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RESEARCH ARTICLE

# "That's not my job": A mixed methods study of challenging client behaviors, boundaries, and home care aide occupational safety and health

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## Abstract

**Introduction:** Home care (HC) aide is among the fastest-growing jobs. Aides often work in long-term care relationships with elders or people with disabilities in clients' homes, assisting with daily activities. The purpose of this mixed-methods paper is to elucidate aides' experiences around the boundary-challenging behaviors of clients asking for services beyond aides' job duties and to identify possible interventions.

**Methods:** A cross-sectional survey of HC aides in Massachusetts (n = 1249) provided quantitative data. Post-survey qualitative data were collected from nine HC aide focus groups (n = 70) and seven in-depth interviews with HC industry and labor representatives.

**Results:** Quantitatively, aides who reported often being asked to do tasks outside their job duties were more likely to report abuse (prevalence ratio [PR] = 1.93; 95%CI: 1.47-2.52 for verbal, PR = 1.81; 95%CI: 1.13-2.91 for physical/sexual) and pain/injury with lost work time or medical care (PR = 1.58; 95%CI: 1.11-2.25). They were also less likely to want to remain in their job (PR = 0.94; 95%CI: 0.89-1.00) or recommend it to others (PR = 0.94; 95%CI: 0.90-0.98). Qualitative data showed that clients' requests for tasks beyond job duties were frequent and can lead to injuries, abuse, and psychosocial stress. Yet, requests often reflected genuine need. Helping clients stay at home, compassion, and feeling appreciated contributed to job satisfaction; therefore, aides can feel conflicted about refusing requests.

**Conclusion:** Client task requests outside HC services are a complex problem. Employer support, training, care plans, and feeling part of a care team can help aides navigate professional boundaries while delivering high quality care.

KEYWORDS
home care aides, mixed methods, professional boundaries, verbal abuse, workplace violence

*It could be simple things like, "Oh, you know, you're going to the coffee shop. Can you get me a coffee?"…To really, I want you to clean my whole fridge out, which wasn't on the [care] plan to, whatever. It's a big issue.*

— Interviewee #1

## 1 | INTRODUCTION

Home care (HC) assistance for elders and people with disabilities is a large, rapidly growing industry. Globally, both the proportion of older people in the population and average life expectancy are increasing.[1] HC workers are in demand to address the desire by elders to age in

place, the civil rights of people with disabilities to participate fully in the community, and the financial goal of lower costs compared to nursing home care.[2] The U.S. Bureau of Labor Statistics estimates that about 3.3 million people worked as personal care aides or home health aides nationwide in 2018, and HC is among the most rapidly growing professions, with 1.2 million new jobs projected between 2018-2028.[3,4]

HC aides are primarily women and disproportionately immigrants and racial or ethnic minorities.[5] Their U.S. national median pay in 2017 was $11.57 per hour and many aides have a second job, with more than half of the workforce relying on public assistance.[3,5-7] Job turnover is high and shortages are challenging for employers and those needing care.[2,5,7] While aides think their work is important, they often do not feel respected or find that their work is equally valued by society, including policy makers and other care providers.[2,6,8]

In the USA, HC recipients may be called consumers, clients or patients, depending on the medical or social service system that oversees their care; in this paper, "client" refers to all care recipients. There are many occupational titles for HC aides, including but not limited to home health aide, personal care aide, personal care attendant, companion, and homemaker.[9] In this paper, the term "HC aide" or "aide" refers to all aide jobs. Aides may be hired through an agency or directly by clients; in this study, personal care attendants (PCAs) were client-hired. While specific tasks vary, HC aides overall provide assistance with activities of daily living (ADLs) such as eating, toileting, bathing, and dressing as well as instrumental activities of daily living (IADLs) such as cleaning and grocery shopping.

Aides generally work one-on-one with clients in the home and can develop close family-like relationships.[10-12] A client care relationship may continue for years, sometimes over a decade. This, combined with the vulnerability and needs of clients as well as the broad caring nature of the job, can result in boundary crossing in which aides perform tasks beyond the specified HC service job duties. Some aides may consider choosing to perform such tasks as a way to provide quality care[13] or as a form of occupational autonomy.[11] In the qualitative formative phase of the Safe Home Care (SHC) Project,[10] we learned that aides were often asked to perform tasks outside their job description. It was reported that these tasks may be requested by a client or client's family member or be offered by the aide and that close relationships may play a role. Client interviews conducted in this phase found that they highly valued the extra tasks.[10]

HC aides' work constitutes both physical and emotional labor that often falls along the blurred line between informal and formal work.[11] The additional physical and emotional labor is uncompensated, may involve aspects of financial or emotional coercion, and may contribute to burnout.[11,14] In a National Institute for Occupational Safety and Health (NIOSH) Hazard Review of Occupational Hazards in Home Healthcare, clients asking aides for help outside the scope of the job was identified as a "subtle" form of verbal abuse.[15]

### 1.1 | Purpose

This study is part of a larger mixed-methods research project evaluating the role of a wide range of work conditions on the occupational safety and health (OSH) of HC aides. The objectives of the study described here were to: (a) examine the phenomenon of and reasons for aides being asked by clients and their family members to perform tasks not formally part of HC services and (b) evaluate the phenomenon's association with negative OSH outcomes. We focused on professional boundary crossing tasks that are specifically requested by the client rather than identified or offered by the aide. We hypothesized that these additional requests play a significant role in aides' experiences of the job; specifically, that they are associated with negative job outcomes including verbal and physical abusive behaviors from clients and family members, job-related injuries/pain, decreased job satisfaction, and increased likelihood to leave the job.

## 2 | METHODS

### 2.1 | Overall project design

All methods and materials were approved by the University of Massachusetts Lowell Institutional Review Board.

Figure 1 shows the sequential mixed-methods structure of the SHC Project studying HC aides in Massachusetts. Phase 1 consisted of a formative qualitative research phase including focus groups of HC aides and interviews with representatives of HC industry and labor, workers' compensation insurers, and clients. This informed the design of phase 2, a cross-sectional survey of working conditions among HC aides. Methods and overall findings from phases 1 and 2 were published previously.[9,10] Phase 3 postsurvey focus groups provided insights about the phase 2 survey results and potential interventions for identified hazards.

### 2.2 | Hypothesis development and design of the mixed methods study

The phase 1 formative research explored experiences of HC aide work and how these might benefit or harm aides' safety, health, and well-being. A theme identified during analysis of the phase 1 focus groups and interviews was that aides were frequently asked by the client to perform tasks outside of the aides' job duties. However, the extent and impact of these transgressions were not entirely clear. Based on these phase 1 findings, we hypothesized that client requests for extra tasks have a negative impact on aides' OSH and job satisfaction. We evaluated this hypothesis in this mixed methods paper using data from phases 2 and 3. While the overall design and data collection of the SHC Project were sequential, with the qualitative phase 3 interpreting the results of the phase 2 survey, the new analyses specific to this paper were performed convergently.

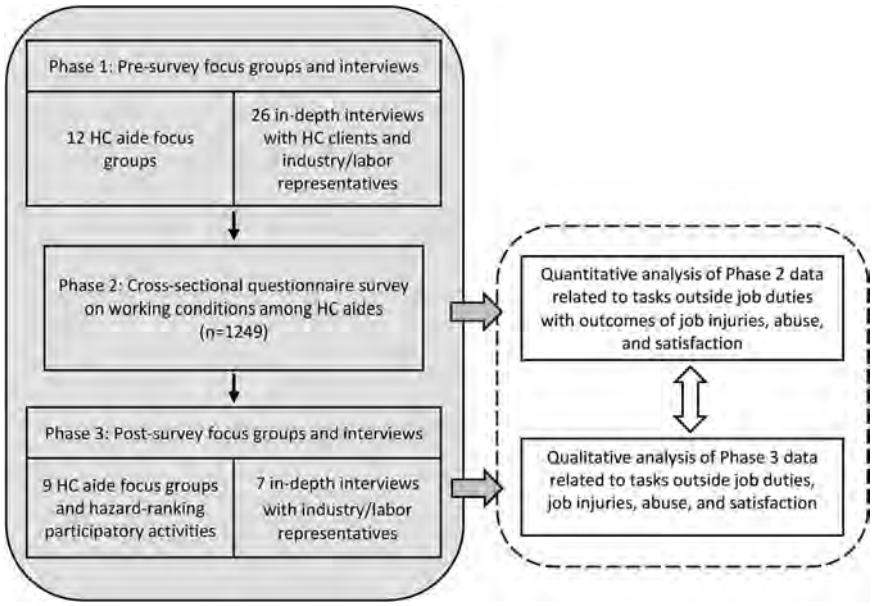


**FIGURE 1** Overall Safe Home Care Project data collection and analyses (shaded box). For the study reported here, the study hypothesis was generated from phase 1 results and data from phases 2 and 3 were analyzed (dotted-line box)

## 2.3 | Quantitative methods: Cross-sectional questionnaire survey

### 2.3.1 | Study population

A cross-sectional survey was administered between September 2012 and April 2013 to assess an array of HC working conditions and practices. Survey design, administration, and overall findings have been published previously.[9] The survey gathered information on 1249 aides including aide demographics, health outcomes, and general conditions of employment, as well as hazards and conditions in specific visits with up to five unique HC clients within the month before the survey.

Agency-hired aides (n = 634) were recruited from seven HC agencies across 16 sites; aides hired directly by clients or their families ("direct-hired", n = 615) were recruited via their labor union. The population in this analysis is a subset comprising 954 HC aides who reported caring for nonfamily members. This restriction was chosen because family caregivers may have different experiences of the aide-client relationship than nonfamily caregivers, on topics including where boundaries lie for determining when a task is outside of job duties, stressors in responding to these requests, and contextualization of working conditions and client behaviors.

### 2.3.2 | Quantitative variables

The main risk factor variable was response to the statement: "My client(s) often ask me to do things that are not part of my job." Responses were coded using a binary variable: Agree or Strongly Agree vs Disagree or Strongly Disagree. To explore potential impacts on aides' working conditions, we focused on five specific outcomes: abuse (two outcome variables), job satisfaction (2 outcome variables), and injury/pain.

Verbal and physical/sexual abuse were defined as aides reporting that they had experienced at least one incident from clients and/or clients' family members in the previous year. Verbal abuse was defined as: "being yelled at or spoken to in an angry or humiliating tone"; "made to feel bad about myself"; "racial, ethnic, religious, or other personal insults"; and "verbal threat of harm." Physical abuse included six categories: "aggressive physical contact, including pinched, scratched, slapped, punched"; "being bitten or spit on by another person"; "bodily fluids thrown at me"; "objects thrown at me"; "being beaten or strangled"; or "sexual assault".

Job satisfaction was assessed with two variables. Aides were asked "If a good friend said that she or he was interested in working in a job like yours, for your same employer, what would you say?" The reply "I would recommend this job" was considered a positive response, while answers of having doubts or advising against the job were negative. Aides were also asked about their future in home care: "plan to stay on the job" represents an answer of either definitely or probably will not leave my job vs definitely or probably will leave.

Injury/pain, the fifth outcome, was assessed by the yes/no question: "While working in home care, have you had any injury or pain that led you to get medical care or lose work time?"

### 2.3.3 | Statistical analysis

Data analysis was conducted with SAS software 9.4. Log-binomial regression was used to estimate prevalence ratios (PR). Confounding was defined as a change in a coefficient of greater than 10%.

## 2.4 | Qualitative methods: Focus groups and in-depth interviews

### 2.4.1 | Study participants and procedures

Phase 3 consisted of nine focus groups of HC aides and seven in-depth interviews of home care industry stakeholders, and builds on methodology developed in the SHC Project's previous research.[10,16,17] The focus groups were conducted March-April 2014 at four HC agencies and at a HC aide labor union office. Only aides who had previously participated in the cross-sectional survey were recruited for these focus groups, allowing for in-depth feedback on survey findings and input on potential interventions. Participants received a financial incentive. Each focus group lasted no longer than 90 minutes and all participants gave written informed consent.

Additionally in phase 3, one two-person and six individual in-depth interviews were conducted June-September 2014 with representatives from agencies, a union, and an industry trade organization. All organizations were project partners in the development or administration of the survey. The interviews were no longer than 60 minutes, conducted during work hours, and a financial incentive was offered to their organization.

### 2.4.2 | Data collection and analysis

*Main sessions of focus groups and interviews*

The interviews and focus groups were conducted by experienced moderators following scripts with open-ended questions. Focus groups were presented with flip charts providing the main survey findings from phase 2. As each main finding was presented, the aides were asked to provide: (a) perspectives on whether the finding was as expected and (b) interpretations and personal experiences surrounding the finding. These personal narratives were often interactive among participants and typically included details of how aides encountered hazardous situations and suggestions for safer practice. Additionally, suggestions for interventions to improve the overall OSH conditions of the job were solicited at the end of the focus group. Interviews followed a similar structure. All sessions were audio-recorded, transcribed verbatim by a transcription service, and verified by the research team. Because this phase was specifically designed to interpret results from the phase 2 survey, the development of which was in turn informed by formative focus groups,[10] these nine postsurvey focus groups and seven interviews were sufficient to reach theoretical saturation in phase 3.

Qualitative analysis of the transcripts followed the grounded theory approach.[18-20] Line-by-line coding was conducted using NVivo 12 qualitative research software to obtain hierarchical 3-level coding of themes. NVivo software allowed for weighting of themes based on the number of different interviews/focus groups in which they were coded. Themes were identified that related to client requests for aides to perform tasks outside of their job duties and the impacts of these requests on the aides' health, safety, and well-being.

To ensure high interrater reliability, the first author conducted the first coding round of all transcripts and the senior qualitative methods investigator verified these codes checking each verbatim quote in the transcript and its corresponding coded theme, performing additional coding to extract more themes if needed. Throughout the process, both met and reviewed the coding; any differences in coding structures were discussed and negotiated. Parent codes were determined a priori based on the focus group/interview guide questions which were developed to explore the cross-sectional survey findings. The child and grandchild subcodes were identified from the transcripts using specific coding techniques (in vivo and open coding)[20] designed to capture the participants' own narratives and wording.

*Semi-quantitative hazard ranking in focus groups*

At the close of each focus group, participants engaged in a multivoting activity to rank the most significant job hazards, from their perspectives. Nine options for hazards were provided based on the questionnaire survey results and formative focus groups: client handling, transfer, and lifting; violence, aggressive client or family members; asked to do things outside your care plan; used medical sharps; blood and feces exposure; indoor air quality; falls, slips, and trips; traffic accidents; and animal attacks or bites. Aides could also add hazards to the list; these were carried to subsequent focus groups. Each participant was given five dot stickers and instructed to place them on a group flipchart next to the hazard(s) that they felt should be prioritized for intervention. Aides could place the dots in any way they chose; selecting different hazards or giving multiple dots to a hazard to emphasize its importance.

# 3 | RESULTS

## 3.1 | Quantitative findings

### 3.1.1 | Demographics

Table 1 presents the population demographics from the cross-sectional survey, along with prevalence ratios comparing the frequency of being asked to do tasks outside the job description for different aide characteristics. Overall, 47% (n = 448) of aides agreed or strongly agreed that "My client(s) often ask me to do things not part of my job". Men were less likely than women to report this, as were aides hired directly by clients compared to agency-hired. These variables may not be independent, as men were over twice as likely to be direct-hired. When analyzed together, gender appeared to be confounded by hire type although both characteristics remained important determinants after adjustment. No other demographic variables were significantly associated with task requests.

**TABLE 1** Cross-sectional survey population demographics and the prevalence of being asked to perform tasks not part of the job (n = 954)

| | | | Clients often ask me to do things not part of my job | |
|---|---|---|---|---|
| | n | % | PR | 95% CI |
| Sex | | | | |
| Male | 93 | 10% | 0.70 | 0.52-0.92 |
| Female | 858 | 90% | | |
| Age | | | | |
| Above age 48 y (median) | 455 | 48% | 1.08 | 0.95-1.24 |
| Less than or equal to 48 y | 476 | 50% | | |
| Race | | | | |
| White | 431 | 45% | 1.12 | 0.97-1.29 |
| Black | 327 | 34% | | |
| Asian | 39 | 4% | | |
| American Indian/Alaska Native | 5 | 1% | | |
| More than one race chosen | 28 | 3% | | |
| Hispanic/Latino | | | | |
| Yes | 154 | 16% | 0.97 | 0.83-1.16 |
| No | 760 | 80% | | |
| Born outside the US | | | | |
| Yes | 383 | 40% | 0.99 | 0.86-1.13 |
| No | 566 | 59% | | |
| Type of employment | | | | |
| Directly hired by client/family | 330 | 35% | 0.70 | 0.60-0.82 |
| Hired through an agency | 624 | 65% | | |

*Note:* Percentages may not total 100% due to nonresponse or rounding. Prevalence ratio for race compares aides who report white race to all other categories.

### 3.1.2 | Association of task requests with OSH outcomes

Univariate analyses were performed to assess whether having client (s) who asked for tasks not part of the job was associated with outcomes of abuse, job satisfaction, and injury/pain (Table 2). Aides who reported receiving such task requests were more likely to report verbal and physical abuse and injury or pain on the job. They were slightly less likely to plan to stay on the job or recommend it to a friend. The demographic variables gender and hire type did not confound any of these associations.

## 3.2 | Qualitative findings

The nine postsurvey focus groups included a total of 70 participants. Fifty-three participants were employed by private agencies with such job titles as home health aide, personal care aide, homemaker, and heavy duty worker. Their tenure in HC work ranged from 2 to 44 years. Seventeen participants were PCAs, represented by the labor union and directly hired by clients, with tenure in HC ranging from 2 to 29 years. Three participants were men and the remainder (67) were women. In total, 59 participants reported race: 35 White, 21 Black or African American, and 3 more than one race. Of 32 participants who responded to a question about ethnicity, two reported being Hispanic or Latino.

In-depth interview participants were five managers/directors in HC agencies, one field nurse supervisor, one union representative, and an executive from an industry trade council. All interviewees were women.

Four major themes related to excess task requests were identified:

- Client requests for tasks outside of the aides' job duties are frequent and can have adverse physical, financial, and psychosocial impacts on aides (see Section 3.2.1).
- Aides have empathy and compassion for root causes of these task requests, some of which derive from genuine unmet needs of the clients (Section 3.2.2).
- Sources of job satisfaction are related to dynamics of task requests (Section 3.2.3).
- Employers can provide helpful policies and tools to reduce and navigate requests (Section 3.2.4).

In the semiquantitative hazard ranking activity, focus group participants reinforced that extra task requests were a significant hazard and needed to be addressed with interventions (Section 3.2.5).

### 3.2.1 | Client requests and adverse impacts on aides

Focus group participants and interviewees alike reported that clients frequently ask aides to perform a wide range of tasks outside of the job description. A single request can easily become a pattern. Doing a task once raises client expectations.

**TABLE 2** Models of the association of being asked to do things not part of the job with outcomes of abuse, job satisfaction, and injury/pain

| | | Single-predictor models Client asks aide to do things not part of the job PR *95% CI* |
|---|---|---|
| Abuse (past 12 mo) | Verbal | 1.93 *1.47-2.52* |
| | Physical/sexual | 1.81 *1.13-2.91* |
| Job satisfaction | Would recommend job to a friend | 0.94 *0.90-0.98* |
| | Plan to stay on the job | 0.94 *0.89-1.00* |
| Injury/pain (career) | Medical care or lost work time | 1.58 *1.11-2.25* |

The most commonly coded extra tasks related to cleaning. Some were extensions of tasks that the aide was supposed to perform, but that the client demanded be done to a higher standard (eg, cleaning the floor on hands and knees). Alternatively, some tasks were extra household cleaning jobs not included in HC services (eg, windows). Aides emphasized that their jobs are not the same as a maid, but clients and their families do not always recognize this:

> *[O]ld people, they're very used to having their house clean every day, every week, and they can't do that, you know. We're not there to clean everything, we're not maids, we're there to do light work.*
>
> — FG3 participant

While aides are not maids, they often perform IADLs that can overlap with this type of work. Interview and focus group participants suggest this can lead to "gray areas" of work or unclear boundaries on where acceptable cleaning tasks end. Clients may also overstep boundaries on behalf of family members, by trying to include dishes, laundry, or grocery shopping for others who live in the house.

Aides were also asked to perform tasks outside the home that clients were no longer capable of. This included physical labor related to home maintenance such as yard work and shoveling snow. Other frequent external task requests were for shopping including clear violations of agency rules, like purchasing liquor, cigarettes, or lottery tickets. Shopping requests can hold a financial burden for aides. Direct-hire aides in particular reported incidents when clients did not reimburse them for miles driven, transportation fare, or for purchases.

The extra task requests can be in conflict with workplace health and safety; for example, clients requesting that an aide clean without the proper personal protective gear or supplies. Frequently, tasks are safety hazards. Clients ask aides to perform heavy lifting tasks that put them in danger of musculoskeletal injury, such as flipping a mattress. Shoveling increases the risk both for back injuries and slips and falls. Tasks at height come with fall risks, such as standing on a stepstool or ladder to water plants or to change curtains—a request that was mentioned in the majority of the focus groups.

Extra task requests can have psychological or emotional consequences, when aides feel guilty about not making a client happy or not meeting their needs, or face hostile critiques about not doing a good enough job. Conflict with a client over tasks can even escalate to a potentially violent situation. One aide described a precarious event which arose from conflict over a task clearly forbidden by agency rules:

> *I went in one time, and my client was upset, and I made sure that he didn't get between me and the door. Because I didn't know what he was going to do…He wanted me take him to the bank to do his business, in my car, and was very angry I wouldn't let him in my car.*
>
> — FG8 participant

Financial vulnerability may exacerbate the stress from task requests. If an aide refuses a task or does not perform it in the manner desired, clients may fire an aide directly or threaten to complain to the agency. However, aides who worked for agencies more often raised job insecurity and financial factors as reasons *not* to do a task outside the job description. They noted that the agency could end their employment if they did something in violation of agency policy or not support aides if they encounter problems while doing an unapproved task. One agency manager described an accusation of theft after an aide went to the bank for a client: "*[Y]ou want to defend your employee but how can you when they broke your own policy?*" *(Interviewee #2)*

### 3.2.2 | Motivations behind client task requests

Aides and interviewees alike recognize that clients' requests for inappropriate tasks arise from both legitimate needs and arbitrary wants. With genuine needs, both interviewees and aides recognized that the clients often had few other options for getting the needs met.

> *I try to put it in the simplest terms that really the service is very limited, but the people are very needy. So, we're basically there to bathe them, to dress them, to prepare meals, and to create a healthy living environment for them…They need more help realistically than this service is providing or is capable of providing.*
>
> — Interviewee #6

Among the clearest examples of genuine needs that aides said they agreed to do outside the job were picking up a client's prescriptions and helping a client get to the hospital for medical care.

Aides report that clients often lack financial resources, and may have little family member support and/or physical constraints that leave them housebound. These factors can result in an overreliance on the one person who they see reliably: the aide. The aide can be seen as their only source for both practical chores and emotional support.

> *I had a very sweet gentleman, 94…[H]e would say…"Why don't you go to lunch with me? Why don't we go to dinner? I'm paying for you." I'm like, no. Paying for my house-cleaning services, not my companionship and dinner. But he was so, so lonely. He had no family…[I]t can be very difficult on you, because there's an emotional situation there, and you hate to say no to them.*
>
> — FG8 participant

Other extra task requests arise from clients' wants. Aides understood the rationale for some of these requests. One frequently-discussed topic was the belief that clients' unacceptable cleaning expectations often reflected the way the clients used to clean but are no longer capable of.

Many client requests were perceived more negatively. Aides frequently described extra client requests as attempts to take advantage of them. Aides' wording suggests willful attempts to get extra tasks done. Some clients were described as *"manipulative"* or said to *"lie"* or *"play games"* to get what they want. Aides described that some clients pushed back against attempts to establish boundaries, such as trying to persuade an aide to violate agency rules and keep it between the two of them: *"Well, if you don't tell [the agency], how are they going to know?"(FG 9)*

### 3.2.3 | Job satisfaction and the dynamics of task requests

The job of an aide is not well paid, and aides expressed feeling that their financial compensation and low societal esteem do not reflect their skills and value. However, aides agreed that the findings of high job satisfaction in the phase 2 survey[9] seemed accurate.

When describing sources of job satisfaction, the word "help" was frequently mentioned. Being a helper can be part of their identity or the values they were raised with.

> *PCAs are drawn to the work because they're helping other people live independently and live fuller lives. And I think PCAs, often the people who I've spoken with — and it's most often women — are doing the work because they were raised with values…like caring for other people.*
>
> — Interviewee #4

Beyond merely helping, aides reflected on the *"necessity of the care" (FG 1)*. Aides described how care can mean literally life or death. Frequently, the aides reported that job satisfaction arises from providing the care that allows a client to live independently in their own home and improving a client's quality of life. They described feeling proud of the quality of work they deliver and the positive client outcomes they observe.

In addition to the importance of the work itself and the helping identity, aides reported that the relational aspect of the job is rewarding. Being liked and appreciated by the client and their family is a major source of satisfaction. Aides described themselves as "*people-pleasers*". *(FG 2)* This may lead to a conscious or subconscious pressure to please the client. Aides stated that they will *"bend over backwards"* or *"go the extra mile"* for a client who expresses their appreciation and is not overly critical. *(FG 5)* Alternatively, a demanding client who is not appreciative of the aide's work or is seen as manipulative was given as a factor in lower job satisfaction.

Many aides described their long-term working relationships as family-like. Aides are often instructed not to get attached, but can find it a difficult balance. They may find it satisfying that a client is so attached that they do not want a substitute aide. However, this can also make them feel guilty about even taking a day off.

In contrast to the sources of satisfaction which can cause aides discomfort refusing task requests, aides also found satisfaction in job aspects related to autonomy and support for professional limits and boundaries. Words like *"freedom"* and *"independence"* described both flexible work schedules and the autonomy they experience as one-on-one care providers.

### 3.2.4 | Support, work team framework, and care plans help aides navigate stressful requests

Employer support plays an important role for aides in saying no to clients. A common strategy to avoid conflict with a client was to shift the blame to an agency. Merely suggesting to the client that they call the agency may be enough to either distract them or get them to back down. Industry interviewees encouraged aides to call them if the client is asking too much and also to position the agency as the authority denying the task:

> *We tell them it protects your job and that they should blame us. They can very nicely and sweetly say, "I'm not supposed to do that but if you call my agency and ask them and if they say OK, I will." And they say, "Oh, no, that's OK." The client knows not to call us.*
>
> — Interviewee #2

By having a shared understanding between client, aide, and agency that some tasks are forbidden, blame-shifting to the agency can also evoke clients' sense of guilt or self-interest. Aides remind clients that they could lose their jobs if found to have done a forbidden task. When clients do complain to an agency, a supervisor listening to an aide's side was important to feeling valued.

Beyond the direct role agencies can play, awareness of being part of a bigger work team can also help aides say no. In over half the focus groups and in interviews, it was noted that refusing a task will protect other aides from being put in the same situation.

> *[E]very time that a client says something to me that they want me to do something, I think of that next girl that's going to come in, you know, not only just me. But there's always going to be somebody that's going to come in after every one of us. You know? So you have to stop and say to yourself, if I do it, they're going to expect everybody to.*
>
> — FG9 participant

A written care plan with clearly specified work tasks was recommended as a helpful tool that could be provided by agencies or other care professionals to help address unreasonable expectations of clients. While new-hire PCAs in Massachusetts receive orientation training about their work duties and rights, they would also like to see clients receive education on tasks and boundaries from home assessment intake professionals such as case managers, assessment nurses, or other authorities.

> *I would recommend that…they sit down with the client and letting them know that the rules and the regulations of a PCA and what is required of them and what's not, to make it verbally and in writing clear…[T]hey don't believe that when we tell them that it's not our job. They don't believe us.*
>
> — FG2 participant

### 3.2.5 | Semi-quantitative hazard ranking of focus groups

HC aides placed a total of 336 sticker dots to rank work environment hazards. In total, 15 topics received multiple votes. Figure 2 presents hazards that received the most votes (77% of all votes). Being asked to do things outside the care plan was ranked the third most important priority for intervention, receiving votes in all nine focus groups. Only indoor air quality and blood/feces exposure ranked higher. When limited to agency-hired aides it was ranked second, following indoor air quality.

## 4 | DISCUSSION

Client task requests outside the job are rarely included in research of OSH hazards or in verbal abuse survey instruments. However, these requests may indeed be occupational hazards. This study found that requests for tasks outside the job are a commonly-encountered issue for aides, and are ranked among the top job hazards for which they would like intervention. Both quantitative and qualitative analyses suggest that extra requests may be associated with OSH hazards and negative outcomes that have been previously identified as concerns in HC, including psychosocial stress,[15,21,22] conflict or abusive client behaviors,[9,23-27] and injury and musculoskeletal pain.[9,28,29] The types of tasks requested, as identified in the qualitative analysis, reflect potential pathways to the negative outcomes found in the quantitative analysis.

In the quantitative model, client/family abusive behavior was the outcome most strongly associated with aides being asked to do tasks not part of the job. This supports the classification of these tasks as a form of workplace violence, and is consistent with the inclusion of such task requests in the NIOSH Hazard Review.[15] The focus group results also support this classification, as aides described receiving criticism, threats, and manipulation from clients in connection with the extra task requests. The finding may also reflect hazardous relational boundary crossing; aides with client relationships described as "overly involved"—a category which includes being available to clients outside work hours and mutual feelings of fictive kinship—have been found to experience more physical violence from clients.[30]

While the quantitative analysis found that client requests for extra tasks were individually associated with aide abuse, injury, and job dissatisfaction, it is worth noting that the relationship among these outcomes is complex. Injury has been associated with both lower job satisfaction and increased turnover.[31-33] Emotional strain and violence have been found to have similar impacts.[33,34] Violence against workers in the similar field of nursing home care has been associated with musculoskeletal pain.[35]

Overall the findings support the initial hypothesis that client requests for extra tasks increase aides' OSH risks. However, the qualitative data indicate that these client requests are complex for aides to navigate because they may also contribute to a sense of esteem and reward that is otherwise lacking from the job. This complexity should be taken into account to develop successful public health interventions.

### 4.1 | Possible interventions

The importance of reliable organizational support in avoiding and navigating extra task requests was one of the strongest themes

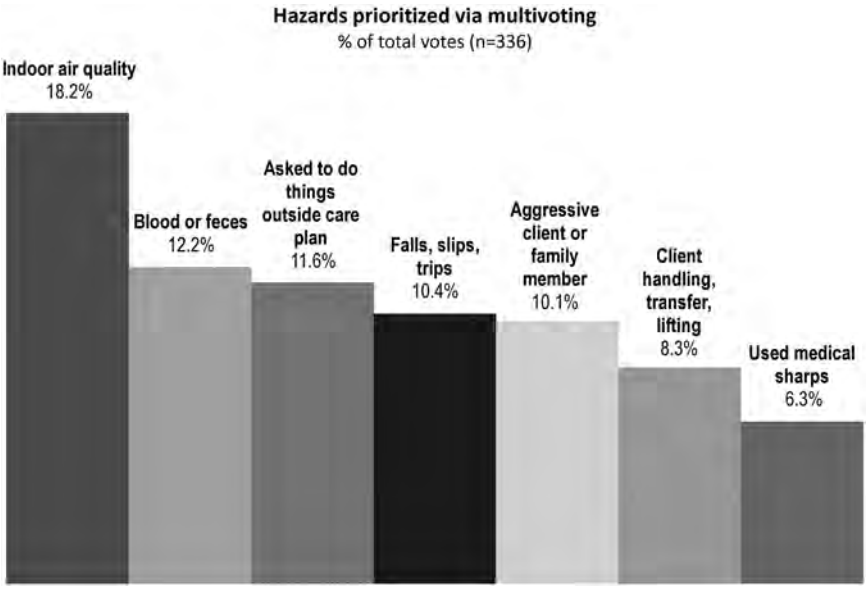


**FIGURE 2** Job hazard ranking by focus group participants using the multivoting participatory exercise. Percent of total votes (n = 336) received by each hazard, all focus groups combined. Hazards receiving the most votes are shown (totaling 77% of all votes)

identified in the qualitative analysis. Existing literature reinforces the qualitative findings that supportive agencies increase aide satisfaction and decrease turnover intent.[32,33,36] Weak supervisor support has also been associated with injury.[31] While the employer for direct-hired aides is the client, for aides with a labor union membership, unions can play an organizational supporting role. Union membership has been found to be correlated with job satisfaction for HC aides.[37]

Our Phase 1 formative research showed that in-service trainings and client intake assessment are crucial intervention points in addressing aide health and safety concerns[10] and the postsurvey qualitative phase 3 confirmed the phase 1 findings. Various trainings may help aides navigate client relationships. For example, the union representing HC aides in Massachusetts has used collective bargaining to achieve paid orientation training for aides and an education program on topics including boundary setting and communication.[38] Consumer-directed aides in Washington State expressed a desire for similar training on assertiveness, communication, and "defining work boundaries" to help prevent violence[26] and NIOSH has included a module on setting boundaries in its safety training materials for home health workers.[39] Client intake offers an opportunity for agencies and home assessment professionals to formally educate clients on appropriate boundaries and limitations of the aide's role, as well as conduct a thorough assessment of client needs and safety concerns in the home. Training on communication and maintaining professional relationships may be useful to offer clients and could be part of overall education on making one's home a safe workplace.

During the focus group discussions, aides provided each other with spontaneous feedback and advice about boundaries and appropriate tasks. Given the isolation of HC work, having peers to check in with may be another resource for aides to handle negotiation of task requests in a highly isolating job. A desire for peer support has been identified in HC research.[7]

The importance of professional boundaries is well established in nursing, and is part of the standard of care for a therapeutic relationship.[40-42] Nurses commit "boundary crossings" when doing tasks that are brief excursions intended to benefit the client.[41] However, HC aides hold a different societal position from nurses and historically in the USA have been seen more as informal care providers than professionals.[43] For example, although states such as Massachusetts exceeded federal requirements, on a national policy level HC workers were not covered under the Fair Labor Standards Act until 2015 for basic occupational rights like minimum wage and overtime pay. They were excluded by the "companionship exemption", a classification that grouped them with casual babysitters and companions to the elderly.[2,43] Reminders of this are seen in the sources of job satisfaction identified from the focus group data, including fictive kinship relationships with clients. They are also reflected in the frustrations of aides when clients do not have a clear understanding of the aide's professional role and limits of the job. Interventions that make HC aides a more respected, integrated, and formalized member of the care team could incorporate both improved support and awareness of appropriate boundary roles, and have been recommended by previous researchers.[2,7]

Written care plans that clearly specify care tasks are desired by aides and may reflect professionalization that supports aides' safety and job satisfaction. However, the job is much more than the formal tasks captured in a list, care plan, or job description; and the small things that aides do that are not technically part of the job description may make the job more satisfying and safer for aide and client.[11,13,14] As aides explained, the *"little in-between things"* that happen in the job outside of what is written explicitly on the care plan are *"[l]ittle things that aren't little things, because they are what make the relationship work."(FG4)*

## 4.2 | Limitations of the study

The agency-hired aides were recruited from collaborating research partner agencies that were members of a HC trade association. Both interviewees and aides noted that these sources may more actively support worker health and safety than other agencies. All PCAs in Massachusetts funded by the public MassHealth system are covered by a labor union; the PCAs in this study may not have the same experiences as client-hired aides in non-unionized settings. Thus, the results may not be reflective of the industry as a whole. For example, non-unionized client-hired aides may have few or no formalized resources for support, and aides at agencies less invested in worker health and safety may face more pressure to perform requested extra tasks; in these cases, the association between task requests and negative outcomes may be stronger. Focus groups and the quantitative survey were conducted in English and may not fully capture the experiences of aides with limited English skills.

The quantitative survey was cross-sectional; thus temporality is unclear and the findings cannot address whether a risk factor associated with an outcome is causal. Bias may exist in the selection of the aides in our study population if aides who were most harmed by clients' requests for extra tasks were more likely to leave the job. This healthy worker selection bias could be accentuated by the high turnover rate in the industry overall. To the extent that requests for tasks outside the job description contribute to turnover, poor job satisfaction, abuse, emotional strain, or injury, the negative effect of extra tasks found in the quantitative analyses may be stronger than observed. As the variables chosen for this analysis were part of a much larger survey, it is unlikely that survey nonresponse contributed to differential bias specifically on these topics, excepting possible turnover-related selection bias discussed above. When aides and industry representatives were presented with survey results, they found them consistent with their work experiences overall.[9]

## 4.3 | Conclusions

Our study found that aides often asked by clients to perform tasks outside their job description were more likely to report physical and verbal abuse, more likely to have experienced a work-related injury, and have decreased job satisfaction. The task requests are varied and frequent. The requests have complex motivations and differing emotional impact on aides. Aides' sources of job satisfaction can be intertwined with meeting client needs. Organizational supports and resources—such as people to turn to and clearly-specified care plans

and job rules—can help aides navigate the requests and reduce conflict. The agencies and the union in our study were aware of this occupational challenge and demonstrated steps to address the issue; the fact that it remains a high priority for aides suggests that more effective or widespread interventions are still needed.

Many clients have greater needs than can be met through the current HC system alone. HC aides, the frontline workforce for direct care provision, are often caught in the gap. The phenomenon of client task requests beyond aides' job duties is one marker and harmful outcome of this systemic gap. With the aging global population and increasing demand for care, more fundamental solutions for meeting needs of elders and people with disabilities may be required to improve aides' working conditions.

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## CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

## DISCLOSURE BY AJIM EDITOR OF RECORD

Paul Landsbergis declares that he has no conflict of interest in the review and publication decision regarding this article.

## AUTHOR CONTRIBUTIONS

NDK, PKM, and MMQ conceived of the study. NDK conducted the quantitative analyses with substantial contributions from DK and MMQ. Both NDK and PKM conducted qualitative data analyses. NDK developed the manuscript. All authors contributed to the interpretation of the findings and substantially commented on iterations of the manuscript. All authors approved the final version. PKM submitted the manuscript.

## ETHICS APPROVAL AND INFORMED CONSENT

All methods and materials were approved by the University of Massachusetts Lowell Institutional Review Board, Protocol Number: 10–040-QUI-XPD. All participants provided written informed consent.

## DISCLAIMER

Contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

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