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Title

The effects of cognitive impairment on nursing home residents' emergency department visits and hospitalizations

Permalink

<https://escholarship.org/uc/item/5dv2n9zx>

Journal

Alzheimer's & Dementia, 10(6)

ISSN

1552-5260

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Publication Date

2014-11-01

DOI

10.1016/j.jalz.2014.03.010

Peer reviewed

THE HOME CARE WORK ENVIRONMENT FOR PERSONAL ASSISTANCE SERVICE WORKERS

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ABSTRACT

Occupational injury is a prevalent problem in long-term care. However, there is a noticeable lack of research related to workers providing Personal Assistance Services (PAS) – the personal care and housekeeping tasks that enable elderly and other disabled adults to live in community settings. We conducted a statewide computer assisted telephone survey of PAS providers (n=855) from California’s In Home Supportive Services program to describe the homecare environment and its impact on the worker’s health and ability to provide care. PAS providers reported on a variety of household and personal care tasks, including client lifting and transfers, as well as on barriers to care delivery. A total of 262 providers (31%) reported musculoskeletal symptoms or acute injuries causing at least moderate pain (defined as ‘prominent’ problems) that had occurred in the prior 12 months; 25% of that group (n=65) reported 12 or more episodes in the previous 12 months of probable work-related musculoskeletal symptoms. Because of these prominent problems, 26 workers missed work, 54 changed their work duties, and 12 had to drop work hours or clients.

SUMMARY

Introduction

Occupational injury is a prevalent problem in long-term care, including in-home services (Bureau of Labor Statistics, 1997). However, there is a noticeable lack of research and policy attention relative to workers providing Personal Assistance Services (PAS) – the personal care and housekeeping tasks that enable elderly and other disabled adults to live in community settings. In California, PAS is often provided through public In Home Supportive Services (IHSS) agencies found in each county. IHSS PAS workers in California are “independent providers,” meaning they are hired, directed, and fired by individual PAS care recipients. The risk of occupational injury in PAS is expected to increase as more of this assistance is obtained through consumer directed models of care such as IHSS.

We conducted a statewide computer assisted telephone survey of IHSS PAS providers (n=855) and recipients (n=918) to identify occupational hazards in home care and the impact of those hazards on worker health, the worker’s ability to provide care, and recipient outcomes. Here we report our initial findings about the

home work environment as described by the PAS providers.

Methods

The PAS provider survey was conducted from June-August 2009 by a trained team from San Francisco State University using computer-assisted telephone interviewing equipment and techniques. Ethics approval for research involving human subjects was obtained from the University of California, San Francisco; San Francisco State University; and the State of California. The research was funded by the National Institute for Occupational Safety and Health (Principal Investigator: Robert Newcomer).

Sampling. The sample was drawn from a statewide population of more than 320,000 recipients and more than 280,000 PAS providers. The PAS provider sample (n=855) was limited to those who provided care for 12 months or more to recipients with at least 2 limitations in activities of daily living, and who were the main paid provider for the recipient. Although relatives may be hired as PAS providers, providers may not be spouses or parents.

Survey. Survey development was guided by the theoretical framework developed by Faucett (2005). The

framework emphasizes the impact of four aspects of the work environment (functional, temporal, physical and interpersonal) as well as work barriers and job strain on worker health and disability outcomes. Our survey of PAS providers included several well-known scales to assess work-related injuries and musculoskeletal disorders (MSDs) and their impact on normal activities, providers' perceptions about factors in the home that may have contributed to these injuries and disorders, and work limitations. Items were drawn from a modified Nordic Musculoskeletal Questionnaire, the Job Content Questionnaire, and the Work Limitations Questionnaire (WLQ-26) to develop the survey (Kuorinka et al., 1987; Karasek et al. 1998; Amick et al. 2004).

Results

Sample. Of the 855 PAS providers, 474 were relatives of the IHSS care recipient and 381 were non-relatives (Table 1). They were predominately female (n=686, 80%) and non-white (n=619, 72%). Although most responded in English, 31% (n=269) chose to respond to the survey in Spanish, Cantonese or Mandarin. The majority ranged from 31-60 years of age (n=624, 73%), with 12% (n=101) over 60. Most had received 12 years or fewer of education (n=502, 59%).

Table 1: PAS provider demographics (N=855 providers)

Demographic	Number	Percent
Gender: Female	686	80%
Age: 18-30 years	126	15%
31-40 years	148	17%
41-50 years	235	27%
51-60 years	241	28%
61-65 years	65	8%
>65 years	36	4%
Education: ≤ 8 years	101	12%
9-11 years	98	11%
12 years	303	35%
13-15 years	221	26%
≥ 16 years	116	14%
Family status: Relative	474	55%
General health: Poor	12	1%
Fair	113	13%
Good	341	40%
Very Good	183	21%
Excellent	203	24%

A total of 262 providers (31%) reported acute injuries or MSD symptoms occurring in the last 12 months and that reached a level of 3 or greater on a 0-10 numerical pain scale, which we defined as 'prominent' problems. Because of these prominent problems, 26 workers missed work, 54 workers had to change their

work duties and 12 had to drop hours of work or clients. A quarter of these affected individuals (n=65) met our case definition for work-related MSD: a prominent problem that had occurred 12 or more times in the last 12 months, with no other potentially explanatory chronic or acute illnesses or injuries reported.

Functional work environment. PAS providers assisted recipients with their activities of daily living for a mean of 10.08 tasks per day (sd=2.49). Table 2 lists the most common PAS tasks. Instrumental activities of daily living (IADL; e.g. cleaning/laundry, shopping, meal preparation) were more common than personal care activities of daily living (ADL; e.g. bathing, dressing, grooming). Thus, nearly all of the providers helped with IADL while roughly ½ to ¾ assisted with one type of ADL or another. Just over half the providers assisted by lifting or transferring the recipient, for example, from bed to chair or chair to commode. Nearly 42% reported between 1-10 lifts/transfers per day, with another 15% reporting up to 20 lifts/transfers per day.

Table 2: Personal service assistance tasks (N=855 providers).

Tasks	Number	Percent
Cleaning/laundry	835	98%
Shopping	817	96%
Meal preparation	813	95%
Medical appointments	790	92%
Transportation	755	88%
Help with medication	699	82%
Dressing	609	71%
Bathing	571	67%
Help with walking	539	63%
Oral hygiene/grooming	525	61%
Lifts/transfers	496	58%
Toileting	430	50%
Help with eating/drinking	406	47%
Other errands	337	39%

Temporal work environment. PAS providers gave a mean of 23.52 hours of care per week (sd=12.23 hours) to PAS recipients. They reported that they were able to take coffee and lunch breaks on a typical day (n=629, 74%), but only 64% (n=493) agreed that they had enough time to get the job done. Furthermore, only 59% (n=502) stated that their hours of work were always predictable. PAS providers also held other jobs: 233 reported providing home care for at least one other person and 197 held non-home care jobs in addition to their PAS work.

Physical environment. Table 3 shows that most respondents felt they had enough access and maneuvering space to manage their work. However, 85% of those who perform lifts or transfers as part of

daily care reported that lift equipment not available in the home. Furthermore, 13% (n=50) of all non-family providers (n=377) reported a lack of supplies or equipment.

Table 3: Physical work environment issues

Physical work environment issues	Number	Percent
Ramps/entrances with no stairs	442	52%
Space to maneuver equipment/provide care	704	82%
Doorways/hallways wide enough for wheelchair	760	89%

Interpersonal environment.

PA providers are hired, directed, and fired by individual PAS care recipients. Difficult interpersonal issues may challenge their ability to work comfortably in the home environment (Table 4). Ten percent of providers reported that the recipient’s family members were demanding, overly helpful, or unhelpful; while 16% reported that the recipient was demanding. Only 2%, however, reported racial or ethnic discrimination related to their work in home care. Table 5 describes other types of barriers to care. Note: Because of their potentially sensitive nature, items about the interpersonal environment and barriers to care were asked only of providers who were not related to the IHSS recipient. Family members who are care-givers may also experience interpersonal difficulties while providing care.

Table 4: Interpersonal work environment issues (n=377)*

Interpersonal work environment issues	Number	Percent
Client’s family demanding, overly helpful, unhelpful behavior	36	10%
Use of alcohol or illegal drugs	3	>1%
Demanding client	62	16%
Racial or ethnic discrimination	6	2%
Language differences	19	5%
Verbal abuse from client or family	19	5%
Physical abuse from client or family	5	1%

*asked only of providers who were not relatives

Only 23% (n=199) had received formal training about how to deliver home care. Most of those who had

received training had learned about lifting and transferring clients, as well as bathing, feeding and assisting them with the toilet. Of those who did receive training, 21% received training directly from their IHSS recipient, while other sources included the IHSS public authority, community colleges, and labor unions.

Table 5: Additional barriers to providing care in the home (n=377).

Barriers	Number	Percent
Cigarette smoke	50	13%
Messy home/clutter	46	12%
Temperature extremes of home	37	10%
Other client behaviors (wandering, threatening, swearing or yelling)	33	9%
Neighborhood violence/crime	25	7%
Provider transportation problems	27	7%
Unsanitary conditions in home	23	6%
Risk of exposure to disease	19	5%
Loud irritating noise in home	15	4%
Aggressive pets	10	3%

*asked only of providers who were not relatives

Discussion

IHSS is a public agency that provides for paid workers to assist elderly or disabled adults to remain in their homes and in the community. These personal assistance services provide an important alternative for long-term care and, as a consumer based model for long-term care, demand is expected to grow as the population ages. Nonetheless, although the research literature in this area is growing, there is little evidence currently to guide policy development related to the protection of workers who provide care in the home, or to assist the recipients of care, who bear the responsibility for the hiring, firing, training and directing of their care providers.

We conducted a telephone survey of PAS providers and recipients of home care in California, using multiple languages to reach a diverse sample throughout the state. In the current report, we analyzed data relevant to a sample of 855 paid providers. Many of these low wage workers experience multiple vulnerabilities due to their minority status and gender, their generally low levels of education, and modest ability to speak English or, in a few cases, even the language of the person for whom they provide care. Furthermore, many are family

members, who may find it challenging to discuss their work environment and obligations with the relative who hires them to provide care. Approximately 10-16% of the care providers who were not related to the care recipient, for example, noted that either the recipient or the recipient's family members posed a barrier to care because they were demanding or unhelpful, and 5% of these non-relatives reported verbal abuse. Additionally, few providers have received training to prepare them to give personal home care.

In addition to the exertion of providing personal care (ADLs), the vast majority engages in physically demanding tasks such as house cleaning. A sizeable minority performs these tasks under time pressure and lacks equipment to lift or maneuver the recipient of care. Little is known, however, about the ergonomics of performing these types of strenuous tasks in the home or their health impacts. We found that approximately 8% of providers met our more conservative case definition for work-related MSDs, and 31% met our definition for prominent problems (either MSD or acute injury) in the last 12 months. For some workers, these problems caused work time or job loss, and they potentially compromised needed care for the IHSS recipient.

In conclusion, PAS work poses considerable risks to an already vulnerable population of low wage workers. The ergonomic risks of providing household care and personal care together are largely under-investigated. We have described numerous challenges in the home work environment. These workers often lack training or equipment related to their work, and they face a diversity of barriers to the completion of their work tasks, including challenging relationships with the recipient of care who has hired them. We have also shown that a sizeable proportion of PAS providers suffered moderate to severely painful injuries or musculoskeletal symptoms over the last 12 months.

In future research using ergonomic, organizational and psychosocial work factors drawn from these survey data, we will report on multivariate analyses of PAS providers' health outcomes and work role functioning. We will also link these survey data with data from our survey of PAS recipients that document their adverse health events over the last 12 months. Using the linked data, we will investigate characteristics of providers and the home environment for their associations with adverse health outcomes for recipients.

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