# Exploring Workplace Violence Among Home Care Workers in a Consumer-Driven Home Health Care Program

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RESEARCH ABSTRACT

Nominal research has examined sexual harassment and workplace violence against home care workers within consumer-driven home care models such as those offered in Oregon. This study examined home care workers' experiences of violence while providing care to consumer employers, the patients who hire and manage home care workers. Focus groups and interviews were conducted in Oregon with 83 home care workers, 99 Oregon Department of Human Services (DHS) employees, and 11 consumer employers. Home care workers reported incidents of workplace physical violence (44%), psychological abuse (65%), sexual harassment (41%), and sexual violence (14%). Further, three themes were identified that may increase the risk of workplace violence: (1) real and perceived barriers to reporting violence; (2) tolerance of violence; and (3) limited training to prevent violence. To ensure worker safety while maintaining quality care, safety policies and training for consumer employers, state DHS employees, and home care workers must be developed. [*Workplace Health Saf* 2013;61(10):441-450.]

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Sexual harassment and workplace violence are associated with negative health and employment outcomes for workers and diminished quality of care for patients (Plichta, 1996; Robinson, Clements, & Land, 2003; Rogers & Kelloway, 1997; Schat & Kelloway, 2000; Schneider, Swan, & Fitzgerald, 1997; Schulte, Nolt, Williams, Spinks, & Hellsten, 1998; Simonowitz, Rigdon, & Mannings, 1997). Although investigators have examined sexual harassment and workplace violence encountered by physicians, nurses, and other health care workers in hospital, clinical, and nursing home settings, a paucity of research exists on the experience and prevention of sexual harassment and workplace violence against home care workers in a consumer-driven home health system (Agnew, Gee, Laflamme, McDonnell, & Curbow, 2002; Anderson, 2002; Anderson & Parish, 2003; Barling, 1996; Barling, Rogers, & Kelloway, 2001; Beauchamp Hewitt & Levin, 1997; Duncan et al., 2001; Geiger-Brown, Muntaner, Lipscomb, & McPhaul, 2003; Lipscomb & Love, 1992; Simonowitz et al., 1997; Snyder, Chen, & Vacha-Haase, 2007; Soares, Lawoko, & Nolan, 2000; Tak, Sweeney, Alterman, Baron, & Calvert,

## Applying Research to Practice

Although limited research exists regarding occupational safety for in-home care providers in a consumer-driven program, it is anticipated that research in this unique health care sector will expand as health care shifts from institutional care (e.g., nursing homes) to home-based, patient-centered care. As the home care sector grows throughout the United States, so will the home care work force. To ensure that programs are created to continually improve workplace safety for home care workers, researchers must broaden their view of occupational health and safety to include these workers. This study design, relying on both quantitative and qualitative methods, can be used to guide future home care worker safety research assessing both the magnitude of violence and sexual harassment experienced by home care workers and the specific patterns of workplace violence in this unique occupational setting.

2010; Tolhurst et al., 2003). Few studies have examined violence toward home care workers, consumer employers (in Oregon, consumer employers are patients or clients who have the authority to hire, supervise, and discharge home care workers), and representatives from state agencies (e.g., the Department of Human Services [DHS]).

Oregon was the first U.S. state to use a Medicaid waiver to direct funds for a consumer-driven home care program for seniors and individuals with disabilities, a landmark decision that has shaped the creation of similar programs in other states (Kassner et al., 2008). The Oregon program enables individuals who need support to continue to live in their homes and communities by providing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and 24-hour availability. The program involves three categories of individuals: (1) home care workers, (2) consumer employers or family members of consumer employers, and (3) DHS case managers and other staff who have frequent contact with home care workers. Home care workers, as employees of the consumer employers, perform ADLs (e.g., bathing and hygiene, dressing and grooming, eating, elimination), provide mobility and cognition or behavioral support, and perform IADLs (e.g., shopping, housekeeping, meal preparation, medication and oxygen assistance, and transportation). Each consumer employer is assigned a case manager through DHS. The case manager is a state employee who authorizes the consumer employer's service hours, determines the services the home care worker can provide, and authorizes payment to the home care worker (State of Oregon Home Care Commission [OHCC], 2008). Case managers provide services to the consumer employers; they do not supervise home care workers, although they often act as intermediaries between consumer employers and home care workers.

In addition to DHS, two other entities, the OHCC and the Service Employees International Union (SEIU) Local 503, are part of the Oregon home care program. The OHCC consists of nine governor-appointed commissioners. Five of the commissioners are consumer employers and four are representatives of DHS agencies: the Governor's Commission on Senior Services, the Oregon Disabilities Commission, and the Oregon Association of Area Agencies on Aging and Disabilities. The OHCC was created in 2000 by a ballot measure that amended the state constitution. SEIU Local 503 is the union representing approximately 11,000 home care workers in Oregon and bargaining on their behalf for wages, hours, and working conditions. SEIU Local 503 is similar to most unions, but has some limitations due to the special circumstances of this group of workers. For example, the union does not have the right to grieve discipline, due to the power of the consumer employer to hire and discharge for any reason, and home care workers in the bargaining unit cannot strike. However, home care workers do have appeal rights and other protections against unfair terminations of their provider number or the ability to grieve contract violations. The union supports home care workers by advocating at hearings that determine provider number eligibility in cases of policy violations. The union also has a strong political program and works with the OHCC to maintain funding for home care worker professional development.

Oregon's home care program uses a consumer-driven model that provides an alternative to more costly institutional care, facilitates autonomy for the consumer employers, potentially improves care and quality of life for the consumer employers, and increases work force opportunities for home care workers (Alakeson, 2010). However, the workplace setting within the consumer employer's home contributes to a complex relationship among the consumer employer, the consumer employer's family, and the home care worker. In this relationship, the weak labor market position of home care workers and their work in consumer employers' homes may render them vulnerable to sexual harassment and workplace violence. These social and employment issues cannot be resolved in the same way more typical employment health and safety issues can be addressed by using employee assistance programs or human resources or security personnel within a hospital, clinic, or nursing home setting. For home care workers, the workplace is the consumer employer's home and the perpetrator of sexual harassment or violence can be either the consumer employer or the consumer employer's family and friends. Limited training initiatives to prevent or respond to sexual harassment and workplace violence are available to home care workers. In addition, Oregon employment policies do not specifically address sexual harassment or violence perpetrated by consumer employers or others in the home against home care workers.

Given the aging population and numerous initiatives focused on shifting care from nursing homes and long-

term care facilities to community-based care, home care is the fastest-growing segment of the health care industry in the United States (Fitzwater & Gates, 2000). In February 2011, it was announced that the Affordable Care Act would provide an additional $4.3 billion in funding for 13 states to establish and expand efforts to move Medicaid beneficiaries out of long-term institutional care and into their own homes and communities (U.S. Department of Health and Human Services, 2011). As the home care sector expands, evidence to address the challenges of a safe workplace is critical for the health of both workers and consumer employers. To examine these issues, Johns Hopkins University School of Nursing, Oregon Health and Science University, and the University of Oregon partnered to investigate home care workers' experiences of sexual harassment and workplace violence perpetrated by consumer employers or others in consumer employers' homes. The goal was to develop policies and training to prevent and respond to violence and improve safety and quality of care.

## METHODS

### *Study Design and Study Population*

This study was part of a larger, sequentially designed, mixed-methods investigation that aimed to assess sexual harassment and workplace violence in the home care sector so that an evidence-based sexual harassment and violence prevention intervention could be developed and tested for home care workers. Investigators established partnerships with academic and community partners (e.g., state and local aging and disability experts from the OHCC and SEIU Local 503) to implement the study. In addition, an advisory board consisting of home care workers, consumer employers, advocates for consumer employers, SEIU Local 503 representatives, DHS case managers, and the OHCC was formed to advise the study team. The collaboration among the academic partners, community partners, and advisory board facilitated recruitment of study participants and provided guidance during the development of focus group and interview questions and procedures.

### *Study Recruitment*

To gain a comprehensive perspective of home care workers' experiences regarding sexual harassment and workplace violence, the study was designed to investigate the perspectives of the three components of the consumer-driven home care program: (1) home care workers; (2) DHS case managers and other staff (e.g., clerks) who work with both home care workers and consumer employers; and (3) consumer employers.

For each population, snowball recruitment was conducted until saturation was achieved. Home care workers were recruited from Oregon counties representing both urban and rural communities with high- and low-population densities, respectively, through advertisements focusing on workplace health and safety distributed at professional training events and in SEIU Local 503 newsletters. In collaboration with the DHS Seniors and People with Disabilities office, the researchers recruited case managers and other staff in the same counties as the home care worker participants. With assistance from the OHCC, the STEPS consumer employer training program, and referrals from case managers, the authors recruited consumer employer participants. Home care worker and consumer employer participants self-selected; case managers were often requested to participate by their supervisors and allowed to participate during the workday.

### *Procedures*

Qualitative (i.e., focus groups and individual interviews) and quantitative (i.e., self-report survey) techniques were used for the study. Before the focus group and interview guided discussions were initiated, each participant was provided with the study purpose and procedures prior to giving verbal informed consent. After consent, participants were asked to complete an anonymous, self-administered, paper demographic and workplace sexual harassment and violence survey. Researchers conducted individual interviews with home care workers who wanted to participate in the study but were unable to attend a focus group or were uncomfortable talking in a larger group. Two trained moderators attended each focus group; only one moderator was present during interviews. A member of the research team interviewed consumer employer participants in a setting where these individuals were most comfortable, usually their homes. All focus groups and interviews were digitally recorded on two recorders after the participants gave permission. No names were recorded, and participants were reminded not to discuss information outside the group. The study was approved by the Institutional Review Board of Johns Hopkins University, Oregon Health and Science University, and the University of Oregon and began in September 2008.

### *Survey*

Prior to the beginning of the focus group and interview discussions, the session moderator asked participants to complete an anonymous survey. The survey included questions about four primary topics:

1. Demographic information, including gender, age, race, ethnicity, type of participant (i.e., home care worker, case manager, or consumer employer), years of experience, hours worked per week or hours of care received per week, number of consumer employers for whom currently working or number of home care workers currently employed, familial and intimate relations between home care workers and current consumer employers, and frequency of contact between case managers and consumer employers.

2. Personal experiences as a home care worker or case managers' personal experiences of receiving reports of sexual harassment and workplace violence committed by a consumer employer or someone else in the consumer employer's home. These experiences included workplace physical violence (e.g., pushing, hitting, slapping, kicking, threat of violence, attacked with a weapon), emotional abuse (e.g., name calling, bullying), unwanted or unwelcome sexual advances or attention (e.g., touching, rubbing, verbal sexual advances, comments about the body), and workplace sexual violence (e.g., threat of sexual violence and/or forced sexual contact and/or rape) (Table 1).

Table 1

**Home Care Worker and Case Manager Survey Questions**

| *Survey Question* | *Home Care Worker* | *Case Manager* |
|---|---|---|
| 1. Physical violence | "Have you ever experienced workplace physical violence (e.g., pushing, hitting, slapping, kicking, threat of violence, attacked with a weapon) by a consumer employer or someone else in the consumer employer's home?" | "Have you ever had a home care worker report to you an instance of workplace physical violence (e.g., pushing, hitting, slapping, kicking, threat of violence, attacked with a weapon) committed by a client or employer, or someone else in the home of a client or employer, toward the home care worker?" |
| 2. Non-physical workplace aggression | "Have you ever experienced workplace emotional abuse (e.g., name calling, bullying) by a consumer employer or someone else in the consumer employer's home?" | "Have you ever had a home care worker report to you an instance of workplace emotional abuse (e.g., name calling, bullying) committed by a client or employer, or someone else in the home of a client or employer, toward the home care worker?" |
| 3. Sexual harassment | "Have you ever experienced or been forced to submit to unwanted or unwelcome sexual advances or attention (e.g., touching, rubbing, verbal sexual advances, comments about the body) by a consumer employer or someone else in the consumer employer's home?" | "Have you ever had a home care worker report to you that he or she is being forced to submit to unwanted or unwelcome sexual advances or attention (e.g., touching, rubbing, verbal sexual advances, comments about his or her body) by a client or employer, or someone else in the home of a client or employer?" |
| 4. Sexual violence | "Have you ever experienced workplace sexual violence (e.g., threat of sexual violence and/or forced sexual contact and/or rape) by a consumer employer or someone else in the consumer employer's home?" | "Have you ever had a home care worker report to you an instance of workplace sexual violence (e.g., threat of sexual violence, forced sexual contact, rape) committed by a client or employer, or someone else in the home of a client or employer, toward the home care worker?" |
| 5. Quit job due to violence | "Have you ever had to quit a home care job because the consumer employer or someone else in the consumer employer's home was violent toward you?" | "Have you ever had a home care worker report to you that he or she is quitting a home care job because the client or employer, or someone else in the home of a client or employer, was violent toward the home care worker?" |
| 6. Quit job due to sexual harassment | "Have you ever had to quit a home care job because the consumer employer or someone else in the consumer employer's home sexually harassed you?" | "Have you ever had a home care worker report to you that he or she is quitting a home care job because the client or employer, or someone else in the home of a client or employer, sexually harassed the home care worker?" |

3. Effects of sexual harassment and workplace violence on home care workers' job status (e.g., quitting a job or turning down a job because the consumer employer or someone else in the consumer employer's home was violent and/or sexually harassing) (Table 1).

4. Training about sexual harassment and workplace violence.

### *Focus Group and Interview Guide*

Structured, population-specific questions were used to guide the 1- to 2-hour, face-to-face, semi-structured focus group discussion and interviews. Specific variables of interest included definitions and examples of sexual harassment and workplace violence, barriers to a safe workplace, risk factors for violence, and training received or

desired to promote safety and quality care. Focus groups and interviews were conducted from March 2009 through February 2010 starting with home care workers, followed by DHS case managers, and then consumer employers. Home care worker and consumer employer participants were compensated $25 for their time and expertise. DHS case managers were not compensated for their participation because the focus group discussions were conducted during work hours.

### *Data Analysis*

Two research assistants entered the demographic survey data into Microsoft Excel and the two data sets were compared; discrepancies were reviewed and remedied. Microsoft Excel was used to calculate basic descriptive statistics for each participating group, including demographic data (e.g., race and ethnicity frequencies, mean age, and years of experience or years receiving home care) and frequency of home care workers' experiences of physical violence, non-physical workplace aggression, sexual harassment, and sexual violence.

A descriptive approach was used for the qualitative analysis. Two authors (L.N. and H.M.) and 17 trained research assistants transcribed 32 focus group and individual interview recordings. Names or identifiers mentioned during the recorded discussions were removed or replaced during transcription. At least one of the focus group or interview facilitators (L.N. and H.M.) reviewed each transcript for accuracy and completeness. The transcripts, in Microsoft Word, were imported into QSR International's NVivo 8 software. Three authors (L.N., H.M., and M.W.) then chose home care worker focus group transcripts to read and code separately. Initial codes were categorized using the focus group and interview guided discussion script categories, which included definitions and examples, magnitude and scope of the problem, risk and protective factors, impact on work performance and health, responses to violence or sexual harassment, and policies and training. After coding the first transcript, the authors conferred to ensure consistent code definitions and to establish inter-coder reliability. The remaining focus groups and interviews were divided among the three authors and coded separately using open coding and an evolving codebook.

The authors met weekly to discuss codebook changes and ensure consistency of the study codebook. Throughout the coding process, the authors established hierarchical coding with comprehensive codes that were further categorized into descriptive codes. When the codebook was finalized, one author (M.W.) reviewed and cleaned codes to remove redundancies. These codes were then combined into "meaningful units according to relatedness into larger units, known as themes" (Leininger, 1985, p. 61). Identified themes bring "together components or fragments of ideas or experiences, which often are meaningless when viewed alone"(Leininger, 1985, p. 60).

The authors then developed the exemplars to illustrate each theme. The following criteria were used when selecting exemplars: (1) logical fit with themes, (2) clarity and strength in message, (3) diversity in speakers, (4) ability to mirror subtle nuances in themes, and (5) singular usage to avoid using exemplars more than once (Hassouneh & Glass, 2008). When selecting the exemplars, the authors referred back to the transcripts and codebook from which they were extracted to ground the comments in context, thereby ensuring accuracy.

Regarding confirmability, the authors engaged in peer review and debriefing during the analysis process as a qualitative mechanism similar to inter-rater reliability in quantitative research (Creswell, 2003). The authors discussed the findings and interpretations during the analysis process to ensure consistency, resolve differences, and develop consensus in interpretation.

## RESULTS

### *Home Care Worker, DHS Staff, and Consumer Employer Demographics*

Eighty-three home care workers in six Oregon counties participated in six focus groups and four individual interviews with trained facilitators. The home care worker participants who provided direct home care to consumer employers through Oregon's home care program were all female, and the majority were White (80.7%) and non-Hispanic (92.7%). On average, they had 9.8 (*SD* = 9.2) years of home care experience and worked an average of 35.2 (*SD* = 27.9) hours per week. The majority of the home care workers (42.7%) cared for a single consumer employer, 21.7% cared for two consumer employers, and 33.7% cared for three or more employers.

Ninety-nine DHS case managers and other DHS staff from the same six counties participated in 12 focus group meetings. The majority were female (85.8%), White (91.9%), and non-Hispanic (92.9%). Half of the DHS employees were case managers (50.5%), 15.1% were home care worker clerks, 13.1% were supervisors, and 21.2% had other job types, with a mean of 7.6 (*SD* = 6.13) years of job experience.

Eleven consumer employers from five counties were individually interviewed in their homes. The majority were female (72.7%), White (72.7%), and non-Hispanic (90.9%). Their average age was 56.4 (*SD* = 7.4) years. Their mean years of experience as a consumer employer was 11.7 (*SD* = 10.8) and they had received, on average, 63.1 (*SD* = 69.9) hours of home care services per week.

### *Quantitative Results*

Reports of experiencing at least one type of physical violence, workplace aggression, or sexual harassment were most frequent among home care workers who responded to the survey on workplace health and safety. Data collected from DHS case managers and other staff supported similar, and even slightly higher, rates of violence and harassment experienced by home care workers on their case loads (Figure).

### *Qualitative Results*

During the focus groups and interviews, all three populations agreed on common definitions and provided similar examples of sexual harassment and workplace violence. Workplace violence included threats of or physical or sexual violence in circumstances related to their

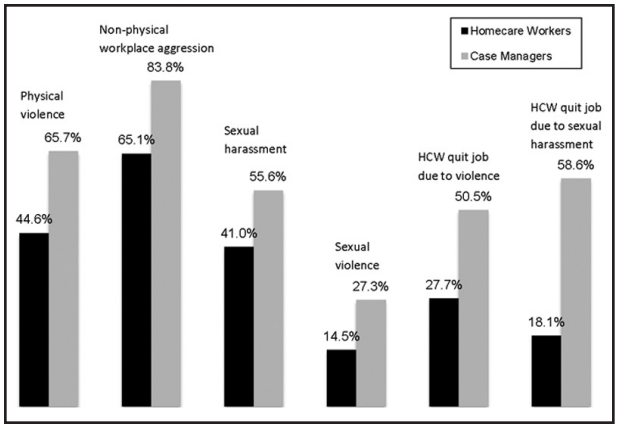


**Figure. Frequencies that home care worker (HCW) participants reported experiencing sexual harassment and workplace violence, as well as frequencies that Department of Human Services case manager participants reported receiving reports of home care workers experiencing sexual harassment and workplace violence. Participants responded "yes" to the survey questions described in the METHODS section.**

work, including any explicit or implicit challenge to their safety, well-being, or health. Sexual harassment was any unwanted, unreciprocated, and unwelcome behavior of a sexual nature that is offensive to the individual involved and causes the individual to be threatened (Table 2). During the discussions, three main themes emerged from the qualitative data: (1) real and perceived barriers to discussing or reporting instances of violence; (2) home care worker tolerance of violence and the state administrative structure put in place to support home care workers; and (3) limited training and resources to support home care workers. These themes recurred within and across interview and focus groups.

***Theme 1: Real and Perceived Barriers.*** For most of the home care workers, these focus groups were the first time they had discussed their experiences of sexual harassment and workplace violence with other home care workers. An overwhelming consensus emerged that home care workers are experiencing violence; however, many did not know that others were experiencing violence and harassment, a common thread among this work force. This finding is partially a consequence of the non-communal, isolated nature of the work, but the researchers found it was also due to a culture of silence. Although the majority of home care worker participants reported experiencing sexual and workplace violence, most felt it was just "part of the job." As one home care worker said:

> I personally feel like there's a veneer of acceptability, like we're home care workers, we're tough, we're patient, we deal with all of this incredibly stressful stuff. And so, it's okay, you know, you just let it roll off. The client just made a mistake, this person just made a mistake, and there's less focus on giving us the support and the tools that we need.

The home care workers' reports were echoed in the DHS case manager focus groups. Nearly all of the case managers reported having received at least one report during their careers of a home care worker experiencing sexual harassment or workplace violence. However, as among the home care workers, it was not something commonly discussed with colleagues or supervisors. The case managers described their primary role as providing service to the consumer employer. No formal policies or protocols are available for case managers when they receive reports of home care workers experiencing sexual harassment or violence, even though policies exist for reporting abuse or neglect of consumer employers by home care workers. Because no clear policy has been established regarding how to handle these situations, reporting the abuse can be perceived as resulting in no action. The case managers reported that they could do little beyond advising home care workers to leave the situation or call the police. Similar to the home care workers, many of the case managers felt that, although it was not appropriate or acceptable, experiencing sexual harassment or workplace violence is expected when providing health care to individuals with particular health issues. Case managers viewed violence as sometimes unavoidable, particularly when working with individuals with cognitive impairments, brain injuries, mental illness, or symptoms of dementia and Alzheimer's disease. One case manager explained:

> It seems like more and more people have mental health-related issues that may not be the basis for why they are meeting our service eligibility criteria, but they're there all the same, and they probably prevent this individual from being able to, even with training, to be able to act as a responsible client employer. There's this balance we try to strike to help people to be responsible employers, but a lot of the mental health issues and behaviors they may have certainly would put home care workers at risk for violence.

Finally, the home care program's current confidentiality policies were cited as contributing to a culture of silence. In the DHS *Homecare Worker Guide* (Oregon Department of Human Services, 2011), confidentiality is addressed in the following statement:

> As a home care worker you will often have access to personal information about your employer. You are legally obligated to keep that information absolutely confidential. Unless your employer gives you specific permission, do not talk about your employer's personal information to anyone, except the employer's case manager or other state representatives from agencies serving seniors and persons with disability. (p. 14)

The interpretations of this statement regarding reporting sexual harassment and workplace violence are varied and broad. Many home care workers and DHS case managers and staff have interpreted "personal information" to include violence and thus do not report incidences because breaching confidentiality can result in loss of eligibility, under Health Insurance Portability and Accountability Act (HIPAA) and Medicaid policies, to practice home care in Oregon. Some consumer employers threaten home care workers with termination if they talk to case manag-

Table 2

## Exemplars of Workplace Sexual Harassment and Violence Reported by Participants Across Groups

| *General Examples of Violence and Harassment* | *Specific Examples of Violence and Harassment* |
|---|---|
| Physical workplace violence | |
| Slapping<br>Hitting<br>Lashing out<br>Stabbing<br>Kicking<br>Spitting<br>Choking<br>Throwing objects | "As a home care worker, people don't look at violence the way I do. When you're taking care of somebody, when they don't want to be messed with, they don't want to have your care, they get upset with you and you're supposed to look at it as, well, that's okay. But when they start to push you or they grab you and you have marks left on you, to me that's violence."—Home care worker |
| Non-physical workplace aggression | |
| Yelling<br>Screaming<br>Swearing<br>Name calling<br>Stalking<br>False accusations<br>Spreading rumors<br>Feigning a disability<br>Manipulation<br>Financial control<br>Threats of physical harm<br>Threats with weapons<br>Cornering | "It scares the hell out of me. It really does. Cause, he's allowed to use knives, he's allowed to use anything in the house. And if he gets mad and in one of his violent moods and he's in the kitchen, God only knows what's gonna come at me."—Home care worker<br><br>"Like, it's not that bad that she called you a fat heifer because she didn't punch you in the face and it's just like, neither one of those outcomes is desirable, no, nobody wants either of these things happening."—Home care worker<br><br>"He got to feeling the wrong way toward me, to the point where I'd go on vacation, he'd threaten my family . . . 'How would you like if I came out there and their throats were slashed?'"—Home care worker |
| Sexual harassment | |
| Sexual remarks<br>Sexual propositions<br>Exposure to pornography<br>Exposure to masturbation<br>Exposure to nudity<br>Whistling<br>Sexual gestures<br>Leering<br>Sexual notes or other correspondence<br>Asking for kisses or hugs | "Professional time means professional time for me and that means professional time for you and that means when they come in to help you eat lunch, to change your shirt, I don't want to have to watch you and your friends watching pornography."—Home care worker<br><br>"Clients choosing to need help with very intimate personal care that really they don't need because they like the looks of the caregiver and want to be exposed in front of the caregiver when it's not necessary for their care."—Case manager |
| Sexual violence | |
| Inappropriate touching of a sexual nature<br>Groping breasts or buttocks<br>Rape | "We have clients who have gone through several home care workers, not because of the client but because of children in the home. Adult children. And there have been, I mean, you know, home care workers washing dishes or whatever and the son will go by and inappropriately touch, you know, fingers across the lower back."—Case manager<br><br>"One particular client I'm thinking of we felt was abusive toward women and sought out home care workers who were women. We had reports from two, three in a row home care workers who were females who he groped during the care and who he had said sexually inappropriate things to during when they provided direct care."—Case manager |

ers about issues in the home. On the other hand, some do report incidents to case managers per the confidentiality guideline; however, as noted earlier, case managers believe they do not have the authority to do anything beyond encouraging home care workers to quit or file a police report. In addition, DHS privacy and confidentiality policies have various interpretations by DHS employees. Case manager participants explained that DHS policies, including HIPAA, prohibit them from disclosing consumer employers' violent or harassing behaviors or warning home care workers of potential dangers. Two case managers said:

> They don't have a clue. I mean, that's the sad part about a lot of these home care workers. I mean, they have the right to know these things, before they go in, before you take a job, you have a right to know what you are getting into.

> There is clearly a need for home care workers to be forewarned of risks. I just don't know how we're gonna go about doing it. Don't know how we're gonna set the law so that they're protected and the client's protected. But it's an issue that I think we're all concerned about. From my perspective, the home care workers need to be protected in terms of knowing what their risks are.

***Theme 2: Tolerance of Violence.*** It is evident that home care workers are experiencing sexual harassment and workplace violence, yet many tolerated the harassment and violence, remaining committed to the consumer employer or at least to the home care industry. Throughout the focus groups and interviews, three recurring reasons surfaced as to why home care workers tolerated violence and harassment. First, financial constraints and the poor economic climate prevented many home care workers from leaving dangerous situations. They relied on the income and health insurance coverage provided by employment. In addition, limited job availability in other fields and the lack of required education or training in the home care industry meant home care workers were willing to tolerate unfavorable conditions to keep their jobs. As one case manager said:

> Some of these home care workers are very dependent on these jobs and desperate for work and living on the edge of poverty and so they, I think, some of them take it because they really need the work to survive.

Second, home care workers tolerated harassment and violence because they feared accusations of abandonment if they acted to end the violence or left the home to escape the violence. DHS defines abandonment as "leaving or deserting an older adult or person with disabilities who cannot care for themselves and depends on the care provider for help" (Oregon Department of Human Services, 2011, p. 16). If home care workers abandon their consumer employers, the workers may lose not only their current home care positions but also their eligibility to provide any home care services in the future. As a result, home care workers remain in dangerous situations such as that described by one worker:

> When he goes to raise his hand at you with his fist doubled and that look on his face, that, to me, is violence. I mean even if it doesn't connect with you physically, it's a threat. And you can't get away from that situation without abandoning your client.

Finally, the very personal nature of home care work can blur professional boundaries, resulting in a higher tolerance for violence or harassment. Home care workers spend many hours, sometimes 24 hours a day, with their consumer employers in a non-professional setting (i.e., the consumer employer's home) performing intimate tasks such as bathing and grooming. For consumer employers who cannot easily leave their homes or do not have many visitors, the home care worker becomes a friend and social outlet. Consequently, because of this personal bond and sense of obligation, home care workers feel responsible for their clients and remain in abusive situations. One home care worker said:

> You can also become emotionally attached to the person you're taking care of. And figure, well they, they're okay, maybe they had a bad day and that's why they called me that name. Then you become in the habit of just taking a little bit at a time, a little bit at a time, especially verbal abuse.

***Theme 3: Limited Training and Resources.*** The focus groups and interviews also revealed limited support for home care workers experiencing sexual harassment and workplace violence. Home care workers have few options: either report the violence to a case manager or to the police, or quit the job. Many home care workers belong to the SEIU Local 503, which provides a free telephone resource line that home care workers can call and report their experiences to a Union representative. However, the Union has no legal power other than reporting the situation to the case manager, DHS, or OHCC office to intervene on behalf of the home care worker experiencing harassment or violence. In addition, program eligibility rules for consumer employers are based on Medicaid criteria. Thus, a consumer employer cannot lose eligibility for care due to abusive behavior. A 2009 rule change does allow DHS to remove an individual from consumer-directed care. The consumer employer would still be eligible to receive Medicaid services, but not through this program. According to the case manager focus groups, the rule is not well known and rarely used.

One case manager described home care workers' support options:

> When they call and they report that this is happening, the only thing that we can really say to them is have you filed a police report? You know, or have you left the situation? Those are their choices. They can file a report or they can leave. Some of them can't even afford to leave.

### *Training on Workplace Violence and Sexual Harassment*

Only 14 home care workers (16.9%), 15 case managers (15.3%), and none of the consumer employer participants reported attending training on preventing or responding to sexual harassment and workplace violence. However, all three groups strongly agreed they needed training in this topic. Suggested components for the home care worker-specific training included assertiveness and communication skills, defining work boundaries and identifying warning signs for unsafe workplaces, how and where to access support resources, how to protect oneself from physical and sexual threats, and how to de-escalate and escape abusive situations.

## DISCUSSION

Quantitative and qualitative findings in this study represent the views of a group of home care workers, DHS case managers and other staff, and consumer employers who agreed to participate in a study on workplace health and safety. Participants across groups identified sexual harassment and violence as currently experienced by home care workers. The focus group and interview discussions revealed several nuances, including a culture of silence shared by home care workers and DHS case managers and staff, varied and complex reasons home care workers tolerate harassment and workplace violence, and limited training and home care system resources for home care workers, case managers and other staff, and consumer employers to prevent and respond to harassment and workplace violence.

Although the participants did self-select and study findings do not reflect the prevalence of sexual harassment and violence for all home care workers, it is evident that some home care workers experience sexual harassment and workplace violence. Given the potential health and safety consequences of harassment and violence, further investigations of home-based health care models, designed to contain costs and improve care for an aging population, are warranted.

## IMPLICATIONS FOR OCCUPATIONAL HEALTH NURSING PRACTICE AND RESEARCH

This study has provided new insights into the challenges of creating safe workplaces for home care workers and providing quality health care in the home. The information revealed from the demographic surveys, focus groups, and interviews was used by the collaborative research team to develop a comprehensive population-based survey, which was randomly distributed to a sample of 1,204 female home care workers in Oregon to accurately understand the burden of sexual harassment and workplace violence for home care workers. Further, the quantitative and qualitative data guided the development of a home care worker training intervention to equip home care workers with the skills necessary to prevent and respond effectively to sexual harassment and workplace violence.

Oregon has implemented a consumer-driven program that benefits Oregon taxpayers through reduced costs, has the potential to enhance quality of life for consumer employers, and creates jobs for home care workers. However, the current system offers only limited workplace safety protections for these workers. Focusing on prevention and response through statewide safety policies, research, and ongoing training for home care workers will not only improve safety for a vulnerable work force, but also likely improve care to seniors and individuals living with disabilities.

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