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**'I wouldn't choose this work again':
Perspectives and Experiences of Care Aides in Long-term Residential Care**

ABSTRACT

Aims: To provide insight into the everyday realities facing care aides working in long-term residential care (LTRC), and how they perceive their role in society.

Design: A qualitative ethnographic case study.

Methods: Data were collected over ten months of fieldwork at one LTRC setting [September 2015- June 2016] in Western Canada; semi-structured interviews (70 hours) with 31 care aides; and naturalistic observation (170 hours). Data were analysed using Reflexive Thematic Analysis.

Results: The findings in this work highlight the underpinned ageism of society, the gendered work of body care, and the tension between the need for relational connections- which requires time- and economic profit. Four themes were identified, each relating to the lack of training, support and appreciation care aides felt regarding their role in LTRC.

Conclusion: Care aides remain an unsupported workforce that is essential to the provision of high-quality care in LTRC. To support the care aide role suggestions include: (i) regulate and improve care aide training; (ii) strengthen care aides autonomy of their care delivery; (iii) reduce stigma by increasing awareness.

Impact:

- **What problem did the study address?** The unsupportive working conditions care aides experience in LTRC and the subsequent poor quality of care often seen delivered in LTRC settings.
- **What were the main findings?** Although care aides express strong affection for the residents they care for, they experience insurmountable systemic and institutional barriers preventing them from delivering care.
- **Where and on whom will the research have impact?** Care aides, care aide educators, care aide supervisors and managers in LTRC, retirement communities, and home care settings.

Key words: care aides, healthcare aides, long-term residential care, nursing, working conditions, work satisfaction, older adults, dementia, moral distress, qualitative research

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Main paper

1. INTRODUCTION

Long-term residential care (LTRC) facilities provide care for the most vulnerable individuals in society, including the oldest old and those living with the later stages of dementia. Even prior to the COVID-19 pandemic, the quality of care delivered in LTRC was an international concern, prompting a global agenda for research and practical improvements (Rolland et al., 2014; Shippee et al., 2017; Tolson et al., 2011). As highlighted by Estabrookes and colleagues (2000), over 100 published reports, in the past 50 years, all from high-income countries have been developed, each stressing the poor conditions of care in LTRC.

During the COVID-19 pandemic a strengthened wave of concern has emerged regarding the current dire state of LTRC (Davidson & Szanton, 2020; Estabrookes et al., 2020; Van Houtven et al., 2020). This has also emphasized the importance of the care aide role, the most prominent healthcare member in LTRC. Care aides deliver upward of 90% of the direct care and therefore holding significant potential for impacting residents' quality of life (Bowers et al., 2003; Caspar et al., 2016; Estabrookes et al., 2015). This paper presents the results of an in-depth ethnographic case study of the everyday experiences and perspectives of care aides and their perceptions of their role within society.

2. Background

2.1 Scope and role ambiguity

Care aides are consistently reported as an understudied workgroup (Caspar et al., 2016; Chamberlain et al., 2017; Cooper et al., 2016; Estabrookes et al., 2015; Mallidou et al., 2013; Scales et al., 2017). Although it is widely understood that care aides, often called health care aide, personal support worker, care assistant, health assistant, nursing assistant, or nurses' aide, are the backbone of the healthcare team in LTRC, there are several critical gaps in our knowledge regarding this profession (Caspar et al., 2016; Ginsburg et al., 2016; Zysberg et al., 2019).

A vital issue is the ambiguity around the scope of the care aide role. The title of care aide has no clear definition and can refer to a diverse and inconsistent range of responsibilities, scope, roles, and authority in LTRC (Zysberg et al., 2019). In general, care aides deliver much of the direct care to LTRC residents, including assisting with personal hygiene, dressing, repositioning, feeding, toileting, and providing emotional support. Yet, due to labour force shifts, a declining workforce (van der Borg et al., 2017) and the growing complexity of care needed (Alders et al., 2019) the duties of care aides have been expanded (Berta et al., 2013) and there is no standardized definition of their scope of practice.

2.2 Understudied and unregulated

The perspective and experiences of care aides directly affect their job performance, and thus, the quality of care delivered to residents (Kinjerski & Skrypnek, 2008). Care aides have a unique insight into the lives of residents in LTRC and the factors that may impede or enhance the delivery of high-quality care (Talbot & Brewer, 2016). Understanding care aides' perspectives and experiences can substantially contribute to the knowledge of good practices within LTRC.

However, despite the increasing importance of their role, care aides are usually unlicensed, considered non-professionals, and have no standardized job description (Estabrooks, et al, 2020). This ambiguity adds to misunderstanding and inconsistency in what the care aide role entails. In Canada, only one province (British Columbia) has made enrollment in a registry mandatory, and this is only for care aides who work in publicly funded organizations (Chamberlain et al., 2019). Berta and colleagues (2013) emphasize that it is nearly impossible to supply Canada's growing and increasingly complex LTRC system without systematic data collection of care aides.

2.3 An arduous, gendered occupation

Care aides in high-income countries are a workforce, prominently made up of migrant women (Adebayo et al., 2019; Fujisawa & Colombo, 2009). In British Columbia, where the present study was conducted, care aides are typically female, over the age of 40 and speak English as a second language (Health Employers Association of BC, 2014; Hewko et al., 2015). Care aides in general also have the lowest level of education, receive the lowest salary, and have the least autonomy in their role (Andersen, 2009; Caspar et al., 2016). They also consistently report persistent concerns over the adequacy of their training (Rolland et al., 2014; Yeatts et al., 2010). On the job in LTRC, care aides may experience daily verbal abuse and violence from residents (Brophy et al., 2019). Alongside this, they are seen as the lowest member in the healthcare hierarchy; and often experience bullying and incivility in their role (Cooke et al., 2019). They experience high rates of burnout and turnover (Chamberlain et al., 2017), as well as moral distress (Braedley et al., 2018). They frequently report that their care is rushed and that, due to lack of time, tasks are omitted, such as speaking with residents and helping with mobility (Knopp-Sihota et al., 2015). Alongside these issues, there is international concern for this role.

2.4 Global shortage

There is an increasing shortage of care aides required to meet the needs of an ageing population. Due to subsequent changing family characteristics (Cylus et al., 2019), and projected shortages of formal and informal carers (Hashiguchi, & Llana-Nozal, 2020), the global demand for LTRC is expected to remain one of the essential features of a high income countries' healthcare system (Muir, 2017). Yet, as the recent COVID-19 pandemic has shown, failing to address staffing issues and care practices in LTRC is a serious public health issue that puts both residents and staff at risk for infection and maltreatment (Davidson & Szanton, 2020).

The picture is not all negative though. A longitudinal research program in Western Canada, TREC, found that care aides report high levels of professional efficacy (Chamberlain et al.,

2019). In a recent meta-analysis, Costello et al., (2019) found that although staff in LTRC in general report moderate levels of emotional exhaustion, and low depersonalization they do report moderate personal accomplishment. At present, very few studies have focused on the unique perspectives and experiences care aides hold regarding their role in LTRC and how they believe their role is perceived in society. The value of such a study lies in providing knowledge that can inform policies and practices aimed at improving support for care aides to enhance their provision of good quality care.

3. THE STUDY

3.1 Aims

To examine the realities of the complexity and working condition of care aides in LTRC and how they perceive their role in society.

3.2 Design

An ethnographic study was designed to achieve an in-depth understanding of the perspectives and experiences care aides had of their role within LTRC, and society at large. Ethnography was used because it aims to create an understanding of those being studied in their natural environments and requires intensive fieldwork to gain a comprehensive and detailed view of a social group and its interactions within its social and cultural setting (Savin-Baden, 2013). Data was generated through semi-structured interviews and naturalist observations with 31 care aides located in one care home.

3.3 Setting

The site of this ethnography, Green Lodge (pseudonym) is a publicly funded LTRC setting in rural Western Canada, situated within a larger, privately funded facility. The LTRC area is on the third floor of this facility, with the first and fourth floor as independent living and the second floor assisted living. The LTRC area housed 230 residents, approximately 190 of whom are living with dementia and employs another 220 individuals, 71 of whom are care aides. Two elevators, side by side, allow access to Green Lodge, with the nurses' station directly to the left of the elevator doors and the residents' dining area on the right. All meals were brought up from the kitchen on the first floor. Most residents' rooms had access to a window and all residents had access to the lounge across from the nurse's station.

3.4 Study Participants

The participant group for this study was care aides employed at Green Lodge. Participants received no personal benefit from participation; however, interviews were conducted during their work time with the consent of their employers, and without their pay or worktime being reduced.

Extra staff were scheduled to cover the care aides who would be unable to complete tasks during their interviews.

The inclusion criteria for participants was that they must be employed as a care aide in the LTRC floor at Green Lodge and they must have experience delivering care to a resident. The only exclusion criteria were if they were unable to speak conversational English. No care aide was excluded based on their English skills.

3.5 Data Collection

Data were gathered by the first author [redacted] over a ten-month fieldwork period (September 2015- June 2016) and involved semi-structured interviews, naturalistic observations, and field notes. In total, 31 interviews were conducted, and 170 hours of participant observations. This took place over a full 24-hour schedule which included 27 days and three nights at Green Lodge.

Recruitment:

Initially, participants were approached about the study with a study information sheet and an in-person meeting with the researcher. With the managers support, the researcher introduced herself to the care aides and presented the research during shift changes at Green Lodge. Potential participants were identified by managers or self-identified themselves to managers or the researcher. The researcher used convenience sampling for the first few interviews to gain rapport with the care aide population at Green Lodge. Finally, maximum variation sampling was used for number of years of care aide experience, gender, ethnicity, shiftwork and age (Palinkas et al., 2015).

A total of 31 care aides at Green Lodge were interviewed. Participants were aged between 26 to 55 years (average 42 years), twenty-six identified as female and five as male. Participants had two months to 32 years' experience working in LTRC (average = 9 years) and had worked in 2 to 8 different LTRC settings (mean = 2.5 facilities). Twenty-six participants identified as White, two as Filipino, one as First Nation, one as Hispanic, and one as Chinese.

Semi-structured interviews

Eight open-ended questions about the care aide perspectives and experiences were used to facilitate conversation. Questions pertained to: (i) why they became a care aide; (ii) a description of their recent shift; (iii) a description of a resident they particularly enjoy caring for, and one that may be difficult to care for; (iv) a staff member they enjoy working with, and one that they may find difficult to work with; (v) a situation where they could delivery care they were proud of and a situation where they were not able to. Each interview evolved into a different conversation, depending on the participants experiences.

Participant observations

Observations were a necessary method to observe interactions between care aides and residents, fellow staff members, and guests in the LTRC setting. The researcher designed an observation schedule built on from previous ethnographic research that focused on staff in LTRC (Baumbusch, 2008; Caspar, 2014; Kelson, 2013) but not on the perspective and experiences of care aides. The observation schedule followed naturalistic inquiry methods by Lincoln and Guba (1985) and allowed [redacted] to free text write at the time of the observation about who care aides were interacting with, what roles they completed and how others interacted with the care aides. In total, 170 hours of observations were conducted with participants over the course of 27 days and three nights. Observations took place in public areas such as hallways, receptions, lounges as well as residents' rooms and staff meeting rooms. This process allowed [redacted] to document everyday observations of occurrences and norms, as well as the thoughts and impressions of these observed events and interactions, which allowed for the process of critical analysis.

Field notes

After each interview and observation was completed, field notes were immediately compiled by [redacted]. Specific categories guided the writing: (i) what events were witnessed; (ii) who was present, and; (iii) interactions between care aides and other members of staff, residents and guests to Green Lodge. Data elicited from field notes comprised descriptions of the interview and observation events and was used to complete the coding of all subsequent data (Lincoln, 1985)

Ethical considerations

Ethical approval for this study was received through both the university and the health authority Research Ethics Board.

Data analysis

Interviews were audio-recorded and transcribed verbatim. After an initial listening/reading of transcripts they were coded using NVivo 10 qualitative analysis software (QSR International Pty Ltd. NVivo, 2014). Through an iterative process of reading and re-reading the text, the codes were then organised into emergent themes by the first author, who regularly consulted with the rest of the authors, with themes influencing subsequent coding and recoding (Braun & Clarke, 2006, 2014, 2019). Interviews continued until data saturation was reached when no new information or themes emerged (Patton, 2002). This was a reflexive team process, where all authors contributed to the reviewing and questioning of the codes, potential themes, and final themes. The analytical process is described in detail below.

The first phase of the thematic analysis is familiarisation with the data. Interviews and field notes were repeatedly read by the first author to become better acquainted and gain an overall understanding of the data. This helped with the nuances of language. This process started after all the interviews were conducted. In the second phase, initial codes were generated based on the familiarisation of the data from interviews and observations. Field notes were analysed using the same initial themes identified from the interviews. In phase three, themes were generated by collating codes into potential themes. At this stage, some themes were disbanded, and some were re-collated based on how often they were brought up in the data and the emphasis of which they were mentioned by participants. This was followed by the fourth phase, where themes were reviewed to check whether they related to the coded extracts and to assure internal thematic coherence. In phase five, themes were defined and named. In phase six, the findings were written up, and comprehensive themes were created, based on the perspectives and experiences of the participants.

Validity and Reliability/Rigour

To ensure the data was trustworthy, the researchers used the criteria set out by Guba and Lincoln (1989). The data was gathered over ten months, a relatively long period, in order to ensure credibility. Multiple methods, including interviews and observations, were used to collect data. Discussions with research peers specialising in other areas of LTRC were regularly performed (on average once every three weeks), to ensure assumptions and biases were kept at bay. In a similar way, the first author was engaged and immersed in data gathering and data analysis, which is essential for building trust in ethnographic studies (Speziale & Carpenter, 2011). The research process was recorded and reported accurately to ensure the reliability of data.

FINDINGS

The aim for this study was examining the realities of the complexity and working condition of care aides in LTRC and how they perceived their role in society. As seen in *Table 1 Summary of Findings*, the Thematic analysis of the interviews and observations, four main themes were identified which highlighted the systemic barriers care aides experience and helped to articulate how care aides make sense of their work.

Table 1 Summary of Findings is attached separately

Unprepared for the work: "Going in blind"

The training care aides received was disregarded once in the LTRC setting, or viewed as irrelevant, leaving them unprepared for the realities of their role. Participants faced a steep learning curve to bridge the gap between their training and their role. As one participant reported, not only did she not "*know anyone who had this job before,*" but she also "*went in kind of blind*" [P18-53; 02/09/16]. During training the students worked with "*maybe four or five residents*", yet when she entered LTRC she "*immediately had 12 residents to work with*" [P18-85; 02/09/16]. On the job training was needed to supplement inadequate formal training. As a participant with less than six months' experience shared:

I haven't learned about lots in school, but it's just—oh, they didn't teach about all that when I went to school. So, when I came here, it was just like, shit—they didn't prepare me whatsoever. But I mean, all the staff here helped me out [P33-95; 06/07/16].

Although they felt unprepared, many care aides spoke to learning on the job, especially from other staff. In addition to feeling unprepared, participants had to quickly learn to cope with inadequate staffing to resident ratios. As one participant stated, "*For the last rotation I was on, I think we were short three out of my five days*" [P25-101; 03/03/16]. In this way, 'normal' capacity is working short-staffed, but this is not what the care aides were prepared for during their training, nor is it what they were expecting when they pursued this career.

While positive mentoring experiences did take place, participants reported working with more experienced care aides who were either unwilling or unable to help them in their new role. A participant shared the following example of when he started at Green Lodge 13 years earlier:

[When] I first started here.. I was brand new to these residents. I asked [another care aide], "What can you tell me about this person?..." "I don't know. Find out yourself." That's the response I got . . . from the person who's been around for a long, long time... [P6-1595; 09/08/15].

Participants shared how they were taught "*the dance*," the point of which is to avoid developing relationships with those in their care:

There's lots of aspects that you learn [in school], and one of them is the dance, where they say, "Don't get too involved in relationships with residents." They call that "the dance." There's a whole book on it....And it's just about getting involved with the residents but not getting too deeply involved, because it's not your place to get too involved. The family is the ones that should be involved and when—if anything happens to the resident, then you don't want to be emotionally dragged into it. ... [P8-225; 09/08/15].

The dance led to what participants described as an awkward juxtaposition between what they were taught to do and the reality of the intimate relationships they develop with residents. Even though care aides have been taught and encouraged not to form relationships with residents, they often explained that this is inevitable.

I am extremely resident-focused. They're like my extended family. I take my job as a privilege. I'm very honored that I am allowed to become adoptive family to people, that people trust me with their loved ones' lives... It's mostly why I'm here... It certainly isn't for the salary [P11-79; 09/10/15].

With such emotional connections for their residents, it is disconcerting for care aides to know that they have entered their role blind to the realities of their care needs, inadequately trained for the scope of their role and placed in a tenuous position of caring.... but not caring too much.

Feeling Powerless: "Screaming into the void"

Many participants shared their experience of having a lack of voice and the dismissal of experiential knowledge. They felt largely unheard and powerless in the organisational structure because of their role. Even though most felt that they knew their residents needs best, participants reported feeling dismissed among the healthcare team. For example, one participant describes the experience of sharing her perspective of a resident's ailment to the staff nurse only to have it disregarded as not important to the care of the resident. "*...it just makes me really sad. It sucks that I can't do anything to help...*" [P34-1468; 06/08/16], and when she tries to offer her intimate knowledge of what the resident may need, she shared that the nurses would tell her, "*Well, you're a care aide.*" [P34-1504; 06/08/16].

Participants felt a boundary drawn by other members of the healthcare team in relation to what care aides could possibly know, and the physical maintenance of resident's care needs. As is highlighted by a care aide with ten years' experience, their role is different, less technical, than that of other health professionals such as nurses, but it is still vital and in need of acknowledgement, "*We may not be a nurse or anything like that, but ..., the care aides are the ones that are keeping [the residents] alive*" [P22-2073; 02/12/16].

They reported feeling powerless and voiceless when it comes to the decisions and maintenance of their residents' care routines as well as when they feel residents were potentially be put in precarious situations.

"It feels a lot like you're screaming into the void a lot of the time. Something's going on. You know something is going on. You say something about it. And you just don't get an answer, or you'll kind of get this non-committer, like, "Oh, yes, we'll look into it. We had a situation with a staff member who was harassing employees and being abusive towards residents. I worked with him for three years... [I was] reporting him the whole time...And every time I said something -- Honestly I directly emailed the [Director of Care] ... and said, "Look. This is happening." She just didn't answer me. I never got an email back" [P34-1522; 06/08/16].

Participants shared feeling powerless regarding the distribution of their time, and protecting their residents from potentially harmful events. Participants described how the policies determining the allocation of their time, often presented as checklists outlining what tasks must be completed, did not reflect what they perceived as the most critical tasks at hand and in reality, inhibited their delivery of 'good' care. Once again, the tension between relational caring and a focus on task-based duties was identified as underpinning the day-to-day experiences of the care aide role. This leads to the third theme.

The illusive pursuit of respect: Caring in a stigmatised role

There was a stark juxtaposition between how care aides viewed their role and how they thought society viewed their role. Participants shared a collective sense that the greater society does not know what their role entails and constantly focuses on toileting and cleaning residents,

Researcher: Do you feel like people know what you're doing?

Care aide: They probably have an idea but they probably don't know exactly what we do....Like some of them call us butt wipers, you know, so [laughs] --...It's like, "Yes, okay, but that's not all we do." [P22-1270; 03/03/16].

Another participant shared an experience when a male friend of his came and visited him after many years and his initial reaction to his current occupation as a care aide.

I actually met an old friend of mine. I haven't seen him for six, seven years ... And they came to our house last week. And he said to me, "So, I hear you're a professional ass wiper now." "You're an ass wiper." And that's the connotation attached to this job, you see? [P8-1366; 09/08/15].

Within the LTRC setting, care aides are often not viewed in a positive light, as is evident from the following excerpt in observational field notes:

"The hairdresser [at Green Lodge] is very opinionated and asked "Why the heck would I want to interview [care aides]?" It seems everyone has an opinion on [care aides]" [Field Note; 05/29/16].

The hairdresser felt that the care aides would have nothing to offer for an interview and that they were not important enough, intelligent enough or informed enough for the time to be spent on speaking to them.

Participants reported that their fellow care aides are there for each other and they work together as much as possible to support and empower one another. As one participant said, "*we stick together . . . and we stick up for each other*" [P21-1791; 03/11/16]. Another participant described how care aides, as a collective, offer their support to residents, especially for those residents who rarely receive visitors:

There's people here that haven't seen family in—(for)ever. So, I mean, they get extra hugs. They get extra love. And for the most part, most of the care aides are like that with them as well. Like, we all recognize that. That's where as a team we're really good" P28-1354; 05/09/16].

Although many care aides claimed an attraction to the role of caring and helping other people who are in need, there was also a constant reporting of bullying, discrimination, and mistrust between care aides. Some participants were concerned about how this may affect the care that residents receive.

Sometimes, [care aides] are good with residents, but then they are very bad to their co-workers. That's not good either, because you are not thinking about your co-workers' feelings . . . If your co-worker felt so bad with what you did and then now, it will reflect to the care that [they will] . . . provide. So, I guess, yes, it should be client-centered, but then you're also supposed to be very sensitive with your environment, with your co-workers. And, yes, I observe. So, yes, there's politics and there's power tripping [P29-905; 05/10/16].

Some reported on the sense of 'politicking' they faced when trying to do the right thing in their job.

When I worked evenings, I got made fun of because I'd still be working up until 10:00 p.m. because some of my residents don't want to go to bed until 9:30 p.m. And what's wrong with that? . . . [The other care aides] would have everybody in bed by 8:00 and then they'd sit at the

nurses' station playing on their phones and make fun of me for still working [P34-2668; 06/08/16].

The three-hundred-and-sixty-degree disrespect that care aides felt regarding their role in LTRC: from society, their colleagues and own fellow team members was evident in their self-reflection, as detailed in the following

Downhearted and overwhelmed: A cog in a broken machine

The LTRC setting was seen by participants as an inept institution, focused on profit and not on delivering good quality care to residents. The frustration of caring in LTRC settings with seemingly irremediably issues was evident among participants. To counteract this grim reality they often discussed something that was labelled as the "Scandinavian fantasy". This was the notion that there had to be a better model, somewhere in the world, for good LTRC. A participant with a dozen years of experience shared how she believed LTRC is done 'better' in other places in the world:

"I honestly believe they need to take the profit out of . . . I mean what does Switzerland do? Like some of these countries" [P24-688; 03/08/16].

Issues relating to moral distress were discussed by most participants. For some care aides, who were raised in a culture with no exposure to LTRC, the notion of institutionalized care for older adults was foreign and misaligned with their cultural practice of intergenerational care. This First Nation participant discussed how, when he initially became a care aide and found the idea of putting the requirements of the LTRC service before the expressed desire of the resident as alarming:

It was tough coming from a First Nations background to a facility . . . Because our elders, when they spoke, we stop and listen. What they said was pretty much like law. So it was hard for me to adjust to a facility. Somebody told me that they just want to stay in bed, and they refused care. And I said, "Okay." I walked away I got told [by another staff member] "Get back in there and get that person up!" So, I went back in... Yes, cause I don't run into too many dementias or any kind of Alzheimer's. I won't run into that or into facilities on First Nation land" [P10-310; 09/15/15].

A Filipino care aide with one-year experience in LTRC discussed how she felt that people did not want to die in the LTRC setting, preferring to die at home. She shared the following during an observation:

She told me how in the Philippines she saw her grandparents come live in her house, even in her room when they got older with cancer and it was time for them to die. She believes everyone would rather die at home... [Field Note; 05/10/16].

The care aide felt that how the resident preferred to die were not actioned, and she was part of a suboptimal situation for their end-of-life care. Despite feeling misunderstood and stigmatised in their role and working in a setting filled with barriers to the delivery of good care, participants continually shared poignant stories about their relationships with the residents as

their reason for staying in this role. As a participant with eight years of experience in LTRC described:

I'm mentally, physically drained [after every shift]. What keeps me going is that when I leave, I feel that I have done something... I've looked after these people today. And I know they're clean and they have something to eat and, yes...I love them [P23-1261; 03/07/16].

This love and respect for older adults and the benefits of the social aspect of their role in relationship with residents was shared among other participants. As one care aides stated,

"I really enjoy talking to people and socializing and I just seem to fit. I like giving care. I love all the interactions with the elderly; it's just they're very honest and real" [P22-20; 02/10/16].

And yet, despite their own belief in the good they were doing, as stated in the title, at least one participant concluded:

"I wouldn't choose this work again . . . Because after 30 years of working as a care aide, I feel like there is no respect in what we do, and in all we do we are belittled" [P17-500; 02/06/15].

And as another staff members described:

A lot of people brand us as professional diaper changers. And it annoys me because there's so much more to it. You know, you're in these people's lives for quite a while. And you see a lot of things. And you can only take so much of it for so long sometimes [P32-49, 05.13.16].

The barriers around the delivery of good care, low quality of life to residents and undesirable working conditions for staff in LTRC are integrated into how LTRC is viewed by both staff and society, creating a downward spiral of negativity, stigma and low morale, and high moral distress for the care aides.

DISCUSSION

This study portrays a raw and disturbing picture of the experiences and perspectives of care aides, and the realities of their role within LTRC. The overall message is that care aides in LTRC are the mainstay of the delivery of care to residents, yet as a workforce, they are an unsupported, unappreciated, 'aching backbone' of our healthcare system, impacting both their delivery of care and the health and well-being of this invaluable workforce. This case study is not untypical of many LTRC facilities in Canada and other high-income countries.

Given the recent COVID-19 pandemic, studies now documenting the psychological effects of point-of-care workers highlight traumatic impacts on their mental health (Lai et al., 2020). As presented in the current study, care aides are already under severe moral, psychological and physical stress. Given the increased factors associated with the COVID-19 pandemic, care aides are predicted to develop symptoms of depression, substance abused, insomnia, acute stress disorder and posttraumatic stress disorder (PTSD) even years post this pandemic (Brooks et al., 2020).

Moral residue, negative lasting effects workers have when they must repeatedly act against their values, is an associated consequence of moral distress (Webster & Bayliss, 2000). Research on moral residue and care aides in LTRC is shown to be associated with detrimental psychological and health effects (Braedley et al., 2018). Given the COVID-19 pandemic and the difficulties LTRC has seen with this, including but not limited to the quarantines and deaths of residents (Davidson & Szanton, 2020), an increase in moral distress and subsequent moral residue is predicted, which may be associated with a reduction in quality of patient care. As discussed in a recent report on the federal standards in LTRC, the conditions of work are also the conditions of care (Armstrong & Cohen, 2020). If the impact of moral residue and burnout is not recognized and remedied, negative repercussions among both this workforce and their residents, regarding workplace wellbeing and quality of life and care will ricochet throughout the healthcare system and the greater population. We are already seeing repercussions of working within the COVID-19 pandemic in the exhaustion and mistrust of this workforce which is evident in the high rates of vaccine hesitancy (NPR, 2021).

Care aides have long been identified by LTRC researchers as voiceless, both in LTRC, and in decision making settings (Hewko et al., 2015). The participants in this study echoed the same mute powerlessness. As discussed by many LTRC researchers (Berta et al., 2013; Estrabrooks et al, 2020), Canada lacks data for managing the LTRC sector. If Canada cannot measure the vital aspects of this sector, it cannot effectively be managed and supported. To ensure the vital training, support and management of this sector is achieved, data needs to be obtained regarding vital aspects of the care aide training and scope of their role within LTRC.

Participants in this study felt some positive team cohesion, yet in confirmation of a recent study's findings, there were high rates of bullying and incivility among one another (Cooke et al., 2019). Their perception of how other members of the healthcare team saw them, as with only body care knowledge was associated with how they felt society saw them only as 'ass wipers'. The gendered notions of unskilled work, body care and stigma related to this work and the corresponding maltreatment of this workforce is a continuation of the narrative of unvalued predominantly female roles in society. To improve the quality of care and work experience of care aides, the true nature of their role must be brought to light in the public eye, thereby reducing the stigma and misinformation surrounding their role in LTRC as 'ass wipers' along with the stigma surrounding the residents they care for, the majority of whom have dementia.

Care aides must be repositioned on the same "side of the fence" as the rest of the healthcare team (Caspar et al., 2016). They need to be viewed as an invaluable component to the wider healthcare team, with team building exercise implemented to enforce a collective culture of care and the value of their work. The importance of involving care aides in research is also pivotal to the societal re-branding of their role. In recent years emphasis has been put on Patient and Public Involvement and Engagement (PPIE) in health research (Boylan et al., 2019). To ensure their perspectives and experiences are incorporated to promote meaningful workforce culture change initiatives, care aides must be included as lived-experience experts, and co-designers in studies, especially regarding developing and implementing ethnographic research in LTRC.

The discourse of unskilled labor (or dirty work) is interesting as it shifts the focus onto individual health care workers to compensate for the irrationalities, challenges and malpractices of the LTC system. The findings of this study highlight how care aides do not have the time needed to deliver the complex, compassionate and relational based care that residents require. The

recommendations from this study to support the care aide profession going forward are nationally to regulate and improve care aide training. Care aides need to be prepared for the realities of their role and their needs to be a clear understanding of their scope of practice. Care aides need to work in an environment with appropriate staffing levels. As highlighted by Estrabrooks and colleagues (2020) one of the most critical components of quality of care is the right amount and type of staffing. Alongside staffing, sufficient time must be made available for care aides to deliver the required complex care needed to residents. This builds on the accounting logic (time-task) identified in the ethnographic work of Diamond (1995). On the ground, care aides need to be given increased autonomy over the care they deliver. Finally, in society, their needs to be an increasing awareness of the role care aides, thus reducing stigma and encouraging respect for this essential workforce that will grow in both size and value in the coming years.

Limitations

The most prominent limitation of this study is that this is a case study of one specific LTRC floor in a more extensive care setting. Since participants in this study spoke about their generalised experiences working as a care aide at an average of 2.5 (range 2-8) different LTRC settings, the findings were drawn from their experiences in a range of different facilities and often across extended periods of time. Another limitation of this study concerns the ethnicity of participants. In this study, most participants identified as white. Considerations of ethnicity must be at the forefront of future LTRC research endeavours to ensure that the lived experience of seldom-heard populations in scientific literature is heard and interventions are developed to best support them. This is crucial given that 53% of care aides in the US are non-white, (Probst et al., 2010), and upwards of 33% in Canada (Government of Canada, 2020), and 23% in the UK are immigrants (Cangiano, 2009). To strengthen the ethical sensitivity of this study, various means for participants to provide input should be offered, including paper survey responses and online data collection methods using smartphones.

CONCLUSION

Currently, care aides embody the backbone of our healthcare system for LTRC. With the coming ageing of the population and the concomitant increase in rates of dementia, this backbone must be adequately supported now for society to be prepared to deal effectively with our ageing population into the future. As stated in the title, and corresponding quote in the findings “I wouldn’t choose this work again...” some participants would not choose this work again, based on their work experience and how their role is belittled in society. It is until care aides are actively listened to and included in the healthcare team, have a regulated standard of education, are have their role appreciated in society, and their important and significant perspectives, experiences, and understanding of their residents' wants and needs will remain an untapped resource that is essential to the provision of high-quality care in LTRC.

Conflict of Interest statement

No conflict of interest has been declared by the authors.

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