Understanding Personal Support Workers and their Role in Ontario

By
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Abstract

There are an estimated 90,000 personal support workers (PSWs) in Ontario providing assistance with daily activities for individuals in hospitals, long-term care facilities, adult day programs and home care yet little is known about them. (Ontario Ministry of Health and Long-Term Care [MOHLTC], 2011b). The goals of this thesis are to better understand where the occupation of PSWs is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization.

The data collection for this case study is based a scoping review of peer review articles and grey literature to describe who these workers are, their education, where they work and regulatory structures that govern their practice. The analytical framework used to examine the professional progression of PSWs is based on the neo-Weberian theory of professions.

PSWs are unregulated frontline providers. Many PSWs are immigrants and visible minority females older than 45 years whose first language is not English (Aronson, Denton, & Zeytinoglu, 2004; Neysmith, Reitsma-Street, Collins, & Porter, 2004; Canadian Research Network for Care in the Community [CRNCC], 2009a). Employment status varies with the majority working in long-term care institutions. However a considerable number of PSWs work in home care. Education for PSWs is not standardized and educational requirements vary by work setting as does wage levels. Turnover is high in this occupation and there is no unifying organization representing PSWs.

This study has brought to the foreground several challenges. PSWs do not meet the neo-Weberian criteria of a profession due to lack of strong leadership, adequate education, autonomy and resources that can support the complexity of a professional body. PSWs who work in the community setting have little or no support from other providers responsible for delegating and directing their work, suffer increased job insecurity and decreased pay and/or benefits.

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List of Acronyms

ACE	Advocacy Centre for the Elderly
ADL	Activities of Daily Living
ALC	Alternate Level of Care
CAAT	Colleges of Applied Arts and Technology
CCA	Continuing Care Assistant
CCAC	Community Care Access Centres
CEO	Chief Executive Officer
CINAHL	Cumulative Index to Nursing & Allied Health Literature
CNA	Canadian Nurses` Association
CNATN	Canadian National Association of Trained Nurses
CNO	College of Nurses of Ontario
CPSW	Certified Caregivers/Personal Support Workers
CRNCC	Canadian Research Network for Care in the Community
CSS	Community Support Services
CUPE	Canadian Union of Public Employees
DONPC	Director of Nursing and Personal Care
ELDCAP	Elderly Capital Assistance Program
GDP	Gross Domestic Product
GLBT	Gay Lesbian Bisexual Transgender
HPARB	Health Professions Appeal and Review Board
HPRAC	Health Professions Regulatory Advisory Council
IADL	Instrumental Activities of Daily Living
LHIN	Local Health Integration Networks
LTC	Long-Term Care
LTCHA	Long-Term Care Homes Act, 2007
MOHLTC	Ontario Ministry of Health and Long-Term Care
MTCU	Ministry of Training, Colleges and Universities
NACC	National Association of Career Colleges
NACC/PSW	National Association of Certified Caregivers/Personal Support Workers
OAHAI	Ontario Aboriginal Health Advocacy Initiative
OANHSS	Ontario Association of Non Profit Homes and Services for Seniors
OCHU	Ontario Council of Hospital Unions
OCSA	Ontario Community Support Association

OECD	Organization for Economic Co-operation and Development
OHCA	Ontario Home Care Association
OHIP	Ontario Health Insurance Plan
OLTC	Ontario Long-Term Care Association
ONA	Ontario Nurses' Association
OPSWA	Ontario Personal Support Worker Association
PEPA	Personal Support Worker Educational Program Accreditation
PSNO	Personal Support Network of Ontario
PSW	Personal Support Worker
RFP	Request for Proposal
RHPA	Regulated Health Professions Act
RHRA	Retirement Homes Regulatory Authority
RNAO	Registered Nurses Association of Ontario
TPA	Transfer Payment Agreement
WHO	World Health Organization

Chapter 1
Introduction

1.1 Statement of the Problem

Personal support workers (PSWs) make up a substantial proportion of Ontario's health care workforce and provide necessary assistance with daily activities in hospitals, long-term care facilities, adult day programs and at home in the community (Canadian Research Network for Care in the Community [CRNCC], 2009a). There are an estimated 90,000 PSWs in Ontario with about 57,000 providing care in long-term care facilities and 26,000 in home care through community health agencies (Ontario Ministry of Health and Long-Term Care [MOHLTC], 2011b). About 7,000 PSWs provide care in hospital (MOHLTC, 2011b). The demands on long-term care will escalate as the population ages.

The result of aging is a rising complexity of illnesses and social challenges. It leads to difficulties for health, social and community care delivery systems as they currently exist (Sinha, 2013). The need for community care workers to deal with these challenges is expected to double in the next decade as the need for long-term care increases (Laupacis & Born, 2012). With multiple demands on PSWs and a growing need for their care, there remain questions around training, scope of practice and work environment for these workers.

1.2 Research Goals

The goals of this thesis are to better understand where the occupation of PSWs is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. In order to address these goals a multistage analysis guided by the following research questions was conducted:

1. Who are PSWs?
2. What is the role of PSWs?
3. What is the training and/or education of PSWs?
4. Where do PSWs work and their relationship to other health care providers?
5. What are the legislative and regulatory structures that govern the work and behaviour of PSWs?
6. What if any is the role of professional organizations representing the interest of PSWs. Do the views vary?
7. What are the challenges and opportunities for PSWs in their development towards becoming a profession?

Chapter 4 of this thesis includes a profile of who these workers are, where they work, their education or training, professional associations that represent PSWs and the legislation that applies this occupation. The neo-Weberian theory of professions is the analytical framework that will be used to structure the discussion. As indicated in Chapter 2, the neo-Weberian theory of professions continues to have many theoretical benefits as compared to other perspectives in analysing the nature and role of professions in advanced societies. For example, neo-Weberianism shows that professionalization does not always follow the linear process based on knowledge and expertise as depicted by Wilensky (1964) in his functionalist overview of professions. The development of professionalization has various socio-political elements involving power and interests in the market at a macro level, and not all learned occupations necessarily become professions (Saks, 2010). Chapter 5 will present a discussion section on whether PSWs should be considered a profession, based on the neo-Weberian theory of professions, in comparison to Registered Nurses, a regulated profession, who often supervise them and have similar historical roles. Professionalization is used to evaluate PSWs because professionalization is typically linked to improved life chances for members of professional groups in the boarder society not least in terms of improved income, status

and power (Saks, 2012). In addition, acknowledged professions typically have a stronger formal knowledge and higher educational base than other occupations. The newly formed PSW Registry, Regulated Health Professions Act (1991) and concerns regarding education of PSWs will be examined (Government of Ontario, 1991a). The thesis is concluded by answering the thesis question – are PSWs a profession and recommendations for the future of PSWs are made so that they can provide the high quality care necessary to meet the healthcare demands of the future.

1.3 Why are PSWs important to the Canadian Healthcare System

Canada's healthcare system, and that of Ontario's specifically, has evolved to respond to acute illness (Ontario Ministry of Finance, 2010a; 2010b). First, the focus is on treating people after a health problem has struck rather than taking a broader proactive approach that might prevent problems or at least mitigate the effects of illness (Ontario Ministry of Finance, 2010a; 2010b). Chronic diseases are the leading causes of death and disability worldwide. Disease rates from chronic conditions are increasing around the world, spreading across every region and pervading every socioeconomic class. The World Health Report 2002: "Reducing Risks, Promoting Healthy Life", indicates that the mortality, morbidity and disability attributed to the major chronic diseases presently account for almost 60% of all deaths and 43% of the global burden of disease (World Health Organization [WHO], 2013). In addition, 79% of the deaths ascribed to these diseases occur in the developing countries. Four of the most pronounced chronic diseases cardiovascular diseases, cancer, chronic obstructive pulmonary disease and Type 2 diabetes are linked by common and preventable biological risk factors, particularly high blood pressure, high blood cholesterol and overweight, and by related major behavioural

risk factors: unhealthy diet, physical inactivity and tobacco use (WHO, 2013). Government needs to create an integrated approach that will focus on all major common risk factors of cardiovascular diseases, Type 2 diabetes, cancer and chronic respiratory diseases is the most economical way to prevent and control them (WHO, 2013).

The Canadian constitution has put responsibility for health care at the provincial and/or territorial level and so there is no national Canadian health care system (Deber, Gamble, & Mah, 2010). Extensive variation exists within and between jurisdictions in how services are managed and delivered, and in health outcomes. Approximately 70% of health expenditure is financed publicly, including almost all physician and hospital services. This publicly-financed insurance is referred to as Medicare (Deber, Gamble, & Mah, 2010). Essentially no services are publicly delivered and Canada uses what can be called a public contract model for its publicly-insured services, under which public money is joined with largely private delivery. The provincially run insurance plans cover residents for certain services primarily those which are medically necessary.

Medically necessary is defined as care provided by physicians and medical care received in the hospital physician consultations and hospital care (Deber, 2003). Government (i.e., public sector) delivers few services. Private (i.e., non-government) providers deliver the majority of services. For example, hospitals in Ontario are private not for profit providers. The majority of physicians are private for profit but are funded largely through public funds. Canadians are concerned about the sustainability of the publicly funded system called Medicare (Deber, 2003). Increasing concern does exist for some observers due to the aging population and the potential increase demand on the health care system (Deber, Gamble, & Mah, 2010).

As indicated in this century the key health issues are increasingly shifting to chronic care questions because the population is aging, but also because some lifestyle problems such as obesity are creating particular health conditions such as adult-onset Type 2 diabetes (WHO, 2013). Canada faces significant aging of its population as the proportion of seniors increases faster than all other age group. In 2001, one Canadian in eight was aged 65 years or over (Health Canada, 2002, p. 1). By 2026, one Canadian in five will have reached age 65 (Health Canada, 2002, p. 1). The Organization for Economic Co-operation and Development (OECD) expects that the total public and private costs of long-term care will more than double from an estimated 1.4 per cent of gross domestic product (GDP) in 2006 to 3.3 per cent by 2050 (Ontario Ministry of Finance, 2010a; OECD, 2011).

Concerns over quality of life have become a priority as vastly increased numbers of people live longer lives with chronic conditions (Peak & Sinclair, 2012). Mean healthcare costs are undoubtedly age dependent; an aging population will indicate increasing aggregate costs (Forget, Roos, Deber, & Walld, 2008). The regular person clearly faces a lifetime of gradually and then rapidly increasing costs as he or she ages. Any particular person, however, is not typical; up to 75 years of age, each individual has a significantly greater probability of incurring low healthcare costs than moderate or high healthcare costs (Forget, Roos, Deber, & Walld, 2008). Health care today consumes 42 cents of every dollar spent on provincial programs; without a change in direction health spending would eat up 70 per cent of the provincial budget within 12 years, crowding out the ability to pay for many other important priorities unless action is taken (Government of Ontario, 2012; Ontario Ministry of Finance, 2010a; 2010b).

Ontario's Plan to transform and change the health care system means structuring the system to meet the needs of today's population, with more emphasis on seniors and chronic disease management (Government of Ontario, 2012). One of the greatest challenges in the health care system are patients (known as Alternative Level of Care or ALC) who are in hospital beds who could also be cared for at home or in the community if the right supports were in place. Moving these patients to the community benefits the system by freeing hospital beds for those who need them, reduces pressure on emergency rooms and is more cost effective (Government of Ontario, 2012). However, some conditions and illnesses require more intensive management than can usually be provided in the community (Knott, 2010). The admission of elderly patients to hospital, their treatment and subsequent discharge can be challenging. Self-sufficiency of the patient depends a great deal on the underlying condition, delivering a treatment plan to an acceptable standard can make the difference between an individual who is a self-sufficient functioning member of the community and one who is disabled and dependent (Knott, 2010). Ontario plans to build capacity in the community with the launch of a Seniors Strategy with a focus on supporting seniors to stay healthy and stay at home longer, reducing strain on hospitals and long-term care homes. Success will be measured by fewer seniors readmitted to hospitals who could otherwise be cared for at home (Government of Ontario, 2012). To reduce readmissions to hospitals the government will provide more access to home care through an additional three million PSW hours for seniors in need. Care Co-coordinators will work closely with health care providers to make sure the right care is in place for seniors recovering after hospital stays (Government of Ontario, 2012). The government has also created the Healthy Homes

Renovation Tax Credit, which will support seniors in adapting their home to meet their needs as they age, so they can live independently at home, longer and have empowered Local Health Integration Networks (LHINs) with greater flexibility to shift resources where the need is greatest, such as home or community care.

As the location of health-care delivery is moving from the hospital to the home and community and clients are discharged to home care and long-term care earlier than before, their acuity upon discharge is higher and the care they necessitate is more complex. The extent of services provided outside hospitals has correspondingly become more complex, and more trained health workers are needed to assist in managing these new cases (Pan-Canadian Planning Committee, 2008). PSWs are a critical component of home care, long-term care and other community health care services (Personal Support Network of Ontario [PSNO], 2012e). They are front line workers who provide a variety of personal care, homemaking and support services to individuals in need of care.

Recognizing the importance of PSWs, the Ontario government already invests $10 million annually to train PSWs for work in the community care sector in areas such as palliative care, acquired brain injury and mental health (MOHLTC, 2012b). The government also provided $27.4 million to increase the base wage of qualified PSWs and improve travel compensation, training and other benefits (MOHLTC, 2012b). PSWs play a critical role in bringing the government's Action Plan for Health Care to life by allowing patients to receive care in the home.

1.4 Significance of Study

As the population ages, the demands on long term care (LTC) will escalate. The need for community care workers in general is expected to double in the next decade as

the demands on LTC increase (Laupacis & Born, 2012). PSWs are the largest group of workers in Ontario's long-term care and home care sector yet little is known about them, who they are and what they do (MOHLTC, 2012b). Further steps need to be taken to understand who these workers are, their education and training, where they work and to ensure that they are equipped to provide high quality care. The variation in work settings with differing degrees of regulatory oversight and inconsistent standards, and the increasing complexity and vulnerability of the patient and client population are requiring closer scrutiny at how Ontario is supporting PSWs in their work (PSNO, 2012e). Is Ontario enabling PSWs to practice safely? Is education or training accessible? Is remaining in the occupation practical and affordable (PSNO, 2012e)? These are all important concerns that need to be addressed if PSWs are to meet the healthcare demands of the future.

As a first step, the MOHLTC has developed a PSW Registry to collect information about the training and employment status of the nearly 90,000 PSWs in Ontario in an effort to better understand them and to increase accountability (MOHLTC, 2012b). However given variations in the work environment and type of care that PSWs provide, there are concerns around what the appropriate next steps in their development should be (Laupacis & Born, 2012). As indicated, the goals of this thesis are to better understand where the occupation of PSWs is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. Should PSWs be considered a profession or a regulated profession like Nursing? The professionalization framework, neo-Weberian theory of professions, used

in this thesis helps to determine how ready PSWs are to meet the healthcare challenges of the present and future and/or identifies necessary changes.

Chapter 2
Theories of Professions

It was necessary to define professions. The search for the definition and theory of professions was restricted to cover from 1962-2013 as this period reflects current trends in society. The search on professions was focused on the major sociological theories of professions such as the Functionalist, Interactionist, System of Professions and neo-Weberian theory. Various library databases, as listed in Chapter 3 - Methods, were searched as well a general search was conducted through Google and Google Scholar. Appendix A lists the references with the author, date, relevance to thesis and type of reference for this section. Personal Support Workers (PSWs) play an important part in Ontario's plan to transform the health care system to meet the needs of today's population, with more emphasis on seniors and chronic disease management (Government of Ontario, 2012).

It is expected that the need for community care workers in general is going to double in the next decade as the demands on long-term care increase (Laupacis & Born, 2012). There is a great deal of variation around the type of care PSW's provide, with some PSWs providing medical care such as changing wound dressings and administering medication, and others providing only personal care such as bathing, transfers from bed and housework. What PSWs can and cannot do varies based on their training, education, supervision and employer policies (Laupacis & Born, 2012). With numerous demands on PSWs and a growing need for their care, there remain unresolved issues around training, scope of practice and work environment of these workers given the changes to the healthcare delivery system. Given variations in education, training and work

environment what should the appropriate next steps be for PSWs in order for them to be able to meet these challenges.

Historically occupations like nursing, as discussed in chapter 4, recognized the need to provide a higher standard of care and did so by implementing reforms in areas such as education, regulation and governance which led to social recognition as a profession and eventually as a regulated profession (Coburn, D'Arcy, Torrance, & New, 1987). The question, explored in chapters 5 then becomes are PSWs a profession and if so should they be considered a regulated profession. This chapter will explore various sociological definitions of a profession and an overview of the theories of professions.

2.1 What is a profession

Are PSWs a profession? The word profession originates from the Latin word "profiteer", to profess, which can also have the meaning of making a formal commitment in the sense of taking a monastic oath (Lester, 2010). This root could suggest that a professional is someone who claims to possess knowledge of something and has a commitment to a certain code or set of values (Lester, 2010). Quinn and Smith (1987) define the professions as "those forms of employment that require an uncommonly complex knowledge base, used by persons committed to the direct benefit of human beings, with minimal societal control placed on their practice, and organized among themselves to ensure that they continue to provide those benefits" (p. 4). There is a difference between an occupation and a profession. An occupation is a career or job. All professions are occupations but not all occupations are professions. A profession is defined by Schwirian (1998) as a "prestigious occupation with a high degree of identification among the members that requires a lengthy and rigorous education in an

intellectually demanding and theoretically based course of study; that engages in rigorous self-regulation and control; that holds authority over clients; and that puts service to society above simple self-interest" (p. 6). For example an individual who has the occupation of a physician is a member of the medical profession; an individual whose occupation is a construction worker does not belong to the construction profession (Schwirian, 1998).

Functionalist theory studies the functions that professions do in relation to society. For instance they can be seen as a means of making expertise accessible to the public good and professional ethics as offering safeguards against external pressures such as those of bureaucracy and the market (Lester, 2010). Emile Durkheim saw professions as moral occupational communities in the new moral order and division of labour of the urban and industrial society (Professions, n.d.). Talcott Parsons defined professions in relation to a specific normative value system, the pattern variables. He viewed professions as occupational groups that had a special autonomy from the emerging bureaucracies of the modern society (Professions, n.d.). In general Functionalists stated that the professionals are a special category of occupations who are assigned a reasonable even generous level of status and material rewards. These rewards are in return for an undertaking of non-exploitation (the presence of an ethical code) the maintenance of standards of training and qualification and other guarantees to society (Crompton, 1990). The process of professionalization is generally described as a series of stages characterized by specific events or changes in the structure of the occupation as it strives to achieve professional status (Wilensky, 1964; Schwirian, 1998). These are:

- Work full time
- Set up standards of training and practice and set up training schools in universities
- Organization local and then national
- Legal protection appears
- A formal code of ethics is adopted (Wilensky, 1964; Schwirian, 1998).

Professionals were expected to use their expertise and knowledge which gave them power over their clients or patients for their good. Functionalism has been criticized by other theorists as a stagnant and uncritical rendering of an idealized account which obscured the underlying tensions, struggles and conflicts with which society, particularly American society, was driven (Saks, 2010).

Interactionist theories are concerned with the interactions that occur within practice situations and the meanings that these have in terms of broader occupational or societal relationship (Crompton, 1990). For Interactionists rather than providing a vital service or function for society, professions were seen to be occupations who use their monopoly of knowledge and technique in order to secure their own advantage by a process of occupational closure (Crompton, 1990). For Becker (1962) the typical process of professionalization includes shedding unprofessional work and attempting to devote one's time and energies to other more professional activities. Efforts to advance the prestige and status of the group may therefore, lead members to view dealing with the lower class or the poor as an obstacle to the quest for higher professional status. As Saks (2010) suggests, Interactionists did not accept the view that professions unique expertise, altruism and ethicality but indicated that these were a mere façade to legitimize professional privileges. Interactionists did not provide systematic evidence of their

findings (Saks, 2010). They did not state what a claim for professional status entails in terms of broader privileges nor did they explore the structural conditions under which particular groups were more likely to be successful.

Abbott (1988) argues that professions are exclusive occupational groups applying somewhat abstract knowledge to particular cases. The evolution of professions results from their interrelations. These interrelations are in turn determined by the way these groups control their knowledge and skill. For professions practical skill grows out of an abstract system of knowledge, and control of the occupation lies in control of the abstractions that generate the practical techniques. For Abbott (1988) the techniques themselves maybe delegated to other workers. Abstraction is the quality that sets inter-professional competition apart from competition among occupations in general. Any occupation can obtain licensure (e.g. beauticians) or develop an ethics code (e.g. real estate). But only a knowledge system governed by abstractions can redefine its problems and tasks, defend them from interlopers and seize new problems as medicine recently seized alcoholism, mental illness, hyperactivity in children and numerous others (Abbott, 1988; Little, 2008).

How abstract is abstract enough to be a professional. What matters is abstraction effective enough to compete in a particular historical and social context, not abstraction relative to some supposed absolute standard (Abbott, 1988; Little, 2008). The sociology of the professions needs to focus on the systems through which the relevant forms of abstract knowledge are created; the educational systems through which occupations acquire this knowledge; and the professional associations that administer both education and current practice through their power of licensing (Little, 2008). These associations

through their leadership and guidance take actions designed and intended to improve the profession and improve the social and economic environment for the profession in the future. Therefore professional development is the direct result of relations between groups and these relations are determined by the way in which professions control their education and skills (Jeremy, 2010). Professionalization is not universal nor does it follow a series of steps. Instead professionalization is the final result of the context in which professions exist (Jeremy, 2010). In such a theory a profession is considered in term of application and actions rather than having a particular form of knowledge.

The neo-Weberian theory of professions exemplified by Friedson (1989) defines a profession as a type of occupation whose members control recruitment, training and the work they do. They emphasize professionalization as a market project and its effect in generating market or employment rewards for those who achieve professional status. For Neo-Weberian professionals are not so much altruists for common good but are powerful groups in society in pursuit of their own and more abstract capitalist interests (Crompton, 1990). Their arguments suggest that the professions are not just seeking to maximize their own returns, but rather, that their powers and practices were associated with the particular roles and functions carried out by professions in a capitalist society. Success differentiates them from other occupations, as professionalization is based on privileged legal regulatory mechanisms that exclude outsiders and are associated with enhanced income, status and power (Saks, 2010). In neo-Weberian theory knowledge and expertise are not at the centre of the definition of a professional although they may be used ideologically as political weapons in both winning and legitimating their much coveted professional standing. Rather, the fundamental key to the definition of a profession is the

sheltered position of professions in the marketplace, with entry to the professions usually gained through obtaining relevant higher education credentials (Saks, 2012).

Studies based on the neo-Weberian theory have analysed professional groups with reference to the concept of social closure drawn from the work of Weber (1968). This relates to the process through which particular social collectives seek to regulate market conditions in their favour, in face of competition. In this way, they restrict access to specific opportunities to a limited group of eligibles, creating a group of socially defined inferiors (Saks, 2010). Professionalization is thereby viewed as a strategy designed, amongst other things, to limit and control the supply of entrants to an occupation in order to safeguard or enhance its market value (Saks, 2010). Medicine has historically retained a position of dominance and power within the health care system. The Flexner Report is the most important event in the history of American and Canadian medical education (MedicineNet Inc., n.d.; Duffy, 2011). It analysed the condition of medical education in the early 1900s and gave rise to modern medical education. It triggered much-needed reforms in the standards, organization, and curriculum of North American medical schools. At the time of the report, many medical schools were proprietary schools operated more for profit than for education (MedicineNet Inc., n.d.; Duffy, 2011). Flexner criticized these schools for lack of defined standards and goals and proposed medical schools in the German tradition of focus on biomedical sciences together with hands on clinical training. Therefore, Flexner's report led to the standardization of medical education delivered by accredited universities (MedicineNet Inc., n.d.; Duffy, 2011).

Physicians maintain significant independence as fee-for-service providers whose medical power is strengthened by medical shortages and professional autonomy (Kenny, 2004). For example by 1869 the College of Physicians and Surgeons of Ontario gained provincial control over the education and licensing of doctors (History of Medicine, n.d.) Friedson in 1970 stated that medicine has achieved professional autonomy and dominance through a political process that has resulted in the medicalization of everyday life (Segal & Fries, 2011). Physicians define their scope of work, define their standards of practice, and maintain the right to enforce those standards. Dominance is maintained through their assumed expert knowledge and the elimination of competition.

The neo-Weberian theory continues to have many theoretical benefits as compared to other perspectives in analysing the nature and role of professions in advanced societies. For example, neo-Weberianism shows that professionalization does not always follow the linear process based on knowledge and expertise as depicted by Wilensky (1964) in his functionalist overview of professions. The development of professionalization has various socio-political elements involving power and interests in the market at a macro level, and not all learned occupations necessarily become professions (Saks, 2010). The application of the neo-Weberian theory has been most extensive in the health care arena in Britain and the United States. This reveals the high standing of medicine which is regarded as an archetypical profession in terms of the position of exclusionary social closure it has gained in these societies, linked to its longstanding power and autonomy (Friedson, 2001; Saks, 2010).

The definition of a profession has the following characteristics in neo-Weberian theory these include: (a) direct market control of specific services through self-governing

associations of formally equal colleagues; (b) more derivative patterns of control by the producer over the consumer where the producer defines the needs of the latter and how these are met; and (c) legitimate, organized occupational independence over technical judgements and the organization of work (Saks, 2010). These three characteristics will be evaluated for PSWs in contrast to nursing which is a regulated profession whose scope of work was historically similar to PSWs and now often supervise them. As indicated, the goals of this thesis are to better understand where the occupation of personal support workers (PSWs) is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. The neo-Weberian professionalization framework is used to determine how ready PSWs are to meet the healthcare changes proposed in Ontario's healthcare plan for the future and/or identifies necessary changes.

Chapter 3
Methods

This chapter will outline the type of study, study questions and the methodology used. The goals of this thesis are to better understand where the occupation of Personal Support Workers (PSWs) is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. The investigation of PSWs in Ontario will be based on a multistage analysis guided by the following research questions:

1. Who are PSWs?
2. What is the role of PSWs?
3. What is the training and/or education of PSWs?
4. Where do PSWS work and their relationship to other health care providers?
5. What are the legislative and regulatory structures that govern the work and behaviour of PSWs?
6. What if any is the role of professional organizations representing the interest of PSWs. Do the views vary?
7. What are the challenges and opportunities for PSWs in their development towards becoming a profession?

This thesis is a qualitative case study on PSWs. Data for this study was collected using a scoping study methodology. The data was then analysed using the neo-Weberian theory of professions framework (Saks, 2010). The scoping review was used to create a profile of PSWs by addressing the first six questions indicated above (Chapter 4). The last question is answered in Chapter 5. Literature from various sources including peer-reviewed journals and grey literature (e.g., historical documents, professional associations' newsletters, websites. etc.) was reviewed for this thesis. As principal

investigator I developed the research question, theoretical framework, study design, data collection and data analysis. See Figure 3-1 below.

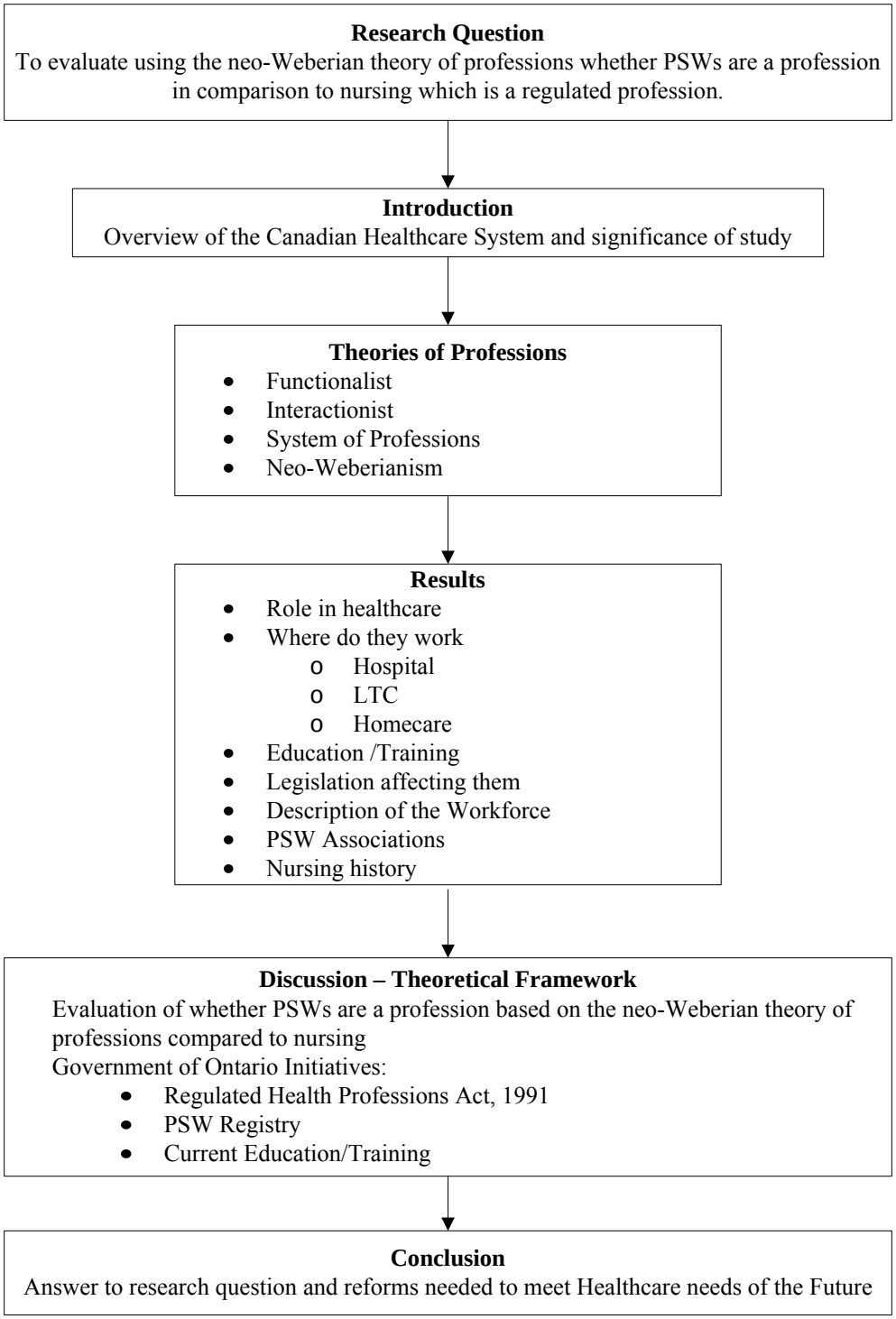

Figure 3-1: Research Question and Theoretical Framework

As previously indicated the study design used is a qualitative case study (Yin, 2003). This design is used to achieve an understanding of where the occupation of Personal Support Workers (PSWs) is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. The definition of a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life or natural context in particular when boundaries between phenomenon and context are not clearly evident (Yin, 2003; Houghton, Casey, Shaw, & Murphy, 2013). The case study method is accurately understood as a particular way of defining cases, not a way of modelling causal relations (Gerring, 2004). The goal of this study is to describe PSWs, not to identify causal relations.

A case study focuses on the "how" and "why" research questions which are explanatory (Yin, 2003). That is, the case study approach allows the researcher to be able to address the "how" and "why" questions to the research problem. For example, why are PSWs important to the healthcare system and how they might fulfil the greater role expected of them based on Ontario's healthcare plan to move care to the community. This approach also does not involve any control over behavioural events and thus allows the researcher to study a phenomenon within its real life context (Yin, 2003). This study does not involve the control over behaviour events. Rather, the goal is to describe and understand who PSWs are and the work that they do. A case study can illustrate certain topics within an evaluation using a descriptive mode which is done for this study (Yin, 2003). Surveys are designed to collect descriptive information. An initial step in developing a questionnaire is to conduct a case study to identify items to include on the questionnaire as well as to gain a better understanding of the group being studied. Data

collected from this case study will also assist in the future development of sampling strategies and selection of distribution methods for a study using a survey for data collection.

One of the disadvantages of a case study design is the lack of rigor (Yin, 2003). In this study data is used from various sources of information. As a result, data triangulation was used to establish the validity of the research findings. Appendix B lists the sources and sections that they apply to. Another disadvantage of case studies is not following systematic procedures or allowing biased reviews to influence direction of the findings. They are often thought not to provide basis of scientific generalization as they are based on a single case. However both case studies and experiments are generalizable to theoretical propositions and not to populations or universes (Yin, 2003). Gerring (2004) indicates that case studies are most useful when the strategy of research is exploratory, rather than confirmatory. This study is an exploratory study of PSWs in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. For this study a scoping methodology is used. The sections below outline what a scoping review is and the stages for the scoping review which is the data collection and categorization phase of the study.

3.1 What is a Scoping Study

Scoping is a novel review methodology for systematically assessing the breadth of a body of literature in a particular research area (Brien, Lorenzetti, Lewis, Kennedy, & Ghali, 2010). Scoping reviews aim to map the key concepts supporting a research area and the main sources and types of evidence available. They can be undertaken as stand-alone projects in their own right, especially where an area is complicated or has not been

reviewed comprehensively before (O'Malley & Arksey, 2005; Levac, Colquhoun, & O'Brien, 2010). A review of Ontario's PSWs has not been previously done comprehensively. This approach makes it possible to identify the gaps in the evidence base, as well as summarizing and disseminating research findings.

The scoping review comprises a type of review of literature that collects, evaluates analytically reinterprets and presents available research evidence (Levac, Colquhoun, & O'Brien, 2010). Some other types of reviews of literature include systematic review; meta-analysis; rapid review; (traditional) literature review; narrative review; research synthesis; and structured review (O'Malley & Arksey, 2005). The difference between a scoping review and a systematic review is that a systematic review generally focuses on a well-defined question where appropriate study designs can be identified in advance whilst a scoping review tends to address broader topics where many different study designs might be applicable. Moreover, the systematic review aims to provide answers to questions from a relatively narrow range of quality assessed studies, in comparison a scoping review is less likely to seek to address very specific research questions nor, consequently, to assess the quality of included studies. (Davis, Drey, & Gould, 2009; O'Malley & Arksey, 2005).

The method adopted for identifying literature in a scoping study needs to achieve in depth and broad results. The scoping study review is directed by a requirement to identify all relevant literature regardless of study design (O'Malley & Arksey, 2005). As familiarity with the literature is increased, researchers will want to redefine search terms and undertake more sensitive searches of the literature. The researcher may not wish to place strict limitations on search terms, identification of relevant studies, or study

selection at the outset (O'Malley & Arksey, 2005). The process is not linear but iterative, requiring researchers where necessary to repeat steps to ensure that the literature is covered in a comprehensive way. The methodology for this thesis is based on scoping review as outlined above.

3.1.1 Stage 1: Identifying the Research Questions to facilitate search

Primary research goal and the parameters, objectives and outcomes are defined below. The scoping review methodology will be used to create a profile of PSWs. The goals of this thesis are to better understand where the occupation of personal support workers (PSWs) is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. The investigation of PSWs in Ontario will be based on a multistage analysis guided by the research questions outlined at the beginning of this chapter.

The theoretical framework will also evaluate if PSWs are a profession based on the neo-Weberian theory of professions and compare and contrast them to nursing which is a regulated profession. In addition, recommendations for the advancement of the PSW occupation will be outlined.

3.1.2 Stage 2: Identifying Relevant studies

Identifying primary studies (published and unpublished) suitable for answering the central research question (O'Malley & Arksey, 2005). To achieve this, research evidence was searched via different sources:

- electronic databases
- reference lists

- government documents
- relevant associations/organizations/institutions websites
- books and articles from libraries and inter-library loans

Decisions were made at the outset about the coverage of the review in terms of time span and language. Studies published between January 1990 and December 2013 are included for the PSW profile. The start date of 1990 was chosen because it was felt that this covered major policy changes in Ontario during which federal transfer payments were reduced and the provincial government started to restructure and reorganize its healthcare system to move to the community. Foreign language material was excluded because the study was focused on PSWs in Ontario and initial searches also did not identify any relevant foreign language material. Techniques and terms used included Boolean operators to expand and narrow searches. Single and combined search terms included: scoping review, Personal Support Worker or Nurse Aide or PSW or personal attendant or care worker (or a combination of these); Long-Term Care Home; nurse and Ontario; PSW and registry; PSW and Ontario; Ontario Ministry of Health and Long term care and acts; Homecare and Ontario; nursing history and Ontario; nurses and Canada. Electronic database searches included: CINAHL (Cumulative Index to Nursing & Allied Health Literature) Plus with Full Text; Pro-Quest; Health Source: Nursing/Academic Edition; Medline; Scholars Portal Journals, Scopus, Web of Science; PubMed; Academic Search Planner; Social Science Citation Index and Publications Ontario, Google and Google Scholar. Books and e-books were searched for through various library databases.

These searches generated a vast amount of literature (thousands of articles) from the various databases on PSWs and nurses making it necessary to narrow the search

further. Some databases generated approximately 20-4000 references and other databases generated only a few or none.

Article selection was based on the title and if the title was relevant to the research thesis outline then the abstract was reviewed. Many of the articles were government or association reports and so the entire report was reviewed for relevance. Additional references were identified by hand searching of reference lists of identified articles or reports and a general internet browser Google Scholar and Google search was undertaken to uncover any additional publications and grey literature. Books on nursing were located through the library database. The various mechanisms for searching identified 389 references.

3.1.3 Stage 3: Study Selection

As articles were reviewed familiarity with the literature increased and it was easier to remove and disregard studies that were not relevant to the thesis. As the focus of this thesis is PSWs in Ontario the search was focused to include only references that contained information on PSWs in Ontario. Nursing history and professional development was not found though journal searches but rather in books about nursing. The inclusion criteria was based on the research questions. Articles were reviewed first title and then abstract based on the inclusion criteria and were excluded if they did not contain the relevant information.

References were included if they addressed any aspect of the goal and associated questions. The search covered 1990–2013 for information on PSWs as this date reflected current policies and trends. A further screening of abstracts and reports was undertaken

and any papers not meeting the inclusion and exclusion criteria based on the research goal and associated questions were discarded. A further 255 papers from 389 were excluded because they were not considered relevant or were not considered to add value to the thesis. Final references included in the thesis are 134.

3.1.4 Stage 4: Charting the data

Articles and reports were identified based on the relevance, credibility and contribution to the thesis information. From each of the applicable reports key items were synthesized and interpreted by sorting and charting the articles and applicable information (Davis, Drey, & Gould, 2009). A consistent approach was used to record information in Appendix B listing the author, date, relevance to thesis and type of reference.

3.1.5 Stage 5: Collating, Summarizing and Reporting the Results

A reliable and consistent approach was applied for reviewing the articles and extracting information as per the research question across all types of articles and reports. In the section on the PSW profile, references were selected and data was extracted to create an overall description of who they are, what they do, where they work and the legislation that affects them. In addition, PSWs were evaluated based on the theoretical framework of professions based on the neo-Weberian theory and compared and contrasted to nursing which is a regulated profession. Data was extracted, analysed and interpreted based on the theoretical framework and the nursing profession example. Based on this research recommendations for the future development of PSWs in Ontario

are made. In doing so the thesis has reported the findings, results and inconsistencies, gaps and prioritized certain important aspects of literature.

3.1.6 Framework Optional Stage: Consultation Exercise

A formal consultation process was not undertaken for this thesis as this thesis goal was to create a PSW profile and evaluate the professional status of PSW with existing literature which depending on the outcome would lead to various consultations with PSWs and stakeholders. Therefore, the various aspects of professional development outlined from the results of this thesis would need to be examined in several follow-up studies. However, the Personal Support Network of Ontario (PSNO) and the Ontario Personal Support Worker Association (OPSWA), National Association of Career Colleges (NACC) and community colleges were contacted to ask permission to use information on their websites and/or for clarification, for the sections on education and of information on their websites.

The limitation of a scoping review is that it does not appraise the quality of evidence in the primary research reports in any formal sense (O'Malley & Arksey, 2005). However for this study a considerable amount of effort was taken to ensure material was used from credible and varied sources such as government documents, association documents, peer-reviewed journals and grey literature. The quantity of data generated can be considerable for a scoping review. This can lead to difficult and challenging decisions about how far breadth (covering all available material) is more important than depth (providing a detailed analysis and appraisal of a smaller number of studies) (O'Malley & Arksey, 2005). In addition, no formal consultation process was undertaken with PSW stakeholders for this study.

The theoretical framework will evaluate if PSWs are a profession based on the neo-Weberian theory of professions and compare and contrast them to nursing which is a regulated profession. The nursing profession was chosen as a comparison to PSWs because nursing is a female dominated profession like the PSW occupation, basic nursing is the scope of work for a PSW, PSWs are often supervised by nurses and most importantly nursing has evolved into a regulated profession. Other groups such as midwifery could have also been used as a comparison. Of necessity the theory chapter begins with a brief overview of the main features of Functionalist, Interactionist and System of Professions and ends with the neo-Weberian theory of professions. The Ministry of Health and Long-Term care initiatives such as Regulation under the Regulated Health Professions Act, 1991 and PSW registry are examined. In addition, recommendations for the advancement of the PSW occupation are outlined.

The location of health-care delivery is moving from the hospital to the home and community. As clients are discharged to home care and long-term care earlier than before, their acuity upon discharge is higher and the care they necessitate is more complex. The extent of services provided outside hospitals has correspondingly become more complex, and more trained health workers are needed to assist in managing these new cases (Pan-Canadian Planning Committee, 2008). With numerous demands on PSWs and a growing need for their care, there remain unresolved issues around training, scope of practice and work environment of these workers given the changes to the healthcare delivery system in Ontario (Laupacis & Born, 2012). Given variations in education, training and work environment what should the appropriate next steps be for PSWs in order for them to be able to meet the healthcare challenges of the future.

Chapter 4
Results: Role of PSWs

This chapter is an in-depth examination of who Personal Support Workers (PSWs) are, where they work, their education and training and the legislation that impacts them. In Ontario, PSWs provide the majority of the direct care services provided in peoples' homes, and in long-term care facilities. The Canadian Home Care Human Resources Study Survey of Formal Caregivers estimates that they carry out most (70–80%) of all paid home care work in the country (Canadian Research Network for Care in the Community [CRNCC], 2009a; Lilly, 2008). PSWs are currently unregulated, frontline healthcare workers who provide support to people in need of assistance with daily activities due to illness, injury, or aging (Personal Support Network of Ontario [PSNO], 2010). They have a unique role in Ontario that is different from that of any other health care or support provider. In basic terms PSWs do for a person the things that the person would do for herself/himself, if she/he were physically and/or cognitively able (PSNO, 2012b). No other profession's scope is similarly described. They have been trained in supportive care, comfort measures, companionship, personal care and support to the family (PSNO, 2012a). The services they provide include personal assistance to older people, people with disabilities and/or chronic health conditions and, in some cases, children (PSNO, 2010; Keefe, Martin-Matthews, & Legare, 2009; CRNCC, 2009a). Therefore PSWs provide a variety of services and the age, health status, conditions, and personal circumstances of clients receiving services from PSWs vary broadly.

In Ontario province-wide health human resource challenges have contributed to the increasing demand for allied health care workers such as PSWs in all care settings

(Health Professions Regulatory Advisory Council [HPRAC], 2006). Other factors impacting the role of PSWs and their scope of work include:

- Increasing demand for services based on growth of the seniors' population.
- On-going interest in replacing and changing traditional models of hospital-based care with community based services.
- Increasing acuity of residents in both long-term care homes and clients in community settings as a consequence of shorter acute care stays.
- Client choices for aging at home.
- Fewer informal caregivers in the home.
- New technologies e.g. smartphones as tools for healthcare record tracking and medication management (HPRAC, 2006).

Normally, PSWs assist with activities such as:

- Activities of Daily Living (ADL) – personal care (feeding, bathing, dressing, toileting), and transferring (walking)
- Clinical Care Services – measuring a client's blood pressure, pulse or temperature; and taking specimens
- Controlled Acts as Defined by the Regulated Health Professions Act (RHPA), 1991 whether under exception, exemption or delegation from a regulated health professional (e.g. administering a substance by injection or inhalation) (Government of Ontario, 1991a)
- Instrumental Activities of Daily Living (IADL) – menu planning, shopping, meal preparation, transportation, etc. (only if done in addition to one of the three above, not solely) (Ontario PSW Registry, 2012a; Ontario PSW Registry, 2012b).

There are three restrictions on these activities legislation, employer policies and training. In addition, the RHPA (1991) sets out certain acts that may only be done by specific health professionals (PSNO, 2012d; Government of Ontario, 1991a). There are only a few circumstances where a PSW may perform some of these acts such as when assisting a person in their home with his/her routine activities of living. There are also

specific guidelines to follow if a PSW is requested to do one of these acts which will be discussed later in this chapter.

4.1 Where do PSWs Work and their relationship to other health care professionals

PSWs work in a variety of settings including home care, long-term care facilities, adult day programs, community support services, supportive housing, group homes, private homes, hospitals, educational facilities to name a few. There are an estimated 90,000 PSWs in Ontario with about 57,000 providing care in long-term care homes and 26,000 in home care through community health agencies (MOHLTC, 2011b). About 7,000 personal support workers provide care in hospitals (MOHLTC, 2011b). The level of supervision under which PSWs work varies by setting and employer. This thesis will focus on PSWs working in long term care (LTC) and homecare as the majority of PSWs work in these environments; however, a brief overview of PSWs in hospitals is provided.

4.1.1 Hospitals

In hospitals, PSWs work mainly in rehabilitation and complex continuing care, and are often known as health care aides (Health Professions Regulatory Advisory Council [HPRAC], 2006). In these locations, PSWs help with ADL and activation activities that assist people in dealing with aging, injury or illness. In hospitals and in long-term care a PSW works under the direction of a Registered Nurse or Registered Practical Nurse (HPRAC, 2006). They often receive instructions from nurses, hospital staff, physicians, and may also receive direction from occupational therapists, physiotherapists and registered respiratory therapists. PSW are responsible for following the directions and instructions given by health professionals, as a part of the plan of

support or care (Ontario Community Support Association [OCSA], 2009c). They must observe and report conditions as instructed, in consultation with their supervisor. In Ontario the majority of PSWs work in LTC.

4.1.2 Long Term Care (LTC)

In Ontario, LTC home services are partially funded and regulated by the provincial government and delivered in municipal homes, charitable homes and nursing homes (not-for profit and for-profit) (Ontario Association of Non Profit Homes and Services for Seniors [OANHSS], 2012). LTC is a provincially regulated program, through the Local Health Integration Networks (LHINs), publicly funded on a cost shared basis with residents as part of the province's healthcare program. Homes are designed for people who need twenty-four hour nursing care and supervision in a safe and home-like environment (Ontario Long-Term Care Association [OLTC], 2011). The province pays for care and associated programs and services, approximately two-thirds of the total cost and the resident makes a contribution to room and board type services through a co-payment, approximately one-third of the total cost. The 65/35 percentage split of funding is based on an average estimated co-payment rate. Homes receive a total of $152.94 per day for each resident (OLTC, 2011; MOHLTC, 2012a). With rate reduction eligibilities, the daily basic rate paid by a resident can range from $34.63 to $53.23 (OLTC, 2011). This does not include preferred accommodation (e.g. semi-private and private room). The province pays for 65% of the cost which includes 24 hour nursing and personal care, recreational and social programs and food (OLTC, 2011). The resident pays 35% of cost which is a contribution towards the room and board services such as housekeeping, laundry, bed linens and furnishings (OLTC, 2011).

In addition to the services funded by the government and the co-payment, residents can procure additional services that vary from home to home. These include cable, telephone, television, transportation, hair care, dry cleaning and other services (OLTC, 2011). Some Long-Term Care Homes and Services are owned and operated by a Municipal government such as the City of Toronto Long-Term Care Homes and Services and so are directly accountable to City Council (City of Toronto Long-Term Care Homes and Services, 2012). City Council does make an annual contribution to the division's operating budget which enables the homes to have a higher level of care and a broader range of service than would be possible based solely on the per diem funding provided by the Local Health Integration Network (LHINs).

All Long-Term Care Homes in Ontario (including those formerly known as Nursing Homes, Municipal Homes for the Aged, and Charitable Homes) are governed by the Long-Term Care Homes Act, 2007 (LTCHA) (OLTC, 2011). In addition, the MOHLTC sets provincial standards and policies regarding the provision of services to residents as well as the operation and management of LTC homes (Saint Elizabeth Health Care, 2008). These standards lead to annual agreements between LTC homes and LHINs. The requirements in the LTCHA ensure that residents of these homes receive safe, consistent, and quality resident-centred care in settings where residents feel at home, are treated with respect, and have the supports and services they need for their health and well-being (OLTC, 2011) (See section on Legislation).

There are approximately 633 LTC homes that operate 77,747 beds in Ontario. Of those, municipalities operate 103 homes representing 16,473 beds, non-profits and charities operate 158 homes representing 19,535 beds and for-profits operate 360 homes

representing 41,475 beds (Saint Elizabeth Health Care, 2008) (OANHSS, 2012). Elderly Capital Assistance Program (ELDCAP) beds which are long-term beds in acute care hospitals make up the balance. Long-Term Care Homes are places where individuals can live and receive support services. Long-Term Care Homes offer higher levels of personal care and support than those generally offered by either retirement homes or supportive housing. There are over 76,000 residents in Ontario's LTC Homes (MOHLTC, 2012c). They are often a choice for seniors who need help with the activities of daily living, supervision in a secure setting or access to 24-hour nursing care. The average age of Long-Term Care residents is 83 years (Saint Elizabeth Health Care, 2008). Those under the age of 65 years account for less than 6% of total residents (Saint Elizabeth Health Care, 2008). More than 85% of residents are classified as requiring high levels of care including constant supervision and assistance in performing one or more activities of daily living (ADL) including dressing, eating or toileting (Saint Elizabeth Health Care, 2008). Approximately 73% of residents have some form of cognitive impairment, including Alzheimer's disease and related dementias (Saint Elizabeth Health Care, 2008). Residents of LTC homes in Ontario require more care and more specialized services than in the past. This trend is attributable to numerous factors including longer life expectancies and advances in medical treatments (Saint Elizabeth Health Care, 2008). Releasing patients earlier from the hospital sector mean that residents with multiple care needs that were previously cared for in chronic care hospitals are now cared for in LTC homes.

Currently there is no provincial staffing standard for LTC homes nor is there a requirement related to fixed hours of care per resident per day or staffing levels (Saint

Elizabeth Health Care, 2008). Each home decides the level and type of staffing that it provides to its residents based on the assessed needs of each resident and available resources. An analysis of staffing data demonstrates that there is considerable variability in the level and type of staffing at each home. The average number of paid hours of nursing and personal care per resident per day varies from 1.9 hours to 5.1 hours (Saint Elizabeth Health Care, 2008). Evaluation of needs of the resident determines the number of hours of care each resident receives. There are however requirements in regulation relating to specific staff including the presence of a registered nurse on a 24 hour basis seven days a week and that each home have a Director of Nursing and Personal Care (DONPC).

In 2007, the Ontario government released information that long term care homes in Ontario were averaging 2.86 hours of nursing and personal care per resident day (Registered Nurses' Association Ontario [RNAO], 2007). This falls short of the 0.59 RN hours per resident per day recommend by the Case Verde nursing home coroner's inquest (RNAO, 2007). Given the available evidence, and the staffing standards in other areas, pending an evidence-based study to determine appropriate staffing levels, Registered Nurses' Association of Ontario (RNAO, 2007) stated that a minimum staffing standard of 3.5 hours per resident per day should be instituted for facilities with an average patient case mix. Currently the staff mix in Ontario is: 20 nurse practitioners in selected LTC facilities in Ontario, 11% registered nurses, 13% registered practical nurses and 75% personal support workers (RNAO, 2007). RNAO suggests that for facilities with an average case mix: 1 nurse practitioner per LTC facility, 20% registered nurse, 25% registered practical nurse, 55% personal support workers/health care aides (RNAO,

2007). RNAO (2007) has indicated that studies have shown strong links between staffing (particularly Registered Nurses) in LTC facilities and patient outcomes including: lower death rates, higher rates of discharges to home, improved functional outcomes, fewer urinary tract infections, fewer pressure ulcers, lower urinary catheter use, and less antibiotic use. The staffing pattern above would result in fundamental improvements in residents' clinical and social outcomes (such as reduced rates of pressure ulcers and falls, decreased aggressive behaviours with improved dementia care, increased residents' and families' satisfaction) and improved system utilization (such as decreased transfers to emergency departments) (RNAO, 2007). In the RNAO recommended staffing pattern PSW account for 55% instead of 75% of the workers in LTC facilities.

PSWs play a very large role in the care of residents living in the LTC facility. They pay attention to the needs, wants, concerns and general well-being of all residents. The PSW job description for each LTC facility varies but most factors are similar (Ontario Personal Support Worker Association [OPSWA], 2012). Table 4-1 details the services PSWs provide.

Table 4-1: Workers assist the residents with their Activities of Daily Living (ADL).

Activities of Daily Living	Description
Showers, tub baths and sponge baths.	Many LTC facilities have specific tub bath days for every resident. Usually, a specific PSW for that shift performs the tub baths. Residents capable of bathing themselves, and resident's bed ridden, have sponge baths most days. (morning and bedtime) However, each facility may have different policies, schedules and bathing equipment.
Mouth care is done by PSW if resident is unable to do.	Cleaning of dentures, partial dentures, and over all mouth care. Checking inside of the mouth with the removal and application of dentures. This is to ensure there are no surface wounds of gums, tongue or any issues with any remaining teeth.
Assistance or performing any incontinent care.	Peri-care is performed during every incontinent product change. Appropriate creams or specific cleaning products are used if necessary.

Activities of Daily Living	Description
Assistance of dressing and undressing.	Residents who are bed ridden or have partial to no mobility, PSW's perform a complete dress/undress.
Applying medicated (if needed and approved) and non-medicated creams, lotions and powders.	Paying close attention to skin appearance. Checking for any surface wounds, unusual bruises, scratches, redness or swelling and signs of any potential pressure sores.
Assistance with positioning in bed.	Residents who are in bed for long periods of time, are repositioned and moved every two hours to prevent pressure sores from forming.
Assistance with grooming.	Assisting female residents with makeup application and male residents with shaving (electric usually).
PSWs ensure hearing aids are being used and working.	PSWs ensure hearing aids are being used and working. Or other personal aids.
PSWs perform simple catheter care if needed.	Cleaning around catheter site, watching for infection or any unusual concerns and the emptying and changing of catheter bags. Documenting the amount of output. Many residents with catheters have different bags for day and night. PSWs change the bag to the residents needs. PSWs work with condom, In-Out and indwelling catheters.
Assisting in transfers.	LTC facilities use equipment to aid in transfers if the resident is unable to bear some or all of his/her weight during a transfer. Ceiling lifts, and mechanical lifts are used in these cases. For residents who partial weight bear, PSW's assist them with transfers from their bed to chair.
LTC facilities have specific breakfast, lunch and dinner times.	PSWs assist residents down to the dining room and back again. In some cases, residents are unable to leave their rooms and a tray of food is brought to them. PSWs will also assist residents to activities, being held in the activity room of the facility.
PSWs document daily, and record any concerns they may have.	They record intake of food and fluid, output if needed, personal care routines completed, skin condition, emotional state, update on any ongoing or recent concerns and more. Each facility has a different form of documentation (i.e. flow sheet, tick sheet, progress notes, etc.) and what is documented may vary.
Most Personal Support Workers, residents and the resident's families, share close relationships with each other.	PSWs have many residents to provide care for but are always ensuring all the residents are in their best condition. Socialization is a huge point of care that a PSW provides. Talking about life stories or current issues and concerns the resident is having, can really improve their overall state of mind. PSWs can talk to family members, and assist them with any concerns they may have about their loved one.

Note: Activities of Daily Living. Adapted from Personal Support Workers in Long-Term. By Ontario, (Ontario Personal Support Worker Association [OPSWA], 2010a) ©2010. Adapted with permission.

They usually work within three shifts a day which are morning, evening and midnight shifts. Positions may be full time, part time or casual. Most shifts usually consist of the same group of PSWs (Health Professions Regulatory Advisory Council

[HPRAC], 2006; Ontario Personal Support Worker Association [OPSWA], 2010a). PSWs working in long-term care homes are required to work under the supervision of a registered practical nurse or registered nurse. The average ratio of PSW to resident is 11:1 or 13:1 (HPRAC, 2006). In general, an RN will have 60 residents under their care and supervision, and an RPN will have 45. Overall supervision and nurse to resident, PSW to resident and nurses to PSWs vary in long-term care facilities.

PSWs cannot administer medications in LTC homes that fall under Ontario's Long Term Care Homes Act, (2007), or a facility governed by one of Ontario's hospital acts (PSNO, 2009). Occasionally, a Registered Nurse or Registered Practical Nurse may delegate the application of topical medications (e.g. medicated lotions or ointments) to a PSW on a one time basis. Such delegation is legal, but must only be done in situations in which the delegation clearly benefits the client and does not pose undue risk. In such a case, the liability is with the member of the health profession permitted by the RHPA (Appendix D) or the employer's policy, to perform the act, and not with the PSW to whom the act was delegated (PSNO, 2009; Government of Ontario, 1991a). The RHPA provides a framework for regulating the scope of practice of health professions in Ontario, under their respective regulatory Colleges (Ontario Aboriginal Health Advocacy Initiative [OAHAI], 2003). The LTCHA (2007) is the legislation that governs Long-Term Care Homes in Ontario (MOHLTC, 2007).

Changes to the LTCHA (2007) outlined a minimum standard of education for PSWs working in that sector/area specifically (Government of Ontario, 2007). These changes did not apply to PSWs working in environments outside long-term care such as home care. Under the LTCHA (2007), an individual may work as a PSW in a Ontario

LTC Home only if she/he is a graduate of a PSW programme that is at least 600 hours in length and meets one of three educational standards, outlined in the Act, Ontario Community Support Association (OCSA), National Association of Career Colleges (NACC) or Ministry of Training, Colleges and Universities (MTCU) (Government of Ontario, 2007; MOHLTC, 2011a).

An individual without the training described above may still qualify for employment, as outlined in the Act, as a PSW in a LTC Home if she/he is:

1. An Registered Nurse or Registered Practical Nurse who, in the opinion of the DONPC, has adequate skills and knowledge to perform the duties of a personal support worker;
2. A student who is enrolled in an educational program for Registered Nurse or Registered Practical Nurse and who, in the opinion of the DONPC, has adequate skills and knowledge to perform the duties of a personal support worker; or
3. A person who is enrolled in a personal support worker program described above and who is completing the practical experience requirements of the program, but the person must work under the supervision of a member of the registered nursing staff and an instructor from the program.
4. A person who was working or employed at a Home at any time in the 12-month period before July 1, 2011 as a personal support worker and who has at least three years of full-time experience, or the equivalent, considering part-time experience, as a personal support worker; (Government of Ontario, 2007; MOHLTC, 2011a).

The fourth exemption does not require that the experience must be in the home to which the individual is applying. However, under the legislation, experience must be in a home licensed under Ontario's LTCHA (2007). This exemption does not include work done in LTC homes in other provinces, because the Act only covers homes in Ontario. In addition, the LTC home must cease to employ as a PSW, or as someone who provides personal support services, regardless of title, a person who was required to have been enrolled in a personal support worker program or the educational program for Registered

Nurses or Registered Practical Nurses if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired (Government of Ontario, 2007).

Currently students trained in Ontario under one of the original three standards at a time when the provincial requirement was less than 600 hours, are facing barriers to employment in long term care (PSNO, 2012a; PSNO, 2012c). Many LTC homes are not accepting PSWs who have been grandfathered under the new LTCHA (2007). This is creating barriers for worker mobility as these PSWs are not allowed in some cases to work in LTC. Clearly the impact on the worker and her/his ability to gain employment should be assessed before the government identifies further educational requirements for entry to practice. These barriers may lead to additional PSWs leaving the workforce. The total estimated annual graduates from all PSW training programs is 7000 and the total estimated number of PSWs leaving the workforce per year is 9000 (PSNO, 2009). Therefore more PSWs are leaving the workforce than graduating from PSW training programs which may be a concern for employers.

The LTCHA (2007) delineates standard of education for PSWs working in that sector specifically (Government of Ontario, 2007). These changes do not apply to PSWs working in environments outside long-term care such as home care.

4.1.3 Home Care

When the Ontario government began examining the transformation of community-based long-term care services in the early to mid-l980s, it was concerned with remodelling services for mainly the well elderly. In the late 1980s, reform

comprised of people living with disabilities (Baranek, Deber, & Williams, 1999). Between the mid-1980s to now, hospital reorganization, medical and technological advancements have shifted acute care and related costs from the hospital sector to the community sector. As a result, the home-care population is evolving to include a larger proportion of acute-care patients (Baranek, Deber, & Williams, 1999). Demographic and fiscal pressures are tempting the government to find more cost-effective ways of delivering care. It is easier to shift costs than to cut them. With the shift of care into the community, care that was originally provided in hospitals has gone from being publicly funded under the Canada Health Act to being technically de-insured (Baranek, Deber, & Williams, 1999). The capping of the Home Care budget and changes to Ontario Health Insurance Plan (OHIP) further threatened this care as a fully insured entitlement. In this way, the home-care sector has become the place for massive shifts in costs by governments from the public to the private sector.

Home care was formally established in Ontario in 1970 and is considered to be a critical element of the formal health care system (Ontario Home Care Association [OHCA], 2011). Home care services are not publicly insured in the same way as hospital and physician services. That is provinces and territories provide and publicly fund home care services at their own discretion (Government of Canada, 1985). Home care service provider organizations can be contracted to supplement the publicly funded care by delivering service to individuals through private pay or through privately-insured employment plans and/or government programs (such as respite programs) (OHCA, 2011). OHCA (2011; 2012) estimates that 150,000 Ontarians purchase an additional 20 million visits/hours of home care services annually in order to remain at home. In

Ontario, publicly funded home care falls under the jurisdiction of the MOHLTC and is locally administered by Community Care Access Centres (CCACs). Ontario's publicly funded and privately purchased home care programs are vital to sustaining the publicly insured health system by enabling early discharge of patients from hospitals, reducing hospital congestion and non-acute emergency room visits. These are two key health care issues that currently concern the province's health system capacity (OHCA, 2011).

The Ontario government has transferred some forms of care that was once delivered in the hospital to the community. In Canada home care falls under provincial jurisdiction, organization and delivery and so it varies from province to province (Denton, Zeytinoglu, Davies, & Hunter, 2006). The Ontario government, in 1997, moved from a system largely organized and run by the non-profit sector to a market-based system whereby service provider organizations compete for contracts to provide home care services (Baranek, Deber, & Williams, 2004). This system is known locally as managed competition. Under managed competition the agencies that can provide quality care at the lowest cost win the contracts (Denton, Zeytinoglu, Davies, & Hunter, 2006). The rationale is that the introduction of market principles will provide greater cost efficiencies in the system (OHCA, 2011). The competitive process was intended to ensure that home care would be delivered by service providers offering high quality at best price to the public following a competitive procurement procedure. However, do individuals want to be cared for in their homes?

Evidence indicates that people want to remain at home for as long as possible, and if given a choice would prefer early discharge from hospital followed by home care (Caplan, 2005; Grunfeld, Glossop, McDowell, & Danbrook, 1997; OHCA, 2006).

Patients are discharged from hospital into home care services quicker and sicker, and home care budgets have not kept pace with the increase of clients coming into care (Denton, Zeytinoglu, Davies, & Hunter, 2006). Technological advances also mean that persons with disabilities are able to receive care and services that facilitate independent living. This too, has resulted in an increase in complex conditions and complexity of services now managed at home or in the community. Publicly funded home care services are designed to complement and supplement, but not replace, the efforts of individuals to care for themselves with the assistance of family, friends and community care (Caplan, 2005; Grunfeld, Glossop, McDowell, & Danbrook, 1997; OHCA, 2006).

A fundamental component of home care is that family and/or friends will provide care to supplement the formal homecare service. This successfully contains costs for the public system but creates challenges for families who are struggling to balance raising children, maintaining formal employment, saving for retirement and caring for a loved one. Middle-aged women (45 to 64 years old) devote almost twice as much time as men do to unpaid care giving. Within that age group, working women spend 26.4 hours a month caring for an aging parent, compared to 14.5 hours for employed men, according to Statistics Canada (Cowan, 2009). An estimated 26% of Canadians cared for a family member or close friend with a serious health problem in 2006 (OHCA, 2011).

Under managed competition, both for-profit and not-for-profit home care agencies respond to a request for proposal (RFP) and compete on a fee-for-service basis every three to four years, although the initial contracts were shorter as managed competition was rolled out. RFPs for nursing services were introduced in 1997 and in 1999. For PSWs, the first RFP was introduced in 1998 and the second in 2000 (Caplan, 2005;

Denton, Zeytinoglu, Davies, & Hunter, 2006). Results of competitive bidding can mean job loss for home care workers, or the hiring of additional home care workers if a new contract area was won by their employer. The change to a competitive environment has led to increased casualization of work (i.e., many more temporary and part-time jobs and a shift to elect-to-work care), increased job insecurity and decreased pay and benefits for home care workers (Caplan, 2005); (Denton, Zeytinoglu, Davies, & Hunter, 2006). This casualization of the home care sector allows employers a flexible labour supply whereby employers can adjust the supply to correspond with changing needs. Casualization permits employers to keep costs down by eliminating the employer's obligations to provide benefits such as vacation, sick leave, extended medical coverage and pensions. The Canadian Home Care Human Resources Study in 2003 stated that the wages of home care workers varied by union status and type of employer for registered nurses, licensed practical nurses and home support workers. Across all three groups, persons working for government or regional health authorities received the highest rates of pay, while home care workers in non-unionized, private, for-profit agencies received the lowest (Denton, Zeytinoglu, Davies, & Hunter, 2006).

The salary for PSWs depends on the employer and work setting. It ranges from approximately $9.00 to $18.00 and can be up to $25.00 per hour (National Association of Certified Caregivers/Personal Support Workers [NACC/PSW], 2012); (Canadian Research Network for Care in the Community [CRNCC], 2009b). MOHLTC has instituted a strategy that has brought the minimum wage for PSWs providing work under contract to the CCACs up to $12.50 per hour and they are compensated for travel time and cost (OHCA, 2008). This applies to PSW's providing work under contract to the

CCAC. However their wage is still significantly less than what workers get paid in LTC and hospitals. Lilly (2008) theorizes that the wage disparity of PSWs working in a hospital vs. home is partially attributable to the historical privileging of hospital settings in Canada, based on a medical-social continuum of health care valuation. Given that the hospital is seen as a highly medical place, whereas the home is considered to be a social place, care giving work enjoys greater financing protection in the former over the later. Lilly (2008) determines that these interpretations stem from deeply gendered historical roots which view the marketplace as a male-dominated setting for practical waged labour, and the home as a female dominated setting for unpaid social pursuits. Therefore, when personal support services shift from public institutions such as hospitals or long-term care into private homes, these activities become invisible to the government, and their provision beyond its domain. Lilly (2008) concludes that the medical versus social nature of the duties performed by PSWs has become secondary to the medical versus social nature of the setting in which these activities take place. This has translated into lower wages for home-based PSWs, essentially resulting in wage discrimination. Therefore, PSWs in homecare may suffer wage discrimination and greater job insecurity than their counterparts in LTC and hospitals.

A large number of PSWs working in home care are employed by agencies contracted by CCACs (CRNCC, 2010). These agencies employ PSWs to work in clients' homes where they are generally responsible for ADL, IADL, and client specific personal and or clinical care needs. The client population differs widely. The number of post-acute clients is increasing as patients are released more quickly from hospitals and as a follow-up to ambulatory procedures (HPRAC, 2006). Other clients require continuing

care to manage chronic conditions. Clients span all age groups. Community Support Agencies also hire PSWs to provide services primarily to the elderly and individuals living with physical disabilities. The role of the PSW differs with the agency's mandate (HPRAC, 2006). Some agencies offer home help, while others provide respite care. In each of these situations, the PSW tends to provide IADL and ADL assistance. Many PSWs working in this sector work split shifts and hold multiple jobs; 92 per cent are female (HPRAC, 2006).

In homecare the RHPA does stipulate an exception that allows someone who is not a member of a regulated profession, such as a PSW, to perform specific controlled acts, such as those that are a routine activity of living or delegated by a regulated health professional (RHPA (1991), Subsection 29(1)). A procedure would be considered a routine activity of living if, over time, the need, response and outcome of the procedure is known (College of Nurses Ontario [CNO], 2012). This definition could apply to a client with diabetes who receives a regular (not sliding scale) dose of insulin to regulate his or her blood sugars. In this situation, the client's condition should be predictable, and he or she should receive the same dose of insulin every day. The injection should be part of the client's daily routine and put the client at minimal risk. If the insulin injection for this client meets the criteria of a routine activity of living, the PSW can be taught to administer the insulin (CNO, 2012). Before teaching this procedure, it is imperative to assess the degree of change in the client's condition over time, the risks to the client of the PSW performing the procedure, and possible resources or supports available to the PSW (CNO, 2012). These client-specific factors and PSW abilities will determine if it is appropriate for the PSW to provide the care.

Delegation is not specifically defined under the RHPA. The CNO (2011) defines it as delegation is a formal process by which a regulated health professional, who is authorized and competent to perform a procedure under one of the controlled acts, delegates the performance of that procedure to someone, regulated or unregulated, who is not authorized by legislation to perform it. This unregulated individual could be a PSW. Delegated acts are usually time limited activities for PSWs (CNO, 2011; 2012). One of the criteria for delegation is that the controlled procedure must be an act that can be delegated. Not all regulated health professionals are allowed to delegate, some acts cannot be delegated and others are restricted in some way. When a regulated health professional delegates an act to another person the regulated health professional remains responsible for the correct performance of the act.

In community and home care settings, the PSW most often works at some physical distance and with limited direct oversight from the supervising health professional. Supervision is often indirect, happening through telephone meetings and chart review (HPRAC, 2006). Standards required of employers need to be strengthened, with employers taking more responsibility in ensuring consistent standards across settings. Given that supervision in home care is often indirect, this places the onus on the CCAC or Community Support Services (CSS) to ensure that service providers have the relevant standards and procedures in place to ensure adequate supervision and the delivery of high quality care (HPRAC, 2006).

4.2 What is the Education and Training

PSWs provide health care services in long-term care facilities, in the community for home care providers, in adult day programs, supportive housing settings, group

homes, hospitals, educational facilities and many other settings. A PSW is currently a unregulated health care worker. There is no registration examination for the PSW to enter into practice. There is no regulating body for graduates of PSW programs; however, the scope of practice is determined by the Regulated Health Professions Act (OSCA, 2009a). Certificates are given to PSWs upon graduation of the program by the training institution. PSW training is offered by Community Colleges, private vocational schools, Boards of Education and not-for-profit organizations. The Personal Support Worker Program/Personal Attendant Program was established through a consultation process that began in 1993. It was the result of a joint initiative of the Ontario Ministry of Health, the (then) Ministry of Training and Education and the OCSA (OSCA, 2009a). All organizations providing PSW training base their programs on the document generated by this consultation "Personal Support Worker Training: Outcomes and Module Outlines" which was published by the OCSA in January 1997. Appendix C provides a comparison of each of the sectors (OSCA, 2009a).

The PSW training was set up in modules with two official exit points:

- Personal Attendant – Completion of the first seven modules; responds to the needs of attendant care workers and the client/consumers they serve who wish to be active in directing their own care, and in training attendants to meet their individual needs; students who wish to confine their role to basic homemaking may also exit the program after the first seven modules. This program has been discontinued.
- Personal Support Worker – Completion of the entire program (14 modules); responds to the needs of workers who require the full range of training to work with clients who have a wide variety of individual needs and varying degrees of ability to direct their services (OSCA, 2009a).

There are differences within the education institutions (community colleges, private career colleges, boards of education and not-for profit organizations) for the

number of hours dedicated to theory, work experience hours, costs and standards of the programs offered (see Appendix C). Community college programs have the most hours of theory and work experience. All graduates of Personal Support Worker programs of instruction must have achieved the ten vocational learning outcomes, in addition to achieving the generic employability skills learning outcome and meeting the general education standard. The community college programs are longer than private colleges (8 months vs. 6 months) in length which is probably due to the generic employability skills and general education requirements that are mandatory for all community college programs. The generic employability skills are those such as communicate clearly and coherently using written and spoken formats, execute mathematical operations with the accuracy and use computers and other technological tools (Algonquin College, 2013; Ministry of Training, Colleges and Universities [MTCU], 2004). The general education requirements are to develop social responsibility and leadership and are intended to cover more than vocational field of study (MTCU, 2004). The National Association of Career Colleges (NACC) provides at a cost teaching material for many Private Career Colleges. The Boards of Education programs are delivered through Adult or Continuing education divisions. The Not-for Profit organization programs are sponsored by PSW employers who contract with these organizations to teach their employees. In terms of cost the Community College and Private Career College programs are higher in cost ranging from about 3,000 to 7,000 for some private colleges (Appendix C).

The Ontario government approved the new training program in May 1997, two years after the submission of the final OCSA report (2009b). By that time, there was considerable demand for training, both from schools anticipating the change and by

future students wishing to take what would become the new standard OCSA (2009b). The OCSA was given the responsibility of disseminating the standards to trainers, students, health professions and the public at large. The government identified the need of a variety of training providers, as well as the necessity of all agencies to adhere to the recommendations for format and content. The government did not, however, implement a single process for program approval, instead relying on the approval mechanisms existing within the various ministries whose responsibilities included the supervision of one or more types of training delivery institutions (OSCA, 2009b). While the ministries' existing training oversight mechanisms have been developed for and in response to specific needs of the agencies they oversee, none have specific expertise in the content represented by the PSW training program. This together with the lack of mechanisms not addressing workforce needs, employer input, and demands for the program led to programs being developed without the strong support, guidance and oversight that the Resource Group (the group in charge of this joint initiative of the Ontario Ministry of Health, the (then) Ministry of Training and Education and the OCSA) saw as essential (OSCA, 2009b). As a result, standardization was sacrificed for expediency. The variations in PSW training programs which have developed over the past decade present challenges to students, employers clients and impact the quality of care and the sustainability of Ontario's health system itself (OSCA, 2009b).

4.3 What are the Legislation and regulatory structures governing PSWs

There are several Acts that apply to PSWs:

- The Regulated Health Professions Act (RHPA) (1991) which provides a framework for regulating the scope of practice of health professions in Ontario.

- Home Care and Community Services Act (1994) which govern home care and the CCACs in Ontario.
- Long-Term Care Homes Act (2007) which is LTCHA is designed to help ensure that residents of long-term care homes receive safe, consistent, high-quality resident-centred care.
- Retirement Homes Act (2010) which establishes mandatory care, safety and administrative standards for retirement homes.

4.3.1 Regulated Health Professions Act, 1991 (RHPA)

The RHPA provides a framework for regulating the scope of practice of health professions in Ontario, under their respective regulatory colleges. It includes a general Act, a Procedural Code for all the regulated health professions, and profession-specific Acts. The RHPA does not govern the practices of traditional healers or Aboriginal midwives (Ontario Aboriginal Health Advocacy Initiative [OAHAI], 2003). Provisions in the RHPA also include a definition of "personal support services". The RHPA defines "controlled acts" that may only be performed by specified regulated health professionals. However, in some situations, PSWs may perform certain controlled acts by exception, by exemption, or under delegation by a regulated health professional. The Act outlines the manner in which Colleges (e.g. College of Nurses of Ontario) operate with regard to health care professionals. The Act also regulates the manner in which Colleges are to deal with complaints against a health professional. Colleges are responsible for:

- Regulating the practice of a health profession;
- Developing and maintaining standards of qualification for those who apply for certificates of registration; and,
- Developing and maintaining standards of professional practice, knowledge, skill and professional ethics for its members (OAHAI, 2003).

The Act also mandates the Colleges to set up a number of Committees.

The RHPA outlines the duties of other authorities:

- The Minister of Health has power under the Act to direct Colleges to perform a number of duties.
- The Health Professions Appeal and Review Board (HPARB), as outlined in the section titled "The Complaints Process of the Regulatory Colleges", are mandated to review decisions made by the regulatory Colleges with regard to complaints. It also conducts appeals of registration decisions made by the Colleges.
- The Health Professions Regulatory Advisory Council (HPRAC) provides advice and guidance to the Minister of Health regarding changes to the RHPA and other matters regarding the regulation of health professions (OAHAI, 2003); (Government of Ontario, 1991a).

The Procedural Code under the RHPA establishes the structure of each College which regulates a regulated health profession (OAHAI, 2003).

PSWs are currently not a regulated health care profession, meaning there is no governing body which sets standards for the skills and knowledge needed to practice as a PSW, and the services they can provide. PSWs are often supervised in various institutional settings by regulated health professionals, often nurses. As indicated in the sections above PSWs cannot dispense medication in Long-Term Care but can in homecare (PSNO, 2009). In homecare the Regulated Health Professions Act (1991) does stipulate an exception that allows someone who is not a member of a regulated profession, such as a PSW, to perform specific controlled acts, such as those that are a routine activity of living or delegated by a regulated health professional (Regulated Health Professions Act (1991), Subsection 29(1)). Although PSWs are currently not a regulated profession do they meet the standards of a profession or a regulated profession, this is discussed in the next chapter.

4.3.2 Home Care and Community Services Act 1994

Home Care and Community Services Act (1994) governs home care in Ontario. The Act outlines access to and availability of services, support for caregivers, integration of services, quality of services, and delivery of services. The Act defines "homemaking services" as ironing, shopping, meal preparation etc. and "personal support services" as helping with personal hygiene and activities of living (OCSA, 2012). These definitions were consulted when the Ontario PSW Registry was created. Certain definitions from the legislation are directly pertinent to the issue of who should be captured by the Registry or how to define "PSW" for the purpose of the Registry.

To help identify individuals eligible for registration, regardless of vocational or occupational title, the PSW Registry's official definition of "personal support services" using the Act's definitions of "homemaking services" and "personal support services" were used as a guide (OCSA, 2012).

4.3.3 Long-Term Care Homes Act 2007

The Long-Term Care Homes Act (2007) (LTCHA or the Act) replaces the three current pieces of legislation which governed long-term care homes: the Charitable Homes Act, the Homes for the Aged and Rest Homes Act and the Nursing Homes Act (Government of Ontario, 2007). The LTCHA is designed to help ensure that residents of long-term care homes receive safe, consistent, high-quality, resident-centred care (MOHLTC, 2011a).

The goal is to create long-term care home environments where residents feel at home, are treated with respect, and have the supports and services they need for health and wellbeing.

The way to achieve this goal is through:

- An on-going, province-wide commitment to the health and well-being of Ontarians living in long-term care homes; and
- Collaboration and mutual respect among residents, their families and friends, long-term care home licensees, service providers, caregivers, volunteers, the community and governments (MOHLTC, 2011a).

Certain sections of the Long-Term Care Homes Act (2007) are pertinent to PSWs. Section 6 of the LTCHA and sections 24 to 29 of the Regulation set out the requirements relating to plans of care and care planning, including assessing and reassessing residents and planning, delivering and evaluating their care, beginning when they are first admitted to the Home (MOHLTC, 2011a). The LTCHA and the Regulation require an integrated interdisciplinary approach to care planning and delivery as well as the involvement of the resident, his or her substitute decision-maker (if any) and any person designated by either of them, in developing and implementing the plan of care (MOHLTC, 2011a). The plan of care must cover all aspects of the resident's care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care.

The Act details the qualifications that an individual must possess in order to work as a personal support worker in a long-term care home. The "qualifications" outline those who have or are acquiring formal education from a recognized program as outlined in the Act, and those who do not have formal education but have experience working as a personal support worker (MOHLTC, 2011a). The Act also contains provisions that are

pertinent on how to handle complaints against PSWs. It describes procedures for licensees of long-term care homes to deal with, investigate, and report on complaints (MOHLTC, 2011a). Finally, the Act contains definitions that establish a process for reviewing, suspending, or terminating PSWs.

4.3.4 The Retirement Homes Act 2010

The Act establishes mandatory care, safety and administrative standards for retirement homes by regulation (Government of Ontario, 2010). Under the Act, a retirement home is generally defined to mean a residential complex or the part of a residential complex that is occupied primarily by persons who are 65 years of age or older, occupied or intended to be occupied by at least the prescribed number of persons who are not related to the operator of the home, and where the operator of the home makes at least two care services available, directly or indirectly, to the residents (OCSA, 2012). The definition exempts premises or parts of premises that are governed by or funded under certain provincial programs, including domiciliary hostels and homes for special care.

The Act also creates the Retirement Homes Regulatory Authority (RHRA), with the power and obligation to enforce the Act including licensing homes and conducting inspections and investigations (OCSA, 2012). The Act contains a definition of abuse detailed in terms of the actions, complaints or behaviours warranting suspension or termination of PSWs. This definition of abuse is essentially identical to that in the Long-Term Care Homes Act (2007) with slight differences in wording. RHRA administers the Act and is responsible for education and compliance with respect to the Act. The Act therefore sets out resident rights and protections and corresponding obligations on

operators of homes. The Act does not list that PSWs require any educational or training requirements to work in a Retirement Home. It also does not list what PSWs can and cannot do in a retirement home.

Except for the RHPA, (1991), which is considered to be an umbrella Act regulating the scope of practice of health professions in Ontario, the other Acts such as the Home Care and Community Services Act (1994), Long-Term Care Homes Act (2007) and the Retirement Homes Act (2010) are all sector specific Acts which indicate the requirements for that sector. PSWs do not have an Act specifically for their role like the Nursing Act, 1991 for nurses.

4.4 Who are PSWs – PSW Profile

In Canada, women primarily make up the home support labour force and a high proportion of these women are immigrants and visible minorities (Aronson, Denton, & Zeytinoglu, 2004; Neysmith, Reitsma-Street, Collins, & Porter, 2004; Canadian Research Network for Care in the Community [CRNCC], 2009a). In long-term care settings for example, overwhelmingly, the majority of care workers are female, and many are 45 years and older. This trend is present in countries other than Canada, such as the US, Denmark, France, the Netherlands, and Australia (Korczyk, 2004). As per the CRNCC (2009a; 2009b) the average age of a PSW in community support services is 45.6 years old and nearly three-quarters of care workers in Canada are 35 years or older, compared with 61% of workers in the overall workforce.

PSWs reflect the ethnic and racial diversity of Ontario. The overall visible minority population of Ontario is estimated at 2.7 million, almost 23% of Ontario's total population (CRNCC, 2009a). In comparison, visible minorities are over-represented

among PSWs, making up 42% of this labour force (CRNCC, 2009a). While working conditions in institutional long-term care can be difficult, those in home care can be worse (Korczyk, 2004). Home care workers often work alone, late at night, and in remote areas, leading to safety concerns. Because the workplace is a client's home, it may not meet minimal workplace safety standards for air quality, fire hazards, or cleanliness (Korczyk, 2004). Violence and verbal abuse may be concerns, and basic amenities such as drinking water and bathroom facilities may not be provided. Care work is often "invisible" work. Care workers may be low-paid, part-time, or temporary workers, and in the case of workers in home care, may not have a usual workplace where they can receive professional supervision, collegial support, and training (Korczyk, 2004). However, they have become increasingly important as medical advances allow more persons with complex needs to live in the community rather than in specialized institutions.

4.5 What is the role of professional organizations

PSW associations do not receive government funds to support the work of representing their members, guiding and advising government, developing standards and best practices and improving access to the services they provide (PSNO, 2012e). The OPSWA is the first legal organization for PSWs in Ontario (OPSWA, 2010b). OPSWA was created to meet the demands of PSWs all over Ontario who wanted a professional association. It is run by a board of directors and an advisory committee (OPSWA, 2010b). OPSWA is in contact with the MOHLTC regarding the issues for PSWs in Long Term Care/Retirement and Home Care. The PSNO is another PSW association and is a division of the OCSA whose members are community-based, not-for-profit organizations

that provide a wide variety of services to help people live at home (PSNO, n.d.). The mission of the PSNO is to help personal support service professionals carry out their work more effectively by offering access to information, resources and tools as well as providing opportunities to connect with a network of professionals in the field (PSNO, n.d.). PSNO wants to create an environment to share information and bring issues forward as well as the promotion of best practices and high performance in the workplace. The National Association of Certified Caregivers and Personal Support Workers (NACC/PSW, 2012) claims to be a professional association representing Certified PSWs and has an educational program for PSWs in Ontario and around the world. The Ontario government does not recognize this program for employment in long-term care homes. The vision and mission of the NACC/PSW is to maintain, promote and enhance a recognizable professional status for front-line health Caregivers/Personal Support Workers and Professional Childcare Workers. The discussion section further discusses these organizations and outlines in detail what educational programs are offered by some of these associations.

4.6 History of Nursing

In Canada, women had the main responsibility for healing from the time of the first French settlement in the early seventeenth century until the late nineteenth century. Under severe working conditions and physical hardships and constant lack of funds nursing sisterhoods provided medical services to settlers, soldiers and Native Americans through long winters, wars and endless epidemics of typhoid and smallpox. The French nursing orders created the first Canadian hospitals beginning with the Hotel Dieu in Quebec City and the Augustinian Hospitallers of Dieppe in 1639 (Coburn, D'Arcy,

Torrance, & New, 1987). Where pioneers in Canada did not have a nursing order to aid with the sick they relied on the self-taught and handed down skills of women who had knowledge of herbs for healing. The mother or grandmother acted as doctor, nurse and apothecary for the whole family. These skilled women often tended to an entire area. Women became the healers for their communities.

Numerous pioneers immigrated to Canada from Great Britain and Ireland in the mid-eighteenth century. Immigrants had been inspired and encouraged to come to Canada because they were essential for the country's economic growth. The epidemics, in 1832-1854, were created by mass transport of undernourished poor in overloaded and congested ships resulting in cholera, typhoid and smallpox (Coburn, D'Arcy, Torrance, & New, 1987). These epidemics then threatened immigrants as well as the population at large. In response to these epidemics nurses, mainly immigrants, working for a low wage were introduced into hospitals (Mansell, 2004). By Confederation, a strong medical profession had established schools in Ontario and the number of doctors increased significantly. In 1867 the Canadian Medical Association was formed. In 1869, under the Ontario Medical Act, a new College of Physicians and Surgeons of Ontario, empowered and authorized to examine would-be practitioners and university graduates, was incorporated (History of Medicine, n.d.). Advances in medical science in the late nineteenth century placed huge demands on hospital staff and procedures and encouraged the rise to dominance of the medical profession and the institutionalization of healthcare services. Medical Knowledge became dominated by those in medical schools and medical services were increasingly concentrated in hospitals (Coburn, D'Arcy, Torrance, & New, 1987). The institutionalization of health care meant that women who were once

independent practitioners often volunteering their services were denied education or training and were subsequently lowered to a subservient position within the medical profession.

In the 1860's in England, Florence Nightingale established the new nursing profession which set the pattern for nursing in many countries (Mansell, 2004). Nursing educators were interested in forming nursing as a respectable profession for women. The educational recommendations, one of which was to socialize the quality of passiveness in nurses, of Florence Nightingale were used to exploit women with low socioeconomic status into low paid, hard work by the promise of respect and upward mobility in this new women's "profession" (Ross-Kerr & Wood, 2003; Coburn, D'Arcy, Torrance, & New, 1987). Essentially they were used as a source of cheap labour for hospitals. It was easy to justify low wages as nursing was considered a public service and an extension of a woman's role within the home consequently income was supplementary.

Nursing education in Canada began in 1874 in St. Catharines, Ontario, after worldwide recognition of Florence Nightingale's efforts in nursing education. Nightingale believed that nurses needed to be educated and trained to care for patients properly (Mansell, 2004; Coburn, D'Arcy, Torrance, & New, 1987). She demonstrated her point by dramatically lowering mortality and morbidity rates of soldiers in the Crimean war in 1856, when she and a small group of nurses provided care for wounded soldiers. Canadian nurses were organized into the Canadian National Association of Trained Nurses whose main goal was to elevate the educational standards of the profession. They were interested in obtaining legislation to regulate the registration of nurses. Registration and regulation was a crucial issue in establishing the skill and

training that nurses required and was an attempt to limit the title of "trained nurse" to those who had the necessary training or education (Coburn, D'Arcy, Torrance, & New, 1987). Nurses were trying to protect themselves against the nurses' aides who were forced to accept very low paying jobs and domestic duties in order to make a living. Another choice would have been for nurses to include these women within their training and registration hierarchy that would have recognized different levels of nursing with different scope of work such is recognized today in nursing with the titles of Registered Nurse, Registered Practical Nurse and Nurse Practitioner.

Furthermore, now community colleges offer education and training for PSWs. Qualified graduates of these programs may also be eligible to apply their academic credits toward further study as a Practical Nurse (Durham College, 2013). In this way there could have historically been levels of care from Nurses' Aides to Registered Nurses each having their own scope of work. The exploitation of these women continued to trouble nursing associations well into the next century.

The history of women has shown that they have always had to strive for the right, often considered a privilege, of higher education (Mansell, 2004; Coburn, D'Arcy, Torrance, & New, 1987). The progress of nursing to professionalization consisted of the development of a knowledge base unique to nursing which involved doing specialized complex intellectual work (Ross-Kerr & Wood, 2003). Nursing education moved into the universities in 1919 with the inception of a degree program in nursing at the University of British Columbia. All provinces are moving to implement the proposal for a baccalaureate degree as an entry to practice for nurses in Canada (Ross-Kerr & Wood, 2003). The development of master's and doctoral degrees in nursing and nursing

research give nurses the intellectual leadership and professional knowledge required for professional practice (Schwirian, 1998). Achieving exclusive right to practice, embodied in law, is an important step in professionalizing nursing and added to its status and prestige. The first stage of the drive by nurses to gain control of professional nursing practice extended from the enactment of the first provincial legislation regulating nursing, in Ontario in 1922. The second stage was the development of mandatory acts regulating nursing in each province. This certified that the practice and practitioners would be more strictly regulated. Legislation incorporating mandatory registration requires a definition of nursing and an explanation of the scope of nursing practice (Ross-Kerr & Wood, 2003). Ontario passed the Regulated Health Professions Act (1991) and incorporated a new approach namely, regulating professional procedures. The Act regulates nursing and professional groups under 21 individual professional acts. Nursing is regulated by the Nursing Act (Government of Ontario, 1991b). Nursing therefore is a regulated profession.

In comparison, personal support workers are currently unregulated workers employed in a variety of public and private sector settings. They work in long-term care homes, home care and private settings such as retirement homes and private homes (HPRAC, 2006). Individuals now generically described as PSWs were previously known by a variety of other job titles, including: health care aides, personal attendants, home supporters, visiting homemakers, respite care workers, palliative care workers and supportive care assistants (HPRAC, 2006). What PSWs can and cannot do varies based on their training, education, supervision and employer policies (Laupacis & Born, 2012). However given variations in the work environment, education and type of care that PSWs

provide, there are concerns around what the appropriate next steps should be for them to be able to meet the changes proposed by the province in the move of healthcare from hospital to community. In the home they will be the healthcare worker that spends the greatest amount of time with clients who are increasingly requiring more complex care. A comparison of nursing and PSWs is provided in the discussion section.

Chapter 5
Discussion

The neo-Weberian theory is an important tool in analysing the nature and role of professions in advanced societies. This definition of a profession has the following characteristics in neo-Weberian theory these include: (a) direct market control of specific services through self-governing associations of formally equal colleagues; (b) more derivative patterns of control by the producer over the consumer where the producer defines the needs of the latter and how these are met; and (c) legitimate, organized occupational independence over technical judgements and the organization of work (Saks, 2010). These three characteristics will be evaluated for Personal Support Workers (PSWs) in contrast to nursing. As indicated, the goals of this thesis are to better understand where the occupation of Personal Support Workers (PSWs) is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. This professionalization framework helps to determine how ready PSWs are to meet the healthcare challenges of the present and future and/or identifies necessary changes.

5.1 Direct market control of specific services through self-governing associations of formally equal colleagues

By controlling recruitment, training and the labour market professions further acquire a monopoly over services by keeping their essential services in scant supply (Schwirian, 1998). A successful outcome depends on representatives of the occupation convincing key state officials that there is merit in terms of public protection and other factors in supporting a legal framework sustaining exclusionary closure (Saks, 1995). Nursing Leaders and Associations have played a key role in the development of nursing

in Canada. Nursing's birth and early development occurred under the protective watch of the medical profession and hospital administrators.

Nursing Leaders such as M.A Snively and G.E. Livingstone came from the same class, ethnicity and had the same goals of the male dominated medical profession (Mansell, 2004). As a result of their efforts the Canadian National Association of Trained Nurses (CNATN) was formed in 1908. In 1909 CNATN affiliated with the International Council of Nurses. The establishment of nursing schools and the recognition of the requirement of expert and special training to treat the sick by Canadian Society supported the growth of nursing. Early struggles focused on registration to limit the title of nurse to those who had the requisite education. In 1951 legislation was passed giving the Ontario Nurses' Association (ONA) full power over admission and certification in comparison the medical profession had received this power 82 years earlier (Coburn, D'Arcy, Torrance, & New, 1987).

The College of Nurses of Ontario (CNO) is the governing body for registered nurses, registered practical nurses and nurse practitioners in Ontario. The College sets requirements to enter the profession, establishes and enforces standards of nursing practice, and assures the quality of practice of the profession and the continuing competence of nurses (Ontario Nurses' Association [ONA], 2013). ONA is the union representing 60,000 registered nurses and allied health professionals and more than 14,000 nursing students providing care in hospitals, long-term care facilities, public health, the community, clinics and industry (ONA, n.d.). Canadian Nurses Association (originally CNATN) has been the voice of nursing in Canada influencing public policies, expressing the viewpoints of nurses on health and nursing issues, and playing an integral

role in the Canadian political process and the development of nursing in Canada (McIntyre & McDonald, Realities of Canadian Nursing, 2010). The Canadian Nurses Association's (CNA) power of representation has had an influence on legislative changes to the Canada Health Act (1984) and has guaranteed that the national and provincial plans of the future of the health care system are guided by primary health care and the Canada Health Act. CNA is the voice of nursing and as such focuses on the power of representation and self-regulation. To date there has been no organization recognized as the official voice of the PSWs by the Ontario government (PSNO, 2012e).

In comparison, PSW associations do not receive government funds to support the work of representing their members, guiding and advising government, developing standards and best practices and improving access to the services they provide (PSNO, 2012e). As indicated the Ontario Personal Support Worker Association (OPSWA) is the first legal organization for PSWs in Ontario (OPSWA, 2010b). In a 2011 letter to the Ministry of Health and Long Term Care (MOHLTC) OPSWA has outlined several areas of concern. The first concern is that PSWs require additional supervision and training, also a recommendation by Health Professions Regulatory Advisory Council (HPRAC), but are not receiving this essential surveillance. Lack of oversight can lead to putting vulnerable populations at risk which may well lead to an avoidable hospitalization. It also forces PSWs into providing care outside of their scope of practice and normally delivered by other health care professionals (i.e. giving out fentanyl patches, enemas, diabetic medication, etc.).

OPSWA (2011) has also indicated that PSWs are not provided with a standardized curriculum across the province. Course material and clinical experience

differ from one educational facility to another. HPRAC, Canadian Union of Public Employees (CUPE Ontario) and the Ontario Council of Hospital Unions (OCHU/CUPE) an Advocacy Centre for the Elderly (ACE) and Ontario Nurses Association (ONA) have all recommend that additional steps be taken within the current system to improve the training and education of PSWs and their staffing and supervision (HPRAC, 2006; CUPE Ontario & OCHU, 2012; ACE, 2011; ONA, 2012a). OPSWA is particularly concerned about PSWs graduating without literacy and fluency in English. Moreover, students unable to complete the required clinical and written competencies are graduated and are in the workforce. Trainers and teachers are bullied and harassed into passing undeserving students who are unsuitable for the caring and compassionate role of a PSW (OPSWA, 2011). As indicated the Personal Support Network of Ontario (PSNO) is another PSW association and is a division of the Ontario Community Support Association whose members are community-based, not-for-profit organizations that provide a wide variety of services to help people live at home (PSNO, n.d.).

It is the belief of the PSNO that one, consistent training standard should be applied as soon as possible for reliable, consistent outcomes in PSW training (PSNO, 2012a). PSNO recommends that all training sectors and PSW stakeholders be brought together to collaborate on this work. A clear mandate for the work, guiding principles that recognize and value the contribution of all in the process and shared accountability for the end result is the goal for PSNO. PEPA is a program developed by PSNO (PSNO, 2012a). PEPA is responding to the increasing demand that PSW programs become more accountable, which is meant to ensure the public that their program can meet benchmarks

that were developed by PSW stakeholders and are based on the MOHLTC PSW Program Standards in Ontario.

As indicated the National Association of Certified Caregivers and Personal Support Workers (NACC/PSW, 2012) claims to be a professional association representing Certified PSWs in Ontario and around the world. It offers a Certified Caregivers/Personal Support Workers (CPSW) as an International program of study for Certification as a Caregiver/Personal Support Worker. There are 800 hours of classroom study and an additional 200 hours of Internship for a total of 1000 hours (NACC/PSW, 2012). This program includes additional physiology and anatomy courses not included in other programs. However the MOHLTC has not approved PEPA, CPSW or any other PSW association program or accreditation (MOHLTC, 2011a). The three standards are the Ministry of Training, Colleges and Universities' PSW vocational standard (provided by Colleges of Applied Arts and Technology), National Association of Career Colleges' (NACC) standards and the Ontario Community Support Association's (OCSA) standards which are the only approved standards.

OPSWA (2011) has indicated that there should also be better access to more satisfactory recourse to patients and clients as a means of addressing instances of abuse and misconduct. There are also reports of certain facilities of not requiring the Vulnerable Sector Police Clearance (OPSWA, 2011). PSWs are being asked in some employer settings to dispense medications, and administer suppositories and injections. These activities are controlled acts, according to the Regulated Health Professions. These acts should be performed by nurses or other regulated health professionals. Most PSWs do not have the knowledge base or clinical expertise to be delivering this care. PSWs are

being called upon more heavily to help reduce health care costs and meet the needs of health recipients (Collins, Hogan, & Piwkowski, 2012). Unfortunately, this increasing reliance on PSWs has resulted in the downloading of tasks from Registered Nurses and Registered Practical Nurses onto PSWs. This trend is referred to as 'role drift.' Due to a lack of training standardization and loose regulations governing the PSW profession, this shifting of tasks is of paramount concern to ensure quality care is provided by PSWs to care recipients. Aside from strongly indicating that being overworked is a concern, the majority of PSWs working in Long Term Care (LTC) expressed that pressure to perform tasks outside normal role was a concern, with 35% indicating it was very concerning and 45% saying it was concerning (Collins, Hogan, & Piwkowski, 2012). This suggests that among PSWs working in LTC in this study sample, that role drift is a strong concern.

These are some of the concerns that seem to be occurring with more frequency and could result in severe repercussions such as a negative effect on patient outcomes. (OPSWA, 2011).

OPSWA (2011) has recommended the following:

1. "All employers of PSWs must ensure either an RPN or RN documents their delegation of all controlled acts to PSWs prior to each shift/visit. According to the CNO, RPNs and RNs who delegate controlled acts must evaluate the PSW's competency and, if necessary, train the PSW to competency…hence creating a check and balance for quality of care provided by PSWs.
2. Establish a curriculum standard that specifies:
    a. Mandatory topics for course material
    b. Minimum standards for written and practical experience
    c. A minimum number of placement hours, and
    d. Facilities providing clinical placements must demonstrate due diligence regarding appropriate police clearances, and provide workplace abuse training specific to PSWs role.

3. All PSW training programs must actively recruit and involve workplaces on a professional advisory committee that meets quarterly to offer clear guidelines on the requirement of supervision during the program (this is also a recommendation of HPRAC) and to ensure PSWs are given the best preparation in order to assist clients when entering the workforce. This will provide workplaces, as stakeholders, the opportunity to identify gaps in the PSW skill set. {HPRAC, pg. 21, Stakeholders identified several gaps in the PSW skill set, including: Teamwork, communications and literacy skills; Understanding of human growth and development across the lifespan: Understanding of people living with disabilities; Knowledge of specific care issues associated with palliative care, Alzheimer's and dementia.}
4. Given OPSWA's growing list of concerns and feasible recommendations, we know that we have a considerable amount of work to do. Our hope is to partner with stakeholders and government in addressing the problems with PSW training, scope of practice, and employment criteria."

Nursing Leaders and Associations have played a key role in the professional development of nursing in Canada. The Ontario government does not recognize any one association as the official voice of the PSWs which has delayed progress of supporting PSWs (PSNO, 2012e). The Registered Nurses Association of Ontario (RNAO) with funding from the Ontario Ministry of Health and Long-Term Care, in 2000 embarked on a multi-year project of nursing best practice guideline development, pilot implementation, evaluation, and dissemination. ``Strengthening and Supporting Families through Expected and Unexpected Life Events`` is one of seven (7) nursing best practice guidelines that were developed in the project (RNAO, 2002). Nursing and other health professional organizations receive government funds to enable the work of representing their members, advising government, developing standards and best practices and improving access to services. Unfortunately PSWs do not (PSNO, 2012e). Some PSW organizations such as the PSNO are divisions of employer associations which can lead to a conflict of interest with employer vs. PSW issues. Others such as NACC/PSW sell PSW educational programs that do not meet the current Long-Term Care Homes Act,

1991 educational requirements for PSWs. There are also competing interests between nursing and PSWs. As indicated, currently the staff mix in Ontario's Long-Term Care facilities is: 20 nurse practitioners in selected facilities, 11% registered nurses, 13% registered practical nurses and 75% personal support workers (RNAO, 2007). RNAO suggests a staff mix of: 1 nurse practitioner per facility, 20% registered nurse, 25% registered practical nurse, 55% personal support workers/health care aides (RNAO, 2007). The RNAO recommended staff mix increases the number of nurses employed by Long-Term Care facilities and decreases the number of PSWs. Employing more PSWs is a cost saving measure for employers as the hourly rate for a PSW is $9-18 versus the hourly base rate for registered nurses is approximately $22-40 (Canadian Research Network for Care in the Community [CRNCC], 2009b); (National Association of Certified Caregivers/Personal Support Workers [NACC/PSW], 2012; Registered Nurses' Association of Ontario [RNAO], n.d.b). The multitude of associations, the lack of strong, united leadership exclusively committed to advancing PSWs, and competing interests with nursing have limited the development of the PSW occupation. What is needed is strong united PSW leadership which focuses on the power of representation, similar to the nursing example, with common goals that initiates the necessary changes.

5.2 More derivative patterns of control by the producer over the consumer where the producer defines the needs and how these are met

Nursing is a self-regulating and self-governing profession and government provides society with a legal definition of nursing and what is within its scope of practise (McIntyre & Thomlinson, 2003). Nursing associations and individual nurses advocate with government to guarantee that nursing legislation and subsequent rules are in the best interest of the public to ensure safe and appropriate health care (McIntyre & Thomlinson,

2003). At both provincial and federal levels, positions and offices are being created for senior nurse executives. The first federal Principal Nursing Officer, Verna Huffman Splane, was appointed in 1968 and Laura Holland was the first appointed nurse advisory to the British Columbia Ministry of Health in 1938 (McIntyre & Thomlinson, 2003). RNAO CEO Doris Grunspun has received numerous professional and scholarly awards and was invested with the Order of Ontario in 2003. The award was created in 1986 by the Government of Ontario to recognize the highest level of individual excellence and achievement in any field (RNAO, n.d.a).

The concept of power is not generally associated with nursing. The media, public and other opinion makers refer to the power of major corporations, politicians, and medical association but seldom to the nursing profession. The sources of nursing empowerment include:

- Knowledgeable workers who cannot be spared to do lower-level tasks
- Legal powers that legitimise various nurse roles such as nurse practitioner and public acceptance of these roles which are integrated into the health system
- Knowledge as power which confers authority upon the possessor and is the basis for attaining credibility (McIntyre & Thomlinson, 2003).

Nursing leaders have demonstrated an ability to mobilise political strength to influence health and nursing policy. By comparison personal support workers are currently unregulated health care providers. This means that there is no professional self-governing college for PSWs (CRNCC, 2009a). They work under the supervision of a regulated health professional, supervisor, or, in the home under the direction of the client. There is no control over education, training or entry and over the labour market by any college or association as with other professions such as is the case of physicians

(CRNCC, 2009a). PSW associations are relatively new, OPSWA is 3 years old, and are often invited as stakeholders in provincial healthcare initiatives such as the PSW registry. Rather than being the vehicle by which change is initiated, PSWs have their role determined by others e.g. provincial legislation, employer polices and employers or clients.

Legislation such as the Long-Term Care Homes Act states what tasks PSWs cannot perform in Long-Term care facilities and the educational requirements for PSWs who work in these facilities. In addition, the MOHLTC has created a PSW registry to increase accountability but has not mandated as yet but strongly encouraged PSWs to register. Legislation, employer, training and current experience determine what tasks a PSW may perform not PSWs nor their associations (Hamilton, n.d.).

5.3 Legitimate organized occupational independence over technical judgements and the organization of work

The members of the profession can call upon a distinctive, methodological body of knowledge in assessing, treating or serving a professional group's clients/patients. The core activities accomplished by members of the profession must be distinct as a clear integrated whole and must be broadly accepted as such within the profession (HPRAC, 2006). If professional health practitioners are to be able to control the tasks they must perform and be consistent in predicting the outcomes of their actions, they must have at their disposal a well-defined body of scientific knowledge that will enable them to comprehend the bases and consequences of their actions.

Most nursing knowledge development has been in the realm of empirical knowledge which is concrete knowledge that can be tested and proven. Other types of

knowledge lend valuable information to nursing such as ethics, personal knowledge and esthetics based on observation and physical experience (Schwirian, 1998). Nursing knowledge has emerged from being physician-directed and task oriented to focus on the maintenance and wellness of clients, a perspective and body of knowledge unique to nursing.

The College of Nurses of Ontario is the governing body for registered nurses, registered practical nurses and nurse practitioners in Ontario, Canada (CNO, 2013). The nursing profession has been self-regulating in Ontario since 1963. Self-regulation is a privilege granted to those professions that have shown they can put the interests of the public ahead of their own professional interests. It recognizes that Ontario's nurses have the knowledge and expertise to regulate themselves as individual practitioners and to regulate their profession through the College (CNO, 2013).

There is no absolute body of knowledge unique to the PSW occupation (HPRAC, 2006). The Registered Nurses' Association of Ontario (RNAO) has stated that PSWs do not work within a distinctive systematic body of knowledge, but follow a clearly defined plan of care created by the employer and/or supervisor.

The College of Nurses of Ontario stated that:

> The work of PSWs is directed by a plan of care developed by a regulated care provider. The PSW does not organize the care plan, but is responsive to it in supporting the client. The PSW does not perform an assessment. The circumstances in which a PSW may perform treatments are carefully prescribed under the direction and supervision of a regulated health professional. Most importantly, where the PSW receives instruction in performing activities that may be within the nursing scope of practice, the instruction is tailored to individual clients. The PSW does not have the educational training to transfer these skills to other clients (HPRAC, 2006, p. 9).

This opinion was shared by educational institutions. George Brown College of Applied Arts and Technology, said:

> Most critically, PSWs do not practice within a distinctive systematic body of knowledge, but rather follow a clearly defined plan of care defined by the employer or a regulated care provider. Where PSWs are required to perform delegated duties that are within the nursing scope of practice, the nurse must ensure that the PSW is able to accept this delegation. In doing so, the PSW is directed by and responsive to a plan of care for a specific patient, developed by a regulated care provider, and is instructed to provide care specifically tailored to an individual patient (HPRAC, 2006, p. 9).

PSWs work with a limited knowledge base developed through education, training and experience. Their knowledge base does not allow them to redefine problems and tasks and seize new problems. Their associations do not receive government funds to support the work of representing their members, advising government, developing standards and best practices and improving access to services (PSNO, 2012e).

The PSW OCSA educational program was designed to standardize the skills, capabilities and portability of training for individuals providing personal support. Individuals educated at the PSW level are qualified to provide personal support, homemaking, attendant and respite services to patients/clients in their own homes and various institutions like Long-Term Care facilities (Ontario Association of Community Care Access Centres [OACCAC]; Ontario Community Support Association [OCSA]; Ontario Home Health Care Provider's Association [OHHCPA], 2000). In certain circumstances, PSWs are delegated controlled acts by a regulated health professional. This delegation is client-specific and does not mean that PSWs are assessing or treating their own patients or clients (HPRAC, 2006). They are merely playing a supportive role by assisting regulated health professionals in carrying out care and treatment plans

(PSNO, 2012d). While an individual trained as a PSW is expected to use judgement in responding to the needs of persons within the limitations of their role, they are not expected to diagnose, assess, or to respond to acute or unforeseen situations (except when emergency assistance is required) (PSNO, 2012d). These duties are left to the individuals (professional, consumer or caregiver in any combination) whose responsibility it is to organize and monitor the services provided.

Some have maintained that the body of knowledge of PSWs is basic nursing care, and that PSWs are now performing tasks that were done in the past only by Registered Nurses and Registered Practical Nurses. Others disagree, stating that with improved educational standards for Registered Nurses (BSc) and Registered Practical Nurses (College diploma); the activities performed by PSWs are no longer part of nursing care (HPRAC, 2006). The scope of practice of PSWs involves solely activities that the client would do for himself or herself if physically or cognitively able and that PSWs do not practise independent judgement, nor do they make decisions in the care of patients but simply follow care and treatment plans developed by regulated health professionals (PSNO, 2012d). Their job is dissimilar to current nursing. Therefore, the PSW occupation does not function within its own clearly defined body of knowledge nor is this knowledge theoretical or abstract that generally defines a profession.

Professional autonomy is the right and privilege provided by a governmental entity to a class of professionals, and to each qualified licensed caregiver within that profession, to provide services independent of supervision (Professional Autonomy, n.d.). PSWs contribute to the quality of life of clients/patients who live in facilities and at home by promoting their independence, dignity, social, emotional and physical well-being in

addition to their mobility, personal appearance, comfort and safety (OCSA, 2009c). They support individuals and their families and may work as a member of a team. In addition, they observe and report patient changes in condition to the most appropriate person. They carefully follow the care and treatment plans of others. Overall, they do not have the authority to initiate any action with respect to a patient – they cannot make independent changes to the plan of care or the implementation of the care plan. They are expected to use judgement in responding to the needs of persons within the boundaries of their role, they are not expected to diagnose, assess, or to respond to acute or unexpected situations (beyond any emergency assistance which might be required) (OCSA, 2009c). These responsibilities are entrusted to the persons (consumer, professional, or caregiver in any combination) whose role is to organize and monitor the services provided. They have no freedom to make decisions and clinical judgements within their scope of practice. They are directly supervised by a regulated health professional, usually a nurse, and/or are an employee of an institution or organization (Schwirian, 1998). Therefore autonomous or independent thought and judgement do not play an active role in the care that PSWs provide for patients.

In general, PSW associations have no control over education requirements, educational institutions or delivery of services to clients. PSWs cannot be considered a profession based on the criteria of the neo-Weberian theory of a profession which consists of market control of services, demarcation of consumer needs and occupational independence over work judgements.

The struggle to achieve professionalization has been long and hard for nursing but it has advanced through education, regulation and governance beyond its historical role

into the regulated profession it is today. PSWs provide vital services to vulnerable populations, including the disabled population, the frail elderly and those recovering from medical treatments (MOHLTC, 2012b). As with nursing the path to providing quality care may stem from registration, regulation and education. To increase accountability of PSWs the Ontario government has investigated the possibility of regulation under the RHPA and has now implemented the PSW registry.

5.4 Regulation under the Regulated Health Professions Act, 1991

If PSWs are to be considered as a regulated profession then they must meet the criteria of the RHPA (HPRAC, 2006). The HPRAC is recognized under the RHPA, with a statutory duty to advise the Minister on health professions regulatory matters such as whether unregulated health professions should be regulated (HPRAC, 2012). The RHPA is a legislation which applies to all regulated health professions. Each profession has the common RHPA and also has its own profession-specific regulations and college (Government of Ontario, 1991a). The founding of a self-regulatory college for the profession includes financial obligations for members of the profession.

In 2005 the MOHLTC, Honourable George Smitherman, requested the HPRAC to review and prepare a report regarding the regulation under RHPA of PSWs. The HPRAC submitted its report in 2006 to the Minister (HPRAC, 2006). HPRAC (2006) evaluated PSWs using the following criteria:

- Body of Knowledge
- Risk of Harm
- Membership's Support and Willingness to be Regulated
- Leadership's Ability to Favour Public Interest
- Sufficiency of Supervision

- Complaints Process
- Education & Training
- Educational Standardization
- Economic Impact of Regulation

HPRAC's central recommendation to the Minister was that PSWs should not be regulated as a profession under the RHPA as they do not meet the above criteria (see Appendix D for a detailed discussion of each criterion). One of the reasons for not regulating PSWs is the need for the founding of a self-regulatory college which includes financial obligations for members of the profession (HPRAC, 2006). Members of the profession must be necessarily numerous to staff all committees of a governing body and be willing to accept the full costs of regulation. At the same time, the profession must be able to sustain a separate professional association (HPRAC, 2006). The costs may not be well understood by PSWs, who earn low wages and many of whom work only part-time, and may be prohibitive. There should also be better access to more satisfactory recourse for patients and clients as a means of addressing instances of abuse and misconduct by PSWs (HPRAC, 2006). Instead of regulation under the Act there is a need for additional important steps to be taken within the current system to improve the education and training of PSWs and their staffing and supervision. HPRAC recommended that a Registry for PSW not be implemented as an alternate to regulation under the RHPA due to cost, need for legislation, the complexities involved in housing the registry with the Ministry and confidentiality issues for PSWs and patients (HPRAC, 2006). HPRAC indicated that if a Registry is to be considered certain stipulations such as mandatory registration, creation and maintenance by a central agency must be adhered to.

5.5 The PSW Registry

PSWs play a vital role in the delivery of services to vulnerable populations, such as the disabled population, the frail elderly, those recovering from medical treatments and those requiring increasing complexity of care at home (MOHLTC, 2012b). The Ontario MOHLTC developed the PSW Registry to increase accountability and accumulate information about the training and employment status of the nearly 90,000 PSWs in Ontario in an attempt to better understand PSWs (MOHLTC, 2012b).

The Ontario government in June 2011 consulted with key PSW stakeholders (e.g. PSW associations, unions) on the development and implementation of the registry (OCSA, 2012). The government stated its plan to enter into a Transfer Payment Agreement (TPA) with an appropriate partner to develop and implement the registry and, with the input received from many stakeholders, identified the guiding principles of the registry (OCSA, 2012). These guiding principles, listed below, were outlined in a letter to stakeholders from the Ontario Minister of Health and Long-Term Care in 2011:

- A phased implementation process for mandatory registration of PSWs employed by publicly-funded health care employers, beginning with the home care sector. Publicly funded employers are those receiving funding from the Ministry of Health and Long-Term Care, the Local Health Integration Networks or the Community Care Access Centres;
- Guaranteeing as much of the current PSW workforce is entered/recorded in the registry as possible, including grand parenting; and
- Tiered approach for access to the registry for clients/patients and family caregivers to assist self-directed care, and for employers to support their use of the registry, in the first instance, to fill vacancies (OCSA, 2012).

The government subsequently retained the OCSA, to set up the infrastructure for the development and implementation of the Ontario PSW Registry (the Registry) (OCSA, 2012). OCSA is a provincial association that promotes supports and represents the

shared goals of its members, which are providers of community-based not-for-profit health services (OCSA, 2013).

At this time, the Ontario PSW Registry is for the following groups of workers:

1. Those who have completed a formal Ontario PSW program that meets the requirements of one of the Ministry of Training, Colleges and Universities (MTCU), the National Association of Career Colleges (NACC), or the Ministry of Health and Long-Term Care/Ontario Community Support Association (MOHLTC/OCSA) standards.
2. Those who have not completed a formal Ontario PSW program but are currently employed to provide personal support services in Ontario.
3. Those who have not completed a formal Ontario PSW program, and are not currently employed to provide personal support services, but have been employed in that capacity, in Ontario, at some point in the five years prior to their registration (Ontario PSW Registry, 2012a); (Ontario PSW Registry, 2012b).

The Ontario government has specified that registration will be mandatory, however as yet it is strongly encouraged for all PSWs employed by publicly-funded health care employers (OCSA, 2012). Note that this does not include those PSWs who work in the private sector (e.g. retirement homes, private homecare). The first phase of the Registry's implementation is focused on the home care sector. Criteria 2 and 3, indicated previously, comprise a "grand parenting" provision that would be removed if and when the government determined that a PSW certificate from a recognized program is a mandatory requirement for employment to provide personal support services (Ontario PSW Registry, 2012a; 2012b). See Appendix E for detailed information on the registry and application form.

The Ontario Registry is much more complex and has a multi-faceted purpose (i.e. access for self-directed care for public, job board, increase public protection) in comparison to the other two provinces that have PSW registries, British Columbia and

Nova Scotia (OCSA, 2012). The British Columbia Registry and the Nova Scotia Registry differ from each other and Ontario's Registry due to different mandates (see Appendix E). The British Columbia registry purpose is to increase public protection. The Nova-Scotia registry's purpose is to connect publicly-funded employers with registered job seekers.

The Ontario PSW Registry opened and started collecting information on June 1, 2012. At this time Registration will be mandatory for all PSWs currently employed by publicly-funded employers within the home care sector (Ontario PSW Registry, 2012a); (Ontario PSW Registry, 2012b); (OCSA, 2012). As indicated earlier, publicly funded employers are those receiving funding from the MOHLTC, the Local Health Integration Networks or the Community Care Access Centres. In the future, date as yet unknown, these employers will be required to hire only PSWs that are on the registry.

One of the major complaints about the PSW registry is that it is being set up by an employer led group, the OCSA (Canadian Union of Public Employees & Ontario Council of Hospital Unions [CUPE Ontario & OCHU], 2011). For instance, employers investigate and discipline in the workplace, therefore giving an employer oversight of the registry where such investigations and disciplinary actions are reviewed is a conflict of interest (CUPE Ontario & OCHU, 2012). Giving control of the Registry to an employer organization limits occupational independence and control by PSW associations over their members in comparison to a profession like nursing where the CNO controls investigations and discipline of nurses. Advocacy Centre for the Elderly, a specialty legal aid clinic, (ACE, 2011) recommends that the data quality can only be assured and maintained if the collection, management and updating of the Registry is done by the

Ministry or a department of the Ministry. Further, ACE has some concerns regarding quality of the data and confidentiality if it is done by an external organization or third-party without any affiliation to the Government. CUPE has advised that optional sections of the application which allow access to PSWs personal contact information need not be filled in to protect PSW confidentiality (CUPE Ontario, 2013).

Another concern is that the registry will not accept complaints from members of the public or employers and it is as yet unclear how this mechanism of complaints, review and if necessary removal from the registry will work. There is no due process or representation clause, or appeal process for a PSW who loses the right to practice based on a complaint (ACE, 2011). For ACE (2011) registration for all PSWs should be mandatory and the registry should have any information regarding termination of employment as a result of allegations of neglect/abuse. ACE (2011) submits that clients who receive services from both publicly funded and privately operated agencies are entitled to the same level of protection.

Currently, there is no clear method of how mandatory registration will be enforced and data is verified (Fantoni, 2013). The ministry wanted all publicly-funded PSWs in the home care and community services sector to be registered as of April 1, 2013 but this has been delayed due to lack of registration by PSWs and enforcement of mandatory registration by the province (Fantoni, 2013). There is no process for grand-parenting to include educational certification from outside of Ontario and internationally to ensure personal support workers who have attained credit for their skills and competence are recognized (ONA, 2012b). Although not the registry directive, key for

most PSWs, the registry does not mean that there will be improved wages or working conditions.

There is no agreement to the future governance or operation of the registry. OCSA builds and hosts the database until March 13, 2014 (ONA, 2012b). ONA has suggested that Health Force Ontario would be an appropriate permanent housing body as a neutral location that could also verify accuracy, integrity and ensure privacy of the data (ONA, 2012b). Ontario is still in its early stages of Registry development and it is still unclear what its final role will be. In addition to the registry the Ontario government is attempting to standardize the educational requirements for PSWs in certain sectors such as LTC facilities.

5.6 Education

Personal Support Workers do not need a PSW certificate to work as a PSW in Ontario (PSNO, 2010), however as of July 1, 2011, with changes to the new Long-Term Care Act, a PSW certificate will be a mandatory requirement for all new PSW hires for Long-Term Care. The following summarizes PSW education:

- PSWs are unregulated health care workers.
- There is no certification" nor "registration" process.
- There is no PSW regulating body (PSNO, 2010); (Canadian Research Network for Care in the Community [CRNCC], 2009a).

Some confuse a college PSW certificate with professional certification. A college PSW certificate merely shows that the individual has completed a course of study. It is not the same as certification or registration as health professionals understand the term.

- Some private career colleges misleadingly use the terms "certification" and "registration" in their advertising.

- End-of-course examinations or entry examinations are not required in order to receive a PSW Certificate. However, some private career colleges offer a "national exam" or a "provincial certification exam." Such exams are neither recognized nor required to work as a PSW (PSNO, 2010).

The Ministry has suggested not one but three PSW educational standards. The regulation under the Long-Term Care Homes Act (2007) requires that, as of July 1, 2011, PSWs employed in long-term care homes, with limited exceptions, have completed a program that meets one of the three-educational standards:

1. Ministry of Training, Colleges and Universities' PSW vocational standard (provided by Colleges of Applied Arts and Technology). This Ministry standard only applies to vocational PSW programs provided by Ontario Colleges of Applied Arts and Technology (CAATs).
2. Vocational PSW programs provided by Ontario's private career colleges (PCCs) and Boards of Education must adhere to one of two standards which are the National Association of Career Colleges or the Ontario Community Support Association's (OCSA) or provide a disclaimer, informing students that they will not be eligible for employment in LTC (CRNCC, 2009a; PSNO, 2010).

In summary, the terminology around certification for PSWs in Ontario is not standardized. As a result, there is much confusion around what a PSW certificate means. There are no national standards, programs, exams for personal support workers. Each province sets its own training and performance requirements and standards (CUPE Ontario & OCHU, 2012). In Ontario there is no generic job description for PSWs and their knowledge and skills vary widely within the province. To be considered a professional a standardized job description and knowledge base is necessary to control services, how consumer needs will be met and to have independent control over technical judgements. In comparison, Nova Scotia and British Columbia, who also have PSW registries, have standardized PSW education programs and established registries.

In 2000, Nova Scotia created the Continuing Care Assistant Program (CCA) that consists of a minimum 840 hours with 330 hours of lab or practicum (clinical) and 510 hours of classroom theory. Although this program is offered in a variety of settings, the core program is similar (CUPE Ontario & OCHU, 2012). The CCA program is offered through community colleges, licensed nursing homes/homes for the aged, home support agencies, Nova Scotia Work Activity programs and through private career colleges. In BC, The Care Aide Registry's mandate is "to establish a standard, provincially mandated" program and in 2008 the standardized Health Care Assistant program began (CUPE Ontario & OCHU, 2012). The new Health Care Assistant program raised the standard for the classification. Now the program needs to be much longer in order to meet the new standard.

There is a confusing array of providers, standards and programs in Ontario. Employers determine which program is most suitable (CUPE Ontario & OCHU, 2012).. Those employers most concerned about profit will favour those with the most basic training in hope of acquiring cheaper labour. Those employers most concerned about the knowledge of their staff will favour better trained PSWs (CUPE Ontario & OCHU, 2012). For the public/clients, who are unable to become experts on the training standards of PSWs or the hiring practices of the organization providing care, it will be the luck of the draw. A much better approach would be one standard program delivered by non-profit educational providers.

The HPRAC found in 2006 that some stakeholders wanted a more standardized training program that could give other health care team members an improved understanding of the PSW's capabilities and responsibilities, particularly in regard to

delegating controlled acts (HPRAC, 2006). Results of a survey conducted by Canadian Research Network for Care in the Community (CRNCC, 2009a) of 364 PSWs from across Ontario revealed that PSWs needed more training in areas of mental health (64%) and chronic disease management (63%). Over half indicate more training is required in medication management (59%), Gay Lesbian Bisexual Transgender (GLBT) seniors (54%), dementia (52%), and palliative care (51%) (CRNCC, 2009a). Training care workers especially those who provide home care becomes more important as medical advances permit more persons with complex needs to live in the community rather than in institutions (Korczyk, 2004).

Education and training in the classroom and the workplace is necessary to provide the horizontal and vertical career mobility that will keep workers in the profession. Moreover, the care worker's frontline role needs to be recognized in service delivery (Korczyk, 2004). A better paid and better trained workforce will provide better care, which should be the ultimate goal of workforce policies. To the extent that education and qualifications are relevant to job performance, the quality of care will suffer if untrained workers are hired or if they do not receive training after being hired (Korczyk, 2004). Education and training become a critical issue as Ontario's plan is to move the location of health-care delivery from the hospital to the home and community; the extent of services provided outside the hospital become more complex resulting in the need for better educated and trained workers to manage these cases (Pan-Canadian Committee, 2008).

Chapter 6
Conclusion

There is currently no universally accepted definition or protection for the title Personal Support Worker (PSW). The title incorporates jobs previously known as health care aide, personal attendant, home support workers, etc. PSWs are front line workers who provide a variety of personal care, homemaking and support services to individuals in need of care (PSNO, 2012e). PSWs make up a considerable proportion of Ontario's health care workforce and provide much needed assistance with daily activities in hospitals, long-term care and educational facilities, adult day programs and at home in the community. There are approximately 90,000 PSWs in Ontario and it is estimated that they carry out most (70–80%) of all paid home care work in the country (Ontario Ministry of Health and Long-Term Care [MOHLTC], 2012b; Canadian Research Network for Care in the Community [CRNCC], 2009a). The goals of this thesis are to better understand where the occupation of Personal Support Workers (PSWs) is in its development towards becoming a profession; and what the challenges, opportunities, and prospects are towards this realization. The neo-Weberian theory of professions is used as the theoretical framework to analyse the PSW occupation in comparison to nursing.

The neo-Weberian framework used in this thesis to evaluate if PSW is a profession includes the following characteristics: (a) direct market control of specific services through self-governing associations of formally equal colleagues; (b) more derivative patterns of control by the producer over the consumer where the producer defines the needs of the latter and how these are met; and (c) legitimate, organized occupational independence over technical judgements and the organization of work

(Saks, 2010). The evaluation of these three characteristics for PSWs is summarized below in comparison to nursing which is a regulated profession.

The first characteristic is direct market control of specific services through self-governing associations of formally equal colleagues (Saks, 2010). Neo-Weberians often have analysed professional groups with reference to the concept of social closure drawn from the work of Weber (1968). This relates to the process through which particular social groups seek to regulate market conditions in their favour, in face of competition. In this way, they restrict access to specific opportunities to a limited group of eligible individuals creating a group of socially defined inferiors. Professionalization is thereby viewed as "a strategy designed, amongst other things, to limit and control the supply of entrants to an occupation in order to safeguard or enhance its market value" (Saks, 2010). The history of nursing shows that women without the requisite education, such as PSWs, are not accepted within the nursing hierarchy. Historically nurses were trying to protect themselves against the nurses' aides who were forced to accept very low paying jobs and domestic duties in order to make a living. Nursing leaders and associations have distinguished themselves by establishing a nursing knowledge base. Early struggles focused on registration to limit the title of nurse to those who had the requisite education. Nursing leaders and associations have advocated for health care policy that promotes health and prevents illness in addition to curing disease, rehabilitating, and providing palliative care (McIntyre & Thomlinson, 2003).

Nursing considers PSWs as not having their own knowledge to warrant the status of a regulated profession (Health Professions Regulatory Advisory Council [HPRAC], 2006). Moreover the Registered Nurses' Association of Ontario (RNAO) has stated that

PSWs do not work within a distinctive systematic body of knowledge, but follow a clearly defined plan of care created by the employer and/or supervisor (HPRAC, 2006). As unregulated health care providers PSWs have not been able to form a self-governing college (CRNCC, 2009a). They work under the supervision of a regulated health professional, supervisor, or, in the home under the direction of the client (CRNCC, 2009a). There is no control over education, training or entry and over the labour market by any college or PSW association as with other professions such as is the case with nursing. Therefore PSWs do not meet the above criteria to be considered professionals.

The second criteria for professions in the neo-Weberian theory of professions is that professions exercise more derivative patterns of control by the producer over the consumer where the producer defines the needs of the latter and how these are met (Saks, 2010). Nursing associations and individual nurses advocate with government to guarantee that nursing legislation and subsequent rules are in the best interest of the public to ensure safe and appropriate health care (McIntyre & Thomlinson, Realities of Canadian Nursing, 2003). Rather than being the vehicle by which change is initiated PSWs have their role determined by provincial legislation, employer polices, training and experience. Legislation such as the Long-Term Care Homes Act, 2007 states what tasks PSWs cannot perform in Long-Term care facilities and the educational requirements for PSWs who work in these facilities (Government of Ontario, 2007). In addition, the Ministry of Health and Long-Term Care (MOHLTC) has created a PSW registry to increase accountability and to learn more about PSWs in the province. Legislation, employer, training and current experience determine what tasks a PSW may perform not

PSWs nor their associations. Therefore, PSWs do not meet the second criteria for a profession.

The last criterion of the neo-Weberian theory of professions is the legitimate, organized occupational independence over technical judgements and the organization of work (Saks, 2010). The members of the profession can call upon a distinctive, methodological body of knowledge in assessing, treating or serving a professional group's clients. The core activities accomplished by members of the profession must be distinct as a clear integrated whole and must be broadly accepted as such within the profession (HPRAC, 2006). Most nursing knowledge development has been in the realm of empirical knowledge which is concrete knowledge that can be tested and proven. The members of a profession can call upon a distinctive, methodological body of knowledge in assessing, treating or serving a professional group's clients or patients. The core activities accomplished by members of the profession must be distinct as a clear integrated whole and must be broadly accepted as such within the profession and result in predicable outcomes (HPRAC, 2006). While an individual trained as a Personal Support Worker is expected to use judgement in responding to the needs of persons within the limitations of their role, they are not expected to diagnose, assess, or to respond to acute or unforeseen situations (except when emergency assistance is required) (PSNO, 2012d). These duties are left to the individuals (professional, consumer or caregiver in any combination) whose responsibility it is to organize and monitor the services provided.

The scope of practice of PSWs involves solely activities that the client would do for himself or herself if physically or cognitively able; PSWs do not practise independent judgement, nor do they make decisions in the care of patients but simply follow care and

treatment plans developed by regulated health professionals (PSNO, 2012d). Therefore, PSWs do not meet the last neo-Weberian criteria for a profession. Lack of strong leadership, lack of associations that represent all PSWs and lack of the development of a future vision which guides the occupation have all resulted in a lack of power to control their own role in healthcare. For nursing standardization in training and education, strong leadership and legislation have steered the way to professionalization which are missing for PSWs.

As seen with the nursing profession it is education that leads to the development of leaders, autonomy and legislation as it provides society with assurances that these individuals can provide unique services and value that benefit its member. Approximately, only 20 percent of the PSW workforce has received formal education in community and career colleges or through continuing education programs through school boards, and the remainder through in-service training has led to unequal skills throughout this occupational group (HPRAC, 2006). This variation presents challenges to graduates in transferring their knowledge and skills across institutions or jurisdictions and to employers who are seeking some level of standardization in competencies from their employees (Association of Canadian Community Colleges, 2012).

Currently PSW educational standards vary depending on the type of educational institution delivering the training. The educational standard for Ontario must cover all their education, no matter the type of institution that delivers PSW education. The Ministry of Training, Colleges and Universities has partnered with the MOHLTC to develop a common educational standard for PSW programs (Bickford, 2013). Various stakeholders have been invited to participate in its development. It is unclear what this

process by the ministries will involve; however, what is necessary are structured discussions with all stakeholders to determine current and future needs of clients in all sectors (hospitals, Local Health Integration Networks, Community Care Access Centres, Community Support Services, PSWs). Subsequently to develop a scope of work for PSWs that meets needs in all sectors and to finally develop a standardized education and training program that meets these needs.

The salary for these workers depends on the employer and setting. It ranges from approximately $9 per hour to approximately $18 per hour and can be up to $25 in some facilities (CRNCC, 2009b; National Association of Certified Caregivers/Personal Support Workers [NACC/PSW], 2012). Many of their positions are casual or part-time resulting in a low salary for many PSWs and no benefits. Training care workers especially those who provide home care becomes more important as medical advances permit more persons with complex needs to live in the community rather than in institutions. Training whether in the classroom or the workplace also is essential to provide the horizontal and vertical career mobility that will keep workers in the profession. There may be few options to employer or public sector funding to train care workers (Korczyk, 2004). Since care work is usually a low-paid job, PSWs are unlikely to have or be willing to invest their own funds to acquire needed qualifications. In addition, the care worker's frontline role needs to be recognized in service delivery. A better paid and better educated and trained workforce will provide better care, which should be the ultimate goal of government policies (Korczyk, 2004).

In terms of regulation, PSWs do not meet the criteria for regulation under the RHPA and do not have the resources for other means of regulation (HPRAC, 2006). The

registry is still in its early phases and its evolution is yet to be seen into a regulatory body. The neo-Weberian theoretical framework for professions has identified that improvements are needed in leadership through associations, education, legislation, compensation, staffing and supervision for PSWs. The Ontario government is starting to recognize the critical role PSWs will have in their plan to move healthcare to the community. It is essential for PSW associations to provide leadership and partner with government and other stakeholders to implement the necessary improvements.

In conclusion, PSWs do not meet the neo-Weberian criteria of a profession due to lack of strong leadership by PSW associations, adequate education, autonomy and resources that can support the complexity of a professional body. This alienation has been intensified through a process of social closure by nursing compounded by the lack of support for PSW associations by government. The PSW role in healthcare becomes imperative as the location of health-care delivery is moving from the hospital to the home and community as clients are discharged to home care and long-term care earlier than before, their acuity upon discharge is higher and the care they necessitate is more complex (Pan-Canadian Planning Committee, 2008). The extent of services provided outside hospitals has correspondingly become more complex, and more educated health workers are needed to assist in managing these new cases (Pan-Canadian Planning Committee, 2008). The obstacles to professionalization are compounded by a predominantly older often immigrant and visible minority female workforce whose first language is not English (Aronson, Denton, & Zeytinoglu, 2004; Neysmith, Reitsma-Street, Collins, & Porter, 2004; Canadian Research Network for Care in the Community [CRNCC], 2009a). What are crucial are reforms in education, training, governance and

compensation in general to elevate PSWs to a position where they are able to meet the healthcare demands and challenges of the present and future.

There are many options for future work in this area. A study to explore what are the career options for PSWs who want to advance in their profession? For example at this time PSWs are able to take bridging courses available through community colleges that allow them to become a practical nurse. The Ontario Ministries and/or Health Canada's steps to standardize educational requirements for PSWs could also be studied. The total estimated annual PSW graduates from all PSW training programs is 7000 (PSNO, 2009). The estimated number of PSWs leaving the workforce per year: up to 9,000 (PSNO, 2009). Future work could be to conduct a survey to determine PSWs' intentions relating to leaving their current job, leaving their sector and transferring to another health care sector, or leaving the profession (Berta, Laporte, Deber, Baumann, & Gamble, 2013). In addition, a study could be conducted to examine the working conditions of PSWs in various sectors.

In Ontario, women predominantly make up the homecare labour force, and a high proportion of these women are immigrants and visible minorities (Aronson, Denton, & Zeytinoglu, 2004; Neysmith, Reitsma-Street, Collins, & Porter, 2004; Canadian Research Network for Care in the Community [CRNCC], 2009a). Visible minorities are over-represented among PSWs, making up approximately 42% of this labour force. The black feminist scholar P.H. Collins states that "race, gender, social class, ethnicity, age and sexuality are not descriptive categories applied to individuals. Instead these elements of social structure emerge as fundamental devises that foster inequity in resulting groups" (McIntyre & Thomlinson, Realities of Canadian Nursing, 2003, p. 363). Therefore,

gender in society is not value neutral and so the gendering nature of knowledge, work, and institutions impacts the value given to that knowledge or work in society. Future research should investigate the effects of gender and race on the development of the PSWs occupation. This would include semi-structured interviews with PSWs, associations and an analysis of how gender and race has affected other occupations.

The British Columbia (BC) Care Aide and Community Health Worker Registry mandate is to increase public protection and publicly funded employers in BC can only hire registered Healthcare Assistants. The Ontario PSW registry had a similar purpose to the BC registry. Survey work and semi-structured interviews need to be conducted with the Ontario PSW registry (Ministry and Stakeholders) to understand why the registry is not mandatory for PSWs who want to work for publicly funded employers as was originally intended.

A key recommendation of Sinha (2013) in the report to the MOHLTC was "The Ministry of Health and Long-Term Care should provide more support to its Personal Support Worker (PSW) workforce by strengthening its new PSW Registry by requiring mandatory registration, requiring a common educational standard for all future registrants, and developing a complaints process that can protect the public and the profession" (p. 18). A vital part of strengthening the PSW workforce is strengthening and collaborating with the PSW associations. Some of the above recommendations have also been made by PSW associations. The associations can provide expertise about the workforce to guide the development of a common standard, encourage not hinder their members to join the registry and provide expertise to develop a compliant process. A

study of PSW associations and how they can support the Ontario government to reach their common goals would benefit both the PSW occupation and their clients.

Data collected from this study will assist in the development of questionnaires for the above studies, to better structure questions for the PSW workforce, including employment characteristics (e.g., the type of work, the place of work, salaries) and to identify the type of training and education needed.

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Appendix A

Reference List for Theory of Professions

Author	Year	Title	Source	Thesis Section
Abbott, A.	1988	The System of Professions – An Essay on the Division of Expert Labor	Book	What is a profession
Becker, H.S.	1962	The Nature of a Profession	Book	What is a profession
Crompton, R	1990	Professions in the Current in Context	Journal Article	What is a profession
Friedson, E.	1989	Theory and the Professions	Journal Article	What is a profession
Friedson, E.	2001	Professionalism: The Third Logic	Book	What is a profession; Discussion
History of Medicine	n.d.	The Canadian Encyclopedia	Report	PSW workforce; What is a profession
Jeremy	2010	STS 903 – Interdisciplinarity Seminar	Internet Site	What is a profession
Kenny, A.	2004	Medical dominance and power: A rural perspective	Journal Article	What is a profession
Lester, S.	2010	On professions and being professional	Report	What is a profession
Professional Autonomy	n.d.	Professional Autonomy	Internet Site	What is a Profession
Professions	n.d.	Blackwell Encyclopedia of Sociology Online	Internet Site	What is a profession
Quinn, C.A.; Smith, M.D.	1987	The Professional Commitment Issues and Ethics in Nursing	Book	What is a profession
Saks, M.	1995	Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine	Book	What is a profession
Saks, M.	2010	Analyzing the Professions: The Case for the Neo-Weberian Approach	Journal Article	What is a profession; Conclusion
Saks, M.	2012	Defining a Profession: The Role of Knowledge and Expertise	Journal Article	Introduction; What is a profession

Author	Year	Title	Source	Thesis Section
Schwirian, P.	1998	Professionalization of Nursing: Current Issues and Trends	Book	PSW workforce; What is a profession
Segal, A.; Fries, C.J.	2011	Pursuing Health and Wellness	Book	neo-Weberian theory
Weber, M.	1968	Economy and Society: An Outline of Interpretive Sociology	Book	What is a profession
Wilensky, H.L.	1964	The Professionalization of Everyone	Journal Article	What is a profession

Appendix B

Reference List for PSW Profile, Discussion, Conclusion and Appendices

Author	Year	Title	Source	Thesis Section
Advocacy Centre for the Elderly (ACE)	2011	Submission to the Ministry of Health and Long-Term Care Concerning the Personal Support Worker Registry	Report	PSW Registry
Algonquin College	2013	Algonquin College - Registrar's Office	Internet Site	Education and Training
Aronson, J.; Denton, M.; Zeytinoglu, I.	2004	Market-Modelled Home Care in Ontario: Deteriorating Working Conditions and Dwindling Community Capacity	Journal Article	PSW Workforce
Association of Canadian Community Colleges	2012	Canadian Educational Standards for PSW	Report	Conclusion
Baranek, P.M.; Deber, R.B.; Williams, A.P.	1999	Policy Trade-offs in Home Care: The Ontario Example	Journal Article	Home Care
Baranek, P.M.; Deber, R.B.; Williams, A.P.	2004	Almost Home: Reforming Home and Community Care in Ontario	Book	Home Care
Berta, W.; Laporte, A.; Deber, R.; Baumann, A.; Gamble, B.	2013	The Evolving Role of Personal Support Workers & Health Care Aides in the Long-Term Care & Home and Community Care Sectors	Journal Article	Conclusion
Bickford, S	2013	Development of a common educational standard for personal support worker (PSW) programs in Ontario	Document From Internet Site	Conclusion
Brien, S.; Lorenzetti, D.; Lewis, S.; Kennedy, J.; Ghali, W.	2010	Overview of a formal scoping review on health system report cards	Report	Methods
Canadian Research Network for Care in the Community [CRNCC]	2009	Ontario Personal Support Workers in Home and Community Care: CRNCC/PSNO Survey Results	Report	Statement of Problem; PSW Profile; What is a profession
Canadian Research Network for Care in the	2009	Personal Support Worker – Survey Monkey	Report	Home Care; PSW Workforce; Conclusion

Author	Year	Title	Source	Thesis Section
Community [CRNCC]		Results [PowerPoint Slides]		
Canadian Research Network for Care in the Community [CRNCC]	2010	Home Support Workers in the Continuum of Care for Older People	Report	Home Care
Canadian Union of Public Employees & Ontario Council of Hospital Unions [CUPE Ontario & OCHU]	2011	Response to the Proposed Ontario Personal Support Worker	Report	PSW Registry
Canadian Union of Public Employers & Ontario Council of Hospital Unions [CUPE Ontario & OCHU]	2012	Submission Regarding Personal Support Worker (PSW) Educational Standards in Ontario	Report	PSW Registry; Education
Caplan, E.	2005	Realizing the Potential of Home Care Competing for Excellence by Rewarding Results	Report	Home Care
City of Toronto Long-Term Care Homes and Services	2012	Commitment to Care	Report	Long-Term Care
Coburn, D.; D'Arcy, C.; Torrance, G.M.; New, P.	1987	Health and Canadian Society – Sociological Perspectives	Book	History of Nursing; Discussion; Theories of Profession
College of Nurses' of Ontario [CNO]	2011	Legislation and Regulation: RHPA: Scope of Practice, Controlled Acts Model	Report	Home Care
College of Nurses' of Ontario [CNO]	2013	What is CNO?	Internet Site	Discussion
College of Nurses' Ontario [CNO]	2012	Working with Unregulated Care Providers	Report	Home Care
Collins, K.; Hogan, T.; Piwkowski, M.	2012	Drifting Off Course: Examining Role Drift Among Personal Support Workers in Ontario	Report	PSW Workforce; Discussion
Cowan, B.B.	2009	Caring for Aging Parents	Journal Article	Home Care
CUPE Ontario	2013	Personal Support Worker (PSW) Registry	Document From Internet Site	PSW Registry

Author	Year	Title	Source	Thesis Section
Davis, K.; Drey, N.; Gould, D.	2009	What are scoping studies? A review of the nursing literature	Journal Article	Methods
Deber, R.; Gamble, B.; Mah, C.	2010	Canada: variations on a common theme	Journal Article	Introduction
Deber, Raisa	2003	Health Care Reform: Lessons From Canada	Journal Article	Why are PSWs important to healthcare; Home Care; Conclusion
Denton, M.; Zeytinoglu, I.U.; Davies, S.; Hunter, D.	2006	The Impact of Implementing Managed Competition on Home Care Workers' Turnover Decisions	Journal Article	Home Care; PSW Workforce
Duffy, T.	2011	The Flexner Report - 100 Years Later	Journal Article	Introduction
Durham College	2013	Personal Support Worker	Internet Site	History of Nursing
Fantoni, B	2013	PSW Registry Puzzling to Professional Groups	Article In A Periodical	Discussion
Forget, E.; Roos, L.; Deber, R.; Walld, R.	2008	Variations in Lifetime Healthcare Costs across a Population	Journal Article	Introduction
Gamble, B.	2010	Case Study Research	Presentation Slides	Methods
Gerring, J.	2002	Case Study Research: Principles and Practices	Book	Methods
Gerring, J.	2004	What Is a Case Study and What Is It Good for?	Journal Article	Methods
Government of Canada	1985	The Canada Health Act, 1985	Report	Home Care
Government of Ontario	1991	Nursing Act 1991	Report	History of Nursing
Government of Ontario	1991	Regulated Health Professions Act, 1991	Report	Research Question; PSW profile; Long-Term Care
Government of Ontario	1994	Home Care and Community Services Act, 1994	Report	Home Care and Community Services Act, 1994

Author	Year	Title	Source	Thesis Section
Government of Ontario	2007	Long-term Care Homes Act, 2007	Report	Long-Term Care; PSW Registry
Government of Ontario	2010	Retirement Homes Act	Report	Retirement Homes Act, 2010
Government of Ontario	2012	Ontario's Action Plan For Health Care	Report	Why are PSWs important to healthcare.
Grunfeld, E.; Glossop, R.; McDowell, I.; Danbrook, C.	1997	Caring for Elderly People at Home: The Consequences to Caregivers	Journal Article	Home Care
Hamilton, L.	n.d.	Personal Support Worker Scope of Practice	Document From Internet Site	Discussion
Health Canada	2002	Canada's Aging Population	Report	Why are PSWs important to healthcare.
Health Professions Regulatory Advisory Council [HPRAC]	2006	The Regulation of Personal Support Workers under the Regulated Health Professions Act (RHPA) 1991	Report	PSW Profile; Long-Term Care
Health Professions Regulatory Advisory Council [HPRAC]	2012	Health Professions Regulatory Advisory Council – Home	Internet Site	Discussion
Houghton, C.; Casey, D.; Shaw, D.; Murphy, K.	2013	Rigour in qualitative case-study research	Journal Article	Methods
Keefe, J.; Martin-Matthews, A.; Legare, J.	2009	Consultation on human resource strategies for home support worker recruitment and retention Phase 2: Pan- Canadian consultations. Background Document. In partnership with The Canadian Home Care Association	Report	PSW Profile
Knott, L.	2010	Professional Reference	Internet Site	Introduction
Korczyk, S.	2004	Long-Term Workers in Five Countries: Issues and Options	Report	PSW Workforce; Education; Conclusion
Laupacis, A.; Born, K.	2012	Ontario's Plan for Personal Support Workers	Internet Site	Statement of Problem; Significance of Study; Theories of Professions; History of Nursing

Author	Year	Title	Source	Thesis Section
Levac, D.; Colquhoun, H.; O'Brien, K.	2010	Scoping Studies: Advancing the Methodology	Journal Article	Methods
Lilly, M.	2008	Medical versus social work-places: Constructing and compensating the personal support worker across health care settings in Ontario, Canada	Journal Article	PSW Profile
Little, P	2008	Understanding Society Blogspot.ca	Internet Site	Significance of Study; What is a profession
Mansell, D.J.	2004	Forging The Future – A History of Nursing in Canada	Book	History of Nursing; Results
McIntyre, M.; McDonald, C.	2010	Realities of Canadian Nursing	Book	Discussion
McIntyre, M.; Thomlinson, E.	2003	Realities of Canadian Nursing	Book	Conclusion
MedicineNet Inc.	n.d.	Flexner Report...Birth Of Modern Medical Education	Internet Site	Introduction
Ministry of Training, Colleges and Universities [MTCU]	2004	Personal Support Worker Program Standard	Report	Education and Training
National Association of Certified Caregivers/Personal Support Workers [NACC/PSW]	2012	Certified Caregiver/Personal Support Worker – Frequently asked questions about the PSW Role	Report	Home Care; Discussion
Neysmith, S.; Reitsma-Street, M.; Collins, S.B.; Porter, E.	2004	Provisioning: Thinking About All of Women's Work	Journal Article	PSW Workforce
O'Malley, L.; Arksey, H.	2005	Scoping Studies: Towards a Methodological Framework. International Journal of Social Research Methodology	Book	Methods
Ontario Aboriginal Health Advocacy Initiative [OAHAI]	2003	Regulated Health Professions Act	Report	Long-Term Care; Regulated Health Professions Act, 1991
Ontario Association of Community Care Access Centres [OACCAC]; Ontario Community Support Association [OCSA]; Ontario Home Health Care Provider's Association [OHHCPA]	2000	Role and Value of Homemakers/Personal Support Workers in the Health Care System A discussion Paper	Report	Discussion

Author	Year	Title	Source	Thesis Section
Ontario Association of Non Profit Homes and Services for Seniors [OANHSS]	2012	Municipal Delivery of Long-Term Care Services: Understanding the Context and the Challenges	Report	Long-Term Care
Ontario Community Support Association [OCSA]	2009	History and The Development of the Personal Support Worker	Report	PSW Workforce; Education; Conclusion
Ontario Community Support Association [OCSA]	2009	Personal Support Workers Training Backgrounder	Report	Statement of Problem; Why are important to healthcare system; PSW Profile; Education
Ontario Community Support Association [OCSA]	2009	Role of Persons Trained as Personal Attendants or Personal Support Workers	Report	Hospital.
Ontario Community Support Association [OCSA]	2012	The Ontario Personal Support Worker Registry – Public Report	Report	Home Care & Community Services Act, 1994; The Retirement Homes Act, 2010; PSW Registry
Ontario Community Support Association [OCSA]	2013	About OCSA	Internet Site	PSW Registry
Ontario Home Care Association [OHCA]	2006	Ontario Home Care Association	Report	Home Care
Ontario Home Care Association [OHCA]	2008	Ontario's PSW Stabilization Strategy	Report	Home Care
Ontario Home Care Association [OHCA]	2011	Submission to Drummond Commission	Report	Home Care
Ontario Home Care Association [OHCA]	2012	Home Care in Ontario – Facts and Figures	Internet Site	Home Care
Ontario Long-Term Care Association [OLTC]	2011	Who Pays for What?	Report	Long-Term Care
Ontario Ministry of Finance	2010	Chapter 5: Health	Report	Why are PSW important to the healthcare system
Ontario Ministry of Finance	2010	Ontario's Long Term Report on Economy – Chapter 3: Long-Term Sustainability of Ontario Public Services	Report	Why are PSW important to the healthcare system
Ontario Ministry of Health and Long-Term Care	2007	Regulation under the Long-Term Care Homes Act, 2007	Report	Long-Term Care
Ontario Ministry of Health and Long-Term Care [MOHLTC]	2011	A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10	Report	Statement of Problem; Where do they work

Author	Year	Title	Source	Thesis Section
Ontario Ministry of Health and Long-Term Care [MOHLTC]	2011	Ontario Creating Registry For Personal Support Workers	Report	Statement of Problem
Ontario Ministry of Health and Long-Term Care [MOHLTC]	2012	McGuinty Government Updates Co-Payment Rates and Improves Rate Reduction Program	Report	Long-Term Care; Long-Term Care Homes Act, 2007
Ontario Ministry of Health and Long-Term Care [MOHLTC]	2012	New Long-Term Care Home Quality Inspection Program	Report	Long-Term Care
Ontario Ministry of Health and Long-Term Care [MOHLTC]	2012	Statement to the Legislature by Debra Mathews	Report	Why are PSW important to the healthcare system; Significance of Study; PSW Profile; PSW Registry;
Ontario Nurses' Association	n.d.	Ontario Nurses' Association - Home	Internet Site	Discussion
Ontario Nurses Association [ONA]	2012	Ontario Nurses Association Submission to the PSW Educational Standards Consultation	Report	Discussion
Ontario Nurses' Association [ONA]	2012	Submission to the PSW Registry Steering Committee	Report	PSW Registry
Ontario Nurses' Association [ONA]	2013	Frequently Asked Questions	Internet Site	Discussion
Ontario Personal Support Worker Association [OPSWA]	2010	Frequently Asked Questions	Report	Discussion
Ontario Personal Support Worker Association [OPSWA]	2010	Personal Support Workers in Long Term Care Facilities	Report	Long-Term Care
Ontario Personal Support Worker Association [OPSWA]	2011	Letter to HealthForce Ontario	Report	Discussion
Ontario Personal Support Worker Association [OPSWA]	2012	Welcome to the Ontario Personal Support Worker Association	Report	Long-Term Care
Ontario PSW Registry	2012	Ontario PSW Registry: PSW Fact Sheet	Report	PSW Registry
Ontario PSW Registry	2012	PSW Registry	Internet Site	PSW Registry

Author	Year	Title	Source	Thesis Section
Pan-Canadian Planning Committee	2008	Valuing Health Care Team Members	Document From Internet Site	Why are PSWs important to the healthcare system; Education; Conclusion
Peak, T.; Sinclair, S.	2012	Using Customer Satisfaction Surveys to Improve Quality of Care in Nursing Homes	Journal Article	Why are PSWs important to the healthcare system; Conclusion
Personal Support Network of Ontario [PSNO]	2012	Supporting a Vibrant PSW Workforce Submission PSNO Budget 2012 Submission	Report	Why are PSWs important to the healthcare system; Conclusion
Personal Support Network of Ontario [PSNO]	2010	PSNO Oral Submission to the standing Committee on Social Policy Bill 21 Retirement Homes Act, 2010	Report	Results; Discussion
Personal Support Network Ontario [PSNO]	n.d.	Overview	Internet Site	Discussion
Personal Support Network Ontario [PSNO]	2009	What is a PSWs role in medication?	Report	Long-Term Care; Regulated Health Professions Act; Conclusion; PSW Certificate Program Comparisons
Personal Support Network Ontario [PSNO]	2011	Training Organizations Comparisons for Ontario	Report	PSW Certificate Program Comparisons
Personal Support Network Ontario [PSNO]	2012	About Personal Support Workers	Report	Why are PSWs important to the healthcare system; Significance of Study; PSW Profile; PSW Registry; Conclusion
Personal Support Network Ontario [PSNO]	2012	Applying for a Job in Long Term Care Homes	Report	Long-Term Care
Personal Support Network Ontario [PSNO]	2012	PSNO Submission for the Consultations on Educational Standards of Personal Support Workers	Report	Results; Discussion
Personal Support Network Ontario [PSNO]	2012	What Can a PSW Do? Role of Personal Support Workers Areas and Responsibilities	Report	PSW profile; Discussion
Quinn, C.A.; Smith, M.D.	1987	The Professional Commitment Issues and Ethics in Nursing	Book	What is a profession
Registered Nurses Association of Ontario	2002	Nursing Best Practice Guideline	Report	Discussion

Author	Year	Title	Source	Thesis Section
Registered Nurses Association of Ontario	n.d.	Registered Nurses Association of Ontario - Home	Internet Site	Discussion
Registered Nurses' Association Ontario	2007	Staffing & Care Standards for Long-Term Care Homes	Report	Long-Term Care
Registered Nurses' Association Ontario	n.d.	Careers in Nursing	Internet Site	Discussion
Ross-Kerr, J.C.; Wood, M.J.	2003	Canadian Nursing- Issues and Perspectives	Book	History of Nursing;
Saint Elizabeth Health Care	2008	People Caring for People: Impacting the Quality of life and care of Residents of Long-Term Care Homes	Report	Long-Term Care
Sinha, S.K.	2013	Living Longer, Living Well	Document From Internet Site	Statement of the problem
World Health Organization	2013	Programmes and Projects	Internet Site	Introduction
Yin, R.K.	2003	Case Study Research: Design and Methods	Book	Methods

Appendix C: PSW Certificate Program Comparisons

Training Institution	Number of grads (approximate) (20100	Theory Hours	Practicum (Work Experience) Hours	Program Costs	Training Standard Used	Accrediting body	Other Information
22 Community Colleges	1500	Average of 384 hours, including general education (non-vocational courses)	Average of 386 hours	$3,000-$4,000, plus various fees	MTCU 2004 PSW program standard	MTCU Colleges Branch	Colleges that teach the PSW program can be searched through a portal link on the MTCU website: http://www.edu.gov.on.ca/eng/general/list/college.html
130 Private Career Colleges	3100 (estimated)	285 hours vocational education (some PCCs requirements may vary from this)	355 hours (some PCC requirements may vary from this)	$2,800-$6,900	2011 Revision of MOHLTC/ OCSA PSW Program Standard	Some PCCs accredited through PSW Educational Programme Accreditation (PEPA) Many use NACC teaching materials	The National Association of Career Colleges (NACC) provides teaching materials for many PCCs. NACC materials are proprietary--the rights to use them must be purchased Their use by private career colleges is not mandatory. For a listing of the PCCs currently approved by MTCU to provide PSW programmes, see: www.edu.gov.on.ca/eng/general/searchpcc.html
21 Boards of Education	2600	380 hours vocational education	270 hours	$300-$1,000	2011 Revision of MOHLTC/ OCSA PSW Program Standard	Virtually all accredited through PSW Educational Programme Accreditation (PEPA)	Must be delivered through Adult or Continuing Education Divisions Boards that teach the PSW programme are listed on the CESBA (Continuing Education School Board Administrators) website: www.cesba.com
Not-for-profit organizations	300	320 hours vocational	280 hours	Fees based per course, not per student	2011 Revision of MOHLTC/ OCSA PSW Program Standard	PSW Educational Programme Accreditation (PEPA)	Not offered as open-registration programs. PSW programs are sponsored by employers who contract with the NFP to teach their employees.

Based on Health Professions Regulatory Advisory Council (HPRAC) 2006 data, Continuing Education School Board Administrators (CESBA) 2011 data, OCSA 2010 data
Total estimated annual graduates from all trainers: 7000
Estimated number of PSWs leaving the workforce per year: up to 9,000 (PSNO, 2009).
Note: Program Comparisons: PSW Training Organizations Comparisons for Ontario.
By PSNO, 2011. © 2011 PSNO: Adapted with permission (Personal Support Network Ontario [PSNO], 2011).

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Appendix D

Regulated Health Professions Act, 1991 (RHPA)

The RHPA provides a framework for regulating the scope of practice of health professions in Ontario, under their respective regulatory Colleges (Ontario Aboriginal Health Advocacy Initiative [OAHAI], 2003). The RHPA outlines the duties of other authorities such as the Health Professionals Regulatory Advisory Council (HPRAC) which advises the Minister who decides on whether unregulated health professions should be regulated, whether regulated professions should no longer be regulated, amendments to the RHPA, a health profession act or a regulation under those acts, quality assurance and patient relations programs of Ontario's health regulatory Colleges, and on other matters referred to it by the Minister (HPRAC, 2006).

If PSWs are to be considered as a regulated profession then they must meet the criteria of the RHPA. HPRAC is recognized under the RHPA, with a statutory duty to advise the Minister on health professions regulatory matters such as whether unregulated health professions should be regulated (HPRAC, 2012) In 2005 the Minister of Health and Long Term Care, Honourable. George Smitherman, requested the HPRAC to review and prepare a report regarding the regulation under RHPA of PSWs (HPRAC, 2006). The consultation and research processes for the project was extensive. Interviews were held with individual PSWs and groups and associations representing PSWs; education and training institutions; regulated health professional colleges; organizations and associations representing providers, consumers, facilities and disease support organizations; and advocacy associations (HPRAC, 2006). The HPRAC submitted its

report in 2006 to the Minister (HPRAC, 2006). HPRAC (2006) evaluated PSWs using the following criteria:

- Risk of Harm
- Body of Knowledge
- Membership's Support and Willingness to be Regulated
- Leadership's Ability to Favour Public Interest
- Sufficiency of Supervision
- Complaints Process
- Education & Training
- Educational Standardization
- Economic Impact of Regulation

D-1 Risk of Harm

HPRAC determined that in the work of PSWs there is a risk of physical and psychological harm for patients when there is insufficient professional supervision, when clients do not have adequate recourse, or when employers are careless in ensuring that standards are met (HPRAC, 2006). HPRAC concluded that improved supervision, adequate recourse for clients and patients, superior PSW training and the application of diligent employer standards are suitable methods of addressing the issue of harm.

D-2 Body of Knowledge

In preparing its guidance on the regulation of new professions, HPRAC studies whether the members of the profession can call upon a distinctive, systematic body of knowledge in assessing, treating or serving a professional group's clients or patients. The core activities performed by members of the profession must be distinct as a clear integrated whole and must be broadly accepted as such within the profession (HPRAC, 2006). HPRAC determined that there is no definitive body of knowledge unique to the

PSW occupation (HPRAC, 2006). The Registered Nurses' Association of Ontario (RNAO) stated that PSWs do not practice within a distinctive systematic body of knowledge, but follow a clearly defined plan of care defined by the employer and/or supervisor (HPRAC, 2006). Therefore the PSW occupation does not function within its own clearly defined body of knowledge.

D-3 Membership's Support and Willingness to be Regulated

To be ready for self-regulation, an occupation must prove a willingness to be regulated. Members of the occupation must support self-regulation for themselves, with sufficient numbers and commitment that widespread compliance is likely (HPRAC, 2006). Members of the profession must be necessarily numerous to staff all committees of a governing body and be willing to accept the full costs of regulation. At the same time, the profession must be able to sustain a separate professional association. While there are a number of organizations such as Personal Support Network of Ontario (PSNO), Ontario Association of Personal Support Workers (OPSWA), The National Association of Certified Caregiver Personal Support Workers (NACPSW), PSWs do not have an association that is fully representative of its membership (HPRAC, 2006). PSWs as a group have not convincingly demonstrated widespread support, willingness or likelihood of compliance with regulation (HPRAC, 2006). There are many costs, responsibilities and complexities of professional self-regulation. PSWs are low wage earners and often work part-time and would not be able to sustain the costs of regulation as a separate college. Some have suggested that PSW should be regulated under CNO (College of Nurses of Ontario) or as part of an existing college. CNO has not endorsed the position of regulation of PSW under the CNO to lower costs (HPRAC, 2006). It was

concluded that PSWs are not sufficiently familiar with the requirements of regulation, or adequately organized or equipped to support self-regulation.

D-4 Leadership's Ability to Favour the Public Interest

For self-regulation, the profession's leadership must show that it will distinguish between the public interest and the profession's self-interest, and in self-regulating will favour the former over the latter (HPRAC, 2006). The lack of a totally developed professional association representing the majority of PSWs makes it problematic and challenging to identify leadership which can confirm that the role of advocacy for the profession is understood as having different goals and requirements than the promotion and protection of the public interest.

D-5 Sufficiency of Supervision

To assess the adequacy of supervision, HPRAC reviews whether a significant number of members of a occupation practice without having the quality of their performance monitored effectively, either by supervisors in regulated institutions, by supervisors who are themselves regulated professionals, or by regulated professionals who assign tasks to the profession under review (HPRAC, 2006).

In publicly-funded acute, long-term and community care settings, work is broadly supervised by the facility, the Community Care Access Centres or the agency-employer. PSWs are generally supervised by a Registered Nurse or a Registered Practical Nurse (HPRAC, 2006). CCACs and long-term care homes are subject to accountability agreements with the Ministry of Health and Long-Term Care, or are subject to

regulations, standards and rules under the Long Term Care Act. Supervision in private retirement homes is more variable, with no regulatory oversight.

Rather than regulation what is needed is greater supervision of delegated acts performed by PSWs and is an important and serious matter in the provision of care by PSWs (HPRAC, 2006). Delegated acts carry the most pronounced risk of harm if improperly carried out.

D-6 Education and Training

Personal support workers prepare for the job in one of two ways - through in-service (employer-based) training, or in classroom programs offered by community colleges, boards of education, private colleges and not-for-profit organizations (HPRAC, 2006).

D-7 Educational Standardization

Concerns and questions regarding the abilities of PSWs, their use in the workplace and status as members of care teams could be resolved by standardizing educational outcomes and curriculum similar to other health care professions such as nursing (HPRAC, 2006).

Most stakeholders thought that the Ministry of Training, Colleges and Universities should mandate a basic core curriculum for career and community colleges and boards of education that offer PSW training, with mandatory accreditation of these programs (HPRAC, 2006). Graduating PSWs would have a uniform standard of competency and minimum skill-sets that employers could depend upon.

Employers noted that there should be meaningful consultation to confirm that the curriculum meets the needs of the workplace. HPRAC concludes that the development of standardized educational outcomes for all providers of PSW training programs would be valuable (HPRAC, 2006). HPRAC is not recommending a province-wide certification examination for entry to practice, as there are significant concerns regarding proficiency in written English, questions/concerns relating to the certification of existing PSWs, and no consensus regarding which organization would best administer such an exam and the costs.

D-8 Economic Impact of Regulation

The founding of a self-regulatory college includes financial obligations for members of a profession. The costs of regulation may not be well understood and may be prohibitive for many PSWs (HPRAC, 2006). This may have the unintended outcome of reducing the size of the workforce at a time when demand for PSW services continues to escalate.

In summary, HPRAC's central recommendation to the Minister was that Personal Support Workers should not be regulated as a profession under the Regulated Health Professions Act (1991). In addition, there should also be better access to more satisfactory recourse for patients and clients as a means of addressing instances of abuse and misconduct by PSWs (HPRAC, 2006). HPRAC indicated that if a Registry is to be considered certain stipulations such as mandatory registration, creation and maintenance by a central agency must be adhered to. Instead of regulation there is a need for additional important steps to be taken within the current system to improve the education and training of PSWs and their staffing and supervision (HPRAC, 2006).

Appendix E

The PSW Registry

The Ontario Ministry of Health and Long-Term Care developed the PSW Registry to accumulate information about the training and employment status of the nearly 90,000 PSWs in Ontario in an attempt to better understand PSWs (MOHLTC, 2012b).

The Ontario government in June 2011 consulted with key PSW stakeholders on the development and implementation of the registry (OCSA, 2012). The government stated its plan to enter into a Transfer Payment Agreement (TPA) with an appropriate partner to develop and implement the registry and, with the input received from many stakeholders (e.g. Alzheimer Society of Toronto, BC Care Aide & Community Health Worker Registry, Centre for Independent Living in Toronto, Employers of Personal Support Workers) identified the guiding principles of the registry (OCSA, 2012). These guiding principles, listed below, were outlined in a letter to stakeholders from the Ontario Minister of Health and Long-Term Care in 2011:

- A phased implementation process for mandatory registration of PSWs employed by publicly-funded health care employers, beginning with the home care sector. Publicly funded employers are those receiving funding from the Ministry of Health and Long-Term Care, the Local Health Integration Networks or the Community Care Access Centres;
- Guaranteeing as much of the current PSW workforce is entered/recorded in the registry as possible, including grand parenting; and
- Tiered approach for access to the registry for clients or patients and family caregivers to assist self-directed care, and for employers to support their use of the registry, in the first instance, to fill vacancies (OCSA, 2012).

The government subsequently retained the Ontario Community Support Association (OCSA), to set up the infrastructure for the development and implementation of the Ontario PSW Registry (the Registry) (OCSA, 2012). OCSA is a provincial association that promotes, supports and represents the shared goals of its members, who are providers of community-based not-for-profit health services (OCSA, 2013).

At this time, the Ontario PSW Registry is for the following groups of workers:

1. Those who have completed a formal Ontario PSW program that meets the requirements of one of the Ministry of Training, Colleges and Universities (MTCU), the National Association of Career Colleges (NACC), or the Ministry of Health and Long-Term Care/Ontario Community Support Association (MOHLTC/OCSA) standards.
2. Those who have not completed a formal Ontario PSW program but are currently employed to provide personal support services in Ontario.
3. Those who have not completed a formal Ontario PSW program, and are not currently employed to provide personal support services, but have been employed in that capacity, in Ontario, at some point in the five years prior to their registration (Ontario PSW Registry, 2012a); (Ontario PSW Registry, 2012b).

The Ontario government has specified that registration will be mandatory for all PSWs employed by publicly-funded health care employers (Ontario Community Support Association [OCSA], 2012). Note that this does not include those PSWs who work in the private sector (e.g. retirement homes, private homecare). The first phase of the Registry's implementation is focused on the home care sector. Criteria 2 and 3, indicated previously, comprise a "grand parenting" provision that would be removed if and when the government determined that a PSW certificate from a recognized program is a mandatory requirement for employment to provide personal support services (Ontario PSW Registry, 2012a; 2012b).

E-1 Application Form

The current application form includes: contact information, education and training information (including credential and credential status, program and school information, and specialized experience), employment information (including employment status, current employer information, most recent employer information, and employment history), employment availability, and health human resource information (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012).

E-2 Submission of Application

Workers may register online at www.pswregistry.org, or they may submit a hardcopy application by mail, fax, or in person at the Ontario Community Support Association (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012).

E-3 Verification of Eligibility

To verify eligibility for registration, the Ontario PSW Registry requires applicants to submit a completed application form and one of the following supporting documents:

- Individuals holding a PSW Certificate from a recognized Ontario program are required to submit a copy of their certificate. Otherwise, the Registry will also accept a copy of an individual's transcript from their Ontario PSW program.
- Individuals who do not have an Ontario PSW Certificate, but are currently employed to provide personal support services in Ontario must submit a confirmation of employment letter from a current employer. If they cannot do so, the Registry will accept a pay stub (provided that it indicates the individual's position with the organization) or a Record of Employment from Service Canada.
- Individuals who do not have an Ontario PSW Certificate, are not currently employed to provide personal support services in Ontario, but have been employed in that capacity in Ontario in the five years prior to registration are required to submit a confirmation of employment letter from the most recent employer. If they cannot do so, the Registry will accept a pay stub (provided

that it indicates the individual's position with the organization) or a Record of Employment from Service Canada (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012).

E-4 Access to Registry Information

At this time, the public and employers have access to a registrant's:

- First, middle, and last name
- Registration number
- Registrations effective date
- Last updated date (Ontario PSW Registry, 2012a; 2012b).

E-5 Employer Access

Access to the data fields listed means that employers can verify that future employees and current staff members are registered (Ontario PSW Registry, 2012a); (Ontario PSW Registry, 2012b); (OCSA, 2012). In addition, publicly-funded home care employers may also ask the Registry to produce a report listing all of their registered staff members to serve as proof of compliance.

In order to better support employers in the filling of positions, the Registry will have a job board viewable only by registered individuals (Ontario PSW Registry, 2012a); (Ontario PSW Registry, 2012b); (OCSA, 2012). Publicly-funded home care employers may submit their job postings to the Registry, which will be reviewed by Registry staff, and registrants will have the opportunity to apply to the postings that are of interest to them.

Future steps could include a registration process for publicly-funded home care providers in order to access the job board and self-manage job postings (Ontario PSW

Registry, 2012a; 2012b; OCSA, 2012). A list of publicly-funded home care providers has already been compiled.

E-6 Public Access

Access to certain data fields permits members of the public to verify that a PSW is registered. While the Minister's April 2012 letter indicated that the Registry should provide a client or family caregiver with information on the PSW's training and experience, many Steering Committee members were hesitant to allow access to that type of information as they felt that the public is ill-equipped to understand, utilize and apply it effectively (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012). With a lack of a single provincial educational standard or some statement as to the link between education and competency, it was felt that this information would:

- Create public confusion and misunderstanding as to why some workers have a formal PSW certificate and others do not; and
- Deter employers from considering workers with on-the-job training, despite the fact that a formal certificate is not a requirement for employment in home care, and has only recently become a requirement in long-term care (Ontario Community Support Association [OCSA], 2012).

Therefore, there is no public access to education fields in the registry.

E-7 Enhanced Access

There is great potential for the Registry to allow clients seeking care to search for and contact PSWs seeking employment (Ontario PSW Registry, 2012a); (Ontario PSW Registry, 2012b); (OCSA, 2012). In order to fully support clients and family caregivers in self-directed care, and to provide links between PSWs and potential clients, the technical infrastructure of the Registry includes the capacity for an enhanced search portal and/or a publicly-accessible job board. The search portal can match potential

clients with PSWs meeting specific search criteria, and it could provide access to additional information about PSWs who consent to such release (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012). Examples of such information could include: specialized skills that he/she may have; availability to work; Local Health Integrated Network (LHIN) Region in which she is available; and telephone number and/or email address as provided by the PSW him/herself (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012). The current application form includes these fields and directs PSWs that providing this information is optional.

The job board could allow members of the public to post job opportunities, accessible only to registered individuals, detailing the specific needs and requirements of the client (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012). It would then be a registrant's choice to respond to a job posting or not.

E-8 Privacy of Information

The Registry has to weigh the collection, use, and disclosure of information with the rights, privacy, and security of registrants' personal information (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012). Numerous privacy experts were consulted and a threat risk assessment done to develop a database with the utmost consideration for the protection and privacy for personal information.

E-9 Complaints, and Reviewing, Suspending, and Terminating Registration

The Registry should continue to develop and implement processes for the review/suspension/termination and reinstatement of PSWs on the Registry directed in general by the following:

- The Registry should accept employer findings of abuse and neglect as defined in the Long Term Care Homes Act (2007).
- The Registry should accept notifications regarding registrants' relevant criminal convictions.
- The Registry should have a reinstatement process for those who have been suspended or terminated from the Registry (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012).

As the implementation of this process will take some time to accomplish, the Registry needs to retroactively implement a self-declaration statement whereby applicants and registrants would declare that they do not pose a risk to public safety (i.e. have not been dismissed for reasons of abuse, do not have a relevant criminal conviction, etc.) (Ontario PSW Registry, 2012a; 2012b; OCSA, 2012). This should be considered a weak assurance of public safety, and it is a short-term measure toward providing a level of peace of mind that registrants do not pose a known risk to the public until a formal process is developed.

The Ontario Registry is much more complex multi-faceted purpose in comparison to the British Columbia Registry and Nova Scotia Registry (OCSA, 2012). The British Columbia Registry and the Nova Scotia Registry differ from each other and Ontario's Registry due to different mandates.

Comparison of the British Columbia, Nova Scotia and Ontario Registries.

	British Columbia Care Aide and Community Health Worker Registry	**Nova Scotia Continuing Care Assistant Registry**	**Ontario Personal Support Worker Registry**
Primary or Partial Purpose	To increase public protection.	To connect publicly-funded employers with registered job seekers.	Multi-faceted Purpose: To better recognize PSWs for the work they do for Ontarians; To help government better meet the needs of the people they care for; To provide public access to the Registry

	British Columbia Care Aide and Community Health Worker Registry	Nova Scotia Continuing Care Assistant Registry	Ontario Personal Support Worker Registry
			to support self-directed care; To provide employer access to the Registry to support the filling of vacancies and verification of employees' compliance with the Registry; To provide linkages between PSWs and potential clients; and, To provide peace of mind to clients and their families that a PSW listed on the Registry does not present a known risk to public safety by establishing a process for reviewing, suspending or terminating PSW registration.
How Purpose is Fulfilled	Mechanism through which registrants may be removed from the Registry for abuse against a patient. Since publicly-funded employers are required to hire only registered individuals, removal from the Registry renders an individual ineligible for new hire by publicly-funded employers.	Mechanism through which publicly-funded employers are granted a higher level of access to data that includes registered job seekers' telephone numbers and/or email addresses. However, publicly-funded employers are not required to hire only registered individuals.	Elements unique to the Ontario PSW Registry include: allowing employer access to the Registry to facilitate the filling of vacancies, allowing public access to support self-directed care, creating linkages between PSWs seeking employment and clients/family caregivers seeking personal support services, and accomplishing a degree of "peace of mind" that an individual listed on the Registry does not pose a "known risk" to the public. Registry will develop processes for the review/suspension/termination and reinstatement of PSWs.
Policy and Functional Differences	The BC Registry is not mandated to connect employers with registered job seekers; therefore employers do not have access to registrants' contact information. Unlike in Nova Scotia, employers have access only to a registrant's name and registration number.	The NS Registry is not mandated to increase public protection; therefore it does not have a mechanism through which registrants may be removed from the Registry for abuse against a patient.	The Ontario Registry will be mandatory, and publicly-funded employers will be required to hire only registered individuals as well as to ensure that current staff members are registered.
Education	For the purpose of the registry, an HCA is a person holding	For the purpose of the registry, a CCA is a person holding	Ontario does not have a provincially standardized PSW curriculum. Students may acquire a certificate by completing

	British Columbia Care Aide and Community Health Worker Registry	**Nova Scotia Continuing Care Assistant Registry**	**Ontario Personal Support Worker Registry**
	formal HCA certification, having completed BC's provincially standardized support worker curriculum.	formal CCA certification, having completed NS's provincially standardized support worker curriculum.	a program that meets the requirements of the Ministry of Health and Long-Term Care (MOHLTC), National Association of Career Colleges (NACC), or Ministry of Training, Colleges and Universities (MTCU).
Grand parenting	Individuals without formal HCA certification were eligible to register until June 28th, 2010 if they performed the duties/tasks described in the generic job description.	Individuals without formal CCA certification are eligible to register if they have been employed in the capacity of personal care worker prior to the policy effective date of April 1st, 2006, and have been employed within the 12 months prior to application. For workers with on-the-job-training, the generic job description clarifies what is meant by "in the capacity of personal care worker." These workers are referred to as "CCA Counterparts."	Ontario PSW Registry is for: Those who have completed a formal Ontario PSW program that meets the requirements of one of the Ministry of Training, Colleges and Universities (MTCU), the National Association of Career Colleges (NACC), or the Ministry of Health and Long-Term Care/Ontario Community Support Association (MOHLTC/OCSA) standards. Those who have not completed a formal Ontario PSW program but are currently employed to provide personal support services in Ontario. Those who have not completed a formal Ontario PSW program, and are not currently employed to provide personal support services, but have been employed in that capacity, in Ontario, at some point in the five years prior to their registration.

Note. Registries. Adapted from The Ontario Personal Support Worker Registry: Public Report. By OCSA, 2012. ©2012 Ontario Community Support Association. Adapted with permission.