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OCCUPATIONAL RISK PERCEPTION IN HOME HEALTH CARE WORKERS

by

Wendy Anne Smith

DISSERTATION

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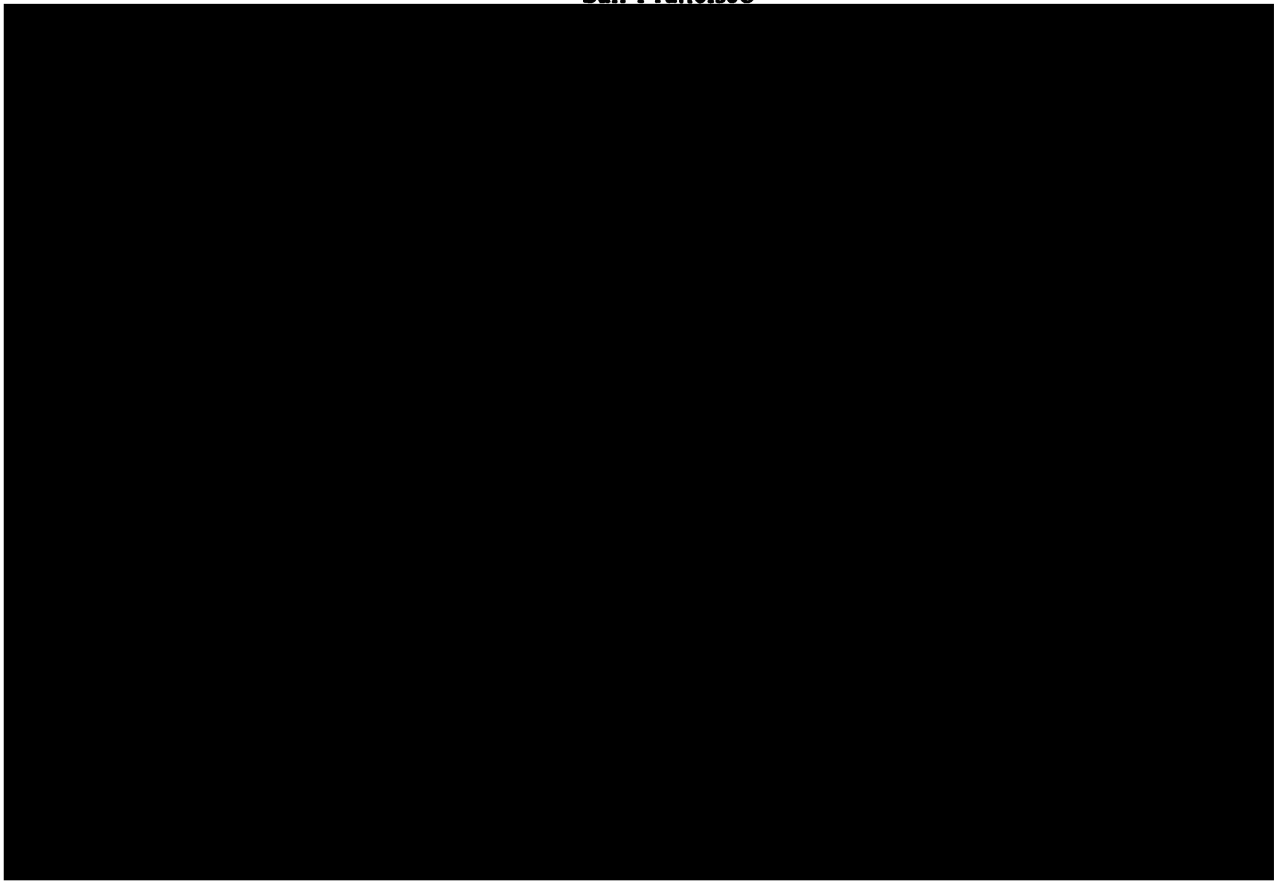


ABSTRACT

OCCUPATIONAL RISK PERCEPTION IN HOME HEALTH CARE WORKERS

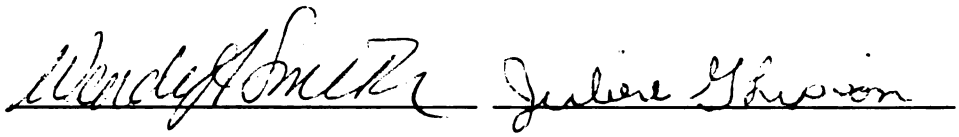
Wendy Anne Smith

This descriptive study generated a theory that described and explained occupational risk perception in home health care workers (HHCWs). Participants included 29 individual home health care workers who were employed by three home health care agencies. Semi-structured interviews and observations of workers as they went about the work of delivering health care in the home environment generated data which were analyzed using grounded dimensional analysis.

Analysis revealed three general dimensions, each of which represent a perspective of the work process significant to the worker's perception of risks: 1) the physical environment of work, 2) relationships of work, and 3) the institutional structure and requirements of work. In this group of workers, the dimension most salient to risk perception was the physical environment of work. While relevant, the dimensions relationships of work and institutional structure and requirements of work were not as central as the first named to the worker's story. A deliberative process called "tucking away" was revealed to be an important part of the perception process used by workers to assess and manage risks in the work environment. This symbolic deliberative process, while covert and fluent for the expert worker, was a more conscious and less-fluent process for the novice worker.

Analysis also uncovered a paradox found to influence the worker's perception of risk. The paradox identifies that the positive attributes of the home care work environment which stimulate and challenge workers may well be the same attributes that contribute to a heightened perception of risk.

The findings serve as the components of a proposed explanatory model of occupational risk perception in home health care workers, which can be used to better understand risk perception in relationship to unstructured and unpredictable work environments.



Wendy Anne Smith Juliene Lipson RN, PhD

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Introduction to the Problem

In the United States, home care agencies of various types have been delivering health care services in the home for over a century. In the past, services were provided predominantly by non-profit community groups. It wasn't until the social programs of the 1960's that home health care established a foot hold as a reimbursed service. At that time home health care was a slow growing industry with a relatively small work force (Rice, 1989; National Association for Home Care [NAHC] 1992; 1993). At this time home health care workers (HHCWs) were performing relatively low-technological health care. In the late 1970's and early 1980's, this picture changed abruptly and dramatically with changes in government reimbursement, added entitlement, and with the initiation of prospective payment systems, i.e., diagnostic related groups (DRGs) (NAHC, 1992; 1993).

Contemporary home health care work in many respects is as complex and technological as traditional hospital work. Over the past decade, as a result of the dynamic nature of home care work, a vast work force has been mobilized to provide care to persons in their home environment. It is a work environment that

is relatively unknown and difficult to generalize about because of the uniqueness and non-uniformity of individual households. Health care work in the home environment is different than health care work in a structured institution such as the hospital. The social contract between worker and patient in home care work is one of guest and client, respectively. In the home, the client has a much greater control over the work process itself which includes such factors as furniture and equipment, timing of care, and giving permission for other persons to be present during care, i.e., family or friends.

Although there are similarities between home health care delivery and health care delivery in the traditional hospital institution, there are many differences that define home health care as a new health industry. The home health care industry grew by 19 percent during 1990 alone (Caserta, 1991). With a rapid expansion of the work force in a new industry, worker protection and hazard control mechanisms often lag behind worker needs. In some situations the hazards and the risks of injury or illness are not yet known, or, they are assumed to be similar to those experienced in comparable industries. The latter assumption appears to have been the case in the home care industry, where the hazards and attendant risks of the traditional hospital environment have been extrapolated to health care work in the home environment (White & Smith, 1993). Minimal or no consideration has been given to the distinct differences in the social contract and its impact on worker health and safety. Additionally, little is known about the personal experiences of workers in such situations. How does

the constant unpredictability related to the variety of unstructured work environments of the home (defined as "the home"), affect worker safety? How do workers deal with such unpredictability? The above concerns were the impetus for seeking further knowledge regarding home care worker experiences which prompted this investigation.

The home health care (HHC) industry has experienced explosive growth in the past twelve years (Humphrey, 1988; Rice 1992; Kavesh,1986;). With the average annual growth rate being over 20 percent for the last 8 years (Health Care Financing Administration (HCFA), 1990). In 1977, the number of Medicare-certified home health agencies was 2,496; by 1990, that number had increased to almost six thousand. If one were to include those agencies not certified for Medicare reimbursement, the number swells to 12,497 as of 1993 (NAHC, 1992; 1993). The growth in HHC is explained by a number of factors, which include:

1. the recognition by hospitals and for-profit agencies that HHC could be a source of enterprise and profit (Humphrey, 1988);
2. cost containment measures imposed by government and insuring institutions instigated DRGs, resulting in earlier discharge for patients from acute care settings. High-tech care traditionally carried out in the hospital domain could now be provided in the home setting (Council on Scientific Affairs, American Medical Association, 1990; Woodin & Davis, 1990); and

3. demographic changes with an increasing aged population of those suffering from chronic disease and living alone with no social support systems in place. These persons are a great majority of those discharged from acute health care facilities "sicker and quicker" (Kavesh, 1986; Lipscomb 1989).

HHC industry growth requires a rapid expansion of the work force. A growth in the number and categories of clients requires a skill mix of workers that included both skilled (nurses, physical and respiratory therapists, and other trained professionals) and unskilled (housekeepers, nurses aides/attendants) worker categories. In the past it has been common to think of health care workers as those who provide direct patient care in traditional acute care environments. The fact is, approximately 75 percent of health care workers now work in such non-traditional settings as skilled nursing homes, adult health day-care, private clinics, research facilities, and emergency response teams, with the bulk in home health care agencies (U.S. Dept. of Labor, 1992).

Health care workers, whether in traditional institutional facilities or in non-traditional work environments, are designated by the U.S. Department of Labor as service workers. Service workers, especially health care workers, experience high rates of occupational injury and illness that in some cases exceeds that of industries commonly perceived as being "dangerous" (U.S. Dept of Labor, 1970, 1978, 1990, 1992).

In summary, health care workers generally are at increased risk for occupational injury and illness. This increased risk for HHC workers is attributed to the lack of structure in the work environment and the unique social context of the work environment.

Statement of the Problem

While the occupational risks of traditional institutional health care workers have been described and researched, minimal information exists about the occupational risks of non-traditional health care workers such as home health care workers (HHCWs). Many of the hazards and subsequent risk for occupational injury and illness for health care workers are assumed to be similar to those experienced by hospital workers. It is true that health care workers in the home environment may face the same hazards as their counterparts in the hospital environment, such as blood borne diseases and musculoskeletal injuries. However, such factors as unpredictability, less control of the physical environment, and differing social roles of caregiver and client may intensify or possibly decrease the occupational risk for illness and injury in home care work. The HHCW'S perspective of what constitutes a hazard, or, the extent of risk posed by a particular hazard may be different from the institutional worker's perspective. The concept of the home as a safe environment, as well as the social context of the worker as a guest in the home of the client, may affect a person's perception.

Little information exists about work experiences and work hazards as seen from the perspective of home health care workers. Workers in the hospital setting do not routinely face hazards associated with pets, automobiles, or unsafe access or egress to the place of care as do home care workers. These conditions alone create a whole different set of hazards for those who deliver health care in the home setting. Yet, many of the work protection practices and administrative policies utilized for worker safety in the institution have been automatically applied to the work environment of the home (White & Smith, 1993).

Purpose of the Study

The purpose of this descriptive study was to investigate the factors that are involved in the perception of occupational risk in home health care workers (HHCWs). The specific aim of the study was to generate a theory that describes and explains the HHCWs perception of work-related risk.

The study attempted to answer the following research questions:

1. What are the physical and psychosocial factors which structure the perceptions of risk in the environment where home health care is delivered?

2. What are the various processes and strategies utilized by workers to assess if a hazardous situation is immanent or present?

3. What are the various actions and behaviors workers elicit to manage or negotiate the perceived hazards and maintain a safe work environment?

4. What are the factors that impede or facilitate the management and negotiation of a safe work environment from the perspective of the HHCW?

Need for the Study

In the explosive atmosphere of the home health care industry, it is imperative that the health concerns of workers be addressed. Since more agencies are entering the industry and employing more home health care workers, there are ever increasing numbers of workers placed at risk. Occupational health research needs to acknowledge the home environment as being unique and distinct from the traditional health care environment such as the hospital. It is necessary to realize that those same high-risk complex care procedures previously done only in the hospital setting are now performed by health care workers in the home.

Occupational health research abounds with studies that are predominantly epidemiological in nature. In order to describe and explain the day to day work experiences of HHCWs, a naturalistic approach to occupational health research is appropriate. This study attempted to describe and explain the day to day work

experiences of HHCWs, in the natural environment of the community and more specifically the home.

All occupational health research is motivated by the need to promote a safe and healthful workplace. Worker protection is enhanced by research that identifies occupational risks, worker management strategies and successful mitigation of risks. Prevention and protection programs based on worker input and self-identified needs have the potential to be effective in preventing occupational health and illness. This study presents an accurate account of how home health care workers view their work world, an account of what is dangerous about their work environment, and an account of how they deal with the dangers and risks. The suggested prevention strategies offer techniques that may prove to be successful in reducing occupational risk to home health care workers.

CHAPTER TWO

HOME HEALTH CARE WORK: A HISTORICAL PERSPECTIVE AND LITERATURE REVIEW

Definition of Home Care Services and Clients

Home health care is defined as the delivery of health services in the client's own home by health professionals and para-professionals (Keating & Kelman, 1988; Lipscomb, 1992). It is also a program of mostly intermittent services that are organized and managed primarily from a nursing perspective. Health professionals such as nurses, social workers, physical therapists, and respiratory therapists provide specialized and technical health care. Para-professionals such as nursing aides, medical attendants, housekeepers, and respite/comfort workers provide care and assistance with activities of daily living. Home health care can precede or follow acute hospital care, convalescent or long-term care, or can be utilized in conjunction with respite care.

According to analysis of agency records and required reports for accrediting and regulatory purposes, the majority of home health care clients are the elderly. The National Center for Health Services Research and Health Care Technology Assessment (1985) reports that the most intensive users of home care services are the elderly. The elderly average 22.3 home care visits annually, with 78 percent of all home health care visits received by Americans older than 65

years. Hays (1986) found that patients receiving Hospice services had a mean age of 68 years. The user rate of services increases dramatically with increased age. Females use more services than do males (NAHC, 1992). Most of the patients cared for by home health agencies suffer from heart disease, cancer, stroke, or orthopedic related problems with the average length of service being approximately one month (Speigel, 1987). Lusby, Martin, & Schietinger (1986) estimate that 17 to 22 percent of clients with AIDS are using home health care services at any given time. A recent study of home care agencies in Northern California, demonstrated that over 95 percent of agencies care for persons with Acquired Immune Deficiency Syndrome (AIDS) (White & Smith, 1993).

The need for the further expansion of home care services is clearly evident with the demographic trend of an increased aging American population, a majority of whom are is chiefly female. The need for home care service expansion is reinforced by trends in the changing social structure of family from an extended family to a more nuclear.

Home Health Care Work and Home Care Workers

Historically, home care has been synonymous with nursing care. Patient care outside the institution is greatly influenced, managed, and controlled by nurses. Home health clients' needs are viewed as primarily nursing in nature. However, in order to get home care services covered under Medicare in 1965, the

American Medical Association (AMA) demanded a medical diagnosis for reimbursement (Rice, 1992). Essentially AMA wanted a piece of the lucrative pie by insisting that physicians control client access to care. In order to pass the legislation, the AMA pressured the government to mandate physician certification for all professional and non-professional services rendered by a home care agency (Mundinger, 1983).

The Bureau of Labor Statistics (BLS) reported that while most industries were in decline in 1990 due to the recession, home care employment increased 19.2 percent - a rate almost triple the rate of growth for the health care industry in general. The most in-demand personnel in HHC includes home care aides, physical therapists, respiratory therapists, occupational therapists, and support personnel (NAHC, 1992; 1993).

The home health care staff mix varies in relationship to the client and community needs. The client case mix in relation to diagnoses determines the number and type of personnel employed by an agency at any one time. For example, skilled clinicians are required if there are many clients with high-technology needs. If the agency also provides care to a substantial number of chronically ill clients with less-skilled nursing care needs, then home health care aides, working under the supervision of nurses, constitute a larger percentage of the staff. A large client population with rehabilitation needs requires the services of professional therapists and technicians who collaborate with nurses. As a result of this varying relationship between case mix and skill mix many workers in the

home care industry are part-time or on-call workers.

Despite the skill mix, it is usually nurses who provide the majority of home care services. Approximately 94 percent of the 1.35 million persons who received home care services prior to 1978 received some nursing care, while 40 percent received the services of home health aides (Irwin, 1978). Nursing care visits account for nearly one-half of all visits (Rice, 1992). So while home health care is controlled financially and politically by physicians, the nature of the work and the care delivered is within a nursing framework.

The home health care setting creates a milieu in which the home health care worker is the guest of the client and family (or related social support system). At the same time being recognized as a skilled professional (or one who is practicing under the auspices of a skilled professional). The situation provides the foundation for a partnership between client and worker, as contrasted to the more dependent role of the patient in the hospital setting. In home health care terminology, the unit of care is not classified as "the patient", as in the institution, but, rather "the client". The terminology and relationship establishes a much greater sense of control by the client over the work of home health care (Keating & Kelman, 1988).

Workers in the home care industry may be employed by any one of several agencies providing home health care who may or may not be Medicare-certified. The types of agencies include: 1) public agencies owned or operated by state or federal agencies, 2) the Visiting Nurses Association (VNA), 3) hospital based

home care agencies, 4) proprietary (for profit) agencies, and 5) private (not-for-profit) agencies (National Association for Home Care (NAHC), 1992 & 1993).

The Development of a New industry

The first home care agencies in the United States were established in the 1880's. Their numbers grew to 1,100 by 1963 and to more than 12,000 currently. This total includes home health agencies, home care aide organizations, and hospices which are collectively known as "home care agencies."

The NAHC (1992) has identified a total of 12,497 home care agencies in the U.S. This number consists of: 1) 6,129 Medicare-certified home health agencies, 2) 1,110 certified home care aide organizations and hospices, and 3) 5,258 home health agencies, home care aide organizations, and hospices that do not participate in Medicare. While home care agencies of various types have been providing high-quality, home-delivered services to Americans for over a century, the majority of the growth has taken place since the 1965 enactment of the Medicare Entitlement legislation. Medicare made home health services, primarily skilled nursing and therapy of a curative or restorative nature, available to the elderly in 1965. In 1973, certain disabled younger Americans were included in the benefits, with hospice benefits added by 1983 (Rice, 1992).

In the 1980's, the number of Medicare-certified home health agencies leveled off at around 5,800 due to increasing Medicare paperwork and unreliable

payment policies. Consequently, in 1987 a lawsuit was brought against the Health Care Financing Administration (HCFA) by a coalition of U.S. Congress members, consumer groups and NAHC (Lynch, 1994; NAHC, 1992). The outcome of the suit was a subsequent revision which increased Medicare's annual home health benefit outlays to about 175 percent of previous levels. By June 1992, the number of certified home health agencies had risen to an all time high of 6,129 (NAHC, 1992).

The growth in the number of Medicare-certified home health agencies has been accompanied by changes in the mix of their owner/operators otherwise know as sponsors, or as "auspices". From 1967 to 1992 agencies sponsored by proprietary (free-standing for-profit agencies) and hospital based agencies have shown the greatest growth of 31.9 percent and 27.5 percent, respectively (HCFA, 1993).

When inflation of the 1980's threatened both the United States economic and health care systems, the federal administration responded by initiating cost-containment programs which greatly impacted Medicare-reimbursed health care and especially hospital care. The program's plan was to contain costs by paying for in-patient hospital care estimated on the previous year's budget. In order to estimate costs for care, the diagnostic related groups (DRGs) were developed. DRGs were a mix of variables characterized by: certain medical diagnoses, the extent of illness, the patients' characteristics (age and accompanying conditions),and average length of stay for the illness, along with other statistical

data (Keating & Kelman, 1988; Rice, 1992). As a result of the DRG's prospective payment system (PPS), hospitals are awarded predetermined amounts of money for patient care. In terms of financial gain, it remains in the hospital's best interest to facilitate early discharge. As a result, many patients are discharged from the hospital to home "very sick and ill" (Balinsky & Starkman, 1987). Other third party insurers followed suit and developed their own PPS. The phenomenon's impact on the health care system brought the high technology of acute care into the home setting; consequently, home care clients required more complex nursing care and more home health nursing services. The phenomenon added further impetus to the already burgeoning industry of home health care.

Experts predict that the home care industry will grow at an annual rate of 12 percent from 1991 to 1996 (NAHC,1993). Recent studies indicate that the nursing shortage in home health care is not a result of a shrinking supply but results from an increased demand for registered nurses in the home health care area (Lynch, 1994; White, 1991). A study by the American Nurses Association indicated that the nursing shortage in home health care approximates the hospital shortages of the late 1980's (White, 1991). In California alone, more than nine million home visits were made to 475,000 homebound clients in 1991; nationwide, six million clients were visited by workers from approximately 15,000 home care agencies (Greer, 1994). The influences of client characteristics and demographics, changes in health care financing and reimbursement, and the longstanding entrepreneurial nature of the American health care industry have directed the

emphasis of care from the acute care institutional environment to the home environment. This trend has created an explosive home health care industry (Humphrey, 1988; Keating & Kelman, 1988; Martin, 1988; Rice, 1992; White & Smith, 1993).

Health Care Workers as an At-risk Population

The hazards encountered by health care workers are numerous. Although it might be assumed that health care industries are at the forefront in providing occupational health care to their employees and are proactive in mitigating workplace hazards, there are many indications that this may not be the case (Emmett & Baetz, 1987; Felton, 1990; Poitrast & Zenz, 1994). Health care is one of the largest industries in the United States, employing approximately 8.8 million persons (U.S. Department of Labor, 1981; Wilkinson, et al., 1992). By the year 2000, the work force is predicted to be greater than 10.1 million workers (Rogers & Haynes, 1991).

Although the Bureau of Labor Statistics provides data on the incidence of occupational disease and injury, reporting and data have been shown to be inadequate. In spite of this, in 1984 there were over 291,000 occupational injuries, with over 11,000 occupational diseases reported by workers in the health service industries (U.S. Department of Labor, Occupational Safety and Health Administration, 1984). Overall incidence rates of occupational injuries in the health service industry in 1993 were 10.9 per 100 full-time workers compared to

13.8 in heavy construction and 7.5 in mining (National Safety Council, 1993). Health care work is one of the more dangerous forms of work. Of the 12 industries designated as service, the health care industry had the fourth highest rate of injury. Nurses and workers providing direct personal care had an injury rate of 15.5 per 100 full-time workers (DiBenedetto, 1995). This approaches and in some cases exceeds that of industries commonly perceived as of being "dangerous" (U.S. Department of Labor, 1970, 1978, 1990).

It is estimated that about 4.5 million workers, or 4 percent of the total U.S. work force, are employed in an institutional (hospital) environment (U.S. Department of Labor, 1990). The total number of workers employed in home health care is not well established, since minimal descriptions are available only on the number of full-time equivalent (FTE) workers employed in Medicare-certified agencies in the survey years 1987 and 1990. In 1987 a total of 108,112 FTE workers were employed; by 1990 a total of 146,958 FTE workers were employed indicating an increase of 35.9 percent over the three year period (NAHC, 1992). Because many workers in the home health care field are contingency or part-time employees and the above numbers represent full-time equivalents, the actual total number of employees is much greater. Although NAHC has identified a total of 12,497 home care agencies and hospices in the U.S., only 7,239 (approximately 57 percent) are Medicare-certified. Subsequently, there are definitely more home health care workers not identified when only Medicare-certified agencies are surveyed. It has been established that approximately ten percent of all registered

nurses (RN) now work full or part-time in the home health care industry (NAHC, 1992).

A variety of workers are employed in HHC. In a recent survey, Smith and White (1993) found that of home health care workers employed in direct client care, 36.5 percent were RN's, 27 percent were home health aides/attendants, 15.8 percent were therapists (e.g., physical, respiratory, speech and occupational), and 14.2 percent were homemakers (e.g., cleaners, shoppers, sitters) or others. A total of 3,223 direct-care workers were employed by some 52 home care agencies responding, with the number of direct-care employees per agency ranging from six to 52 (Smith & White, 1993). Due to inadequate information, a need exists to better describe the numbers and characteristics of workers employed in the home health care industry, especially those involved in non-Medicare-certified home care work.

There is a wealth of information and research on the occupational health risks of health care work done within an institutional environment (DiBenedetto, 1995; Behling & Guy, 1993; Emmett & Baetz, 1987; Lowenthal, 1994; Rogers & Haynes, 1991; Szabo, et al., 1983; Triolo, 1989a, 1989b; Wilkinson, et al., 1992; Williamson, et al., 1987a 1987b; Zoloth & Stellman, 1987). Since comprehensive occupational (or employee health) programs in institutional facilities have been in existence for more than 15 years, progress has been made to identify and mitigate risks faced by workers in such settings (Emmett, 1987; Lowenthal, 1994; NIOSH, 1977; Rogers, 1991; Szabo, 1983). Yet, there is a dearth of information and

research on the occupational health risks of health care work in the community or home environment. Health care workers in the home environment may face the same risks as their counterparts in institutions; however, additional and/or very different risks may exist since the work environment is less standardized, less predictable, and less controlled.

Occupational hazards and stressors in health care work are usually described under the following four categories: biological, chemical, ergonomic and physical, and psychosocial (Berger, 1984; DiBenedetto, 1995; Emmett & Baetz, 1987; Rogers & Haynes, 1991; Triolo, 1989a, 1989b; Williamson, et al., 1987a, 1987b).

Biological Hazards

The home environment presents a variety of infectious and biological hazards for the HHCW. Moreover, quality control and risk management measures may be difficult to implement due to the unstructured nature of the home work environment. In comparison the their institutional infection surveillance, hospital infection control departments/committees have limited experience in active home care infection surveillance (Lorenzen and Itkin; 1992). This may result in an assumption that there is less risk of infection, and thus exposure, in the home than in the hospital setting.

OSHA has estimated that greater than 5.6 million health care and related occupations are at risk of exposure to Human Immunodeficiency Virus (HIV) and

Hepatitis B. Virus (HBV) (DiBenedetto, 1995). Several studies have recently estimated the risk of acquiring HIV from institutional occupational exposure to be 0.4 percent (Centers for Disease Control (CDC)), 1988; Gerberding, 1987; Marcus, 1988). The risk for hospital acquired Hepatitis B virus (HBV) is estimated to be 7 to 30 percent (Seef, 1978). Each year approximately 18,000 health care workers acquire HBV and more than 250 die from work-related exposure and complications (DiBenedetto, 1995; CDC, 1988).

Studies show that needlestick injuries significantly increase the risk of exposure to both HIV and HBV. Most occupationally-acquired HIV infections have been associated with needlestick injuries, while nearly one-third have been the result of exposure to non-intact skin or mucous membranes (CDC, 1988). Due to the nature of their work registered nurses have the highest incidence of needlestick injuries among all health care workers (Neuberger et al., 1988). The true extent of exposure to health care workers from needlestick injuries is not known, however, because health care workers under report needlestick injuries (Harmony, 1983; Jackson et al., 1986).

Research on risks from needlestick injuries to health care workers employed in settings other than hospitals has been minimal. Environments that have been studied include nursing homes (Crossely, 1990), physicians' offices (Thun et al., 1989), dental offices (Klein, 1988; Friedland & Kahl, 1990), and blood bank settings (McGruff & Popovsky, 1989). Rather than focusing on the actual experiences or perceptions of workers at risk, the studies have surveyed

directors of the practice setting, regarding reported needlesticks and/or the existence of and compliance with guidelines preventing exposure (Lipscomb, 1992; Backinger & Koustenis, 1994).

The occupational risk of exposure to biological and infectious agents in the home work setting has been the topic of very few published papers (Backinger & Koustenis, 1994; Frawley, 1988; Lipscomb, 1992; Simmons et al., 1990; Stevens, 1989; Weinstein, 1985; White & Smith, 1993; Rule, 1994). Only two cases of Acquired Immune Deficiency Syndrome (AIDS) associated with home health care work have been described in the literature (CDC, 1986; Rademaker et al., 1987). There is no need to believe that the risk of infection from occupational exposure to infectious and biological agents is any less in home care work than it is in institutional work. In fact, the risk may be greater since White and Smith (1993) in their Northern California study, demonstrated that 96 percent of home care agencies provide care for persons with AIDS and HIV related disease. Backinger and Koustenis (1994) report that approximately 17 to 22 percent of clients with AIDS (14,000 to 18,000 according to 1992 figures) are visited by home health care agencies at any given time. Home health care workers care for clients with HIV infection in all stages of the disease, with a majority of home care given during the terminal stage. Yet, it is still unclear at what period during the HIV infection a client is most infectious and therefore likely to transmit the virus; it may be during the terminal stage that clients are more infectious (Gerberding, 1991). Consequently workers who care for HIV clients in the terminal stage of the

disease may be at a greater risk of infection than those who care for clients in the earlier stages.

With the advent of DRGs, patients are discharged from the hospital "sicker and quicker" (Humphrey, 1988). This practice requires that home care services must be as technologically skilled and diverse as services delivered in the hospital. Clients who previously received complex-skilled care in hospitals are now receiving those same care skills in their own homes (e.g., dialysis, chemotherapy, total parenteral nutrition, pharmacological infusions, respiratory support and involved wound or ostomy care) (Journal of the American Medical Association (JAMA), 1990).

While infectious and biological hazards in home health care work may be similar to those in hospital work, the home health care worker may be at a greater risk for exposure because of the non-standard environment of each client's home. Because the home environment of each client varies, there is the lack of safeguards and controls which are usually employed in the hospital setting. It is impossible for infection control and safety committees to manage and control the intangible environment of home care in the same manner that is attainable in they structured environment of the hospital. Thus, there may be a greater risk of exposure in the neighborhoods and homes where home care work is carried out. While the home care agency must comply with the rigorous infection control standards set by hospital and home care licensing agencies and bodies, the actual community and home does not mandate such compliance.

In order to be licensed and receive Medicare reimbursement, the home care agency must have quality control/risk management measures in place. Although some of these measures include infection control issues relating to employee protection, others do not. Recent regulation, such as the Blood Borne Pathogen Standard by OSHA (29 CFR 1910.1030), and the 1993 policy and procedure guidelines for occupational tuberculosis exposure, mandates: 1) that all employers identify jobs and work practices in which potential exposure exists, 2) develop standard procedures for work practices involving potential exposure, and 3) provide education and training (Goldstein & Johnson, 1991; OSHA, 1992). Additionally, the July 1991 passage of Senate Bill 198 in California mandated that every employer establish, implement, and maintain a formal and effective occupational injury and illness prevention program (California Department of Labor, 1991; Hellman & Gram, 1993; OSHA; 1994). These state and federal safeguards to protect employee health and safety have only recently been implemented. Actual regulation and enforcement is another issue and will be difficult in an industry such as home health care where agencies vary from small private businesses with contract or contingency workers to major proprietary or hospital owned businesses with both permanent and contract employees. Regardless of the controls in place by the home care agency, the work environment will continue to be under the domain and control of the client.

Chemical Hazards

Chemical agents, certain pharmacological agents, and cleaning preparations present as hazards to the health care worker. In the hospital setting, worker exposure to these types of agents is often controlled via elaborate engineering devices such as scavenging or ventilation systems. In the institution work practices may are often restructured to accommodate such devices. In the home setting, however, it is more difficult even impossible to utilize such engineering measures to restructure work practices in order to reduce toxic exposure.

Many chemical and toxic agents found in the institutional setting are hazardous to the human body due to their carcinogenic, mutagenic, and teratogenic properties (DiBenedetto, 1995; McAbee, 1993; Rogers & Haynes, 1991). Agents such as formaldehyde, ethylene oxide, anesthetic gases, virucidal and bacteriocidal products, and antineoplastic agents are extremely hazardous to those who use them in their work. In the hospital setting, the major routes of exposure for these hazards are via inhalation of fumes, vapors, and dusts, or through contact with skin or mucous membranes.

Many of these agents are not present in the home environment and therefore do not pose a risk to HHCWs. However, antineoplastic agents are commonly used in the care of home health care clients consequently workers do have a potential for human exposure. Home infusion therapy and chemotherapy are now considered routine services provided by many agencies. While home infusion therapy and chemotherapy are convenient for clients and their families,

the risks to workers of exposure to antineoplastic agents exists in the preparation and infusion stage of the procedure, as well as in the disposal of contaminated wastes which includes the equipment and supplies used and the body wastes of the client receiving the treatment (EPA, 1990; Stevens, 1989; Weinstein, 1985). Safety mandates that the drugs are prepared in a laminar flow hood by a licensed pharmacist and delivered to the home by a licensed professional; they should never be prepared in the home setting. Once in the home, these drugs (which usually require refrigeration) must be stored away from food, cosmetics, and frequently used household areas (Stevens, 1989).

Crudi and colleagues (1982) found that a significant problem for home health care nurses who handle antineoplastic agents was the matter of contaminated waste disposal. Specifically, 90 percent of all nurses polled were not taking any precautions; they were simply throwing the waste down the drain.

The Joint Commission for the Accreditation of Health Care Organizations (JCAHO) issued the Standards for the Accreditation of Home Care Agencies in 1988. Included in these standards are outcome standards which address the use of hazardous substances in the home setting (JCAHO, 1988). Several recent text books on home care nursing practice (Keating & Kelman, 1988; Martinson & Widmer, 1989; Rice, 1992) spend only a minimal amount of time discussing the risks to home care workers administering antineoplastic agents and disposing of wastes.

Many agencies have established standards and policies for the

administration of antineoplastic agents and actually utilize only specialists in this involved procedure. This practice may be safer for the specialists who are familiar with the procedures and associated risks. However, this practice also magnifies hazardous exposure by increased frequency and duration for these particular workers. In the State of California, workers who administer antineoplastic agents or who are exposed to hazardous substances must receive training and education related to these substances on an annual basis. Smith and White (1993) found that although 86 percent of agencies surveyed in Northern California had formal policies, only 75 percent of agencies had any formal training or education regarding hazardous substances.

Virucidal agents are used to treat HIV associated illness and childhood viral respiratory illnesses. These agents pose a threat to the workers who administer them because they are delivered in aerosol form. While recent worker protection programs have been established and standardized in the hospital setting, similar concerted efforts have not been noted in the home care setting. Of home care agencies that provided respiratory aerosolized treatments, only 51 percent had formal written policies and only 47 percent had any formal training and education programs (Smith & White, 1993).

Other hazards in the home environment can result from exposure to the chemicals in the home for personal use by the client. These include such things such as pesticides, herbicides, insecticides, or chemicals associated with hobbies or other home activities like painting and home maintenance (e.g., de-greasing agents

or solvents). Even routine "under-the-sink" chemicals such as lye, bleach, and pine tar solutions can be hazardous if not used properly. The home health care worker must diligently assess the environment for chemical hazards.

Ergonomic and Physical Hazards

Physical injuries are a potential serious problem for all health care workers. Ergonomic related injuries, primarily back injuries, account for the greatest number of worker compensation claims in both the hospital and home health care setting (Behling & Guy, 1993; Fieldstein et al., 1993; Smith & White, 1993).

Health service workers suffered occupationally related injuries 1.4 times more frequently than workers in other service industries such as education, business, personal and legal services. The annual rate of occupational injury and illness per 100 full-time employees in health service work is 10.2 overall, yet for nursing and direct care employees it was 15.5 (DiBenedetto, 1995; U.S. Department of Labor, 1993). Back injuries from heavy lifting and improper lifting techniques are a significant problem and account for most lost work days (Garrett, Singiser & Banks, 1992; Venning, 1988). The magnitude of back pain in hospital workers is thought to be underestimated by use of accident reports of compensation claim data. A survey of 503 randomly sampled nurses found that 26 percent had experienced work-related low back pain without filing any report, compared to 12 percent who had filed at least one report (Owen, 1984). Fifty percent of all worker compensation injuries in a health care setting are usually

associated with the back (Meierhoffer, 1992;). Patient handling has been implicated in most studies of work-related back pain in hospital workers. Tasks required of nursing personnel and others who give direct patient care (e.g., radiology technicians, therapists, etc.) pose unique ergonomic problems. Patients tend to be heavy, inefficiently shaped for lifting, and lack convenient handholds. Furthermore, patients are unpredictable and may suddenly collapse or resist movement. Assistance in moving patients is often unavailable because of the urgency or emergency of the situation as well as due to under-staffing (Harber et al., 1985). The weight burden of transferring dependent patients often exceeds the maximal permissible load as defined by the National Institute of Safety and Health (NIOSH) (Fieldstein, 1993; DiBenedetto, 1995). More than 40,000 nurses report illness secondary to back pain, this amounts to over 764,000 lost work days (Garret, Singiser & Banks; 1992).

Williamson and associates (1987) and Hunt (1978) have reported that hospital employees are at risk from other physical hazards such as exposure to ionizing radiation which is used in a variety of diagnostic and treatment procedures. Health care workers are also at risk from non-ionizing radiation emitted from recently developed technology also used during client treatment programs such as, laser beams, microwaves and magnetic fields (DiBenedetto, 1995; Winburn, 1990). Excess noise, heat, and lighting problems are also considered to be physical hazards for hospital employees.

Home health care workers may face even more problems with ergonomic injuries. The problems are compounded by the fact that no one home environment is like another. Patient rooms or other work areas in the hospital environment are very standard and conform to strict local, state and federal requirements (e.g., building codes, fire codes, lighting codes, entry and egress codes, etc.). Stairways, doorways, windows, toilet facilities, counter top heights, flooring, lighting and heating, ventilation and air conditioning systems are usually uniform. If a problem arises in the hospital regarding any of these areas, then the hospital employee alerts the department or person responsible for the particular area. Breaches in this process often result in accidents or injuries. Although beds are uniform in the hospital setting and can be raised or lowered to accommodate the needs of the care-giver and client, back injuries associated with moving patients are of great magnitude. In the home environment there is no such uniformity, no department to call, and no one to rely on for personal safety except oneself.

There is little data available about the rate of ergonomic injury in home care workers. In a recent Northern California study home health agency directors were asked to rank the occupational injuries that had been reported over the last calendar year, back injuries were rated first, needle stick injuries were second, and musculoskeletal injuries other than back were rated third. Fourth on the list of injuries were motor vehicle accidents (MVAs) (Smith and White, 1993). Obviously, MVAs are not reported as a major injury in the hospital setting.

However, for the home health care worker who drives in a variety of neighborhoods and weather conditions, and generally under stressful time constraints, driving absorbs a major portion of the work day presenting a potential hazard (Smith & White, 1993).

Workers in home health care face challenges delivering care in unpredictable and non-standard environments. Procedures as complex and technological as wound care/dressing change, ostomy care, intravenous catheter care, administration of toxic drugs, and tracheostomy care, are often carried out in poorly lit, frequently cluttered, and marginally clean bedrooms or dining rooms. Often the procedures are done while leaning over large-sized beds or mattresses on the floor, all the time being watched by family members or family pets. Such is the nature of health care delivery in the home environment. If a worker assesses the environment and finds it hazardous, the worker must then inform the client of the problem and advise them to rectify the situation. It is also the worker's responsibility to report the hazards to the home care agency. However, because the worker is a guest in the home of the client, the situation is one of advisement or recommendation rather than a directive. Workers cannot force clients to change their homes. Nevertheless, agencies can refuse to send workers into home environments which are hazardous.

Psychosocial Hazards

Psychosocial hazards such as stress and violence are a significant and

potential risk in all health care delivery settings. Psychosocial hazards associated with hospital work are described in detail by Triolo (1989a, 1989b), Celentano & Johnson (1987), and McAbee, 1994. Psychosocial hazards are composed of factors both intrinsic and extrinsic to the job. Psychosocial stressors include physical and mental overload, job insecurity, role ambiguity, poorly designed work schedules, fearful and anxious client population, and numerous other facets unique to health care work (McCarroll-Bittel, 1985; Veninga, 1982). Stress has been described as a significant contributor to the injury and illness rates of hospital employees. Stressed workers make more mistakes and have more accidents, some of which involve and affect patients (Celentano & Johnson, 1987).

Of all the occupational health issues relevant to home care work, the issue of work related stress is one in which there is a fair amount published (Bartoldus, Gilley & Sturges, 1989; Bolle, 1988; Carr, 1989; Goodwin, 1987; Marvan-Hyman, 1985; McCarroll-Bittel, 1985; Smith, 1988; West & Savage, 1988a, 1988b; Zerwekh, 1990). Home care workers continually deal with emotionally demanding situations which often in high levels of stress. Workers tend to feel isolated when out in the field, especially when working with dependent and needy populations who most often are medically under-served (Bartoldus et al., 1989). Social support, although acknowledged as meager, is available in the hospital setting in the presence of peers and co-workers. Conversely, the worker in the home environment is somewhat isolated for most of the work day. Without support, the potential for burnout is high and turnover is common, especially in para-

professional workers (e.g., aides, attendants, homemakers etc.) (Berger & Anderson, 1984; Haemmerlie & Montgomery, 1982; Lynch, 1994).

Although job-related stress in home health care workers has been examined, little or no research has been done about the way workers cope with this stress. A majority of studies have been conducted from the perspective of administrators or clients, rather than from the point of view of the workers (Fashimpar & Grinnell, 1978; Hutchins, et al., 1978; Trent, 1986). West and Savage (1988) did describe sources of stress from the workers perspective; these included: 1) pressure of work, 2) difficult cases and visits, 3) feelings of helplessness and inadequacy, 4)lack of management support and recognition, 5) transportation difficulties, 6) difficulties with co-workers, 7) a lack of peer support, and 8) inadequate supplies or equipment.

Security Risk. Personal violence is a reality for all health workers it poses both physical and psychosocial risk. Although it is prevalent, increasing, and well recognized, until recently personal violence has not been acknowledged as an occupational hazard (Britt, 1992; California Dept. of Industrial Relations, 1993; Soloff, 1987). There is a need to describe and identify factors that can be predictive for violence in high-risk settings so that measures can be instituted to prevent further assaults. Recently there has been more interest in epidemiological inquiries into the prevalence of assaults and associated risk factors (Lipscomb & Love, 1992; Olson ,1994). However, as with most occupational illnesses and injuries, under-reporting is a problem especially if audits of records are used to

gather data. Under-reporting stems from the perception that assaults are part of the job for health care workers (Lanza, 1983; Lipscomb & Love, 1992; Madden, 1976; Poster, 1989). The Ontario Nurse Assault Survey found that only five percent of those nurses assaulted in Ontario filed workers compensation claims (Lisa & McCaskell, 1994; NAPT, 1992). Lion (1981) found that five times as many assaults occurred at a State psychiatric hospital as were reported. In fact, some sources have even suggested that violence towards health care workers is in some way precipitated by staff themselves (Lavoie et al., 1988). Others suggest that workers feel being assaulted somehow represents a performance failure and discourages workers from filing reports (Lion, Snyder and Merrill, 1981).

There are certain locations and personnel who are at greater risk for violence. In the acute care hospital, one work area that is at a greater risk than others for violent assaults is the emergency department. Patients and families present with injuries and trauma and are under an immense amount of stress. In addition, many injuries treated in the emergency department, especially inner-city emergency departments, are a result of violent crimes (Kurlowicz, 1990). Subsequently, the violence can extend into the hospital setting. Conn and Lion (1983) identified risk factors related to assaults by patients as: inadequate training, staffing patterns, time of day, and containment activities (Lipscomb & Love, 1992). Fottrell (1980) found that nursing staff are consistently assaulted at a rate greater than other workers. It is assumed the exposure is much higher for nursing staff as they spend more time interacting with patients as well as setting and

enforcing limits (Haller & DeLuty, 1988). Consequently, these individuals are at higher risk because of their work role or location and require resources to reduce or mitigate the risk.

Adequate security is an essential component in an assault prevention program. Regular meetings between security staff and health care workers are vital for discussing strategies for preventing violence in the high-risk locations (Lipscomb & Love, 1992). Education and training of health care personnel is by far the most common strategy in recognizing and preventing assaultive behavior (Poster, 1989). However, in the acute care hospital setting, less than 50 percent of administrators surveyed stated that their emergency department nurses receive formal training in recognizing and managing the violent patient (Lavoie, 1988, 1992).

The safety of employees who deliver care in inner city, crime ridden is a major concern for home health agencies who service these areas. Encountering weapon and drugs in the homes of clients is fairly commonplace (Nadwairski, 1992). While some of the previously described prevention strategies may not be transferrable to the home care setting, education and training is one appropriate strategy any home health care agency can easily initiate regardless of size or geographic area. Security personnel accompanying workers, while costly and cumbersome, is not uncommon. Some agencies which send staff into areas with high violent crime rates do send "escort/security persons" along with personnel (Condon, personal communication, 1991; McCarroll-Bittel, 1985; Nadwairski,

1992). However, this is not the usual practice for the majority of home health care agencies. Carrying noise alarms, two-way radios, spot lights, cellular phones, and mace while walking between car and client home may be appropriate. Once in the home, it would be almost impossible for a worker in trouble to communicate with emergency or security officials. Mobile phones are utilized by some nurses and staff entering high risk neighborhoods or territories. The reality of home care work is that there is a large group of workers, predominantly women, providing care in clients' homes in a variety of neighborhoods often at unusually dangerous times (evening and night hours).

Many of the clients of the home health care worker are already under an immense amount of stress due to their living arrangements. Their health condition further compounds this stress by adding a measure of unpredictability. The safety of home health care workers in the field is a realistic problem in many communities, often making it difficult to recruit qualified home care professionals.

Although recently published home health care text books focus on patient care and nursing practices, they give little attention to the personal safety hazard associated with home care work (Keating & Kelman, 1988; Martinson & Widmer, 1989; Rice, 1992). In a thorough review of the literature, there was no statistical data on the incidence of personal violence, either threats or actual assaults, and/or injuries in home health care workers. There is clearly a need to investigate this phenomenon from both an epidemiological focus and from the worker's personal experiences.

There are many hazards associated with health care work whether it is in the institution or the home. While some hazards are unique to one environment but not the other, other hazards are significant contributors to illness and injury in both environments. As described, occupational health issues in the hospital setting do not always parallel, the occupational health issues in the home environment. Yet, knowledge of hospital risks certainly aids in the assessment of home health care risks.

There is a wealth of occupational research and literature in regarding the hazards and risks of hospital workers which may be applicable to home health care workers. Conversely, there is a paucity of research on the occupational hazards and risks in the home health care industry. It is imperative that the health care needs of these workers be addressed. The explosive growth of the home health care industry, with more agencies entering the industry and employing more workers, places an increasing number of workers at risk. Occupational health researchers need to acknowledge the home environment as a workplace and assess the risks and hazards attendant to the work of health care in such an environment. Only with solid evidence can occupational health professionals lobby for necessary regulations and controls and to promote and maintain a safe work environment.

CHAPTER THREE

Theoretical Framework and Literature Review

Introduction

In order to explore the complex phenomenon of occupational risk as perceived by Home Health Care Workers (HHCWs), an appropriate theoretical framework must be selected to guide such an examination. The Symbolic Interaction (SI) framework provides an ideal framework for this purpose. SI is based on three premises relevant for this study:

1. Human beings act toward things on the basis of the meanings that the things have for them.
2. The meaning of such things is derived from social interaction with others.
3. These meanings are understood through an interpretive process used by the person in dealing with the things he encounters (Blumer, 1969).

The following three assumptions, that are relevant and complementary to the premises of SI, were used to guide this study of occupational risk perception in HHCWs.

First, the concept of risk in the work of home health care is essentially a social construct. Risk is a perception and definition of one or more attributes in

the work situation which is seen as hazardous or threatening. Such perception, though not necessarily universal, is frequently experienced, and attended to and dealt with in a variety of ways.

Secondly, the work of home health care is governed by rules and expectations associated with and affecting both worker roles and agency or organizational requirements. Such rules and expectations may impact on the home care worker's perception of work and the risks associated with work. In other words, the worker works for an agency and does not function in the work place independent of the needs of the agency. For example, agency rules determine what care is reimbursed and what is not, how long one can spend visiting a particular client, and how many clients are to be seen within a given work day. Also, the work role of a particular category of worker affects what can be done. For instance, the work duties and activities of the physical therapist are considerably different than those of the registered nurse or the home health aide.

Lastly, the coordination of clinical work and organizational requirements are best seen as accomplished within a context of negotiation between the HHCW and the client. This is essentially a symbolic interactional process. Although every worker going out to the client has to coordinate clinical work in terms of organizational requirements, there is still room for negotiation. For example, a nurse can negotiate with her supervisor for certain types of clients in her area of expertise, or, for more time with a client with a particular type of condition. Likewise, the nurse can negotiate with her fellow workers for work in geographic

areas or work with particular clients, or particular visiting times; most importantly, the HHCW worker must negotiate with and coordinate her work with the client.

Thus, a worker's perception of risk is a definition of workplace attributes as hazardous or threatening and it is related to the meaning that the attributes have for the worker. The meaning is derived from the worker's interaction with the self and others. Likewise, the work of home health care is a negotiated process, arrived at and decided on, in interaction with the multitude of participants in the work world.

With SI as a theoretical perspective, and with the above assumptions in mind, data were gathered to describe the circumstances or conditions under which home care workers perceive risk, what they see or fail to see as hazardous, and how they deal with or ignore it. Moreover, since hazards can be seen as ranging from slight to great, or from vague to specific, and from barely probable to imminent, this study reveals the complexity of risks and responses in HHC work.

The Historical Foundation of Symbolic Interactionism

The ideas that became known as Symbolic Interactionism were generated by scholars of philosophy, education and sociology during the late nineteenth century. The ideas emanated from intellectual thinkers exposed to major social change, in a world characterized by massive immigration and domestic migration, and when urbanization and industrialization were proceeding rapidly (Fisher &

Strauss, 1978). They sought ways to describe and explain individual and societal survival in the midst of such social restructuring.

The three major philosophical influences on the development of interactionist thought were pragmatism, Darwinism and behaviorism. All three emerged from the attempts of researchers to redefine the methods for studying social change.

These new concepts were called Social Interactionism, and later came to be known as Symbolic Interactionism. The concepts were blended to create an image of humans as conscious and deliberative beings, who attempt to adjust to the world around them. The process of adjusting was described as a recognition and retention of those characteristics that enable individuals to adapt to their surroundings. It was recognized that individuals not only adapt in themselves but simultaneously adapt their surroundings to facilitate survival and gratification. Symbolic Interactionism was an outgrowth of the attempt to characterize society as evolving and dynamic, where the individual was not only product of society but the producer of society.

The symbolic interactionism perspective is a blending of older traditions of American sociology, all of which were to varying degrees a product of the intense interest in social reform and reconstruction. George Herbert Mead codified his ideas and those of such other social thinkers as Dewey, James, and Cooley, to produce a synthesis that stands as the conceptual core of modern interactionism (Turner, 1986). George Herbert Mead was brought to the University of Chicago

by Dewey in 1894, but his major impact on sociologists did not begin until the 1920's (Fisher & Strauss, 1978). While Mead died in 1931 with few written expositions of his ideas and theories (Manis & Meltzer, 1972), a colleague of Mead's, E. Faris, and a graduate student of Mead's, Herbert Blumer, continued to teach Mead's work. During the 1930's and 1940's both men passed on their respective interpretations of the Chicago Sociological tradition to students (Fisher & Strauss, 1978). In 1934, aided by students and graduates, Blumer posthumously chronicled Mead's ideas in a work entitled Mind, Self, and Society (Mead, 1934).

This prolonged oral tradition, coupled with the fact that the major synthesizer of the theory, George Herbert Mead, was really more a philosopher than a theoretician, resulted in the development of numerous sub-theories and conceptual controversies (Blumer, 1969, 1980; Charon,1987; Fisher & Strauss, 1978; Kuhn, 1960; Manis & Meltzer, 1972; McPhail & Rexroat, 1979,1980). The conceptual and methodological differences prompted the divergence of Symbolic Interactionism into two major schools of thought; the Iowa school and the Chicago school (Manis & Meltzer, 1972).

Blumer took the Chicago perspective to the University of California, Berkeley, in 1952. His view espoused the inductive conception of human beings as active agents in constructing the social environment, which in turn influences their perceptions and behavior, thus further reconstructing the social environment. He emphasized the subjective aspects of the theory and identified interview and observation as the most appropriate methods to utilize the a SI framework.

The Iowa School, led by Manford Kuhn from 1946 to 1963, supported a more deductive approach, and adhered to a more positivistic paradigm. In keeping with this paradigm, the Iowa perspective attempted to operationalize some of the concepts proposed by Mead (Manis & Meltzer, 1972; Turner, 1986). Quantitative methods, that were related to Mead's concepts, such as the standardization of tools by which to measure significant variables, were accepted as the appropriate method for the Iowa school.

Between these two divergent perspectives, there is a welter of partial orientations and understandings which bear varying relationships to the original philosophizing/theorizing of Mead (Charon, 1989; Fisher & Strauss, 1978; Manis & Meltzer, 1972;). Modern sociological scholars such as Shibutani, Turner, Glazer, Denzin, Charon, Strauss, and Schatzman hold to the Symbolic Interactionist tradition more closely aligned with Blumer (Shalin, 1986). In contemporary sociology, Interactionism increasingly has come to mean "Symbolic Interactionism"; both critics and interactionists tend to utilize Blumer's version of Mead and of Symbolic Interactionism (Fisher & Strauss, 1978; Charon, 1989).

A majority of the previously mentioned thinkers were connected with the University of Chicago's Department of Sociology; this department, under the leadership of William Thomas and Robert Park, became world renowned for research in the area of social relations, especially race and urban relations (Fisher & Strauss, 1978). The mainstream of Chicago interactionist thinking stems from the writings and teachings of these early sociologists (Fisher & Strauss, 1978).

The Central Themes of Human Behavior within Symbolic Interactionism Perspective

Central Themes

Although there are two major schools of Symbolic Interactionism (Chicago and Iowa), the differences are largely methodological. Both accept the ideas of human behavior that were developed by Mead. Mead's ideas, while logically consistent, were never elaborated to the point of hypotheses or formal theory (Rose, 1962). The central themes as described by Charon (1989) and Warriner (1970) are:

Humans are symbol users. Symbolic interactionists place enormous emphasis on the capacity of humans to create and use symbols for communication. Unlike animals, language has liberated humans from instinctual and biological means of communication. Mead stressed language as being central to all human behavior and thought. Language is a human activity, a social symbolic activity which uses symbols to communicate and indicate meaning (Charon, 1989; Lindesmith, Strauss & Denzin, 1978). All human societies have languages. In spite of hundreds of different languages in the world and with numerous dialects within each, linguistic behavior is universal. Each language is complex, intricate and systematic - the carrier of a great wealth of experience and attitude (Judd, 1926). Language is passed down from generation to generation, non-biologically. Newborn infants are unable to speak their parents' tongue; They do not acquire the ability to do so as a result of maturation (Lindesmith, Strauss and Denzin,

1978). Language is learned only by living in a society. Like all other social skills, it must be learned within the context of a social group (Judd, 1926). Language is the outcome of common experiences of members of a social group. Mead described an interdependence between the individual and society; each individual depends on society for symbols. Without other people, each individual would be without a symbolic life and all the things that symbols make possible. But the reverse is also true: complex human society demands and depends on human symbolic life and language (Charon, 1989).

Humans use symbols to communicate with each other and create mutual social patterns. Because humans have the ability to interpret the gestures of others, they are able to anticipate the responses of others and adjust their behavior accordingly. Lindesmith, Strauss and Denzin (1978) describe this process as the actor imaginatively assuming the position point or point of view for another person. Mead (1934), termed this basic capacity as "role-taking"; it is the ability to see the other's attitudes and dispositions to act. Without this ability to read gestures and to use these gestures as a basis for putting oneself in the position of others, interaction could not occur (Turner, 1986). Without interaction, the development of humans and the patterns of social organization would not be possible.

Through interaction with society the self or person is created and acquires capacities. Conversely, because of these capacities the human is a creator of society. It is symbolic interaction with others that makes humans unique as a species and enables each individual to possess distinctive characteristics. For its existence, society is dependent on the capacities that humans acquire as they grow and mature. These human capacities were defined by Mead (1934) as the Mind and the Self.

Mead theorized that thinking is the work or activity of the Mind; as such, the Mind is not a structure but a process that emerges out of humans' efforts to adjust to their environment on a social level. Thinking is deliberation that interprets and assesses the significance of a phenomenon. Thinking allows humans to deal with conditions around them; it was theorized to be situational and dependent on context and temporality. Thinking was described as "talking to self"; an activity that requires the knowledge and use of language. Mind, as described by Turner (1986) is "the capacity to think, to symbolically denote, weigh, assess, anticipate, map, and construct courses of action" (p. 314). With the capacities of mind, humans can name, categorize, and orient themselves to constellations of objects, including themselves as object, in all situations.

The Self is derived from and defined in interaction with society. It is a relatively stable set of conceptions that people have about themselves (Turner, 1986). The Self is the object that people inject into their definitions of situations. It has also been referred to as self-image, self-concept or self-identity. It is the

view one has of oneself as object in a social situation. While it is recognized that one has a relatively stable idea of Self, a major identity, the individual does have other sub-identities which become actively dependent on the situation and context.

In summary, these themes constitute the core of the symbolic interactionist framework. Humans create and use symbols. They communicate with symbols. They interact through role-taking, which involves the reading of symbols emitted by others. What makes them unique as a species is the existence of mind and self, these human capacities arise out of interaction. Conversely the emergence of these capacities allows for the interactions that form the basis of society (Turner, 1986).

Major Concepts of Symbolic Interactionism Related to the Phenomenon of Risk Perception

From the central themes outlined above, the concepts most relevant to the phenomenon of risks perceived by workers in HHCW will be explained in more detail. These concepts are Interaction, Mind, and Perspective.

Interaction

Interaction is defined as human beings acting in relation to each other; taking each other into account, acting , perceiving, interpreting, and acting again (Charon, 1989). It is dynamic and relational in nature; there is no beginning or ending point. In context of the phenomenon, the HHCW acts in relation to those

persons who are part of their work world, i.e., clients, family of clients, colleagues, employers, and even their own family. The process becomes quite involved: 1) the situation and the individuals encountered are taken in to account by the worker, 2) the worker interacts with the individuals and the situation, (i.e., goes about the work), 3) the other individuals interact, 4) the worker perceives the situation as presenting risk or opportunities for risk, 5) the worker interprets what this means for him or her, and 6) the worker acts again according to the perception and interpretation. Such acts may result in a variety of responses including: 1) organizing and planning, 2) identifying hazards and associated risk, and 3) managing or manipulating the risk via work practices, escaping the situation, or even ignoring the perceived risk. One must recognize that this same interactive process is occurring simultaneously in others present in the work world of the home. The process of interaction, as outlined above, changes individuals, workers, clients, and families, and result in a changing work environment and society in general.

Mind

Interaction is not simply what is happening between individuals; it also denotes what is happening within individuals (Charon, 1989). The mind as interpretive process takes the perceptions of the HHCW in regard to his or her work, and interprets them as being risky or not. The worker's action is based on this interpretation and definition of the situation and the meaning it has for them.

The worker engages in a conversation or interaction with the self, in order to interpret the situation. The process attempts to consider all possibilities, probabilities and outcomes based on the proposed action. It is a constant comparative conversation, a mental trial and error process that takes place at a amazing rate of speed. This process, what is commonly called thinking, is called symbolic interaction in the SI framework. This is also what symbolic interactionists mean when they define Mind as a process, or as Blumer called it, "...conscious covert activity...." (Blumer, 1962, p. 181).

There is constant think-talk conversations with the Self, as one interacts in every situation encountered. In interaction with others, there is simultaneous interaction with the Self. As the worker participates in the work world (driving to the office, arranging the daily visits, driving to the homes, entering the home and providing the necessary care) the worker is in a continual conversation with the Self. From this conversation, the worker determines what is important or meaningful or immanent or dangerous in each situation. What is important in the context of this phenomenon is the question asked of the self, "what presents as a risk to me, what should I do about it, what if I do this, the outcome could or will be so and so, how will I manage that?" and so on.

Perspective

A perspective is an ordered view of one's world, a view about the attributes of various objects, events, and human nature. It is an order of things remembered and expected as well as actually perceived; it is the matrix through which one

perceives his situation (Charon, 1989). One's perspective comes from significant others and reference groups. Reference groups can vary from an individual such as a significant other, to groups of a few such as a craft club or hobby group, or to those that encompass thousands to millions such as a political party or a religion. Shibutani (1955) states that individuals can have many reference groups and can have many different perspectives, including different perspectives of the Self. For the individual, the perspective most operational and at the forefront at any one period in time depends on which group he or she is interacting with and the needs of the situation. HHCWs, as members of several reference groups, may have many perspectives operational at any one time as they go about their work. These may include the perspectives of a nurse, a woman or man, a religion, a parent, etc. Each role with matching identity will generally provide one or more perspective.

The beliefs and values paramount in one's life, including religious, political, philosophical, cultural and ethnic, can also offer perspectives to help define a situation. A particular perspective in any given situation may incorporate any one of these beliefs or values, or, as is more common, be a combination of the individual's beliefs and values; in fact they may even be in conflict with each other. Some perspectives are easily combined or merged, or, parts of the perspective are easily shared, while others are not. For example, caring for persons regardless of social status or belief is thought to be part of the perspective shared by nurses as a reference group. However, a fundamentalist Christian nurse may have difficulty caring for and dealing with a client who wishes a therapeutic abortion. The

nurse's perspective of Self as a good fundamentalist Christian is linked to her belief that abortion is murder and anyone that assists in the process is a murderer. This perspective may not easily merge with that of the collective perspective of nursing, and the nurse must decide what perspective will be foremost. This example of competing or incompatible perspectives seems fairly clear, but, a majority of the time the delineation or differences between and among perspectives is much more cloudy, even to the extent that the individual may not recognize it. Perspectives affect how one views a situation, especially when the definition or interpretation of a situation involves assessing for risk. A HHCW who has recently moved from the structured hospital setting, where work risks are more clearly defined and known, to the home care setting may have a different perspective in regard to the risks of home care work. From these few examples it is easy to understand why perspective can be an important concept in assessing the HHCW's perception of risk.

Symbolic Interactionism as it Relates to the Perception of Risk

In relation to the concepts outlined above, Symbolic Interactionism provides the most appropriate theoretical framework for the study of perceived risk in the workplace, especially when the workplace is the "home" and the work is that of human care. As described in the literature review, the home as a setting for the delivery of health care and as a work environment presents challenges to the worker that are unique and variable. Dynamics such as these are not usually

experienced in the traditional institutional work of health care, therefore it would be important to operationalize the process that determines risk perception under such dynamic and unpredictable work conditions.

Though the perception of the individual worker is the outcome of interest, the study focuses on the process from which the perception is derived. The workplace of the "home" contrasts to that of the hospital because it is more symbolic and personal. The home presents a multitude of symbols that remind the worker of the personal nature of the workplace. For example, the bed linens are unique to the client and are probably expressive of his or her taste, the equipment used for care may originate at times from the kitchen or bathroom cabinets, and often the clothing worn by the client at home is very different and more personal than that worn in the hospital. In addition, the social contract for care is different in the home because the care giver enters the home at the request and with the permission of the client; the worker role is that of a guest. The health care of individuals in the home environment involves social processes of the most intimate nature. Most of the care is given in the client's bedroom, which he or she may intimately share with another. The environment is filled with such personal objects as artifacts or photos of family, clothing, and even pets. Clients in the home give the worker more directions; they direct much of the flow of care and give instructions about how they want a particular dressing changed or how they wish their tracheostomy cleaned and changed. Consequently, they have much greater input into their care than does the patient in the hospital.

The perception and management of risk in the workplace is central to the health and welfare of HHCWs. Slovic (1987) states that the ability to sense and avoid harmful environmental conditions is necessary for the survival of all living organisms; it is an evolutionary necessity. Human survival and avoidance of danger is aided by the human adaptive capacity to codify and learn from past experiences. Humans can use this information to anticipate and interpret the possible or probable consequences of situations (acts and behaviors) through reflexive thinking-conversations with the Self. In contrast to animals, humans have the capability that allows them to alter their environment as well as respond to it (Slovic, 1987). HHCWs use these capacities and capabilities to assess risk and manage a safe work environment.

From a symbolic interactionist perspective, and in this study, risk is conceptualized as a social construction. It is a perception of hazardous attributes or dangerous situations in the workplace. In view of the unpredictable and dynamic nature of the home care environment, it is assumed that hazards are frequently encountered to the extent that the perception of risk is not always an overt process. The actual or potential dangerous situations are then variously dealt with and attended to via the covert process of symbolic interaction.

Risk assessment is a complex discipline, not fully understood by its practitioners, and even less by the lay public (Slovic, 1992). Risk perception and assessment researchers have been attempting to explicate the mentalistic interpretive process defined as risk perception for the last two decades (Slovic, 1987).

A review of the literature reveals very few studies where this mentalistic interpretive process has been described or explored within a sociological framework, and especially not within a symbolic interactionist framework. A majority of the research in risk perception is conducted from a epidemiological perspective and has been quantitative in nature, with a focus on statistical probability and prediction (Covello & Abernathy, 1984; Edwards,1961; Fischhoff, 1978; Starr, 1967; Tonn, Travis, Goeltz & Phillippi, 1990; Zeckhauser & Viscusi, 1990). Risk assessment and perception research is constructed from theoretical models which are based on assumptions and judgments and findings are analyzed using a variety of statistical methods that include factor analysis and regression (Slovic, 1986).

In contrast to the probablistic analyses described above, many researchers have attempted to develop a qualitative as well as quantitative approach to assess the complex and subtle opinion that people have about risk (Kahneman, Slovic & Tversky, 1982; Nisbett & Ross, 1980; Slovic, 1987; Slovic, Fischhoff & Lichtenstein 1981). Researchers have sought to discover what people mean when then say that something is (or is not) "risky", and to determine what factors underlie those perceptions.

Slovic (1987; 1992), Fischhoff and Lichtenstein (1976; 1979), and Fischhoff, Slovic and Lichtenstein (1979, 1978) have been prolific in their production of risk assessment research. In these studies they have used detailed and lengthy questionnaires to explore the individual's perception of risk, and their expressed

preference for various kinds of risk/benefit trade offs (Slovic, 1992). The questionnaires elicit both quantitative and qualitative data that include: magnitude estimates, numerical rating scales, traditional attitude questions, non-traditional word-associations and scenario generation. Data has been reported using both descriptive and statistical methods such as uni-dimensional and multi-dimensional factor analysis and regression. This general approach is collectively referred to as the psychometric paradigm (Slovic, 1992).

In working with the paradigm, Slovic and colleagues (1981) have proposed a set of mental strategies, or heuristics, that people employ in order to make sense out of an uncertain world. This process has been described as a set of steps one applies in decision making. It can also be applied to predict how one will assess a situation as risky. While this mentalistic process is valid in some circumstances, in others it has led to inaccurate predictions and outcomes (Slovic, 1992). The psychometric paradigm has its own assumptions and limitations. It assumes people can provide meaningful answers to difficult if not impossible questions ("What is the risk of death in the United States from nuclear power?"). It is important to note that in contrast to the current study of HHCW, the psychometric paradigm typically assesses cognition and not actual behavior. Data collection occurs in blocks of time and is far removed from the natural setting of the where the risk occurs.

One of the most important assumptions of the psychometric paradigm which the current study embraces, is that risk is inherently subjective. Risk does

not exist "out there", independent of minds and cultures, waiting to be assessed. Human beings have invented the concept "risk" to help them understand and cope with the dangers and uncertainties of life (Slovic, 1992).

There is no such thing as "real risk" or "objective risk." As a consequence, it is important to understand that all approaches to the study of risk assessment and perception have assumptions regardless of the qualitative or quantitative nature of research design and methods. The nuclear engineer's probablistic risk estimate of a nuclear accident or the toxicologist's quantitative estimate of a chemical's carcinogenesis are both based on theoretical models. Regardless of the discipline the structure of models is subjective and assumption-laden, and the researchers' inputs are dependent on judgement. Other researchers such as Glaser & Strauss (1967), Schatzman (1991), Strauss (1978), and Strauss & Corbin, (1990) have their own models, assumptions, and subjective assessment techniques. It was no accident in this current study that attributes and characteristics of what constitutes risk were left undefined. This was done to allow the inherent subjectivity of risk to be expressed by the participants.

Slovic (1992) claims that the psychometric paradigm encompasses a theoretical framework that assumes that risk is subjectively defined by the individual who may be influenced by a wide array of psychological, social, institutional, and cultural factors. A similar theoretical framework guides this study of HHCW. However, there are those (Tonn, Travis, Goeltz & Phillippi, 1990) who contend that while the psychometric paradigm encompasses such a

theoretical framework its design and methods do not necessarily support it.

Interestingly enough, where this study diverges from the psychometric paradigm is in design and method. Long, closed-ended questions on survey instruments, administered in stable controlled environments, cannot capture the human capacity to assess, problem solve (make decisions), and act in hazardous or dangerous situations. This study approached the task of uncovering and explaining risk perception from the vantage point of the decision makers (the workers) by observing and collecting data in the natural setting of the experience.

There are many positive correlates in the literature between beliefs of personal vulnerability and protective behavior (Janz & Becker, 1984; Kirscher, 1984). Conversely, there are studies that show that greater perceived susceptibility did not lead to greater action (Joseph, 1987; Kirscht, 1988; Leventhal, 1970). Recent literature gives evidence that a consistent optimistic bias exists concerning perceptions of personal risk. When asked about risks to themselves, people claim that they are less likely to be affected than their peers (Bauman & Siegel, 1987; Joseph, 1987; Weinstein, 1987; Weinstein, Klotz, Sandman, 1988; Weinstein, 1980). Optimistic bias is robust and widespread and appears with a diversity of hazards and samples (Weinstein, 1989). The phenomenon of optimistic bias in personal risk perception is important to consider because it may seriously hinder efforts to negotiate and manage risk (Weinstein, 1989).

Sociological research on risk perception such as that by Short (1984) and Keown (1989) claim that perception and acceptance of risk have their roots in

social and cultural factors. Short (1984) offers that response to hazards is mediated by social influences transmitted by reference groups. Benthin and associates (1988) examined perceptions of risk and benefit from thirty activities that put people at risk. Included were problem behaviors such as excessive drinking, smoking cigarettes, taking drugs, having unprotected sex, and socially approved risk taking such as playing contact sports and motor cycle riding. The results showed that participation in risk activities was related to cognitive and social perceptions. Cognitively, people who engaged in risky activity report greater knowledge of its risks, less fear of the risks, less personal risk, more personal control over risk, less ability to avoid the activity and higher participation in the activity by others. From a social viewpoint, participants in risky activities reported greater peer influence, less desire for regulation of the activity by authorities, and greater benefits relative to risk. It was also noted that highly dangerous activities are greatly admired. In a follow up study, Easterling (1989) applied sophisticated multi-dimensional factor analysis to the data and showed that people who are involved in multiple risky activities are more sensitive to peer or reference group influence, which may be related to the admiration factor noted above (Slovic, 1992).

Other studies in risk perception (Szalay & Deese, 1978) have explored ways to measure risk and associated stigma by using word-association technique to evoke the imagery, knowledge, attitudes beliefs, and affective states associated with specific environments (Slovic, 1992). Szalay and Deese (1978) claim that this

technique is an efficient way of determining the contents and representational systems of human minds without requiring those contents to be expressed in full discourse. The assumptions and theory underlying this approach is of interest to the current study. Based on Goffman's work (1963), the Stigma Study examined the stigmatization of a community secondary to perceived hazards and risks evident in the community.

Stigmatization, as it is noted by Goffman (1963), denotes a victim "marked" as deviant, flawed, spoiled, or generally undesirable in the view of some observer. When the stigmatizing characteristic is observed, perception of the "victim" changes in a negative way. Prime targets for stigmatization are members of minority groups, or the communities where a majority of the population are members of minority groups. The groups include such persons as: 1) the aged, 2) persons afflicted with physical or mental disabilities and deformities, and 3) behavioral deviants such as criminals, drug addicts, homosexuals, and alcoholics (Goffman, 1963; Slovic, 1992). In the Szalay and Deese (1978) study, the "victim" was the environment. Stigma along with increased or exaggerated perception of risk was reported by participants in reaction to a toxic chemical spill. In the case of the current HHC study, the phenomenon of increased or exaggerated risk perception in reaction to social stigmata may be a factor to consider. This is especially evident if one considers how closely the client population of home care work matches those groups or persons identified by Goffman (1963) as prime targets. Thus, not only are the client population subject to stigmatization, but the

environment and homes in which they live may also be subject to stigmatization. Such stigmatization is influenced and enhanced by the media, and home care workers may be influenced to the point of perceiving exaggerated or enhanced risk when in these areas. It is unclear whether workers are stigmatizing clients and neighborhoods or whether it is more a case of negative stereotyping. Never the less it is believed that negative stereotyping tends to be a precedent with stigmatization being the consequence (Goffman, 1963).

A review of risk perception literature reinforces a symbolic interactionist framework in that the literature describes risk perception as a mentalistic interpretive process. It further defines the process as one that involves the awareness, the recognition, and the ascribing of meaning or significance of the particular situations. The process is not easy for the individual to explicate because it is mostly a covert process. This deliberative process of negotiating a safe environment can be explained as symbolic interaction.

While this mentalistic process sounds very predictive for behavior, it has been shown to be fallible. It is fallible from the symbolic interactionist perspective because the research did not take into account the capacity of the Self to have various self-identities. The ability of individuals to have a repertoire' of self-concepts which are dependent on situation and context may contribute to the phenomenon of optimistic bias. In turn optimistic bias is based on the assumption that vulnerability is related to self-concept. Furthermore, the majority of researchers did not acknowledge the role of reference group membership and perspective.

Tonn and colleagues (1990) add that past research in risk perception can be extended in a number of ways that allow subjects more flexibility in expressing their risk beliefs. They add that the factor analytic method restricts subjects to the use of only those concepts and risk agents that are provided within the questionnaire. They call for more qualitative, nonempirical data collection studies. Empirical studies have typically tested how well subjects' estimation probabilities of risky events correspond to objective probability estimates, and whether subjects manipulate probabilities according to the rules of probability theory (Tonn, Travis Goeltz & Phillippi, 1990). However, it is obvious that due to inherent subjectivity, subjects' empirical risk perceptions are typically inaccurate (Tonn, Travis, Goeltz, & Phillippi, 1990). While research of this nature has been very important to advance the knowledge base, it has done little to address how people symbolically represent and manipulate risk beliefs. Most likely, the "word association" method and stigmatization research comes closest to capturing risk as a symbolic entity.

Summary

The phenomenon of risk perception is complex. It is assumed to be a mentalistic interpretive process and a covert trial and error thinking process, which home care workers experience in interaction with the environment and significant others in the workplace. This researcher contends that the symbolic interactionist framework best describes and explains it as a "vast interpretive process in which people singly and collectively guide themselves by defining the objects, events, and

situations they encounter (Blumer, 1969, p. 132)." Studies in risk perception have not acknowledged the framework of Symbolic Interactionism as a guide for explorations of why and how persons perceive themselves at risk. This study examined risk perception in unpredictable work environments within a symbolic interactionist framework for the purpose of revealing some otherwise unknown characteristics of the deliberative and interpretive process known as risk perception. It also attempted to explore how people symbolically represent and manipulate risk beliefs.

CHAPTER FOUR

METHODOLOGY

The purpose of this chapter is to describe the methodology used for this study and to discuss how the data were analyzed. Chapter Four is divided into four sections: (1) the research design; (2) the research method; (3) data collection methods; and (4) data analysis methods.

RESEARCH DESIGN

A naturalistic study explored the perceptions of home health care workers regarding the dangers and attendant risk perception by them in their work. A descriptive inductive approach is most relevant in studies with phenomena that are either under-investigated or unexplored, as in the present area of study (Aamodt, 1983; Chenitz & Swanson, 1986; Schatzman & Strauss, 1973). Qualitative methods are used to describe and interpret to the greatest extent possible the phenomenon of interest from the participant's viewpoint (Leininger, 1985). The characteristics of a qualitative design include: 1) paying attention to the social context in which events occur and have meaning, 2) putting an emphasis on understanding the social world from the viewpoint of the participants, 3) using a primarily inductive approach, and 4) data collection techniques that include interviewing, participant observation, and sampling of supportive documents and other printed material (Cobb & Hagemaster, 1987).

RESEARCH METHOD

The grounded dimensional approach (Glaser & Strauss, 1967; Schatzman & Strauss, 1973; Schatzman, 1991; McCarthy, 1991)) was used to collect, code, and analyze data. Relevant for studies looking at unexplored phenomena, the grounded dimensional approach offers an interactionist perspective for describing and examining the complex human experience and its context. The approach is designed to systematically investigate data gathered in a natural setting. Moreover, the method allows for in-depth examination of conditions under which the phenomena occur as well as the contexts and circumstances for variation and impending consequences (Glaser, 1978; Schatzman, 1991). The term "grounded" refers to theory evolving from data rather than from prior theoretical understandings.

The dimensional analysis approach to grounded theory is built on the central ideas and premise of grounded theory as developed by Glaser and Strauss (Glaser and Strauss, 1967; Glaser, 1978; Strauss, 1987; Schatzman, 1991). Despite grounded theory's centrality to dimensional analysis, dimensional analysis has it own unique procedures, epistemological assumptions, and logic. The qualitative approach to theory development mandates that the research question be explored without a preconceived theoretical framework, as the terminal objective is to generate theory, not to test theory (Strauss & Corbin, 1991). Dimensional analysis and grounded theory methods come from the philosophical perspective of

Symbolic Interactionism, the major premises and concepts relative to this study of which were outlined in the previous chapter.

RESEARCH SETTING AND SAMPLE

Research Setting

The research was conducted in the work environment of home care. This environment included: 1) the home care agency and its physical environment, 2) the community in which the agency is based, 3) the community in which the client lives, and 4) the home and property of the client.

Three home care agencies were selected that serve client populations in various geographic settings that are representative of rural, urban, and inner city locations. The various geographic settings addressed the attendant hazards assumed to be related to geographic location. For example, rural areas have less travelled and maintained roads, homes are more isolated, and assistance is not as readily available. In inner city areas, parking may be more difficult, there may be a greater incidence of crime and violence, and living conditions are usually more crowded and stressful.

Contacts were established with the following HHC agencies: 1) a large non-profit, hospital based, home health care agency serving the suburban and inner city areas of a large metropolitan area in Northern California with an estimated

visit rate of 10,000/month; 2) a medium sized hospital-based home care agency of a hospital that provides service to rural and suburban clients in a southern portion of a North Bay county, with an estimated visit rate of 1,200/month, and 3) a medium sized hospital-based home health care agency that provides service to rural and suburban clients in a northern portion of a North Bay county with an estimated visit rate of 1,200/month.

The Research Sample

Human Subjects Assurance

Approval for the study was obtained from the Committee on Human Research at the University of California, San Francisco (H6399-09935-01), and from the administration of each home care agency (Appendix B). The approval included consent forms and observation criteria. Research approval was obtained in writing from the chief executive officers of the participant agencies.

Written consent was obtained from all home health care workers and administrators participating in the study (Appendix C). The client of the home care agency was not an informant in the study and was not interviewed. However, because the researcher entered the client's home to observe care, oral consent from the home care agency client was obtained (Appendix E) in a manner that complied with agency policies and with the criteria established by the Committee on Human Research at the University of California, San Francisco. When the worker's case load was known, clients were informed by phone the day prior to the

visit that a nurse researcher would accompany the worker and oral consent was obtained at this time. If the worker's case load was not known, clients were asked for permission for me to accompany the worker when the calls were made to schedule the time of the visit. In only one instance did a client refuse to have me accompany the worker into the home. In this case I waited in the worker's car for the worker to complete the visit.

Several measures were undertaken to assure confidentiality of participants during the study. The procedure for maintenance of confidence of the interviews and audiotapes was explained to each participant. No names were used on any forms or during audiotaping. Audiotapes were transcribed as soon as possible following the interview. Only code numbers or pseudonyms were used on any written material. All data was/is kept in a locked file. All participants were assured that none of the information shared or observed would be available to personnel in the agency where they are employed so that their work status would not be threatened in any way by their responses. I explained to participants that any reporting or publication of study results would not include their names and that the information would be reported in such a way that they will not be identified. The consent forms clearly explained all of the above considerations. Clients of the home health care agency were assured that consent or refusal to allow the researcher to be present during their care would in no way affect or impact on the current or future care they receive from the agency. All participants were encouraged to ask questions about the study, and were told that

they had the right to refuse to answer any questions or withdraw from the study at any time. None of the participants refused to answer any of the questions and none withdrew from the study.

Nature and Size of Sample

A convenience sample was composed of home care nurses, and nurses aides/attendants who provide care for clients in the home setting. In addition home health care administrators/managers were invited to participate. Criteria for selection of participants included those individuals over the age of 18 who could understand and communicate in English and who agreed via verbal and written consent to participate in the study. The worker category was limited to the two groups (nurses and home health aides) who make the majority of home visits and who spend the greatest amount of time working in the clients' home (Rice, 1993) so as to best capture the nature of home care work. Sampling for the complexity and mix of clients was a consideration. No active measures were taken to recruit workers who saw clients with particular diagnoses or complexity of care, but I did theoretical sampling in an informal manner, and no formal client demographics were obtained.

With the permission of the agency, I attended staff meetings in all three agencies and gave a brief presentation of the study to the workers. The presentation emphasized the purpose and need for the study, a description of data collection techniques, and measures to protect anonymity and confidentiality. I

requested that volunteers who wished to participate in the study contact me in person or by phone.

The sample size in grounded dimensional analysis is similar to that in grounded theory method and is determined by how rich and complete the data is in describing the emerging dimensions and perspective. Twenty nine home health care workers were interviewed and/or observed in interaction with numerous clients in a variety of settings and environments; these interactions are referred to as sample incidents. That is, each client visit became a sample incident because it necessitated the worker entering a different environment and dealing with a different client/family, a different diagnosis and plan of care, in a different neighborhood or home. The number of sample incidents observed by the researcher was 102. There was an attempt to obtain an equal number of interviews in each type of setting (rural, suburban and urban) and with each category of worker. As in grounded theory research, the general rule in dimensional analysis is to sample until saturation of each dimension is reached and no new data are generated (Glaser, 1978; Glaser & Strauss, 1967; Schatzman, 1991; McCarthy, 1991).

Participant Characteristics

Such characteristics as age, sex, education, and length of time in home care, and previous nursing work experience were assessed for each worker. In addition, years of work experience in home care as a provider of care and as an administrator were elicited from administrators (Table 1).

TABLE 1: PARTICIPANT CHARACTERISTICS

#	Educational Preparation	Age	Sex	Race	Territory	Years Health Care	Years Home Health
1	Certified Aide	33	F	C	Rural/Suburban	6	3
2	Diploma RN	50	F	C	Rural/Suburban	30	10
3	Certified Aide	33	F	C	Rural/Suburban	3	3
4	Masters RN	29	F	H	Rural/Suburban	5	0.5
5	Bachelors RN	40	F	C	Rural/Suburban	23	15
6	Bachelors RN	35	F	C	Rural/Suburban	8	5
7	ADN RN	47	F	C	Rural/Suburban	15	3
8	ADN RN	42	M	C	Rural/Suburban	15	3
9	Masters RN	43	F	C	Suburban/Urban	8	2
10	Diploma RN	64	F	C	Suburban/Urban	40	14
11	Certified Aide	55	F	C	Rural/Suburban	3	0.7
12	Masters RN	43	F	C	Suburban/Urban	19	6
13	Bachelors RN	36	F	A	Suburban/Urban	8	6
14	ADN RN	44	F	C	Rural/Suburban	19	4
15	Bachelors RN	41	F	C	Suburban/Urban	8	8
16	LVN	45	F	C	Suburban/Urban	23	6
17	Certified Aide	23	F	L	Rural/Suburban	1	0.7
18	Bachelors RN	38	F	C	Suburban/Urban	12	5
19	ADN RN	44	M	C	Suburban/Urban	13	3
20	Bachelors RN	34	F	C	Rural/Suburban	12	3
21	LVN	49	F	C	Suburban/Urban	30	9
22	Bachelors RN	43	F	A	Suburban/Urban	15	10
23	Certified Aide	54	F	A	Suburban/Urban	15	10
24	Certified Aide	32	F	A	Suburban/Urban	3	2
25	Bachelors RN	40	F	C	Rural/Suburban	18	10
26	Bachelors RN	33	F	C	Rural/Suburban	10	5
27	Masters RN	54	F	C	Suburban/Urban	30	3
28	Bachelors RN	42	F	C	Rural/Suburban	20	15
29	Certified Aide	42	F	C	Rural/Suburban	12	4

C = Caucasian A = African-American L = Latino

TABLE 2: CHARACTERISTICS OF NURSES

#	Educational Preparation	Age	Sex	Race	Years Health Care	Years Home Health
1	LVN	45	F	C	23	6
2	LVN	49	F	C	30	9
3	Diploma RN	64	F	C	40	14
4	Masters RN	43	F	C	19	6
5	Bachelors RN	36	F	AA	8	6
6	Bachelors RN	41	F	C	8	8
7	Bachelors RN	38	F	C	12	5
8	Associate Degree RN	44	M	C	13	3
9	Bachelors RN	43	F	AA	15	10
10	Diploma RN	50	F	C	30	10
11	Masters RN	29	F	L	5	0.5
12	Bachelors RN	35	F	C	8	5
13	Associate Degree RN	47	F	C	15	3
14	Associate Degree RN	42	M	C	15	3
15	Associate Degree RN	44	F	C	19	4
16	Bachelors RN	34	F	C	12	3
17	Masters RN	43	F	C	8	2
18	Bachelors RN	40	F	C	23	15
Mean ($\bar{x}$)		42.60			16.80	6.25

C = Caucasian AA = African-American L = Latino

TABLE 3: CHARACTERISTICS OF HOME HEALTH CARE AIDES

#	Educational Preparation	Age	Sex	Race	Years Health Care	Years Home Health
1	Certified Aide	33	F	C	6	3
2	Certified Aide	33	F	C	3	3
3	Certified Aide	55	F	C	3	0.7
4	Certified Aide	23	F	L	1	0.7
5	Certified Aide	54	F	AA	15	10
6	Certified Aide	32	F	AA	3	2
7	Certified Aide	42	F	C	12	4
Mean ($\bar{x}$)		38.80			6.14	3.34

C = Caucasian AA = African-American L = Latino

TABLE 4: CHARACTERISTICS OF MANAGERS

#	Educational Preparation	Age	Sex	Race	Years Manager	Years Health Care	Years Home Health
1	Masters RN	54	F	C	3	30	3
2	Bachelors RN	40	F	C	2	18	10
3	Bachelors RN	33	F	C	3	10	5
4	Bachelors RN	42	F	C	9	20	15
Mean ($\bar{x}$)		42.25			4.25	19.50	8.25

C = Caucasian

Of the 29 participants, 4 were managers and of the 25 direct care workers, 18 were nurses; this included 16 registered nurses (RN) and 2 licensed vocational nurses (LVN). The licensed vocational nurse worker category was collapsed into the registered nurse worker category because in all three agencies they provided direct skilled nursing care and, therefore, were assumed to have the same work experiences as registered nurses. This category is referred to as the nurse category.

Nurse participants range in age from 29 to 64 with a mean of 42.6 years (Table 2). All but two of the nurses are female. Fifteen (83%) of the nurses are Caucasian, two (11%) are African-American, and one (6%) is Hispanic. The total years of nursing experience per nurse participant range from 5 to 40, with a mean of 16.8 years. Nurse participant years of experience in home health care range from 6 months to 15 years with a mean of 6.25 years. In regard to educational background, two are licensed vocational nurses, two are diploma nurses, four hold associate degrees in nursing, nine are baccalaureate prepared, four are presently continuing their education at a graduate level in nursing or a related field, and two nurse participants hold graduate degrees in nursing. Eight (44%) nurses work in agencies that provide visits to the rural and suburban setting and ten (56%) work in agencies that visit clients in the suburban and urban/inner-city areas. The majority (14) or 78% of the nurse participants work as generalists and four (22%) work as specialists in the areas of hospice, H.I.V./hospice, enterostomy/wound, and respiratory care. Of the nurse participants, two regularly work the evening shift

and were interviewed and observed on that shift. Three regularly work the weekend day shift; these were also interviewed and observed on the weekend. Four of the 18 nurses had worked at least one night shift, or had been called out during the night in the past calendar year.

Seven home health care aides (HHA) participated in the study (Table 3). Home care aide participants range in age from 23 to 55 with a mean age of 38.8 years. All of the aides are women, four are Caucasian, two are African-American, and one is Hispanic. The total years of health aide experience per participant ranges from 3 to 15 with a mean of 6.6 years. Years of health aide experience in home care per participant ranges from eight months to ten years with a mean of 3.3 years. All seven of the home health aides are certified (certified Aide). Of the seven aides five work for agencies that provide care to clients in the rural and suburban areas, while two work for agencies that visit clients in the suburban/inner-city areas. Of the home health aide participants, two regularly work the weekend day shift and were interviewed and observed at that time. The aides are more likely to work weekends as part of their job requirement than are the nurses.

The four administrator/managers who participated in the study (Table 4). range in age from 33 to 54 with a mean of 42.2 years. All of the administrator/manager participants are female, their total years of nursing experience per participant range from ten to 30 years with a mean of 19.5 years. Total years of home care experience range from five to 15 with a mean of 8.2

years; total years of administrator/manager experience in the home care industry range from two to nine years with a mean of 4.2 years. Regarding education three administrators are baccalaureate prepared and one holds a master's degree in health sciences/business. Of the administrator participants, two routinely work one to two weekends a month, and all occasionally go out with workers to visit clients, as part of the orientation process or as problems arise.

Data Collection

Methods

The grounded dimensional approach encompasses multiple sources and methods for data collection. Data sources and collection strategies vary depending upon the nature of the study being conducted. The research strategies that were used in this study included participant observation in the work activities of home care workers, and semi-structured interviews with home care workers and home care administrators.

Observation

Participant observation is the strategy of "being in or around an ongoing social setting for the purpose of making a qualitative analysis of that setting" (Lofland, 1971, p. 93). It is a "method in which the observer participates in the daily life of the people under study---observing things that happen, listening to

what is said, and questioning people, over some length of time" (Becker & Geer, 1970, p. 133).

In depth observation of home care nurses and nurse aides as they went about their work activities provided data on a great range of verbal and non-verbal behaviors. I recorded observations at the time they happened or immediately following observation periods. The kind of things observed and noted were the sequencing of work such as: receiving the assignment, arranging for visiting times via phone, driving through communities to homes, entre' into the home, various nursing care activities in the home, and exit from the home. More subtle things were observed, such as verbal and non-verbal interactions amongst agency personnel, and between the client and the worker, and the worker and other individuals in the home. Detailed observations concentrated on the particular work chores and activities once the worker entered the physical environment of home care, namely the neighborhood and the home.

Observations were recorded in field notes and organized as : 1) observational (ON), 2) theoretical (TN), or 3) methodological notes (MN) (Schatzman & Strauss, 1973). Observational notes record events as they happen through observation and listening. As pure description of things said or done in the context, there is no interpretation of the events as recorded. Theoretical notes record interpretations of meanings of events observed that have conceptual importance. As a running account of the investigator's analytical thoughts, they serve as preliminary analysis. Methodological notes record the process of the

research investigation. The following are examples of such notes that I took on the way to a clients' home.

> ON: Very foggy and damp, winding way through heavy morning traffic, heading out way into the country, parking is adequate around the home. Did not lock up car. Can see lady sitting in wheelchair waiting for aide to arrive. Small older home, small rooms and narrow hallways, no doors on bathroom door to accommodate wheelchair.
>
> TN: Must check if there are different actions dependent on where the client lives, i.e., when do you lock and when do you not? Where one parks or does not park. I guess home care people have to be careful about the clients' property, what happens it they damage or destroy a clients' property?
>
> MN: Taping in car works but radio on at the same time is a major problem, I will have to ask them to keep radio off or down. Also I think a mike attached to the lapel will be better than me holding one.

An additional component of field-note recording is "Memoing". Memos are separate from the text of the filed notes, the memo serves as an expansion of a conceptual idea (Schatzman & Strauss, 1973) (Appendix F).

Interviews

Interviewing is most valuable to elicit people's beliefs, attitudes, values, knowledge, perceptions, or other subjective orientations or mental content (Gordon, 1980). Patton notes that, "The fundamental principle of qualitative

interviewing is to provide a framework within which respondents can express their own understandings in their own terms" (1980, p. 205). The semi-structured interview is best for exploratory studies and was the approach used in this study. An interview schedule consists of a list of information required from each respondent (Appendix D). The process of obtaining the information was fitted to the nature of each respondent and did not always follow the prescribed format. Important issues not included in the format were pursued when they come up in the interview.

Semi-structured interviews were conducted and audiotaped with permission of the worker (Appendix C). Interview questions included topics that elicited the following information about health care work: comparisons between various other health care and home care jobs, descriptions of the typical types of tasks and duties of home care work, negative and positive experiences related to work, descriptions of vulnerable situations and techniques used to manage vulnerable situations. If the worker expressed discomfort with or refused to be audiotaped, I was prepared to take notes. However, no participant refused to be audiotaped. The completed interviews were transcribed.

Theoretical Sampling

As dimensions rose from the data they served to direct me to subsequent data to be collected and where to find it (Glaser & Strauss, 1967), to sample in greater depth certain events or characteristics I believed would enhance the

emerging theory. Theoretical sampling increases validity and reliability through the discovery of variation. By seeking variability in populations or events guided by the emerging theory, increased theoretical opportunity allows for the making of comparisons and enhances the establishment of linkages (Glaser, 1978). I used theoretical sampling to enhance the reliability of this study through sampling in a variety of geographical areas, in a variety of agencies, various categories of workers (and administrators), and workers on various shifts with various professional experience and educational background.

Procedure

The initial phase of the research and data collection began with gaining entre' into the research environment, specifically, the home care agencies that served clients in a variety of geographic locations. Once entry into the setting was established, I arranged to attend staff meetings to familiarize staff with me and with the study. In the meetings, I briefly described the study, answered questions about the study and invited volunteers to participate in the study. While attending staff meetings I made general observations that identified selected individuals and situations crucial to specific research questions (Schatzman & Strauss, 1973).

The next part of the study consisted of arranging to accompany workers as they went about their work of delivering care in the homes of clients. I accompanied the workers as they drove through the community on the way to client homes. At this time, I made cursory evaluations and observations of the

community and neighborhood to identify general characteristics. Interviewing began at this time, soliciting demographic information before interview questions were initiated.

The semi-structured interviews of home care workers and administrators comprised the second aspect of data collection. Workers and administrators were interviewed at a time that did not interfere with the flow of work or the delivery of care to the client. Mostly, I interviewed workers in the car as we drove from agency to client and client to client. Interviews were begun or completed as we ate lunch, or while sitting in the parking lot at the end of the day. Interviews with administrators took place in their offices at the respective agencies. Interviews ranged from one to 2.5 hours. Interviews that took place in the worker's car on the way to client visits were interrupted but it did not affect the character or quality of the data. In many cases these interviews were richer because the event of the home visit or the nature of the environments through which we drove stimulated questions and encouraged spontaneous worker opinions and explanations. The completed interview data was transcribed as soon as possible after the interview so as not to lose some of the nuances experienced during the interview process not picked up by the audio tape format.

The final step in the procedure consisted of careful observations of workers as they went about their range of work activities. No interviews were conducted in the homes of clients; descriptions of what was said and done by those being observed were recorded in field notes as described earlier.

Data Analysis

While the grounded theory approach is an established and known analytic method the dimensional analysis approach to data analysis is relatively new. As such it is important to describe this unique approach in more detail. First, it is relevant to understand the historical context of the evolution of dimensional analysis. Second, the assumptions of the method are outlined and finally the working tool, the matrix with its various components are explained in more depth.

Historical Development

The dimensional analysis approach was developed by Leonard Schatzman and emerged from an enduring interest in developing a general theory of analysis for interpretive acts. His concern as a qualitative researcher and graduate student mentor was to develop a method that lends itself as readily to analyzing data from interpretive research as to the explanation of routine interpretive acts (McCarthy, 1991; Schatzman, 1991). The approach operates from the assumption that analysis is a natural, generic process of thinking and evaluating which is learned very early in human development. The development of this analytic social process is congruent with language development and is practiced and experienced constantly from birth (McCarthy, 1991; Schatzman, 1982; 1986; 1991). Schatzman (1991) believed that there is a model for analysis that is as useable for the scientist as was the generic process of analysis is for the individual.

The development of the grounded theory approach to qualitative investigation by Schatzman's colleagues and fellow researchers, Glaser and Strauss (1967) influenced him and provided a workable framework to critique while developing his own ideas (Schatzman, 1991).

Eventually Schatzman's personal experiences as a mentor for graduate students doing field research contributed most to the development of dimensional analysis. In his fieldwork classes he consulted with numerous students who used the grounded theory method with varying degrees of success. In assisting students to develop strategies that facilitated use of the grounded theory method, he was able to generate several assumptions which serve as a basis for dimensional analysis (McCarthy, 1991; Schatzman, 1991)

Dimensional Analysis

In grounded dimensional analysis the interest is in: 1) gathering data about what persons do or do not do in terms of action/interaction, 2) the range of conditions that give rise to that action/interaction and its variations, 3) how conditions change or stay the same over time and with what impact, and 4) the consequences of either actual or failed action/interaction or of strategies never acted on (McCarthy, 1991; Schatzman, 1991; Strauss & Corbin, 1990). The theory that emerges inductively is grounded in the empirical data from the phenomenon under study and remains closely connected to the data. Throughout the process of data collection analysis occurs simultaneously. A story or theory is generated by: designating data and creating dimensions, differentiating dimensions, creating

perspectives and assigning position in the explanatory matrix (Figure 1), and integration or reconstitution (McCarthy, 1991; Schatzman, 1991; Strauss, 1987).

Assumptions

Schatzman's first assumption was that research analysis is no more than an extension and elaboration of ordinary thinking, a natural analysis, that is called into use when situations arise for the individual that are problematic and where action is required (Schatzman, 1991). The individual is not aware of the process. An event occurs, for example, one cannot find a parking spot; one does not overtly say or consider "...now I have to go to problem solving mode." However, the instant one realizes that a problem exists, such thoughts come streaming, "what will I do?", "what is going on here?", "who or what is involved"? "why is this happening"? "what are the possibilities? These questions and more lead the individual to a course of action and/or explanation for what has happened. It is a process that home care workers activate continually as they go about their work in numerous problematic situations and unpredictable environments.

Schatzman's second assumption is that models, theoretical and methodological, are very helpful and important guides in the analytic process in both a scientific and natural context. This assumption arose out of the recognition that if individuals are faced with problematic situations that require decisions or actions, they decide or act with greater expediency and success if they have the structure and guidance that a philosophy or theory can offer. The importance of

theoretical and methodological models is more evident when the situation becomes more problematic. Then there is a greater need and urgency to find a substantive model that gives a "name" to the situation and a methodological model that gives a means of working through it (McCarthy, 1991). What happens if there are no existing models suited to the situation at hand? The analyst must then resort to natural methods to construct a "story" or explanation (Schatzman, 1991).

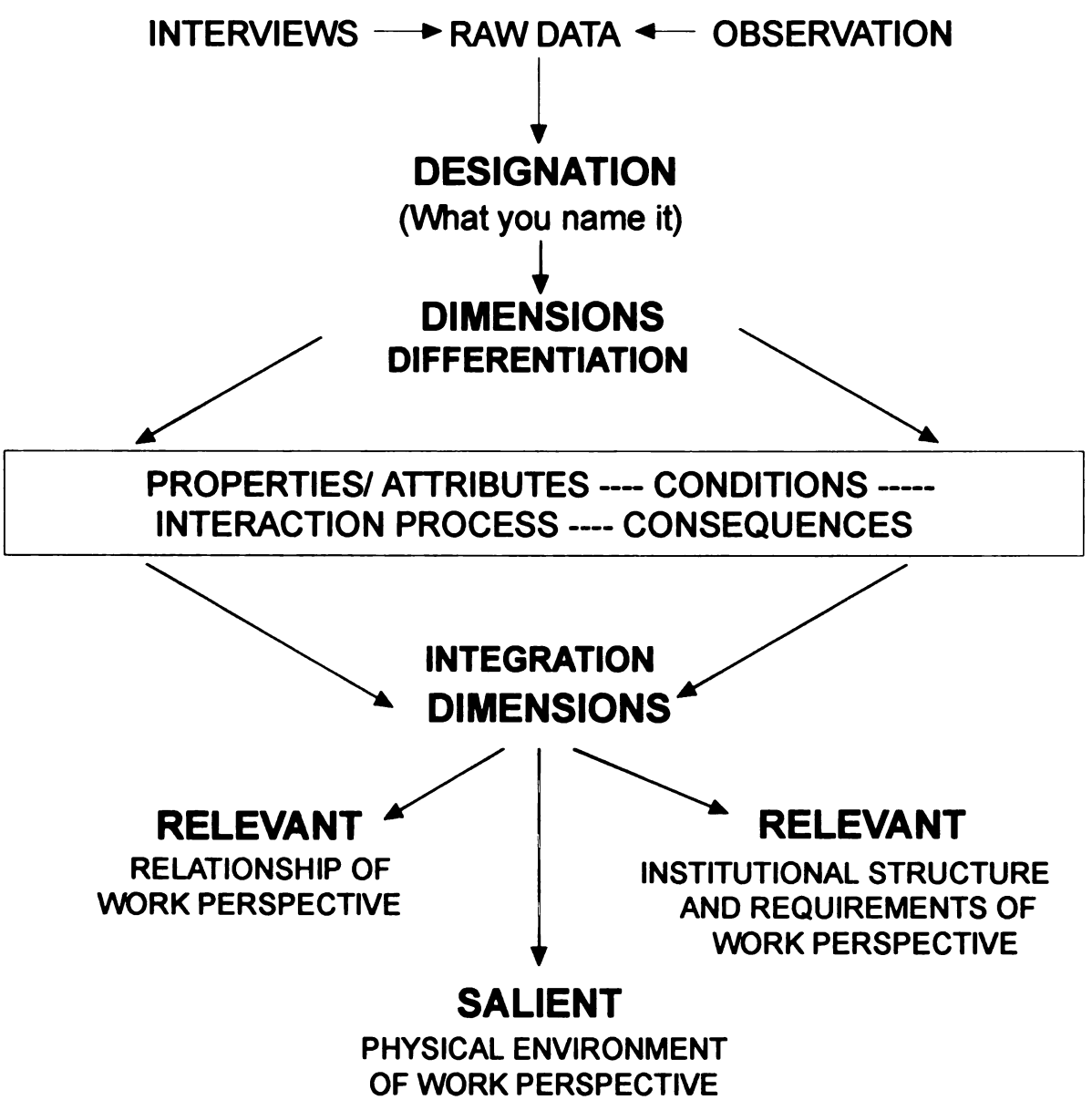
His third assumption is that even though students used the natural process numerous times a day, it is not recognizable to them as an analytic method. Students analyzing naturalistic data need theoretical and methodological anchorage, especially when the data become unmanageable and problematic. In response, Schatzman developed a teaching tool that articulated and depicted the natural problem solving model and called it the explanatory matrix (McCarthy, 1991; Schatzman, 1991). The majority of Schatzman's students used the grounded theory method and, while an advocate of the method, he came to believe that grounded theory is perceived and designed strictly for method; it does not have a theoretical paradigm for anchoring its operations despite the fact that interactionist vocabulary is a significant part of its pedagogy (Schatzman, 1982; 1986; 1991). The successes of his students based on using grounded theory and working from such a matrix were gratifying and prompted him to further develop his ideas into a more uniform and logical process called dimensional analysis (McCarthy, 1991; Schatzman, 1991).

FIGURE 1

DIMENSIONAL ANALYSIS EXPLANATORY MATRIX

BASIC QUESTION - "What is going on here?"

PERSPECTIVE



RISK PERCEPTION

Structure

The explanatory matrix (Figure 1) is a universally applicable model for both lay and scientific reasoning and is central to the dimensional analysis approach. It provides an explanation, based on a social interpretive process, about the relations among things people and events (McCarthy, 1991). By assigning assorted story elements (pieces of data) to the various positions on the matrix, the analyst can develop a story (explanation) about relationships among things, people, and events in any problematic situation. In a research context, creating a story or explaining a situation using such analytic processes is referred to as substantive theory generation (Schatzman, 1991).

Data within the matrix are framed as being salient, or relevant or marginal. Salient data are those data that are absolutely necessary for, or central to, understanding what is happening in the story. Relevant data are those data that are important but not crucial to the story. Marginal data are those data that have minimal impact or consequences on the story. The various components of the matrix are considered analytic tools and will be described in more detail; they include: (1) designation, (2) dimension, (3) property, (4) perspective, (5) condition, (6) interaction, and (7) consequence. See Figure 1.

Designation In order to create a story or explain a situation, one must first **designate** or name the items. In relation to this study the designated items that emerged from the raw data include: worker, clothing, agency, supervisor, rules, tasks, client, territory, and home. As the researcher begins analysis of the

transcribed data, items are **designated**, or in terms of the grounded theory method, coded or categorized. In short, language is applied that reflects the cognition of all things and processes involved in the analysis (McCarthy, 1991). **Designation** establishes a vocabulary which initially identifies things and events and their place on the matrix. **Designation** or coding links the world of abstract indistinguishable things to a conceptual world of distinguishable attributes of things (Schatzman, 1986).

Dimension is here defined as any concept or category viewed as an aspect or abstract attribute of some complexity. When this view or perspective on a concept is taken an analytic process is indicated (Schatzman, 1986). **Dimensions** and **properties** are considered attributes that expand simple denotation by description and eventual connotation (McCarthy, 1991). It is not enough in telling a story to just denote an item; the public, the reader, needs more description, value and meaning. To expand the study example, the designation of worker is expanded to included the properties of the worker such as: gender (male or female) category (nurse or aide), or experience (expert or novice). In summary, to dimensionalize is to add a level of analysis. **Dimensions** provide abstract contexts or references for **properties** which in turn, provide measurement or description for **dimensions** (McCarthy, 1991).

Conditions are those dimensions judged by the analyst to be salient --that is, they are central and necessary to the story in accordance with a particular perspective. As such, **conditions** are powerful components of the matrix. They

can affect and direct action/interaction in the context of the situation. Conditions that workers applied to visits serve as examples of these powerful components. For example, conditions of work such as workers not making visits to "the projects" after 10 A.M., or not accepting twice daily (B.I.D.) dressing changes on project dwellers or clients in areas where violent crime is commonplace.

Action/interaction is the social process of relating to a person, place or thing. It is defined as human beings acting in relation to each other, taking each other into account, acting, perceiving, interpreting, and acting again (Charon, 1989). Teaching, sharing, caring, talking, avoiding, and crying are all forms of action/interaction that workers expressed in describing their work.

Consequences are the perceived outcomes or implications of these interactions (McCarthy, 1991; Schatzman, 1982; 1986; 1991). The consequence of a worker avoiding an unsafe street or corner is safe passage, or reduction of risk.

Context adds limits to the expansive nature of the analysis by identifying boundaries or parameters within which inquiry will be confined. It is a relatively static component of the matrix in that it contains all the "givens" in the situation to be analyzed (McCarthy, 1991; Schatzman, 1982; 1986;1991).

Perspective, in contrast, is a dynamic component in the matrix. Perspective prescribes dimensions, selects properties as relevant and assigns them to a location on the matrix. A perspective is the most crucial and central of dimensions in a given situation. As the most salient dimension it provides a vocabulary for items, a line of reasoning of how items are related. **Perspective**, in this study is risk

perception of workers, the viewpoint or angle from which the data are analyzed.

The following example illustrates the relationships between the above concepts/tools. Risk perception is the perspective; it is the viewpoint or angle from which the data are analyzed, and home care work is the context (McCarthy, 1991; Schatzman, 1982; 1986; 1991). Home care work involves a worker (under the condition of employment) driving (action/interaction) to various homes to assess and provide health care (interaction and condition) for clients (under condition of homebound status), and as a result, the worker is sometimes called on to deal with risky and dangerous situations (consequence).

Parts of the dimensional analysis paradigm, in particular the explanatory matrix, have been used as a guide by several researchers, but few have articulated its use. Dimensional analysis was chosen as a method of analysis for this study because the majority of problematic situations that were described by home care workers were common everyday events in the communities and homes frequented by workers. Also, strategies that workers chose to "read" and negotiate these risks closely parallel the process used in dimensional analysis to develop an explanatory model. The vocabulary of the explanatory matrix is very similar to the words workers used to describe how they made decisions about action in the event of a risky or problematic situation. The following worker comment illustrates:

> From my experience [perspective] this is one bad area, lots of drugs, people walking all over the street and hanging out [attributes and conditions]. So I avoid interacting with this stuff and I have a safe way [action] to the client's house. I drive a little further [consequences] but it pays off. I don't have to deal with the problem folks.

It seemed appropriate to implement dimensional analysis as a scientific analytical process to explain actions and decisions that result from a complementary natural analytic process.

Process

Dimensional analysis describes and defines analysis as a specification, differentiation, and subsequent integration of the parts and attributes including their context (McCarthy, 1991; Schatzman, 1991). Describing the dimensional analysis process is just as difficult as describing grounded theory analysis because in each method there is no linear, sequential, step-by-step approach to data analysis. Both methods use an interactive process in which all levels of analysis occur simultaneously. In this study, data analysis occurred simultaneously with, and throughout, the process of data collection and helped direct and focus the type and extent of data collected. In the grounded dimensional analysis the researcher theoretically samples a study area with a diversity of data and works with data to discover emergent dimensions and their properties (McCarthy, 1991; Schatzman, 1991). As data collection continues, driven by analysis and emerging theory, the researcher begins to synthesize dimensions and properties and pose hypothetical possibilities of relationships amongst data (Glaser & Strauss, 1967). The conceptual devices used to accomplish these processes are wholly consistent between the constant comparative method and dimensional analysis (McCarthy, 1991; Schatzman, 1991). Both these methods of analysis involve a system of

identifying and grouping data by coding or dimensionalizing, and both rely on constant conceptual comparison. What differentiates the two approaches is the timing of the application of these devices in organizing and implementing the analysis (McCarthy, 1991). What follows is brief description of dimensional analysis as it was implemented in this study. For the purposes of explaining the various component parts, a sequential format will be used. McCarthy (1991) describes dimensional analysis as a sequence of three phases or stages: (1) the Designation Stage, (2) the Differentiation Stage, and (3) the Integration Stage.

I. **Designation Stage** - In this first stage the researcher begins to use language - words and terms- to designate objects and events and their various properties (attributes) and dimensions. Designation is done with initial data without any regard to where it fits in the explanatory matrix (Schatzman, 1991). This stage is parallel to the grounded theory strategy of "open coding", except that it makes no difference in dimensional analysis whether codes first appear as conditions, context, structure, or process.

The main concern of the researcher using dimensional analysis is to answer the question: "What all is involved here?" This process allows expansion of the data to continue until a "critical mass" of data are assembled. At this point in the analytic process, all codes are referred to as dimensions and are related to the phenomenon, and occur universally in the various interview samples. These dimensions serve as "headings" under which the researcher can group and organize data. A single dimension is merely one of several attributes or abstract aspects of

a constructable reality. In this study for example, early designation developed the following dimensions:

weather: hot, cold, foggy, rainy, icy, good, bad, seasons, related activity.

territory: dangerous, safe, rural, isolated, suburbia, inner-city, city, country.

homes: apartment, project, housing, rental, owned, old, new, filth, squalor, cramped, cluttered, dangerous, shack.

After an interview or field note is dimensionalized, a "face sheet" is used to exhibit the dimensions extracted (Appendix A1 & A2). At any time during designation, the stage of differentiation can begin.

II. Differentiation Stage - While the goal of the first stage is to expand what the data are telling about the experienced situation or event, the goal of the second phase is to limit the data either to make it more manageable or to direct it (McCarthy, 1991). In this stage the researcher identifies a perspective of the emerging theory, which provides a purposeful orientation but limiting nature to the analysis.

In this stage the researcher is forced to identify the salient dimensions. The perspective developed is that dimension which is the most salient or all encompassing. It is one that offers the most explanation about the experience. In this study through the process of differentiation dimensions identified in the designation stage were categorized and/or collapsed into the manageable dimensions of **physical work environment, institutional structure and requirements of work** and, **relationships in the work.**

It is the perspective of the researcher that determines the designations assigned to various dimensions and properties within the explanatory paradigm. Only after a critical mass of dimensions have been assembled can a perspective be selected. The researcher must make sure that sufficient dimensions have been revealed to answer the question, "What all is involved here?" Theoretical dimensions compete for centrality; the researcher uses the various competing perspectives or central concepts to test the logic of the emerging theory. Constant comparisons are made with the competing perspectives and the multitude of dimensions to test which perspective best offers an explanation or story of "what all is involved" (McCarthy, 1991; Schatzman, 1991). The most salient dimension in this study appears to be **physical work environment,** with the other two dimensions being relevant but not central to explaining the home health care worker's perception of work related risk.

At this point in the analysis, diagraming is a very helpful exercise. It is a way to visually represent the dimensions and how they fit together (Corbin, 1986; McCarthy, 1991). The initial diagrams help to put together some beginning ideas, later they become more complex and help finalize or integrate the theory (Corbin & Strauss, 1990).

III. Integration Stage - This final stage of the analytic process involves the reconstitution of the various parts of the explanatory model that have emerged from this grounded dimensional approach. Relationships and interactions among the dimensions become evident - and a theory emerges (Schatzman, 1991).

Saturation of Data

The researcher continues in the analytic process of comparing the developing theory until saturation is reached and no new data are collected that either enhance or detract from the developing theory (Corbin & Strauss, 1990; Glaser & Strauss, 1967; Strauss, 1987). When integration of concepts and relationships become coherent and complete, the theorization is complete.

In summary, dimensional analysis de-mystifies the analysis of qualitative data, while maintaining the logic and purpose of the grounded theory approach. Dimensional analysis is a scientific articulation of ordinary problem solving thinking skills. As an analytic approach, it is a most appropriate choice for this study which proposed to generate a theory or model that explains the ordinary thinking skills of workers in problematic situations.

Evidence and Credibility

As long as quantitative criteria are used to evaluate and critique qualitative research there will be criticism leveled at validity and especially reliability procedures. The point is that there are basic ontological and epistemological differences that impact on the role of the researcher in the research process and on how and what data is collected. Therefore, it is inappropriate to evaluate a qualitative study on the basis of quantitative criteria.

Criticisms of qualitative research frequently include subjectivity,

unreliability and invalidity. Such criticisms occur when qualitative studies are evaluated using criteria for quantitative studies (Lincoln & Guba, 1985). The criteria for validity and reliability are not used in qualitative research in the same way as they are in quantitative studies.

Validity

Validity refers to the ability of the data and the subsequent theory to capture the truth. In the grounded theory approach where the process is inductive, the theory evolves inductively and directly from the data. Grounded theory uses multiple data sources and methods to increase validity. There are two forms of validity, external and internal. External validity has to do with generalizability to other populations while internal validity answers the question: "Do the observations represent real differences or are they artifacts of the observational process?" (Denzin, 1970. p. 199). External validity is handled by demonstrating the representativeness of the units (subjects) studied (Chenitz & Swanson, 1986). Demonstrating internal validity is handled via various techniques such as "flip-flopping" or "red-flagging. An example of "flip-flopping" is when participant makes a statement such as "we don't need to lock our cars in the country", then the researcher would ask, "when would you consider locking your car in the country?". "Red-Flagging" is technique that the researcher uses to ask a contrary question, it is utilized when the participant uses words such as, "never" and "always" to describe situations. For example, the participant states, "we always

use this type of bandage", then the researcher asks "well, what if you didn't have it in your supplies and you had to change the dressing." it helps ferret out those conditions and situations that are contrary to accepted or mandated behavior.

For internal validity, the researcher must, through the data, rule out intrinsic factors that may distort or bias the theory. These factors include historical factors, participant maturation, participant bias, reactive effects of the observer, changes in the observer and peculiar aspects of the situation in which the observations were conducted.

Intrusiveness

Researchers who use quantitative methods criticize us as being intrusive and, inevitably, influencing the behavior of the participants so that the researcher is misled by the participants, or receives inaccurate or biased data (Hutchinson, 1986). The goal is to have the study present findings that are characteristic of the variables being studied, not the characteristics of the investigator. This goal is much more elusive in qualitative research than in quantitative research (Swanson, 1986), because artificial separation of researcher and informant would compromise elicitation of quality data. This criticism is handled by deliberately acknowledging the challenge, and by describing how the researcher was influenced by the informant and the process. Rapport and trust between researcher and participant enhances elicitation of good data, as long as the researcher is clear about his/her input and effects on participants. Researchers commonly take the developed

grounded theory back to the respondents in order to check internal validity in terms of the fit of the theory with their experience.

Reliability

Reliability refers to dependability or accuracy of the data observed or provided by the informants (Lincoln & Guba, 1985). A major critique of small qualitative studies are their inability to be replicated (Chenitz & Swanson, 1986). Even with the same data, the probability of two analyses to be the same is unlikely, because no two researchers are exactly alike. However, in naturalistic research and qualitative analysis, the theory is considered reliable if it works in a similar situation and allows for interpretation, understanding, and predicting of phenomena (Chenitz & Swanson, 1986). Kirk and Miller (1986) add that in general the emphasis in qualitative research has been on the development of greater validity at the expense of reliability. They suggest that the way to demonstrate reliability is to document and emphasize the plausibility of reasoning reflected in the type of concepts chosen to describe the theory.

Reliability serves as a foundation for validity. In the grounded theory approach reliability is established with: 1) agreement and consistency in information provided by informants, and 2) the saturation of categories occurs when no new information is yielded (Strauss & Corbin, 1990). This is achieved through theoretical sampling, and sampling until no new data is being elicited with each successive interview or observation.

CHAPTER FIVE

FINDINGS

The study focused predominantly on the home health care workers' perspectives on their work and the risks associated with this type of work. It is evident from the data that home health care is a complex process. It is a process that involves three interacting dynamic dimensions, which in turn are impacted by three central conditions. The dimensions represent the worker's perspectives, and experience of their work and the associated risks. The three dimensions are: 1) physical work environment, 2) relationships of work, and 3) institutional structure and requirements of work. In this chapter I will first describe the three dimensions and various sub-dimensions that contribute to the phenomena of work-related risks in home care. I will propose an explanatory model (Figure 5) that describes the dynamic relationship among the various dimensions and the conditions of control, predictability, structure, and familiarity. Finally I will elaborate on two other components of the model that are contributory to risk perception and that are unique to this study. The two components are the deliberative process of "tucking away" and the paradoxical nature of work risk.

The Dimensions of Work Risk

As described in the previous chapter, it is in the differentiation stage where the theoretical dimensions emerge that compete for centrality. A salient dimension is that dimension which is absolutely necessary or central to understanding what is happening in home care from the worker perspective; it is the dimension that contributes most to the story. Relevant dimensions are those that are important but not crucial to the worker's view of the home care work process. Marginal dimensions have minimal impact or consequence; in this study, marginal data were collapsed and reconstituted within the various relevant dimensions and sub-dimensions. Because the theoretical dimensions are a creation of perspective they are not concrete entities; they exist as dynamic, fluid entities which vary in their contribution (salience or relevance) to the risk perception of any given worker. In the diagram of the proposed model of risk perception (Figure 5), the boundaries are depicted as dashed lines which represents the dynamic nature of the boundaries. The investigator recognizes that for any given HHCW, in any given home care environment, with any given client, that dimensional relevance and salience may fluctuate, thus the dimension's contribution to risk perception may vary. However, overall in this study, for this sample the degree of contribution (salience or relevance) remains as depicted in Figure 5.

Salient Dimension

Physical Work Environment Perspective

This dimension encompasses the physical context or geographic area, where home health care work is carried out. The Physical Work Environment is a very important contributor to the risk experienced by workers. There are many sub-dimensions to this salient dimension (Figure 2).

As previously described, all three agencies give care within distinct geographic areas, varying from rural to suburban to urban-inner city locations. Each of these environments holds special risks for workers as they go about the tasks of delivering care. An in-depth description of this dimension is best accomplished by sub-dividing it into the distinct geographic areas and describing the sub-dimensions of each. The summary will explicate the similarities and differences.

Rural territories. Under the salient dimension of physical environment/rural, the major sub-dimensions of risk identified by workers in providing care to rural clients are: 1) driving and access maintenance, 2) home structural integrity and hygiene, 3) pets and farm animals, 4) isolation, 5) personal safety, and 6) the weather.

Workers describe rural territories as challenging in that dangerous structural conditions exist in some of the old homes, moreover older folks who often live alone and in isolated areas often have difficulty maintaining

housekeeping, pet care, and other activities of daily living. Many of the HHC workers clients are older persons who have lived in rural isolation all their lives. Many have lived in the same homes for many years; they resist loss of independence, and do not want to go into a nursing home or board and care facility.

Some of the challenges of home care in a rural environment are characterized as follows:

> the streets and addresses are very hard to find. Often the numbers are not sequential, driveways are long or go back far off the main road. Lots of times the driveways or roads off the main highways aren't even paved! They are bumpy and potted in the dry weather and then they become mud holes and booby traps in the rain.
>
> A lot of the clients like this man are elderly, they have lived in some of these places for years. He is a 93 yr old man, living alone in a ramshackle little shack at the end of a long country off-road. The road is not paved and a creek crossed the road, and one day I just couldn't get to him because of heavy rain, you would have needed a four-wheel drive big truck. Anyway, here he is in the same place for 50 or more years, heated it by wood stove, there was junk everywhere and the place was covered in soot. He wasn't into interference, he would let you change the dressing but you couldn't mess with his lifestyle, he made that clear.

Field notes augment the description.

> In heavy rain we drove 10 miles out toward the coast to visit an elderly client with a leg ulcer. In order to get to the house we had to drive about 200 feet down a dirt road. Difficulty parking next to house, couldn't get up slope, wheels kept spinning in mud. Got out into puddles of rain and mud. Client lived alone 1000 sq. ft. old wooden house, rotting steps and front door that sticks. Entered home after knocking a lot, client in one small room, very hot, overpowering smell of wood smoke from leaking ancient wood stove, no hot water.

In another interview a worker described a similar experience:

> X was a client I was seeing and he really need to go into a board and care home, his place was a disaster, I was scared when I was there because I could see the stove pipe was unhooked from the wall and if he lit the stove it would blow; you could tell the place had been burned, the ceiling was black. I called all the right people, but they said if he's competent, we can't do anything. It was a fire hazard. My goal was not to get the stove fixed but to get him relocated, he needed to get out of it, it was squalor, I hated to sit down in there, and I felt like I wanted to take a shower afterwards.

> I've walked up steps lined with moss and slippery as ice. I don't know which is worse, that or rotted-out wooden stairs. Both are booby traps. Many of the old people can't keep up with the care and maintenance a home needs, so its not unusual to visit clients in homes that are unsafe. You do a safety check, and you let them know what the problems are and you can facilitate some retro-fitting or repairs but only if they want you to.

Pets can be a problem in any of the environments; but the number and variety of "pets" in the rural setting give home care nurses great concern. The following "dog" incident was described by a worker:

> Lots of these rural homes have assorted pets, of course you have your regular dog problem everywhere, but, up in these hills people have them for protection as well as company. If the dog is doing what its supposed to do, it will bark and growl at you, I don't blame the dog or the client for this. But, if the dog is out when I get there I don't get out of my car until its tied up. I sit and beep the horn or the car until the owner or whoever comes to get it. When I call I try to remind them of this if I think about it. Once I didn't make a visit because no one came to attend to the dog. You just can't trust them not to bite you. I went to the nearest phone, which was about 4 miles away, and called the client to reschedule, then I called the office and told them.

Farm animals can be as much a problem as is emphasized by these workers:

> Its not so much the dogs as the other "pets". I drove up to this house in the country and a gaggle of geese ran up to the car hissing and flapping their wings. There was no way I was getting out.

> I was worried about the dog that was barking at me, but then there was this old sow that was roaming out and free in the front of the house. They came and got the dog and I just didn't think twice about the pig, but once I stepped out of the car and started to walk up to the house, the pig ran towards me and wham, it bit me. I was just so stunned, it was hard to live that one down with my fellow workers and the ER workers who treated me.

Workers have to drive to the client's home in the various areas. However, driving in rural areas can present problems for workers because of the isolation factor; roads are less traveled and maintained. One worker put it this way:

> Driving to rural areas takes longer, if you have to drive more between visits you can't make as many visits. Also, if you break down, or have a flat, there's no gas station around the corner to walk to. One time I was coming around a bend at 25-30 mph and there in the road were four cows. They had escaped from the field and were eating this green grass on the side of the road, half on and half off the road. I had to swerve to avoid them.

The isolation factor is more significant for workers who make visits in off hours:

> Making evening and night visits are hard in rural areas. Usually it's really dark, because there are no street lights. Often you have to find homes you are not familiar with and you spend a lot of time looking, going back and forth. When I work p.m.'s I make my rural visits as early as possible while its still light. You need a good reliable car for visits out here."

Isolation is also a factor when a worker needs help with a client:

> You're all alone out there in the field, and if it's a new patient, you never know what you will walk into, it could be scary at times. Or, if it's a regular patient, it's not like if the patient goes down that you can call a neighbor to come and help you. Often there's no one else in the home. Or, if you have car problems, there is no phone to call for help, you have to have a frontier attitude because you are isolated. If something went wrong, like you were in trouble, in danger, who would know, no one can hear your screams.

Suburban territories. Under the salient dimension physical environment/suburbia, the major sub-dimensions identified by interviewees as risks to worker safety are: 1) identification/location of client/home, 2) driving and parking, 3) physical organization of home, and 4) pet and home hygiene.

Suburban areas are different and yet similar in the risks that they hold for workers; finding the right house can be as difficult in suburbia as in the outlying rural areas. Hygiene and pet problems tend to be similar. Some practices, such as the "knock and walk in" technique described by the following worker, are a threat to worker safety regardless of location of the home. She describes this scenario:

> Finding the right place is not always easy; a lot of these housing tracks look the same, same style house, same paint job, and lots of cul-de-sacs. Some charts have lousy directions on them. Never rely on your fellow workers for directions, get them from the client and then check it out in the Thomas Street Guide. I've gone up to the wrong house before. It says on the client chart "knock and walk in" and then it's not the right house, big problem! One time I went up to this guy's house and it said on chart "walk in", I walked in and a man in there looked really surprised to see me. I knew something was wrong. I said "Mr X?" He said "no he lives across the street" it could really have been a disaster. What if he thought I was a prowler or burglar, and worse, what if he'd had a gun?

Contrary to rural locations, isolation and infrequently traveled roads are not a concern in suburbia. However, dealing with other drivers and traffic flow can be a problem. A worker offered the following scenario:

> Driving in these tracts [housing development] you have to go slower to catch the street names, but then people get mad and honk at you or give you other "signs." There's more traffic and people to worry about and I try to avoid parking in the client's driveway at all costs. One time I did and my car leaked a little oil. The husband was mad and called the agency.

Finding the correct house requires one to be on the look-out and drive slower. As described above, other drivers can be less than polite. This field note entry illustrates:

> We had figured out the route we would take, but once we got in the housing development, we got confused, we slowed down to read house numbers. A driver behind got impatient, drove around us angry, scowling and gave us the "finger". Finally we drove to a supermarket and phoned the client for better directions. Lots of cul-de-sacs and circular type roads, like a maze.

Suburban homes are no-less cluttered than any other home. When someone is ill, he or she often cocoons him or herself into one room. In many homes, that room is the bedroom where the work space is tight. Also, during illness, when emotions are often fragile and more on the surface, people are more vulnerable and more easily ruffled. The following description of outward appearance versus inward experience capture the nature of this phenomenon:

> Just because these houses are in a middle class neighborhood and look nice and have nice yards, it doesn't mean the people don't have their problems. Most of the time it's the people they live with who give the client the most problems and they also give the worker problems. The family and loved-ones are stressed and stretch by the client's illness. So, when you may want to have them reorganize their furniture a little to facilitate your work and their own maneuvering, they can be resistant and difficult. The recommendation may be one more adjustment and change they can't deal with. So, lots of times you're maneuvering around in a small room that has a big bed and lots of equipment. You're squeezing between the wall and the bed, you could hurt yourself because you can't use very good body mechanics. Also the hallways are sometimes too narrow for walkers or wheelchairs and the rooms are small for all the stuff that is in them. The worst are mobile homes.

Home hygiene and housekeeping is as much a problem in suburbia as it is in any location. Workers have trepidations about putting their bags or supplies down; one agency asked workers to take in a newspaper on which to put their bag. The normal amenities of health care work such as warm water, clean sterile surfaces, soap, and appropriate equipment, often must be supplied by the worker/agency. It takes a lot of resolve to act and behave like you feel comfortable in squalor, which in some cases is no exaggeration, as the following worker shared:

> I have been in homes in middle class areas that were pigsties, some older people, and younger for that matter, have pets and they let them do their business all over. I have come out of some places with flea bites and covered in dog or cat hair. I resent it but at least I'm not allergic. People in these areas are no different than anywhere else; the outward appearance of the home or neighborhood is no clue. You have those who value cleanliness and those that don't or those who can't because of age or disability. Most of the time though it's because they don't care.

Inner city/urban territories. The major sub-dimensions identified by participants under the salient dimension of physical environment/inner-city, that impact on the risks perceived by workers are: 1) proximity to violent and/or criminal activity, 2) personal safety, 3) client protection devices and techniques, 4) guard animals, 5) client demographics, 6) telephone access, 7) driving and parking, 8) temporality (time of day and year), and 9) home hygiene. The major sub-dimension, that of proximity to violence and criminal activity, relates to all the others in that the closer the work is to criminal and violent activity the more active and influential are the other sub-dimensions.

Making home visits in the inner-city urban areas offer a vast array of challenges for the worker; despite these risks there are workers who claim they would work nowhere else. Workers made statements like:

> ... safe suburban-middle class doesn't appeal to me at all...I would find it boring and many of the clients I have seen in those areas don't need my help in the same way these folks down here do.

Another added:

> ...I can be more helpful to these people in the neighborhoods, their diagnoses and problems are more of a challenge; figuring out how to help them and get support form them is a challenge: the whole thing is more challenging.

The majority of inner-city work risks are related to violence and personal safety issues. The major catalysts for the violence are poverty and drug activity. Workers remain "on guard," no matter where they go in the cities of this Northern California urban area. In field observations, the researcher noted that poverty was much more evident in the inner-city territories than in suburbia and rural territories. Many of the inner-city clients, just by the nature of where they live, are victims of the drug activity and random violence. A worker who visits a high volume of clients in a large senior citizen complex stated that:

> This building's in bad crime area. What happens is that people have to ring the buzzer to be let in and the older folk can't hear or get confused and let them in, this way people get in a get up to no good...We have seniors there who leave their doors unlocked or open because they can't get up to open them for us. Well the jerks know this and just go along a hall till they find one open, then whammo! they're in and they burglarize or accost the old folks , and I'm sure us if we were there at the wrong time.

Another visitor gave this insight:

> These older folks have lived in these neighborhoods for a long time. Back in the days when they raised their kids, the place was respectable. Now

> those who can move have done it and those who had to stay are trapped. They are victims; they are afraid to go out; many are disabled; they are easy prey for the druggies', and property values have really gone down.

According to one worker who has worked in the inner-city areas for more than ten years, some of the clients may not be direct victims of the social disintegration of the inner-city neighborhoods as a result of drug activity. Yet, indirectly they are victims because many clients who are elderly and have chronic disease, and who are clients of the home care agency, are raising their grandchildren and great-grandchildren. These children are abandoned by their parents as a result of drug addiction.

The victimization of the residents was evidenced by the multiple protection devices that are in use in some of the homes that were visited. In many cases, all lower windows had bars on them and the front porches were enclosed with wire mesh and electronic metal gates. These posed problems for workers in that it meant multiple entry and exit steps to access and leave the residence. The client controls the ability of the worker to enter or exit. In the event that the worker had to make a hasty exit as a result of a dangerous situation, these barriers would definitely compromise the safety of the worker. In one incident described by a worker it seems like it did:

> This nurse walked into a client's home. When she walked in it was very inviting and nice, it was someone she had been seeing for awhile. As she walked in the door was closed behind her. It was one of those iron bar doors which many of our clients have on their doors. Anyway it shut behind her and this woman was angry about something totally unrelated to the nurse, and she proceeded to just slap and kick and victimize the nurse, and the nurse eventually escaped, but the bars made it harder."

Some clients have animals for protection purposes. The animals that are used for self-protection and company were not described by workers as being a problem, unless they were allergic to animals or it was a sanitation problem. The animal situation that posed a problem for workers was when clients kept pit bull dogs. Workers felt that these animals were not "pets" in the true sense, but, were used by some clients to protect their livelihood of drug dealing. In describing these types of clients, a worker had this to say:

> Dogs are not necessarily a problem for me. Yet, if they have a pit bull I am immediately suspicious. I make an agreement with them that if they want me to come, they have to secure the dog out of the house. One guy, a young man, didn't keep the agreement. I told him (through the screen door of his run-down apartment) that I couldn't make the visit. He said he'd put the dog in the bathroom but looking at the bathroom door, with a huge hole gnawed in it, I said no and left. People who have those types of dogs have them for other things than for pets; it's usually to protect "stuff [drugs]"

Weapons and guns are other means that clients use to protect themselves. All the agencies across the board had a rule that there were to be no weapons visible or accessible when the home visit was taking place. Yet, in several homes where visits and observation were made, weapons were visible and very close to the area where care was given. However, no worker discussed this with the client while being observed. When asked about the guns, workers acknowledged that they had seen them but either it didn't bother them or they felt like it was not a good time to bring up the subject. They described it this way:

> We know they have guns; it's no secret, I don't necessarily like to see them out when I'm there but these old folks live alone and are scared. I don't want to become over imposing; it will affect the work I'm trying to do."

> We were changing this bed and, wa-la, out falls this gun that was loaded. Not knowing them I just kept quiet and went ahead and took care of this woman and they took the gun and moved it to another room. It wasn't until later when I got back to the office that I called them and let them know that there was a problem with having a gun in the environment there, especially loaded and wondered if they would be able to help us by doing X, Y, and Z. So they unloaded the gun and put the bullets in one place and the gun in another part of the house, and were able to show a staff member where that was. So that's another thing too, you want to go in and you want to do what you are really sent out there to do; you don't want to make a lot of big issues, you need to keep things in focus. I think we could have made a bigger issue had they not been compliant with our request.

Another worker regularly visits an older amputee for dressing changes. He has a 12 gauge shotgun hung right beside the bed where the dressings are changed, but she does not see it as a problem or a threat to her. Workers' reactions to the presence of weapons is conditional based on a series of variables that were elaborated by one worker in the following way:

> ...it depends on the circumstances, what the age and sex of the client is, what the diagnosis is, is it secondary to a violent act related to criminal behavior; if they are psychologically stable, if the family is stable, if there is any suspicious behavior or unusual activity such as drug use or alcohol use, who is hanging about at the home, are they family members or "hangers-on." I take all these things into account anyway in deciding how safe I feel. If any one of the cues are there and there were weapons visible, then I would get out of the home as quick as I could and then I would tell my manager and give the client a call to tell them we couldn't come back, period, or until changes are made. If I felt unsafe in the least, I would never be confronting or challenging to a client or family member at the time and in person, it wouldn't be a good idea.
>
> I was in a home once where I know there were weapons. I didn't see them, but I know...about five of the people had weapons on them. Most people don't flash their weapons, so I don't think about it. Everybody, no matter how bad they are, are on their best behavior when you come to take care of their mother...they don't want trouble...I'm one of the good things that is happening to them and they know it.

One nurse, an expert with more than ten years of experience in visiting and working with clients in the inner city, claims that being "on guard" is essential to maintaining sanity in such work conditions. "Not all areas [of the city] are bad" was a common statement of home visitors who worked the inner city territories:

> In X I must be on guard no matter where I go, but less on guard in some areas than in others...

In areas that we visited she stated that:

> I have to be very on guard over here, I have advised the office about one area in here that is really bad. I told them not to take clients who live there. Because if I won't go there, they know not to send anyone else. There are not too many places I won't go.

Areas in which there is a higher density of both poverty and violence are the housing projects. These environments require a home visitor to be extra watchful and careful. One expert talked about these places as being "tedious":

> Projects can be very tedious places. They are a haven for drug dealing and associated activities, you even hear gunfire during the day. Gunfire during the day is a very bad sign that the dangerous people in this area don't hold to the norm of when violence occurs, as most of the violence occurs in the late afternoon and on into the night. Because of the number of people, they [the projects] are a draw for those who like to "hang-out." The high rise projects can be very dangerous; stairwells are especially bad spots. In one of these buildings I visit there have been many murders in the stairwells. Stairwells are high use spots for dealings and using. Housing projects, whether high rise or low rise, are poorly maintained, the elevators don't work and the stairwells are not maintained. Elevators can also be a problem. You could call up the elevator and walk in on a "situation" [a drug buy or use] going down. In some buildings, the elevators are controlled by the dealers.

It is essential to know where the pockets of increased risk and danger are. Visitors talk about good streets, bad streets, bad intersections and so on.

Knowledge and familiarity of the working environment is an essential condition of worker safety, as characterized by the following workers:

> ...there are good streets [safe] and bad streets, you have to know this and avoid the bad spots by making detours around them; you just make a few extra turns. Some streets are good on one end but bad on the other. You don't know this unless someone tells you, it's not something that's in the orientation manual.

> Most of the problem areas center around a liquor store because a lot of time the liquor store owners are involved in the drug trade. They have the people hooked in several ways, they sell liquor and give credit, they let the people run tabs, they also cash checks with little or no ID., not personal checks though because the majority of these people don't have accounts or checking accounts. The stores will cash the welfare checks, but will charge enormous percentages. The people are totally in a catch-22 situation. Have you noticed how many liquor stores there are down here? Some areas have one on every corner; they are a haven for crime and drug activity. People with nothing better to do hang out here, that's why some areas are bad and need to be avoided. Also these liquor stores are owned by other minorities, they prey on the less fortunate minorities. Just about every store has a phone, but don't ever try to use one. Notice how there is always someone standing by the phone - a public phone. These folks guard the phone and keep it free for incoming orders and calls to the dealers. If you really have to phone someone then it's best to have a car phone or to go to somewhere like a Safeway or Lucky store.

It would seem essential for the beginning worker to have knowledge of the workings of the neighborhoods in the various inner city areas. Having a worker out visiting and working in the inner city without knowledge of social processes and activities at work on the streets, and without awareness of the safe and unsafe areas, could be a very risky management policy, as well as being potentially life-threatening.

There is a temporal nature to the level of unsafe activity on the streets. It is a matter of "timing", and is related to the time of the day, the time of the

month, the time of year, and the weather. This is a less important factor in other home care environments. Making visits to some of the more unsafe areas should be avoided at the first of the month because this is when people get their checks, as recounted by this worker:

> ...making visits to some of the more tedious areas should be avoided at the first of the month. This is when people get their checks and there is always a lot of activity, things going on, drugs are heavy at this time. The dealers understand the relationship; they get their shipment at the end of the month so as to be ready.

Terms such as "activity," "energy," and "rhythm" were used by interviewees in describing the feel of the streets. Workers talked about "the streets" as though they were an active dynamic force which was conditional in relation to "time."

> ...at certain times of the month there is more activity on the street because people have got their checks. Sometimes you can tell something is awry there is a whole different rhythm to their activity, and it usually deals with their illegal type activities and you can kind of sense the energy.

Time of day is a consideration when safety is an issue. Workers start out early in the day to visit in the less safe areas. Those persons tending to illegal activity do so in the afternoon and night hours so they are not out on the streets in the early morning. An interviewee added, "there are drugs everywhere here, but, usually most of those involved in it aren't doing a whole lot during this time of day." Sometimes client care is affected by this temporal risk phenomenon, as described below:

> I will rarely make afternoon visits in here. You won't find me doing too many visits over here in the projects after about one or two [p.m.].... There are some neighborhoods I won't do a B.I.D. [twice a day visit] because it's fine in the morning, but, in the afternoons its not worth it for me to come back to do that second wound care. So, there are clients where I let the

> doctor know when he orders it, "no, I can't do a B.I.D. on this one." The doctors understand. We call the shots when it comes to that.

Weather also impacts the nature of the activity on the streets. According to those interviewed, prostitution activity is affected by the weather as well as the time welfare checks are received. When the weather is warm and during the summer months, when school is out there are more young people on the street. There are certain areas, corners, intersections, and streets in which they congregate. One worker pointed out one particular area to me and added:

> ...you can see as many as one hundred or so people out, in these two blocks on some days. They don't look out for lights, they cross the street at random, they don't care what the light says, so you have to be very careful. When it really gets hot, people have less tolerance, things can be more tedious. You just have to keep your eyes open.

Negotiating traffic and parking are major concerns for workers in the downtown areas of urban cities. Many visits are made to clients in residential hotels, boarding houses, or senior citizen complexes, where parking is very limited or non-existent. Workers look for safe parking lots that are close to the home, such as supermarket lots. The workers are responsible for "feeding parking meters" if they need to park in a metered spot or a pay lot. At times visits may exceed the time on the meter and a worker must decided whether to terminate the visit post haste, run down and re-feed the meter or risk getting ticketed. Home health care workers have no special parking privileges with the city; many talked about parking tickets which they pay for out of their own pockets.

Home hygiene is as much a problem in the inner-city locations as in the rural and suburban areas. One of the visits I made with a worker was to a home

that was utter squalor. The worker characterized it this way:

> The therapist will only come when I am here. The downstairs apartment was raided about a year ago for drugs. They had a great big drug bust, so the downstairs is essentially like they left it...

Observation revealed a downstairs apartment that looked like it had been hit by a bomb. It was burnt out with no doors or windows, and the walls were covered with graffiti. We ascended a metal, rickety staircase to the upper apartment and knocked loudly for at least ten times on the door. Finally a man of about 50, in a filthy, stained pair of trousers came shuffling to the door and let us into a dark, smoky, filthy, unorganized apartment of four rooms. The client was in a bedroom. There was no light, the window was broken, and she was lying in disheveled sheets, and was smoking. Urinals, ashtrays and old food were on either side of the bed. On leaving the worker shared this thought with me:

> I deal with [clients] in a very low economic area... frequently I have clients who are developmentally disabled and just don't have the literacy to understand what is going on... Although her husband tries his best...I am dealing with people who don't have a lot of education... I make them feel comfortable, they have to live there all day, I'm just in there for a few minutes, so I try to look relaxed, look like I'm in Piedmont somewhere, and I sit there and treat them with respect. so they feel comfortable. Then they will talk to me... Otherwise they realize that you don't want to be in their home and that you think you are better than they are, and they get real resistant to you.

Going into someone else's home at any time is a risk to workers but the first visit is probably more risky because the worker knows so little about the client, the family, and the home. The environment is less predictable at this time than at any other time, and the worker is less familiar with the clients and family.

Workers realize this and have more trepidation about first visits, or as the following worker put it, they feel vulnerable;

> On new clients you try to get prepared for them by getting information and a feel for what is going on over the phone, or from the referral, but you really never know until you walk in and actually meet them, what you are in for. Sometimes we get info from the hospital if they seem weird, but who knows who lives in the home? You don't, sometimes you never find out. There's one house I go to that has several generations living there, it's quite dysfunctional. I know them now but the first time and for a few visits after I felt vulnerable.

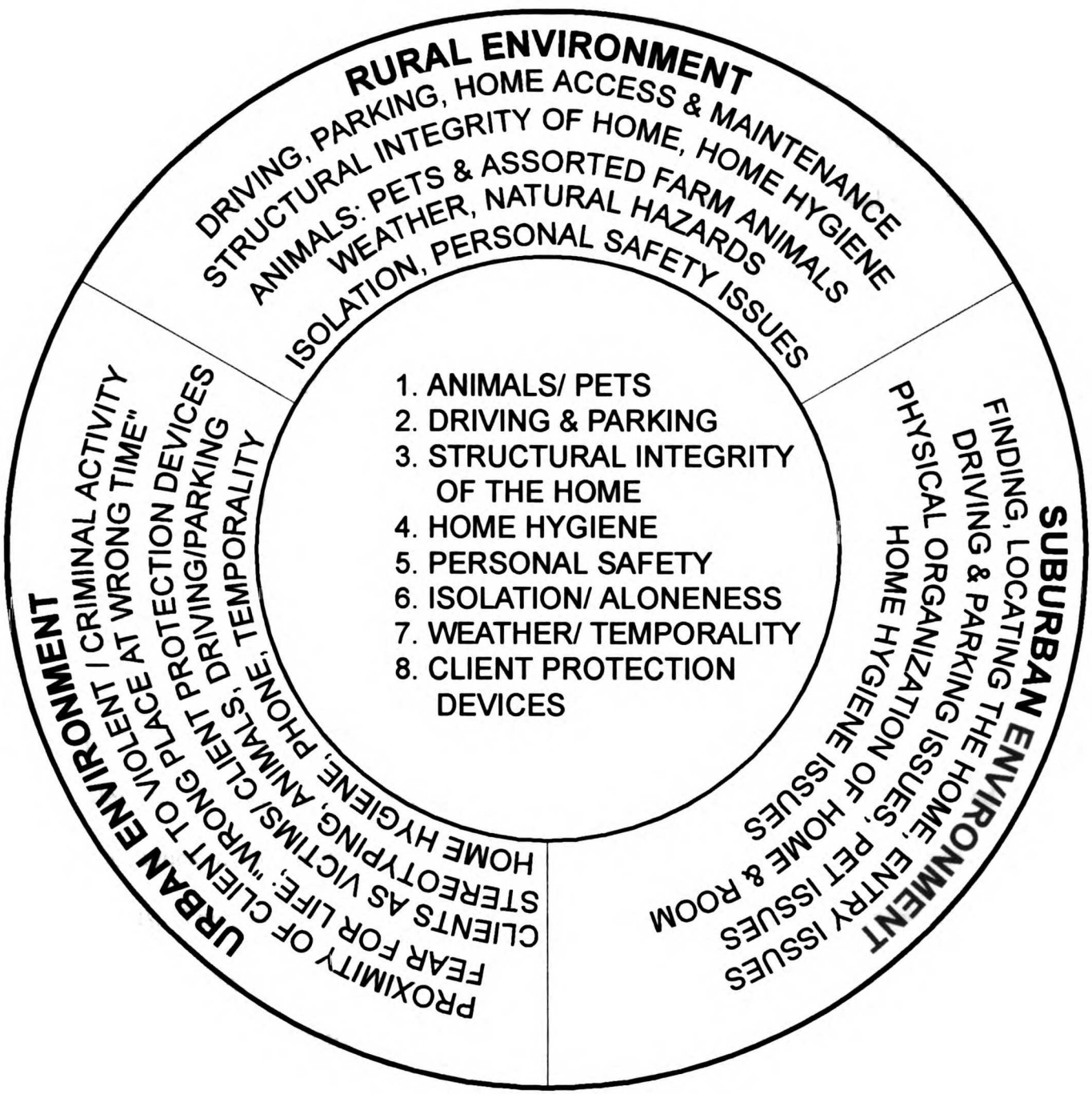
Summary

As described, the dimension of physical environment is very salient to the risk perception of these home health care workers as they go about their work in the various territories sampled. The degree of its contribution is variable and conditional, and geographic location is a significant condition. Each type of geographic location has risks associated with it, and worker control over some of the risks is more active and possible in some instances and locations than in others. The sub-dimensions influencing the perception of risk that are evident across the three geographic locations are: 1) animals/pets, 2) driving and parking, 3) home structure and hygiene, 4) personal vulnerability/safety, and 5) weather/temporality.

FIGURE 2

SALIENT DIMENSION & SUB-DIMENSIONS

PHYSICAL ENVIRONMENT OF WORK PERSPECTIVE



Relevant Dimensions

Relevant dimensions give support and are related in some way to the salient dimension. In this study, marginal dimensions have been collapsed and integrated into the relevant dimensions. Relevant dimensions are not able to give the complete story or explanation for "what all is going on" yet they are necessary and relational to each other and the salient dimension. The relevant dimensions in the data are: 1) relationships of work perspective, and 2) institutional structure and requirements of work perspective.

Relationships of Work Perspective

The dimension of relationships of work, while not salient is very relevant and contributory to the worker's perception of risk. Interacting and relating with various persons who are part of the work world is a major portion of the work of home health care, these interactions and relationships are not without risk. The worker interacts and relates to Mead's concept of the Self, as a worker, as a professional (if appropriate), and as the person he or she is beyond the work identity. The worker also interacts and relates to supervisors, fellow workers, and colleagues in the health care community as well as to the client and families of clients. The sub-dimensions of this relevant dimension include: 1) relationship to Self, including perspective of Self with the various identities of Self, 2) the worker-peer/colleague relationship, and 3) the worker-client relationship that includes family/caregivers.

Interacting and Relating to the Self. The worker perspective is the ordered view of their world, a view about the attributes of various objects, events, and human nature. One's perspective is the matrix through which one perceives his situation (Charon, 1989). The influence of significant others and reference groups contributes to one's perspective. As described in chapter three, the perspective of the HHC worker which is most operational and at the forefront at any one period in time is dependent on which group he or she is interacting with and the needs of the situation. As a member of several reference groups, the HHC worker may have many perspectives operational at any one time, as he or she goes about his or her work.

The data related to interacting and relating to Self seemed to fall into four major groups: 1) Self at risk, 2) Self other than worker, 3) Self as professional, and 4) Altruistic Self.

The workers perspective of the **Self as at risk** was the primary concern of the researcher. The underlying question was "what is the risk of home care work? How do workers recognize it and once recognized, how do they manage it?" In aligning with the assumption of risk as a subjective experience, the study was approached with a global, loosely defined concept of risk in order to allow workers to define risk. Therefore, caution was used not to overly sensitize the worker to the concept of risk. In the semi-structured interview (Appendix D), inquiries were made about all aspects of home care work. There was avoidance of the term risk unless it was brought up by the worker. However, some instances

prompted more structure than others.

Workers, in sharing their work world, had many opinions about themselves in relation to the daily hazards. Workers who had switched to home care from other work environments expressed the following ideas:

> I was "fried" you know, burned out at my old job. I have had multiple jobs in clinics and hospitals. I felt like a time-bomb, a disaster waiting to happen...you know, like make a mistake or get hurt or something...

In essence this worker was telling me that she felt at risk in the previous job setting and she moved to home care to avoid risk. Her perspective was that she was at less risk in the home care work environment than in the hospital or clinic environment. Another interviewee added:

> I know there are things out here [home care setting] that really can be scary, like problems with people, violence, driving and stuff, but the hospital had its problems too!

The realization that certain hazards and dangers exist in most work environments and life situations was a common theme of the participants. Workers did not expect the guarantee of a totally risk free work environment. They recounted that, ..."if you know about the risks, you are on guard, and you deal with it." One worker put it this way:

> ...Yea, there are lots of dangers doing home care work, but most of them are things you have to be careful of in your life anyway, like robbery, mugging, and car stuff. We go to places where these things happen more often, so you're on guard. You can't hide and bury your head in the sand, you know they are there and you're careful.

Another worker claimed that:

> There's nothing that I see at work that I don't see or hear about in my own neighborhood or on T.V. This stuff [referring to drug activity] is everywhere, in the high class places and in the low class places. You just hear about it more in the low class places because they don't have money to buy it. In the high class places it's hidden more.

This comment can be explained as stigmatization of communities based on the demographics of individuals and groups within the area. Interestingly, in this group of workers, the phenomenon of over-exaggeration and perception of risk as a result of stigmatization did not seem to be a factor.

If workers are aware of the hazards and risks of the workplace, how do they manage knowledge of such? The following description succinctly captures what many workers expressed:

> You have to be on guard especially in very high risk places, but you can't be constantly thinking about it [risk]. It would be overpowering. You could become paralyzed by it and you would then put yourself in more danger because of the messages you would send.

The messages were explained in more detail:

> ...the way you look, like a scared animal, moving fast, looking over your shoulder all the time, not acknowledging people around you and on the street, stuff like that.

An expert (10 years in home care as a nurse and two years as a supervisor) put it this way:

> There's a place you reach, in between where you don't obsess, because then you would be useless, you'd be burned out in no time. Yet you don't want to become so nonchalant that you get careless. You know your area, the neighborhoods, you know how to act you are very aware of but not overwhelmed by the risks. You store your plans, how you would react or deal with problems, so you can call it up any time."

The process described has been labeled "tucking away"; it is an example of an in vivo concept. In this process the worker assesses the situation, is aware of the hazards, and has developed plans to apply to various problem scenarios. According to the Symbolic Interactionist framework, this interactive process is present in all humans and is a basic human characteristic that allows us to learn from and avoid situations that are problematic. The process itself remains very basic, but its application becomes more complex as the individual develops and experiences the world. The more varied one's experiences, the more flexible and adaptable is the process.

This assumption is borne out in the study in that it was evident that the newer, less experienced, novice workers (less than one year in home care) expressed greater concerns about the risks than did the more expert workers (greater than two years). A novice explained her concerns this way:

> ...ever since it happened [bad experience] it just has added to my concerns about my safety, I wonder if I should stay with homecare...When I told my supervisor about it, and the other nurses, I felt no support. I guess the risk is just part of the job and I have to deal with it, but I feel nervous a lot.

A supervisor put it this way:

> Sometimes the new people are over cautious and reactionary but it is probably a safer situation that the seasoned people who become too nonchalant. They are not serious about what's out there - the risks - as they should be. I worry about them more.

Under the sub-dimension of self at risk, the major concepts that are contributors to the worker's perception of risk are acknowledged universal risk, sensitization, vulnerability, "tucking away", and life experiences.

Although the perspective of Self as a worker contributes to the perception of risk at work, ones' identity of **Self other than worker** (the generalized Self) is a part of that whole. The other identities or self-perspectives that come from life experiences proved important enough for participants to reveal and explain as they shared their perception of risk. It is impossible to discount the impact of the other identities, such as wife, father, mother, single parent, breadwinner, on the perception of work risk. The following worker comments emphasize the contribution of self identities to risk perception:

> Well I'm not to worried about taking care of AIDS or HIV positive clients but my husband is real concerned. He doesn't want me to do it, he wants me to refuse. It hasn't come up as an issue yet, and if it does I'm not sure of what I will do. He worries about me getting it from clients and also I have a little boy.
>
> ...no I didn't tell my husband about it [bad experience]. He was asleep when I got home and if I had awakened him to tell him he would have had a fit. He would have made me quit there and then. Then the next time I saw him awake the next day, the situation didn't seem so bad in the daylight.
>
> I've learned not to tell them at home all the things that go on or that I experience because it would just cause problems. My kids would be afraid for me and my husband would not want me to continue this work. On the other hand he has a lot of exposures to dangerous things like paint and solvents, so his job isn't without problems.
>
> My kids only have me, so as a single Mom I have to be extra careful about how I go about my business. I can't risk putting myself in dangerous situations. I need to evaluate the consequences not just on me but my family.
>
> With my health problems I don't do any lifting. If the client or family can't help me then I tell my boss and we arrange for someone to meet me at the house. As a back injured person, I know what its like to be disabled and I make a point of reminding myself of what it felt like every time I get the urge to lift, it is a frustrating experience.

> There are people [fellow workers] who think it's "macho" to go into the dangerous areas, or to go places that are considered off limits. I won't and I have to take the heat for it. It's not overt sneering but more underhanded, like snide comments. When it happens I think of the other people in my life who I am responsible to, like my husband and kids.

The worker perspective, self at risk, is a significant contributor to risk perception. The perception of risk is enhanced or exaggerated by the view of oneself being in danger and vulnerable. This perspective is influenced by life experiences, both in and out of the work environment, as well as peer group or reference group support or negation.

Under the sub-dimension self - as - other (that is, the perception of one's self as other than a home health care worker), the major conceptual contributors to risk perception are consideration for significant others, fear transference, life experience, and image and projection of self on peers.

Regardless of the type of work the perspective of one's self as a **professional autonomous self** is a necessary part of the role socialization of the professional (Freidson, 1986). Autonomy has been cited by many researchers as a positive attribute of work that affects the workers' perception of most, if not all, aspects of the workplace (Bush, 1988: Deutsch, 1988; Karasek, 1981; Karasek et. al., 1981; Lazarus and Launier, 1978).

Job autonomy was characterized by workers in this study as freedom or latitude in work schedule, permission to independently organize and execute job tasks within institutional parameters, and independence with consultation as needed in care procedures (Karasek et. al., 1981). When asked about their work

and satisfaction with that work, workers overwhelmingly spoke of the positive aspects of their work. The following are a few of those comments:

> It gets pretty crazy at times and its even dangerous at times making home visits, but I can adjust my schedule to make things less risky. For example, I can choose to visit the bad places early in the morning, or I have the right not to visit if I think something looks dangerous. Of course I have to have good reasons and documentation why I didn't go, but I do have that independence.
>
> The autonomy in this job is good, I count my blessings every day. You can control the number of clients you see, to a certain extent. We all see approximately five to seven clients a day. But it is negotiable, you can see eight or so one day and then three to four the next day. If I need to go to a doctor's appointment or do whatever, I can do it! This flexibility has really been helpful since I went back to school.

The degree of autonomy varied from agency to agency and among categories of workers. In most instances, the nurses had more autonomy than the home health aides did in all areas of work. Home health aides do not schedule the number of clients they see per day, they are assigned. However, they do have latitude in deciding how best they should organize their day, and who to visit when. Aides expressed great satisfaction with the scheduling despite differing degrees of autonomy, as is evidenced by the following worker comments:

> I like it [the work] a lot, I have five to six patients a day and that's considered a eight hour job. After I've done my patients, sometimes it doesn't always take eight hours, I've got time left to do whatever I want or need to do, its my time. A lot of times I need to get home for my child, so I do my paperwork in the evening at home. On the days that I have very hard patients, ones that take a long time or need full care, they [the agency scheduler] just gives me four or five. They [the agency] knows I have to be done by 3 p.m. so I can pick up my child.
>
> ...you are kind of more your own boss, you set your own schedule. They [the agency] tell you who to see, and how many to see, but how you go about doing it, it's your call. Once you've done your clients, you are done

> for the day. If you start early you get done early and can go home. You have "X" amount to do, and when it gets done is up to you, you're responsible. I don't have kids at home, but if I wanted to pick them up and take them somewhere, i.e., a game, I could work that into my schedule.

Autonomy in work practices and client care procedures was described by participants as important in giving workers a greater sense of control in an otherwise unpredictable work environment. The worker has a mission from the agency to go into the home "to care" for the client. While there are many other factors and conditions attached to the process, the ultimate decision of "how" to carry out the mission resides with the worker regardless of job category. Other factors related to the institutional structure of home care that also direct work will be discussed later. The following worker comment epitomizes the importance of having control, i.e., autonomy, in work practices and its relevance to the nature of risk perception.

> We go in and assess what the priorities are, even though we are doing wound care and that is the main medical reason we are there. We look at the whole picture, if we think they need help with personal care we can ask for it [send an order (request) to M.D., who usually signs it and approves it]. We can decide what supplies are needed, and we can figure out how we want to organize the care of the client. We make a plan and we follow it until we feel we are no longer needed. Even though we need the Dr's. "X" on the orders, they are developed by us, and they are what we feel is needed in the given situation. We have control of the situation to a major extent, as long as the client agrees and goes along with us; usually they do.

> ...oh I really enjoy this job, I usually try to spend about an hour with each client, but its entirely up to me. I give them the complete works, which is the bath, the shampoo, the nail care, the bed change, minor meal preparation, safety check and so on. Whatever is needed I do. Some people take less time because they are more able to care for themselves., they are less disabled. Even as an aide, I can decide what needs to be done and I can change it as needed, as long as I let the Case Manager know. I feel I have a lot of leeway. It makes me feel like I am in control.

Participant responses in regard to job autonomy generally provided positive comments about the perception of control over some of the risk in the workplace. However, the described autonomy in work practices which give the worker a sense of control does not come without some cost. For example, being autonomous and able to change work practices and schedules means that the worker is for the most part working independently. This means that the worker is alone in the physical environment of work. Rarely were two or more workers observed in the same home or environment at the same time. The lack of direct physical and emotional support by colleagues and peers was viewed by some workers as contributing to the perception of risk. The following comments describe worker concerns about "being out there alone":

> I love working out in the community, I see different people, I go to different homes, it rarely gets boring. But, there are times I miss having other nurses around just to bounce ideas off or to recheck your wound assessment. It helps to have the opinions of others in making judgement calls about a clients condition. At times I wished there was someone else I could ask "what do you think?, or what do you see? or hear?
>
> Sometimes you get pretty isolated for all the good things I like home care for - independence, flexibility - what you lose is the camaraderie. Like you could say "hey, this wound doesn't look good, what do you think?, what would you do?" Just the confirmation that you get in the hospital that you are doing it right, you don't get that in home care. You are making judgement calls all day long alone... nine times out of ten you did the right thing, but it feels lonely at times.
>
> You're on your own if the client goes down [falls to floor and can't get up] it's just you. It has happened to me and you try your damndest to get them up, but you can screw up yourself and your back too easily. It's not like the hospital where you can call down the hall for help, or call for the porters to help you. So, you have to call the fire department, and they come out in the fire truck to get the patient up. It's embarrassing but that's the policy. I know people have messed up their back trying to do it alone.

> You go from home to home and you may have some way of knowing what to expect in the neighborhoods, but really you're out there alone. Sometimes the family or caregiver is helpful and supportive, but you can't count on it. Its great to have the independence but the other side of the coin is that you're on you own! Some people like this and can take it day after day, others they don't make it in home care because it can be lonely and dangerous and they can't handle it.

These workers stated that the autonomy and independence enjoyed by HHC workers doesn't come without risks. The risk may be physical such as in trying to move or lift a client without help. Or the risk can be personal safety issues such as in going into homes or being out in the community. Often in places one would not otherwise frequent alone. Or the risk could be a professional issue in that peer consultation is not as readily available "out there" in the community setting as it is in the hospital or clinic setting; thus workers make judgements about client conditions in isolation.

Consequently autonomy in work has polar qualities in its contribution to the perception of risk in the workplace of home health care. Its positive contribution is that it is related to job satisfaction and a perception of control over work practices. Its negative contribution is that it puts workers in a position of isolation and a sense of "being out there alone."

Under the sub-dimension of self as professional, the major conceptual contributors to risk perception are job latitude, serving self, accountability, isolation, vulnerability, and negotiation in work.

The **Altruistic self** has been said to play an important role in defining the work of most of the "helping professions", i.e., nursing, ministry, social work, and

teaching. It is especially associated with professions where a majority of the workers are female (Melosh, 1982; Reverby, 1987;). This unselfish regard or devotion to others, which often comes at a cost to self, was alluded to several times by participants. Altruistic motives, while not labeled as such by workers, became evident as workers shared their reasoning in relation to risky behavior. Workers shared the following explanations:

> ...well if I don't go there [in reference to a dangerous neighborhood] who will...? The poor client would be abandoned, not to mention his wife.
>
> I didn't really want to go back, it was scary, but the client really needed us to be there. Someone's got to be there for these people. It's not their fault that they live where they do. They are as much at risk living there, as we are in going there.
>
> When I'm scheduling times, I will move anything just to make her visit in the afternoon. That's what she wants and needs. If it doesn't work out well sometimes I have a big space during the afternoon with no one to see and then I have to work overtime, which I can't charge for ....
>
> ...you put up with a lot of things, when I'm bathing older folks or having them in the shower, I keep the heat up high, because they get so cold. It gets so hot and unbearable at times for me, also I get wet because I have to hold them up in the shower or tub to wash them properly. It's more of a problem for me in winter, when I leave their stifling hot homes wet and go out into the cold.

All of these comments demonstrate ways in which workers stretch the concept of caring to include altruistic activities that they know increase their risk. When asked if they felt at greater risk while participating in the above described activities, most participants admitted "probably", but, could not see any alternative. The fact that it was their choice to participate was a significant factor in clouding the perception of the activities as being risky. As was described in the previous

chapter, dangerous or risky activities are perceived as less risky if participation is voluntary. Also, "optimistic bias", the idea that "it won't affect me", or that "I am some way immune to the danger", contributes to one's perception of voluntary risky behaviors.

Altruism and distinct work boundaries could be viewed as juxtapositional concepts that workers have to contend with in any form of "care" work. In a sense, altruistic endeavors put workers at risk because they blur the boundaries of where work ends and altruism begins. It can also be confusing to the client. What one worker might do for them in the course of work another worker may not, and could be viewed by the client as "not doing their job." Unclear work boundaries can create problems for workers and clients alike, resulting in problems of client dependence and attachment. In discussing this issue workers shared the following:

> Yeah, some clients really latch on to you, it feels good, some clients step over the boundary and get into your heart, and you try to do as much as you can for them. Some [clients] want our phone numbers and want to call us at home. That would be a big mistake. I don't mind telling them about myself if they ask, after all I know so much about them and they are letting me into their home. It would be like cheating in a way, to expect someone to be really truthful with us if we are not willing to be truthful and share ourself with them... I don't ever give out my personal phone number to clients, I tell them to call the agency.

In certain types of home care work, like hospice care, the boundaries become quite fuzzy for the client. Often it takes more initiative on the part of the worker to maintain boundary definition. This is evidenced by the following workers' comment:

> ...one man was caring for his wife who was dying. He spent hours going through the phone book to see if he could find my name and home phone number. He didn't want to call the on-call person. He made lots of calls before he found me. You'd be surprised how many clients out in the community will find out where you live without you telling them.
>
> Hospice work is one of those places that it [blurred boundaries] is more likely to occur. The business didn't have the safeguards that it should have had. Of course you have a lot of the Nursing business that isn't focused or doesn't take into account the co-dependency issues of work. So, there are a lot of nurses out there giving their own phone numbers and pager numbers to clients, thus making themselves susceptible.

Another worker shared the following words of wisdom given to her by a teacher:

> It's normal at times to have hazy boundaries but when you recognize they are hazy, correct it and take action. There are times when you will consciously cross those boundaries to do certain things, that's o.k., just know that you don't have to and you don't want to be doing it all the time. Once in a while it may occur and that's human.

Sometimes it's hard for home care workers to distinguish between altruism, caring, and just plain work because the boundaries separating these concepts in the home care situation are hazy. The problem is that when these boundaries become hazy, the workers may not perceive an increased susceptibility to danger and/or unsafe work conditions. Even if they do, they may have an optimistic opinion of what it means for them. This is what is described in chapter three and referred to in the literature as "optimistic bias." The home care workers in this study appeared to have a firm grasp on the problem of boundaries, in that they were aware of where work boundaries ended and personal boundaries began. Workers were conscious about decisions which allowed boundaries to become hazy. They were also aware of the increased work risk that this held for them. Under the sub-dimension altruistic self, the major conceptual contributors to the

perception of risk are boundary confusion, responsibility for others, abandonment fear, confusion about the concept of caring, attachment, and dependence.

Interacting and Relating to Peers and Colleagues. Relating to peers and colleagues is a necessary and integral part of home care work. In order to have a coordinated approach to managing client care, the individual worker must interact with numerous fellow caregivers such as nurses, aides, nurse consultants, physical therapists, respiratory therapists, social workers, physicians, and insurance managers. Depending on the complexity of the client's health and social condition any one or all of these workers may be involved in the care of a client. As described earlier, workers' identities and individual perspectives are associated with relating to various others and groups of others, contributing to one's perception of risk.

The significant dimensions related to risk perception, under the sub-dimension interacting and relating to peers and colleagues, are communication, peer opinion and subjectivity, consistency in agency philosophy, protecting status quo, gatekeeping, liability concerns, and working the system ("fudging" and manipulation).

Workers as **peers** interacted and related to each other via several modes of communication. While the more formal communication is written, the majority is informal and verbal. In one of the agencies, phone mail accessed by all workers was the principle form of communication regarding client information. This was

true especially in regard to emerging client conditions or changes in the plan of care. None of the agencies had a formal verbal "report", which is used in the hospital setting. In two of the agencies, information regarding clients is given and passed on in a less informal manner in "one on one" verbal exchange.

Client charts helped to augment the verbal relay of information. However, the majority of chart information was geared toward the reimbursement process, and did not address client care or risk management issues in enough detail to be helpful. Across agencies the chart information was described as not very helpful in preparing workers to enter new environments and visit clients they had not previously seen. In all three agencies there are places on the chart to relay information that can aid the worker in anticipating risk and avoiding danger, i.e., dogs, number of persons in home, nature of illness, hazardous environmental situations. However, on several occasions when workers were accompanied on visits to a new client, information that would have been helpful was not on the chart.

Workers shared that if they were not familiar with a client and/or visit environment, most of the time the chart was not very helpful in predicting visit expectations. In fact, most of the time, workers claimed they went out on new visits more or less "blind". Workers added that if there was information on a chart alerting them to possibly hazardous situations, they appreciated it and were more cautious on the first visit. However, because a peers' perception of risk or a dangerous situation was not necessarily the same as their perception, they

found it minimally useful. The following descriptions of workers' experiences emphasize some of the problems:

> ...charts are no better, they don't help. Directions are usually not good, I always call and ask the client despite what it says on the chart. I've gotten burned too many times. One time I was up in the hills, the chart said the client was "Pinky" something or other, for the life of me I couldn't find the house based on the other nurse's directions. I was ready to leave and then I saw a pink house, I thought I will take a chance and ask at that house. Well it was "Pinky's" house, I was lucky.
>
> The chart said "Dog" in big letters in the alert box, so I called the client and said I want you to have the dog outside when I come, chained up. The client never said anything or questioned me so I thought he understood. I get to the house and the client peeped through the door and said the dog was in a room with the door closed. I said ok. I went in and did the dressing change on the leg and I heard this whining sound. When I asked what it was, they said the dog, this dog turned out to be a 16 yr old, crippled dog with no teeth. I was all upset for nothing, and I felt like I had caused the client undue stress.
>
> I work weekends and I had to see this client for X who was off, the chart was not helpful in telling me what to expect in the home. By the address I figured I should go early. Well sure enough I call and this man answers the phone in a sleepy voice, I said I was coming to see the client in about 45 mins. When I got there, the street was pretty quiet because it was early Saturday a.m., however when I walked in the house there was 3 or four people sleeping or whatever, sitting up, in the living room. I asked where the client was, she was his Mom and in the back bedroom. It seems the other folk were "friends" who were there "to see his Mom" the night before. Obviously this was not something the other nurse could have known about. So in this situation the chart was of no help. I got in, and got out fast, and I did make a note on the chart to ask who was in the home prior to making each visit.

On one chart a worker had alerted other workers to possible danger, by writing on the chart, "lives in a lower socioeconomic area". Some workers took exception to this and criticized the worker for designating an area as dangerous just because "poor folks live there". Thus, experiences and characteristics that one

worker perceives as dangerous may be seen as over reactive and prejudicial by another. Likewise, client visits in several neighborhoods, which felt unsafe to the researcher and the accompanying worker, had been described as a "piece of cake" by the previous visitor.

There are gaps in the written information workers receive about clients, environments and care plans. As forms of interaction between workers, charts are fallible. While they are legal documents, charts are not free from opinion and subjectivity. Because the perception of risk is a subjective experience, what one worker may be alerted to as being dangerous or hazardous may not signal the same to another worker and information in the chart may reflect this phenomenon.

The most convenient time for workers to share information with each other about the clients, communities, and work related problems was during the morning "getting ready" period. This time period varied in each agency, but, generally occurred between 7:30 a.m. and 9:00 a.m.. During this time, workers compared their experiences with the clients they shared. It was also a time to gossip and problem solve about personal and professional experiences. Workers received support and advice from their peers, when they shared risky or dangerous situations. While fellow workers were generally described as supportive, a few workers shared that they had felt "put-down" or ridiculed by fellow workers when they had described scary situations. One worker described the feelings of pressure she felt from fellow workers who claimed she was over-reactive:

> ...I know how I felt and it was very scary, I didn't want to go back there or in that area again. One person [worker] said maybe I was watching too much T.V. news or crime shows. I wanted the agency to refuse to take clients in that area. Yet, this worker said "oh I'll go there, I'm not afraid" now how does that look, its ok for X to go there but no one else should go there. Does that mean X is brave or stupid. I felt the agency should make a rule and stick by it. I also felt that as fellow workers we should respect the feelings of each other. I felt like X was being macho, but I would never say it aloud, like she did to me.

Another worker described the following experience:

> ...after the meeting I took her aside and told her, "I'd appreciate it if you kept your opinions of others to yourself, especially if they are putdowns. I feel like we are all doing the best we can." "Y" was out of line, she said "Z" was "carrying on" about areas of XXXX street being unsafe, she said that "Z" is probably scared in her own neighborhood. "Y" then told me "well if she's that scared she'd better get out of the business."

All agencies had team meetings at least once a month, these meetings were designed to discuss client care issues and work practice related issues. The meetings usually involved discussions about agency policies and procedures, and some interaction in relation to work conditions and associated risk. In one of the meetings attended, a discussion was held that related to employee safety in coming and going from the office on weekends, nights, and afternoon shifts. This phenomenon seemed to be a problem in all three agencies because all three agencies had free standing offices, with minimal security protection "off-campus", from the main hospital buildings.

In the meeting, employees voiced their concerns about entry and exit from the office, especially when it was dark, and when no other workers were present. Employees shared feelings of vulnerability, with the majority of the workers supporting the employees who shared their concerns. Following the meeting, a

concerned employees shared this:

> I hate to keep bringing it up, this is the third meeting at which we've "talked" about it. I guess I'm branded as a complainer or troublemaker, at least that's how I perceive it. The other people [workers] who don't work when its dark or on weekends, are getting sick of hearing about it. They are supportive but I fear if we keep harping they may get fed up. At least today there were some viable suggestions and I hope they are acted on. If not, I guess I'll bring it up again and face the music.

Peer interaction and relationships are influential on a workers' perception of work-place risk. Peer interactions can be supportive of the worker's experience and an aid in mitigating risk. On the other hand, interactions can be non-supportive and may make workers question their experiences and perceptions of risk. Because the nature of risk is inherently subjective, interactions with peers can either enhance or create feelings of vulnerability where none previously existed, or, create an atmosphere of safeness when one does not exist.

Colleagues are defined as persons who are part of the work, but who do not include agency co-workers or families and clients. Colleagues consist of physicians, physician office staff, hospital staff (the most notable being nurses and discharge planners), and reimbursement representatives (such as Medical/Medicare or insurance company case managers/authorization workers).

Although these groups of persons are necessary at times they can be a troublesome component of the work of home care. They can either make the job easier and thus less stressful and risky, or, they can create or add to a stressful, risky situation. It is hard for clients to separate the worker who comes to their home to deliver care from the behind - the - scene workers mentioned above.

The above workers who are not involved in direct care are responsible to order, facilitate, authorize or deny care procedures and equipment. As a front line worker, the home care worker takes the brunt of a clients' wrath and anger when negative reimbursement or authorization situations arise.

Some physicians are easier to interact with than others. A good number of physicians accept, approve and return the plan of client care ("the orders"- devised by the home care worker) without question and in a timely manner. The "orders" are the written formal plan for client care that the nurse formulates after a first visit to a client. The agency submits the "orders" to the physician to be approved, before the agency can begin to be reimbursed for the care. Note that in chapter two it was mentioned that care cannot be reimbursed unless "ordered" by the physician. In reality, the physician very rarely sees clients in their home environment and has little awareness of the clients' true health needs in relation to that environment once out of the hospital. The agency often gets a call from the discharge planner or the ward nurse indicating that the physician has "ordered" home care for a hospitalized client post-discharge. If the client is already at home, the agency then gets a call from the physicians' office staff, rarely from the physician, telling them that home care has been ordered. The agency then forwards the usually meager information to the nurse who calls the client and arranges a first or "intake visit". The nurse visits the client, assesses the situation, and formulates a plan of care that the agency will utilize to service the client. This written formal plan is then submitted to the physician to be signed and

returned to the agency. The length of time this process takes varies according to the agency, the physician, and the physicians' office staff. The steps of this process was uniform across all study agencies. Although recent technological advances such as modems and fax machines have sped up the process, home care services usually still precede having the signed and approved written orders in hand. This can put the worker in a tenuous situation regarding professional liability. Workers proceed into persons' homes operating on the assumption that the physician will approve the suggested plan.

Most of the time, physicians sign and return the orders with full approval. There are some situations where the physician lacks real knowledge of the client's home situation, and may change part of the plan and disapprove of other components "suggested" by the nurse. One area that is more often challenged than others is the client's need for home health aide care i.e., personal care such as minor meal preparation, bathing, dressing, toileting, and ambulation. Some physicians are very rigid in their interpretation of the Medicare directives for home health aide service. Yet, they also have little or no idea what is really going on in the clients' home situation. For example, the clients may cope well with their illness in the hospital while eating prepared meals or being assisted with personal care activities and ambulation. Yet, in the home environment, they may have no one to prepare their meals, or to assist them in bathing or dressing. The nurse recognizes the clients' needs beyond those of the immediate medical condition and treatment.

As one nurse put it:

> I don't know what it is like in the other agencies or in other areas [geographic] but our doctors don't make home visits. I've had clients who I've seen for a year or more and I never hear from or see their doctor. In some instances they don't either, except for 3 or so times a year and then its at the doctor's office. I shouldn't complain though I guess, the doctor signs my supplemental orders without a problem and sends them back. He doesn't interfere or make life difficult for us.

Another worker added:

> It's fine for a doctor to give an order for a walker and ambulation three times a day. Yeah that is what the client should do, but the doctor has no idea if where or how the person lives. Have you ever observed a nurse or physical therapist trying to ambulate an elderly hip client, using a walker in a mobile home? The hallways are narrow, the bathroom is postage stamp sized. It just doesn't work. So we have to change the order, or figure out a way to "kind of" carry out the order. We have ways of making it work for the client, for us, given the environment. Most of the time if I call the doctor (if I can get him) and say "look this is the reality" then the doctor says ok.

Trying to interact with physicians by phone or in person is often a challenge for the worker. Once out of the office setting and on the road to making client visits, the worker is not easy to contact. For the remainder of the day the worker is fairly inaccessible to the physician, unless the worker has a car phone. In all agencies studied a majority of nurses carry beepers depending on the agency; few to none of the aides carry beepers. Therefore, back and forth communication between worker and physician or other contacts is difficult and limited. If someone beeps the worker, then the worker must find a phone to return the call. This could necessitate using a public phone, which in certain locations can be dangerous. Or it means using the client phone on arrival at the home. Workers may also need to call a physician while at a client's home to

report a change in condition or emerging problem. As is usually the case, the physician is not immediately available requiring the worker to stay and wait for a return call. Long waits for returned calls can upset the worker's schedule. If workers could not get a hold of the physician immediately, they would leave the clients' number and only wait for an extra five or so minutes. An additional complication to this "connecting process" was the gate keeping actions of the physicians' office or clinic staff. Gatekeepers are employees of the physician who work in the "front office" or receiving area of the office. These people are hired to act as a buffer zone for the physician, while most do this with some degree of tact, many are overzealous. Workers complained of never getting to speak to physicians about their concerns regarding clients due to overzealous gate keeping. A worker recounted this experience:

> I had a client who was deteriorating mentally, it wasn't a dire emergency or anything and I made the mistake of telling the receptionist this. But each visit the client was less with it cognitively. I called the doctor and left a message with the front office person, that I needed to discuss this with him. I tried for a week calling every 2 or so days, I didn't want anything to happen to her and I felt liable. Finally I got mad and I happened to be going by the office on a visit to another client, so I went right in there. I went in the office and told them who I was and what the problem was, they made me wait 15 mins but damn, I was staying put. When I finally got to see the doctor, he apologized and claimed he was not aware of the problem or my trying to reach him. Who really knows where the problem was. Now whenever I call that office I make sure they know it's me and I get a call back within a couple of hours.

In the above description, the worker was describing her vulnerability from a professional or legal perspective. She felt that she was at risk as a worker until the physician was aware of the client's condition.

Sixty percent of nurses interviewed and observed told me that when they had finished their day of client visits, they either went back to the office or went home to try and connect with physicians. Of the 29 workers interviewed, only three workers had car phones. Two of those were owned and operated by workers who were reimbursed by the agency for calls related to work. The other car phone was cumbersome, but was owned and operated by the agency for use by workers on the evening or night shift.

It was brought to my attention by workers that in some cases a physician may not be as experienced or as knowledgeable about the management of a client health problem as the home care worker. These situations included conditions that required the complex management of wounds, diabetes or dementia. During observations, wound care management was the most common reason for home care visits. Workers assessed and managed the care of wounds on a daily basis; in some client cases, this was done on a twice daily basis. Even in some of the more involved wound cases, physicians saw wounds on an average of once every two to three weeks. Clients complained of doctor applied dressings often being inadequate or falling off compared to nurse's dressing management. In fact, many of the clients with chronic ulcers don't see a physician on a regular basis, and only when the nurse identifies a problem. Nurses, and especially the wound care nurse specialists, were extremely knowledgeable about more contemporary approaches to wound management. In several situations, nurse specialists were observed "suggesting" modalities of treatment to physicians. At times, nurses advocated on

behalf of the client for the right to carry out a particular modality, as describe in the following scenario:

> This client has dementia and a chronic leg ulcer, he has had ulcers for over a year and we have been coming here to change it every day. He has a doctor who is trying to manage his wound, but who doesn't see him very often and doesn't really know or care what is going on. I don't totally agree with the doctor's plan, I think we could be more aggressive about it, but I do what the doctor wants. It puts me in a bad position. Last week after some convincing I finally got the doctor to okay a sequential compression device to try to push some of the fluid back into the blood vessels.

Another worker added this:

> ...I tried to get the doctor to let me try Sorbisan which is new wave stuff that wound care people are raving about. Finally the doctor said okay...you know sometimes these doctors consider themselves wound experts, when they aren't. They do their own thing that they have been doing for years, "wet to dry-wet to dry" and they won't listen to us. They are not really in touch with the changes in the field. It puts you in a funny spot...

Workers described being either "put in a bad position", or "in a funny spot", when situations such as these presented professional risk, especially when practice and patient care is compromised in order to placate another professional.

Hospital workers as colleagues are not always as helpful to the home care work process as they could be. Information on a new client is often very sketchy. However, one must keep in mind that hospital personnel only know the patient from the perspective of the hospital environment. They know little about the client's home life or social condition. Although a lot is known about the medical condition, at times even this information is lacking. Communication between home care workers and hospital personnel is problematic in that a lack of information on a client increases the risk to the worker on the first home visit.

The following examples of communication problems between hospital personnel and home care workers describe the situation.

> My client had been admitted to the hospital, I knew he had no money for meds when he was discharged. In anticipation I went up to the unit on my own time and said to the nurses, "would you have the doctor check this box because MediCal will cover 5 days of medication when he's discharged and it will buy us time..." So he came home and I went back to start his care, and he didn't have the meds. I even wrote a note to the doctor and put it on the front of his chart but he was transferred to another unit and they didn't transfer the note to the new chart. I was angry and frustrated.

> ...it's two different worlds, what goes on in the hospital and what we deal with out here. The transfer process between them [the hospital] and us gets screwed up. It makes it difficult for us, in what to expect from the client and family, but it makes it really hard on the client.

Unfortunately, available information may alert the home care worker to risk may be not appropriate once the client is home. The following example describes such a situation.

> We had been told by the hospital that the family was angry and demanding and at times one of the family members had been threatening. So I went to the first visit feeing apprehensive and on guard. Well I got there and everyone was as gracious as possible. I never felt in any danger and neither did any of our workers. The family was probably just scared and under stress when the client was in the acute part of his illness. When the client was recovering and was in his own home we didn't see any of it. It goes to show that when you do get the scoop from the hospital it might not fit what we see in the home and vice versa.

The home care worker also interacts with and relates to individuals representing the reimbursement institutions of home care. In most situations, the interaction takes time away from the care process as well a being a frustrating experience. While most of the interaction is handled through intermediaries such as billing and authorization people within the agency, the nurse may need to

interact with insurance or entitlement workers. This interaction adds to risk perception in home care work by increasing worker stress and frustration. Hampered ability to carry out responsibilities to clients can often lead to client and family anger and frustration. The following workers' experiences epitomize the problem:

> Well this client only was allowed eight visits, so we did the eight but he really couldn't manage. I called the MediCal worker and I went round and round with her. I had to argue and justify the need for a couple more visits like a lawyer. The worker wasn't rude or anything, they understood the situation, but didn't waiver a bit. These people [MediCal worker] follow the rules to the inch. They listen to the needs of the client but they are somewhat impassioned. The real loser are the clients because they aren't getting what they need and we can't do our job properly.
>
> I have got to know some of these folks [reimbursement workers] by name, I think it helps my case or at least the client's case. I don't always give the whole story, we all fudge, we tell them what they need to know.
>
> This one lady was M & M [MediCal and MediCare] and she'd had a stroke, and also had dementia. Essentially she was to the point of being recovered from the stroke, she didn't really need skilled home care. What she did need or what the family needed was help with dressing and bathing. You see when the physical therapist or the nurse is not in on the case then the home health aide cannot visit. We told the family we had to terminate, they begged and we squeezed a few more visits, but finally had to terminate. They were angry, they treated us like we made the rules, they didn't understand, the last visit was very uncomfortable, I couldn't wait to leave. Now talk about at risk.

In all the agencies workers who engaged in the majority of interactions with colleagues turned out to be the nurses. Home health aides, for the most part, interacted mainly with peers, clients, and families. Relationships and interaction with colleagues impacted on the work world of the home care worker by: 1) increasing or mitigating job related stress, 2) creating situations of increased

professional liability, and 3) affecting the relationship of client and worker and client and family. Consequently, relationships and interactions with colleagues both directly and indirectly impact on a workers perception of workplace risk.

Interacting and relating to clients and families. Of all the relationships in home care work, the one having the most significant impact on the perception of risk associated with work is that between the worker and the clients and their families. It was not possible to deal with the relationships between clients and worker and worker and families as separate interactions. More often than not, families are involved in the care process. As a result, the worker must attend to and deal with everyone as a unit. When families are not involved in the care process, then the worker deals only with the client. The relevant concepts of this sub-dimension that contributed to the workers' perception of work risk were: engagement of clients and families involved in stressful events, turf control, intimidation, dysfunctional family dynamics, front line representation, emotional boundary issues, and cultural and social conditions. These individual concepts are often difficult to separate out. Home care workers enter clients lives during extremely emotional events and stressful situations. Clients and families are enmeshed in dealing with conditions of illness, financial burden, death and grief, and disability and dependence.

Physicians, hospital and clinic workers, and case workers also deal with such human conditions as part of their work. Yet, they do so as a result of the

client presenting to them on their "turf." The traditional or institutional health care work environment is under the control of providers. Conversely, home health care workers interact with clients and families on the clients' "turf" - the home. In the privacy of their home, the client feels more at liberty to express emotion and anger. Such an experience may place home health care workers at a greater emotional and or physical risk. How some workers negotiated and managed their work while dealing with clients and families is described below:

> It wasn't the client who gave me the problem, he was a sick old man. The son answered the door, he was about 6' 4" and he had on these tight, I mean two sizes too small, tight, Spandex bike shorts, no shirt and a beeper. He stood at the door in the most intimidating stance. Then when I was sitting down next to the client, the son came up and stood over me, pretending to reach for something. He goes, "are you uncomfortable?" and I go "no, should I be?" The father was negative, he was a bilateral amputee and I figured my odds were better with him than with the son, he was the lesser of two evils. I tell you it was overt sexual intimidation and I felt real anger and aggression coming from the son. Well then his beeper went off and he ran in and put on some sweat pants and said "I'll be back". I got out of there as soon as he left. I was shaking, I went to the next client, she was a blind kind old lady, right away she knew something was wrong, she could tell. Well I called my manager, I was so scared. I thought he might see me on the street, I tell you I was intimidated.
>
> Some of our nurses had a problem with a clients son, the client was an old man who really need our care. Well the son was a pain in the ass, he was threatening and belligerent and he often had been drinking. He was verbally abusive to some of the nurses and made threats, not to them but to other people in the medical field. He told one of the nurses he had a gun and might use it. We had a meeting and decided to terminate care, we did inform the police to investigate if there was elder abuse. They [the agency] wanted someone to go back in to bring out the chart so we could officially terminate. I told the nurse on the case you are crazy to go back there, if they want the chart that bad they [the manager] should go get it.
>
> Working with other people watching you is something you get used to, it happens all the time with home care. The family is all around they want to learn how to take care of the client. At times they are more of a hindrance

> than a help, and teaching them how to do the care takes a lot longer than just doing it yourself, but we've got to help them become independent of us. Usually its never the client that is a problem, or is a threat, or who complains about you [worker], mostly its the family. Actually most of the time it's a pleasant experience.
>
> Usually it's not the clients who give you hassles. Well, sometimes they can be combative or verbally abusive but its because they are confused or demented. The big problems come from those who live with them, or the family members. They see us [home care workers] as part of the big picture, part of the system that's giving them problems.

On the other hand, the experiences of working with clients and families on their "own turf", in the home, has its rewards. Workers come to know families and clients in a way that doesn't exist in the more formal institutions of health care. Sometimes workers attend clients for a year or more, they often experience a deep sense of loss similar to that of losing a family member, when these long-term clients die. The following experiences recounted by home care workers describe this phenomenon:

> ...there is a couple who died, the husband shortly after the wife, where I still have twinges when I pass their home. You share a little bit of something and you give something to one another in the process of doing home care. You take a chance of getting fond of somebody and when you take that risk, then you hurt. To me the alternative is you will never hurt and you will never have the feelings you share with the folks [clients] you visit.
>
> When you're in peoples' homes the trust is stronger, we are on their turf, they don't have to have us, okay they need home care but they don't need this particular agency. They [clients] like doing things for us too. For some it's a cultural thing. If someone comes to your home, even if it is to give a bath or take a BP, then the custom is to treat them like a guest. In this one family the daughter and son made sure I had a nice little cup of espresso waiting for me at every visit. Most of the time I loved it, it took a little longer, but even when I was rushed or didn't feel like it, I drank it and made a fuss about it. They were trying so hard, it was very touching.

> Some [clients and families] want to give you things. I accept cards, and some goodies like candy and cookies, but nothing else. I am not allowed and I would never accept money or other stuff. In some cases families want to give you personal things, especially after the client has died. I refuse, except once about four years ago I accepted a little china figurine. The client had wanted me to have it and had told her family, I was very touched, I still have it, and I think if here when I look at it. When I have a bad day at work, it helps me keep in focus.

Workers struggle to keep the contract between worker, client and family as professional as possible; for the most part they are able to succeed. However, because of the uniqueness of this work environment, the boundaries can become hazy and are breached at times. The blurring of boundaries can affect the worker's perception of risk in the work place. This occurs especially in long-term care cases, where a given worker may visit a client one to three times a week for a year or more. Just as familiarity with an environment can decrease the unknown aspect of home care work, it can also precipitate the risk of attachment of worker to client. Attachment issues for the worker and dependence issues for the client are a much greater risk for worker and client alike in the home care setting. The following examples of worker experiences with such situations emphasizes the risk.

> I really loved this older lady, I had been visiting her for about sixteen months, I gave her personal care three times a week. We really shared a lot about our lives. She knew as much about me as I did about her. When she died, I felt like I had lost my Auntie or a close family member. I went to her funeral, but it felt strange, I think I felt as bad as the family. There have been about three clients and families that I have got really close to, in the five years that I've been doing this.

> The hard part is when say the hubby or wife dies and leaves the other, they are not only alone but they don't have the help and the company of us coming in every few days. I feel like we are deserting them. Several times I've felt so bad that I have continued to go see them on my own time, just as a friend. It just breaks your heart to see these folks alone in their homes.

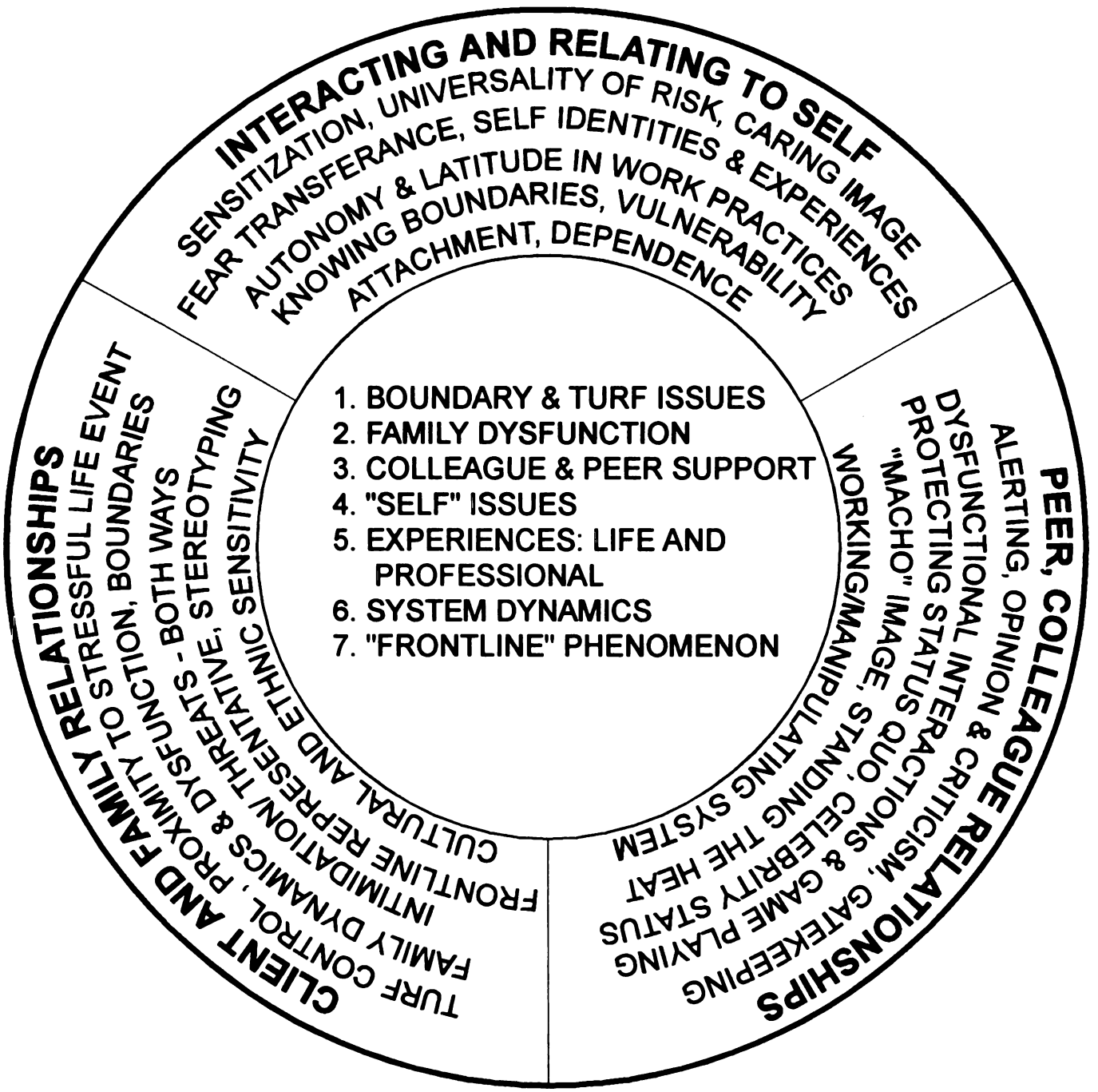
The social realities of health, illness, disability, and death are more evident to the home care worker than they are to health care workers in hospitals and clinics. The experience is different for home care workers because they see the social consequences of these conditions. They also see how the client and family react and deal with them in the familiar environment of home. This reality changes the experience of both the client and the worker. While such insight has its rewards, it is also not without risk.

The dimension of Relationships of Work is relevant to the risk-perception of HHC workers as they go about their work caring for clients and families in the home. The degree of relevance varied among workers and within agencies, being directly related to the contribution of the sub-dimensions. The sub-dimensions influencing perception of risk, evident across the dimension are: 1) boundary and "turf" dynamics, 2) degree of client/family dysfunction, 3) trade-off of autonomy versus isolation, 4) support of peers and colleagues, 5) self-identity and expectations, 6) life and professional experience, 7) health care delivery system dynamics, and 8) representative of "the system" (Figure 3).

FIGURE 3

RELEVANT DIMENSION & SUB-DIMENSIONS

RELATIONSHIPS OF WORK PERSPECTIVE



Institutional Structure and the Requirements of Work Perspective

The second relevant dimension which emerged from the data was Institutional Structure and the Requirements of Work. Home health care as an entity of health care delivery does not exist independent of the impediments/barriers attached to other forms of health care delivery. This part of the findings describes and discusses barriers that control reimbursement and the work of home health care. Next, it will be shown how these impediments along with the individual agencies' philosophy and organizational structure impact on the workers' perception of their work and its inherent risks. Finally the actual job tasks and requirements of home care work and their impact on the workers' perception of work and work risk will be discussed. In exploring the previous dimension, issues shown to be important to worker risk perception such as interaction with reimbursement and physician colleagues were discussed in detail from a personal interaction perspective. The focus in this dimension related to reimbursement issues and professional control will be from an institutional perspective.

Institutions of Home Care.

Medicine as an institution. In previous chapters, the evolution of contemporary home health care was explained in detail. As described earlier, in order to get the professional institution of medicine to support the entitlement programs of the 1960's, the U.S. Congress mandated that medicine would have

control over ordering and approving reimbursement for home health care. Medicine did not necessarily want to do the work of home health care, although it wanted to control access to home care services. This creates a dilemma based on the fact that physicians want very little to do with the active, hands-on, day to day direct care given in the home. Moreover, the physician has limited knowledge of what constitutes the work of home care. Consequently, he or she has difficulty relating to home care workers whom they do not interact with on a face to face basis. Essentially, the physician could be characterized as an absentee landlord in the process of home health care delivery. Other individuals who represent medicine, are actually involved in the organization and implementation of home health care delivery. These include, but are not limited to, such entities as hospitals, clinics, charitable organizations, professional organizations, religious groups, and private capital venture corporations. The way the organizations and workers interact impact on the risk perception of the home care worker. This process is often confusing and not easy to negotiate.

Workers know that they must have written orders from the client's physician in order to provide home health care. Yet, in most instances the orders they operate under are developed from standardized care plans. These orders often have little individuation, and are usually written by the nurse who made the initial visit. The physician gives cursory attention and approval to these orders and then signs them. The workers realize that the physician knows little about the client's needs beyond the medical treatment. Even the medical treatment as

directed by the physician may need adjustment in order for it to be appropriate in the home environment. The result of this is that often workers are placed in a legal compromise. On one hand, they are directed by the physicians orders, yet those orders may not be in the best interest of the client in their home environment. The following dilemma is described by a worker.

> Well the order on the chart said to do a wet to dry dressing, I just couldn't see this dressing working for this guy, so I used sorbisan instead for about six or so days and there was great improvement in the ulcer. When I called the doctor I had to couch the way I presented the situation to him. I suggested we try using sorbisan, even though I had already been using it. He agreed and we kept on with it, and now the ulcer is only a small spot. I had to make sure that I was going to be on for six or so days, I didn't want to get anyone else in trouble.

When asked why she initially hadn't called the doctor to change the treatment, she answered:

> Well I considered it, but I wanted to test my theory and see if it would work. I knew the wet to dry wouldn't because this old guy was up shuffling around so much and it's my experience that they fall off easily. It would have taken me a couple of days anyway to do it all above board. First you try to call the doctor, often it takes a day or so to get to them if your lucky, then I would have to write a supplemental order and send it off for him to sign. Before I went to all that trouble I guess I wanted to see if it would work. There are lots of times where we function like this. The whole process is so complicated. I feel very safe, and very positive about my assessments and judgments, so I take the risk.

Another situation where the mandate of control by physicians is weakened or ignored occurs when worker safety takes priority over orders for twice a day visits to individuals in a high risk neighborhood. An expert nurse put it this way:

> ...there's no way that I will do a p.m. dressing change, on that guy, living where he's living. I called up the doctor and said, "I'll go once a day, in the early morning to do it, but that's it. It's too dangerous to go back there in the afternoon." The doctor said okay, he didn't give me any gaffe, because

> he knows what that area is like. I doubt that he's ever been there himself or ever will go. My manager agreed, just across the board no BID dressing changes in that area.

A manager added this remark:

> I trust my staff, they are good experienced people, when they tell me they didn't follow an order to the tee, or had to change an order then there is a good reason. We then just try to write a supplemental, and get it signed as soon as possible, so we can cover their butts. 99% of the time the doctor signs it and no problem. They also know that we are the experts, when it comes to giving care out there.

The absentee landlord phenomenon along with the complicated process of physician approval prompts some workers to take chances that put them at risk. Situations such as those described occur frequently and mandates that workers negotiate the day to day realities of delivering health care in the home environment.

The institutions of reimbursement and entitlement. The institutions of insurance reimbursement and entitlement approval are cumbersome for the worker to negotiate. Since the majority of home care clients are elderly, their care falls under Medicare entitlement. In the three agencies that were part of this study, 90 percent of client care was reimbursed by MediCare and MediCaid (Medicaid in California is called MediCal). Workers shared that MediCare as a reimburser is the most lenient, exerting less control over the plan of care and work activities than either MediCal or private insurers. Even so, the bureaucracy is an incredible hurdle for workers to negotiate, often places them in positions of risk, and compromises the plan of care.

Consequences and dilemmas related to interactions between reimbursement

workers and home care workers have been described. Despite the sometimes collegial and cordial interactions among workers, the home care worker can still be placed in a compromised position. As a "frontline" representative of the system, the worker may face the wrath of families and clients when care is compromised or cut off. Many private insurance plans are capitated, placing increased pressure on the home care worker to fulfill the plan of care within a given fee structure. This given fee structure actually translates into a fixed number of visits and control over the type of worker skill mix in relation to the diagnosis of the client. These fixed variables do not recognize or take into account the impact of the social environment and the nature of the family dynamics, both of which can either augment or complicate client care. The following worker's comment epitomizes the situation:

> Whoever admits the client... applies a kind of formula on how to do the care plan, if its followed correctly and if the client and their diagnosis fits its perfectly then usually the number of visits will match when the care plan goals are attained and the client can be discharged. Sometimes it's not developed very well, or other things happen and you are still in there [the case is still opened] even though on paper everything is signed off and the goals are technically met. Often we are still in there trouble-shooting on other issues. Then we have to rewrite the care plan and resubmit to the doctor and to the insurance, so we can get an okay to make further visits and so the agency can get paid. It is a hassle, the agency gets mad at us, and sometimes money is lost.

Guides have been developed to assist workers in developing care plans. These are located in what is referred to as the "red book". The "canned plans" have been developed for various client problems, i.e., home care plan for client who has had a colectomy with a colostomy or a home care plan for a client who has had a total

knee replacement. Such guidelines help the home care worker estimate the types of problems to anticipate, the goals to establish, the number of visits it should take to accomplish this. The following worker's comment gives some insight into use of the "canned plans".

> ...it's a good book to get started with, it's a great learning guide especially when you are new at all this. The problem is the plans are too detailed and a lot of what they say doesn't make sense for all people, in the real world. There is certain rote stuff that you apply to everyone, you know hydration, ambulation, bowel and bladder stuff, safety stuff. What it does do is not "reinvent the wheel", you can use the same phrases and same goals for lots of different clients. I pick and choose to individualize to a particular client.

Workers must exercise caution about the plans they formulate. When complications arise that extend the care process and necessitate more visits, supplemental orders are generated to adjust the care plan for resubmission to the doctor and to the insurer. Workers are put in the position of meeting the need of the client while complying with capitation and Medicare criteria.

It is important for the home care worker, especially the nurse case manager, to know the "ins and outs" of the insurance maze. All study agencies had staff personnel who were intimate with the reimbursement criteria and rules, and who assisted and consulted with the nurses to negotiate the process. However, it is necessary for workers to become familiar with the criteria in order to make decisions about particular care procedures and products while out in the field. They need to know that the agency will be reimbursed for the procedure, or, that the product is covered and the client will not incur any expense. Families and clients become angry if they have to pay out of pocket for a procedure or

product suggested by the nurses, which is not covered by entitlement or insurance. The nurse then risks the wrath of the agency, which may have to pick up the tab or the wrath of the client left with an unexpected bill. How do workers learn this process? The following worker explains:

> You learn some of it in orientation, at the beginning the liaison nurse [staff person who is knowledgeable and manages insurance issues] gleans it out for you and helps you. Then usually as you go along, if you stay within the range the insurance promised and you assessed then you don't have hassles with them [the insurers and the agency]. But, if you miscalculate, or have a new problem or situation in the home or with the client, and this means that you have to stay in for more visits, then you tell your manager. Then depending on the agency, you or your manager or the claim people in your agency start calling the doctors and the insurance or MediCare people to get extensions or adjustments. With new people we spend a lot of time saying..."don't do this it's not covered etc., ...do this because it is well covered etc.... In home care as opposed to the hospital, it's mandatory that you learn this reimbursement stuff. If you do things that aren't covered, they [the agency] gets really pissed at you, because it's a loss of income to them. The insurance stuff is why we have tons of paperwork in home care.

Workers in all agencies complained about the excessive paperwork, most of which is related to reimbursement issues. The following description of the process emphasizes the amount of paperwork required.

> ...yeah, tons and tons of paperwork. I figure half my day is client care and half my day is paperwork. In order to get payment, because that's how home health care works, you have to document. You have to document to justify why people need home care. It's a lot of order writing, charting, and charting in home care is more complex than in the hospital, because you are not just telling what you've done you have to be justifying everything. We are constantly telling MediCare why we need to be in there. A lot of it is charting that is negative, if we start saying the client is feeling better or they can do this and that, then we are putting ourselves out of business. So we tend to only chart the negative stuff with small gains.

As a result of this rigorous need to document, meet criteria, and justify home care work, the worker is often placed in the position of needing to "fudge" or "work the system." The worker may feel the need to elaborate client conditions and situations in order to justify reimbursement criteria.

Workers often "fudge" on a clients' "homebound status". "Homebound status" is the term given to a client, who because of his or her illness, is unable to venture into the community (clinic or office) with enough regularity to receive necessary health care. Some clients fall into a grey area in regard to the definition of "homebound". While they venture out for occasional trips, it may not be often enough to receive the daily or every other day treatments provided by the home care agency. In other words, clients may go to the beauty parlor, lunch, or another health care provider such as the dentist; however they may not be well enough to go out to receive treatment.

Another situation where "fudging" occurs, and which was briefly mentioned in the previous dimension, involves essential personal care, i.e., bathing, dressing, feeding which cannot be given by the caregiver in the home or the family. This type of care is given by the home health aide. Unless the client also needs skilled care given by a nurse or physical therapist, he or she can't receive personal care or the services of the home health aide. The services of the home health aide are contingent on the need for skilled services. This is a common problem often occurring toward the end of a client's program of care, when there is still a need for help with personal care but skilled care is no longer necessary. In certain

situations, the nurse or the therapist recognizes the need and will "stay on the case", supposedly giving skilled care, while allowing the home health aide to continue on the case. At this point, the skilled care is sometimes classified as "instructional or teaching" care. Situations like these put the workers in a position of "not telling the truth completely", as described by the following worker.

> ...we do it constantly [fudging] as you will see, this lady, doesn't really need us to make a visit to discharge her we could have done it by phone, and it would have been less expensive for Medicare. I hate not telling the truth completely. On the other hand by going there I can see if everything is okay and discharge her. If you say to most clients over the phone, "how is everything" they will tell you "okay", they will not give you answers to questions not asked. Being there is good, one question leads to another, you can check nothing has changed since the last visit and you can have a clear mind when you discharge them. There is always fudging because if someone falls through the cracks of being truly "homebound" we make them completely "homebound" on paper because it gets too complicated to explain why we feel they need home care. Justifying what we really feel in our judgement is necessary gets too complicate. If they are not "homebound" then we can't visit, and then the next thing you find is that in a week or two they are in the hospital and that is far more expensive.
>
> I have never completely outright lied, I have though, not completely described the situation as it is. I would not lie about anything if I did not feel right about it in my professional judgement. We, or at least I, always operate in the best interest of the client and no one else.

As described, the workers are placed in a legally sensitive position, facing a threat of liability, or at least admonishment. If investigated, the agency faces the threat of non-payment for the services rendered, if discovery reveals services have been manipulated. Workers understand and accept this risk, feeling justified in what they are doing under the pretext of professional and ethical arguments for their decisions. Managers were less willing to acknowledge the practice of "fudging". However, they admitted that the system is large, and unmanageable at

times; and that, ..."people on the frontlines know what is best, a few bucks spent in an unauthorized manner can save the insurers thousands of dollars in the long haul."

Another reimbursement issue placing the worker at risk is the process of discharging a client under family protest. Clients are discharged because the plan of care is complete and the goals for home care have been met, or, because the number of authorized home visits have been completed. Some families and clients disagree with the judgement of the worker, or, the authorization doctrine; they become hostile and threatening to workers. This is a greater problem with clients who are only MediCal reimbursed or clients who have private capitated insurance plans. Workers are seen as the "frontline" representatives of these institutions because they are visible; families and clients have difficulty separating the worker from the reimbursing institutions. Consequently, workers are placed in compromising situations that can be fraught with risk, as the following situation describes:

> ...if their [family] eyes would have been bullets I'd have been dead. I could see their point and I advised them to call the client's physician to complain or try to extend, but they only saw me as part of the system. I took another worker with me on the last visit because I felt unsafe, everyone was emotionally on the edge. They now had to take over with the care, although most of it was changing the colostomy and ileostomy, the client was bummed and couldn't face doing it. I wouldn't be surprised to see him back in the hospital in a month or so for skin breakdown. I get as frustrated with the system as the families do, I had drawn out the discharge and squeezed an extra visit or two as it was. I just couldn't do it anymore.

Workers described several risks incurred secondary to the processes and criteria handed down from the reimbursement institutions of home care. In dealing with these institutions as part of the home care work process, workers incur risk involving personal safety, legal, professional, emotional, and ethical concerns.

The major contributors to the risk perception of workers that are attributed to the sub-dimension of Institutions of home care are financial control, control over practice, multi-layered bureaucratic systems, "frontline representative" phenomenon, client advocacy, and ethical dilemmas related to manipulating the system.

Agency structure and philosophy. Size, financial structure, and agency philosophy influence perceived risk of home health care workers. Of the three agencies in the study, one is considered a large agency (based on number of visits per month and size of staff) while the other two are smaller agencies. The large agency services an area of approximately 120 square miles and logs an average of 10,000 client visits each month. The two smaller agencies are similar in that they serve geographic areas averaging 100 square miles and log an average of 1,200 client visit per month.

All of the agencies are hospital based organizations and are considered not-for-profit agencies. Each agency operates as a separate entity from the organizational structure of the parent hospital, having its own organizational

structure. The structure of the agencies varied minimally and was related primarily to staff size. The large agency has a staff of 150 full time equivalent (FTE) workers including support staff, while the two smaller agencies each had a staff of 30 FTE workers, with support personnel. All the agencies had an executive officer in charge of client care. The larger agency had several more supervisorial levels vertically and horizontally to this position. In the smaller agencies, this position was held by the chief executive officer or director. Below the director of client care, the vertical structure of the agencies as a whole was very similar. The number of persons at each level was dependent on size. All agencies had supervisors, team leaders, case managers, various therapists, specialist nurses, staff nurses, and home health aides. In the smaller agencies, direct client care was carried out by the team leaders and those under them in the organizational structure. In the large agency, direct client care began with the case managers and was carried out by those employees under them in the organizational structure.

When employees were asked about management's concern for worker welfare when they are out in the field giving direct care, employees agreed that there was a greater understanding and empathy for worker experiences if their manager also had field experience. All but one of the middle level managers interviewed had experience in the field, and two of the managers currently made regular field visits. One of the practicing managers offered this comment:

> My people know that I can relate to their experiences out there, I think it really helps. They see me as a credible home care nurse as well as their

> boss. I think they share their problems and concerns with me more freely than say other workers do with their supervisors. They know I will respond, I will investigate or take things further, they know I really listen.

Managers who are familiar with both sides of home care work (management and direct care) were viewed favorably by participants as supportive and empathetic. Workers regard managers who possess a realistic understanding of work in the field as easier to approach with fears and concerns. One worker expressed:

> I was having a problem with the "extended family" they were somewhat belligerent and argued a lot with each other when I was giving care to the mom. I shared my concerns with my manager, and we talked about what I could do, to avoid putting myself in a position of aligning with one side or the other. She even went out on a visit with me. She could see what I had to deal with, I felt very supported. She was not afraid to get her hands dirty and helped me with the care. It meant a lot to me.

Managers with field experience have an understanding of the risks and day-to-day hassles that workers face. Workers definitely appreciate this level of understanding, especially in those managers who directly supervise field employees.

All the agencies had a risk management entity in their organizational structure. In the larger agency, this was in the form of a committee; while in the smaller agencies it took the form of one or more persons who were responsible for following up on accidents, incidents, or problems related to client care. Staff meetings appeared to be the forum for discussing concerns or problems related to worker risks or concerns. At the staff meetings attended, there were discussions about building perimeter safety and office entre' and exit safety. The problem was

based on the fact that each one of these hospital based agencies was located "off-campus". That is, each one of the agencies had an office location somewhere other than on hospital grounds, usually in privately owned buildings accustomed to routine office hours and use. As a result, employees felt that the offices where not particularly well secured for entry and exit during hours other than 8 a.m to 5 p.m., or on weekdays. Employees who had to use the buildings during evening, night or weekend hours felt quite vulnerable to risk for personal injury. In all three agencies, management was trying to facilitate a safer situation. However, the process was time consuming. The problem related to the fact that the owners/landlords of the buildings are unaccustomed to the type of activities and hours of use that home care requires. In most instances, landlords/owners did not provide 24 hour security, such as provided on the hospital campus. When agencies stay within the hospital campus, there is round-the-clock security provided by hospital security schedules.

Other situations compromising personal occurs when employees make evening or night visits, or, make client visits in dangerous areas. The larger agency in this study had recently contracted to use the services of an escort service, or "rent a cop" as they were characterized by the employees. Unfortunately, no participant could describe the process by which to engage the escort service; many were skeptical about it usefulness. Additionally, utilizing this escort service was not an on-the-spot kind of service but had to be planned ahead of time. The philosophy of all agencies was that workers "would not make the

visit if things looked or felt unsafe." The smaller agencies had no escort service available and they relied on the above philosophy. Managers respected and supported workers who failed to make client visits as a result of perceived danger. However, several workers claimed that there was some question about the sincerity of this philosophy. The following workers recount:

> ...sure they say that but you have to have a lot of justification not to make a visit. Then there's always someone else [a worker] who thinks they are macho enough to go in there, so that undermines it too. If you do refuse to visit more than once or so then you'd better start looking for another job.
>
> Yes, the agency says "if it's dangerous, don't go", but you'd have to be hard pressed to convince some of the supervisors about what you found to be a problem. It's like an inquiry, "well, so and so went and things were ok, how come they weren't when you went?" I've felt very challenged by managers and other nurses who seem to be intimating that I'm too timid or over reactive.
>
> One place I went to had two or three dogs untied in the front yard, I sat a beeped my horn but no one came to tie them up. I left and when I called my supervisor she was mad at me because the client's family had called and said I didn't make the visit, they were going to discharge the agency. The supervisor, instead of supporting me and seeing the danger, was angry. She already knew that this family was kind of crazy. Why would she not relate to my story and listen to them?
>
> There are times when the agency is more concerned abut keeping the clients than protecting the workers. Even when there have been blatant violations like guns visible in the house, in a bad neighborhood, the agency worries more about the "client's feelings and rights" than they do about worker safety. They [the agency] say one thing but really don't act on their so called philosophy.

In some instances, workers felt that agencies failed to honor their philosophy and did not support the workers' perception of danger. Employees were left wondering how to proceed in situations they perceive as dangerous.

Employees are confused when statements of support for employee decisions were not followed up by appropriate action on the part of the agency.

Pay structure was another significant operational variant among and within the agencies participating in the study. In one agency, all workers were paid on an hourly rate with an expectation that workers would see an average of 5.8 clients per day. Another agency paid on a per visit basis, indirectly workers were paid for each visit they made with the expectation that they would see between 5 to 6 clients per day. The last agency had a mixed structure with some employees being paid by the hour and others being paid by the visit. This situation evolved because employees originally had been given a choice of being paid hourly or by the visit. The new and current policy mandated that all new employees were hired on a pay per visit basis. This policy is the current trend in direct care employee reimbursement.

Some workers expressed concern over the pay per visit structure because they felt it affected the quality of care. They saw it as a means for the agency to increase the workload, i.e. workers are tempted to see more clients, thereby reducing the amount of time spent with each client. They felt this trend increased worker risk, because it entailed more driving and parking, more interactions per work day with clients and families and more exposure to high risk neighborhoods. Workers expressed the following concerns in regard to a pay per visit policy:

> I'm on an hourly rate, it was my choice to do it this way ...for me pay per visit rate would change my practice in that I would become motivated by the almighty dollar. I would be tempted to give less attention and concern to the client. It would affect my being with people [clients] in a way that

> allows them to open up versus a more hurried and mechanical approach. I think it makes people [workers] choosing to see more clients, they have to get done and out of the home quicker. I think it affects the quality of care.

Another added this:

> I don't have the choice, but pay per visit makes me feel like I'm on a treadmill, it's just not the way nurses are used to being paid. I find myself, constantly thinking about the next client. What route I'm going to take, where I will park, etc? It's more like a rat race, I feel very pressured to see six or so clients. On the other hand that is what is also expected of the hourly rate people, so it's not really too different, but it feels like we are under more pressure.

> I am an hourly worker and I see about 5-6 clients a day, on a really good day with no complications have seen up to seven but that is unusual. There are pay per visit people though who see 7-8 and even more on a regular basis, I worry about those people, how can they do that and do a good job. I wonder if the managers check up on them or if management thinks they are just "crackerjack-hotshot" workers. I would think they would wonder how do they do it and do a quality job. The bottom line though is how much money can be made?

Contrary to the above, workers previously described how important autonomy and independence were in making this type of work attractive. Freedom over scheduling and arranging one's work day and client visits gave workers a sense of control over the work and the way the work is carried out. In the previous relevant dimension this was seen as one of the more positive aspects of home health care. Yet, the above workers raised some important issues relative to risk perception they emphasized the subjective nature of risk perception, clarifying that what is perceived as risk to one worker is perceived as autonomy and independence to another.

Under the sub-dimension of agency structure and philosophy, the major dimensions that contribute to the workers' perception of work risk are mixed

agency messages, productivity pressures, manager empathy/support, and agency security.

The requirements of work. The requirements of work are those tasks and routines necessary to do the work of home health care. There are several expectations and tasks unique to home health care work that are not necessary to other types of health care work performed in hospitals and clinics. These include: 1) the necessity for and use of the worker's personal car and insurance coverage, 2) taking the care to the clients' environment instead of the client coming to the workers' environment, resulting in an isolated worker providing care in nonstandard environments, 3) overwhelming, non-computerized, record keeping to meet reimbursement requirements, and 4) self-scheduling and organization of the work.

The major dimensions relative to risk perception that emerged in the data were: 1) minimal control over work environment, 2) nonstandard work environment, 3) isolation, 4) control over schedule, 5) versatile and adaptive work force, 6) oppressive documentation, and 7) worker personal and financial liability.

Personal car use and liability. The use of one's own car and risking financial liability in driving from client to client is a necessity for the home care worker. Rather than the client coming to the worker for services in home care the worker brings services into the home. In similar types of occupations, were the services are brought to the home, in most instances a car and insurance are

supplied by the employer. Home health care workers for the most part were not happy with the situation regarding personal liability and personal car use. Workers expressed the following concerns about supplying transportation and insurance as a requisite to work in home health care:

> Driving so much, every day is a concern to me, I'm a lot more at risk for an accident than people who drive to a job and park the car for eight or so hours, then drive home. I feel more of a sense of danger on the freeways add to this rain or people driving like maniacs and I feel much more at risk than when I just drove to work and parked in the hospital parking lot. The agency had the Police Department come in and go over with us, what to do if your driving and someone is hassling you or following you. You ignore them, get off at the next exit, and drive to the nearest police station...I know all the locations of the police stations around here. ...we get 28 cents per mile as reimbursement for the use of our own car, every week we hand in our mileage. We write down the miles on the odometer when we start the day, and from client to client, and at the end of the day. It gets added up and we get reimbursed. Its [reimbursement] something to cover gas but it really doesn't cover it all, no way!
>
> We had a defensive driving class, and in orientation they show a movie about driving. You couldn't do this job around here if you didn't have a car, I don't know if anyone has ever challenged that legally though, like what if you didn't have a car but were a great home care nurse? I haven't had any accidents, so to speak, I have run out of gas and I have had a flat tire. My husband insists that I have triple A, they came both times, to rescue me. I did have to walk about 3/4 ths of a mile when I had the flat tire, I was out in the boonies. The money we get for reimbursement I think it's 27 cents per mile, probably only covers gas with a tiny bit over, because I average about 45-50 miles a day. It certainly doesn't cover the wear and tear, the insurance or the maintenance. I haven't told my insurance company that I use it for work, my rates would really go up.
>
> One thing you need is a reliable, safe car, its one of the major parts of the job. They reimburse me 28 cents per mile and that is it, I just found this out a couple of weeks ago that as far as insurance and damage to the car in the case of accident we are completely on our own. I was shocked by that. I thought those businesses that have company cars, you as the employee are not financially responsible for anything that happened to the car. So, why is it different for us, in earning a living we are helping the company make money by using our own car. I have a feeling it evolved from ... I

have to get controversial with you right from the beginning, but I think it evolved from the practice of women being exploited, because this is primarily a female profession. I think in professions that are mainly male and where one has to drive a lot, men get company cars and if they get an accident situation where they are provided for. I think its interesting that none of the women I have worked with have ever seem to have thought about the discrepancy. My manager told me that in the nine years that the agency has been operating there have only been two accidents, so that's pretty good.

I find it stressful... I had an accident. I had just gotten my car, changed insurance and stuff, the car was a nightmare. I was going on a visit, it was 9:30 am, and a car plowed right into me on the side of the car. It was raining lightly, I really thought for a moment "this is it, I have had it" I spun over to the other side of the street and regain control of the car. It was scary afterwards I didn't take that street for the longest time. ... I was out of work for a couple of weeks. I went to my physician eventually, I didn't think of it as job related, nobody in the agency told me it was job related and to go to the hospital E.R. and fill out forms, nobody told me that. I got out of the car and went into this bar to call the office to tell them I had an accident, they didn't say "go to the E.R or stuff" so I drove my smashed up car to my client's house and sat down and thought, "oh I don't feel well." I had to tell my manager, "hey, this is worker's comp. and here I am covering my own health bills. Finally I ended up going to the E.R. filling out all the forms, it ended up being a lawsuit.

It was a mess, I had to rent a car because my car had over $3,000 worth of damage to it, I had to pay the rental cost and had to miss a few weeks of work. ... I finally got a lawyer. It was mishandled by the agency, by my insurance, by the insurance of the person who ran into me, it caused me a lot of emotional distress. That was quite a while ago, we have a different manager and now we have a policy.

My car got totaled about a month ago, while it was parked in front of a client's house. He didn't have any insurance, my insurance covered it all. ... the insurance company asked a lot of questions and now I will be paying premiums that reflect using my car for business, which is much more. I also had to rent a car for a month so I had to take care of that expense too. The agency never shared any of the liability.

The risks that workers described involve both fear of injury to self and property due to the driving exposure, in addition to the financial risks related to car repair, rental, and insurance coverage in the event of an accident. Even

though the expenses associated with personal injury are covered by worker's compensation insurance, the emotional expense is significant. The vehicle repair or replacement, along with the subsequent increase in insurance premiums regardless of fault, are not covered by the agency.

Care procedures in nonstandard environment. Taking the work to the client requires the worker to be extremely adaptable. Since homes and living arrangements vary significantly, the worker must be competent with the tasks and duties of work to be able to complete the required work in a variety of settings. In traditional health care where the client presents himself for treatment in the environment of the worker, like a hospital or clinic, procedures remain fairly standard in their execution. While the clients may vary, the procedure for an enema, wound irrigation, or ostomy change remains standard, since the environment is standardized and equipment is standard and available. Standardization of environment is not a given in home care work, subsequently quite often procedures and equipment must vary and adapt to not only the client, but also the environment. A majority of the work done on or with clients in the hospital is usually done with the client undressed, wearing a hospital gown, and while the client is lying on a bed. In home care the work, the care is carried out with the client in many positions, on a multitude of types of furniture, and while wearing various combinations of attire. Again, this requires the home care worker to be very inventive and adaptable. Workers attempt to do their work with as little disruption to the client or the home as possible; often this comes at the

workers expense. While some of the concepts and worker protection practices implemented in the hospital setting are universal and applicable to home health care workers, such as universal precautions and body mechanics, they often need adaptation for effectiveness in the non-standardized home environment. The following worker comments describes such experiences:

> It can take several visits before we [worker] feel comfortable or familiar with the house and the layout, and before we figure out how to do some of the procedures and get the routine down, and that stuff makes the visit longer initially. For example, every time I went there I had to wait for the person [client] to get ready, to get undressed, to get on the bed or the couch. Also the supplies kept disappearing faster than I could imagine, so sometimes I would be short stuff. I need to irrigate and pack this incision while leaning over this frilly bedspread, on a queen-sized bed. The house was packed with junk, and the bedroom was worse, and the kitchen and bathroom were filthy.
>
> Finally, I got the routine figured out, and got the time down to 40 mins. for the visit. It took me 2 weeks though. I made it clear to the client when to expect me and to be ready, to be undressed and to be positioned where they wanted the procedure done. I made a check-off list of supplies and I made sure that the client was to check it and let me know when I called in the morning, of what was needed. I also brought extra stuff in my bag. I asked the family if they could make sure there were clean towels to cover the client and if they could clear up some of the junk around the bed. I approached by saying it wasn't safe in case the client had to get up at night. It took awhile, and some organization and adjustment but things did get easier. I always made sure I had my own roll of paper towels and liquid soap to wash and dry my hands with.
>
> Mr X was having tube feedings and don't ask me, but some of the equipment went missing between visits. I think someone in the family need it for "some other venture," anyway I found some large gauge tubing in my bag, that I knew was clean, and got a funnel from his kitchen and was able to manually give him the feeding. He hadn't eaten for 15 hours, and the family hadn't called to tell us about the missing stuff, I guess because they probably knew what had happened to it. I called the pump people, and arranged for new stuff to be brought over, but you never know what will be waiting for you. You have to be creative and adaptable.
>
> Sterile technique is a challenge, you are dealing with pets, pet hair, other

> people watching and many times unclean bedding and clothing immediately adjacent to the sterile field. You do your best to protect the client and to protect yourself.

In one situation I observed a nurse give an enema:

> The client was very frail and hard of hearing, the attendant in the home did not speak English, and all the time a small dog ran around and yipped at us, while jumping on and off the bed. The nurse was trying to protect the bed with towels and chux's, while reassuring the client, inserting the enema tube and keeping the dog out of the area. I asked her what was going through her mind and if the dog was a problem. She was kneeling on the floor at one point because the bed had no legs and was just a box spring on the floor. She answered... "no problem, I didn't want to embarrass the client, it was an uncomfortable procedure and I thought the dog might help her. I try to kneel whenever I can it saves bending over and saves my back, and it was important to me not to get the bed soiled. You can only apply so much of that body mechanic stuff in this area [home care]. You get used to lots of distractions, sometimes you don't do things like you would do them in the hospital, you have improvise. Each place is different and the way you would do one thing in one home is not how you would do it in another.

She went on to add this:

> Homes are different, the places we go and the people we see live their lives the best they can, it can be scary and sometimes it's dangerous but it's also interesting and never boring. That's probably why I love this work. You have to figure out how you can do a good job with what you have. Its tough sometimes and the people [clients and families] are a problem, but you learn to deal with lots of different types, a majority of them are great.

Workers in home care must be adaptable, creative and willing to accept uncertainty and lack of familiarity. Workers recognize that the unpredictability of the work environment has attached risks and their skill competency is challenged as they perform complicated procedures under less-than-ideal conditions. Workers must be prepared for contingencies, such as inadequate supplies, client readiness, and unusual locales for client treatment procedures. Yet, workers also

recognize that this degree of flux and unpredictability also prevents the work from becoming routine and boring, and they rise to the challenge.

Isolation in the field. Another unique requirement of home care work discussed previously, is that of working alone, isolated from one's peers or colleagues. Similar to hospital work, home care work requires the worker to do heavy physical work, such as lifting, pulling, turning and assisting the client, in order to reposition or move them from one place to another. If willing family members are not available to assist in the home, the worker must rely on his or her own strength and technique to accomplish the task. In the hospital, a variety of means are available for the worker to drawn on for assistance. There are peers and co-workers, and some institutions even have special teams of "lifters and movers"; there is usually someone a worker can call on for assistance. Although some examples of workers thoughts in regard to this aspect were previously described, the following comments reinforce the descriptions of risk associated with "being all alone out there [the field]."

> If you came with me tomorrow you will really see what I have to do. Tomorrow I have a lady with Multiple Sclerosis, she is total care and cannot move or help me at all. It's so hard to move her and lift her, I really need help. The problem in this business is that if the family is not there to help, or can't help, then you have to arrange for two people to meet at the house, it takes lots of coordination and then two people are involved in the visit. I don't know if the agency gets paid for two, or if they only get paid a flat fee for the visit.
>
> This one guy that I see has huge leg ulcers on the front of his upper leg and the back of his lower, left leg. When you need to examine the ulcers, and change the dressings, it would really help to have another person there to hold the leg up, he can't do it; he's too obese and weak. Well I figured out a way I could examine and change the dressings on both without him

> changing position. I had his nephew put up a hook in the ceiling, then we hung a continuous piece of 4 inch thick wrap from it, long enough to reach the client's bed. He would put his heel in it and I would kind of winch up his leg, that way I could do the whole thing. It would have been easier just to have another person to hold it but trying to arrange for another nurse or aide to meet me there was too cumbersome.
>
> Getting them [clients] in and out of the shower, or worse, the bath tub is when I could use an extra body every night after seeing her that day I had pains in my back. I finally had to tell this 250 Ib woman that I could not handle her getting in and out of the tub. She was angry at me, and pleaded with me each visit to get her in the tub, lamenting how good a tub bath would feel, and how its not fair she can't have one. I figured out that we could put a bench in the shower and I could shower her down. Even if we would have had two extra bodies it would have been tough, given a wet body and the confined space of the bathroom. My manager supported my decision and said it was unsafe for both the client and myself to continue with the tub business. I still felt kind of bad though.

Working alone leaves one feeling isolated and at times frustrated. Choices and decisions are often made alone where the advice or opinions of a co-worker would be beneficial. Workers also realize their physical limitations and must plan to get help or adjust the work procedure to accommodate their own and their clients' capabilities rather than take unnecessary risk.

Charting. Computerized record keeping has become the major mode of charting in the institutional setting. However, in home care in the three agencies studied, charting is done by hand and is a labor intensive part of the work. Workers quoted as much as 30 to 50 percent of their day spent justifying why they are in the home and the care they give. Workers claim that the chart is not a helpful medium for worker communication about risk, or to communicate client condition. They claim that the focus of the client's chart in home care is to satisfy and justify reimbursement. Worker comments in the context of charting and

worker communication have been described in detail previously. The following comments focus on the excessive nature of charting in home care.

> I never have time to really do my charting while I'm making visits. I usually make notes and then when I take a break (which I rarely do) or when I'm at lunch I try to catch up with the morning stuff. The afternoon visits are done after work or in the evening at home. There are so many places to chart, and note single items. On top of the client stuff we have to keep track also of our time spent on another sheet and then on another the milage we travel. Of all the things we do I think charting is the most frustrating to me anyway.

> Charting is a pain, we write all this stuff down in the chart, but its not in a form that is very helpful to the people who have to see your client on your day off. Its very helpful to those people in the business office who copy it into a computer, so the agency can bill for services.

> If you thought charting was bad in the hospital, welcome to home care. We spend a lot of effort charting in a negative way. I have got used to it now, but seeing that I'm into prevention, it was a problem to have to chart negatively, you don't chart what's right here? you chart what's wrong here! We focus on the problems because that's how we get reimbursed; we don't focus on the positive attributes of the clients. I wonder how does this view of life affect the worker? and maybe other life situations. If you are going out to these clients and you are not looking for what is right but what is wrong, how does that eventually transfer over to your life? Reimbursement is based on negativity. I guess philosophically it bothers me.

The function of charting in home care is a philosophical concern for some workers who perceive that their work is a more positive experience for the clients and the community than the documentation conveys. The majority of workers complained about the quantity of paperwork required to document care. They questioned if computerized records would improve the quality of information. While the handwritten work may decrease with computerization, the question remains regarding the usefulness for the client chart in minimizing worker risk.

Scheduling and organizing work. The home care worker has a given number of clients to see in an eight hour work day. As previously described, some workers see clients and are paid per visit, while others are paid by the hour. In all of the study agencies, the bottom line is that over a two week period of time, an average of 5.8 clients are visited by workers per eight hour day, regardless of worker pay arrangement. One agency paid its workers 1.6 hours per visit, and that time included driving time, coffee breaks, lunch breaks and charting. This translated into 5 to 6 clients per eight-hour day, depending on the type of client visited. Obviously, some clients have more complicated problems and require a longer visit time, while others maybe a quick recheck.

Case managers, who usually are nurses, are responsible for organizing the long-range schedules. The case managers oversee the management of clients by all disciplines. They organize the visit schedule for all clients under their supervision for anywhere from a week to a month in advance. The case managers then give the template of the projected schedule to the manager in some cases and in others to a "scheduler". In larger agencies, a scheduler receives the template from the case managers and works with the various schedules to produce a grand schedule. This is how agencies plan coverage around employee days off, and procure contingency workers for periods of high census (increased number of visits).

Workers are aware of what clients are scheduled to be seen on a daily basis. Unless the client has special needs, such as medications or treatments that

have to be given at very specific times, there is room for adjustment and negotiation. Workers generally know the clients they are scheduled to see one to two days prior to the day they are to visit. This is how workers acquired permission for the researcher to accompany them on visits, by calling the clients in advance. Nurses have more control over the scheduling than do the home health aides; however, the aides are consulted regularly by case managers and schedulers in regard to their opinions on clients and visit schedules.

Nurses and aides alike are responsible for calling clients the day before, or on the morning of the visit, in order to arrange an appointment time convenient to both worker, client, and family. There is room to negotiate moving a client's scheduled day to the next day if no specific time needs are to be met. This way, time can be allotted to clients who may require a longer visit, if workers have personal needs to be attend to, or to add a new client who will require an admission visit of 1.5 hours. Scheduling must also allow for meetings, which may include team meetings, staff meetings, committee meetings, or educational/mandated in-service meetings. In some instances, visits are made in addition to meetings. A worker may make three visits, attend a meeting for two hours, and then make another two or three visits. How this is handled varies according to the agency. Such situations may require the worker to work an additional two hours to their normal eight hour day. Workers and schedulers collaborate on plan amenable to agency and worker.

Workers accommodate clients' wishes in scheduling as much as possible.

When they phone, they state "I would like to come and see you at around 10:00 am, allow for 15 minutes on either side, does that sound okay?". "I've got you down on the schedule for 1:15, so be ready for me around then, Okay?" Asking "permission" to visit gives the client the illusion of having some control over the situation. In a majority of instances, the clients agree without a need to adjust the schedule. If adjustment is necessary, then the negotiation begins. Although there are times the client is not flexible, they must accept the time offered by the worker. If an agreement cannot be reached, they can either be reschedule for the next day, or another worker is assigned to visit. These situations are few and far between. The nurse is not allowed to visit the client if the client has a physician visit that same day; the agency will not be reimbursed for the visit. However, the aide may visit and give non-skilled, personal care. Some clients like to, or agree to be visited early in the morning or late in the day, in order to accommodate a worker's personal needs. For instance, workers who live closer to some clients than to the office may begin their day or end their day by seeing a client who is close to their home. None of the agencies had firm policies regarding checking in or checking out of the office prior to beginning or ending the workday.

The following worker comments give a sense of the attitudes and experiences related to the very essential work task of scheduling.

> I like the flexibility of organizing my own schedule, I like the independence. Its nice being able to have a chance to do things you need to. I mean if I need to go to the dentist, I go. In wage earning it's nice to have that independence. Most of the time I see six client's a day, I will try to accommodate them but I have my limits. If someone can't see me because they are going out to lunch or the beauty parlor, well forget it. Yet, if one

> of my people [clients] calls and is in pain or really needs me I'm there as soon as I can be. I feel I have more control over my work and thus it becomes my practice.
>
> When I'm figuring out my day I check the schedule usually the day before and then I set up a tentative schedule, then I call my clients sometimes the night before and see if the time I assigned will work. I rarely have to make major adjustments. If I go in the office in the morning then I try to go right home after my last visit. If I start seeing people first then I go into the office in the afternoon. It depends on who I am seeing, some I can start seeing at 7:30 am, others I can't see until 8:30 or 9:00 am. It just depends which ones are on my schedule. If it works out right then I plan this circle starting off by first seeing the client who is the greatest distance from the office or my house. Then I work closer and closer to the office or home as I go through the day. The exception is if I have to see a client in a bad, or risky area, then I go there first or second. I would never go to those areas later in the morning or afternoon. It [schedule] gets complicated but I am the one who makes it up, so I only have to blame myself.

Scheduling is a very complicated required work process. Workers perceive that their participation in the process gives them a degree of control in an otherwise unpredictable work world. Workers try to accommodate client wishes to control excessive driving. To use the work time efficiently, they have to set limits. Workers map out a route for the day either figuratively or literally, then they attempt to locate the scheduled visits onto this map according to were the client lives and the probable length of the visit.

The dimension of Institutional structure and Requirements of work is relevant to the risk perception of HHC workers as they provide care in the nonstandard, unpredictable environment of the home. The major sub-dimensions influencing the perception of risk in this relevant dimension are: 1) control issues

over the work environment, 2) control issues over work practices and procedures, 3) worker personal and financial liability, and 4) management commitment to a philosophy of worker safety (Figure 4).

FIGURE 4

RELEVANT DIMENSION & SUB-DIMENSIONS

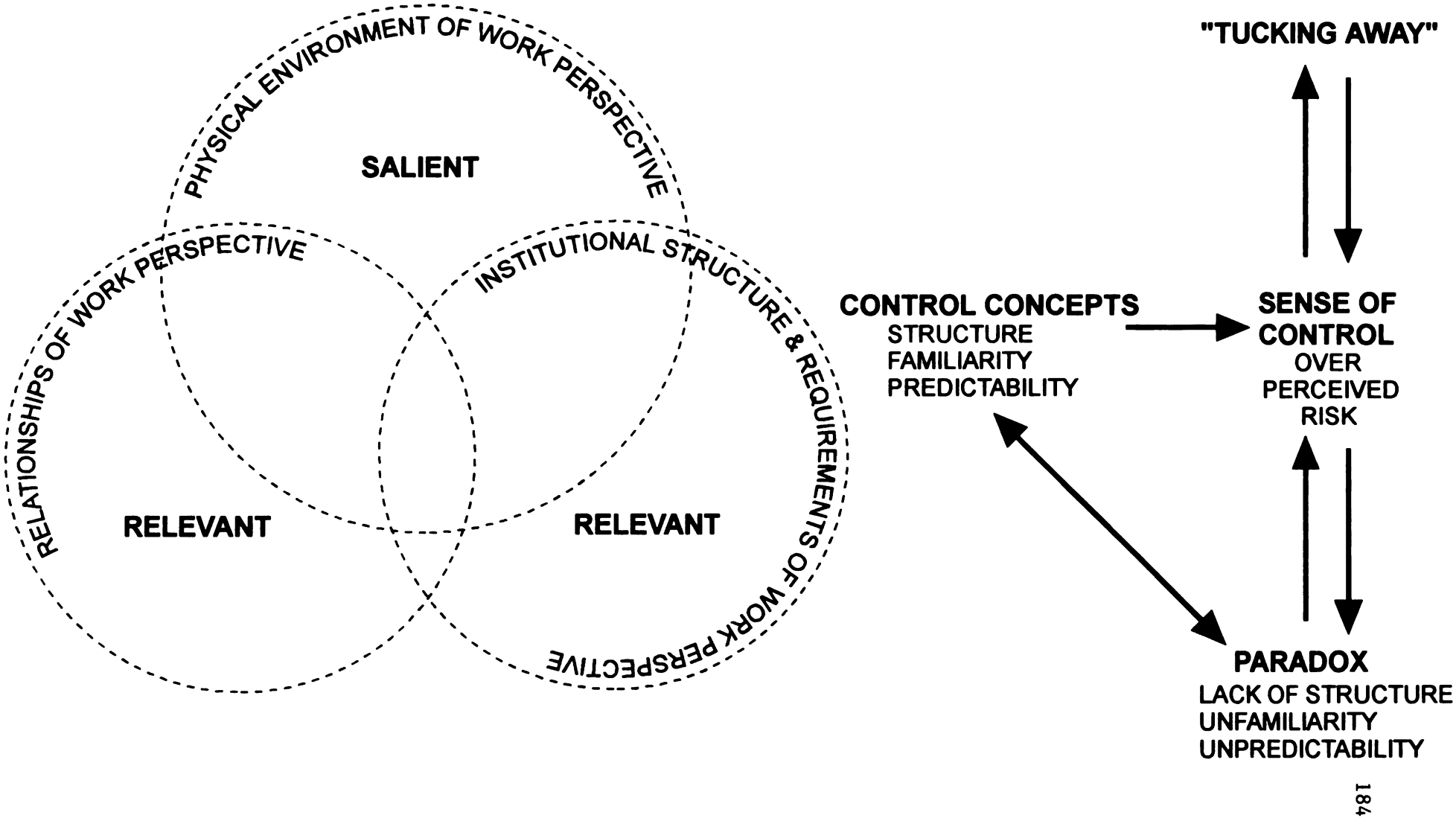
INSTITUTIONAL STRUCTURE & REQUIREMENTS OF WORK PERSPECTIVE

Summary

The dimensions which contribute to the perception of occupational risk in home health care workers have been described in detail. They illuminate the variety of concerns for workers as they go about the work of health care delivery in the home. In this study, the salient dimension of **physical environment of work** emerged as the most contributory to the variety of hazards and dangers in the workplace. While very important, the relevant dimensions of **relationships of work** and **institutional structure and requirements of work** overall did not require the same worker attendance or account for the same degree of concern as the **physical environment of work.**

Although these three dimensions share many commonalities, the boundaries separating them are for the most part transparent to the worker. This allows for overflow of cause and consequence. For example, an identified risk in the physical environment, such as "proximity to violent crime," may be related to and affect the relationships between worker and family, especially if a family member is involved in criminal activity. Likewise, institutional structure may have a significant effect on the client's family and the worker's relationship with the client and family. Workers did not compartmentalize the various risks into dimensions as they told their stories. Dimensionalization was used to render the mass of data manageable. The three dimensions interact and compliment each other in many instances, as they describe and explain the experience of the home health care worker in negotiating and managing the hazards of work.

FIGURE 5
RISK PERCEPTION: AN EXPLANATORY MODEL



Dashed lines indicate dynamic boundaries of dimensions
Depending on cohort, the degree of interaction and intersection of dimensions will vary

The Explanatory Model and the Interactive Nature of the Components

The following introduces the explanatory model of risk perception in home health care workers. It describes the dynamics of the boundaries and the relationships among the various dimensions revolving around the conditions of control, predictability, and familiarity (Figure 5).

Dimensional Relationships

The dimensionalization process of data analysis utilized the explanatory matrix in order to manage large masses of data. In designating and integrating data the explanatory matrix demonstrates the interactive nature of the data in the narrative form. The salient and relevant dimensional perspectives emerged out of the interactions and relationships among data. Some data are shared among all three dimensions, between two dimensions, or are the sole property of one dimension. This can be seen when one compares the major sub-dimensions that are listed at the center of each of the diagrammed dimensions. As such, the developed model proposes that the dimensional boundaries are dynamic, and the dimensions do not stand alone as isolated entities with rigid boundaries. The previous detailed discussion of the dimensions, their properties, conditions, and attributes described many of the interactions and intersections between the dimensions and the multitude of sub-dimensions. For example, the dimension **relationships in work,** shares many descriptions of risk related to relationships with peers, colleagues, and families that are also characteristic of and described in the dimension **institutional structure and the requirements of work.** The

interaction and intersection of the dimensions, are hypothetically depicted in the model in Figure 5, with the dashed lines representing the dynamics of the dimensional boundaries.

Control Concepts

The data in this study revealed not only the dimensions of occupational risk perception in home health care workers, but it also addressed the nature of the contribution of each of the dimensions to risk perception. In this study, the dimension that was the salient or most explanatory contributor was **physical environment**. The dimensions that were important, but not crucial to the perception of occupational risk were **institutional structure and requirements of work** and **relationships of work**. The salient or relevant nature of a dimension is not as definitive as it appears. In some individual situations described by the workers, the degree of salience or relevance fluctuated. For example, in some work situations in which the worker perceived risk, while the physical environment may have been important, the relationship with the family or client may have been as contributory to the perception of danger or emotional stress. Thus, for the individual in certain situations, the contributory value of each of the dimensions to the perception of risk can be a dynamic property. Not all identified dimensions are contributory all the time, for all workers, in all situations. However, in analyzing the data as an aggregate, the centrality of the dimension **physical environment of work** was evident and crucial to the perception of work risk.

Other major components of the explanatory model are labeled "control concepts." In the multiple scenarios described by workers, the conditions of control, predictability, and familiarity were identified as having a significant impact on the perception of risk. The unpredictability that workers' experience in the field is offset somewhat by the sense of control that workers feel they have over scheduling and work practices. With the ability to schedule clients as described, workers can have control over the time of day clients are seen and can control the order of client visits, as well as the route taken to complete the visits. Workers also enjoy a sense of autonomy once out in the field. They exercise their autonomy to assess client needs, create a work plan, and resolve how to accomplish it.

Each visit is unpredictable. This is particularly true in environments that tend to be unstable and volatile, such as inner city areas or extremely rural areas. Even in stable environments, changes in family dynamics, increasing social stress, and institutional variations all impact on the predictability of the visit. However, the first visit a worker makes to a new client holds the greatest risk. The worker knows little about the client, the family dynamics, or the social circumstances of the health problem. Familiarity with communities, neighborhoods, families, clients, care plans and work procedures gives the worker a sense of comfort or ease in the workplace; it reduces the perception of risk. If a worker is familiar with a situation, there is a certain sense of predictability and a sense of control over the situation.

Tucking Away

Another component of the model is an in-vivo concept that workers described as "tucking away." In experiencing non-standard, unpredictable work environments, workers acknowledged that the variety of risks they have to deal as part of their work could be perceived as overwhelming. However, in an effort to seek meaning and some aspect of control over this phenomenon, workers philosophically agree that risk is universal in all life experiences both in and out of the work place. Home health care workers accept that risk is inherent to the nature of their work because their work takes place in an environment, the home, that someone else (the client) controls.

This Mind process labeled "tucking away" allows the worker to acknowledge the hazards and dangers associated with their work, and at the same time prevents them from becoming paralyzed by the immensity of these dangers. The "tucking away" process has two phases. In the first phase, the worker acknowledges and categorizes a hazard. In this phase, they assess the meaning and consequence of the danger to The Self as an individual. In the second phase, the worker formulates an action plan to deal with the hazard in the event that the risk becomes immanent, and they store it for retrieval on demand. Subsequently, if the worker encounters a situation or experience recognized as matching their "tucked away" definition of risky, the worker retrieves and initiates the action plan. As the workers become more experienced in their work, the repertoire of plans becomes more extensive, and the workers have more options for action. Also,

with experience the "tucking away" process becomes more and more covert. As a result, a preoccupation with the hazards and dangers of the work becomes less and less. Consequently, in the novice home health care worker, the "tucking away" process is more overt. The novice has fewer options and action plans to draw on in times when risk is immanent. In order to survive in home care, a worker adopts the philosophy of universal risk, and becomes proficient in this "tucking away" process. Those that do not succeed in this process usually self select to another field of health care work, or work beyond the health care field.

The description of "tucking away" simplifies a very complex and protective mind process of risk assessment and deliberative action. The process of "tucking away" is a covert activity of Mind described in chapter three as a "mentalistic heuristic." The covert nature of the process proved to be a challenge in attempts to uncover (un-covert) how workers defined and managed the unpredictable nature of the home health care work environment.

Paradox: "The Upsides are the Downsides"

One of the most interesting findings of the study, also an in-vivo concept and an important component of the model, was one that came directly from the interview question, "What is attractive to you about this particular job and home care work in general?" In describing the things that made the job interesting, exciting, challenging, dynamic, independent and rewarding, workers had to make comparisons with other health care work and other work in general. In making

those comparisons, participants realized that many of the positive aspects unique to home care work were also the same characteristics that contributed to the risks associated with the work. The realization led many to describe a paradox, "the upsides of the job are the ones that create the downsides." This finding was unique in the fact that it emerged from a process of self-discovery, it became a "personal realization" of the participants.

Some of the positive job attributes of home care work have been identified as autonomy, independence, and self-sufficiency. Yet, these same attributes also create a situation where the worker is often an isolated, solitary, vulnerable representative of a vast, bureaucratic, health care system. Workers described having the greatest impact, or "doing the most good", and "feeling the most needed", in those environments that held the greatest risk. So, for many workers a greater degree of job satisfaction was associated with work in some of the more unpredictable, more unstable work environments.

A worker summarized the paradox this way:

> I know what I like about this job, and I know what makes it dangerous and can cause me problems, and for the most part there is not a lot of difference between the two. The thing that tips the scale for me though, is that the feedback I get from the good things or the upside of the job, is more rewarding and is greater than any of the bad consequences. Or at least it has been so far. I think what happens when that situation reverses is that people get out of the business [the work]. I don't think people [workers] think about this intellectually and weigh the good and the bad, they just know how they feel about their job. When you have a bad day, or a bad week, there are enough positive feedbacks to offset it; if there aren't, then it's dangerous for you to continue to do this work.

It can be argued that there is "good and bad" in most life experiences including work. Yet, in home care work, the paradox exists that the "good" or the positive attributes of the work are also the attributes that contribute to the "bad" or negative attributes of the work - specifically the risks of that work.

Summary

In this exploration of occupational risk perception in home health care workers, from a worker perspective the dimension **physical environment of work** was revealed to be a salient contributor to risk perception. In addition, the dimensions of **relationships of work,** and **institutional structure and requirements of work** were found to be relevant to the perception of risk. These three dimensions do not contribute to the worker's perception in isolation of each other. They are interactive and dynamic, with waxing and waning boundaries relative to the specific home care worker and home care work environment.

The conditions of predictability, structure, and familiarity have been shown to be influential in impacting on the sense of control and ultimately the perception of risk. Workers seek to have a sense of control over the various hazards of work by engaging in a risk assessment and deliberative planning Mind process that has been labeled "tucking away". This process is less covert in the novice home health care worker than it is in the experienced worker. Because of this, the expert home health care worker has more options for dealing with work related risk.

Workers in home health care realized they are faced with a paradox, in that the "upsides of the job are the downsides of the job." Workers discovered the reality that the positive attributes of work in home health care can be the very same attributes that create dangerous and hazardous conditions and contribute to the perception of risk.

The above described interacting factors involved in the process of occupational risk perception in home health care workers is best understood through the proposed explanatory model (Figure 5). The explanatory model, in dimensional analysis serves to link and describe relationships among context, conditions, attributes, interaction and consequences of the phenomenon of occupational risk perception.

CHAPTER SIX

SUMMARY, LIMITATIONS AND IMPLICATIONS OF THE STUDY

The purpose of this final chapter is to: 1) briefly summarize the substantive theory developed in this study of occupational risk perception in home health care workers, 2) discuss the relationship of the findings to the literature, 3) delineate the limitations of the study, and 4) present the implications for practice and future research.

Substantive Theory

This study sought to explore the process of worker risk perception in home health care work. The substantive theory generated allows one to understand and accurately assess how workers negotiate and manage a safe working environment. The theory is presented in the form of an explanatory model and elaborates the components and factors that contribute to the sense of risk in the home care work environment. It reveals how the perception of occupational risk is inherently subjective and variable among workers even under identical conditions.

The proposed model has three related parts. The first identifies how workers assess and characterize experiences and interactions in the work place, which they perceive as risky. The second recognizes the paradoxical relationship of control concepts such as predictability, familiarity, and structure, and their influence on the perception of risk in the work environment. The third part uncovers the process of "tucking away", as a deliberative process developed over

time by workers, which helps them to create a sense of control over the work environment.

Moreover, the study demonstrated the salience of the worker's perspective of physical environment and the relevance of the worker's perspective of relationships in work. Also from a worker's perspective it identified the relevant organizational institutions and work practices that are major contributors to the perception of risk.

The Relationship of the Theory to the Literature

Previous research provides little insight into the complex process of risk perception from the perspective of the home health care worker. Risk perception research, and especially occupational risk perception, has been studied from the perspective of administrators or managers rather than the worker's viewpoint. A majority of these studies have utilized quantitative methods with data often gathered away from the natural work setting. As evidenced by the citations in Chapter two, much of the information regarding the risks of home health care work have been extrapolated from hospital based research. From such research findings interventions have been employed that have little relevance to the experiences and work practices of home care workers. This study presents a different perspective, that of the worker. It first described and explored the physical and psychosocial factors influencing and affecting worker safety in the natural environment of home care work. Secondly, it explained the various processes and strategies that workers utilize to assess danger or risk to themselves

in the home care work setting. Thirdly, it described in the workers' own words the actions and behaviors they take to negotiate perceived hazards so as to produce and/or maintain a safe work environment. Finally, it explored the factors that workers perceive to be facilitative or obstructive to the process of negotiating a safe work environment. This exploration of occupational risk perception in home health care workers is a unique approach to both risk perception and home health care work.

Throughout the study, regardless of this unique approach, themes and concepts emerged that coincided with themes in the literature. One such coincidence was evident when workers described how they assess for and categorize work situations as threatening or dangerous. In perceiving risk they compared their perception with scenarios and cues they had stored or "tucked away". In finding a stored match or similarity, they coupled it with a previously stored successful plan of action. This behavior for the most part is covert and involved a constant comparative process. This constant comparative process, in which workers engage routinely in negotiating and maintaining a safe work environment, reinforces the choice of research method and data analysis utilized in the study. This interactive process involves the worker interacting with the work environment as well as interacting with the various perspectives of the Self. This includes the Self as novice, the Self as mother, the Self as vulnerable, and so on. The "tucking away" process as it was labeled in this study, is a symbolic interactive process. Slovic, Fischhoff, and Lichtenstein (1977, 1984) identified a

similar process and described it as a set of mental strategies or heuristics. It is especially useful in making sense and giving direction in uncertain situations. However, it is important to note that the literature did not appear to address the impact of life experience, both on and off the job, affecting one's ability to apply the heuristic. The findings of this study imply that this symbolic interactive process or heuristic is more covert, adaptive, and articulate in the expert home health care worker than in the novice home health care worker.

Another area where the study findings paralleled the literature is associated with the phenomenon of "optimistic bias" (Bauman and Siegel, 1987; Joseph, 1987; Weinstein, 1987, 1989; Weinstein, Klotz & Sandman, 1988). Home health care workers freely and fluently acknowledged the risks associated with home care work. In many instances, they described dangerous work scenarios from which they had safely extricated themselves. They went on to claim that other workers may not have had the same safe outcome. Such optimistic bias was more evident in the stories of expert workers than in the stories of the novice workers. This phenomenon was verified by managers who expressed concern for the safety of expert workers who operate under an assumption of optimistic bias. Consequently, these workers perceive themselves to be invincible and may not take the necessary safety precautions. The phenomenon is compounded by the fact that these expert workers enjoy the notoriety they receive from their peers when they take on risk-laden work schedules. The literature does describe an admiration factor related to risk taking, Easterling (1989) noted that people who

involve themselves in multiple risky activities are more sensitive to peer or reference group influence.

The data also supported the concept of stigmatization, or at least negative stereotyping, as noted by Goffman (1963), who described its relationship to risk perception. Workers described situations in which negative stereotyping had affected their colleagues' ability to accurately communicate risk to fellow workers. They claimed that the risks perceived by some colleagues arose from a prejudicial base, and were related more to the negative stereotypes attached to the neighborhood and the demographics of the clients rather than to the individual characteristics and qualities of the client or family. However, in accepting that the perception of risk is inherently subjective as well as recognizing the salience of physical environment to risk perception, it may be hard to argue against the fact that for a given worker risk is what he or she perceives to be dangerous and not what someone else (another worker) perceives to be dangerous.

The paradox unveiled in the model is a fascinating phenomenon. As workers shared their experiences, realizations were made that many of the characteristics and attributes of home health care work that contributed to the perception of risk also contributed to the workers' sense of autonomy, control and dynamism. Autonomy and control over work practices and schedules paradoxically affected a worker's perception of risk that arose out of working in unstructured, unpredictable environments. Likewise, while significantly contributing to risk perception, the challenging and dynamic work environments of

home care made work exciting, stimulating, and less tedious. Such lack of structure and predictability affords the worker a chance to be creative and inventive with the consequence that there is a perception of control and risk diminution. The literature has not described the paradox in such a way as revealed in this study. Many studies have described the characteristics of work that increase worker satisfaction and reduce work stress but have not related it to risk perception, nor have they revealed the self-discovery process (Baker, 1985; Karasek, et al., 1981). Recent studies of job satisfaction and stress in home health care work have described similar "satisfying" characteristics (Chubin, 1991; Lynch, 1994; McCloskey, 1990). Yet, none have described the paradoxical phenomenon quite as succinctly and expressively as the workers in this study - "the good things about the job are also the bad things, the risks come with the challenges." Moreover, the majority of studies that have examined job satisfaction have tended to utilize non-naturalistic research designs and quantitative analytical methods.

In contrast to the categorical descriptions of the risks described in the literature, the participants in this study did not conceptualize or categorize their perceptions of work risk as in the literature. No participant spoke of physical hazards, biological hazards or chemical hazards in such a way as is reviewed and outlined in Chapter two. In fact it was surprising that the participants' perception of risk involved very little discussion of such feared hazards. The category of psychosocial hazards was the only category that received significant attention from the participants, especially in the area of personal violence. The participants'

perception of risk was less categorical and clearly more personal; it varied from worker to worker, depending on the perspective of the particular worker. Again, this reinforces how subjective the perception of risk is for the individual worker and possibly why targeting safety education/information to a large heterogenous audience hasn't always been successful.

The theory developed in this study is supported in part by the literature. At the same time, the theory also offers some unique concepts and relationships that add to the bodies of knowledge encompassing occupational risk perception and home health care work.

Limitations of the study

Several factors related to sampling, data collection, and analysis limit the use of the results of this grounded dimensional analysis. In this type of naturalistic research, the investigator specifies the conditions and contexts of the emerging substantive theory (McCarthy, 1991).

Although the explanatory model for occupational risk perception is generally applicable to other populations of home health care workers, the details of the data cannot be generalized to the population of health care workers, or to the population of workers who work in the home environment.

Limitations applied to the population tend to restrict the ability to generalize the results. The population of the study was limited to home health care nurses and aides, and did not include the multitude of workers involved in home care work. The researcher attempted to overcome these restrictions with

the use of theoretical sampling among participants, as well as among agencies sampled, i.e., variation in the size and geographic location of the agencies sampled.

Theoretical sampling led to workers who validated data or who introduced intervening conditions that challenged and enhanced the data derived from participant interviews and observations. The variation in agency size uncovered conditions of the work environment that either directly or indirectly affected the process of risk perception. For example, the greater number and need for relationships among workers, peers, and colleagues in the large agency had a impact on the descriptions of work and perceived risk. Likewise, in the smaller agencies the fewer number of workers and consequently specialist peer workers had an impact on their descriptions of work and perceived risk. Certainly, the various geographic locations of agencies reflected the areas where the majority of home care visits were made, and also impacted on the risk perception of workers. For example, although the agencies in the suburban areas had some urban clients, for the most part they visited clients who resided in suburban or rural areas.

Sample size and variability of the sample were other potential limitations. Thirty workers were interviewed and observed, including eighteen nurses, seven home health care aides, and four managers. While the number of participants is sufficient for qualitative research, it is possible that important data may have been excluded due to sample size. However, the data obtained from the twenty-nine participants using this naturalistic design has a depth and richness that is not

possible to achieve from quantitative research methods. Although the sample was limited to certain kinds of home care workers (nurses and home health aides), these workers are described in the literature as the home care workers who have the greatest contact with clients in their homes (Keating and Kelman, 1988; Martinson and Widmer, 1989; Rice, 1992). Four of the participants were managers they were included to validate or add intervening conditions to the stories of the workers. It was heartening to observe that all the manager participants had field experience, and overall had more years of experience in home health care work than the other categories of workers. Repetition in the data became evident at approximately mid-point in the data collection. Even with the small sample size, the researcher was assured that dimensional saturation was achieved.

The use of semi-structured interviews and the voluntary nature of participant recruitment limits the data to only those nurses, aides, and managers who had a "story to tell", and those who were willing to share their experiences. HHC workers who did not volunteer and who were less willing to share their story may have had different data to contribute. Educational preparation and socioeconomic status varied among categories of workers sampled. Such variability could have affected the data. For example, participants with less education and/or from a lower socioeconomic strata than other workers may have been inhibited or less fluent in telling their stories.

The theory is influenced by the researcher's assumptions and potential for

bias. In qualitative research, subjectivity is valued for its ability to add depth and insight into the phenomenon under investigation. Yet, bias must be acknowledged and identified not only in the data collection process, but, also in the data analysis process. The researcher's interest in the risks facing health care workers, especially home health care workers, was triggered by previous clinical experience and recent research activities (Smith & White, 1993; White & Smith, 1993). The researcher approached the study assuming a dearth of published research in relation to occupational health issues in the home care setting, which was borne out by a review of the literature. In contrast, the researcher assumed that a wealth of first-hand knowledge was available given the appropriate methodology.

Attempts were made to control methodological limitations. Bias was controlled by the researcher with constant reviewing and revisiting of the data, acknowledging universalities, looking for negative instances and contradictions, and by sampling using multiple data sources and methods. Since data analysis began with the collection of the first pieces of data, the researcher constantly compared the designated emerging categories and codes with participants as further data was collected. In some instances, the participants contradicted previous data and analysis. When this happened, the researcher returned to the data, made comparisons, and conducted further analysis to incorporate or reflect the new perspectives. The researcher was vigilant during data collection and analysis in assessing the impact of her input and any effect it had on participant response. Memos and theoretical notes were used to indicate possible influence

and were taken into account during data analysis. Finally, the researcher presented the developed explanatory model to expert home health care workers in order to check internal validity in terms of the fit of the theory to their experience. Additionally colleagues experienced with the grounded dimensional analysis approach were consulted to question and recheck analytic methods.

The most significant limitation to this study is that the theory developed is a new theory. Being in the early stages of development, the theory needs to be challenged in further studies. Concepts need to be refined and the relationships between the components need to be tested.

Implications of the Study and Findings

The ability of workers to safely perform their work without injury or illness is the essence of occupational health. Home health care workers are a unique group of health care workers who perform "caring" work in the context of the home environment. Their work may involve a multitude of highly technological activities that previously were performed in very structured settings such as hospitals and clinics. Yet, the home as a health care work environment is extremely diverse and unstructured. Also, the home health care industry and thus the work force is growing rapidly (Caserta, 1991; White, 1991; Lynch 1994). This expanding work force requires the same attention focused upon it that the institutional health care work force received approximately ten to fifteen years ago. The environment of hospital work and home care work are so different that

the findings/outcomes of hospital based occupational health studies cannot simply be extrapolated to home health care work.

The findings of this study have significant impact in what is known about the work experiences of home health care workers. The implications for this study are three-fold: 1) further research and theory development are needed to test the explanatory model in the research arena of home health care work with different categories of workers. Also further testing of the explanatory model is needed in the research arena of risk perception; 2) there is a need to re-evaluate and challenge home health care work practices, especially those that have been pointed out by workers in this study to be time consuming, ineffective, and obstructive to a safe work environment; and 3) a need to re-conceptualize the concept of work environment and its contribution to occupational risk, especially when the environment is unstructured and unpredictable as in the home health care setting. The most important implication for this study and for any occupational health research is to create a safer work environment. This study discovered and examined the health and safety issues that home health care workers perceive they experience in the course of their work. The following are suggested measures to mitigate the occupational risks described by workers.

A multi-disciplinary evaluation of the various institutions and institutional practices of home health care would be the first step in an over-all reform process. Such reform would in turn direct a re-evaluation of the time consuming and risk laden work practices described in the study. While these seem like

unsurmountable tasks, recent attempts at health care reform, even though temporarily sidelined, will resurface and home health care workers and occupational health advocates need to have a voice in the outcome. In the mean time, home health care agencies, workers and, occupational health experts in home health care can participate in a dialogue that fosters safe work practices in the unstructured environment of home care.

In addition to disseminating the findings of the study to fellow researchers and occupational health professionals, it will be important to get the information to home health care workers. Attending the meetings of home health care nurse interest groups to report on the findings, or publishing the findings in interest group newsletters, will be as important as publishing in professionally refereed journals. In addition, if the study's assumption that the perception of risk is inherently subjective holds, suggesting use of the findings to create a risk assessment checklist for geographic areas and client diagnoses may be contradictory. Because, as described, not all workers will perceive the same risk from the same work encounter or situation. However, using the findings to develop more personal individualized employee education and risk sensitization programs may be an appropriate approach. If this approach is utilized, it makes it even more important that workers have knowledge of these study findings and have easy access (lay language, in lay journals) to other occupational health research related to home health care work. Appropriate health and safety programs for the home health care industry may have better outcomes if they

include small focus group meetings. These types of groups are an ideal forum for workers to share their experiences and perceptions of the work environment. Expert workers could share "tucked away" action plans with novice workers, group meetings could serve as learning opportunities. Also, as in the study workers in "telling their stories" could discover and learn from verbalizing their own attitudes, behaviors and perceptions.

The self discovery process that revealed the paradox is intriguing, and because the characteristics described by workers as the "upside of the job" were shown to impact on risk perception, future studies that compare occupational risk perception with perceived job satisfaction are encouraged. Further research that examines unstructured work environments and makes comparisons across occupations would be fascinating to test the paradox phenomenon and its relationship to job satisfaction and risk perception.

Theoretical research that investigates what the term "work environment" really means would be very helpful. Certainly there are probably many definitions and characterizations of what constitutes a "work environment" especially in home care work - where does it begin and where does it end? Does the work environment only encompass the actual home of the client or does extend to the community? What is the difference in risk perception if one is in the community as a community member, living there, versus being there as a function of one's work? Considering that environment is such an integral component of the meta-paradigm of nursing, such research would be a valuable contribution to the

knowledge base of occupational health nursing.

Finally in general, there is a need for a greater utilization of the naturalistic research design in understanding occupational risk and worker perceptions. Especially considering the subjective nature of risk perception, trying to capture subjective information by using closed-ended questionnaires, or by collecting data in isolation from the lived experience would not render the type of data conducive to a better understanding of risk perception. Studies utilizing data collection via home care worker diaries, or self-audiotaping, may be a helpful addition, and while limited they would add a semi-longitudinal perspective to risk perception. Also, interviews with workers who have self-selected out of the home care health field would allow an understanding of the people who leave home care work and why they leave. It would allow for some comparisons of the risk perception of the workers who leave home care versus the workers who stay in home care. Such comparative study would uncover more information in relation to the "tucking away" phenomenon. It may eventually lead to research that tests the participant generated hypothesis, which suggests that those workers who do not successfully incorporate the process of "tucking away" do not survive in home health care and self select out of home care work.

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APPENDIX A1

#1 FACE SHEET HOME AIDE

TYPES OF RISK **"CAUGHT IN THE SITUATION"**

- personal "being in wrong place wrong time"
- professional
- physical (MS)
  - uncooperative patient
  - rolling/pushing/pulling
  - bed bound
- repetitive lifting
- "taking it's toll"
- personal-wrong direction to home
- political, getting in trouble with agency
  - bureaucracy

CONSEQUENCES OF RISK

- light duty secondary to injury
- off work
- no money
- change in duty
- change in life

PREVENTION

- management of risk
- physical
- belt
- protect muscles

RISK FOR WHO?

- worker
- patient
- "going down" what does this mean?????
- "doing this lady"

PUSHING PEOPLE OUT

- what to do
- who does what first
- hierarchy, if both nurse and aide at home who gets to go first?

QUALITIES OF WORK

- persuade patients to do/to get, busy useless work, urgent, very important
- influence, convince, coerce, teach, help, care

APPENDIX A1

FACE SHEET CONTINUED

WORK

- types of work
  - bather
  - sit
  - IVs
  - wounds
  - meetings
  - participate in team meetings (OT, MSW, PT, RN)
- charting, major problem
  - car, our responsibility
  - home each one is different, each has it's own challenges
  - agency, sometimes more trouble than pts, family or other stuff

-patient care, nurses do skilled care, aides do simple routine personal care.

- arrangement of work
  - around worker's family
  - school
  - personal care

CATEGORIES OF WORKERS

- RN-team leader, I take my cues from her
  - ET
  - perinatal
  - psych
- HHA
- OT
- PT
- MSW

"SEE WHAT I REALLY DO"

- client very obese
- killing me (to lift)
- really physical work
- "back-breaking"

"DOING HER"

- personal care
- doing patients
- do IVs
- who "does" patient?

ABILITY TO SEE WHAT'S REALLY GOING ON

- RN: patient depressed
- HHA: pt not depressed (sees patient more)
- HHA respectful of RN's dx of depression but doesn't agree, but won't say so

CATEGORIES OF CLIENTS

- according to their disease
- personality, dealing with psych stuff
  - sick
  - suicidal
  - depressed
  - crazy

-all these folks can be dangerous

TYPES OF HOME CARE

- sitter (24 hours)
- go from home to home
- visits each day/schedule
- personal care, bathing etc
- skilled nursing, doing treatments
- long term vs short term

APPENDIX A2

FACE SHEET HOME CARE NURSE

TYPES OF AGENCIES

- hospital
- private
- combined
- non-profit

TYPES OF PEOPLE AS HHW

- qualifications
  - education (BSN)
  - certificate (PHN)
- RNs HHAs certified vs non-cert?
  - education
  - length of career
  - types of RNs

SCHEDULING or "grouping the day"

SEQUENCE OF WORK

- get where I'm going, plan journey, have circuit
- get where patient is, parking stuff, get into house
- decide where to sit, quick eyeball of situation
- look house over, assess while doing work, so as not to look snoopy
- layout of house, safety for me and for them
- stuff all over place, organizing stuff
- wash hands good chance to scope the house

"GET A HANDLE ON THAT"

- care of patient
- individual
- role of caregiver
  - as helper
  - as observer

WORK

- own boss
- own schedule
- paid by hour/by visit
- get done early, can do your own thing

TIME "time factor"

- of work , revisit, schedule, regulate your time, exceptions to maintaining schedule of visits

APPENDIX A2

FACE SHEET CONTINUED

RISK

- professional
- emotional
- physical (physical condition/shape of worker)
- financial
    - own car
    - own insurance
    - own liability
- traffic
- traffic ticket
- driving
- parking (planning your parking)
        - safety
        - money
        - short distance from house
- parking meters
- cars (MS injury: twisting & lifting, things in/out of car)
- weather/driving
- don't park in driveway (makes patients mad)
- auto insurance
- no patient transport in worker's car
- HIV (conditions of work)
    - husband doesn't want (family concern about HIV risk)
    - worker OK about HIV, knows how to protect self
- personal (criteria/rules/safety)
- weapons in home
- office not secure
    - off site
    - not safe on weekends
- animals
- filth and squalor of homes is hard to take sometimes, still act like guest!!!
- smokers, especially if home filled with smoke, your own clothes smell like it too.

APPENDIX B
OCCUPATIONAL RISK PERCEPTION IN HOME HEALTH CARE WORKERS PROCEDURE

1. STUDY AIM, BACKGROUND AND DESIGN

The purpose of this descriptive study, using grounded theory, and participant observation, is to discover ways that Home Health Workers (HHCWs) experience, define and deal with occupational health risks to themselves. HHCWs, although generally familiar with health risks and their management in institutionalized settings, are confronted with varied risks in the home setting with which they may not be familiar: i.e. pet attacks, auto accidents, unsafe access to home. This study seeks to ascertain the manner in which HHCWs manage the risks that confront them.

2. SUBJECT POPULATION: INCLUSION/EXCLUSION CRITERIA, USE OF SPECIAL SUBJECT GROUPS, AND METHODS OF ACCESS

Permission to observe and interview HHCW has been obtained from the administrators of The XXXXXXXX of Northern California Home Health Care Agency, The XXXXXXXX Hospital Home Care Agency, and The XXXXXXX Hospital Home Care Agency (see attachment 3.). The subjects consist of nurses, home health aides and administrators. Opportunity samples of each such category will be interviewed (see attached for guide) and observed as they go about their work routine. Subjects will be volunteers, who agree to have the Co-PI. accompany them as they go about their work.

3. PROCEDURES TO BE DONE FOR PURPOSES OF THE STUDY

a. Meeting and informing the staff at the agency, for purposes of recruitment and gaining individual consent.

b. Individuals who have consented will be accompanied at least once on a home visit and will be interviewed for approximately one hour following the visit at a convenient time and place. Informal interviewing will occur in driving to and from the client's home. The Co-PI will observe the HHCW's work with the client in the home and will record field notes.

c. Verbal consent from the clients of the Home Health Agency (in accordance with agency policy) will be obtained the day prior to the visit. The Agency client will be called on the phone by the HHCW (study subject) who will be making the visit. The HHCW will read from a prepared statement which is an explanation of the purpose of the study, and ask for permission for a visitor to accompany her/him on the visit. The HHCW will emphasize that the subject of the study is her/himself and not the client; she/he will then ask for verbal permission for the researcher to be in the client's home at the time of the visit.

4. RISKS: POTENTIAL RISKS INCLUDING POSSIBLE LOSS OF CONFIDENTIALITY,AND DISCOMFORTS TO SUBJECTS. METHODS OF MINIMIZING THESE RISKS

Possible risks include:

a. Unexpected emotional disturbance in the client.
b. Self-consciousness or anxiety in the worker.

The care taken to minimize these risks includes:

a. The cessation of observational or interview activity, when warranted.
b. Any observation of notable discomfort will be followed by modification in observer's behavior and interview or withdrawal from the situation(s).
c. Assurances to both client and worker of anonymity and confidentiality; all notes and recordings will be available to the researchers only and kept in a locked file cabinet in the Co-PI's home or office

5. BENEFITS: POTENTIAL DIRECT BENEFITS TO SUBJECTS AND GENERAL BENEFITS TO SUBJECT GROUP, MEDICAL SCIENCE AND/OR SOCIETY

a. No direct benefits to the client or worker are intended
b. Indirect benefits may include discovery of potential risks; information bearing on this will be presented to researchers, scholars and the agency in abstracted form.

6. CONSENT PROCESS AND DOCUMENTATION

a. Letters of support from The Home Care Agencies have been obtained
b. Consent forms will be read and signed by individual workers and administrators.
c. Verbal informed consent will be obtained from the client prior to the visit and again at the visit.

7. QUALIFICATIONS OF INVESTIGATORS

JULIENE LIPSON, RN, MN, PHD, is an Assistant Professor in the Department of MHCAN in the School of Nursing at UCSF. She is a well respected, well published cross-cultural health researcher. Her areas of expertise include: womens' issues in the workplace, workplace stress, and refugee and minority womens' health issues.

WENDY SMITH, RN, MSN, FNP, DNSc Cand., is an Occupational Health Nursing doctoral student in the School of Nursing, Department of MHCAN. She is an Associate Professor in the Department of Nursing at Sonoma State University. Her research expertise includes: needle handling behaviors of hospital workers, infection control practices in Home Health Care and occupational health issues in Home Health Care.

APPENDIX C
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO BE A RESEARCH SUBJECT

1. PURPOSE AND BACKGROUND

WENDY SMITH, RN, MS, FNP, a Doctoral student and JULIENE LIPSON, PhD. in the School of NURSING at UCSF are conducting a research study to describe the Home Health Care worker's perception of occupational risks. I am being asked to participate in this study.

2. PROCEDURES:

If I agree to be in the study, the following will happen

a. I will be observed while on one of my home visits by Ms Smith.
b. I will also be interviewed by Ms Smith about my Home Health work career. The interview will take place at a mutually convenient time away from the home setting, it will take about hour and will be audiotaped.

3. RISKS/DISCOMFORTS

Being observed may make me feel uneasy and I am free to refuse to be observed or to discontinue the observation at any point in the process. In addition, I may feel uncomfortable about disclosing information about myself, co-workers, or superiors. I have been told that I am free to decline to answer any questions and terminate the interview at any time. If I feel uncomfortable about being audio-recorded, I may refuse and written notes will be taken instead.

4. CONFIDENTIALITY

Participation in research may involve a loss in privacy; however, my records will be kept as confidential as is possible under the law. All study data will be identified only by code number and kept in a secure place. No one will have access to this data except Ms Smith and her advisor Dr. Juliene Lipson. Only Ms Smith will have the codes. After the study has been completed and the data is transcribed from the tapes, the tapes will be destroyed. Data transcription will omit any identifying data. Neither my identity nor that of this agency or the clients' identities will be revealed in any reports or publications that result from this study.

5. BENEFITS

There will be no direct benefit to me from participating in this study. However, the information that I provide may further an understanding of the work and occupational risks in Home Health Care.

6. ALTERNATIVES:

I am free to decide not to participate in this study.

7. COSTS/REIMBURSEMENT

There will be no cost to me as a result of taking part in this study nor will I be paid to participate in this study.

8. QUESTIONS:

I have talked to Ms Smith about this study and I have had my questions answered. If I have further questions about the study, I may call her at (xxx) xxxxxxx, or I may contact Juliene Lipson, PhD. (Ms Smith's Advisor at UCSF) at (xxx) xxxxxxx.
If I have any comments or concerns about participation in this study, I should first talk with the investigator, Ms Smith. If for some reason I do not wish to do this, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the committee office between 8:00 and 5:00 p.m., Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0616, University of California, San Francisco/San Francisco, CA 94143.

9. CONSENT:

I will be given a copy of this consent form to keep.

10. PARTICIPATION IN RESEARCH IS VOLUNTARY.

I am free to decline to be in this study, or to withdraw from it at any point.

DATE _____ **SIGNATURE OF STUDY PARTICIPANT** _____

DATE _____ **SIGNATURE OF PERSON OBTAINING CONSENT** _____

DATE OF SUBMISSION: _____ W A Smith

APPENDIX D1
PERCEPTIONS OF OCCUPATIONAL RISK IN HOME HEALTH CARE INTERVIEW GUIDE

AREAS FOR INTERVIEW EXPLORATION WITH HOME HEALTH CARE NURSES

1. **Occupational career of the worker**

   Briefly what is your educational background?
   How long have you worked as a nurse, as a nurse in home health care and, at this particular job?
   What other nursing jobs have you held?
   Have you worked for other agencies, if so how were they different or similar to this agency?
   Have you had other careers?

2. **Job satisfaction, the positive and negative aspects of home care work.**

   Could you briefly describe the type of nursing activities that are part of your work in home care.
   What is attractive to you about this particular job and about home health care work in general?
   What things about this particular job and about home care work in general bother you?

3. **Exploration of worker's perspectives and experiences with occupational hazards**

   Have you ever been injured or had a health condition related to your work as a nurse? What about while working in home care?
   Have you ever thought about or had concerns about your safety as you go about your work activities?
   What things bother you the most or give you the most trouble?
   Are there situations that make you feel more vulnerable, and can you describe some of them for me?

4. **Discussion of ways of dealing with occupational risks**

   How do you deal with the situations or conditions where you feel vulnerable? What particular methods have you found helpful to reduce feeling unsafe while doing your job?
   Do you have any ideas about what other workers have tried or do in similar situations?

APPENDIX D2
PERCEPTIONS OF OCCUPATIONAL RISK IN HOME HEALTH CARE INTERVIEW GUIDE

AREAS FOR INTERVIEW EXPLORATION WITH HOME HEALTH CARE NURSES' AIDES

1. Occupational career of the nurses aide

Briefly what is your educational background?
How long have you worked as a nurses aide, in home health care and, at this particular agency?
What other nurses aide jobs have you held?
Have you worked for other agencies, if so how were they different or similar to this agency?
What other careers have you had?

2. Job satisfaction, the positive and negative aspects of home care work

Could you briefly describe the types of work activities that you do as part of your job as a home health nurses aide?
What is attractive to you about this particular job and about home health care work in general?
What things about this particular job and about home care work in general bother you?

3. Exploration of worker's perspectives and experiences with occupational hazards

Have you ever been injured or had a health condition related to your work as a nurses aide?
Have you ever thought about or had concerns about your safety as you go about your work activities?
What things bother you the most?
Are there situations that make you feel more vulnerable, and can you describe some of them for me?

4. Discussion of ways of dealing with occupational risk

How do you deal with the situations or conditions where you feel vulnerable? In other words what particular things have you found helpful to reduce feeling and being unsafe while you are doing your job?
Do you have any ideas about what other workers have tried, or do in similar situations?

APPENDIX D3
PERCEPTIONS OF OCCUPATIONAL RISK IN HOME HEALTH CARE INTERVIEW GUIDE

AREAS FOR INTERVIEW EXPLORATION WITH HOME HEALTH CARE AGENCY MANAGERS

1. **Occupational career of the manager**

   Briefly what is your educational background?
   Have you ever worked as a nurse in general and as a home health care nurse in particular?
   What other jobs have your held?
   Have you worked for other agencies, if so how were they different or similar to this agency?
   As an administrator, do you ever accompany workers in the field; do you ever go out on your own?

2. **Job satisfaction, the positive and negative aspects of home care work**

   Could you briefly describe the type of work activities that you do as part of your job here at this agency?
   What is attractive to you about his particular job and about home health care work in general?
   What things about this particular job and about home health care work in general bother you?

3. **Exploration of worker's perspective and experiences with occupational hazards**

   Have you ever been injured or experienced a health condition that was related to your work?
   What have your experiences been like when dealing with your worker's who had injuries or illnesses that were related to their work in home health care?
   What are your concerns as an administrator for your workers safety as they go about their work activities?
   Are there any concerns that are more significant than others?
   Do workers share this/these concerns, what concerns are similar, what concerns are different?

4. **Discussion of ways of dealing with occupational risks**

   How does the agency deal with worker concerns about job-related hazards?
   How free do workers feel to voice their feelings and concerns?
   What happens when a worker is injured while at work?
   What precautions are taken to ensure worker safety, when they are working in areas of higher risk?

APPENDIX E

TELEPHONE SCRIPT FOR OBTAINING VERBAL PERMISSION FOR RESEARCHER TO ACCOMPANY THE HOME HEALTH CARE WORKER ON A HOME VISIT

1. **Personal introduction**

2. **Script to be used to elicit permission for the researcher to accompany the worker on the home visit**

"... I am calling to ask you if you would agree to have another nurse accompany me on the visit tomorrow. She is conducting a research study that is approved by _____ (name of appropriate agency). The study describes what home care workers do and what happens in home health care work. I want to emphasize that she will be observing me, the worker, and not you, the client. If you agree, she will accompany me and remain as unnoticeable as possible. If you begin to feel uncomfortable with her being there, you can just let me know and I will ask her to leave. You are free to agree to, or to decline her request to accompany me. Your decision will not affect the care delivered to you by _____ (Name of agency)."

APPENDIX F

MEMO RISK:

THE TYPES OF RISK

Risk is mitigated or enhanced dependent on the following client attributes: age, condition, frailty, degree of infectivity-diagnosis, socio-economic status-environment, living arrangements-type of home, with whom, neighborhood/geographic area

Risk is mitigated or enhanced by the following worker attributes: age, life experience, nursing experience, home care experience, attitude and philosophy about home care work and nursing/personality, past experiences with some of the risks, degree of ethnic, racial and cultural knowledge and sensitivity, fluency with the system esp insurance/medicare rules, knowledge of the community and community resources, financial status.

Other things include: weather, time of year, time of day, time of month, natural events, social events, time constraints, technology

PHYSICAL RISK

- type of client, age condition/frailty/contagious/diagnosis/social support
- musculoskeletal injury from lifting or transfer with not help/your on own
- falls and trips due to furniture and structural problems/stairs egress/access, bars on doors and windows
- exposure to bloodborne pathogens-blood from wounds and needle sticks
- other infectious disease exposures-viruses,mycobacterium from coughing, breathing and other body substances
- from car accidents/parking
- dog/ animal injuries
- insects/parasites/rodent

PERSONAL INJURY/VIOLENCE

- working in dangerous places/neighborhoods, projects,areas of high violence
- other activities going on that contribute to danger, crime, drugs, car stuff
- dealing with persons who are used to living with violence
- dealing with family dynamics/dysfunctional
- clients low income, poverty, lack of education, different life values/families under stress, families who are controlled by bureaucratic systems, medical/medicare, welfare
- family stress due to illness, social issues like unemployment
- work alone, unpredictable work environments
- may not have own client load, switching seeing diff clients each time.
- new people don't know ropes don't know streets or patterns of neighborhoods and issues, don't know safe procedures-driving and parking.
- clients are victims also
- perception of you as authority person, can call in cops or CPS
- perception of you as medical person with goods-needles, syringes, drugs
- bad combination of female worker, alone, going to dangerous places,in eve or wkeds
- high incidence of substance abuse in clients/families, dysfunction very risky

EMOTIONAL/PSYCHOLOGICAL RISK

- fear of unknown, unpredictability a constant thing to deal with
- fear of known, stories from other nurses, media/radio/TV/ newspaper accounts
- dealing with human being who are under stress secondary to illness, poverty, racism etc
- fear of animals, guard dogs, protect dogs/not pets
- lack of control issue/frustration
- Job stress/time issue/productivity/charting/working within the medicare system
- abusive or dangerous clients
- not being heard by mgt
- attachment to clients, client to nurse or nurse to client, see some for long time, see husband and wife
- dealing with clients very different culturally than self/diff life values

PROFESSIONAL RISK/LIABILITY

- lack of control over treatment plan once out of home
- social contract makes nurse more of a consultant
- not "really knowing" enough about the clients/esp if work call/eves/wkends
- Case manager responsible for other disciplines
- safety issues in relation to clients being home alone/frailty/mental stability
- working with many people and co-ord activities & acting as go-between with client family disciplines and doctor. Dealing with families in general
- MD's don't trust nurse/don't acknowledge education or experience/won't call back to ok orders/ MD's idea of what is happening not correct, never been to home.
- discharging abusive or dangerous clients-abandonment?
- carrying malpractice, hosp vs home care, were is gtr risk
- medication issues/ under client control
- lack of comradeship, social support of peers in field/comparisons of findings and checking judgement

FINANCIAL RISK

- car, damage, broken into, wear and tear, insurance, accident.
- salary/parity with hospital nurse, contract coverage difficulties
- in order to work in some agencies have to have car, so have to be better off financially than nurse who works in institution, car not requirement of job there.
- parking fees, workers responsible!
- Agency practices,if pay per visit what happens when census is low??? WHAT