REDUCING RISK: KEEPING BC COMMUNITY HEALTH WORKERS SAFE

by

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Bachelor of Arts, Communication Studies, University of Calgary 2004

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF PUBLIC POLICY

In the
Faculty
of
Arts and Social Sciences

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SIMON FRASER UNIVERSITY

Fall 2007

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Abstract

Incidents of occupational injury and disease among community health care workers are higher than those employed in acute care facilities. Community health care workers face uncontrolled work environments that can adversely impact their physical and mental well being. Serious musculoskeletal injuries can result from lifting and transferring patients. Slips, falls, blood and bodily fluid splashes, aggressive and violent behaviour from clients, isolated work environments and high workload volumes can attribute to injury.

In this study publicly available data from WorkSafe BC, case studies, and stakeholder interviews, are used to develop policy options. These options are designed to increase awareness and reduce the risk of injury among workers. Using a set of criteria, the options are evaluated and recommendations are made.
Executive Summary

Community health care workers (CHWs) in BC carry heavy caseloads and provide care to many patients in both urban and rural communities in BC. The job they face is often hazardous and risky at best. The following study will examine the risks the CHWs face in the workplace in British Columbia and provide feasible solutions in an attempt to mitigate some of the risk faced by workers, but also ways to reduce the costs associated with injuries.

Background

There are two reasons why patients and caregivers advocate home care: 1) it allows patients to stay in their home when they may otherwise require institutional care 2) it can be more cost effective in certain circumstances. During the 1990s, there was a deinstitutionalization of acute care and a shift toward a reliance on community care. As an integral part of the health care team, CHWs are often the most vulnerable next to long term care workers. This shift has increased the reliance on CHWs who are often exposed to isolated and uncontrolled work environments with little support. CHWs experience higher rates of injury than the average population. CHWs are involved in very physically demanding tasks such as bathing, toileting, dressing, and transferring patients. The nature of these tasks can lead to overexertion and musculoskeletal injuries. Additional sources of injury can range from aggressive patients and pets to slippery surfaces. These risks are magnified in the community. The risks found in patient homes can contrast greatly from the controlled environment of a hospital setting.

At a macro level, organizational challenges can contribute to a stressful work environment. Retention of CHWs and funding cutbacks poses a serious problem. A lack of qualified workers places high demands on the existing workforce, leaving them susceptible to
stress, burnout, and illness. CHWs are poorly compensated and receive few benefits. Relatively few CHWs undergo formal schooling and do not receive extensive OH&S training. Most CHWs are female, older, underpaid, and often marginalized.

**Methodology**

My methodology is composed of three phases. The first stage of the study involves the use of publicly available data from WorkSafe BC on the claims made by community health care workers who have been injured from 2001-2005. Secondary information is provided from a study entitled “No Time to Care: Community Health Workers and the New Economy.” This information helps identify policy options to reduce the number of injuries. The second component of my study is the use of comparative cases (studies) from different jurisdictions who have implemented interventions and/or policies to reduce the rate of injury among community health care workers within their own regions. The third phase is comprised of interviews from key stakeholders.

**Results and Recommendations**

Case studies, interviews, and demographic data provided the basis for the development of policy alternatives. The four alternatives I examine are as follows:

- Increased Knowledge and Training
- Standardized Assessment Tool and Process
- Enhanced Enforcement and Compliance
- Increased Time Allotment for Clients

The alternatives are discussed in detail and include information as to the goals, policy mechanisms, actors, implementation and successful implementation of each proposed policy. I used a policy matrix to assess each alternative based on six criteria: stakeholder acceptability, cost (program and social cost), compliance, ease of implementation, and effectiveness.
evaluation found that the Standardized Assessment Tool and Process (using a standardized risk assessment tool for both client and worker in a joint effort between the health authority and employment agency) had the highest results. My final recommendations were that this policy should be adopted across the province to help mitigate risk associated with the work of CHWs. However, further consideration should be given to long term policies such as increased funding to home care and higher wages to ensure both a healthy and stable workforce population.
Dedication

For my loving family and fury, four legged friends.
Acknowledgements

I would like to acknowledge the following individuals:

Firstly, I would like to thank Dr. Nancy Olewiler for supporting me through a lengthy, but rewarding process. Without her guidance and support, I would have never finished. I would also like to thank the willingness and enthusiasm of Dr. Olena Hankivsky who served as my external examiner. Next, I would like to thank my professors at Simon Fraser University and the University of Calgary. Specific mention goes to Dr. David Taras and Dr. Ron Glasberg who have encouraged throughout my academic career both personally and academically. I would also like to thank Dr. Peggy Patterson and Dr. Patrick Coll for their wisdom and insight. I would like to thank Georgina Hackett and Chris Back from OHSAH, my home care contact on Vancouver Island, Shelagh Locke from WorkSafe BC, and Mona Sykes from BCGEU for their expertise and insight. Personally, I would like to extend my gratitude to my friend Courtney Borroughs for her FI attitude. I am thankful to my family for their love and support. Finally, I must give mention to Neil Braun for his unwavering support and care during the past two years.
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# Glossary

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<th>Term</th>
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<td>Community Health Care Worker (CHW)</td>
<td>Any person who is employed in community care who provides non-medical support to clients such as bathing, dressing, feeding, transferring etc.</td>
</tr>
<tr>
<td>OHSAH</td>
<td>Occupational Health and Safety Agency for BC Health Care</td>
</tr>
<tr>
<td>PEARS</td>
<td>Occupational Health The Prevention Early Active Return to Work Safety Program</td>
</tr>
<tr>
<td>MSI</td>
<td>Musculoskeletal Injuries affect any soft tissue or skeletal structures in the body.</td>
</tr>
<tr>
<td>Health Authority (HA)</td>
<td>BC has five health authorities and one provincial health authority. The regional health authorities oversee the administration of health care (including community care) in a particular region.</td>
</tr>
<tr>
<td>OH&amp;S</td>
<td>Occupation Health and Safety is a general term used to discuss workplace health and safety issues.</td>
</tr>
<tr>
<td>JOSHC</td>
<td>Joint Occupational Health and Safety Committees are established between worker representatives and employers to review incidents of injury in the workplace.</td>
</tr>
<tr>
<td>Assessment Tool</td>
<td>Assessment Tools are used to assess the risks that a caregiver might face in a workplace. Assessments are conducted prior to the entry of a new environment.</td>
</tr>
<tr>
<td>Client</td>
<td>Client is synonym for patient.</td>
</tr>
<tr>
<td>HELP</td>
<td>Healthcare Education and Learning Program is a program administered by OHSAH to educate employers, JOSHC, and union representatives on occupational health and safety issues.</td>
</tr>
<tr>
<td>Workers Compensation Act</td>
<td>Legislation that protects workers in the workplace from occupational injury and disease. Provides guidance for both employers and employees on standards that must be adhered to.</td>
</tr>
<tr>
<td>Health Care Sub sector Collective Agreement</td>
<td>Collective agreement between employer and employee.</td>
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1: Policy Problem

Our society values independence and freedom. For British Columbians unable independently care for themselves, community health care workers (CHW) provide a lifeline through daily living assistance. The work provided by CHWs is not viewed as valuable, rather is often seen as menial. CHWs are primarily women, often have lower levels of education, are underpaid and often face communication barriers with employers. Additionally, workers do not belong to professional colleges like registered nurses (RN) and other health professionals. The educational requirements for employment can vary among employers. Some CHWs are employed by private agencies and therefore do not have union representation. All these factors often leave workers vulnerable to injuries, which may go unreported or underreported. In addition, factors leading to injuries incurred by CHWs and policies to deal with their job risks are often overlooked in occupational health and safety research. In this study I examine the injuries of professionals who provide medical services in community to provide background information on the types of injuries found among those employed in the community. However the predominant focus is on CHWs who provide non-medical care in the form of daily assistance.

Community health care workers in BC carry heavy caseloads and provide care to many patients in both urban and rural communities in BC. The job they face is often hazardous and risky at best. Over time, British Columbia has moved from an institutional to a deinstitutionalized model for care. Patients have come rely on CHWs to provide care that would otherwise require hospitalization in an acute or long term care facility. As an integral part of the health care team, CHWs are often the most vulnerable next to long term care workers. This shift has increased the reliance on CHWs who are often exposed to isolated and uncontrolled work
environments with little support. Workers face many risks in their work from lifting heavy patients to hostile work environments that can cause stress, illness, and even injury. Their injuries and occupational illnesses can be caused by body mechanics, patient factors, and environmental factors. The time loss claims incurred by CHWs can result in time away from work, chronic injury or illness, hospitalization, and a decreased level of care to patients. In addition to time loss claims, CHWs can receive injuries that are denied as claims by WorkSafe BC. Workers who do not have benefits can be forced to take unpaid leaves of absence due to their injury or illness. This can pose significant stress and cost to CHWs. Injuries can also be costly to employers if they are required to find replacement workers and also in the form of annual insurance premiums paid to WorkSafe BC. This all adds up to extraordinary costs for employers, patients, and individuals who are employed in the community health care industry.

The following study will examine the risks the CHWs face in the workplace in British Columbia and provide feasible solutions in an attempt to mitigate some of the risk faced by workers, but also ways to reduce the costs associated with injuries. Firstly, I will explore how community care and in particular home care is presently administered and delivered in BC (Chapter 1). Secondly the study will review the history and funding of community care and Occupational Health and Safety (OH&S) regulations (Chapter 3). Thirdly, I will examine some of the environmental and organizational factors that contribute injury among CHWs (Chapter 4). Fourthly, the study will examine data obtained from WorkSafe BC and the Harter and Leier study (2003) to profile CHWs and their injuries (Chapter 5). Fifthly I review the methodology employed in the study (Chapter 6). Case studies and interviews provide the primary foundation for the policy alternatives (Chapter 7 and 8). Finally the policy alternatives, evaluation criteria, analysis and recommendation will attempt to provide a feasible policy option to ultimately reduce risk in BC among CHWs (Chapter 9-12).
2: Present Day Community Care in British Columbia

Many British Columbians access home care as a vital part of their daily existence. There are two reasons why patients and caregivers advocate home care: 1) it allows patients to stay in their home when they may otherwise require institutional care 2) it can be more cost effective in certain circumstances. Community care can be provided either in the home or in the community. Community care can come in the form of adult day programs, meal programs, assisted living, hospice care, and residential care (Government of British Columbia, 2004). Home care services can range from nursing, rehabilitation, and palliative care (Government of British Columbia 2004). The types of services provided can be for chronic, acute, and palliative care patients. The philosophy behind home and community care is to help keep patients, who would otherwise require admission to formal health care facilities, in the comfort of the home and community. (Government of British Columbia, 2005a)

2.1 Administration of Community Health Services and Cost

Community Health Care services are administered by the five Health Authorities in British Columbia. The Ministry of Health gives funds to each of the Health Authorities to provide community care based on the needs of that particular HA. Services may be contracted out by the HA to not for profit or for profit service providers (Government of British Columbia, 2004). Each Health Authority manages community care differently depending on both the available resources and the client population. In some areas of British Columbia some services are provided by private agencies and in some areas certain types of care are provided by the HA.

Community care is not fully subsidized. Certain services are provided at no cost; however, the client may be required to pay for some types of care especially those related to
home support or non-nursing services. Fees for facility care, respite care, home support care, etc are assessed at a daily rate dependent on the client's annual after-tax income (Government of British Columbia, 2007). Nursing and rehabilitation care are provided to Medical Service Plan (MSP) recipients at no cost (Government of British Columbia, 2007). There are a number of community care services available to clients based on the condition of their health, their abilities, and their limitations (See Appendix A) based on information available in the 1994 “A Guide to Your Care” publication (Ministry of Health, Government of British Columbia, 2004). For the purposes of this study, I will focus on services provided in the home (home support and community nursing and rehabilitation). Community Health Workers primarily operate within the auspicious of home support (the provision of non-medical daily care requirements).
3: History, Regulation and Funding of Community Healthcare in British Columbia

Home care has become an important bridge for clients between total dependence in an acute care facility and independence in the community. Between 1990 and 2000, there was a decrease in the number of home care claims in BC, primarily due to a reallocation of reduction of resources; however, there was an increase in the acuity of patients (Penning 2006). Section 3 will discuss the implications of funding and service provision, history of home care, and occupational health and safety regulations for workers. These factors have played an important role in both the delivery of services to clients, but for the purpose of this study the work environment of CHWs in British Columbia.

3.1 Community Health Care Funding and Service Provision

The *Canada Health Act* outlines five principles by which insured services must follow: *publicly administered, comprehensiveness, universality, portability, and accessibility* (Government of Canada, 2002). The primary services covered by the Act include medically necessarily hospitalization and physician visits. Some extended care services are insured under the *Canada Health Act* consisting primarily of the health aspects of home care and ambulatory care services (Government of Canada, 2002). The federal government via the Canadian Health Transfer provides funding to operate community care under the auspicious of each province. Service delivery in community care varies from province to province. British Columbia delegates the administration of community care to regional Health Authorities.[nd1]
3.1.1 Funding and Outsourcing of Community Care

The funding of community care services is complicated and varies from province to province and from client to client. Funding for community care can come from a number of sources including province (via Canada Health Transfer), the province, and municipalities, Veteran Affairs, Indian Affairs and Northern Development. Clients or private insurance fund some services. In a number of jurisdictions including British Columbia “self managed care” allows individuals who meet certain eligibility criteria the ability to manage their own care based on their needs assessment to as opposed to services delivered directly by the province or by health authority (Government of Canada, 1999). There is a perception in the industry that the private sector is growing in service delivery. However, it should be re-emphasized that formal community care services can be provided by public servants, publicly contracted professionals, not for profit in addition to the private sector (Government of Canada, 1999). Community care represents a rapidly growing industry in British Columbia and more generally in Canada. Adjusted for inflation, total government spending on home care represented 3.4 billion or 3.7% of total health care funding in 2003 (Centre for Health Studies and Policy Research, 2007)

3.1.2 Cost Savings to the Health Care System through Community Care

Home care considered a cost effective solution to providing health care; however, costs account for a small percentage of provincial health care budgets. On average, the cost of home care (non-medical services) is about 1/10 of the cost (based on the average daily cost of a hospital bed in BC from $1200-$1700 whereas the cost of home care is approximately $150 per day) (Harter & Leier, 2003). Using a general figure to assess cost effectiveness of home care is difficult as the costs can vary greatly from client depending on their illness, acuity, and care needs. The “National Evaluation of the Cost Effectiveness of Home Care” found that savings in British Columbia (1987-1996) were between 40% and 75% (Hollander, 2001). Generally, costs for clients at the lowest levels of care were 40% of the costs of treatment within a facility and at
the highest level; they were 75% (Hollander, 2001). Clients who have their health deteriorate and subsequently require more care (change care levels) can have costs that run 90% of that comparable facility care. However, there are instances such as when a patient’s condition becomes more acute and the patient subsequently passes away he cost of home care for the patient can cost the system more than, if they had been cared for in facilities (Hollander, 2001).

3.2 History of Community Care in British Columbia

From the late 1970s until the late 1990s, there was a significant reduction in the number of acute care beds available in British Columbia (Sheps et. al, 2000). Significant decreases in acute care beds decreased the average length of stay for patients between 1991-1992 and 1996 -1997 by 12%. This has resulted in a transfer to the increased use of facility-based long-term care or community-based home care (Sheps et. al, 2000). The transition from an institutional model toward a community model was one of the most notable recommendations from the Seaton Commission (1991). The main thrust in the metamorphosis of health care delivery in British Columbia was cost effectiveness. Some of the studies cited by the Commission claimed that 90% of the care received by home care clients was done on an informal basis by unpaid caregivers (Government of British Columbia, 1991). A shift toward a community model resulted in greater reliance on CHWs to provide care. New occupational health and safety challenges emerged for workers practicing in the uncontrolled setting of the community care.

During the early 1990s, the BC Ministry of Health’s Continuing Care Divisions contracted 130 home care agencies across the province comprised of for profit (27%) and not for profit (73%) facilities. However, nursing services were provided by not for profit agencies. Clients who accessed services from the agencies had to contribute to the cost of the care based on a family income test. However, clients who were handicapped were exempt from this test, as well as certain sources of income such as Guaranteed Income for Need, war allowance, and provincial social assistance. Fewer than 25% of clients contributed less than 40 dollars per month to their
care. Clients were not charged for services such as nursing, adult day care, occupational and physical therapy. The province was responsible for costs with nursing, therapy, and home making. The Federal Government contributed to home making costs through the Canadian Assistance Plan (Government of British Columbia, 1991)

3.2.1 Community Care Workers and the Seaton Commission

The Seaton Commission recognized that the work of home care workers is often isolating and irregular. The Commission identified that there was a need to educate workers who were dealing with patients suffering dementia, extended-care needs, and with the terminally ill. Additionally it was determined that there was a need for the standardization and accountability for the care provided by workers. The commission recommended that that the salaries and benefits of home care workers were more equitable with employees with similar roles working in long term care facilities. Secondly, the commission suggested that orientation and inservice education is paramount to ensure that workers have the necessary skills to deal with geriatric and psycho-geriatric (seniors dealing with psychiatric disorders) patients. The last recommendation addressed the issue of employee accountability through the implementation of quality control standards (Government of British, 1991)

3.3 Safety Regulations

The safety of and well being of CHWs is governed by two pieces of legislation: the *Community Health Subsector Collective Agreement* and *Workers Compensation Act* (WCA). The Collective Agreement outlines the conditions of employment between the Health Employer Association of British Columbia and the Health Service and Support Community Sub sector Association of Bargaining Agents. The *Workers Compensation Act* provides employees and employers a set of safety standards and procedures that must be adhered to in the workplace. There are other policies such as the No-Lift Policy, Working Alone Policy, etc from WorkSafe
BC that also affect workers. The following section will briefly outline how the legislation affects employers and employees in the workplace.

3.3.1 Community Health Sub sector Collective Agreement

The terms of employment for Community Healthcare Workers are described in the Community Health Sub sector Collective Agreement. The current Agreement is effective until 2010. The Agreement outlines the conditions of employment for workers including issues of employer relations, bargaining procedures, grievances, and arbitration, discipline, seniority, job postings, scheduling (hours of work), overtime, parental leave, and occupational health and safety. Outlined in Section 22, are the most important points related to injury reduction among workers (Community Health Subsector Collective Agreement, 2006). The agreement outlines the following:

- Both the employer and employee acknowledge the need for a safe and healthful workplace.
- The employer must provide employees with all information pertaining a client’s residence that may affect the safety or health of a worker.
- The employer and union representing the employee will establish a Joint Occupational Health and Safety Committee. The committee’s mandate is to investigate accidents, safety issues, and workload problems related to safety.
- The employer will provide orientation and continued training necessary to ensure the safe performance of work, use of equipment, material handling and patient transfer by employees.
- The employer will implement timely risk assessment tools.
- The employer will implement a written procedure for checking in when employees are working alone or in isolated areas.
3.3.2 Workers Compensation Act

The Workers Compensation Act is the overarching provincial legislation that provides safety regulations for all industries including health care. The Act is divided into four parts: Compensation to Workers and Dependants, Liability of Employers in Industries Not Within the Scope of Part I, Occupational Health and Safety, and Appeals. The following summary of the important highlights the responsibilities of both employers and workers:

- Employers must ensure the health and safety of workers.
- Employers must remedy workplace hazards and notify employees of these risks.
- Employers must provide information, training, instruction and proper supervision to ensure the health and safety of employees.
- Cooperate with joint committees, worker health and safety representatives, the Board (WorkSafe BC), and officers of the Board
- Employees must ensure their own safety, follow safety regulations and policy, and ensure the proper use of equipment.

There are a few important points to take away from this chapter. Firstly, a shift toward a community model has transformed the delivery of care in BC where there is greater dependence on CHWs. Reduced funding levels and patients with increased acuity, has contributed to an environment where workers are dealing with complex care needs, finite resources, and uncontrolled workplaces. The Seaton Commission highlighted two important points: CHWs need adequate education to deal with clients and their compensation levels are lower than their colleagues working in institutional settings. This section highlighted important aspects of OH&S legislation in BC. These policies provide both employers and employees clear safety guidelines for the workplace. However, the implementation and compliance with these policies can vary significantly within the province. Workers still face significant occupational hazards and risks. In Chapter 4, I will discuss how some of these risks manifest in the workplace.
4: Workplace and Organization Challenges

Community health care workers work in very demanding, uncontrolled, and isolated settings. They face a number of both environmental factors and organizational stressors that can affect their well-being. Aronson and Neysmith (1996) describe the home care environment as “work that seeps out if its formal boundaries into informal, unpaid activities.” Cost saving measures by “…home care management seek to depersonalize home care labour are likely to increase its exploitative potential (p.59) The uncontrolled environment of home care and a lack of adherence to policies and safety legislation have affected the safety of workers employed outside an institutional setting. Additionally, a lack of formal provincial regulations surrounding educational credentials of CHWs also can contribute to injury. This section will attempt to identify some of the causes of injury attributed to an uncontrolled work environment, organizational factors, and a lack of OH&S training within formal educational settings.

Community health care employees a number of different professionals including nurses, occupational therapists, physical therapists, social workers, and support workers who provide both medical and non-medical care. Duties provided by CHWs are non-medical in scope. Some of their duties include bathing, feeding, and dressing. These duties often require a lot of lifting and physical exertion on the part of a worker. CHWs often report higher levels of injury and illness than the general population. An Ontario study confirmed that home care workers experience high levels of stress, more so than many other occupations (Denton et al., 2007). Stress-induced conditions reported by respondents included back pain, arthritis and rheumatism, migraine headaches, high blood pressure, stomach and intestinal disorders, and cancer. These conditions were reported at much higher conditions than in other populations in Canada (Denton...
et al., 2007). Other factors such as working in isolation or dealing with aggressive patients can contribute to injury. The following sections describe the specific causes of injury.

### 4.1.1 Overexertion and MSI Injury

A large number of community health care workers experience musculoskeletal injuries (MSI) specifically in the neck/shoulder and lower back region due to overexertion. In health care workers, including CHWs the frequencies of injury are much higher than in the general population (Jarrel, 1997). In the US over 1/3 of workers’ compensation claims are due to back injuries and 50% of these injuries were directly correlated with lifting (Jarrel, 1997). The injury rate for home care workers with back injuries is higher than that of their colleagues who work in hospital or institutional settings (Owen & Staehler, 2003).

The most likely source of back injuries is due to exertion and activities that cause strain on the musculoskeletal system such as transferring, toileting, bathing, etc. There are other factors that can contribute to neck and back pain such as psychological demands, lack of decision-making, lack of time and lack of social support (Horneij et al., 2001). Poor ergonomics and body mechanics can also contribute to back problems. Heavy lifting, standing for long periods of time, and general physical exertion can attribute to injuries (Hedin, 1989). One of the primary reasons that CHWs are more susceptible to injury is that unlike in hospital settings they are often working in isolation and without the support of transfer devices such as patient lifts. Recently, the British Columbia Institute of Technology and the Occupational Health and Safety Agency for BC Healthcare (OHSAH) undertook a yearlong study examining the effectiveness of implementing ceiling lift devices in clients’ homes. The final report of this study has not been made available via OHSAH’s website; however, the preliminary results suggested that during the yearlong study of the use of 40 lifts in clients’ homes, there were no reported injuries. (Back, 2007)
4.1.2 Other Workplace Factor Risks

Other workplace factors contribute to the injury of CHWs. These risks can range from slippery surfaces to aggressive patients. Some of the other dangers in addition to overexertion that workers can be exposed to arise because they care for patients with conditions such as dementia and other mental or cognitive impairments. These conditions often result in aggressive (non-culpable) behaviour (OHSAH, 2007). Dr. Neil Boyd, A Criminologist from SFU spoke to these concerns at OHSAH’s 2007 Home Care Conference by suggesting that due to the acuity of patients’ conditions, the lack of time to build trusted relationships, and the unpredictable work environment facing CHWs makes them extremely vulnerable (OHSAH, 2007). Impacts of the unpredictable environment of a clients’ home can lead to unsafe conditions such as slippery steps/floors, dirty homes, aggressive pets, isolation, injuries from sharp objects, splashes (blood and other bodily fluids), and a whole host of other risks.

4.2 Organizational Factors

Organizational factors have a large impact on the job satisfaction level of home care workers, and in turn, their health and safety. Organizational factors that can leave CHWs prone to both stress and injury include changes in recruitment/retention, restructuring of health care delivery and the levels of compensation of workers.

As the population in Canada ages, we face an increased demand for health care and in particular care for seniors. According to the BC Care Providers 2006 member survey, out of the 41 CHW respondents (35% of 116 total members) retention and recruitment was a top need for the industry and in some geographic regions has become a “crisis” situation (BC Care Providers, 2006). Low wages, isolated conditions and heavy workloads have caused workers to look for opportunities in other industries. [nd9]The lack of CHWs in certain areas can potentially lead to increased workloads for existing workers. Heavy workloads can contribute to increased stress levels, fatigue, and illness. Respondents also felt that in addition to finding skilled care aides and
home support workers, the lack of Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) posed a significant problem. Finally, the survey revealed that due to cuts in relevant college programs (due to lack of enrolment) and losing staff to better paying jobs in areas such as the oil and gas sector, that there is a greater burden on current employees (BC Care Providers, 2006). Retention will become an even bigger issue in the future as demographic and economic trends suggest that the availability of a quality work force is limited at best (Stone, 2004). The demands on the current work force will increase, forcing many workers to work longer hours and put in more overtime. This situation leaves workers very susceptible to burnout and injury.

During the 1990s, Ontario underwent a restructuring in the delivery of home support. The provincial government moved away institutional care to community based care as a result of recommendations made in the Health Services Restructuring Commission (Keller et. al, 2004) Denton et al. reported that restructuring of home care delivery in Ontario caused a deterioration in the health of home care workers (2006). Often restructuring was attributed to cutbacks, and a business vs. care models of organization. This led to increased workloads and a decline in care. Overall restructuring contributed to an increase in reported MSI levels among workers (Denton et al., 2006). Cutbacks in community care has lead to workers having less time to spend with clients, resulting in a “hurried” approach to care leaving them at risk for injury. Workers who carry increased workloads are also susceptible to stress and burnout conditions that often proceed or present themselves as an injury.

The demographic population of community health care workers changed over the 1990s toward a younger, more educated work force. A skilled and educated workforce tends to be fairly mobile as their skills are highly coveted by health care employers. Younger, more educated workers in home care have seen their work conditions deteriorate in comparison to their colleagues that work in acute care and long-term care facilities (Yamada, 2002). More education and skills during the 1990s did not necessarily translate into better wages and benefits. Yamada
found that while some working conditions improved for CHWs, many of them during the 1990s saw little improvement in their living conditions (too many care aides are still at or below poverty level) or benefits (Yamada, 2002). Without adequate compensation and benefits, the stability of human resources, the community health care field can be somewhat volatile with turnover and increased attrition. Occupational Health and Safety Training in British Columbia

In comparison to LPNs and RNs in British Columbia, there is little to no regulation regarding the training required to be a CHW. The tasks performed by CHWs are less clinical in scope than other medical professionals involved in community care. Harter and Leier found in their study “No Time to Care: Community Health Workers and the New Economy” that only 20% of the CHWs they surveyed in British Columbia had formal certification by earning a residential care aide certificate (Harter & Leier, 2003) However, that 81% of the respondents in the reported having OH&S training (Harter & Leier, 2003). The lack of consistency and standardization in OH&S training among workers is another factor contributing the illness and injuries of the CHWs. Due to the lack of regulation, training outside a formal college program is the responsibility of the employer.

Presently most colleges in British Columbia offer either a Residential Care Certificate or a Community Health Care Diploma. I found the most comprehensive program in my scan of BC certificate and diplomas programs in community health care at Vancouver Community College (VCC). The program is 40 weeks in length and certifies students in the following areas: Community Healthcare Diploma, Long Term Geriatric Care Aid Certificate, Resident Care Attendant Certificate, Alzheimer’s Certificate, Mental Health Community Care Certificate, Introductory Pharmacology Certificate, Standard First Aid Certificate, CPR “C” Certificate, Food

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1 Douglas College, University College of Fraser Valley, Camosun College, Thompson River University, Capilano College, Vancouver Community College offer certificates in Residential Care. The programs tend to be around 24 weeks in length and comprised of a curriculum to provide graduate with the necessary skills to under work as CHWs.

2 Vancouver Community College offers a diploma in Community Health Care.
Safe Level 1 Certificate, WHIMIS Certificate (Vancouver Community College, 2007). VCC had the most comprehensive program out of all the colleges that offered programs in this area. In the review of the course content on both the program website and college calendar, VCC was the only program to make mention of OH&S in one course called Clinical Lab Skills (MI 100).³

In Chapter 4, I have outlined some of the most critical workplace and organizational challenges that can contribute to occupational injury and disease. Firstly, CHWs experience higher rates of injury than the average population. CHWs are involved in very physically demanding tasks such as bathing, toileting, dressing, and transferring patients. The nature of these tasks can lead to overexertion and musculoskeletal injuries. Additional sources of injury can range from aggressive patients and pets to slippery surfaces. These risks are magnified in the community. The risks found in patient homes can contrast greatly from the controlled environment of a hospital setting.

At a macro level, organizational challenges can contribute to a stressful and potentially hazardous work environment. Retention of CHWs and funding cutbacks poses a serious problem. A lack of qualified workers places high demands on the existing workforce, leaving them susceptible to stress, burnout, and illness. CHWs are poorly compensated and receive few benefits. Relatively few CHWs undergo formal schooling and do not receive extensive OH&S training. In Chapter 5, I will attempt to establish a demographic profile of CHWs in BC. Understanding the specific risks and associated injuries workers face will help to inform the policy alternatives examined later in this study.

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³“Students focus on key features of responsible and accountable care, including the theory and practice behind promoting safety and comfort; proper body mechanics for safety, positioning, transfer and ambulation; measuring and recording vital signs; personal care and hygiene; general comfort and rest measures; nutritional needs and feeding. Students will receive their Standard First Aid Training, CPR C, Level One Foodsafe and WHIMIS certificates through external examination. This hands on module will provide students with key practical skills for Practicum” (Vancouver Community College, 2007)
5: Demographics of BC Community HealthCare Workers and Their Injuries

Understanding the demographic profile of Community HealthCare Workers in British Columbia is vital to examining policy initiatives that may lead to reducing the risk of injury among the this population. The following section is broken down into three parts and uses data obtained from WorkSafe BC from 1997-2005 and from the study “No Time to Care: Community Health Workers and the New Economy.” Section 5.1 will describe the demographic profile of Community Health Support Service Workers (workers who provide medical services). Section 5.2 will discuss the demographic profile of Childcare and Home Support Workers (CHWs fall in this category and provide primarily non-medical support). Section 5.3 will discuss the responses by participants (primarily CHWs in BC) to the “No Time to Care: Community Health Workers and the New Economy.”

5.1 Demographic and Injury Profile of Health and Community Support Service Workers

The Health and Community Support Classification Unit is one support group within the WorkSafe BC employer classification system. Care workers employed in the Health and Community Support CU primarily offer the medical side of services in community health care. Workers in this group provide a variety of services including but not limited to family crisis support, in-home occupational therapy, in-home physical therapy, in-home rehabilitation therapy, midwifery, home management support, and in-home nursing care. Occupational titles of employees in this classification group can include Community health worker II, Licensed Practical nurse, Occupational therapist, Registered Nurse, Counsellor, Physiotherapist, Nurse Aide, and midwife to name just a few.
5.1.1 Claims per Person Year 2001-2005 (Health and Community Support Service Workers)

Within the Health and Community Support (HCS) Classification Unit classification the average rate of claims per person year declined from 2001 to 2002, but then gradually increased over the period of 2001 to 2005 (See Figure 1). The claims per person year rate can be determined by dividing the claims value for short-term disability, long-term disability, and fatalities divided by the total number of person years in each year.

![Figure 1 Claims per Person Year Health and Community Support Service Workers 2001-2005](image)

Source: WorkSafe BC Data Warehouse Health and Community Support Service Workers Classification Unit 2001-2005

5.1.2 Accidents and Injuries by Health and Community Support Service Workers, 2001-2005

The following section examines the injuries incurred by the HCS classification unit. Table 10-13 in Appendix B provide a detailed explanation of the type of injuries, nature of injuries, body parts affected by injury, and the source of injuries. During the period of 2001-2005, overexertion accounted for almost 40% of accident types. Overexertion by far accounted for the majority of the total claims cost amount from 2001-2005 approximately $6 million. The total days lost for overexertion was also 55,041 more than a combined total from falls on the same level, bodily reaction, and being struck by an object (47,888 total days). The high number of
overexertion injuries shows up in the large number of sprains, strains and tears, which accounted for 75 percent of the total claims between 2001 and 2005. Sprains, strains and tears had much greater costs than all other injuries combined in total days lost (92,513) and total claims cost $10.6 million. Bruises and contusions accounted for only 6 percent of claims while a mere 2 percent of the total claims were a result of a fracture. The most commonly injured body part was the back including the spinal cord, followed by multiple body parts. Back injuries accounted for a considerable amount of time lost from work with over 40,713 days lost and a total claims cost amount of $4.5 million. Multiple body parts and shoulder injuries accounted for the next most common injuries at 14% and 9% respectively.

In addition to examining the injury and the affected body part, it is extremely important to look to the source of the injury to make specific recommendations. The total claims cost of injuries caused by persons other than injured or ill was $5.8 million. The most common source of injury was caused by other persons, followed by the actual injured or ill worker (they cause their own injury), followed by, walkways, and ground surfaces (likely due to slips and falls on slippery surfaces).

5.2 Demographic and Injury Profile of Childcare and Home Support Workers

The Childcare and Home Support classification unit is one of several groups who provide care within the community healthcare sector. The main occupational duties of this group are to provide home support services usually involving non-medical duties. Most of the care workers provide services such as cleaning, cooking, laundry, physical assistance and non-medical care. Occupational titles include attendants, Community Health care Worker I.

Workers are primarily female and have an average age of 43 for those seeking claims during 2001-2005. The average claim in this category cost WorkSafe BC over $8000 and on
average; workers with claims were off work for 45 days. The total number of days lost for the period of 2001 to 2005 was 54,591 days with claims totally $10.1 million over the same period. The majority of workers are employed as childcare and home support workers, followed by assisting occupations in support of health services, paralegals, social service workers, cleaners, nurse supervisors and registered nurses.

5.2.1 Claim Rates 2001-2005 (Childcare and Home Support Classification Unit)

Within the Childcare and Home Support Classification Unit, the average rate of claims per person year declined over the period of 2001 to 2005 (Figure 2)[nd15]. These claims include short and long-term disability as well as claims for fatalities. Figure 2 shows a steady decrease in claims over the time period sampled. Childcare and home support workers accounted for 67% between 2001 and 2005 while workers employed as assisting occupations in the support of health services accounted for 19% of the total claims during this period.

Figure 2 Claims per Person Year Children and Home Support Classification Unit 2001-2005 [nd16]

Source: WorkSafe BC Data Warehouse Children and Home Support Classification Unit
5.2.2 Injury Rates 2001-2005 (Childcare and Home Support Classification Group)

While it can be important to examine the claims rate, it is equally as important to look at the injury rates, the type of injuries that occurred, and the cause of injuries for the Childcare and Home Support classification unit. WorkSafe BC measures injury rates based on total number of claims divided by 100 person hours. The injury rate for this CU has continued to decline since 2001 (See Figure 3). The rate of decline has been quite substantial from a rate of 8.2 injuries to just over 4.1 injuries. The average over the period was 6.1 injuries per 100 person hours.

Figure 3 Claims per Person Year Children and Home Support Classification Unit 2001-2005

![Injury Rates 2001-2005](image)

Source: WorkSafe BC Data Warehouse Children and Home Support Classification Unit

5.2.3 Accident and Injury Breakdown 2001-2005 (Childcare and Home Support Classification Group)

Tables 13 through 17 in the Appendix B show the detailed breakdown of accidents and injuries to Childcare and Home Support Classification Unit from 2001 and 2005. Overexertion accounted for nearly half (46%) of the accidents followed by a fall from the same level at 13%. Overexertion claims totalled 3.6 million, with over 30 thousand working days were lost. As in the other employment category, sprains, strains, and tears which accounted for 74% of injuries. The other 26% injuries were bruises and contusion, other injuries to muscles, tendons, ligaments
and joints, fractures. The total number of days lost due to sprains, strains, and tears was 43,183 between 2001 and 2005. The total claim cost was also a staggering $5.3 million. The back and spine remain the area most vulnerable to injury especially when caused by injuries due to overexertion, accounting for 36% of the total claims and 16,570 days of work lost between 2001 and 2005. Injuries to multiple body parts accounted for 15% of total claims and 10,369 days lost. The largest sources of injuries to Childcare and Home Support workers occur when working with clients or caused by another individual other than the worker (39%) and almost 24 thousand days lost. The second greatest source of injury were floors, walkways, or ground surfaces and can likely be attributed to slipping.

5.3 No Time to Care: Community Health Workers and the New Economy Review

Harter and Leier’s study “No Time to Care: Community Health Workers and the New Economy” (2003) provides additional demographic information about Community Health Care workers. Their study was conducted for the purposes of examining the effects of “under investment” and spending reduction in the health care system. They wanted to examine how these trends affect the work experience of Community Healthcare Workers in regards to environment, education, health and safety, and unionization (Harter & Leier, 2003). For the purposes of my study, specific questions were pulled from the questionnaire that was distributed to 2400 Community Health Workers in the United Food and Commercial Workers Local 1518. Questions of particular interest included those surrounding areas of job satisfaction, safety (injury), and education. Most CHWs have a considerable amount of job experience. Approximately 54% of the respondents to the survey had been employed in their present profession for over 10 years. This indicates that these workers are highly dedicated to their profession, experienced and have a fairly high retention rate.
Despite a high rate of job satisfaction, most CHWs reported low wages. The wage distribution of CHWs who answered the survey tended to lower side of the pay scale. Close to 58% of workers made less than $30,000 per year and all workers with exception of 4 respondents made less than $40,000. According to Statistics Canada, the average wage for women in 2006 in BC was $18.63 per hour (approximately $37,750 a year based on a 40 hour work week) and for unionized workers including men it was $23.36 per hour ($48,588 thousand a year based on a 40 hour work week) (Statistics Canada, 2007).

The time commitment that CHWs put into their profession is similar to most other occupations with the greatest number of workers putting in between 33-36 hours per week. However, one-third of CHWs work part time at less than 26 hours. While the work hours of full-time CHWs are similar to other professions, the intensity in workload can be incredibly demanding. Respondents were asked, “If the time they spent with clients had been reduced” and over 77% felt that it had during the past year. As the time allotted per client was reduced, workers were required to improve their efficiency. Workers were left in a hurried state leaving them vulnerable state for slips, falls, and unsafe lifting of patients.

Workers faced organization challenges including a lack of funding. A change in the levels of funding to the home care sector by the BC government has directly affected workers. Almost 83% of respondents either agreed or strongly agreed that the uncertainty in their jobs makes them worried about the future. A lack of certainty in the workplace can cause mental anguish and impact overall mental health and well-being.

Close to 49% of the respondents to the survey said, they had been injured on the job, despite the majority receiving OH&S training. Overall 81% of respondents received training in health and safety; however, the type, quantity, and intensity of training can vary between agencies and regions. Relatively few caregivers have formal education. Only 20% of respondents reported
having their residential care aide certificate. The biggest barriers to education were cited as family obligations (40%), cost (23%), and time (19%).

There are considerable occupational hazards for CHWs. Over half or 56% of respondents to the survey agreed with the statement “my job requirements put me into situations in which I can be hurt or injured.” Only 8% of respondents felt that they that their job did not put them in danger. In contrast, 55% were not concerned about getting hurt, despite the inherent risks. Most respondents did not have to work with an injury because the Workers Compensation Board of BC (now WorkSafe BC) had accepted their claims, however approximately 8% did have to take an unpaid leave of absence due to their injury when their claims were not accepted by WCB.

5.4 Summary of Important Points Raised by Demographic Study

The information provided by WorkSafe BC for 2000-2005 for the Health and Community Support Classification Unit (medical care providers) and The Childcare and Home Support Classification Unit (non-medical care providers) alongside the survey conducted by Harter and Leier provides a comprehensive analysis of the demographic and injury information about the sector. For the purposes of the rest of this study, the policy analysis and recommendations will focus primarily on CHWs who provide non-medical support, however the policy recommendations may be applicable to other health workers in the community care sector. Table 1 summarizes the data from these studies.

Table 1 Summary of Key Findings

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Health and Community Support Classification Unit (medical)</th>
<th>Childcare and Home Support Classification Unit (non-medical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Duties</td>
<td>• Physical therapy</td>
<td>• Cleaning</td>
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<td></td>
<td>• Occupational therapy</td>
<td>• Cooking</td>
</tr>
<tr>
<td></td>
<td>• Midwifery</td>
<td>• Laundry</td>
</tr>
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<td></td>
<td>• In-home rehabilitation</td>
<td>• Physical assistance</td>
</tr>
<tr>
<td></td>
<td>• In home nursing care</td>
<td>• Non-medical care (bathing, dressing)</td>
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<tr>
<td></td>
<td>• Home management</td>
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</tbody>
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24
<table>
<thead>
<tr>
<th>Occupational Titles</th>
<th>• Community Health Worker II</th>
<th>• Attendants</th>
<th>• Community healthcare worker I</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• RN</td>
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<td></td>
<td>• Physiotherapist</td>
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<td></td>
<td>• LPN</td>
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<tr>
<td></td>
<td>• Occupational Therapist</td>
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<td></td>
<td>• Nurse Aide</td>
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<tr>
<td></td>
<td>• Midwife</td>
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<td>2001-2005</td>
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<tr>
<td>Average Days Lost</td>
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<td>45</td>
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<td>Per Claim 2001-2005</td>
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<tr>
<td>Average Claim Rate</td>
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<tr>
<td>Per Person Year 2001</td>
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</tr>
<tr>
<td>Average Claim Rate</td>
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<tr>
<td>Per Person Year 2005</td>
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<tr>
<td>Average Injury Per</td>
<td>5.4</td>
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<td></td>
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<tr>
<td>100 Person Hours</td>
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<td></td>
</tr>
<tr>
<td>2001</td>
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<tr>
<td>Average Injury Per</td>
<td>4.9</td>
<td>4.1</td>
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<tr>
<td>100 Person Hours</td>
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<td></td>
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<tr>
<td>2005</td>
<td></td>
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<tr>
<td>Most Common Accident Type</td>
<td>Overexertion</td>
<td>Overexertion</td>
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<tr>
<td>Most Common Nature of Injury</td>
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<td>Sprains, Strains, and Tears</td>
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<td>Most Common Injured Body Part</td>
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<td>Back including spine, spinal cord</td>
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<tr>
<td>Most Common Source of Injury</td>
<td>Person other than injured or ill worker</td>
<td>Person other than injured or ill worker</td>
<td></td>
</tr>
</tbody>
</table>

Source WorkSafe Data Warehouse and “No Time to Care: Community Health Workers and the New Economy” (Harter and Leier, 2003)

The following factors drawn from these studies provide the basis for my list of policy options to reduce the extent of injury among Community Health Care Workers.

**WorkSafe BC Data Warehouse 2001-2005 Information**

- Medical and non-medical workers in community health exhibit similar findings.
- The average claims cost for the Childcare and Home Support Classification Unit is considerably higher than that for Health and Community Support Classification Unit.
- The average injury per 100 hours was a lot higher in 2001 for the Childcare and Home Support Classification Unit than for the Health and Community Support Classification Unit. However, by 2005 they were similar.
- Both classification units reported the same most common accident type (overexertion), nature of injury (sprains, strains, and tears), injured body parts (back including spinal cords), and source of injury (person other than injured or ill worker).
“No Time to Care: Community Health Workers and the New Economy” (Harter & Leier 2003)

- Community Healthcare Workers reported relatively low-income levels with 56% earning less than $30,000 per year.
- 77% of the Community Healthcare Worker respondents felt that in a one year span that the time they spent with each client had been reduced
- 83% of respondents felt concerned about the future due to the uncertainty in their jobs.
- 49% of respondents had been injured on the job.
- 81% survey participants had some form of OH&S training.
- Only 20% of the respondents possessed a formal resident care aide certificate
- The greatest barriers to education are family obligations, time and cost.
6: Methodology

My methodology is composed of three phases. The first stage of the study involves the use of publicly available data from WorkSafe BC on the claims made by community health care workers who have been injured and made claims. The main purpose of this data is to identify the socio-economic demographics of community health care workers who have made claims and the types and the rates of injury they have received during a period of 2001-2005. Secondary information is provided from a study entitled “No Time to Care: Community Health Workers and the New Economy” (Harter & Leier, 2003). This information helps identify policy options to reduce the number of injuries.

The second component of my study is the use of comparative cases (studies) from different jurisdictions who have implemented interventions and/or policies to reduce the rate of injury among community health care workers within their own regions. The cases are as follows:

1. A project and partnership between the Occupational Health and Safety Agency of BC, home support agencies, British Columbia Government and Service Employees’ Union, the Workers’ Compensation Board, United Food and Commercial Workers, the Canadian Institute for Health Research, and the Community Alliance for Health Research. This study is entitled “Improving the Health and Safety of Community Health Workers.” (OHSAH, 2005)

2. A Swedish study entitled “From different starting points: A longitudinal study of work and health among home care workers.” (give authors & date)

3. An American study entitled “Decreasing Back Stress in Home Care Workers.” (give authors and date)
The last two studies provide information about the cost of injury in the health care sector and best practice recommendations on how to reduce the risk of injury among community health care workers.

The final aspect of my study includes five interviews with experts within the community health care field. The purpose of the interviews is to help establish what the most effective policy or intervention options for British Columbia health care workers would be at the agency level.
7: Case Studies

Each case chosen is different in scope and tried to target different areas of injury prevention among community health care workers. Overall, the three studies did share a common purpose of reducing the risk and the occurrence of MSI injuries, as these represent the largest number of injuries for community health care workers. This section will examine each case study in depth and explore the purpose of the study, intervention, and finally the recommendation of each study. These cases will provide the basis for policy recommendations on how to reduce the number of claims made to WorkSafe BC among CHWs. Table 2 summarize the basic components of each case.

Table 2 Summary of the Case Studies

<table>
<thead>
<tr>
<th></th>
<th>Sweden</th>
<th>British Columbia</th>
<th>Wisconsin</th>
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<tbody>
<tr>
<td><strong>Purpose of Study</strong></td>
<td>Examines the relationship between the physical and psychosocial aspects of home care employees caring for elderly and handicapped patients.</td>
<td>Examines different interventions to reduce risk among community health care workers in BC.</td>
<td>Three parts:</td>
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<tr>
<td></td>
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<td></td>
<td>1. Determine the perceptions of physical stress in home care work.</td>
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<td>2. Identify what makes these tasks stressful</td>
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<td></td>
<td>3. Implement ways to reduce back stress</td>
</tr>
<tr>
<td><strong>Study Sample</strong></td>
<td>The sample is composed of home care workers in Swedish municipal organization that care for the elderly and disabled.</td>
<td>Five home care agencies participated in this study.</td>
<td>The sample included 33 health care aides from three different home care agencies. Observed 421 tasks over a period of 6 months.</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Longitudinal over 3 years based on the analysis of 63 participants. The participants were divided</td>
<td>Over a 3-year period, five BC home care agencies implemented three interventions. One agency</td>
<td>Observation of health aides and nurse observers over a six-month period and assessing factors (tasks)</td>
</tr>
<tr>
<td>Intervention</td>
<td>Results</td>
<td>Recommendations for Risk Reduction</td>
<td></td>
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<td>--------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
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<tr>
<td>No specific intervention implemented, however the participants in each group were tracked over a 3-year period.</td>
<td>Unfavourable conditions group reported more symptoms of pain, fatigue, neck pain, and somatic symptoms.</td>
<td>Policies that emphasize positive work environment for both supervisors and CHWs.</td>
<td></td>
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<tr>
<td></td>
<td>There were three interventions offered, including training sessions for CHW, the use of a risk assessment tool, and mechanical lift devices.</td>
<td>Training to increase awareness and the assessment tool reduced number of accepted WCB claims and WCB time loss claims.</td>
<td>Implementation of education and risk assessment tools. Further investigation and implementation of violence prevention measures and a review of mechanical lifts.</td>
</tr>
<tr>
<td></td>
<td>Assistive devices such as mechanical lifts, gait belts, hair-washing trays were used to reduce injury.</td>
<td>The three most perceived contributors to stress were body mechanics and patient factor.</td>
<td>Given by both health aides and nurses in the areas of body mechanics, patient factors, environment factors and policy change.</td>
</tr>
</tbody>
</table>


7.1.1 Sweden: “From different starting points: A longitudinal study of work and health among home care workers,” Hedin (1997)

Sweden and the Scandinavian countries have conducted extensive research on occupational health and safety among community workers. Studies such as Ono et al. (1995), Johansson (1995), and Brulin et al. (1999) have all contributed to a large field of injury prevention and reduction in this region (Hedin, 1997). I chose Hedin’s study because it is longitudinal, pays specific attention to issues of work environment, and seeks specific recommendations for improvement from participants. The purpose of this study was to examine the “relationship between health and psychosocial aspect for home care workers employed in the care of the elderly” over a three-year period. Hedin discusses two types of factors that influence physical and psychological state of home care workers and differentiates between objective workload (easily quantified such as number of hours, patients, tasks, etc.) and subjective workload (perceived workload by staff) and how they influences the complaints (both psychological and physical). Homecare workers worked in teams of six to ten with a coordinator for administrative tasks. Sixty-one individuals participated in the three-year study (77% response
rate) however, the sample diminished to 39 individuals at the end of the three year study. The independent variables in the study were the subjective and objective workload. The dependent variables were musculoskeletal and stress symptoms. In this particular study, no specific interventions were introduced. The study notes however, that during the period of the research the Adel reform[nd21] was introduced. The reform saw communities with elderly citizen became responsible for their care and housing needs.

Results

Both groups in the study felt dissatisfied with the information given surrounding organizational changes. However, more staff in the unfavourable conditions (UC) group felt dissatisfied. Generally, the UC group reported higher psychological demands, demands of time, emotional involvement, and knowledge. The UC group in the dependent variable section reported more complaints of neck pain, fatigue, nervousness, somatic complaints (headache, stomachache).

There were no specific recommendations given in this study, however the discussion alludes to some recommendations. Firstly, relationships dominate the work environment.[nd22] The greatest influence is the relationship with management. Policies that influence organizational culture result in positive work environments for CHWs and their managers. Not all injuries are a direct result of physical environment, but rather the accumulation of negative experiences may lead to physical and psychological symptoms of stress. Hedin suggests that there should be investigations of work environment prior to physical environment or organizational changes.


Home care workers in both Canada and the US face increased workloads, higher acuity, more patients and the scarcity of resources. Many tasks that community health care workers undertake demand extreme physical exertion such as patient transfers out of bed, toileting, and
bathing. This study explored the perceived physical stressfulness of home care tasks, identify what contributes to stress, and create solutions for reducing back stress for home care workers.

Thirty-three home care aides from five different home care agencies in Wisconsin participated in the study. All the aides in the study were female and the median age was 37.5 years who had worked 21 months in the home care field. Graduate nursing students followed the thirty-three aides to witness the care of 61 patients. The nursing students observed 421 daily care tasks completed by the care aides. Researchers used two survey instruments in this study. The first instrument obtained demographic information about the participants, while the second assessed the perceived exertion of the care aides in their tasks. The second survey provided respondents with the opportunity to recommend ways to reduce stress, using a Likert scale. The data collected examined the tasks performed, the number of aides needed for each task, the assistive devices used and finally ideas from both aides and observers on how to reduce stress.

There was no specific intervention use pre-test and post-test or a control group and test group. Care aides however did employ the use of assistive aides such as mechanical lifts, gait belts, hair washing trays, and a hand held shower hose to aid in bathing.

Results

The activities that placed the most stress on the lower back included lifting patients into bed, putting on embolism stockings, and transfers to chair. Most tasks were undertaken by aides were carried out alone except for three instances when there was care for a heavier patient (255lbs or more). The least stressful tasks included repositioning the patient in bed and transfer from bed to chair. In total, there were 421 stressful tasks observed. The majority of them (366 or 87%) were caused by direct patient care, while the remaining minority were caused by tasks such as moving furniture. The recommendations of the study were broken up into four categories: body mechanics, patient factors, environmental factor, and policy changes.
• Body mechanics: aids should learn how to use their bodies and ensure that the patient is in close proximity to their body.

• Patient factors: patients should be medicated for aggressiveness.

• Environmental factors: provide patients with adjustable beds and aids should have access to assistive devices for lifting patients; patients should wear non-restrictive clothing.

• Policy changes: provide two aides to lift heavy patients, allot more time for each patient visit, and provide more orientation to aids.

7.1.3 British Columbia: “Improving the Health and Safety of Community Health Workers” OHSAH (2005)

Limited research has been conducted on the subject of reducing risk among community health care workers in BC. This study was carried out over a three-year period and introduced three interventions into the five community healthcare agencies (one control group) and 648 participants. OHSAH determined that there was a critical need to address the risks that CHW face in the workplace. By implementing a series of interventions, OHSAH was able to identify several practices that resulted in a better culture of reporting and a reduction of claims. OHSAH identified three objectives in the study. First, identify common mechanism of injuries, accepted WCB claims, and WCB time loss claims. Second, compare the intervention to the control groups with regard to injuries, accepted WCB claims and WCB time-loss claims. Finally, identify the whether perceptions of safety, organizational culture, safety, and other factors had an impact on the different rates of injury among the agencies. The goal of the interventions was to reduce risks that contribute to injury rates, reported WCB claims, and WCB time loss claims. The experiment introduced three different interventions.

1. The use of an education and training module created to increase awareness around the risks and safety hazard in the work environment. The module discussed other important topic areas such as musculoskeletal injury awareness, bio-hazardous waste and infection control, general hazard identification, and violence prevention.
2. Implementation of a risk assessment tool and resource guide. The assessment tool was created to provide guidance to home support supervisors on how to assess the potential hazards and risks that each worker may face in a particular client’s home. This assessment tool was used in conjunction with other tools to report hazards, pain and discomfort, and a checklist based tool.

3. Development of an equipment registry to provide CHWs with access to mechanical lift devices to aid in the transferring of patients. By the end of the study, 25 lifts were available to the agencies.

Prior to the intervention, participating agencies received a questionnaire to assess the perceptions of staff about their job and demographic information. The questionnaire gathered information about job satisfaction, pain and discomfort during patient transferring, and the work organization.

Results

The majority of the participants were female, aged 20 to 72 years, and most had completed some form of post secondary education. Their median was 47 years. Ninety-six percent felt that their health was good or excellent. Eighty-eight percent described themselves as CHWs and had average employment duration of 7 years. Prior to the baselines questionnaire assessment 39% or 253 employees reported to have received at least one workplace injury. The causes of the injury were overexertion (53%), falls (31%), and biological, chemical or environmental exposure (10%). Twenty four percent of respondents had suffered at least one time loss claim in the past and 19% suffered from one or more time loss claims in the past.

One year after the implementation of the intervention there were a total of 138 participants who claimed to have suffered from one injury and 38 who reported two or more injuries. In the subsequent year, 180 participants reported injuries, comprised of 47% WCB accepted claims and 38% as time loss claims. The distribution of injury causes in the follow-up year was quite similar to the distribution of injuries in the three years prior to the implementation
of the intervention. It was found that there were fewer accepted WCB claims and WCB claims in the among the education and training only group than in both the no intervention group and the combined education and risk assessment tool group or education risk tool and lift equipment group.

**Recommendation**

The study recommended that education and training were crucial for both CHWs and their supervisors. OHSAH suggested a continuation evaluating and improving the risk assessment tool. OHSAH also suggested placing more attention on issues of violence, workplace organization and perceptions of safety, and more investigation as to why the mechanical lift was not well received in the study.

### 7.1.4 Conclusions of Case Studies

Table 3 summarizes some of the findings and recommendations of the three case studies reviewed and how these conclusions can be adapted for use in British Columbia. The OHSAH study provided the most logical and applicable recommendations. Its standardized assessment tool and education models help form the basis of my policy alternatives.

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**Table 3 Case Study Summary**

<table>
<thead>
<tr>
<th>Application of Recommendations</th>
<th>Sweden</th>
<th>British Columbia</th>
<th>Wisconsin</th>
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<tbody>
<tr>
<td><strong>Recommendations</strong></td>
<td>Recommendations on improving the work environment for workers could be part of a multi-pronged policy approach to reducing risk. Changes to creating a more positive work environment can be difficult. There are so many factors such as size of organization, organization structure,</td>
<td>Recommendation made by the Occupational Health and Safety Agency for BC Health care offer organizations practical solutions for helping to educate workers and to reduce risk through a standardized assessment tool. OHSAH also made a recommendation for further study into the</td>
<td>Some of the recommendations made in the study are fairly simple in nature and are not necessarily applicable for a comprehensive policy program. Likely, the most appropriate recommendations suitable to reducing risk in BC among</td>
</tr>
</tbody>
</table>

35
and type of services offered that can make it difficult to make macro policy recommendations difficult to implement. Changes at the organizational level may be more appropriate.

| Strength of Study | The study was fairly comprehensive, it followed workers over a period of three years, and it also classified workers into two groups that helped to clearly illustrate the effects of working in favourable and unfavourable conditions. | The main strength of the study is it evaluates injury prevention in community care in British Columbia as well it lays out clear recommendations. The study acknowledges some of the methodological weaknesses of the study, but attempts to mitigate these factors in the recommendations it provides. | This study has a large sample size as well it employed a unique methodology using self-reporting as well as observation to assess caregivers. The study also highlights recommendations made by participants into very distinct categories. |

| Weaknesses of Study | There were two primary weaknesses found in the study: they study was conducted in Sweden and organization of community care is very different from in Canada. | Small sample size and therefore it was difficult to assess the effectiveness of the interventions | The deficiency of this study comes in the recommendations. The suggested changes were primarily observations of participants and observes and not necessarily founded on anything except for their own experience. No experiment versus control group. |

*Source Hedin, 1997, OHSAH, 2005, and Owen & Staehler, 2003*
8: Interview Results

The three case studies provide some very specific recommendations for consideration. However, the difficulties in relying solely on the case studies are that two of them were carried out in jurisdictions outside British Columbia and that the ODSA study employed a relatively small sample size. Consequently, I felt it was important to review the policy recommendations with expert stakeholders within the community. There following individuals participated in interviews for this study:

- Georgina Hackett, Occupational Health and Safety Agency for BC Health Care
- Chris Back, Director Injury Prevention, Occupational Health and Safety Agency for BC Health Care
- Shelagh Locke, Industry Specialist for Health Care, WorkSafe BC
- Mona Sykes, Occupational Health and Safety Officer, BCGEU
- Anonymous former Home Care Agency Manager, Vancouver Island

8.1 Interview Results

Interview participants participated in a half an hour to an hour-long interview either in person or by telephone. The interview had both structured and open-ended questions with significant time allowed for participants’ thoughts and recommendations. I posed the following questions to the participants:

- What kind of home care agency or organization do you work for? If none, what kind of home care agencies have you dealt with in your work? Have they been public or private? Please describe your role in your organization.
- Have you witnessed or been exposed to work related injury during your practice?
- MSI injuries are suspected as the most prevalent type of injury, followed by surface wounds. What tasks do you think cause the majority of these injuries?
• People or pets are the largest cause of injuries followed by surfaces? Is this consistent with your observation?
• What policy recommendations would you make to reduce the injuries to community health care workers?

Key information from the interviews is shown in the tables below, organized by theme.

8.1.1 Observations on the State of Community Health Care and Nature of Injuries

Table 4 State of Community Health Care and Nature of CHW Injuries Commentary From Interviewees

<table>
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<tr>
<th>Interview</th>
<th>Comments</th>
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| Former Home Care Manager          | • Within community care, there are both private and public agencies. On Vancouver Island, this is evident as the southern region there is primarily private agencies providing care.  
• MSI occur when employees disregard policy.  
• Body mechanics and equipment cause significant injury.  
• Bad luck such as car accidents account for some of the injuries to workers.  
• Dog bites and attacks are a concern.  
• Client safety is an issue that is overlooked.  
• Equipment can be an issue in causing injury however people are the primary cause (client or worker). |
| Chris Bach and Georgina Hackett   | • Currently OHSAs’s PEARS program is only operating within acute care facilities.  
• PEARS is undergoing expansion into other areas of health care including affiliates.  
• Health Authorities sometimes contract home care out services out, but it depends on the region.  
• OH&S policies are generally more consistent within Health Authorities as opposed to the private sector.  
• Varying degree of public vs. private in the lower mainland.  
• We Care is a private home care agency that that provides home care services, but is not considered an affiliate, nor does it have a JOSH committee.  
• MSI are the most prevalent type of injury and is usually caused by repetitive injury.  
• MSI could include injuries to any soft tissue except for organs, tendons, muscles, joints, ligaments, or blood vessels.  
• The most likely source of injury is patient lifting/transferring.  
• Time allotted for each client visit is limited.  
• There is a finite amount of limited funding for care.  
• There is no data collected by OHSAs in the WHITE database on injuries to CHWs.  
• Few organizations have adopted or implemented policies/interventions to specifically reduce injury.  
• Interior Health Authority has done some basic in house interventions.  
• BCIT is working on a mechanical ceiling lift program as a |
continuation to a pilot project undertook by OHSAH.

Shelagh Locke

- There has been an increase in community health support research however, the focus remains in acute care research.
- MSI are the common
- Any time there is a time loss an employer has to do an investigation.
- Overexertion accounts for about 30% of the injuries to CHWs.
- Aggression is underreported
- Most slips and falls are due to icy or slippery conditions in the winter.

Mona Sykes

- CHWs do not have a lot of time to give clients extra attention beyond the basic care duties.
- CHWs do not have the opportunity to provide assistance with grocery shopping, making dinner, providing emotional support etc.
- Workers operate in a hurried and often unpredictable environment.
- Clients have been increasingly more acute and require more care.
- Proper training for CHWs is not provided and the rate of compensation has diminished.
- Believes that the overall quality of health of patients is declining, as there is less care time available.
- Health care in British Columbia is operated under a business model as opposed to a care model.
- MSI are common because people don’t follow policy and use poor body mechanics when using equipment and undertaking tasks.
- Safety assessments to highlight hazards must be conducted.
- Proper equipment is not available to all workers, as families don’t/aren’t willing to install ceiling lifts.
- Poor compliance and policies such as a “no lift policy” don’t necessarily reflect the everyday experiences of workers (ex. If a client who falls on the floor, leaving them or waiting for an ambulance isn’t necessarily the perfect option.)

Source Interviews (2007)

8.1.2 Policy Recommendations from Interviewees

Table 5 Policy Recommendations for Interviewees

<table>
<thead>
<tr>
<th>Interview</th>
<th>Comments</th>
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| Former Home Care Manager      | • Assessments should be conducted by home care agencies, often they are not coordinated with the assessment done by the health region prior to the client coming home. There should be a dual process in how this carried out.  
                                  | • There are not standardized assessment tools across agencies, health authorities, or even in the province.                                                                                           
                                  | • Identifying concerns for both worker/client would likely                                                                                                                                                |
reduce issues of patient safety concerns for clients, but also for workers since they are both working in the same uncontrolled environment.

- Retention is a big issue with relationships. Managers need to have training in how to communicate with employees, but employees also need to take responsibility for bringing concerns to their employers. Staff meetings are crucial to identifying safety risks.
- Policy has to come from a several levels. For example, there has to be a combination of systemic, educational, and performance area changes to policy. At the system level, often caregivers aren’t given the right tools. At an agency level, it is the responsibility of the senior executive to ensure that day-to-day practices are safe. Home care workers are most vulnerable at night and in homes with unexpected risk.
- Having workplace initiatives that are creative, use existing resources, and good communication are likely the best policies/intervention techniques to reduce the risk of injury. CHWs need to be taught how to constructively identify problems and solutions.

<table>
<thead>
<tr>
<th>Chris Bach and Georgina Hackett</th>
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<tbody>
<tr>
<td>• There needs to be a standardized safety assessment that assesses risks for both clients and CHWs. This should be a joint effort between the home care agency and the HA.</td>
</tr>
<tr>
<td>• Assessments need to be conducted prior to the CHW going into a client’s home. This should be a mandatory policy.</td>
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<tr>
<td>• It should be the responsibility of the employer to identify potential risks and mitigate them. However, there has to be a certain level of responsibility and accountability on the part of staff to ensure their safety.</td>
</tr>
<tr>
<td>• Education is critical in helping CHWs identify safety risks within their work environment.</td>
</tr>
<tr>
<td>• There needs to be a culture of trust so that reporting of injuries is required and that workers automatically notify employers of problems that arise or potential safety risks.</td>
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<tr>
<th>Shelagh Locke</th>
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<tr>
<td>• A standardized assessment might tool not necessarily practical option for reducing risk.</td>
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<tr>
<td>• Employers aren’t always held to the standards laid out in legal regulations.</td>
</tr>
<tr>
<td>• College curriculum needs to be revamped to include OH&amp;S content.</td>
</tr>
<tr>
<td>• Only 10% of WorkSafe BC’s Enforcement Officers are dedicated to health care. There is a lack of officers dedicated to community care and there should be some improvement in this area.</td>
</tr>
<tr>
<td>• WorkSafe BC needs to educate, consult, and enforce.</td>
</tr>
<tr>
<td>• Workers need to be better educated and better paid.</td>
</tr>
<tr>
<td>• Employers need more education, resources, tools, and ability to purchase equipment.</td>
</tr>
<tr>
<td>• BC Ministry of Health needs to provide more funding to community care.</td>
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<th>Mona Sykes</th>
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<tr>
<td>• WorkSafe BC needs to provide more enforcement within</td>
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</table>
8.1.3 Discussion of Results

There were some similarities in the themes presented in the policy recommendations by the stakeholders. The policy recommendations were targeted at different groups including employees, employers, Health Authority, colleges, WorkSafe BC, OHSAH, BCGEU and the Ministry of Health. The following points summarize the main recommendations:

- There needs to be an increase in knowledge of workers around the issue of OH&S. Increasing the awareness of workers could occur via two routes: adapting college and formal training programs in community health care and/or providing more extensive orientation and ongoing training to workers already employed in the field.

- Design a standardized assessment tool and process for implementation across the province. Assessments conducted in conjunction with the Health Authority for clients would benefit both parties, as the assessment would identify risks to both clients and workers.

- There needs to be more enforcement of safety regulations and awareness among employers. Increasing the amount of human resources (WorkSafe BC Safety Officers) dedicated to monitoring OH&S regulation adherence in community healthcare may increase employer compliance levels.

- It is vital to create stronger communication between workers and employers around risk and actual injury. Creating a climate where reporting a potential hazard is encouraged, may reduce potential injuries.

Source Interviews (2007)

| the industry and go after employers with a legal order that do not comply with regulations and standards. |
| • There has to be more orientation and training for new workers in the area of OH&S. A joint effort between BCGEU and OHSAH to provide orientation materials would go a long way. |
| • At the Ministry of Health, level there has to be a review of resources and policies surrounding the level of care to clients. Increasing the amount of care for individuals to include house cleaning and maintenance would also help prevent some injuries. If more time were allotted to each client, CHWs would be able to provide more comprehensive care and would be less hurried. |
| • More OH&S training needs to be integrated at the college level. |
• Increase the amount of time allotted to each client to allow CHWs to be more thorough and more careful in their care, thus reducing the likelihood of injury. (Interview Sykes, 2007).
9: Policy Alternatives

I offer four policy alternatives. The goal of the alternatives is provide concrete recommendations that will help to reduce the risk of injury through intervention. The case studies and expert interviews suggest the most significant reduction of risk for CHWs would be to eliminate the need to perform patient transfers and lifting. During 2006, OHS Affiliate implemented a ceiling lift program with the goal of developing a model that could be implemented province wide. For the purposes of this study, I will not be discussing OHS Affiliate’s program as a proposed policy alternative because it has been implemented as part of a trial study. The final report has not been made available as of December 2007, therefore now it is too soon to assess it as part of this study. The most prohibitive consideration in implementing a ceiling lift is cost.

The policies presented in the following section are not exhaustive in scope; these interventions target different stakeholders and offer varying approaches to solving the same issue. The alternatives were created primarily based on recommendations from the stakeholder interviews. The four alternatives are also substantiated from information collected in the data analyzed from WorkSafe BC, Harter and Leier study (2003) and from the literature review. The policy alternatives will be described separately and then will be evaluated in Chapter 11.

9.1 Increased Training and Knowledge

Knowledge and awareness of OH&S issues are vital to ensuring the safety of CHWs. Orientation is a very important aspect for any new worker including training in OH&S policies and procedures. It is important that this information be discussed in a formal setting. A lack of knowledge can often lead to unsafe practices in the workplace.
9.1.1 Goals

- CHWs receive adequate and standardized injury prevention training.
- Improve injury prevention awareness and training.
- Employers and colleges should make it mandatory to engage in a certain number of hours around safety issues. A program of this magnitude would need to be administered through a provincial body to ensure consistency.
- Currently one of OHS AH’s primary mandates is to offer OH&S training through their Healthcare Educational Learning Program (HELP). Within the HELP program there are modules offered both on line and to the JOSH. The HELP program would provide an excellent opportunity for in an effort to coordinate with this initiative OHS AH would need adequate resources to both develop and coordinate the program.

9.1.2 Policy Mechanisms

- Consultation with colleges who provide education for CHWs, Health Authorities, home care agencies, WorkSafe BC, Government of British Columbia, and respective employee Unions surrounding issues of feasibility, responsibility, implementation, and evaluation.
- Expansion of OHS AH’s HELP program through the development of a comprehensive set of modules and courses. Curriculum design would take place over time and would be determined by the complexity of the design.
- Pilot program implemented by OHS AH to test new curriculum before province wide implementation. It is necessary to track rates of injury among sample population against control group.
- Educational and incentive campaign to gain support from stakeholders before provincial wide implementation. It is extremely important that there is support from the ground level as well as at the executive level.
- The project would have to be phased in over time. Colleges through their appropriate academic decision making bodies would have to implement the course content into their community health programs. For CHWs, already practicing in the field the training would have to become a part of the necessary requirements to be employed alongside such existing programs as First Aid, CPR, and WHIMIS. Employers would have to provide the necessary time to engage in training. Modules could be offered online, as an in-service, or as part of an orientation.
- Establish target injury reduction rates to evaluate the success of the program. Monitor data from WorkSafe BC. Additionally, a more specific database to track injuries from participating agencies would provide information that is more reliable than just relying on information available from WorkSafe BC.

4 The modules included in the HELP include “Basics of WHIMIS,” “Online Infection Control, (online), “Joint Committee Boot Camp,” “Inspections,” “Incident Investigation,” “Violence Prevention Planning,” and “Prevention and Management of Aggressive Behaviour.”
9.1.3 **Actors**

- OHSAH in consultation with WorkSafe BC and employee unions would be the primary organizations responsible for content design and program administration.
- Health Authorities, BC colleges, and employers would be responsible for delivery
- Employees would be responsible for attending program either online or in person/
- Government of British Columbia would provide funding for program setup and continued maintenance of program.

9.1.4 **Implementation**

- The program would be implemented in a phased in approach capitalizing on the record of accomplishment that OHSAH’s HELP program has already experienced in acute care facilities. In 2006, the HELP program was expanded to include affiliates (including home care agencies).
- Sustained reductions in injury rates and claims would likely take between five to ten years to be realized.

9.1.5 **Measures of Successful Implementation**

- The primary measure of success would be a reduction in the number of injuries, short-term disability and long-term disability claims being made by workers. Success could be assessed using data from both WorkSafe BC and data bank tracking participating agencies. Targeted reduction rates could be established by WorkSafe BC and OHSAH to monitor the effectiveness of the program.
- Feedback in the form of satisfaction surveys from students and employees could also be used to determine the success of the program.
9.2 Standardized Assessment Tool and Process

Case Managers alongside other appropriate health professionals, prior to commencement of any care provision in the home, develop a care plan for patients. The care plan is designed to determine what services a client is eligible for, what the care needs are of patients, and any monetary cost to the patient (Government of British Columbia, 2005a). Under the Workers Compensation Act, CHWs are required to be informed of any risks and hazards prior to working in a client’s home. Generally, the employer is responsible for conducting their own assessment to identify any potential risks for CHWs. While assessments are vital to ensuring the safety of CHWs, there is a lack of consistency in how they are carried out. Client care assessments are carried out separately from the safety assessment for employees. Additionally there is also a lack of communication and coordination with the assessments carried out on the behalf of the patient by the caseworker and the employer. Currently, Northern Health has implemented a standardized assessment tool to determine a care program for clients (Government of British Columbia, 2005b). The policy is to implement standardized joint assessment process for the Province.

9.2.1 Goals

- Coordinate the standardization of the assessment process through the implementation of a joint assessment program between the Health Authority (on behalf of the client) and the employer (on behalf of the employee)
- Standardize the risk assessment tool and client intake form done at the commencement of service.
- Improve communication between home care agency and client case managers with a common goal of improving the safety for both CHWs and clients.
- Improvement in the identification of potential hazards and dangers helps to reduce uncertainty in the work environment and eliminate potential risks.
9.2.2 Policy Mechanisms

- Consultation process with appropriate stakeholders (unions, health authorities, employers, WorkSafe BC, and OHLSAH) to determine important aspects of standardizing the assessment process.

- Conduct a feasibility study to assess questions of ease of implementation, administration, cost, effectiveness etc of such a policy initiative. The study could employ a pilot project undertaken by several agencies. [nd26]

- OHLSAH has developed a standardized risk assessment tool and client intake form. The risk assessment form covers six areas: MSI risk assessment, assistive devices, chemical hazards, biological hazards and infection control, violence and working alone, and general hazards. The client intake form covers issues such as patient diagnosis, care level, and workplace risks. (OHLSAH, 2007) This availability of this form helps to ease in the implementation of a standardized process. [nd27]

- Mandatory implementation and use of a standardized risk assessment tool and conjoint risk assessment between employer and client case manager (or appropriate representative). Rates of compliance would be measured over a period of time and adjustments would be made to process depending on whether there was a reduction in injury or not.

- Actors

- OHLSAH has already developed a risk assessment tool

- JOSHC, employer, and HA would be responsible for designing a joint process for carrying out the assessments.

9.2.3 Implementation

- The implementation of a joint assessment process and the adoption of a standardized assessment form would take at least several years. There are a number of steps[nd28] that need to be taken before implementation of this program: stakeholder consultation, design, pilot program, review of pilot program, and redesign for province wide implementation.

- Support has to be garnered from all participating stakeholders. A mandatory provincial assessment program would potentially require changes to existing policy and legislation.

9.2.4 Measures of Successful Implementation

- Adoption of a standardized risk assessment tool and process across the province.

- Increased awareness of risks in on the worksite.

- Reduction of in the rate of STD and LTD among CHWs participating in the program.
9.3 Enhanced Risk Reporting and Compliance

One of the most important components of prevention and reduction in the risk of injury is compliance with current regulations as defined by under the Worker Safety Act. Officers employed by WorkSafe BC have the powers to enforce regulations. Prevention of injury among workers often requires officers employed by WorkSafe BC to inspect the workplace of employees to investigate violations of regulation. Officers can obtain compliance with written orders, education, and enforcement. Monetary penalties and/or warning letters can be issued if an officer feels that the violation warrants the order. An administrative penalty can be issued to an employer that repeatedly ignores orders or in a situation where there is a high risk for injury or disease (WorkSafe BC, 2007). In my interview with Shelagh Locke (WorkSafe BC), she highlighted that one of the reasons that injuries occur is that employers do not comply with regulation consistently (2007). Furthermore, there is a shortage of officers dedicated to investigating issues of compliance in the health sector. Locke also noted that acute care often moves to the top of the enforcement priority list, as it is very difficult to try to enforce compliance in the community within private homes (Interview Locke, 2007).

9.3.1 Goals

- To increase the number of officers dedicated to health care sector.
- To increase the human resources available to educate and enforce regulation among employers of CHWs.
- To improve the compliance and awareness among employers.
- To reduce the STD, LTD, and injuries among CHWs with improved compliance.

9.3.2 Policy Mechanisms

- In the interim period, redirect some of the time of officers dedicated to investigating health care sector compliance to investigations and increased consultation with employers in the community care sector. This would be only an interim step until more officers are hired.
- Increase funds allocated to investigation and recruit the necessary officers to support an increase in the compliance among employers. Concerted effort to increase compliance, but also to reduce risk through more education and consultation of employers.
• Awareness campaign to inform workers/employers of the program. Specific focus of the campaign would emphasize that an increase in officers is not intended to be a punitive measure, but rather an effort to improve the culture surrounding reporting risks and ensuring compliance.

9.3.3 Actors

• WorkSafe BC would be the primary actor in this policy program. They would be responsible for the administrative and operational requirements to hire more staff and subsequently to ensure compliance.

• Employers would have to be consulted surrounding the specifics of the program. It would also be important to create buy-in from both employers and employees.

9.3.4 Implementation

• The implementation of such a project would take a considerable amount of planning, consultation and finances.

• An interim solution would be to redirect the time of the officers to working on investigating issues in community care.

9.3.5 Measures of Successful Implementation

• More human resources dedicated to investigating, educating, and enforcing regulation.

• Increased level of compliance among employers.

• Reduction in the number of STD, LTD, and injuries among CHWs.

9.4 Increased Time Allotment for Client Visits

In 1994, the BC Ministry of Health due to ballooning costs and increased pressures on home support services, reallocated funds and access to services. As a result, the most acute patients were given priority and stand-alone housekeeping services were severely reduced (Government of British Columbia, 2005b). Community care loads increased dramatically. Since 2001, home care services have been enhanced and increased as new federal money is distributed to the provinces (Government of British Columbia, 2005b). Vancouver Coastal Health developed the Community Care Network (CCN) to address the individual needs of clients, Fraser Health saw an increase in professional staff and an increase in home support hours by 10 000 hours, and
Vancouver Island Health has enhanced staffing in Port Alberni (Government of British Columbia, 2005b).

Despite the increase in funding and human resources, and studies report that CHWs still are rushed in their work and have little time to spend with clients. As stated earlier, 77% of the Community Healthcare Worker respondents felt that in a one-year span that the time they spent with each client had been reduced Harter & Leier, 2003). In an interview with Mona Sykes (2007) she highlighted the fact that CHWs no longer have the ability to spend extra time with clients and that workers can only provide basic care. As of 2001, allocated home care support hours in British Columbia at the highest care level maxed out at 30 hours per week per client. These levels were much lower in comparison to the 40 hours/week in Quebec and 35 hours/week in the Yukon (Government of Canada, 1999). The Centre for Policy Alternatives (2004) indicated that by 2003, British Columbia had the second lowest levels of home care services among the provinces and that home support hours (between 2001-2003) had fallen 13%. With heavy caseloads and reduced time allotted to clients, CHWs work in a hurried state leaving them prone to injury. The following section will discuss options to alleviate this situation.

9.4.1 Goals

- Improve the care provided to clients by increasing the daily-allotted time.
- Reduce workloads per hour for CHWs by allotting more to be spent with each client therefore reducing the “hurried” state of care giving.
- Reduce the rate of CHWs working alone in isolated or high physical demand clients.

9.4.2 Policy Mechanisms

- Government of British Columbia to review current policies surround maximum weekly-allotted home care hours.
- Government of British Columbia and Health Authorities in a joint task force identify the optimal staffing/client ratio mix, and the optimal number of home care hours to provide to each client per type of need. Guidelines around recommended hours should be reviewed regarding specific conditions/disabilities
• Increase funding to allow for changes to increased allowances.

• Consult with Health Authorities and employers on prospective policy changes. Develop specific strategies with HA on how to increase human resources to handle changes.

9.4.3 Actors

• Government of British Columbia would be responsible for increasing the necessary funding to Health Authority.

• Health Authorities would be partially responsible in implementing program changes by working with local agencies to hire more staff, rearrange deployment of staff etc.

9.4.4 Implementation

• This program would take a significant amount of analysis, political support, monetary funds, administration, and monetary support. Initially, political support would essential to get political by in for changes to the current allocation of time.

• Program should be phased in over a period of time. Cases were clients and work environments that pose the most risk to CHWs should be identified as priorities for increasing allocated home support hours.

9.4.5 Measures of Successful Implementation

• Increased home support hours to reflect levels in line with other provinces.

• Increased allotted time per client to reflect the individual needs of clients.

• Reduction in the number of STD, LTD, and injury rates among CHWs.
10: Criteria and Evaluation

The criteria used to evaluate the policy alternatives for this project emanate from a number of interviews with key stakeholders, the case studies, and information from WorkSafe BC. It is my intent to use a reasonable criteria list that will flexible in evaluating policy alternatives regardless of the organization/government level that is going to implement them. My criteria are stakeholder feasibility, cost, compliance, and ease of implementation. I discuss each criterion and then Table 13 defines the criteria and their measures.

10.1 Stakeholder Feasibility

Stakeholder acceptability is a very important and significant consideration in evaluating alternatives. At the centre of each policy is a need to discuss implementation. Without successful implementation, there is no chance for the policy to successfully make a difference and reduce the risk of injury to CHWs. There are a number of stakeholders involved in the community healthcare sector. One issue that may affect buy-in to a program is that there are a number of health regions with varying political climates and budgets. Secondly, BC provides many community health care services through private organizations. Thirdly, it is important to remember that unions represent many community health care workers in BC. Occupational safety and the prevention of injury should be the first of foremost importance for any employer or employee. However, safety is often put on the backburner when more pressing and time sensitive issues come to play. With each alternative presented there must be an incentive to the employer and/or employee to participate in implementation.
10.2 Cost

The measurement of cost is difficult to assess when risk is involved. As well, there are costs to a variety of stakeholders. The implementation of a new program may require time (measured hourly based on their wage) on the part of a worker. For the employer, there are costs associated with the start-up, implementation, operation, and review of a program. Employers, be they a government entity or private firms/individuals, must have sufficient financial and human resources to run a program. In addition, a criterion of cost can be broken down into two categories 1) program costs and 2) social costs. Program costs are directly related to the financial and human resources required to implement a program. Social costs can be classified in a broader context as to what the long-term benefits or costs of a program may be to the greater community (not necessarily just direct stakeholders).

10.3 Compliance

Compliance is essential for the success of any policy. Compliance entails:

- A plan of action as to how a program is going to be monitored for participation;
- Identification of who will be responsible for the review;
- What course of action will be taken if there is a low participation rate; and
- Identification of sanctions or actions for failure to adhere to the components of the policy.

10.4 Ease of Implementation

Policy alternatives can have the best intentions to address a policy issue, however if they are unrealistic in scope or complexity there is a strong chance they will not be implemented.

Community health care agencies can be private or publicly run and often vary in size. Policy alternatives implemented at this level have to be adapted to the specific agency and their needs
10.5 Effectiveness

Effectiveness measures how well the policy achieves the desired outcomes, in this case, the reduction of risk of injury. The primary measure to assessing effectiveness is to look at the trends in the number of STD and LTD claims. The larger the downward trend, the more effective the policy. Increasing awareness and improving communication can also be extremely important in determining the effectiveness of a program, especially one that that involves prevention.

Table 6 Criteria and Measures for Policy Alternatives Scenario

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition</th>
<th>Measures</th>
</tr>
</thead>
</table>
| Stakeholder Acceptability | The alternative should be acceptable to all parties involved including government, employers, Occupational Health and Safety Agency, WorkSafe BC, employees, and their respective unions. It must receive the appropriate amount of support for it to be successfully implemented. | • Is the alternative beneficial to all actors described in policy description?  
  • Ability of the policy to share responsibility of implementation across the board and not burden one stakeholder over another?  
  • Whether the alternative has a clear goal with a clear outcome that can create buy in. |
| Program Cost           | The alternative should be cost effective and should maximize available existing resources.                                                                                                              | • Is the alternative financially feasible to organization? [nd31]  
  • Does the alternative have make use of existing resources? [nd32]                                                                 |
| Social Cost            | The alternative should attempt to maximize the benefits to society while minimizing cost.                                                                                                                   | • Is there a secondary benefit to society from the implementation of the policy?  
  • Does the policy improve the quality of care for clients?                                                                                                           |
| Compliance             | The alternative must have compliance by all individuals and organizations involved. The must be a certain level of enforceability to ensure that the alternative is effective in achieving its desired outcome of reducing injury. | • Does the alternative must describe a mechanism that will review rates of compliance and steps that can be taken if there is a problem with participation?  
  • Does the alternative should promote accountability?  
  • Is standardization a goal of the policy?                                                                                                                             |
| Ease of Implementation | The alternative should be customized to the specific organization responsible for implementing it. The scope of the alternative must be reasonable and manageable for the organization. | • Is the complexity of the proposed alternative must be appropriate to the organization responsible for implementation?  
  • Is the period of time to implement the alternative reasonable?  
  • Is the alternative flexible and adaptable to various
Effectiveness | The alternative should ultimately reduce the number of injuries and increase the safety of the workplace for CHWs.
---|---

- Is there a noted reduction in STD and LTD claims among workers where there has been a policy alternative implemented?
- Does the alternative increases awareness of safety issues and injury reduction?
- Is there an improved level of communication among stakeholders around safety issues?

10.6 Scoring Method

I assess each alternative with a numeric scoring method for each of the measures for the criteria as follows:

1 = did not satisfy the measure
2 = partially satisfied the measure
3 = fully satisfies the measure

I tally the scores for each policy where each criterion is equally weighted. However, I believe effectiveness will be the most crucial to reducing risk and preventing injury. A discussion of the key findings from the analyzing the alternatives will be summarized. The scoring method is somewhat subjective especially in areas of cost and effectiveness. Without access to very accurate costing figures and academic studies assessing the effectiveness of the policy options, the scores assigned are based on a general knowledge gathered during the research process and the applicable case studies. I consider this when assessing the policy alternatives in the next section.
11: Assessing the Alternatives

Table 7 presents my assessment of the policy options using the measures and their numeric scores. The proposed policy alternatives were chosen because they targeted the problem from an educational and prevention perspective. The alternatives varied in scope and complexity. The policies are not exhaustive in nature, but they varied in nature, giving policy makers considerable choice when choosing which one to implement. The Scoring each alternative using very detailed criteria helps to alleviate some subjectivity.
11.1 Scoring Grid of Alternatives

Table 7 Policy Alternatives Evaluation

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Increased Knowledge and Training</th>
<th>Standardized Assessment Tool and Process</th>
<th>Enhanced Enforcement and Compliance</th>
<th>Increased Time Allotment for Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder Acceptability</td>
<td>-This policy increases knowledge and training of workers and therefore can help them to mitigate risk. This is beneficial to all parties as relies on a principle of prevention. (3)</td>
<td>-The standardized assessment tool and process would be beneficial to stakeholders clients because it improves communication between employers, employees, and the HA. (3)</td>
<td>-Enhanced enforcement could be beneficial to all parties. However, it would not be feasible for officers to visit every worksite, therefore some employers and employees may not be impacted. (1)</td>
<td>-Increasing the time allotments would benefit employees and employers. Employees would be able to work in a more relaxing and less stressful environment. Employers would benefit from having healthy and reliable employees. (2)</td>
</tr>
<tr>
<td></td>
<td>-This policy shares responsibility among OHSAAH, colleges, employers and employees (3)</td>
<td>-This policy would share responsibility among parties; however, the primary responsibility would fall on employers. (2)</td>
<td>-This policy places responsibility primarily on WorkSafe BC financially and in terms of human resource (1).</td>
<td>-This policy does not share responsibility as it places the sole financial responsibility on the provincial government. The Health Authorities and respective employers would responsible for covering additional human resources. (2)</td>
</tr>
<tr>
<td></td>
<td>-This policy has a clear goal to create a training program. There are some limitations to the alternative(1-3) as there may be barriers such as time, cost, and other obligations that prevent an employee from participating. (2)</td>
<td>-Creating a standardized risk assessment process has a clearly outlined goal that is directly related to creating awareness and preventing injury among CHWs. (3)</td>
<td>-Enhanced enforcement directly targets employers that are not providing a safe environment, However this goal does not guarantee that an employer would comply with the direction of an officer unless it was a legal order(2).</td>
<td>-This policy has a clear goal to reduce the overall workload and the time crunch that CHWs face when their time with each client is limited. Increasing the time allotted per client would help to reduce the overall stress and physical demand on employees. (3)</td>
</tr>
</tbody>
</table>

57
<table>
<thead>
<tr>
<th>Program Cost</th>
<th>Social Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Implementing a new training program could be expensive, however if delivered online or within the context of existing training opportunities costs may be reduced to a manageable level. (2)</td>
<td>-Implementing a training program doesn't have a substantial benefit to society, as the benefit is directed more at stakeholders. (1)</td>
</tr>
<tr>
<td>-This policy would make use of existing training resources at OHSAH and within colleges. Employers would require additional resources to implement the resources. (2)</td>
<td>-CHWs with improved OH&amp;S training may benefit clients as the worker will be more knowledgeable in their practice. (2)</td>
</tr>
<tr>
<td>-OHSAH has already developed a standardized assessment tool. Creating a standardized assessment process may require some additional human resources, but the costs would be quite low. (3)</td>
<td>-The alternative does have some benefit to society as a joint safety assessment process for both the client and worker may prevent some costs associated with injuries to clients in their homes. (2)</td>
</tr>
<tr>
<td>-The alternative would capitalize on existing resources such as OHSAH's standardized assessment tool. (3)</td>
<td>-This program is very beneficial to the clients as it standardizes the assessment process of the client’s home. The safety of the client may be greatly improved. (3)</td>
</tr>
<tr>
<td>-Redirecting or hiring new officers to provide enforcement would vary in cost depending on the number of officers hired. If existing officers were used it would have a moderate cost. (2)</td>
<td>-The alternative doesn't directly benefit society as it has a very specific mandate involving WorkSafe BC. (1)</td>
</tr>
<tr>
<td>-The alternative capitalizes on some existing resources; however, this alternative relies on obtaining additional human resources (recruitment of officers). (3)</td>
<td>-The program may seem intrusive to clients as it creates a climate of investigation. (1)</td>
</tr>
<tr>
<td>-Increasing funding for client care would be very costly. (1)</td>
<td>-Allotting more time to clients would be of great benefit to society. Clients with good daily support maybe able to stay in their homes longer and may need less institutional support. (3)</td>
</tr>
<tr>
<td>-This alternative would require additional human resources. As the workload per CHW would be reduced, to offset the demand, additional workers would need to be hired. (1).</td>
<td>-The program would likely increase the quality of care for clients dramatically. (3)</td>
</tr>
</tbody>
</table>
| Compliance | - Program would be both piloted and phased in over a period of time. The participation rate and effect of participation would be reviewed over time (3).  
- Alternative creates accountability among employers, educators, and employees as the education is mandatory for workers (2).  
- Program standardizes safety training and college curriculums (3). | - The program enforces mandatory participation. (3).  
- Alternative creates accountability among employers and employees as it directly tries to improve the work environment for employees by identifying risks (3).  
- The program creates standardization of the risk assessment process across the province (3). | - The program's logistical limitations (impossible for officers to work with every employer in BC) prevent a high participation rate. (2)  
- The alternative creates accountability as the officers are working with employers to improve compliance (3).  
- Standardization is not part of the program (1). | - This program does not require employee or employer participation. The policy does not directly target risk reduction through prevention. Rather the policy attempts to improve the overall working conditions for workers, thereby reducing stress created in the workplace. (1).  
- Increasing the time allotted to clients creates a sense of accountability in government. It forces the government to recognize that a certain level of funding is required to ensure a healthy workload for CHWs (2).  
- Program does not promote standardization.. (1). |
| Ease of Implementation | - This program would require many stakeholders to implement and administer implementation. Introducing new curriculum would complex in scope (1).  
- The program would take likely five to ten years to implement (1).  
- The curriculum for the training could be adapted to the needs of the provider and redesigned as necessary (3). | - This program would require coordination among employers and HA. This may prove difficult in logistical planning (2).  
- The program would take a few years to implement (2).  
- The program could be flexible in how the assessment process was carried out, however the goal of standardization may reduce some flexibility (2). | - The program would be quite manageable for WorkSafe BC if given the appropriate resources (3)  
- If funding were available, hiring the necessary officers would take less than a year (3).  
- The program could be flexible in how officers are deployed (3). | - The alternative could prove quite complex in coordinating with appropriate bodies (2)  
- Increasing funding and workforce capacity could take at least a couple of years (2).  
- The program is flexible initially, but long term may not be as flexible (2). |
| Effectiveness | - In combination with other interventions education has reduced the number of STD and LTD claims. This is supported | - A standardized risk assessment tool has proven effective at reducing the number of STD and LTD claims | - Increasing the number of officers may help to mitigate risky environments for workers; | - A Wisconsin study recommended that increasing the time per patient visit or |
by several other studies. Workers with higher levels of education also reported lower amounts of injuries (OHSAH, 2004) (3).

- Training and awareness are the primary of this alternative (3).

- The alternative does promote a climate of reporting injuries; therefore increasing communication (OHSAH, 2004) (2)

<table>
<thead>
<tr>
<th>(OHSAH, 2004). (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A standardized tool will help to improve the awareness among workers as it highlights potential risks (3).</td>
</tr>
<tr>
<td>The standardized assessment process requires the HA, employer and employee to interact, therefore increasing communication (3).</td>
</tr>
<tr>
<td>However, it is difficult to establish a direct link to the decrease of STD and LTD claims. (1)</td>
</tr>
<tr>
<td>This policy alternative will promote awareness, as one of the duties of officers is to educate (3).</td>
</tr>
<tr>
<td>Will increase communication between WorkSafe BC and employers, but may not improve communication with employees (2).</td>
</tr>
<tr>
<td>working in pairs may decrease the chance for injury (Owen and Skalitsky–Staehler, 2003) (2).</td>
</tr>
<tr>
<td>This policy doesn’t directly support an initiative to improve awareness around safety issues, although it does indirectly (2).</td>
</tr>
<tr>
<td>The policy doesn’t necessarily improve communication between employer and employees (1).</td>
</tr>
</tbody>
</table>
11.2 Key Findings

Table 8 summarizes the scores assigned in the scoring grid by each criterion. I then discuss the implications for each policy.

Table 8 Policy Alternatives Evaluation

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Increased Knowledge and Training</th>
<th>Standardized Assessment Tool and Process</th>
<th>Enhanced Enforcement and Compliance</th>
<th>Increased Time Allotment for Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder Acceptability</td>
<td>8/9</td>
<td>8/9</td>
<td>4/9</td>
<td>7/9</td>
</tr>
<tr>
<td>Program Cost</td>
<td>4/6</td>
<td>6/6</td>
<td>5/6</td>
<td>2/6</td>
</tr>
<tr>
<td>Social Cost</td>
<td>3/6</td>
<td>5/6</td>
<td>2/6</td>
<td>6/6</td>
</tr>
<tr>
<td>Compliance</td>
<td>8/9</td>
<td>9/9</td>
<td>6/9</td>
<td>4/9</td>
</tr>
<tr>
<td>Ease of Implementation</td>
<td>5/9</td>
<td>6/9</td>
<td>9/9</td>
<td>6/9</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>8/9</td>
<td>9/9</td>
<td>6/9</td>
<td>5/9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>37/48</td>
<td>43/48</td>
<td>32/48</td>
<td>30/48</td>
</tr>
</tbody>
</table>

11.2.1 Increased Knowledge and Training

- The Increased Knowledge and Training alternative scored fairly well with an overall 37 points out of 48. The alternative performed poorly in two of the five categories (cost and ease of implementation).

- The higher cost associated with the program can be primarily attributed to the administration and the development of the program. Implementing any mandatory training using standardized modules is daunting and potentially lead to a quagmire of red tape. Questions that arise can include what should be the learning objectives for the course, how many hours are required, how should the course be delivered, and how the program can be adaptable to different learning environments (college vs. field). These are all fundamental issues that account for some of the reasons as to why the Increased Knowledge and Training did not receive higher scores in these categories.

- One of the other issues that arose within this policy option was the length it would take to implement a course. Any course development at a post secondary level can require a significant amount of time to pass through the red tape of the approval process. Another
issue is that while content of the course may be standardized, the delivery can vary with each instructor.

• The greatest strength of this policy option is that it would likely receive good reception from most stakeholders and that it acts in a preventative measure by empowering CHWs to ensure that they are taking the proper measures to guarantee their own personal safety.

11.2.2 Standardized Assessment Tool and Process

• The Standardized Assessment Tool and Process received the highest score out of all the alternatives with 42 points out of a possible 48. This alternative received nearly perfect scores in all the categories except for ease of implementation.

• One of the concerns raised in the ease of implementation category included the complexity of implementing this system in every health authority, with every employer, every client and every patient. The massive nature of the project could be quite overwhelming to the parties involved [nd37] in the implementation and the project could get mired in technical and logistical difficulties ultimately defeating the entire purpose of the project. However, if the project was phased in over time it may alleviated some of the technical and logistical concerns. It is essential that a standardized tool be used in conjunction with a standard assessment process. The program is dependent on the both aspects working in tandem. The project could also take quite a few years to implement before it is running successfully throughout the province.

• An additional concern raised by the project is that in an attempt to “standardize” employers and the associated HA (managing client case assessment) may lose some of the flexibility they may have had before the implementation of the program. One of the ways to mitigate this concern is to develop a tool and process that still contains certain requirements and standards, but also allows the employer to customize it to suit the needs of a specific case.

• The greatest strength of this program is that it attempts to prevent injuries by increasing awareness. However, the alternative goes a step further than providing better education to CHWs as it attempts to bridge the communication barrier between employers, employees, the HA and the client. Many of the safety needs of the CHW are the same as those of the client. If risks can be mitigated on both fronts, the safety for both parties can improve dramatically.
11.2.3 Enhanced Enforcement and Compliance

- This alternative scored 32 out of a possible 48 points. The alternative performed poorly in the stakeholder acceptability category receiving a score of 4 out of 9. It also lost points under compliance and effectiveness.

- One of the reasons why this alternative performed poorly under the stakeholder acceptability criterion is that policy does not directly involve employees. Rather it relies on employers to ensure safety standards are maintained. Additionally, the policy relies solely on WorkSafe BC to develop and administer.

- One of the questions raised in the stakeholder interviews was the idea that it is hard to tell employers how to operate their businesses. Enforcement often brings a negative connotation – it is seen as punitive rather than preventative. In addition, efforts to increase enforcement may create a culture of opposition rather than cooperation. WorkSafe BC may be seen as the “cop” coming to enforce the law, rather than as a resource to improve working conditions for employees, (saving employers from large expenses related to injury). Even if the industry was saturated with inspection officers, it is impossible to inspect every worksite. Employers that maintain high standards are not rewarded for their commitment to safety. Should this policy be implemented it is imperative that both the education and enforcement of safety regulations are balanced.[nd38]

- The greatest strength of this policy option is that implementation in relatively quick and involves only one party responsible for the administration of the program.

11.2.4 Increased Time Allotment for Clients

- This alternative received the lowest score with 30 points out of a possible 48 Overall; the alternative received low scores in all categories except for stakeholder acceptability and social costs. The lowest scores were under program cost and compliance.

- The greatest caveat to this program is the cost. Increasing the time allotment per client would likely be quite costly to an already strapped system. Increasing the amount of time that workers spend with clients does not necessarily mitigate safety risks in the home; however, it does allow the CHW to provide care that is more thorough in a less hurried manner. Costs are also high because the system needs more CHWs in total to alleviate the workload for existing workers by allowing them more time per client. This may prove
extremely difficult unless wages rise and working conditions improve to induce more
people to become a CHW. Current demand outstrips supply, but with wages for CHWs
in the public system, there has been little incentive for people to enter this vocation. This
policy option thus requires a major change in funding.

- The alternative does not promote accountability or standardization under the compliance
category. One of the greatest problems with the policy is that it indirectly tries to reduce
injuries rather than using a direct approach.

- The most positive factor associated with this alternative is that it may improve the care
provided to clients. With improved care, the work environment for employees may
dramatically improve.
12: Recommendation

After considering the demographic data, case studies, information interviews, and policy assessment it is my recommendation that a Standardized Assessment Tool and Process program be reviewed and implemented in British Columbia. My reasoning is as follows:

- The policy received the highest score in the scoring grid and particularly under the effectiveness criterion (perfect score). The policy out performed all of its competitors.

- Four out of five interview participants agreed that assessment was vital in reducing risk and preventing injury.

- Much of the groundwork for this program has been completed by OHSAH in their “Improving the Health and Safety of Community Health Workers” study. Currently an assessment tool is available online and is available to employers. OHSAH in their study stated that one “strategy to reduce injury within the healthcare environment has been to use evidence based, systematic risk assessment tools to identify risks of injury in the workplace, with the goal of making the worker’s environment safer “ (OHSAH, 2005).

- The program is not as complex as some of the other alternatives. It capitalizes on some existing resources. It should be noted that there may be a need for more human resources to carry out the joint assessments between the HA and the employer.

- Creating a joint client and worker assessment prior to the commencement of care delivery serves to improve the safety of both parties and the overall quality of care for the patients. The quality and quantity communication between the patient and the worker may be increased.

- Finally, the project attempts to break down communication barriers and increase awareness every time a worker enters a new worksite. This repeated process is fundamental, the more it is practiced the more it becomes routine. The program also attempts to involve all stakeholders and does not burden one party more than another.
12.1 Further Steps and Limitations of Alternatives

The Standardized Assessment Tool and Process achieved the highest ranking in the comparison evaluation of the alternatives. However, it should be noted that it is not the only viable policy alternative. A combination of all alternatives would likely have the most impact on reducing risk because each targets the problem from a different perspective. The following suggestions are some possible ways that the other alternatives could be incorporated:

- Using a standard OH&S course as described under the Increased Knowledge and Training alternative could introduce students to the Standardized Assessment Tool and Process to familiarize them with the process of assessing risk prior to the start of working in a new place. The more familiar a worker is with the tool, the more likely they will remember the key components while working. Assessing for risk needs to be completed on a continuous basis as the work environment can change daily.

- Increasing the time allotted to clients could be beneficial to more than just employees and employers. The quality of care for clients could be dramatically improved if CHWs were given time to care. CHWs could attend to both the physical and emotional needs of clients. Instead of implementing an overall increase in allotted time, clients identified with increased needs (highly acute patients, complex psychological issues, and clients that are physically difficult to move) may benefit from more time from a CHW. High needs clients often place extraordinary demands on clients, therefore having more time to care for them, may make it easier on workers. This option may actually be the most beneficial policy to CHWs in the long run as it would dramatically change the work environment, giving workers more breathing room.
• Enhanced Enforcement is also another very important component of reducing risk. Enforcement is a key component in any safety program. Legislation, policy, and programs are only as strong as those who implement them. Having a third party to enforce them can be equally important. Increasing officers dedicated to investigating community care could be done on a smaller scale than proposed in the original policy. Dedicating the time of one WorkSafe BC officer could be done on a trial basis for six months.

There are certain limitations to each of these alternatives. The alternatives have not been implemented on a jurisdictional basis; therefore, their long-term effectiveness has not been measured. Costs for each of these alternatives may vary and specific dollar costs were too difficult to establish for the scope of the project. I have attempted to address some of the logistical challenges associated with each alternative; however, there can be unforeseen challenges that arise even after implementation. This study has attempted to address the prevention of injuries; however, it has not addressed reducing the impact of injuries that do occur. For example, it is important there are programs available to workers that help them get back to work at an earlier date and to reduce the long-term effects of injury.

The alternatives proposed in this study have not undergone rigorous scientific trials that may be able to evaluate the efficacy of a program like a Standardized Risk Assessment Tool and Process. It is important that before any of these programs are implemented that they are reviewed by an organization like OHSAH, where professional occupational hygienists and ergonomists can evaluate their ability to potentially reduce injury.

Finally, one of the limitations of my study was the fact that I did not interview workers themselves. I felt that the demographic data and a stakeholder interview with Mona Sykes from BCGEU would provide sufficient representation. In hindsight a survey of CHWs surrounding the proposed policy options may have actually changed my recommendations. Ultimately, the
recommendations I have made are based on balancing factors such as cost and effectiveness. Implementing the Standardized Tool and Assessment Process alternative may be the most effective solution in the short term. However, over the long run, factors such as the funding of community care, wages, benefits, training, and job security may be more beneficial in the attempt to reduce risk and the costs associated to injuries and illness incurred by CHWs. My recommendation is that the entire community care system in BC needs to be examined as the demand for community health workers increases with an aging population.
13: Conclusion

Community care is a vital service in our healthcare system in British Columbia. It is imperative that the Government and associated Health Authorities provide high quality and accessible care to clients that require community care services. One of the major hurdles looming on the horizon is to ensure that there is a workforce to fulfil the needs of an aging population. As health care continues to evolve and the epidemic of chronic illness rises, we will become increasingly dependent on providing care – especially in a community setting. Often we overlook the non-medical needs of clients and focus more on the direct medical requirements of clients. However, we must ensure that the client is living in a safe and hygienic environment. Clients continue to have daily needs (such as personal hygiene, nutrition, and home maintenance) that are met by CHWs.

In this study, I have examined the role of the CHW in the community. CHWs often face hazardous, isolated, and uncontrolled work environments in the private homes of clients. The duties they perform as physically demanding and often exhausting. CHWs are very susceptible to injury and face high rates of MSI. Some of the other challenges they face in the workplace can include aggressive patients and slippery surfaces. Organizational challenges such as recruitment, retention, low wages, and a lack of OH&S can also affect the well-being of workers.

In order to reduce the risk of injury in the workplace for CHWs I evaluated four policy alternatives: Increased Knowledge and Training, Standardized Assessment Tool and Process, Enhanced Enforcement and Compliance and Increased Time Allotment for Clients. These policy alternatives were derived from the demographic data I reviewed, case studies, and interviews. In the end, the most appropriate policy alternative was the Standardized Assessment Tool and Process for several reasons. The alternative was based on an existing pilot project conducted by
OHSAH, is capitalized on existing resources, it involved a variety of stakeholders (shared responsibility) and it addressed risk reduction from a prevention standpoint. It is critical for the future of community care in BC that there is a stable workforce, CHWs have a safe and happy work environment, and that clients receive adequate care according to their needs.
## Appendix A

### Table 9 Summary of Community Support Services in British Columbia

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Services</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Support</strong></td>
<td>Bathing, dressing, grooming, and light cleaning to maintain a safe living environment.</td>
<td>Client eligibility is determined by a Case Manager.</td>
</tr>
<tr>
<td><strong>Choices in Support for Independent Living (CSIL)</strong></td>
<td>Self managed care model that is designed to give clients choice in their care. Clients are given a set of funds to hire staff and manage the necessary care.</td>
<td>Clients are eligible for CSIL if they require daily personal assistance and if they have the ability to manage all areas of their care. Groups of five individuals can set up as a non-profit society and manage the funds on behalf of a client. Certain conditions allow for family members to be paid for taking care of clients.</td>
</tr>
<tr>
<td><strong>Community Nursing and Rehabilitation</strong></td>
<td>Registered therapists and nurses provide medical care (non-emergency) as well ensure that words missing</td>
<td>Care is provided to British Columbians that need chronic, acute, and palliative care.</td>
</tr>
<tr>
<td><strong>Adult Day Programs</strong></td>
<td>Programs offer personal care services, recreation, caregiver support, and in some centers transportation and meals.</td>
<td>Provide care to both seniors and adults with disabilities.</td>
</tr>
<tr>
<td><strong>Care Giver Respite</strong></td>
<td>Provides relief and respite to informal care givers such as family or friends.</td>
<td>Provided to clients who are receiving informal care.</td>
</tr>
<tr>
<td><strong>End of Life Care</strong></td>
<td>Provides care to terminally ill clients.</td>
<td>Eligibility is determined by a physician when it has been determined that a client has less than six months to live.</td>
</tr>
<tr>
<td><strong>Assisted Living Residence</strong></td>
<td>This level of care provides accommodations to clients who remains independent but needs services such as meal preparation, daily grooming, 24 response, and housekeeping.</td>
<td>This type of care is available to clients who still have the ability to make informed decisions about their care, who can communicate with staff, and can use a 24 hour response system.</td>
</tr>
<tr>
<td><strong>Facility Care</strong></td>
<td>Facility care provides complex 24 hour personal and nursing care.</td>
<td>Priority is given to seniors and individuals with disabilities.</td>
</tr>
</tbody>
</table>
hour personal and nursing care to patients who are no longer able to look after themselves.


Eligibility for Care

To be eligible for occupational therapy, nursing care, or rehabilitation therapy clients need to meet the following criteria:

- be a resident of British Columbia;
- be a Canadian Citizen or have permanent resident status*; and
- require care following discharge from an acute care hospital, care at home rather than hospitalization or care because of a terminal illness.

To be eligible for services that are subsidized, such as home support, assisted living, adult day care, case management, residential care services and/or palliative care services, clients must:

- 19 years of age or older;
- have lived in British Columbia for the required period of time
- Canadian Citizen or have permanent resident status; and
- be unable to function independently because of chronic, health-related problems or
- have been diagnosed by a doctor with an end-stage illness.

(Government of British Columbia, 2004)
## Appendix B

### Table 10 Accident Types Health and Community Support Service Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Accident Type</th>
<th># STD/LTD/FTL Claims</th>
<th># STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overexertion</td>
<td>1,243</td>
<td>39%</td>
<td>$5,912,082</td>
<td>38%</td>
<td>55,041</td>
</tr>
<tr>
<td>Fall on Same Level</td>
<td>405</td>
<td>13%</td>
<td>$2,444,542</td>
<td>16%</td>
<td>16,418</td>
</tr>
<tr>
<td>Bodily reaction</td>
<td>380</td>
<td>12%</td>
<td>$1,647,149</td>
<td>11%</td>
<td>13,067</td>
</tr>
<tr>
<td>Bodily reaction and exertion, NEC</td>
<td>274</td>
<td>9%</td>
<td>$1,824,992</td>
<td>12%</td>
<td>15,284</td>
</tr>
<tr>
<td>Struck by object</td>
<td>141</td>
<td>4%</td>
<td>$424,824</td>
<td>3%</td>
<td>3,119</td>
</tr>
</tbody>
</table>

*Source: WorkSafe BC Data Warehouse Health and Community Support Service Workers Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))*

### Table 11 Nature of Injury Health and Community Support Service Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Nature of Injury</th>
<th># STD/LTD/FTL Claims</th>
<th># STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sprains, strains, tears</td>
<td>2,356</td>
<td>75%</td>
<td>$10,623,567</td>
<td>68%</td>
<td>92,513</td>
</tr>
<tr>
<td>Bruises, contusions</td>
<td>185</td>
<td>6%</td>
<td>$369,951</td>
<td>2%</td>
<td>3,246</td>
</tr>
<tr>
<td>Nonspecific injuries and disorders</td>
<td>111</td>
<td>4%</td>
<td>$306,455</td>
<td>2%</td>
<td>2,661</td>
</tr>
<tr>
<td>Other injuries to muscles, tendons, ligaments, joints, etc. not classified</td>
<td>90</td>
<td>3%</td>
<td>$856,354</td>
<td>6%</td>
<td>8,450</td>
</tr>
<tr>
<td>Fractures</td>
<td>74</td>
<td>2%</td>
<td>$1,027,423</td>
<td>7%</td>
<td>6,458</td>
</tr>
</tbody>
</table>

*Source: WorkSafe BC Data Warehouse Health and Community Support Service Workers Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))*
Table 12 Body Part Affected Community Support Services Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Body Part</th>
<th>STD/LTD/FTL Claims</th>
<th>STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount $</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back, including spine, spinal cord</td>
<td>1,126</td>
<td>36%</td>
<td>$4,519,352</td>
<td>29%</td>
<td>40,713</td>
</tr>
<tr>
<td>Multiple Body Parts</td>
<td>454</td>
<td>14%</td>
<td>$2,602,539</td>
<td>17%</td>
<td>20,147</td>
</tr>
<tr>
<td>Shoulder, including clavicle, scapula, and trapezius muscle if should is mentioned</td>
<td>285</td>
<td>9%</td>
<td>$2,760,058</td>
<td>18%</td>
<td>21,930</td>
</tr>
<tr>
<td>Leg(s)</td>
<td>199</td>
<td>6%</td>
<td>$1,043,686</td>
<td>7%</td>
<td>7,650</td>
</tr>
<tr>
<td>Multiple trunk locations</td>
<td>127</td>
<td>4%</td>
<td>$553,001</td>
<td>4%</td>
<td>5,375</td>
</tr>
</tbody>
</table>

Source: WorkSafe BC Data Warehouse Health and Community Support Service Workers Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))

Table 13 Source of Injury Community Support Services Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Source of Injury</th>
<th>STD/LTD/FTL Claims</th>
<th>STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount $</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-other than injured or ill worker</td>
<td>1,125</td>
<td>36%</td>
<td>$5,811,505</td>
<td>37%</td>
<td>51,478</td>
</tr>
<tr>
<td>Person-injured or ill worker</td>
<td>551</td>
<td>18%</td>
<td>$2,773,887</td>
<td>18%</td>
<td>21,386</td>
</tr>
<tr>
<td>Floors, walkways, ground surfaces</td>
<td>457</td>
<td>15%</td>
<td>$2,994,612</td>
<td>19%</td>
<td>20,973</td>
</tr>
<tr>
<td>Other tools, instruments, equipment</td>
<td>234</td>
<td>7%</td>
<td>$1,345,579</td>
<td>9%</td>
<td>11,993</td>
</tr>
<tr>
<td>Highway vehicle, motorized</td>
<td>155</td>
<td>5%</td>
<td>$531,012</td>
<td>3%</td>
<td>4,829</td>
</tr>
</tbody>
</table>

Source: WorkSafe BC Data Warehouse Health and Community Support Service Workers Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))
### Table 14 Accident Type Children and Home Support Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Accident Type</th>
<th>STD/LTD/FTL Claims</th>
<th># STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overexertion</td>
<td>523</td>
<td>46%</td>
<td>$3,599,650</td>
<td>50%</td>
<td>30,018</td>
</tr>
<tr>
<td>Fall on Same Level</td>
<td>147</td>
<td>13%</td>
<td>$830,542</td>
<td>12%</td>
<td>6,541</td>
</tr>
<tr>
<td>Bodily reaction</td>
<td>102</td>
<td>9%</td>
<td>$321,061</td>
<td>4%</td>
<td>3,195</td>
</tr>
<tr>
<td>Bodily reaction and exertion, NEC</td>
<td>71</td>
<td>6%</td>
<td>$517,811</td>
<td>7%</td>
<td>2,950</td>
</tr>
<tr>
<td>Struck by object</td>
<td>47</td>
<td>4%</td>
<td>$269,183</td>
<td>4%</td>
<td>1,996</td>
</tr>
</tbody>
</table>

Source: WorkSafe BC Data Warehouse Children and Home Support Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))

### Table 15 Nature of Injury Children and Home Support Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Nature of Injury</th>
<th>STD/LTD/FTL Claims</th>
<th># STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sprains, strains, tears</td>
<td>851</td>
<td>74%</td>
<td>$5,277,714</td>
<td>73%</td>
<td>43,183</td>
</tr>
<tr>
<td>Bruises, contusions</td>
<td>70</td>
<td>6%</td>
<td>$281,358</td>
<td>4%</td>
<td>1,826</td>
</tr>
<tr>
<td>Nonspecific injuries and disorders</td>
<td>44</td>
<td>4%</td>
<td>$196,768</td>
<td>3%</td>
<td>1,608</td>
</tr>
<tr>
<td>Other injuries to muscles, tendons, ligaments, joints, etc. not classified</td>
<td>38</td>
<td>3%</td>
<td>$244,584</td>
<td>3%</td>
<td>2,308</td>
</tr>
<tr>
<td>Fractures</td>
<td>27</td>
<td>2%</td>
<td>$250,902</td>
<td>3%</td>
<td>2,466</td>
</tr>
</tbody>
</table>

Source: WorkSafe BC Data Warehouse Children and Home Support Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))
Table 16  Affected Body Part and Home Support Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Body Part</th>
<th># STD/LTD/FTL Claims</th>
<th># STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount(^{\dagger})</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back, including spine, spinal cord</td>
<td>417</td>
<td>36%</td>
<td>$1,942,574</td>
<td>27%</td>
<td>16,570</td>
</tr>
<tr>
<td>Multiple Body Parts</td>
<td>167</td>
<td>15%</td>
<td>$1,254,971</td>
<td>17%</td>
<td>10,369</td>
</tr>
<tr>
<td>Shoulder, including clavicle, scapula, and trapezius muscle if should is mentioned</td>
<td>114</td>
<td>10%</td>
<td>$1,035,347</td>
<td>14%</td>
<td>9,041</td>
</tr>
<tr>
<td>Leg(s)</td>
<td>64</td>
<td>6%</td>
<td>$450,360</td>
<td>6%</td>
<td>4,347</td>
</tr>
<tr>
<td>Arm(s)</td>
<td>55</td>
<td>5%</td>
<td>$782,214</td>
<td>11%</td>
<td>4,596</td>
</tr>
</tbody>
</table>

Source: WorkSafe BC Data Warehouse Children and Home Support Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))

Table 17  Source of Injury and Home Support Classification Unit 2001-2005

<table>
<thead>
<tr>
<th>Source of Injury</th>
<th># STD/LTD/FTL Claims</th>
<th># STD/LTD/FTL Claims % of Total</th>
<th>Claim Cost Total Amount(^{\dagger})</th>
<th>Claim Cost Total Amount %</th>
<th>Days Lost Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-other than injured or ill worker</td>
<td>446</td>
<td>39%</td>
<td>$2,900,485</td>
<td>40%</td>
<td>23,968</td>
</tr>
<tr>
<td>Floors, walkways, ground surfaces</td>
<td>173</td>
<td>15%</td>
<td>$716,576</td>
<td>10%</td>
<td>7,039</td>
</tr>
<tr>
<td>Person-injured or ill worker</td>
<td>172</td>
<td>15%</td>
<td>$1,128,868</td>
<td>16%</td>
<td>8,591</td>
</tr>
<tr>
<td>Other tools, instruments, equipment</td>
<td>77</td>
<td>7%</td>
<td>$561,379</td>
<td>8%</td>
<td>5,343</td>
</tr>
<tr>
<td>Highway vehicle, motorized</td>
<td>48</td>
<td>4%</td>
<td>$368,811</td>
<td>5%</td>
<td>3,768</td>
</tr>
</tbody>
</table>

Source: WorkSafe BC Data Warehouse Children and Home Support Classification Unit 2001-2005 (Short Term Disability (STD), Long Term Disability (LTD) and Fatality Claims (FTL))
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