of program quality. The research goals were met using document analysis and key informant interviews. A summary of responses to the research questions is provided below.

7.1 Question 1: How are PSW certificate programs designed?
All PSW programs in Ontario must now adhere to the same program standard which identifies 14 areas of competency for PSWs (Appendix C). This standard is set by the Ministry of Training, Colleges, and Universities. Individual schools are responsible for designing a curriculum based on that standard and must have their program approved by the appropriate body. The body or bodies that provide this oversight vary depending on the type of institution the school is. There are three types of schools as will be outlined below. All the programs offer a mix of classes, labs, and clinical placements, however the exact number of hours allocated for each of these components varies based on institution type. The majority of the teaching is done by registered nurses.

7.1.1 Question 1i: What types of institutions offer PSW programs and how many are there?
There are a total of 128 institutions in Ontario that offer a PSW program. Programs can be offered at 3 different types of institutions: 1) colleges of applied arts and technology (CAATs, n=23), 2) private career colleges (PCCs, n=84), and 3) schoolboard continuing education programs (SBCEs, n=21). Programs varied in duration from 4 months to one year. There was also variation regarding total program hours and the amount of time spent on clinical placement (see table 5.3).

7.1.2 Question 1ii: What are the application and admission requirements?
Each school sets its own admission requirements; however, they shared a number of common characteristics. All programs require a clean criminal record check, and medical clearance confirming that their immunizations are current and that they are in good enough health to engage in the physical aspect of the program. All programs require completion of a first aid certificate before attending the clinical placement; however, some PCCs include first aid certificate training in the course work. In general, CAAT programs had the most stringent requirements for admission because most require the completion of specific high-school courses
at a College of University level. In contrast, credits earned in a school-board based PSW program can be applied towards a high-school diploma, making them a good option for individuals who want to finish high-school while completing vocational training.

7.1.3 Question 1iii: How are program standards set and evaluated?

MTCU sets the standard that all the programs must adhere to, and each institution designs a curriculum based on that standard. The CAATs use internal curriculum committees to evaluate and update their curricula. The committees are comprised of past and current students, teachers, and community members, such as PSW employers.

The PCCs must submit their curricula and other program information to the PCC branch within MTCU. The majority of programs in the PCC sector are members of, and purchase a curriculum from the National Association of Career Colleges Association of Career Colleges (NACC). This makes the process of being approved by PCC branch easier for NACC member programs because the curriculum has already been approved and NACC provides revisions to PCC branch when updates to the curriculum are needed. There are a few PCC programs that do not use the NACC curriculum. Graduates of these programs cannot obtain work in LTC homes because of provisions within the LTC Act. PCC branch conducts random checks of programs for quality assurance, and also investigates complaints about specific schools.

SBCE programs are governed by the Ministry of Education and provisions regarding their operation are set out in the Education Act. In addition to this, SBCE schools can be accredited through the Personal Support Worker Program Accreditation (PEPA). As part of the accreditation process, staff from PEPA review the programs curriculum and design, and conduct a site visit.

Most of the variation in program design affects the student more so than prospective employers. A SBCE education is cheapest, and a good option for individuals who need to complete their high school education while preparing for work. CAAT programs are the best option for individuals who want to pursue further education in a CAAT or a university because credits earned at a CAAT can often be applied to another CAAT program or a university program. PCC programs are the most expensive, however there are more of them and they are easier to get into. The programs are also shorter, making them a good option for people who need to enter the
workforce quickly. Most employers felt there was no difference in the quality of graduates from the different program types, although a few felt strongly that PCC grads were less well trained than graduates from the other institution types, and a few felt that SBCE grads were less well prepared.

7.1.4 Question 1iv: What are the similarities and differences among the programs?
Each institution type is governed by its own legislation and quality assurance mechanisms. During the data collection timeframe, all of the PCC and SBCE programs offered the same 13 modules. The CAAT programs each determine individually how to ensure the learning outcomes are met and course titles vary. CAAT students also take electives and each program offers more than 13 courses.

7.2 Question 2: What is the content of PSW certificate programs?
In addition to the 14 vocational learning outcomes identified by the program standard, Mosby’s Canadian Textbook for the Support Worker appeared to be the most common feature of certificate program content. The book contains a total of 48 chapters (see Appendix D for table of contents). The textbook covers the learning outcomes identified by the standard in varying depth. The text provides detailed instructions on how to carry out tasks such as bathing, dressing, personal grooming and feeding. It also provides information on settings where PSWs work, PSW clients, and issues that PSWs must be aware of, such as safety and abuse. The standard and the textbook agree that PSWs must be able to recognize the signs that a client is being abused, however neither source mentions the potential for client’s to be abused by PSWs.

7.2.1 Question 2i: What are the competencies expected of graduates, and how are they covered by the programs and training materials?
Graduates are expected to meet the 14 learning outcomes identified by the MTCU standard. All of the programs in the analysis include a course that explains the role of support workers. All of the PCC and SBCE programs use the same 13 modules described in the OCSA and NACC program outlines. In some instances, course titles may correspond directly to one of the 14 outcomes, in other cases, the content is discussed throughout a variety of courses.
7.2.2 What are Stakeholder Perceptions of Program Quality?
The key informant interviews identified several areas where knowledge was weak and education could be improved. The key informant opinions as to where education could be strengthened were consistent with the researcher’s observations regarding topics that were not substantially covered in the text and program data.

The PSW role in making assessments is a revised component of the standard which places more emphasis on the need for PSWs to use critical thinking abilities to make decisions about when to involve RHPs. Both PSWs and PSW supervisors reported challenges in practice settings related to this outcome; however, there was significant divergence of perspective as the nature and cause of the challenges. Some PSW supervisors felt that at times PSWs wait too long to make reports about the client status, leading to an escalation in their care needs. On the other hand, PSWs and other informants were of the view that there was a significant tendency among regulated staff to trivialize or mistrust PSW feedback.

Conversations with the key informants revealed that there were significant differences of opinion regarding the appropriate extent to which PSWs should be involved in medication administration. Teaching on the subject of medication administration in programs and in employment settings should be improved to clarify this issue.

Several PSWs and supervisors said they could benefit on more education regarding boundaries. Some supervisor cited sharing of personal information from the PSW to the client as concern. Other supervisor and PSWs relayed accounts of PSWs making changes to the client’s home without consulting them.

Related to this, a number of PSWs expressed confusion as to how to interpret the philosophy of client-centred and directed care, especially as it pertained to clients with dementia.

Other PSWs observed that they would like additional training on how to motivate clients to participate in restorative activities outlined in the plan of care.

Significant gaps in knowledge around abuse were also identified. Some PSWs wanted to have more training on how to protect themselves against abuse in the workplace. Others were of the opinion that more awareness needed to be raised regarding the abuse of clients by PSWs.
Abuse is a particularly complicated issue for PSWs. The evidence from the literature review was that clients do not see PSWs as authority figures the way that they do regulated care providers due to the vocational nature of their role. As a result, the assumption that health care providers have power over the patient that underlies the abuse provisions of the RHPA do not necessarily apply to PSWs. However, PSWs providing ongoing care to chronically disabled, elderly, or cognitively impaired clients, especially in the largely unsupervised home care settings, are in a position to abuse clients. This complex interplay of power dynamics between the PSW and the patient mean that the PSW has the potential to be either the victim or the perpetrator of abuse. The information from the documents and the key informants suggested that teaching with regards to this complicated power dynamic and its implications regarding abuse in care settings, was limited. As suggested by the study in the literature regarding the abuse of PSWs in LTC, the materials regarding the abuse of PSWs tended to normalize this phenomenon, while obviating its prevalence. Coverage of the abuse of clients by PSWs was absent from the documents.

Several supervisors and PSWs were of the opinion that programs could improve how they prepared PSWs for the realities of certain care settings. The LTC supervisor was of the view that new grads were not sufficiently prepared for the size of the patient case load in LTC and struggled to provide care in the required time frame. All of the PSWs in the analysis had at least done a clinical placement in the LTC setting, with some having worked in this environment for several years. One PSW had worked primarily in LTC, and had only recently begun working in home care. All of the PSWs who had LTC experience stated that providing care to their case load in the required time frame and in accordance with the principles of dignity was challenging at best. While this issue was raised in the context of questions about education, this appeared to be more of an issue of system resources and understaffing in LTC that is unlikely to be impacted by changes to education.

In home care, supervisors identified a need for improved preparation for delivering care outside of a controlled, clinical environment. Supervisors said new graduates seemed very surprised by poor hygiene conditions or limited space in client’s homes. As noted in the chapter on system design, PSW students rarely attend a clinical placement in home care since this is more costly due to insurance requirements. The researcher was able to tour a home care simulation lab at the facility where the CAAT program instructors teach. The lab is a spacious, bachelor apartment
unit, wherein students are asked to audit the room for health and safety concerns. The instructors place items such as a rubber mouse in the closet and an empty wine bottle on the night stand, which students are expected to document as health and safety hazards. While an ingenious strategy for providing students with a feel for the home care setting, a lab such as this one is unlikely to prepare a student for the range of states that might exist in a client’s home. It is inevitable that substantial on-the-job training will always be required in this area since some of the concerns raised in home care are region-specific. For example, bed bugs might be relevant to an urban area, but less relevant to a rural one.

The key informants were unanimous in the view that due to changes that have taken place in the sector over the last 15 to 20 years, some sort of formal education is required to prepare people for the role. Some key informants, including the Alzheimer’s advocacy group representative and the staffer from PEPA, observed that education alone could not ensure success as a PSW. They observed that qualities such as adaptability, creativity and good communication skills are essential to providing quality personal support. While they believed education could enhance these qualities, they did not believe these qualities could be taught.

7.3 Summary and Reflections on the Impact of Professionalism

The analysis suggested that prior to the introduction of the new MTCU standard, there was variation in the content, and the depth with which that content was covered across the program. In addition to ensuring the standardization of the content, the learning outcomes were updated to reflect the increase in the complexity of care provided by PSWs. None of the key informants perceived that PSWs needed training in any areas that were not identified by the standard, so in that sense, the standard appears to be highly comprehensive. The new standard has been updated to reflect PSW involvement in making assessments, which was previously referred to as observation. Additionally, the prior content regarding the individuality of the person has been updated to reflect the philosophy of client-centred and directed care, which is now pervasive in the health sector. The documents, combined with the informant perceptions, also suggested that content with regards to palliative care, mental health, cognitive impairment, and responsive behaviours had been expanded. This was consistent with the perception of some key informants that PSWs could benefit from more learning in these areas. According to the key informants, palliative care and responsive behaviours are areas where PSWs receive significant on-the-job
learning. On the whole, the data gave the impression that changes made to the standard were very sensitive to the needs identified by the sector.

Some of the difficulties with PSW role enactment in the areas of interprofessional teamwork, assessments, medication administration, and helping relationships seemed connected to the impact of theories of professionalism on the PSW. The standards states that PSWs are members of an interprofessional team; however several key informants, including PSWs perceived that PSWs were not viewed as team members by regulated professionals, which was reflected by the fact that they are not included in the care planning process. PSWs are heavily involved in implementing the care plan. Some informants perceived that the exclusion of PSWs from the care planning process was detrimental to the client because at times PSW assessments regarding the success or failure of care plan interventions, or client care needs was not being reflected in the care plan. While the content with regards to assessments has been expanded, it appeared to the researcher that some of the PSW’s ability to enact this learning outcome was impacted by attitudes stemming from the perception that the PSW is not a professional.

It also appeared to the researcher that the idea of professionalism impacted PSW learning with regards to helping relationships, client-centredness and directedness, and abuse. According to the key informants and the documents, the status quo is that PSWs are taught, in programs and on the job, by a professional. The vast majority of the time this professional is a nurse, and occasionally a physical therapist. As described in the sections on each of these outcomes, much of the literature on professional boundaries, client-centredness, and abuse is predicated on the fact that the health care provider has more power in the provider-client relationship. As discussed in chapter 2, belonging to a professional group entails possessing knowledge that the population being served by the professional does not, and also that the population being served is not knowledgeable enough about the service being provided to assess the quality of the professionals performance. It is these criteria that give the professional more power in the relationship than the population being served. While the PSW does not have power in the relationship as a result of exclusive knowledge, the PSW could in some situations still have power over the client as a result of the client’s reliance on care from the PSW. This power imbalance is amplified if the client is cognitively impaired, or otherwise unable to communicate their desires or concerns. The issue is further complicated by the fact that clients may not regard PSWs with same esteem with
which they regard “professional” care providers. The literature review, documents, and key informant perceptions all indicated that PSWs are quite vulnerable to abuse and mistreatment from clients. All of this suggested to the researcher that the learning outcomes with regards to boundaries, client-centredness, and abuse had very different implications for the PSW, as compared to regulated professionals. It appeared to the research that PSWs’ location in a professionalism gray zone led to contradictions in the expectations of the role. For example the PSW is expected maintain professional boundaries, but is also expected to act as a companion for the client. Thus, in the areas of boundaries, client-centredness, and abuse, it appeared to the researcher that attitudes with regards to the PSW and professionalism would impact the PSWs ability to enact the expanded content.

There are multiple definitions of professionalism in the literature, each of which emphasizes different characteristics. Four characteristics of professionalism were identified in Chapter 2: a) they possess specialized knowledge, attained through established training programs, and attested to through certification procedures; b) they provide services to members of the public; c) there is a risk to the public if the services are not done properly; d) the clients who receive these services are often not in a position to judge quality, or even whether the services are necessary; accordingly, there is an agency relationship with the clients receiving the service (i.e. caveat emptor is not an appropriate way to manage the relationship)”. PSWs clearly share characteristics b and c. Were graduation from a certificate program made a legal requirement for obtaining work as a PSW, they would meet characteristic a. As it stands, graduation from a certificate program is an employer requirement in many settings, and legally required in long-term care facilities. The fourth characteristic is the most ambiguous when applied to personal support work. Whether or not clients are in a position to judge quality depends significantly on what type of care is being provided, and the status of the client. For example, a cognitively impaired client living in a facility would not be in a position to judge quality, whereas a client living at home who requires minimal ADL support might be actively involved in directing care. Nevertheless, given the potential vulnerability of the client population, and the intimate nature of the care being provided, it is safe to say that caveat emptor is not an appropriate way to manage the relationship. In short, PSWs now meet enough of the characteristics of a profession that it is in the public’s interests that some regulations be established, even if one could debate whether they would still fully meet the definition.
7.4 Final Thoughts and Areas for Further Research

Given the intense pressure on the health care system to maximize economic efficiency, the role of the PSW is likely to continue to grow. While not required by law, the review of employer job postings in LTC and home care revealed that almost all employers now require a PSW certificate or some nursing education. The requirement for formal certification increases the prestige and validity of an occupation, in this case making the public more likely to accept increasingly complex care being delivered by PSWs. Simultaneous to the introduction of managed competition for the home care sector in Ontario, there was a need to legitimize a vocational worker delivering care previously delivered by a professional; PSW certificate programs fulfilled that need. While the rationale for the trend towards certification as a requirement for PSWs is undoubtedly multifaceted, key informants from all the stakeholder groups considered by this study agreed that formal education needs to be a requirement for the role in the current climate.

While changes to the program standard paralleled areas where key informants said more training was needed, there a number of inconsistencies in the design of the program, across and within the different institution types. Some of these differences have the potential to impact perceptions of program quality, despite the increased standardization of the content. For example, the fact that PCCs elect to refer to the credential they award as a diploma, whereas the other institution types refer to it as a certificate. The PCC program is no more advanced than the other program types, and if it were bound by the same credentials framework that the CAATs are bound by, the program they offer would not meet the definition of a diploma. The use of this term by the sector give the impression that there are two different levels of education available, which could mislead prospective employers, especially those hiring a PSW independently for themselves or a family member.

If programs do not succeed in instilling an adequate understanding of concepts such as boundaries, client-centredness, abuse, communication, and interprofessional team work in PSWs, there are few mechanisms to systematically address any resulting poor care of misconduct, placing significantly responsibility for the quality of care delivery on the education process. If PSW certificate programs are to keep pace with the current needs of the job, the following recommendations that merit further exploration are listed and elaborated upon below:
1. Experienced PSWs could be more actively involved in teaching PSW students. This would create more opportunities for students to learn about concepts such as professional boundaries, helping relationships, accountability, and abuse using examples that are directly relevant to their impending practice.

2. Consider more joint training sessions for nurses and PSWs on the job. This would allow nurses and PSWs to collaborate on solutions to challenges in the care setting, build consensus regarding the proper approach to patient care, and develop greater respect for each other’s scope of practice.

3. Consider involving PSWs in the care planning process in LTC and home care. PSWs deliver most of the paid care in these settings; however, are usually not consulted on the development of the care plan they are responsible for implementing. This, in conjunction with the fact that their feedback is not taken seriously by regulated staff means that PSW often modified or discard the care plan interventions without informing regulated staff or ensuring that the care plan is updated. This in turn poses a challenge for patient safety, since the legal document of the care plan does not then accurately reflect the care that was delivered.

4. MOHLTC and other key stakeholders should explore whether or not graduation from a certificate program should become a legal requirement of holding oneself out as a PSW, and if yes, determine what type of body should be established to regulate this. This is consistent with the opinion of the key informants that formal education is now needed to adequately perform the role. Admittedly, exploration of this issue is complicated by the fact that as discussed above, the level of care provided by PSWs work varies widely based on the setting and individual patient needs, meaning that education may not be necessary in some scenarios, or to perform some tasks.

As discussed above, PSWs face challenges that are specific to their occupation in each of the learning outcomes, many of which nurses are unlikely to have direct practice experience with. Further research should explore knowledge translation strategies for conceptual and theoretical learning that are tailored to the PSW, including whether or not some of the instruction in certificate programs could be provided by PSWs to ensure that PSW students have the benefit of learning about theoretical topics from real examples from PSWs with practice experience.
In addition to exploring the potential for PSWs to provide some of the teaching, further research should explore whether any benefits could be derived from creating more opportunities for PSWs and nurses to learn collaboratively. Several of the key informants advised that the low status of PSWs makes it less likely that they are included in the care planning process, despite the fact that they will be delivering most of the care stipulated by the care plan. Moreover, hierarchical dynamics between nurses and PSWs in care settings appear to be leading to a communicational disconnect between the two labour groups. PSWs believe that nurses do not listen to, validate, or act on their feedback, while nurses feel that PSWs are not sufficiently proactive about reporting issues with the patient’s condition. Despite the extent to which nurses and PSWs are expected to collaborate on the job, it seemed that opportunities for both labour groups to train and work through issues together were few and far between. It is possible that the creation of more opportunities for nurses and PSWs to train together has the potential to alleviate some of the communication challenges that emerge on the job. For example, nurses and PSW working in the same place could arrive at a shared understanding as to when it is time to involve a nurse.

Lack of respect for PSW observations puts homecare clients at particular risk since PSWs often have more contact with the client than other members of the care team. This suggests that various members of interprofessional care teams could benefit from more opportunities to build consensus as to what constitutes a relevant observation and when and how the observation should be reported. Several informants also reported that PSWs struggle to have their feedback regarding the efficacy of care plan interventions implemented. This too could potentially be improved by more collaborative learning on the job that builds consensus among team members as to how the care plan is developed and priorities determined, with sensitivity to feasibility in terms of resources and regulations. Interprofessional learning opportunities during course work are only possible at CAAT programs where Practical Nursing students are matriculating at the same institution. Otherwise, the only opportunity for interprofessional learning is on the job. Supervisors within agency 2 stated that training was typically provided in a role-specific manner to ensure that the content and teaching strategies were relevant to that care provider population. While it makes sense that much of the training is provided in a role-specific manner, there did not appear to be any structural barriers to providing training that is relevant to the entire team jointly. Rather, any barriers that existed seemed attitudinal in a manner that is consistent with
some attitudes regarding professionalism, in that the emphasis on vocational learning and the provision of teaching that is led by, but also divided from, regulated professionals further entrenches the PSW as a vocational labourer, rather than a professional, despite the fact that in the current health care climate, there is significant overlap between the role of PSW and the role of the nurse due to increasing assignment of nursing tasks to the PSW.

Any further research in this area would require a more thorough understanding of PSW on-the-job role enactment than was acquired by this study. Further research could include an observational study that conducts a rigid analysis of the work related demands, compared against the training standard.

In the absence of regulatory legislation for PSWs, there are few mechanisms to systematically address poor care or misconduct on the part of PSWs, placing significantly responsibility for the quality of care delivery on the educational process. Given this, it is unsurprising that efforts are being made to standardize the educational process, and require formal training. At the time when data for this study was collected, programs were not yet required to comply with the new standard. Further research in this area could include conducting another study with similar objectives in a few years to determine if and how the revised curriculum has been implemented, and how this has affected stakeholder perceptions of program quality.

This study provides a detailed description of Ontario’s PSW educational programs, and perceptions of program quality, and has the potential to be helpful to policy makers who are considering creating or standardizing a PSW program in their jurisdiction. The perceptions of program quality, and stakeholder suggestions regarding program improvements could be helpful to educators and policy makers seeking literature to guide program evaluation and quality improvement initiatives.
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Appendix A: Regulated Health Profession in Ontario

The Regulated Health Professions Act (RHPA) was enacted in 1991. The years indicate when that profession was added to the RHPA. Currently the professions added after 1991 have established transitional colleges

- Audiology and Speech-Language Pathology (1991)
- Chiropody and Podiatry (1991)
- Chiropractic (1991)
- Dental Hygiene (1991)
- Dental Technology (1991)
- Dentistry (1991)
- Denturism (1991)
- Dietitians (1991)
- Homeopathy (transitional college, established 2007)
- Kinesiology (transitional college, established 2007)
- Massage Therapists (1991)
- Medical Laboratory Technology (1991)
- Medical Radiation Technology (1991)
- Medicine (1991)
- Midwifery (1991)
- Naturopathy (transitional college, established 2007)
- Nursing (1991)
- Occupational Therapy (1991)
- Opticianry (1991)
- Optometry (1991)
- Pharmacy (1991)
- Physiotherapy (1991)
- Psychology (1991)
- Psychotherapy (transitional college, established 2007)
- Respiratory Therapy (1991)
- Traditional Chinese Medicine (transitional college, established 2006)

\(^2\) (Government of Ontario, 1991c)
Appendix B: Interview Guide

An interview was conducted with at least one representative from each stakeholder category.

Employer Interview
1. What do you consider to be the scope of the PSW role?
2. Do you prefer to hire PSWs with certificates? Why/Why Not?
3. What proportion of your PSW staff has on-the-job training only?
4. What is the most important quality in a PSW?
5. How are PSWs involved in advocating for client independence?
6. How is a client’s care plan developed?
7. What aspects of the care plan are PSWs responsible for?
8. Do PSWs carry out any tasks that overlap with nursing? If so, which ones?
9. Do PSWs carry out delegated controlled acts? If so which one?
10. What is meant by the activation process?

PSW Interview
1. How do you describe your job?
2. Was holding a PSW certificate a job requirement?
3. Why did you decide to become a PSW?
4. Can you describe how your training program prepared you for the work you are doing now (specific examples)?
5. What aspects of your current role have you learned on-the-job?
6. Did your program provide information regarding specific conditions such as Alzheimer’s and Diabetes?
7. What is the most important quality in a PSW?
8. How are PSWs involved in advocating for client independence?
9. Describe your involvement in the development and execution of clients’ care plans?
10. Do PSWs carry out any tasks that overlap with nursing? If so, which ones?
11. Do PSWs carry out delegated controlled acts? If so which one?
12. What is meant by the activation process?
Client Interview

1. Explain your understanding of a PSWs’ role
2. Do you prefer to hire PSWs with certificates? Why/Why Not?
3. What is the most important quality in a PSW?
4. How are PSWs involved in advocating for client independence?
5. How are clients involved in the development and execution of their care plan?
6. Do PSWs carry out any tasks that overlap with nursing? If so, which ones?

Educator

1. What is your educational background?
2. What is your professional background?
3. Do you teach about care plans?
4. What is meant by “The activation process”? 
Appendix C: MTCU Common Standard Vocational Learning Outcomes³

Personal Support Worker

The graduate has reliably demonstrated the ability to:

1. **Role of the Worker**: Work within the personal support worker role in community, retirement homes, long-term care homes and/or hospital care settings* in accordance with all applicable legislation and employer’s job description, policies, procedures and guidelines.

2. **Accountability**: Act responsibly and be accountable for own actions while recognizing the boundaries of knowledge and skills within the personal support worker role that require collaboration with the clients, families, supervisors and/or other members of the interprofessional care/service team*.

3. **Interprofessional Teamwork**: Participate as a member of the interprofessional care/service team* and maintain collaborative working relationships in the provision of supportive care* in community, retirement homes, long-term care homes and/or hospital care settings*.

4. **Client-Centredness and Directedness**: provide client-centred* and client-directed* care that is based on ethical* principles, sensitive to diverse client and family values, beliefs and needs, and which follows the direction of the plan of care/service plan*.

5. **Helping Relationships**: Establish and maintain helping relationships* with clients and their families reflecting open communication, professional* boundaries, employer’s policies and adhering to confidentiality and privacy legislation.

6. **Assessments**: Identify relevant client information using basic assessment and communication skills and report and document findings in accordance with the requirements of employer policies and procedures and all applicable legislation.

7. **Safety and Comfort**: Promote and maintain a safe and comfortable environment for clients, their families, self and others including the implementation of infection prevention and control

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³ (Ministry of Training Colleges and Universities, 2014)
measures and emergency first aid procedures that are in keeping with the plan of care/service plan*, employer policies and procedures, and all applicable legislation.

8. **Activities of Daily Living**: Assist clients across the lifespan with routine activities of daily living* by applying basic knowledge of growth and development, common alterations in functioning, disease prevention, health 6 II - Vocational Standard promotion and maintenance, rehabilitation and restorative care*.

9. **Medication**: Assist clients with medication* in keeping with the direction of the plan of care/service plan* and under the direction and monitoring of a regulated health professional* or most accountable person* and in accordance with all applicable legislation and employer’s policies.

10. **Instrumental Activities of Daily Living**: Assist with household management tasks* and instrumental activities of daily living* in accordance with the plan of care/service plan* and considering the preferences, comfort and safety of clients, families and significant others.

11. **Respite**: Assist clients who are caring for dependent individuals* considering client and family choices, professional* boundaries and the direction of the plan of care/service plan*.

12. Identify and report situations of neglect, and potential, alleged or witnessed/actual incidents of abuse, and respond in accordance with all applicable legislation and employer’s policies and procedures.

13. **Palliative and End-of-Life Care**: Assist in the provision of culturally relevant* palliative and end-of life care* to clients experiencing life threatening illness and to their families and significant others, from diagnosis through death and bereavement, and in accordance with clients’ choices and the plan of care/service plan*.

14. **Cognitive Impairment, Mental Health Challenges, and Responsive Behaviours**: Use identified approaches and best practices to support positive and safe behaviour in clients experiencing cognitive impairment, mental health challenges and/or responsive behaviours*.

Note: The learning outcomes have been numbered as a point of reference; numbering does not imply prioritization, sequencing, or weighting of significance.
Appendix D: List of Chapters in Mosby’s Canadian Textbook for the Support Worker

1. The Role of the Support Worker
2. The Canadian Health Care System
3. Workplace Settings
4. Health, Wellness, Illness, and Disability
5. Working With Others: Teamwork, Supervision, and Delegation
6. Working With Clients and Their Families
7. Medical Terminology
8. Client Care: Planning, Processes, Reporting, and Recording
9. Managing Stress, Time, and Problems
10. Ethics
11. Legislation: The Client’s Rights and Your Rights
12. Caring About Culture and Diversity
13. Interpersonal Communication
14. Body Structure and Function
15. Growth and Development
16. Caring for the Young
17. Caring for Older Adults
18. Common Diseases and Conditions
19. Safety
20. Preventing Infection
21. Abuse Awareness
22. Promoting Client Well-Being
23. Body Mechanics: Moving, Positioning, Transferring, and Lifting the Client
24. Exercise and Activity
25. Home Management
26. Beds and Bed Making
27. Nutrition and Fluids

4 (Kelly, Sorrentino, Wilk, Remmert, & Schuh, 2013)
28. Enteral Nutrition and IV Therapy
29. Personal Hygiene
30. Grooming and Dressing
31. Urinary Elimination
32. Fecal Elimination
33. Rehabilitation Care
34. Mental Health Disorders
35. Confusion, Delirium, and Dementia
36. Speech and Language Disorders
37. Hearing and Vision Problems
38. Caring for Mothers and Infants
39. Developmental Disabilities
40. Assisting With Medications
41. Measuring Height, Weight, and Vital Signs
42. Wound Care
43. Heat and Cold Applications
44. Oxygen Needs
45. Assisting With the Physical Examination
46. The Client Having Surgery
47. Caring for a Client Who is Dying
48. Your Job Search
Appendix E: Table of NACC and OCSA PSW Program modules

* 1 school-board program provided information regarding how many hours were allocated for each module. 4 PCC programs provided this information.

<table>
<thead>
<tr>
<th>Module</th>
<th>PCC Hours</th>
<th>SBCE Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuality of the Person</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Role of the Worker</td>
<td>18</td>
<td>12 or 21</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>18 [n=2] or 22</td>
<td>27</td>
</tr>
<tr>
<td>Providing Optimal Support/Care Planning</td>
<td>12 [n=1] or 28</td>
<td>18</td>
</tr>
<tr>
<td>Abuse</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Household Management and Meal Preparation</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Assisting a Person with Mobility</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>Assisting a Person with Personal Hygiene</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>Assisting the Family</td>
<td>12 [n=1] or 18</td>
<td>18</td>
</tr>
<tr>
<td>Cognitive Impairment and Mental Health</td>
<td>35 or 31 [n=1]</td>
<td>30</td>
</tr>
<tr>
<td>Assisting a Person with Medications</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Assisting A Person Who is Dying</td>
<td>22 or 12 [n=1]</td>
<td>15</td>
</tr>
</tbody>
</table>
Appendix F: Controlled acts\(^5\)

(2) A “controlled act” is any one of the following done with respect to an individual:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3. Setting or casting a fracture of a bone or a dislocation of a joint.

4. Moving the joints of the spine beyond the individual’s usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.

6. Putting an instrument, hand or finger,
   a. beyond the external ear canal,
   b. beyond the point in the nasal passages where they normally narrow,
   c. beyond the larynx,
   d. beyond the opening of the urethra,
   e. beyond the labia majora,
   f. beyond the anal verge, or
   g. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.

\(^5\) (Government of Ontario, 1991c)
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.


11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32.