WORK-RELATED STRESS AMONG HEALTH CARE AIDES IN ASSISTED LIVING FACILITIES: A DESCRIPTIVE EXPLORATORY STUDY

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Dedication

The Prophet Mohammed (peace be upon him) said:
Those who do not thank people, they do not thank Allah

To those in my life who mean so much to me, those who never let me down and love me for who I am: my parents, Adnan and Muniera, thank you for all your love, prayers, and support throughout my life.

I dedicate this thesis to my wife, Elham, whose love and support was there for me through every struggle I faced in this study and who encourages me in everything I do. I could not have finished this research without your help and support.

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To my children, Esraa, Sarah, and Ahmad, I wish that you grow up to be bright, talented, happy, and independent adults capable of dreaming and making your wishes come true.

This thesis is the beginning of my journey. Thank you, Allah, for always being with me.

Abstract

Mohammed Al-Hassan

Work-related Stress among Health Care Aides in Assisted Living Facilities:

A Descriptive Exploratory Study

The growing percentage of older Canadians presents challenges for health care providers in assisted living facilities (ALFs). Health care aides (HCAs) provide vital support and care to individuals who live in such facilities. Immense pressure is placed on the HCAs. Stress derives from many facets of one's life; however, work-related stress is increasingly prominent. The purpose of this descriptive, exploratory, qualitative thesis is to describe, understand, and explore the experience of work-related stress among HCAs in ALFs. Semi-structured face to face interviews with 14 participants were conducted. Four main themes emerged from the research: (a) the meaning of work-related stress; (b) genesis of work-related stress; (c) how stress affects/changes workers' lives; and (d) how HCAs cope. Research findings from this study will enable employers and service providers to identify stressors in the workplace, reduce work stress, and improve individual well-being. Further, I identified what the ideal workplace from an HCA's view.

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I would like to acknowledge those whose contributions made this research study achievable.

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Finally, a special thanks to the health care aides in this study who so generously shared their thoughts and experiences. I hope I have accurately captured your voices and that your message is heard through this work. I appreciate your readiness to openly share your thoughts and experiences with me. This research study would not have occurred without you.

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Chapter 1: Introduction

Health care aides (HCAs) are front line workers who play a key role in providing care to older residents in private, group living, and facility-based settings (Berta, Laporte, Deber, Baumann, & Gamble, 2013; Health Professions Regulatory Advisory Council [HPRAC], 2006). Because of the shortage of skilled professional health care workers, HCAs have begun playing an important role in the health care system as a more cost effective source of labour than more formally skilled occupations (Berta et al., 2013; Sengupta, Ejaz, & Harris-Kojetin, 2012). However, the health care system, especially the eldercare sector, is facing a shortage of qualified staff and high turnover rates, which create numerous challenges (Giver, Faber, Hannerz, Strøyer, & Rugulies, 2010). By 2016, the projected shortage of HCAs in Alberta will be 21,733 (Alberta Continuing Care Association [ACCA], 2012). Residents of assisted living facilities (ALFs) are vulnerable because of their advanced age and underlying chronic medical conditions (Hooyman, 2014). Therefore, HCA shortages are significant in ALFs because HCAs are the front line workers who help provide quality care to residents, and they are the most important but the largest group of providers at ALFs. Immense pressure is placed on the HCAs because of the need for one-to-one interaction with residents, while also responding to their various needs and demands. For that, this research aimed to describe, understand, and explore the experience of work-related stress among HCAs in ALFs. In this chapter, I discuss the background of the study as well as the purpose of the study, research questions, rationale and significance of the study, clarification of the key terms, and an overview of the research design.

Background and Problem Statement

The population of the world is aging and people everywhere are living longer than before. The percentage of the aging population is growing faster than any other age group because of increased life expectancy; life expectancy is considered to be a valid indicator of a country's overall health. Health status has improved due to developments in sanitation, nutrition, medicine, and medical technology and decreased fertility rates (World Health Organization [WHO], 2014), which changed the demographic landscape of countries worldwide. The population of Canada is also becoming older. The aging of Canada's population is predicted to increase quickly as the first wave of baby boomers started turning 65 in 2011 (Statistics Canada, 2010).

Similar to the rest of Canada, Alberta's population is growing and aging. According to Statistics Canada (2011), Albertans are not only living longer, they are also living healthier. Moreover, the number of Canadians over the age of 65 in Alberta has increased three fold since 1974, from 130,045 to 385,241 in 2009 (Government of Alberta, 2010). This emergent population of older Canadians will present challenges for health care providers and the Canadian health care system, particularly in ALFs and home care centres (Howie, Troutman-Jordan, & Newman, 2014). Furthermore, the health care system and the caregiving community institutions face extraordinary challenges in providing and meeting the demand for high-quality care at ALFs because of increasing demands and the ongoing shortage of health care providers to care for elderly (Hooyman, 2014).

The aging population often needs greater assistance in their activities of daily living. Aging combined with many age-related conditions, such as Parkinson's disease

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and Alzheimer's disease, decrease the functionality of this older population and restrict their independence (Bayer, 2011). Because of the aging population and the subsequent growing number of older Canadians, the necessities of organized ALFs have emerged (Hawes, Phillips, Rose, Holan, & Sherman, 2003). ALFs are rapidly expanding in Canada. ALFs can be defined as settings that enable older Canadians to receive care and observation in a home-like setting which focus on offering supervision, personal care assistance, and services to elderly (Resnick, Galik, Gruber-Baldini, & Zimmerman, 2010, p. 197).

HCAs in ALFs provide vital and basic support and care to individuals who live in such facilities. HCAs are an important component of the continuing care sector in Alberta and other Canadian provinces (ACCA, 2012). Immense pressure is placed on the HCAs because of the need for one-to-one interaction with residents, while also responding to their various needs and demands. In addition, HCAs must meet the expectations of management, other staff, and the residents' families. These competing demands create more responsibility and accountability for HCAs.

Stress can come from many aspects of human life. People are confronted with many issues and experiences in their personal lives that can cause stress. Working in ALFs with elders and their family members on a daily basis can cause stress for the worker. According to the United Nations (UN) and WHO, work-related stress has become a global epidemic (Collins, 2006). DeVries and Wilkerson (2003) reported that stress is fast becoming the most common cause of worker disability; 40% of employment turnover is expected due to stress, and 25% of workers find work as their largest life stress. Additionally, increased expenses related to employment stress problems and

compensation claims have been accentuated by many researchers (DeVries & Wilkerson (2003).

The health sciences literature is abundant with studies and information regarding work-related stress among many different professions. However, there is little known about work-related stress among HCAs. There is a lack of documentation and understanding of work-related stress in this group of health workers. Thus, the question remains: What is the experience of work stress for HCAs? In this study, my plan was to discover, explore, and understand the work-related stress experienced by HCAs.

Purpose of the Study

The purpose of this descriptive, exploratory, and qualitative study was to describe, understand, and explore the experience of work-related stress among HCAs in ALFs. It is important to understand how work-related stress affects HCAs, the factors that workers identify as causing the greatest burden, and how they cope with this stress because HCAs are the front line workers in ALFs, and because it is crucial to maintain an adequate HCA workforce and safe environment for practice. These workers comprise more than 70% of the direct care providers in the continuing care sector and provide 80–90% of the care to residents (Marcotte, 2009; Scott & Cassie, 2007). Furthermore, HCAs are an important part of the health team in acute care facilities (Alberta Health, 2013).

Research Questions

The purpose of the study was to examine HCAs' work-related stress experiences, outcomes of work-related stress, and coping strategies. For this reason, my central research question was: How do health care aides experience work-related stress in assisted living facilities? This research also sought to explore the following questions:

1. What factors contribute to work stress among HCAs working in ALFs?

2. How do HCAs cope with work-related stress?

3. What types of organizational and institutional supports are in place to assist HCAs to cope with work-related stress?

4. What types of personal and social coping strategies are employed by HCAs?

5. How do these stressors and the resulting stress impact the daily lives/work of HCAs?

Significance of the Study

The increasing number of aging Canadians who will need health and social care in ALFs, coupled with the pressure to keep this care inexpensive, represents a tremendous challenge to the health care system in Canada. The aging population has resulted in an increasing demand on the Canadian health care system and HCAs in ALFs (Yamada, 2002). Most ALFs employ HCAs because it is economical to do so (Marcotte, 2009). According to Statistics Canada (2011), in Alberta (AB) there are 15,025 HCAs, and in Lethbridge, AB, there are 785 (including 700 female and 85 males, respectively).

The significance of this study was rooted in the paucity of research that identified and described work-related stress among HCAs. This study was significant because of the limited literature about this phenomenon and the expected rise in the number of elderly in Canada within the next 25 years. This study focused on HCAs who work in ALFs and their experience with work-related stress. An understanding of how HCAs experience and cope with stress may lead to a decrease in stress levels at the individual level and influence policy makers, employers, and workers by understanding the factors that contribute to stress and how they can cope with it. Finally, this study gave voice to

this group of workers to share their experiences and personal stories. It was anticipated that research findings from this study would enable employers and service providers to reduce work stress and improve personal well-being.

Clarification of the Key Terms

There are several key terms in this study that will be defined: work-related stress, health care aides, and assisted living facilities. It is important to present these terms in order to reach a common understanding of the study focus.

Work-Related Stress

The National Institute of Occupational Safety and Health (2008) has defined work-related stress as "the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, needs of the worker" (p. 1). The Canadian Centre for Occupational Health and Safety ([CCOHS]; 2012b) defined work-related stress as "the harmful physical and emotional responses that can occur when there is a conflict between job demands on the employee and the amount of control an employee has over meeting these demands" (para. 2).

Health Care Aides

There is no uniformly accepted definition of HCA. HCA is a personal caregiver who assists people with their daily activity needs as they deal with the effects of aging and disease and who provides basic activity of daily living to residents in ALFs (Alberta Health, 2013; Marcotte, 2009). The Canadian Nurses Association (2008) defined HCAs as "an umbrella term used to describe care providers or assistant personnel who provide some health service and who are not licensed or regulated by a professional, government or regulatory body" (p. 1).

Assisted Living Facilities

There is no uniform definition or consistent use of terminology for assisted living facilities (National Centre for Assisted Living, 2001) either in Canada or internationally (Health Council of Canada, 2010). ALFs provide a supportive, semi-independent environment that includes hospitality services and a 24-hour emergency response system (Alberta Health, 2013). ALFs are nonmedical, community-based, residential settings that provide housing, food service, one or more personalized services, and a safe environment for older Canadians with physical and mental disabilities (Freiheit et al., 2011; Health Council of Canada, 2010).

Research Design Overview

A research design is defined as a "systematic inquiry that uses disciplined methods to answer questions or solve problems" (Polit & Beck, 2012, p. 3). The purpose of my design was to acquire and understand the experiences of work-related stress among HCAs. The idea of exploratory research is to understand the keystones of specific phenomena, explore the relationships among phenomena, and provide promising insights, whereas, descriptive research provides new information (Polit & Beck, 2012). The purpose of a descriptive, exploratory qualitative design is to identify, discover, and describe a phenomenon never studied before or for which there is little known; to explore and describe factors that influence and interact with it; and to explore the in-depth meaning of the phenomena of interest for the researcher and community (Polit & Beck, 2012; Sandelowski, 2000).

Adams and Schvaneveldt (1991) pointed out unique features of descriptive research, which include being holistic, flexible, focused, and selective. Using the holistic

feature, the researcher seeks to understand the phenomenon in its entirety with as much detail as possible. By being flexible in exploring the phenomena of interest, the researcher is not locked into a rigid design. Thirdly, the research is focused on events that are in the process of taking place or have already taken place. Finally, by being selective, the researcher's focus is on some concepts while at the same time excluding others. Descriptive research questions focus on describing phenomena in rich detail, with particular emphasis on "how and who" research questions (Neuman, 2011; Polit & Beck, 2012). In contrast, exploratory research questions are very broad, framed to an area poorly understood, are open, broad, and probing, and seek to answer the "what and why" questions (Neuman, 2011; Polit & Beck, 2012). A descriptive, exploratory, qualitative research design can capture complete, holistic, dynamic, individual aspects of the human experience of the research topic (Polit & Beck, 2012). I chose a descriptive, exploratory, qualitative research design to explore and describe the experiences of work-related stress among HCAs in ALFs. Through this design, it was possible for me, as the researcher, to deeply engage and interact with HCAs through in-depth interviews.

Chapter Summary and Thesis Structure

The proportion of the Canadian population aged over 65 years is growing, and the demand for quality care facilities is likely to increase. ALFs will continue to play an important role in the overall provision of care services for the aged. Thus, it is important to understand what contributes to stress among HCAs who contribute more than 80% of the work force in ALFs. In this chapter, I provided an overview of the background, problem statement, purpose of the study, research questions, and significance of the study, as well as clarification of key terms. In this chapter, I also presented an overview

of my research design, my research perspectives, and theoretical framework. The inquiry question for my research was: How do health care aides experience work-related stress in assisted living facilities? Based on this question, a descriptive, exploratory, qualitative approach was determined to be well suited for this study because little is known about this topic.

Four chapters follow this introductory chapter. In the next chapter, I will discuss relevant literature in the areas of aging, HCAs, ALFs, and work-related stress, and I will outline the uniqueness of the study. Chapter Three describes the research design used in this study, which includes the theoretical framework, methodology, sampling, data collection method, data analysis, and ethical considerations. Chapter Four presents the findings of the study and answers the research questions. Chapter Five offers a discussion of the significance of the research findings, highlights the implications of the study and research dissemination, and provide recommendations for future research.

Chapter 2: Review of the Literature

In this chapter, the current literature relevant to the study is presented and organized into four sections: (a) aging; (b) assisted living facilities (ALFs); (c) health care aides (HCAs); and (d) work-related stress, including coping mechanisms and the consequence of work-related stress. Governmental reports and other relevant literature to the research reported are discussed. A comprehensive search for recent articles from 2000 to 2014 was completed, using MEDLINE, EMBASE, AMED, Cumulative Index for Nursing and Allied Health Literature, Google Scholar, Pro Quest dissertations and theses, Cochrane databases, government and provincial websites, and other websites. Several combined subsets were searched, which included aging, assisted living facilities, health care aides, work-related stress, nursing attendant, nursing aide, and older Canadian. The search was limited to the English language only.

As the literature review progressed, it became clear that there were few studies conducted on work-related stress among HCAs in Canada and at the international level. A few studies discussed work stress among HCAs in hospitals and long-term care facilities. For example, Hsu and colleagues (2007) used a quantitative research design to study work stress among nursing home care attendants in Taiwan. The purpose of this study was to identify associated factors that affect care attendants in nursing homes and strategies to relieve these problems. The questionnaire was completed by 110 participants from nine different facilities. The results revealed there many sources of work-related stress, such as insufficient ability, stressful reactions, heavy workload, trouble in care work, poor management, and working time problems (p. 736). Hsu and colleagues suggested using management strategies to relieve work stress as they found that work-

related stress related to human resource management and quality of care. Examples of potential management strategies are adequate staffing and job training on caring and coping skills to deal with the residents.

Tak, Sweeney, Alterman, Baron, and Calvert (2010) examined individual and organizational risk factors for injuries to nursing assistants from assaults by nursing home residents, and showed that 34% of participants reported experiencing physical injuries from residents' aggression in the previous year; also, participants who worked in Alzheimer care units were more likely to experience such injuries, including being bitten by residents. The authors suggested that reducing mandatory overtime and having a less demanding workload might decrease work place violence.

These two studies (Hsu et al., 2007; Tak et al., 2010) and others highlight the need to pay attention to the quality of care and staffing issue, inconsistent title for HCA, inconsistent education and training, potential causes of work stress, and multi-faceted nature of stress and its origins. Although, these two studies were quantitative, provided ideas related to work stress theories and help to read and find the appropriate theories, upon which to build my interview guideline.

Aging

The world's population is aging and living longer in both developing and developed countries. The percentage of the world's population over 60 years will increase from 11% to 22%, and the number of older people is expected to increase from 605 million to 2 billion between 2000 and 2050 (WHO, 2012, Slide 1). Moreover, there will be 400 million people aged 80 years or older by 2050 (WHO, 2012, Slide 2). Given this trend, the WHO has noted the importance of preparing health care providers and

societies to meet the specific needs of this segment of society. This includes training and education for health care providers in the elder care sector, preventing and managing chronic diseases associated with aging, and developing and designing sustainable policies and facilities for the older population (WHO, 2012, para. 2). Consequently, there is a need for more health services and human resources in the health care sector to deal with expected increases in the aging population.

As in other developed countries, Canada's population is aging. According to population projections by Statistics Canada (2010), older Canadians could account for more than quarter of the population by 2036 ("Age Structure," para. 1). The aging of Canada's population is projected to increase as the baby-boomer generation, those who were born between 1946 and 1965, turns 65 (para. 1). The number of older Canadians is projected to increase from 4.2 million to 9.8 million between 2005 and 2036. In 2001, according to Statistic Canada, the older Canadian population was 3,888,550, which had increased by 27% in 2011 to reach 4,945,065, and it will continue to increase by 17% in 2036 to be more than 10 million older Canadians. Many factors have contributed to the aging of the population in Canada, such as low fertility rates, increased life expectancy, and the effects of the baby-boom generation (Turcotte & Schellenberg, 2006). The concern is that the Canadian health care system needs to meet the growing health care needs of older Canadians (Canadian Institute for Health Information [CIHI], 2011). Furthermore, the numbers of government reports about health services for the aging population have demonstrated that this issue is at the forefront for policy makers and the public.

In Canada, it is commonly understood that those 65 and over are older Canadians (CIHI, 2011; Federation of Canadian Municipalities [FCM], 2013). Although Canada's population remains younger than those of many industrialized countries, many chronic conditions affect older Canadians, such as asthma, back problems, arthritis or rheumatism, high blood pressure, and obesity (CIHI, 2011; Turcotte & Schellenberg, 2006). The aging population will have an effect on the health services we need and the ways we build infrastructure. All individuals and segments in society need to play active roles in meeting the needs of older Canadians (FCM, 2013; Government of Alberta, 2011).

Similar to the rest of Canada, Alberta's population is growing and aging. According to Statistics Canada (2011), Alberta has the lowest percentage of older Canadians compared to other Canadian provinces; older people were about 11% of Alberta's population (405,725) and 15% of Lethbridge population (12,730) in 2009. The number of older Albertans is increasing as is their proportion within the general population. In 2012, there were 425,000 older Albertans, half of whom were female and lived in two largest cities (Government of Alberta, 2012). Alberta's aging population will increase demands for continuing care services that provide health, personal care, and housing services to support independence and quality of life for these older Canadians (Government of Alberta, 2011). Alberta's health system needs to adapt to meet the changing needs of Alberta's aging population.

In 2012, one in five Canadians was at retirement age (CIHI, 2011). By 2050, that number will have changed to one in four (FCM, 2013). The baby boomer population is reaching older Canadian status, and soon there will be a significant need for quality

homecare services for these individuals. Now, older Canadians are living longer and with fewer health conditions than previous generations (CIHI, 2011). At the same time, many older Canadians have at least one chronic disease or health condition. Policy makers, health care services, and service providers need to understand the consequence of the demographics of this changing and aging population to include strategies that contribute to the health of the community and the aging population (CIHI, 2011; FCM, 2013).

The aging population is a key issue facing Canada and most other developed countries. Managing health care quality and reducing the costs for this demographic are two focus areas in the Canadian health care system (CIHI, 2011). The baby boomer generation has been changing the health care landscape in Canada (FCM, 2013). Health care costs per capita increase with age and many believe that an aging population threatens the sustainability of the Canadian health care system (CIHI, 2011). The main point is that the aging population will require more care and will place a heavier burden on health care and social systems. Therefore, elderly individuals will likely move into ALFs, which means increased demands on HCAs for their daily life activities. This increasing demand may have negative implications for HCAs and increase their work-related stress.

Assisted Living Facilities

As people age, everything changes, including their lifestyle, requirements for everyday life, and housing needs. Older Canadians' physical and mental health becomes dependent on others, such as family, friends, or institutions like ALFs (Smith & Gove, 2010). Also, aging is often accompanied by disease and disability and a greater need for assistance with daily activities and personal care (Ramage-Morin, 2005). Persons at such

ages are at increased risk of chronic disease and physical and cognitive impairments that affect their ability to keep their independence (Golant, 2001). Many older Canadians now live in ALFs.

There are many types of supportive living settings in Alberta, including assisted living, lodges, seniors' complexes, and group homes (Dunn, 2002). There are 143 lodges with 8,500 beds, and there are around 12,000 beds in other supportive living settings (Dunn, 2002). With the prediction of an aging population in Canada, the health care system is facing the necessity of organized assisted living facilities and nursing homes. Alberta's supportive living system is the combination of health, personal care, and accommodation that support elderly Albertans' independence, well-being, and quality of life (ACCA, 2012). Supportive living is divided into four levels, ranging from a level one resident who needs minimal health services (i.e., fairly independent) up to level four residents who need many health services (ACCA, 2012).

Living in ALFs is the alternative living option for older Canadians rather than living alone or with their families (Hawes et al., 2003). Assisted living is a new phenomenon in Canada; it first appeared in the Canadian context in the 1990s (Centre for Health Services and Policy Research [CHSPR], 2012; Hawes et al., 2003). ALFs are already widely available in the United States and have emerged as an important solution for the aging population in the USA (Golant, 2001), and ALFs are an increasingly important care option for older people in North America (Freiheit et al., 2011). Given that the aging population, coupled with health care costs, requires a greater focus on home care and that the number of people receiving home care in Canada has grown rapidly (CHSPR, 2012, p. 1), ALFs may be a reasonable solution.

There is no consistent definition of assisted living or consistent use of

terminology, either in Canada or internationally (Health Council of Canada, 2010). ALFs

offer a supportive, semi-independent environment that includes hospitality services and a

24-hour emergency response system. ALFs are nonmedical, community-based,

residential settings that provide housing, food service, one or more personalized services,

and a safe environment to older Canadians with physical and mental disabilities (Freiheit

et al., 2011; Health Council of Canada, 2010). ALFs have been known by a number of

different names in different provinces. Mollica (as cited in Crook & Vinton, 2001) found

14 different terms used for assisted living, which included:

> assisted living facilities / homes / residences, residential long term/care facilities,
> personal care boarding homes, shelter care facilities, supported residential
> living/care facilities, community-based residential facilities, homes for the aged,
> large group/adult care homes, board and lodging, registered housing with
> services, comprehensive personal care homes, enriched housing programs,
> residences for adults, basic care facilities, and boarding homes. (p. 69)

> The Government of Alberta (2011) uses the term "supportive living facility" and

defines it as

> any residence, whether for-profit or not, that undertakes through its ownership or
> management to provide housing, meals, and one or more personalized services for
> a period exceeding 24 hours to one or more adults who are not relatives of the
> owner or administrator. (p. 1)

ALFs are one example of supportive living facilities that are situated in levels three and

four. Nursing homes, group homes, adult family living spaces, and family care homes are

other examples of supportive living facility at Alberta (CHSPR, 2012).

Generally speaking, there are no standards for housing, nursing, and personal care

services provided in ALFs; also, there is no commonly accepted definition of what

services should be provided in ALFs and who is responsible for the cost and delivery of

these services (Dunn, 2002). Therefore, without standards in ALFs, residents may not be receiving an appropriate level of care, housing, or personal care services (Dunn, 2002). However, British Columbia, in 2002, was the first province in Canada to regulate ALFs (CHSPR, 2012).

The Government of Alberta offers many services and programs for older Albertans. Furthermore, meeting the basic needs of older Canadians with assistance to perform the activities of daily living should be a major concern of public policy makers over the next few decades (Keefe, Légaré, & Carrière, 2005). In Alberta, Alberta Seniors and Community Supports has developed a supportive living framework and a framework of supportive living facilities that provide definitions of supportive living, clarify the roles and responsibilities of providers and residents, and provide common terminology for supportive living in Alberta (Alberta Health, 2013). The objective of Alberta Seniors and Community Supports is to standardize the regulations pertaining to the services provided in ALFs in Alberta.

There have been increased demands on ALFs in Canada. Golant (2001) argued that a growing older Canadian population with significant levels of physical disability and cognitive impairment has led to increase demands for ALFs rather than admission to long-term care facilities. ALFs respond to the need of older Canadians who want to live independently, but who require a certain level of services and support in acativities of daily living and personal care. ALFs are becoming much more important in creating a livable space for older Canadians to help them to maintain their vitality, healthy lifestyle, and even their freedom (Health Council of Canada, 2010). ALFs serve mainly frail older Canadians, most of whom use a walker or wheelchair, but some of whom quite

independent. ALFs are rapidly expanding in Canada. With this increasing number of

ALFs, the need for skilled workers who can meet older Canadians' needs is increasing.

Thus, HCAs appear to be a solution to address this need because they already comprise

more than 70% of workers in ALFs (Marcotte, 2009; Scott & Cassie, 2007).

On the whole, older Albertans represent a vulnerable segment of province's

population because many of them depend on others for their financial and physical needs.

Alberta's population is aging and the cost of care is expected to increase (Dunn, 2002). In

Alberta, ALFs have become a common housing option because of the growing numbers

of older Albertans and inadequate housing and health care to accommodate their needs.

Older Albertans with chronic illnesses or disabilities would prefer to receive health care

and personal care services in their own homes or in ALFs' homelike settings

(Government of Alberta, 2011). In 2012, there were 25,000 residents living in more than

700 licensed supportive living settings in Alberta (Alberta Health, 2012). Demographic

information relating to the older Canadian population in Canada has indicated that there

will be a significant increase in the need for ALFs, which means an increase in HCAs

because all ALFs in Alberta have HCAs (Alberta Health, 2013). Although the numbers of

HCAs employed in ALFs is increasing, there is currently a lack of uniform standards to

govern their work and work environment. These are challenges that can contribute to

work-related stress and the possible lack of agreed-upon standards to say what and how

the work of HCAs is conducted.

Health Care Aides

The increasing number of aging Canadians who will need health and social care,

coupled with the need to keep this care inexpensive represents a tremendous challenge to

the health care system in Canada (ACCA, 2012; Berta et al., 2013). The aging

population, the increase in chronic medical conditions due to aging, and the increased

demand on health care systems have resulted in great demand for HCAs (Demone, 2011).

Because of the shortage in skilled professional health care workers, HCAs now play an

important role in the health care system as a cheaper and more cost effective source of

labour than more formally skilled occupations (Berta et al., 2013; Sengupta et al., 2012).

However, the health care system, especially the eldercare sector, is facing a shortage of

qualified staff and a high turnover rate, which creates a challenge for aging societies

(Giver et al., 2010). HCAs not only provide basic health services (i.e., physical and

personal assistance), but also emotional support for the elderly and their families (ACCA,

2012; Sengupta et al., 2012). The increased use of HCAs has emerged due to many

reasons, such a shortage of professional health care providers, increased dependence on

ALFs, and an aging population (Pan-Canadian Planning Committee on Unregulated

Health Workers, 2009).

Furthermore, as a result of the expansion of ALFs, there is an increasing number

of HCAs employed in this field. This number is predicted to continue to increase sharply

over the next decades. HCAs now constitute a significant and valued part of the health

workforce (College of Nurses of Ontario, 2009). Internationally, there seems to be an

increasing trend toward using HCAs, predominantly in supportive living and home care

settings (Canadian Nurses Association [CNA], 2008).

There is no uniformly accepted definition of HCA (ACCA, 2012; Berta et al.,

2013). The HCA is a personal caregiver who assists people with their daily activity needs

as they deal with the effects of aging or disease. HCAs, unlike registered or licensed

professional health care workers, are unregulated in Canada, and are not licensed or regulated by a professional, government, or regulatory body, nor recognized as a profession (Berta et al., 2013; CNA, 2008; Cummings et al., 2013). There is no national standard for education of HCAs in Canada (Demone, 2011).

Many names and job titles are used to refer to HCAs across different provinces and sometimes within the same province in Canada (Church, Diamond, & Voronka, 2004; Demone, 2011). According to Human Resources and Skills Development Canada (2012), there are other titles for similar positions, such as health care aide (HCA) in Alberta and Quebec; and as hospital attendant (HA), nurse aide (NA), nursing attendant (NA), personal care attendant (PCA), resident care aide (RCA), patient care aide (PCA), assisted living worker (ALW), nursing home attendant (NHA), and home support worker (HSW) in British Columbia and Saskatchewan (Demone, 2011; Lum, Sladek, & Ying, 2010; HPRAC, 2006). In the United States, they are called attendants, care partners, home care aides, home health aides, medication technicians, nurses' aides, nursing assistants' orderlies, resident assistants, or service associates. In Australia, they are referred to as aged person care, assistant in nursing, community worker, direct care worker, and disabled person care; and in South Africa they are referred to as community health workers or community home care workers (CNA, 2008).

HCAs are the main health care providers in ALFs and are key supports for older Canadians' quality of care because of their direct contact and care role with residents (Marcotte, 2009). HCAs provide care to individuals in various health care settings including hospitals, long-term care homes, and ALFs (HPRAC, 2006). Based on survey findings, it has been estimated that HCAs carry out most (70–80%) of all home care work

in Canada (Demone, 2011). In Canada, HCAs are working in ALFs; their roles appear to be more attentive in providing personal care and supportive services than technical skills (CNA, 2008; Pan-Canadian Planning Committee on Unregulated Health Workers, 2009). Moreover, Church and colleagues (2004) argued that an HCA is one of the lowest-paid jobs in the health sector and the largest workforce; also HCAs are less trained, and the only unregulated group within the health care workforce. In the USA, the average hourly wage for HCAs who were working in the public sector in 2003 was $14.41, and for the private sector, it was between $11.66 and $12.04 (Church et al., 2004). However, these wages vary depending on which province you live in. Unfortunately, the actual number of HCAs working in the Canada is unclear. In 2005, there were more than 2.6 million HCAs working in the USA, 221,000 in the United Kingdom, 875,000 in Brazil, and 59,000 in Argentina (CNA, 2008).

Very little is known about HCAs in the literature. However, there are increasing efforts to study this group of health care workers because of the important role they provide to elder care, "with respect to fairly basic information including the nature of their preparation, their work motivations, their attitudes toward their work, and their aspirations" (Berta et al., 2013, Background section, para. 5). It is clear that there is a need to focus on this group, but in safe ways that produce good outcomes for the workers, older people, and community. A large number of HCAs are immigrants, and many HCAs come from certain countries more than others: especially new immigrants from the Philippines (Pan-Canadian Planning Committee on Unregulated Health Workers, 2009). In Canada, it is assumed that the HCA workforce includes internationally-trained nurses and physicians who are waiting to be Canadian-certified in their professions (CNA,

2008). HCAs are mostly middle-aged women, and some men, often foreign-born, and newcomers (CNA, 2008; Cummings et al., 2013).

In Canada, there is a remarkable number of HCAs who have not completed any training program. Some HCAs depend on previous work in related occupations; others bring health care training they received in another country (HPRAC, 2006). In addition, there is no consistent training requirement for HCAs entering the workforce nor is there a national standard for education and training of HCAs in Canada (CNA, 2008). Training for HCAs varies from province to province, and many HCAs are trained by employers, while others receive formal training in colleges (HPRAC, 2006). There are many educational and training routes leading to employment as an HCA (HPRAC, 2006). HCA programs are offered at 21 community colleges in Ontario, and the programs are usually eight months long (HPRAC, 2006). The Alberta HCA training program is considered to be the shortest program in Canada; the length of the program is 16 to 20 weeks, and the minimum requirement is Grade 10 or equivalent (Cummings et al., 2013).

In Alberta, HCAs are unregulated health workers who work in three continuing care sectors: long-term care facilities, assisted living facilities, and hospitals (Cummings et al., 2013; Demone, 2011). According to the ACCA (2012) workforce survey, HCAs in Alberta work under the supervision of a nurse or other health professional and provide basic care to residents at ALFs and must finish a recognized program to be eligible to work as an HCA. There are ten private and eight public post-secondary institutions licensed to provide HCA training programs in Alberta, and these programs vary in length and delivery options. Wages vary by employee and employer, with the average wage starting between $17.32 per hour and $21.48 per hour.

In summary, the older Canadian population is growing due to demographic changes, which has resulted in the increasing need for care (Giver et al., 2010). According to some authors, HCAs have become the heart and the frontline for the Canadian health care system (Association of Canadian Community Colleges [ACCA], 2012; Demone, 2011). There is no standardized educational background (i.e., standardized curriculum) across Canada for HCAs (ACCA, 2012). ALFs need health care providers who exhibit compassion, ethics, team work, and enthusiasm and have appropriate training (ACCA, 2012). Working as HCAs is emotionally and physically challenging, and salaries are not seen as adequate when compared with those from other health care sectors (ACCA, 2012).

Work-Related Stress

People are confronted with many situations in their personal lives that can cause stress. Another major stressor is associated with work. According to the United Nations (UN) and WHO, work stress has become a global epidemic (Collins, 2006). DeVries and Wilkerson (2003) reported that stress is fast becoming the most common cause of worker ill health and disability; 40% of turnover is expected due to stress, and 25% of workers find work is their largest life stressor. Additionally, increased expenses related to work-stress problems and compensation claims have been identified as significant among individual workers (Collins, 2006). Fisher (2001) stated that approximately 30% of North American workers were affected by stress, and workplace stress has been described as a substantive problem for workers and employers (Patrick & Lavery, 2007). In Europe, stress is one of the most reported work-related health problems and is estimated to affect

22% of workers, making work-related stress one of the main health concerns and safety challenges (Milczarek, Schneider, & Rial González, 2009).

Moreover, work-related stress is the main cause of "sickness absence" in the UK, with work-related stress and the consequences of illness related to stress costing £12 billion each year and the loss of 40 million working days yearly in UK industries (Shrivastava, 2014). Palmer, Cooper, and Thomas (2004) noted that "any employee can suffer from stress regardless of age, status, gender, ethnicity or disability" (p. 2). Work-related stress is a combination of high demands and a low amount of control over the situation (CCOHS, 2012b). Stress is everywhere in the workplace and considered to be an earnest health problem (DeVries & Wilkerson, 2003). Stress has become increasingly implicated in causing illness, absence from the workplace, requests for modified work, or even early retirement. However, little of the existing literature on work-related stress that I was able to identify concentrated on HCAs. I hope that this study will inform policy makers, employers, and unions, and that it will be of interest to HCAs too. To gain a deeper understanding of work-related stress, I reviewed literature related to defining stress, sources of work-related stress, consequences of work-related stress, signs and symptoms of stress, and how one might cope with stress.

Defining Stress

The concept of stress has been of global interest for the last several decades. However, there has been no universal way of looking at this concept, which refers not only to an important theoretical problem, but also affects every aspect of life (Milczarek et al., 2009). The definition of stress as a concept ranges from basic to omnibus, and debate continues regarding the most adequate definition that reflects different

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understandings of the concept (Milczarek et al., 2009). Stress, as a phenomenon, is difficult to define, and it is hard to find a definition that everyone agrees upon because it is a subjective feeling experienced by individuals (Baum, Revenson, & Singer, 2012); what is a stressful situation for one individual may be not for others. Thus, there are many definitions of stress.

Stress was a concept introduced in the 1930s by Hans Selye, who defined it as "a non-specific response of the organism to any pressure or demand" (Milczarek et al., 2009, p. 14). The National Institute of Occupational Safety and Health (2001) has defined stress as "the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, needs of the worker" (p. 1). Furthermore, CCOHS (2012b) defined work-related stress as noxious or negative effects that can occur when there is a conflict between job demands and the amount of control, which could be harmful to physical and/or emotional reactions. The European Agency for Safety and Health at Work (as cited in Milczarek et al., 2009) has approved this definition: "Work-related stress is experienced when the demands of the work environment exceed the workers' ability to cope with (or control) them" (p. 14). In other words, stress is the result of any emotional, physical, social, or economic factors that require a response or change beyond one's ability to cope.

Sources of Work-Related Stress

One can easily fathom that working in ALFs could be a very stressful position, because individuals work with such a vulnerable group of people who are not capable of performing their daily living activities, and staff face demands from this job as previously outlined. The health sciences literature provided abundant studies and information

regarding work-related stress among many different professions. However, the literature lacked documentation of how work-related stress experiences are understood by HCAs. Thus, the question remains: What is the experience of work stress for HCAs? First, one needs to know what the sources of work-related stress are.

Working in the health care field is extremely stressful, where caregivers provide a great deal of themselves emotionally in the process of caring for their clients, while giving little attention to themselves (Giver et al., 2010). Health professionals reported the highest rates of work-related stress compared to other jobs (Health and Safety Executive [HSE], 2014). There are many stressors HCAs encounter throughout the process of acquiring and keeping trust with management, family, and residents. Work-related stress for HCAs comes from a variety of sources including patient care, which is the most stressful, as well as co-worker and supervisor relationships, workload, and work schedule (Lin, Yin, & Li, 2002).

There are many sources of work-related stress such as workload, shiftwork and hours of work, lack of skills and training, lack of appreciation, threat of violence, role conflict, and role ambiguity (CCOHS, 2012b; National Institute for Occupational Safety and Health, 2008); and lack of managerial supports, work-related violence, and bullying (HSE, 2014). Barling, Kelloway, and Frone (2005) identified various sources of work-related stress, such as organizational role stress, work schedules, organizational justice, poor leadership, work-family conflict, harassment and discrimination, workplace aggression, physical work environment, and work place safety. In addition, ACCA (2012) identified many factors that increase workplace stress among HCAs, such as

working short-staffed, heavy workloads, low wages and benefits, and not being recognized or respected by others.

Moreover, more origins of work-related stress in the health care field were identified by researchers, such as insufficient staffing, working short- staffed, poor communication, and staff attitudes (Curry, Porter, Michalski, & Gruman, 2000); lack of training and knowledge and dealing with frail residents (Lerner, Resnick, Galik, & Flynn, 2011); caring for another person (King, 2008); and shift work, working more than one job, physical violence, and working long hours (Parent-Thirion, Fernández Macías, Hurley, & Vermeylen, 2007). Stress is a serious issue for health care workers. According to the National Population Health Survey, physicians experience the least amount of stress, while HCAs experience the highest levels of stress (CIHI, 2006). However, some employees may be at a higher risk than others; every individual is different from others, and how they perceive stressors and the ability to cope with these stressors (Bickford, 2005).

Consequences of Work-Related Stress

Stress can have an impact on overall health. As posited by Griffiths, Knight, and Mahudin (2009),

> Work-relate stress is best understood as a negative emotional state which, if persistent, can lead to the development of both mental and physical illness. In particular, anxiety, depression, cardiovascular disease and musculoskeletal disorders have been associated with the report of stress and poor working conditions. (p. 9)

The impact of work-related stress on HCAs is less known than are the well-documented effects on other occupations such as registered nurses. Work-related stress can have multiple origins and can impact employees, employers, and community. Work-

related stress has a negative effect on the health of employees and on workplace

productivity (Bickford, 2005; Griffiths et al., 2009). Furthermore, the quality of patient

care provided may also affect health care worker stress (National Institute for

Occupational Safety and Health, 2008). Work-related stress is not a disease, but it can

lead to increased physical problems, such as heart disease, back pain, gastrointestinal

disturbances, and psychological effects, such as anxiety and depression (CCOHS, 2012b;

HSE, 2014).

Griffiths and colleagues (2009) noticed that work-related stress is responsible for

more lost working days than any other cause and is a significant contributor to illness

among workers, which can be connected to absence and turnover. Stress may affect

workers' behaviour including:

> lack of confidence, poor relationships with colleagues, poor quality work, social
> withdrawal, and poor time management. They may also, smoke, drink, or take
> recreational drugs more than usual. At the organizational level, increases in
> disputes, complaints and grievances, sickness absence, staff turnover and
> customer dissatisfaction may also be indicative of work-related stress. (p. 12)

Signs and Symptoms

There are many physical and psychosocial signs and symptoms that can indicate

someone is experiencing stress. The following are some examples:

1. Physical signs and symptoms, such as headaches, chest pain, high blood

   pressure, muscle aches and fatigue, and insomnia;

2. Psychosocial signs and symptoms, such as anxiety, anger, mood swings,

   hypersensitivity, apathy, and depression;

3. Behavioral symptoms, such as increased use of alcohol or drugs, increased

   smoking, withdrawal or isolation from others, neglect of responsibility, poor

job performance, and poor personal hygiene (CCOHS, 2012b; National

Institute for Occupational Safety and Health, 2008); and

4. Behavioural changes, such as changes in diet, sleep patterns, and exercise

habits (Griffiths et al., 2009).

Chapter Summary

The increasing number of aging Canadians who will need assisted living care,

combined with the requirement to keep this care reasonable, represents a challenge to the

Canadian health care system. Therefore, some response must be made to address what

will become an immediate need in the near future. Understanding work-related stress

issues among HCAs is important. Work-related stress not only leads to negative effects

on individuals' psychological and physical health and performance, but also to negative

effects at the organizational and community levels, which in turn leads to reduced

individual ambitions and motivation to provide good health care to residents in ALFs.

There has been increased global interest in the issues of job stress. Essentially, work-

related stress can overwhelm an HCA's helping and coping capabilities, decreasing his or

her effectiveness in a helping job. Despite the multi-dimensions of work-related stress

among HCAs, it is a complex phenomenon with potential side effects for HCA, resident,

and the HCA-resident relationship. The current study has provided additional important

knowledge of the factors that may contribute to work stress among HCAs. A discussion

of the research methodology and analysis is presented in Chapter Three.

Chapter 3: Methodology

The purpose of this chapter is to describe the research approach used to explore and understand the experience of work-related stress among HCAs in ALFs. I will outline the research process that I undertook, including philosophical justification, theoretical framework, design, sample and setting, data collection and analysis, research rigor, and ethical considerations.

Philosophical Justification

As the researcher, I recognized that my beliefs, nursing back ground, working as an HCA, my social life, and work experiences as well as my assumptions could influence the research process. Everybody has his or her own philosophical assumptions and paradigm. Choice of an appropriate paradigm is seen as a required step to justify the use of a particular research method (Hall, 2012). A paradigm is "a world view, a general perspective on the complexities of the real world" (Polit & Beck, 2012, p. 11). Paradigms for human inquiry often answer the basic philosophical questions related to ontology and epistemology (Polit & Beck, 2012). Paradigms are associated with ontological and epistemological assumptions, where ontology refers to what exists in the world and the ontological assumptions address the nature of reality (Nord & Connell, 2011). Epistemology refers to how we come to know about what exists in the world (Nord & Connell, 2011). The epistemological assumption addresses the nature and grounds of knowledge.

A paradigm is based on the researcher's worldview. My nursing experiences and working as an HCA, researcher, and teaching assistant provided me with a number of professional and personal lenses for approaching this project. Consequently, my

philosophical assumptions were shaped by my own worldview and my personal and work experience. My approach arises from social constructivism. The basic principle and central assumption of social constructivism is that reality is socially constructed (Bloomberg & Volpe, 2012). In other words, "individuals develop subjective meanings of their experiences-meanings directed toward certain objects or things. These meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrowing meanings into a few categories or ideas" (Creswell, 2014, p. 8). In addition to the emphasis on the socially constructed nature of reality, social constructivism research acknowledges the close relationship between the researcher and what is being studied (Creswell, 2014, p. 8).

I situated my research in the social constructivism paradigm, and the methodology that was the best suited for this research was a descriptive, exploratory, qualitative design. This method is interactive and provides the opportunity to obtain multiple perspectives of the meanings, experiences, and processes that affect an individual's experience. This study was focused on exploring the personal experiences and understanding of work-related stress and coping mechanism from an HCA's perspective. It was recognized that although there might be similarities between the HCA responses, the experience and context remained unique to each individual. Social constructivism was applicable to my study; the participants were expected to describe a different experience related to their own perceptions of work-related stress.

The purpose of this study was descriptive and exploratory in nature, and I made no attempt to naively assume a singular view or presume that all HCAs who have experienced work stress had a similar viewpoint. However, there was a possibility of

common experiences and patterns among the participants. For example, there might be common conditions that contributed to work-related stress and coping, common approaches to dealing with work-related stress, or common experiences of what it is like to live with workplace stress.

Theoretical Framework

Most researchers use theory to guide their work, to locate their studies in larger scholarly backgrounds, or to map the structure of the specific concepts they will explore in detail (Marshall & Rossman, 2011). A theoretical framework is "a structure of concepts, theories, or both that is used to construct a map for the study" (LoBiondo-Wood, Haber, Cameron, & Singh, 2012, p. 44). It provides the researcher with a way to understand how a phenomenon comes to exist, while guiding the researcher to determine the questions to be asked or answered throughout the data collection phase (LoBiondo-Wood et al., 2012; Polit & Beck, 2012). In this study, I have used two theories related to stress, which include (a) the transactional model of stress and coping (Glanz, Rimer, & Viswanath, 2008; Lazarus & Folkman, 1984) and (b) the job demands-resources model (Demerouti & Bakker, 2011; Schaufeli & Taris, 2014).

The Transactional Model of Stress and Coping

The transactional model of stress and coping (TMSC) was an appropriate theory for my research. This theory attempts to explain how people deal with stress: that is, environmental and internal demands that exceed a person's resources and threaten his or her well-being. The TMSC proposes that stress is a result of the transaction between persons and their environment and does not exist as an incident nor does it dwell in a person or the environment (Lazarus, 1966; Lazarus & Folkman, 1984). This theory

explains that "coping strategies are learned deliberate responses used to adapt to or change stressors [and] a person's perception of mental and physical health is related to the ways he or she evaluates and copes with the stresses of living" (Polit & Beck, 2012, p. 137). The main point is how different people perceive an event or situation in different ways, which means that the main causes of effects on behaviours and health status are specific to an individual's perception rather than the stressors (Glanz et al., 2008). Stress is viewed as a relationship between individuals and their environment (Krohne, 2001; Lazarus & Folkman, 1984). From this view, one can see work-related stress as a result of "the interactions between individual workers' characteristics and the work environment" (Glanz et al., 2008, p. 213; see also Lazarus & Folkman, 1984). The TMSC contains two main concepts, which include (a) appraisal concept and (b) a coping concept (Lazarus & Folkman, 1984).

Appraisal. Appraisal is cognitive in nature and involves primary and secondary appraisal. Primary appraisal is defined as "a person's judgment about the significance of an event as stressful, positive, controllable, challenging, benign, or irrelevant" (Glanz et al., 2008, p. 215). Primary appraisal is a cognitive process that relates to a personal judgment about confrontation. Primary appraisal includes two main concepts: (a) susceptibility; and (b) severity of a threat (Lazarus & Folkman, 1984). Secondary appraisal is considered to be "an assessment of a person's coping resources and options" (Glanz et al., 2008, p. 216). That means secondary appraisal depends on a person's control of the stressor and his or her coping resources to deal with the primary appraisal (Glanz et al., 2008). Secondary appraisal has three components: (a) blame or credit, (b) coping potential; and (c) outcome (Krohne, 2001). The key examples of secondary

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appraisal include the perception of the ability to change the situation, manage emotional

reaction, and expectations about the effectiveness of coping resources (Glanz et al.,

2008). Each pattern of appraisal leads to different kinds of stress. Lazarus (as discussed in

Krohne, 2001) distinguished three types of stress: (a) harm; (b) threat; and (c) challenge.

      Coping. Coping is closely related to the idea of cognitive appraisal. Lazarus and

Folkman (1984) defined coping as the cognitive and behavioral efforts made to decrease

or tolerate the stressors (p. 223). The main purpose of coping is to manage perceived

stress and related negative results as these arise (Weinstein & Ryan, 2011). According to

TMSC, coping appears to be the actual schemes used to facilitate primary and secondary

appraisals, which can be positive or negative (Glanz et al., 2008; Lazarus & Folkman,

1984).

      There are two dimensions along with the coping concept these are emotional

regulation and problem management (Glanz et al., 2008). Emotional regulation strategies

are most adaptive when the stressor is constant, while problem management strategies are

adaptive for stressors that are inconstant (Glanz et al., 2008, p. 217). Emotional

regulation coping efforts are controlled by changing the way one thinks or feels about a

stressful event, which comes from social support, venting feelings, avoidance, and denial

(Glanz et al., 2008; Lazarus & Folkman, 1984). However, avoidance and denial may

affect the psychological health status of the workers (Lazarus & Folkman, 1984). In

contrast, problem management strategies change the stressful event through "active

coping, problem solving, and information seeking" (Glanz et al., 2008, p. 217), which

means managing the problem within the environment or the person (Lazarus & Folkman,

1984). The last component of TMSC focuses on the outcomes of the coping efforts,

which may affect psychological and physical well-being, health behaviours, and health status (Glanz et al., 2008; Lazarus & Folkman, 1984).

To recapitulate, it is important that work-related stress research be based on a theoretical framework (Edwards & Burnard, 2003). TMSC suggests that there are three major phases, which include (a) appraisal of the stressors; (b) coping efforts; and (c) outcome, whether positive or negative (Glanz et al., 2008). Furthermore, there are many sources of work-related stress, with each unique professional group facing different types of stress (Edwards & Burnard, 2003). The goal of this study was to describe the experience of work-related stress from the perspective of HCAs, which might be different from the perspectives of others. It was necessary to see the world as HCAs do in order to understand how they create and enact their seeing. To connect that to social constructivism, TMSC is based on three major phases of appraisal, coping efforts, and outcome, and these phases are socially constructed. For this research, it was assumed that each participant has developed subjective meanings, which are varied and multiple, of his or her personal experience toward work-related stress.

The Job Demands-Resources Model

The job demands-resources (JD-R) model was developed by Bakker and Demerouti in 2001 (as discussed in Demerouti & Bakker, 2011). The JD-R model is considered to be one of the leading job stress models used in work stress research (Schaufeli & Taris, 2014). In the JD-R model, the main assumption is that every job has its own specific risk factors that connect with work-related stress (Demerouti & Bakker, 2011; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001).

The JD-R model suggests that working conditions can be classified into two groups: (a) job demands; and (b) job resources, both of which lead to different outcomes (Demerouti & Bakker, 2011; Demerouti et al., 2001). Job demands can be defined as "those physical, psychological, social, or organisational aspects of the job that require sustained physical and/or psychological (cognitive and emotional) effort or skills and are, therefore, associated with certain physiological and/or psychological costs" (Demerouti & Bakker, 2011, p. 2), such as physical work overload, physical environment (e.g., lifting heavy objects), time pressure, shift work, role ambiguity, poor relationships (Demerouti & Bakker, 2011; Demerouti et al., 2001), interpersonal conflict, and job insecurity (Schaufeli & Taris, 2014). Job resources, according to Demerouti and Bakker (2011), could be defined as any "physical, psychological, social, or organisational aspects of the job that are either/or: 1. functional in achieving work goals; 2. reduce job demands and the associated physiological and psychological costs; 3. stimulate personal growth, learning, and development" (p. 2), such as feedback, job control, rewards, participation, job security, autonomy (Demerouti & Bakker, 2011; Demerouti et al., 2001), strong work relationships, and social support (Schaufeli & Taris, 2014).

Another assumption of the JD-R model is the interaction between job demands and job resources; that when job demands are high, additional effort is needed to achieve personal goals and to prevent negative outcomes that come with physical and psychological problems like fatigue and irritability (Schaufeli & Taris, 2014). Furthermore, the JD-R model also assumes that work stress results from high job demands and low job resources, which will cause physical and psychological health problems, such as depression and heart disease (Schaufeli & Taris, 2014). The job

demands and job resources of work characteristics are divided into two independent

psychological processes: (a) health impairment; and (b) motivation (Demerouti, Bakker,

& Fried, 2012; Demerouti et al., 2011). Health impairment occurs when very demanding

or chronic job demands, such as work overload, drain employees' mental and physical

resources and lead to physical and psychological problems (Demerouti & Bakker, 2011;

Demerouti et al., 2001; Demerouti et al., 2012). In contrast, the motivational process

assumes that "job resources have motivational potential and lead to high work

engagement, low levels of cynicism and excellent performance" (Demerouti & Bakker,

2011, p. 2).

To summarise, my theoretical outlook about work-related stress and coping in this

study has been informed by the TMSC and JD-R models. TMSC explains how people

deal with stress and how they perceive an event or situation in different ways (Lazarus &

Folkman, 1984). The JD-R model assumes that every job has its own stress-related risk

factors and categorizes working conditions as demands or resources that lead to different

outcomes (Demerouti & Bakker, 2011).

From social constructivism viewpoint, this research aimed to understand how

HCAs create individual and shared meanings around the experiences of work-related

stress and engage coping mechanisms. Social constructivism does not deny the impact of

each job and its factors that connected with stress, but focuses on investigating the

personal experience of work-related stress on the individual and his or her work life. The

experience of work-related stress is affected by individual and contextual influences,

time, and physical and mental maturation. TMSC examines stress with the view as to

how an individual interacts with the environment and the associated coping mechanism,

while the JD-R model focuses on working conditions and physical and psychological outcomes. Each participant has a unique experience of work-related stress, so using both theories to guide my research and interpret my data was suitable for this research.

Design

A research design is a "systematic inquiry that uses disciplined methods to answer questions or solve problems" (Polit & Beck, 2012, p. 3), while qualitative research is defined by Creswell (2014) as "an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (p. 4). The purpose of my research design was to acquire and understand diverse data on a particular subject, thereby trying to understand the perceptions and experiences of work-related stress and answer the research questions.

The objective of exploratory research is to understand the keystones and the base of particular phenomena, to explain the relationships among phenomena and to provide promising insights (Polit & Beck, 2012). The purpose of a descriptive, exploratory, qualitative design is to identify, discover, and describe in depth a phenomenon never studied before or one for which more needs to be known (Marshall & Rossman, 2011; Sandelowski, 2000).

Descriptive, qualitative approaches usually are a combination of sampling, data collection, analysis, and re-presentation style (Sandelowski, 2000). Research questions generally focus on describing phenomena in rich detail, while focusing on the "How and Who" questions (Neuman, 2011; Polit & Beck, 2012). Exploratory research questions are very broad, framed to an area poorly understood, they seek to answer the "What and Why" questions (Neuman, 2011; Polit & Beck, 2012).

A descriptive, exploratory, qualitative research design has the potential to capture complete, holistic, dynamic, individual aspects of the human experience of the research participants (Polit & Beck, 2012). Qualitative research can also explore a topic that has been widely researched quantitatively, like my identified topic, but which has had little qualitative consideration (Polit & Beck, 2012). The purposes of a descriptive, exploratory, qualitative research design are to "build rich description of complex circumstances that are unexplored in the literature" (Marshall & Rossman, 2011, p. 68), to investigate little understood phenomena, and to document and describe the phenomenon of interest. Furthermore, my nursing background, working as an HCA, being a naive researcher, and my belief that reality is constructed through human activity and that knowledge is a human product and is socially and culturally constructed led me to choose this research design to explore and describe the experiences of work-related stress among HCAs in ALFs. This approach also enabled me to be close to my data (Sandelowski, 2000). In addition, this design was the best choice to convey straightforward everyday depiction of a phenomenon (Sandelowski, 2000).

Sample and Setting

Sampling

The main purpose of sampling in qualitative research is "to increase the efficiency of a research study" (LoBiondo-Wood et al., 2012, p. 261) and "to discover the meaning and to uncover multiple realities, not to generalize to a target population" (Polit & Beck, 2012, p. 515). The sample is the group of people selected to participate in the study because they meet specified criteria (LoBiondo-Wood et al., 2012). In this research, the sample was drawn from a specific HCA population. In order to obtain a deeper

understanding of the work-related stress, a purposive sampling technique was used in the beginning followed by snowball sampling, which is a common sampling strategy in qualitative research (LoBiondo-Wood et al., 2012).

Purposive sampling involves choosing cases with an information-rich data source for the research (Neuman, 2011; Polit & Beck, 2012). In other words, the sample is meant to include cases of interest and exclude those who do not suit the purpose of the research. Cases are chosen because they reflect a particular characteristic (LoBiondo-Wood et al., 2012). For example, in my study, participants were selected because they had experienced work-related stress in their place of employment. In this study, a purposive sample provided the means to investigate a specialized population of HCAs working in ALFs in two Southern Alberta communities.

The purpose of qualitative research is to generate an in-depth understanding of the perspective of a purposively selected group of participants. For the purpose of this study, a total of 14 HCAs at three ALFs were interviewed. Data collection stops when data saturation occurs or the analysis does not yield new insights and becomes repetitive (Hesse-Biber & Leavy, 2011; LoBiondo-Wood et al., 2012). The purpose of this sample was to select cases that were easy to reach, convenient, or readily available (Neuman, 2011). Four to five participants from each facility were considered to be adequate in identifying the appropriate themes to the experience of work-related stress among HCAs in ALFs. As only nine HCAs initially volunteered to participate, I also employed a snowball sampling strategy.

Snowball sampling relies on asking initial participants to identify and refer additional study participants (Polit & Beck, 2012). Snowball sampling relies on selecting

participants in a chain or network, so it is also called a chain referral (Neuman, 2011).

There are many advantages for this kind of sampling, such as lower search costs and time

(Bryman & Teevan, 2005; Polit & Beck, 2012). I used snowball sampling to strengthen

the research findings and to obtain sufficient participants.

Inclusion/Exclusion Criteria

To be eligible for participation in this study, participants had to meet the

following criteria:

- Currently employed as an HCA who provides care to residents in ALFs,

- Assists with all activities of daily living, including bathing, toileting, transferring, and feeding,

- Must have been employed at the facility for a minimum period of twelve months, and

- HCA must have identified English as their preferred language of communication at work.

The sample in this study ($N = 14$) was derived from the target population of

HCAs currently working. This study was conducted in two Southern Alberta

communities. Participants for this research were recruited from three sites of a Christian

hospital-based, not-for-profit organization, which serves more than 6,000 residents across

Canada. The first site had 90 living suites and a 10-bed dementia care cottage. The

second one had 40 living suites, a 76-bed dementia care cottage, and 5 community

support beds. The third site had 50 living suites, and 35geriatric mental health care beds.

Recruitment Strategies

Recruiting is a complex process and needs careful consideration. Participants were recruited through the placement of posters (see Appendix A) that were placed in each facility in different locations, including meeting rooms, dining rooms, and staff lounges, after permission was given by the employer. These posters included a summary of the research study, purpose, inclusion criteria, and the contact information of the researcher. Six weeks from the start of data collection; I posted another poster, which was approved by the Human Subject Research Committee of the University of Lethbridge (see Appendix B). After that a new recruitment strategy was adopted, which was to approach staff at the nursing station at each ALF and explain the project. This strategy was also approved by the Human Subject Research Committee.

Data Collection

Data were gathered through semi-structured interviews with 14 participants from three ALFs in Southern Alberta. According to Creswell (2014), there are many forms of interview designs that can be developed to obtain rich qualitative data. For my study, a face-to-face, semi-structured interview was conducted. Each interview lasted between 30 to 60 minutes in length, though four interviews were more than 60 minutes in length.

Kvale and Brinkmann (2009) defined a semi-structured interview as an "interview with the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena" (p. 3). A semi-structured interview is an interview that is guided by pre-developed questions, but is open to following and pursuing issues that are brought up spontaneously by the participants (Kvale & Brinkmann, 2009). The semi-structured interview approach posed the same questions to

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all participants, but also allowed me the flexibility to explore answers more deeply and gather more information than is found in a structured interview (Bryman & Teevan, 2005). However, there was no guarantee that the data would be standard across participants because each could respond differently to the same questions. The interview guide was informed by the primary research question.

A semi-structured interview is a valuable method to explore topics when little is known about them. It assists the researcher to examine the meaning of the participant's experience from their view, and allows the researcher to probe and explore the topic more deeply (Liamputtong, 2013). On the other hand, there are many disadvantages; it can be time consuming, the interview guide may differ among participants which means that not all questions may be used with each participant, and the interview process itself is very demanding and exhausting for the researcher (Liamputtong, 2013).

The use of pilot interviews assisted me with refinement of the questions and to find ways to eliminate barriers (Marshall & Rossman, 2011). Two pilot interviews were conducted and used as additional self-critiquing tools, which were used to enhance my interviewing skills prior to actual data collection. The pilot interviews also helped me determine if there were limitations or problems within the interview guide, which then allowed me to make required changes prior to the implementation of the actual study (Kvale, 2009). These interviews were transcribed and analyzed in the research findings because they were interviewed within the actual sample and helped provide valuable information. The pilot interviews helped me to refine my interview guideline questions (see Appendix C).

Data Analysis

Qualitative data are descriptive data, which come from interviews, field notes, and

memos and are not numerical in form (Liamputtong, 2013). Qualitative data are "messy,

ambiguous, time-consuming, creative, and fascinating" (Marshall & Rossman, 2011,

p. 207). According to Braun and Clarke (2013) qualitative data aimed to "give voice to a

group of people or an issue; provide a detailed description of events or experiences;

develop theory; [or] interrogate the meaning in texts" (p. 19). Therefore, analyzing

qualitative data is a difficult task for qualitative researchers (Creswell, 2014). Data

analysis could be described as organizing raw data to make them more meaningful, clear,

and understandable (Liamputtong, 2013). Rubin and Rubin (2005) defined data analysis

as:

> the process of moving from raw interviews to evidence-based interpretations that
> are the foundation for published reports. Analysis entails classifying, comparing,
> weighing and combining the material obtained during data collection to extract
> the meaning and implications, to reveal patterns, or to stitch together descriptions
> of events into a coherent narrative. (p. 201)

I transcribed half of the interviews; the others were transcribed by a professional

transcriber, which allowed me to become familiar with and explore the data deeply

(Braun & Clarke, 2013; Halcomb & Davidson, 2006). Each interview was audio-recorded

and transcribed verbatim and used as a primary data source (Halcomb & Davidson,

2006). I transcribed each interview immediately after finishing the interview. All the

names and identifiers were removed, which maximized the security of the information.

Verbatim transcription is considered to be foundational to the analysis and interpretation

of verbal data (Halcomb & Davidson, 2006). Poland (as cited in Halcomb & Davidson,

2006) defined verbatim transcription as "word-for-word reproduction of verbal data, where the written words are an exact replication of the audio recorded words" (p. 39).

Thematic qualitative analysis was used to analyse data in this research. Braun and Clarke (2013) defined thematic analysis as "a method of identifying themes and patterns of meaning across a dataset in relation to a research question" (p. 175). I chose this strategy for many reasons. First, thematic analysis is considered to be the foundational method of qualitative analysis that novice researchers should learn early, and it provides basic skills that will be useful for other data analysis methods in a qualitative study (p. 180). Second was the "flexibility in terms of theoretical framework, research questions, methods of data collection and sample size" (p. 180). Third, the results from thematic analysis are easily accessible to an audience. However, there are many weaknesses in using thematic analysis, such as the limitation of the interpretation power if not based on an existing theoretical framework (p. 180)—something that was not a problem in this research. Braun and Clarke suggested three steps for thematic analysis, which include (a) familiarization and data coding; (b) identifying patterns across data; and (c) analysing and interpreting patterns across data. The application of these steps in my study is further described in this section.

Familiarization and Data Coding

I became familiar with the data by reading the transcripts for the first time without making or attempting to interpret the data. Then, I re-read the transcripts and wrote my initial ideas in a code log book. I organized the data into meaningful groups, started to produce my initial codes from my initial list, and collected data relevant to each group from the entire data set. Then, I made notes in the margins about significant subthemes

that emerged; I made as many notes as possible using key words expressed by the participants, which were useful later in developing themes. By reviewing the initial codes in the two pilot interviews, I was able to refine my codes and delete the repeated words or phrases. I searched for connections among and started to organize those initial codes in a systematic process, where all the relevant codes were grouped together.

Coding is the first step in data analysis (Creswell, 2014; Neuman, 2011). Coding includes the names, tags, or labels given by the researcher to chunks of data to describe them, which are then categorized, summarized, and accounted for in each piece of data (Liamputtong, 2013; Neuman, 2011). Coding played a vital part in thematic analysis. I needed to perform initial and axial coding, where codes, themes, and subthemes were linked and integrated together (Polit & Beck, 2012). I organized the natural data into conceptual categories and created concepts, codes, categories, themes, and main themes (Neuman, 2011).

Coding is defined as "a progressive marking, sorting, resorting, and defining and redefining of the collected data" (LoBiondo-Wood et al., 2012, p. 335). I used a complete coding approach in this step. Complete coding is defined as looking within the transcripts to detect anything related or relevant to the research questions (Braun & Clarke, 2013). For each code, I collected all the relevant coded data in one document file with a clearly titled name. The codes came from different sources such as a literature review (How do HCAs cope?), the actual words or phrases in the data (e.g., Let it go, Venting), and my own interpretations (e.g., genesis of work-related stress) (Marshall & Rossman, 2011). I entered seven interviews into the NVivio 10 software program to help me code and analyze (Creswell, 2014; Liamputtong, 2013; Polit & Beck, 2012). The computer

software was helpful in storing and organizing all qualitative data sources in one place, which allowed me to connect all data together (Creswell, 2014).

Identifying Patterns across Data

This step starts when all data have been coded, and the researcher has a long list of the different codes and potential themes across the data set (Braun & Clarke, 2013). Analysis includes sorting the different codes into potential themes and collecting the relevant coded data within the identified themes (Braun & Clarke, 2013). At this step, I started searching for patterns and moving forward from codes to themes (Braun & Clarke, 2013). I read each transcribed interview carefully line by line, and I highlighted and divided the data into meaningful and insightful codes and themes. These themes captured the important data in relation to the research question and the main topic, which means that a theme is a central meaningful concept about the data with relation to the research questions. These themes were broader than a code, expression, or idea from the actual data or consistent phrases. By the end of this stage, all my data were organized in a systematic way; each theme and all the relevant data were saved in the same places. Moreover, this step enabled me to review and refine the themes by checking if the themes worked in relation to the code and the entire data set or not. I tried to narrow my themes to major ones; also, I started to generate a map for my themes and tried to connect them in a visual way. This step allowed me to go back and check my codes and themes to see if they were really related or not. By going back, I was able to come up with new themes or subthemes.

Analysing and Interpreting Patterns across Data

This step involved continuous analysis to refine the specifics of themes and create a definition and clear name for each theme (Braun & Clarke, 2013); this mean "identifying the 'essence' of what each theme [was] about (as well as the themes overall), and determining what aspect of the data each theme capture[d]" (p. 92). At this point, my data were more thoroughly organized into themes, which could then be reported and written up in my findings and discussion sections. This was the final step for analysis, which included relating the analysis back to the research question and literature review, and comparing and producing a final report of the analysis (Braun & Clarke, 2013).

Rigor and Trustworthiness

A rigorous approach to research is crucial in order to lead the methods choices that researchers must make during their research and to set the reasoning by which they conduct data collection and data analysis (Creswell, 2014). A rigorous approach includes trustworthiness, credibility and authenticity, transferability and applicability, dependability, and confirmability. Credibility is achieved to the extent that the research methods ensure confidence in the truth of the data. Transferability is the extent to which the results can be transferred to other settings in different contexts. Dependability refers to evidence that is acceptable, constant, and stable over time, and confirmability refers to objectivity.

Credibility and Authenticity

Credibility is considered one of the most valuable assets of any research. To realize the meaning and the importance of reliability and validity, it is necessary to know the various definitions of reliability and validity given in both quantitative and qualitative

research perspectives (Golafshani, 2003). Reliability and validity are central concerns of all measurement and the "ideas that help to establish the truthfulness, credibility, or believability of findings" (Neuman, 2011, p. 208). In quantitative research, validity means true or correct and how the conceptual and operational definitions integrate together (Neuman, 2011). On the other hand, in qualitative research, validity means truthfulness, which means "offering a fair, honest, and balanced account of social life from the viewpoint of people who live it every day" (p. 214). Creswell (2014) discussed many ways to ensure credibility, such as prolonged engagement, peer debriefing, member checks, and triangulation.

The credibility of this research was established using different strategies. First, open-ended interviewing techniques and semi-structured questions were used to guide the interview, and I purposively selected participants to give the research credibility (Carpenter & Suto, 2008; Liamputtong, 2013). This kind of interview and sampling allowed participants to express their experiences about work-related stress freely.

Second, member checking, or participant validation, is another way to increase credibility (Liamputtong, 2013). Carpenter and Suto (2008) defined member checking as the procedure whereby researchers pursue clarification from their research participants and determine whether participants feel the data are accurate and describe what they want. Each participant was given the opportunity to review his/her transcribed interview. Member checking occurred with six participants after I had reviewed the transcribed interview line-by-line to ensure accuracy (Creswell, 2014); they indicated that my transcription, potential themes, and my interpretation of their experience were acceptable.

Third, I employed a peer reviewer, who reviewed my codes or themes in order to determine the quality and effectiveness based on his/her evaluation of the interview transcripts (Creswell, 2014). This person was able to validate or question the findings and the links between data (Creswell, 2014). In addition, my supervisor and I engaged in peer debriefing all through this research to ensure its credibility.

Fourth, Liamputtong (2013) argued that reflexivity of the researchers makes the study more credible. Researchers have their own perspectives and positions that they will bring into the research process (Liamputtong, 2013), and this was achieved through my previous nursing background and my current employment as an HCA. This research was more meaningful through combining both perspectives and experiences of the researcher (Liamputtong, 2013). One of the most common sources of research ideas is the experience of actual problems in an individual's field of work. I have been exposed to many problems in my personal experience, as I worked as a Registered Nurse (RN) in emergency departments in Jordan and Qatar for ten years and now as an HCA in an assisted living facility for five years. My research ideas are based on what I have observed and experienced first-hand in my work environments. Working as an RN and HCA and being a graduate student provoked my interest in this research area. To maintain reflexivity throughout the research process, as a result of my personal and professional experiences, I kept a research diary for my research process. This diary contains descriptive notes of interviews, observations, and so forth. My personal and professional background could be viewed as a strength so long as it did not overshadow the voices of the participants. I have to acknowledge that at some level, this might have affected my perception of the results. Therefore, peer examination by the supervisor and

colleagues further promoted and challenged my own reflexivity and thus the credibility of the study.

Transferability and Applicability

Transferability refers to generalizability of the result (Liamputtong, 2013, p. 26). Transferability implies how accurately the findings from this study may be generalized or applied to other groups or individuals with different settings or circumstances (Carpenter & Suto, 2008; Liamputtong, 2013). The findings in qualitative research are not intended to be generalized to a larger population in the same sense as quantitative research. One way to promote transferability in qualitative research is through rich and thick description (Liamputtong, 2013).

Rich, thick description is when the researcher writes in detail everything about the research settings, recruitment process, methods, and participants, so the readers are able to make a decision about transferability (Liamputtong, 2013). It is the researcher's responsibility to provide adequate information about the research so that the others can evaluate the transferability and applicability of the data to other settings (Polit & Beck, 2012). The main feature of thick description in an interview-based qualitative study is to provide direct passages from the transcripts to support the interpretation of the data to help the reader understand how the researcher came to the particular theme. Therefore, a thick description of research procedures, methods, settings, and recruitment process has been provided to ensure that others conducting similar studies, but in different contexts or settings, may consider the suitability of transferring the results from this study (Polit & Beck, 2012).

Dependability

Dependability refers to stability and reliability of the data (Polit & Beck, 2012). Dependability is a way to determine the consistency of the data and that the findings from the study are reliable (Polit & Beck, 2012). In order to ensure dependability of the results of this research, I used an audit trail so that other researchers who wish to repeat this research may have access to information about the process. Consumers should be able to see how the researchers conducted their study and explained their findings (Liamputtong, 2013). A description of research procedures, methods, setting, and recruitment process has been provided to ensure dependability (Polit & Beck, 2012). Further, I used direct passages (i.e., thick description) from the transcripts alongside a presentation of my themes, thus linking my interpretation to the actual data for the reader to assess and understand how I came to the particular theme. An audit trial is an essential strategy for ensuring dependability and confirmability of findings in qualitative research (Liamputtong, 2013).

Confirmability

Confirmability shows others that the research findings and interpretations were not invented by the researcher, but are linked clearly to actual data (Liamputtong, 2013; Polit & Beck, 2012). According to Lincoln and Guba (as cited in Liamputtong, 2013), "confirmability is seen as the degree to which findings are determined by the respondents and conditions of the inquiry and not by the biases, motivations, interests or perspectives of the inquirer" (p. 27). Polit and Beck (2012) claimed that to ensure confirmability, "the findings must reflect the participants' voice and the conditions of the inquiry, not the researcher's biases, motivation, or perspectives" (p. 585).

I think that objectivity means openness and honesty in the presentation of the research findings. Openness can be thought of as the ability of the audience to follow the logic from the interview through to the findings. Researchers should remain neutral, so findings depend on the nature of the phenomena and the individual experience of participants, rather than on the personality, beliefs, and values of the researcher and the researcher's perceptions of the results. Another way to put it is to say that a researcher can study, explore, describe, or discover phenomena with no direction of the result. The final findings were not inspired by personal feelings, explanations of the results, or personal preconceptions. An audit trail is one way to ensure confirmability in qualitative research, so I have provided detailed information regarding the research procedure and how my data were analyzed.

Ethics

When conducting human research, one must be careful of ethical and data protection issues. Conducting research with people requires special consideration of the possible risks to participants. Because this study involved human participants, I followed and met the requirement of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada [Tri-Council], 2010). The project was approved by the Human Subject Research Committee (HSRC) at the University of Lethbridge before any data collection began (see Appendix D). Moreover, I received ethics board approvals from the facilities where I conducted my study. Participation in this study was completely

voluntary, and participants could withdraw from the study at any time even after starting or during the interview. No compensation was offered to participants.

In addition, the anonymity and confidentiality of all participants and data were protected (Hesse-Biber & Leavy, 2011). To protect anonymity and identity, several steps were taken. First, the signed consent forms (see Appendix E) were stored with the demographic sheets (see Appendix F) in a secure area in locked offices at the University of Lethbridge, with access restricted only to me, as the researcher. Second, the audio files were kept in a separate location from the signed consent forms and the demographic sheets. Third, the audio recordings were only kept until they had been transcribed and reviewed by me, then they were destroyed as were my notes. Fourth, all audio files were labelled with a code; therefore, the transcribed interviews did not contain the participant's name or any identifying information from the interview. Fifth, all participants were informed that no names or identifying features would appear or be released in the final report. All names used in the interview were replaced with pseudonyms. The study participants chose or were assigned a pseudonym. The pseudonyms were also used on the participant's demographic sheet (see Appendix F), to which only I had access.

Confidentiality must be protected in all kinds of communication. "Qualitative researchers are socialized to believe that, in order to ensure honest dialogue and avoid harming respondents they must promise confidentiality and get informed consent before they publish information obtained from their research" (Baez, 2002, p. 35). Research that involves sharing personal experience may result in a person revealing more than intended. I offered every participant a copy of their interview transcript, which they could edit and censor if they wished. Before the interview started, each participant signed the

consent form, and permission for audio-recording was granted. Moreover, during the interview, participants were informed that they could request that the audio recorder to be switched off, they could take a break at any time, and/or they could withdraw from the study at any time.

Participation in research that discusses sensitive subjects like work-related stress can initiate painful memories and elicit emotional discomfort. Therefore, it was important that I be aware and prepared to respond appropriately should any such situations occur. There were some questions that might elicit emotional discomfort, such as "What emotions did you experience following this difficult situation?" and "What makes the situation difficult?" Prior to the interviews, I advised participants that some questions of a sensitive nature would be asked and that participants did not have to answer a question that made them feel uncomfortable.

Given the research topic, it was necessary to provide a safe environment for the participants and to ensure that there were no breaches of confidentiality, so no one was at risk. For that, a safety protocol was created that outlined the steps that would be used to protect the confidentially of participants (see Appendix G). In case of any discomfort or if a participant became upset because of the topic of the study or for any reason, I had a specific protocol in place. These incidents occurred twice during the interviews, and for those instances, I tried to calm him/her down, offered to stop the interview and schedule another day for the interview, which was declined, and/or talk about different topics.

Thorne (1980) defined informed consent as a consent that is knowledgeable, exercised in a situation of free power of choice without any elements of force, and made by individuals or legally authorized representatives who are competent or able to choose

freely. Before the start of data collection, written consent forms were explained and obtained from each participant. The consent form clearly stated that participants could withdraw at any time without reason, after which any data previously collected from them would be destroyed and not be included in the study (see Appendix E). If at any time after data collection a participant decided to withdraw, she/he could do so freely by contacting me. Further, participants were informed verbally before they read and signed the informed consent that outlined their voluntary participation.

Participants were given the option to receive a reader-friendly version of the final summary report of the research study, and they will be provided with a link to read the article once published. Participants who want a copy of the final report provided their contact information in the consent form (see Appendix E). Furthermore, my telephone number and email address were included in the informed consent document, if the participant wished more information on the study or its findings. However, to protect their anonymity and confidentiality, names and contact information of participants will not be included in publications and presentations on the research findings. There were no specific financial benefits gained for participation in the study. Participants were aware that they are contributed to knowledge of work stress among HCAs, which may be used in the future to improve the work place environment and possibly their lives.

Chapter Summary

The proportion of the older Canadian population, aged over 65 years, is predicted to continue to grow in the next decade. Owing to the growing proportion of older Canadian citizens, the demand for quality care facilities is likely to increase in Canada. ALFs will continue to play an important role in the overall provision of aged care

services. Thus, it is important to understand what contributes to stress among HCAs, who comprise more than 75% of the work force in ALFs. In this chapter, I provided an overview of the methodology used in my research. The purpose of my research was to understand and explore the experience of work-related stress among HCAs. For this purpose, I used a descriptive, exploratory, qualitative design. Furthermore, I discussed my data collection strategy, which was semi-structured interviews with 14 HCAs from three different ALFs in Southern Alberta, and I used purposive and snowball sampling for recruitments. Thematic analysis was used to analyse the data. Ethical considerations and research rigor were discussed, and I ended with identifying the limitations and research bias that impacted this study. In Chapter Four, I outline and explain the findings of this study. In Chapter Five, I offer a discussion of the study discussion and recommendations and research dissemination.

Chapter 4: Results

The purpose of this research was to gain an understanding of work-related stress and coping as perceived by health care aides (HCAs). A qualitative, descriptive, exploratory design was used, and data were collected from HCA participants using face-to-face interviews in which participants were asked to reflect on a difficult situation they had experienced in their work as an HCA. Probes were used throughout the interviews to draw out rich details regarding each HCA's situation. The findings from the individual experience of work-related stress as described by participants are presented in this chapter, which include the demographic data, analysis of the qualitative interviews, training, and the main themes that resulted in five findings.

Data from 14 interviews conducted in three assisted living facilities (ALFs) in Southern Alberta are analyzed and interpreted in this chapter. This analysis and interpretation are structured around the central research questions of this study, which was: How do health care aides experience work-related stress in assisted living facilities? Furthermore, this research also sought to explore the following questions: (a) What factors contribute to work stress among HCAs working in ALFs; (b) How do HCAs cope with work-related stress; and (c) How do these stressors and the resulting stress impact the daily lives/work of HCAs?

Demographic Data

Although staff-resident ratio was not collected during the interviews or through the demographic information sheet, generally speaking, there was no fixed staff-resident ratio across the three facilities. The average staff-resident ratio varied with the floor, shift, and the site. On the regular floor, on average, the ratio on the morning shift was one staff

to eight residents, while on the evening shift, the average ratio was one to 17. On the

other hand, in the cottages, which are secure dementia care units, the average morning

ratio was one to six and one to 12 for the night shift.

The demographic information of the research participants provides a clear

perspective of their age, experience, gender, and education. The study's sample consisted

of two male HCA and 12 female HCA participants, for a total of 14 participants. The

female participants ranged in age from 20 to 49 years, with an average of 33 years; male

participants ranged in age from 36 to 38 years, with an average of 37 years. Each had

between 2 and 17 years of accumulated experience as an HCA. All but two were born in

Canada. Ten participants had an HCA certificate from Canada (eight from Alberta, one

from Ontario, and one from Saskatchewan), two participants were nursing students, and

two received their nursing experience and education outside of Canada. The distribution

of the participants by age, gender, experience, and education is shown in Table 1.

The frequency and percentage distribution of other characteristics that describe

the participants are noted in Table 2 and summarized here. The majority of the

participants ($n = 12$) considered English as a first language. Nine participants were

assigned to work on a regular floor, two participants were assigned to work at the cottage,

and three participants were assigned to work on both the regular floor and cottage. Half

of the participants worked evening shifts, two participants worked both day and night

shifts and three participants worked all shifts. More than half were in a part-time position,

and of the remaining participants, there was an equal distribution for full-time and casual

positions, with three participants each. Eight participants worked fewer than 24 hours per

week, and the rest more than 24 hours, but less than 48 hours per week. Six worked fewer

than seven hours per day, three participants around eight hours per day, and five worked

more than eight hours per day. Finally, in regards to the changes of their work

assignment, half of the participants claimed their assignments changed every three

months, four participants reported their assignment changed on a daily basis, and three

reported the assignment never changed (see Table 2).

Table 1.

Frequency and Percentage Distribution of Participants by Age, Gender, Experience, and Education

Category	Number of Participants	% ($N = 14$)
Age		
20–29	6	43%
30–39	4	29%
40–49	4	29%
Gender		
Male	2	14%
Female	12	86%
Experiences (Years)		
1–5	8	57%
6–10	3	21%
11–15	1	7%
> 15	2	14%
Education Level		
HCA Certificate	10	71%
LPN/ RN student	2	14%
RN outside Canada	2	14%

Table 2.

Frequency and Percentage Distribution of Participants by Demographic Information

Category	Number of Responses	% ($N = 14$)
Working Assignment		
Floor	9	64%
Cottage	2	14%
Both	3	21%
First Language		
English	12	86%
Other	2	14%
Working Hours/ per week		
> 24	8	57%
< 24	6	43%
Working Hours/ per day		
> 7	6	43%
7–8	3	21%
> 8	5	36%
Working Shift		
Day	2	14%
Evening	7	50%
Night	2	14%
Mix	3	21%
Frequency of Assignment Changes		
Daily	4	29%
Every 3 months	7	50%
None	3	21%
Employment Status		
Full-time	3	21%
Part-time	8	57%
Casual	3	21%
Educational background		
Nursing experience	4	29%
3–6 months HCA program	6	43%
> 6 months HCA program	4	29%

Analysis of the Qualitative Interviews

Thematic analysis of the qualitative interview data was guided by existing

theories, which included (a) the transactional model of stress and coping (Lazarus &

Folkman, 1984); and (b) the job demands-resources (JD-R) model (Demerouti et al.,

2001), to generate an understanding of the participants' views and experiences of work-

related stress. Names used in this study are pseudonyms, which helps to maintain the

anonymity of the participants. The following section focuses on the training background

of the participants, and thereafter, the four main themes generated from the study will be

discussed in depth.

Training

When the participants were asked if they participated in a specific program or

training for their role as a HCA, there was a wide range of answers. Six completed a

training program lasting three to six months, and three completed a training program fotr

six months to one year. Of the remaining five, two were international RNs and three were

nursing students. Further, among those who had training, seven participants received their

training in Alberta through different institutions, and the other two received their training

outside Alberta in either Ontario or Saskatchewan. All participants agreed that training is

important. Two participants talked about the training program length as insufficient. Judy

said,

> It's very important. I think it should be longer though . . . because I don't think
> just anybody would get into it. I think if it was a longer education to get into this
> type of job, different people would do it.

Kat pointed out that the training program needs to be standardized to help and

ensure that all HCAs provide a high quality of care to residents across the province. Other

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participants talked more about the advantages of this training program for HCAs and for

residents. For example, it was perceived that training may increase safety for residents

and staff, help decrease medication errors, prevent infections, provide quality care, assist

the HCA to be aware of the rights and responsibilities of both residents and staff, and

even learn about work stress and how to deal with it. Lena highlighted these ideas:

> People start without any knowledge in the healthcare profession. They worked there because they're paying a good salary. There are so many mistakes that happen and not really proper care, and they didn't care about the residents in general accepting that work. I think it's really important to know what they're doing, how they have to do it to prevent infection and protect themselves for not crowding near the bed or something else, and the whole procedure and how to do it properly.

> Chloe and Jill brought up the idea of people "off the street" who are employed as

HCAs, but who have no healthcare background and do not know how to communicate

with residents or other co-workers. Jill said,

> There were a lot of people that were there for like 35 years and they just got grandfathered in. Like these are people that walk in off the street; they never took these courses or modules or anything and they grandfathered them in, and that's where I've seen so many problems with you know, attitude and . . . they could do the physical part of it but they didn't have the connection of like dealing with people and stuff. . . . I've seen a lot of them were like kind of nasty people; they would just yell at the residents and talk to them like they were little kids and stuff, and there was no respect that way and that.

The three ALFs provide continuing in-service education courses for HCA. The

courses were seen as helpful and rich with information according to many participants.

However, a few participants saw those courses as insufficient, not beneficial, or even as a

source of increased stress. Joyce said,

> We had a medication course, which was actually useless because it was about how to give medication which we do. Actually, they talked about neglecting abuse with residents—a class that we've had here when we get the medication course, but it just touches on the topic. . . . It's not in-depth.

Judy further supported the notion of in-service education courses as a source of stress

when she said,

> We had a med course to take, and it was mainly because people weren't doing their jobs. So everybody had to take the med course, which caused stress because you're doing your meds, you understand it and . . . you have to do it again. So that was a little bit stressful.

Participants identified that there were no standardized training programs across Canada

or even Alberta, which could be seen as a source of workplace stress.

Participants had different desires to be an HCA. The main reason was helping

other people, especially the elderly; many participants had personal experience taking

care of one of their family members. Iliana said,

> I grew up with my grandmother; I was raised with her throughout my whole life. So being elderly and knowing their likes and dislikes, it was kind of . . . more or less the caring part because outside of work, I was helping taking care of my grandmother.

Another reason was that working as an HCA was perceived as a good entry point to the

nursing field, as several of the participants were simultaneously nursing students or

planning to study nursing in the future. Sue shared her thoughts:

> Well, I thought it would be a good experience to learn to improve on my bedside manner because I was going for my LPN. So it was a good kind of transitionary job for me. And during my first year of schooling, I applied for that assisted living worker job, and it just seemed like a good fit at the time.

Finally, many participants admitted that they did not have the desire to work as an HCA

in the beginning, but they wanted to try a new and different job without any intention to

work in the health field. Jordan said,

> I became a health care aide 'cause I just wanted a different job. I changed careers it seems every five to ten years; I like to do a different job, and I just got tired of what I was doing, and I thought I would go into health care and see what there is.

In contrast, two participants were frustrated when they came to Canada as skilled worker immigrants, but could not work as an RN as they had back home. The closest work they could find in their field was working as an HCA. Mark said:

> I immigrated to Canada five years ago. I struggle with my registration as RN in Canada. I was RN back home, I worked there for 10 years, and they did not recognize all my study or my experiences [in Canada]. Can you believe that, and they are talking about shortage in nursing and long waiting time at the ER.

The above discussion provides a general overview of the training and background of the sample. The next section focuses on the main topic: work-related stress among HCA, and includes a detailed discussion of each of the four main themes that were generated.

The Main Themes

Four main themes were generated through this research: (a) the meaning of work-related stress; (b) genesis of work-related stress; (c) how stress affects/changes workers' lives; and (d) how HCAs cope. Subthemes were also identified for each of these themes (see Table 3). These main themes were generated based on thematic analysis, which was guided by the transactional model of stress and coping (Lazarus & Folkman, 1984) and the JD-R model (Demerouti et al., 2001), to highlight the participants' views and experiences of work-related stress.

Table 3.

The Four Main Themes

Main Theme	Subtheme	Categories
1. Meaning of stress	a. Identifying work-related stress	
	b. Stressed out / dissatisfaction	
2. Genesis of work-related stress	a. Behaviours, attitudes, and situations	• Residents and resident families' attitudes, behaviours and situations • Leadership stressors (LPNs aren't one of us and Unapproachable management) • Other staff (It's hard to work together)
	b. Challenging work environment	
3. How stress affects/changes workers' lives	a. Physically draining, exhausting	
	b. Mentally hard / emotionally drained	
	c. Affects my life/ affects my work	
4. How do HCAs cope?	a. Venting	
	b. Chill out	
	c. Stress courses	

Theme 1: The Meaning of Stress

This theme was one of the major themes identified across all of the participants. In this first main theme, I report how HCAs defined the work-related stress from their viewpoints, signs and symptoms of being stressed, stress level, and dissatisfaction. This theme is further divided into two subthemes: (a) identifying work-related stress; and (b) dissatisfaction.

Identifying work-related stress. All participants found it difficult to explain their understanding of work-related stress. Two participants could not define work-related stress or found it hard to define because English was not their first language. The majority of participants defined work-related stress in terms of physical, psychological, and emotional perspectives, and they connected work-related stress to staff, residents, and the work environment. The following is representative sample of participants' comments about the definition of work-related stress. Jill defined work-related stress as:

> Physically and mentally drained, like just overload; an overload of emotions I guess with what's going on. Like you can feel frustrated, you can fell exhausted. I even get like muscle tension all through my shoulders and up into my neck

While Kat talked about two types of stress, bad and good, and considered the bad stress more dominant, she emphasized physical symptoms:

> I think there is good stress, you are stressed, and there is bad stress. I feel like the bad stress, it takes over the good stress, so it's not something that I can just leave at work and then go home and be fine. I feel like it takes time to actually lie down. So my definition, it's quite broad. I don't think I could just put it in a sentence. I think it's more symptomatic than anything—just how my body reacts to it.

Chloe identified physical and mental stress. She noted that physical stress happens when you work on the regular floor by providing care that requires more physical effort, like carrying, holding, or lifting residents, while mental stress comes from working with a

resident who has dementia and lives in the cottages, which comes from their disease

progression and violence. As well, Chloe talked about staff stress, which she related to

peer pressure, domineering and condescending attitudes, and staff bullying. Chloe

explained the types of stress and gave some situations and experiences as follows:

> It's recently become stressful. There are two different kinds of stress that I've
> identified, because I've been noticing the stress that comes with this job. The first
> comes from taking care of the residents, it's a physical stress, you know you've
> got your phone on you, you're constantly being called, there's a task for you to
> do. So it's very physically demanding. Then downstairs, it's mentally. You're
> maybe helping someone with a bath, but you can sit down for most of the day; it's
> very mentally demanding.

Then Chloe added another type of stress; she said,

> Then the third kind of stress is the staff—your peers, your co-workers. There's
> drama, there's people want things a certain way, and if you are defiant then they
> get upset with that. So even though they aren't in a management position, they
> become domineering and condescending, and I've been at the brunt of many. I
> don't have much of a spine so it's hard for me to talk back and defend myself, but
> you know there are staffs bullying, and it's actually been very stressful.

> Even though participants found it difficult to define work-related stress, they

identified the signs and symptoms of work-related stress according to their beliefs,

awareness, and personal experiences. The signs and symptoms were physical signs (i.e.,

objective), psychological and emotional symptoms (i.e., subjective), or a combination of

both. The following are participants' comments about how they know if they are stressed.

For instance, Sue said,

> I can tell physically, physiologically, my shoulders tense up, and I breath really
> heavy, and I'm just constantly looking everywhere, and not exactly my focus isn't
> where it should be, and I'm just in hyper mode trying to get everything done, and
> at that point usually mistakes end up being made.

As another example, Mary said,

> I get anxious, and I'm a very emotional person, I can be really mad, and then all of a sudden I'll start crying. So for me, my anxiety is heightened because of stress that other people are putting on, or just the job itself is putting on.

Participants identified many reasons for being stressed from working as a HCA, such as physically and psychologically demanding work; working short-staffed; violence/aggression from residents; and lack of support from management, direct supervisors (LPNs), and other co-workers. The following comments relate to what the HCAs had to say about reasons for being stressed:

> I get stressed out because of the abuse that we deal with verbally, physically, and from our patients. I don't feel there is support from management or a governing body to support us as healthcare aides. We are really left on a limb, and we don't have someone advocating on our behalf. And I get stressed out because the job is very demanding physically and mentally. (Kat)

> Sometimes you can be stressed out from the residents if you're working with people that have Alzheimer's, and you're just not having a good day because of their illness and then other times, it could be staff. Maybe a lot of staff you're working with, maybe they're not doing what you think they should be doing. (Judy)

When I asked participants about their stress level (on a scale of 10, where 1 was a zero stress and 10 was the maximum stress), all participants differentiated between bad days and good days. On the bad days, the stress level ranged from 6 to 10, and on the good days, the range was from 1 to 3. Two-thirds of the participants' stress level on the bad day was more than 8. Participants revealed that the bad days not every day but at least once a week. One participant described her stress level one day as 12 out of 10. Participants' rankings for stress tended to fall at the end of the scale, with little in the middle, which might affect how people perceive or manage stress. Lena said,

> The worst day, I would say 12. Where some days, I could stay there and cry or have to go out because to get my head clear and to start over because it's too

much. When you come there and there is nothing done. The whole cottage looks like a messed place. There are still the suppers on the table. The food is on the floor. Two people fighting. The other is crying, and the worker who is on the day shift is sitting on the computer and twiddling, then I really could freak out.

Dissatisfaction. Dissatisfaction is the state of being discontented or disappointed.

Dissatisfaction from working as an HCA appeared across the participants. More than

one-third of participants were not satisfied with their job. Joyce and Judy spoke about

causes of dissatisfaction and connected that to other co-workers and education. Joyce

stated,

> I'm not satisfied at all. I don't want to do it. Just because working for the staff you work with is very frustrating at times, and you really have no say as a health care aid and sometimes residents get on your nerves.

Joe and Linda cited different causes of reduced work satisfaction, including perception

that the job was mentally and physically draining and demanding. Linda said,

> It used to be a lot better. Now it's not very satisfying. It's like a hell of a lot more demanding and way more expected of you. I really like looking after residents and getting to know people and that's my reason why I'm still there.

Lena and Mark are both international nurses who are dissatisfied with their job because

they feel underemployed. Lena is going back to school to finish her nursing registration

process so she can work as an RN in the future. She said,

> I still want to be going back into nursing. That's what I did for years, I feel like here I do undergrad staff work. The last thing I did is just trying to get an English test done. Right now, I'm taking a break and just go to work. I need a break to think and to go over all the stuff.

> However, many HCAs reported satisfaction with their job despite the perceived

high levels of stress. The satisfaction arose from a passion for doing the job, which was

considered to be financially rewarding, according to many participants. Alayna talked

about her passion to do this job, and she said,

I like it because I know what I'm doing, and I'm good at what I do, so I like what I do. I like the fact that I know that I could do it good, so I'm pretty satisfied with it. I'll give it probably maybe seven out of ten. [her satisfaction rate]

Kat was satisfied with her job and even saw it as a challenging job. Kat said,

I find it rewarding; I think it's a really good job. I love what I can do, but at the same time, it's very challenging physically and mentally. You are dealing with so many different types of individuals with really different needs, and you really need to know what you are doing. I am very satisfied of my job, but I find the challenge is really because of friction with how much I really enjoy my job, I think.

The individual's degree of satisfaction or dissatisfaction varied between participants and was associated perception of work and stress.

Theme 2: Genesis of Work-Related Stress

In this second main theme, I report the sources and origins of work-related stress from HCAs' viewpoints. This theme is divided into two sub-themes: (a) behaviours, attitudes, and situations; and (b) challenging work environment.

Behaviours, attitudes, and situations. Behaviours, attitudes, and situations that challenge HCA can be further sub-divided into three categories: (a) residents and families; (b) leadership stressors; and (c) other co-workers. Each will be discussed in this section.

Residents and families' attitudes, behaviours, and situations. Residents and their families' attitudes and behaviours and the situations that resulted from those attitudes and behaviours were reported numerous times, with 13 participants citing this as one of the main sources of their work-related stress. Within this category, participants talked about dealing with residents and how that added to stress on a daily basis due to a change of the resident's moods, residents constantly calling and demanding, and residents' preferences. Alayna discussed some of these difficulties as follows:

When I'm in with her, I'm like, "Oh I've got to get out of here because I've got to still go and change this person and this person needs that." So it's really stressful. I did not know her shower's going to take that long, because after her shower she still wants her teeth—I have to brush her teeth, and she wants a bottle of water poured down—I have to like actually pour it down her throat while she is sitting and that takes some time. So I had to come to back to her, and she was upset about that. So, that's very stressful—actually, I think that's a ten . . . that is really stressful.

Moreover, most behaviour and attitude issues had to do with residents' violence or aggression towards others. Ten participants reported residents' violence as a source of stress. Three kinds of residents' violence were identified: physical, verbal, and sexual. Most of the participants admitted that these violent behaviours were due to disease progress, misunderstanding, or miscommunication. More than half of the participants reported that they experience physical violence, which included, but was not limited to, scratching, pushing, throwing objects, grabbing, biting, and slapping from residents. Linda shared her experiences with physical violence:

Some residents are really abusive. Like [name of one resident], she wants to sit in a specific spot at the dinner table, but that's not her spot, and you have to move her. I tried to move her, and she would slap at me and hit me and start yelling, then it affected all the other residents. . . . It became extremely stressful. Four people were complaining that she gets her way all the time because she's being abusive. Another example of that would be [her] running into other residents with her wheelchair.

Verbal violence from residents was reported by all the participants, and many HCAs considered it part of their daily routine because it was a constant and ongoing issue and part of their work as an HCA. Verbal violence included the resident yelling, screaming, being degrading, constant calling, and racial comments. All of the participants acknowledged these behaviours were due to disease progression, but nevertheless, it caused the HCAs to feel stressed. Kat commented,

When you have residents yelling at you and degrading you, verbally aggressive with you, that definitely triggers, you want to react but you can't, and so that person, if they are constantly doing that, it can cause stress, because you want to avoid that. You don't want to have to take care of them, but you have to, and it can be harmful because the things that they can say can be very personal and very hurtful.

According to six participants, were all female sexual violence was noted by. Sexual violence was noted defined by participants. These participants reported that they experienced inappropriate sexual behaviours at work from residents. In Mary's point of view, she described a sexually violent situation that happened to her:

[Name of one resident] would always try to hug you or touch your butt; he's touched my butt many times. I tell him, "You can't be doing this; you're a grown man, and you have your life. That's something that you don't want to deal with. . . . It's uncomfortable . . . And then [name of one resident]. . . I walked in at night because I wasn't sure if we were supposed to check him. It was like his first night here, and he was sitting on the toilet, and I said, "Did you need anything?" And he's like, "Oh no, I'm just sitting here masturbating." And he was telling me all about, "Well my wife cut me off 20 years ago and this and that." So it was just . . . it was just really, really uncomfortable.

The HCAs expressed a range of emotions when they experienced violence from residents. Some participants talked about feeling uncomfortable, being scared, or even feeling disrespected and degraded, as a result of the residents' behaviours. At the same time, some felt empathetic toward the residents because their health conditions lead to the inappropriate behaviour that is directed at others. Finally, some participants spoke about having their self-esteem damaged by the way they are treated, while others were concerned that they may inappropriately react to the residents and perhaps hit back, which could mean they would lose their job. The following quote represented the feeling and emotions associated with different situations with residents. Mary described her feeling as follows:

I've had [name of one resident] hit me numerous amounts of times. It just kind of brings you down a level. . . . It doesn't feel good. Like with [name of one resident] how he was waving his arms and like so physically mad for virtually no reason—nothing that we could have done. . . . It's scary . . . it's stressful in that sense, but I know that it's not the end of the world for me. I'm not going to get hurt really bad.

Resident families' attitudes and behaviours were also cited as a concern by HCAs in the study. Disrespect, lack of appreciation, rudeness, and mistreatment of HCAs were all experienced. Participants described situations where the families looked down at staff and failed to provide the requisite equipment or personal items such as shower chairs, shampoo, and skin lotions. This example was provided by Jordan:

You do have the odd family members that do complain about lots of things. You also have family members when you ask them to purchase stuff that the resident really needs shampoo for example, they don't buy it, and then the resident suffers, and you can't do anything.

Additionally, families' misunderstanding of the policies and miscommunications between HCAs and family members were noted by many participants. Examples included when HCAs asked a resident's family member to leave the room when they were providing care, or a family member being impatient to wait for help from other co-workers. The following is Mary's experience with family members:

When [name of one resident]'s son was in here, he was very hard to deal with. There's some that won't leave the room when you try to do care. So it made it really difficult. When [name of one resident] her daughter was there, she wouldn't leave the room; she would be there while you're doing the care, and you've got to make sure everything's right no matter what, but with the family there, it's always in your head, "She's watching me do this, this is her mother." It's just stressful. It can be very stressful if you don't want to go into their room or something like that because they're always looking down on you like you're their maids.

Another example was given by Sue, who said,

We have a lady whose husband back in the day was one of the better doctors in Alberta. I have my gown on and everything, and she needs to go to the bathroom, and she's a sit-to-stand transfer, so I had to wait for somebody. Meanwhile, the

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husband is pressuring me saying, "It's okay; I can help you" and I'm trying to explain to him, "No, I can't let family help me do this; that's not our policy, it has to be at least two staff at the facility." He was getting pretty upset, and he was saying, "Do you know who I am?" Like he was yelling at me—raising his voice.

Neglecting residents by not visiting on a regular basis or not visiting at all and family members making a decision counter to resident's well-being was discussed. For instance, some family members refused to give residents certain medications like antidepressant drugs or pain killers because they believe it is not beneficial for the residents even though the residents are restless or in pain. It is clear that family members' attitudes toward residents and staff are seen as a source of work-related stress for HCAs.

Feelings and emotions associated with HCAs' experiences with family members were varied, and included feeling sad about residents' conditions or feeling degraded or not important. Judy said,

> Sometimes, if I can't help them to understand what needs to be done and if they are upset and I'm trying to . . . Just the other night, I had explained to a resident that her clothes in her basket were actually dirty clothes. She thought maybe someone had thrown them in there, clean from the laundry room, so she was crying, which bothered me, and I had to explain several times, "No. They were dirty and not clean."

Many participants talked about family members feeling guilty for their family member's condition. Kat commented,

> I think they have a lot of things going on too. Some of them don't come around very often, and when they do come around, I think they feel guilty, and then we are the first ones that they can kind of target and pick on and blame for whatever it may be. Then, some of the families are very appreciative because they can't be there, and they know that we are the ones that are there for them. So it just depends on the type of person.

However, all participants talked about many "good" families and how they are appreciative and cooperative with staff because they cannot be physically there, and they know that HCAs help their family members. Participants admitted that those who are

appreciative counter the negative experiences with other families and decrease the stress level among HCAs. There were examples of some family members helping HCAs by doing the daily routines, such as washing the resident's face or doing the laundry. Clearly, family members' attitudes and behaviours are a workplace factor related to stress, which cannot be so easily controlled.

Leadership stressors. Leadership stressors are related to interaction with higher positions which in this study mangers and LPNs. Leadership stressors were reported by all participants and can be subdivided into two categories: (a) direct supervisor stressors, which in this case were the LPNs (e.g., "LPNs aren't one of us"); and (b) manager stressors (e.g., unapproachable management).

Some participants commented that "LPNs aren't one of us*."* LPNs' behaviours and attitudes in different situations were reported by many participants as a source of work-related stress. Lack of control by HCA, lack of involvement in decision making, aversive behaviour, leadership style, lack of support, and lack of respect were examples of LPNs' perceived behaviours and attitudes. Chloe talked about one particular LPN whose abrasive behaviours were seen as unpleasant and rude with HCAs. Chloe said,

> There is this one LPN that I always felt very abrasive towards because she was just always very rude to me when I first got hired, and she won't talk to me. She hates me. I don't know. . . . She's always not liked me, and apparently she comes that way off to a lot of people.

Another example was from Sue who believed that some LPNs saw themselves as higher than other staff. She described how the relationship between LPNs and HCAs could be improved. Sue said,

> Depending on their attitude and if they feel that they're higher up, if they're above you just because of a different pay cheque. There has to be a level of respect established there; the HCAs are doing their grunt work. There will always be the

really good ones [LPN], and there's always a couple bad ones in there—HCAs as well unfortunately. This particular person [one LPN] was very condescending, and basically said to the HCAs, "You guys don't know anything about medications, you shouldn't be doing this, or this, or this," and just really pointing out all the negative things and not saying, "Instead of doing this, how about we try it this way." It's about their approach with people and that can be very upsetting. Well you're calling me stupid basically, nobody likes to have that. When they have the hierarchy of different positions, [such as] HCA to nurse to doctor, it's like a totem pole basically, but what we don't realize is it has to be like a web, and we have to work together.

Furthermore, nine participants expressed feelings that LPNs were less helpful and incompetent. The following is an example from Jill, who described LPNs' behaviours and attitudes and how they are not helpful:

If you call for help, they'll just say, "Well you know like try giving them a snack or try this." I've been here for how many hours, and this person is not responding. You know I've tried this, I've tried that, and it's not working. If they've got PRNs and often times they have PRNs [when it needed] that are available and the LPNs don't want to give them. I think part of it is because they have to leave the main building, and walk outside, and come over, and it's cold, and so they're just like, "I don't think that they need a PRN," or whatever, and they're not even able to assess the situation because they're not there.

Indeed, leadership stressors, from both LPNs and managers, were reported by participants as a source of work-related stress. Leadership stressors included behaviours and attitudes, leadership style, and lack of support and respect.

Participants considered managers' behaviours, attitudes, and the resultant stressful situation related to that as part of work-related stress. Participants identified these stressors as unapproachable management, poor relationship with managers, communications, and leadership style. Jill spoke about her personal experience, on her first day of work, when she met the manager:

Like [the name of the manager] is like to me unapproachable and can hardly say, "Hi," or look at you. And [name of another manager], the first time I ever met her, she was coming down the stairs, and I was going up, "Hello," like I say hi to people when I'm passing them, and she's like, "And who might you be?" Just like

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that. I said, "I'm Jill." "Jill who?" and I said, "And who might you be?" She's like, "I'm the assistant manager," and I was just like, "Oh my gosh." and she's like, "I'll be seeing you," like trying to intimidate me. I felt like it was awful. I just feel like they don't have an open, friendly atmosphere; like that they don't care about you.

Other participants revealed that lack of support and lack of respect, not showing concern for the well-being of a person, and not listening to HCAs' ideas and suggestions were sources of work-related stress. Kat talked about disrespect and unfairness from her manager and commented,

I find them degrading to us as healthcare aides. I don't feel that they respect us or understand what they expect of us, and any extra thing that comes up gets put on our job description, and I don't think that's fair. I feel intimidated by them. I only hear from them if I do something that's wrong in their eyes or not okay. I've been at this company a long time, and I can remember one thing that they have said that was nice, supportive to me of what I did, but usually I don't hear from them unless there is something that they need to talk to me about like something bad. I think management thinks we are disposable; they don't treat us respectfully or of high importance. We are at the bottom of the totem pole, and they are at the top, and I feel that they don't value us, and they show that they feel to me that they are more [concerned] about the money coming in from the resident than they are about the staff that they have there.

Linda talked about an enormous gap between staff and management related to management behaviours and attitudes and how the HCAs cannot approach management if they need something:

I think there are a huge gap between staff and management because you can't approach management. They're very unapproachable. [Name of the manager], some days she's good. Other days, she's worse. It's like she's going through menopause. She goes through these worse mood swings. It's like you have to catch her at the right moment where she's smiling, and you're like, "Oh, my God; I can talk to her now!"

Moreover, feelings and emotions derived from negative experiences with management were discussed by participants. Being afraid and scared was reported by five participants. Alayna described her feelings:

I am so scared of management. Like every time I see [the site manager's] name beside my name, I like start sweating, and I'm like, "Oh my gosh; what did I do?" and I'm just like freaking out. I have no clue why I'm scared from management. It seems there's always something wrong; there's always a new memo out. Like now, we're not allowed to have our coffee breaks at the nursing station. The only place we're allowed to eat is downstairs in the family dining room. So we have to take our food, go downstairs to the dining room, and then come back up, I don't like that at all. We should have a lounge room upstairs for staff.

Joe and Judy and most of the other participants talked about disrespect and lack of appreciation from management. Joe said,

You do such a good job, and you work your butt off, and they don't even show recognition for it. That's stressful, because it's like, "Why am I killing myself to make you look good?" So, pretty much, you are making everybody else look good, and you are putting yourself in the shitter. You are making your management look good, and while you are doing so well, somebody else is doing so crappy, and yet you are getting blamed for it too. So then, what's the point?

However, two participants stated that they felt appreciation and recognition from management, or they did not see management as a part of work-related stress. Mary said,

I know management does appreciate what we do, and [the manager] has told me, "You know we want to make sure you're comfortable in your position . . . and let you know that we appreciate what you do" and all this, so that's good.

Lack of support and respect, not listening to HCAs, and unfairness were revealed from participants as a source of work-related stress. Those leadership stressors, are controllable, and if we eliminate or decrease those stressors, workplace stress will be less.

Other workers. Finally, participants identified other staff could be part of their work stress, stating, "It's hard to work together." Participants frequently reported attitudes and behaviours of co-workers as one of the main sources of stress at their workplace. The most reported examples of co-workers' attitudes and behaviours included offending, degrading, emotional abuse at the workplace, bullying, and mobbing. Jordan described what happened to him or to other staff in front of him:

It's the attitude problem towards other people and the back stabbing, which is rampant. We had a casual . . . she was orientating a casual, and the casual had a piece of toast. And my co-worker went up to her and says, "You go up to the kitchen right now and pay a buck fifty because that's how much that piece of toast cost you." And I'm like, "Wow." I didn't say anything to her then but I confronted her about that and other things. And that's just one example how stressful it is with that woman I work with and how she treats people and why I have to sometimes not be very nice to her.

Other participants talked about working with incompetent staff and bad work relationships as sources of work-related stress. Judy said,

There have been co-workers where they are not doing their job. You don't feel that the person is doing their job; it causes a great deal of stress because you'll feel like you're just saying it for nothing. If you get to know all the residents on your floor so if there's someone who should have had a shower and you know they didn't have a shower from another worker, it causes stress because you don't think it's right and if you're there and you make sure your work is done and when others are there getting paid the same as you and they're not doing their work, it does cause stress and resentment.

Other participants also noticed that lack of team work, poor communication between staff, and refusing to be one of the team were mentioned as sources of work-related stress, which also connected to having incompetent staff on your team. For example, Iliana described working alone, not in a team, as a war zone:

There was times when you communicate, how are we going to work this team together, but then one person doesn't want to be a part of the team, they want to do their own thing, and it's like, "Well when I need you are you going to be there?" and basically you get told, "No," that's when it's stressful. It's like you know when you pass a person in the hallway it's like, "Oh why is this person, like why are they like that, why won't they help?" And that's when you feel the stress of like, "Well if this person calls they're going to need me because that person won't help." If your team doesn't work that just . . . it's almost a war zone you're walking into . . . a war zone.

More than half of the participants admitted that working with unqualified, incompetent casual co-workers caused the most stress at their workplace. Mark shared his experience of working with casual staff:

Just three days ago one of the staff called in sick and they cover his shift with casual. I did not see her all the time even at supper time I don't care about that . . . but the bad thing the LPN called me at 9 pm asking me to do 3 residents of the casual staff, which they are heavy I mean they need a lot of care, and I discovered later she did not do anybody. . . . Just imagine and the big problem she is still working at [site.] Unbelievable!

Lena focused on the younger generation of co-workers and how she felt many were incompetent, made a lot of mistakes, with their main concern financial gain:

They just got a degree from school and think, "Now, I'm going in healthcare." If you talk a little bit with them, they have no idea why there are there. They just know what they have on a patient. The dreams to buy, a new cellphone, and you can ask in here about computer, internet. They know everything, but if they have to do some work there or they just lie, "I did it already." You can prove it that they did not do it. They are not qualified giving good care for the resident. They do a lot of mistakes, even if you tell them, "You have to be careful and watch what he's doing." "I don't care." They have this attitude, I don't care.

Other participants discussed that bad training or training by an unqualified or inappropriate person was the cause of having incompetent staff. Iliana commented about this point:

Other people, it's just in the evening and new staff who are trained by the unqualified person. . . . When you get the orientation that they are orientated by the wrong people; . . . it's people with less education, lazy people, and of course, they will show them to do less work as possible. It stresses me really out because I'm not like this.

Much work-related stress sources came from co-workers' behaviours, attitudes, disrespect, and working with incompetent staff. Mangers should work on these stressors that can be controlled.

Participants noted that they felt afraid, scared, and anxious as a result of negative experiences. They also felt animosity towards these co-workers numerous times. Chloe said,

Whenever I work, I'm worried about working on her rotation, I'm concerned. I'm starting to get over it because I feel like I need to think like, "It's her problem not

mine that she's not talking to me," kind of thing, but it still makes working hard. I'm afraid to work with her on that hallway 'cause I'm afraid of her. . . I feel like I did the right thing.

Feelings and emotions from negative experiences with co-workers were reported by both genders. Mark noted,

I remember the night HCA was bad, and every night I go home scared I had forgotten something and start these, you know, the bad thinking—like maybe she will do something bad to my residents and say I did that . . . Oh my God, it was a very bad feeling . . . when you can't sleep because you are afraid. I thought about quitting this job because of that.

Participants who worked as casuals talked about their experiences in this unique working arrangement. "Being a casual itself is a stress," Sue said. Stigma from being casual and challenging as a new staff was discussed by casual participants. Sue shared her experience:

Being casual can be so difficult…that just in itself, not work…like having that type of position being work related; not being in the loop all the time, and when people don't document things that are pertinent to that particular resident, for example, how they transfer, or did they have a fall or something, what time do they go to bed…that's important for me to know because after I know that I can organize my day and figure out, "Okay I need to be here at this time and go here and go there." And when people fail to do that with me, I make mistakes, I don't do things the way they would like me to, and then I come back the next day and I get chewed out because I didn't do how they're usually used to taking care of people, so that can be a little bit stressful.

Without a doubt, participants reported working with casual staff as a source of stress, while casual workers see them self of being casual is a stress.

Male perspectives. Gender differences were noted regarding experiences between staff members and between staff and residents. This information needs to be interpreted with caution because of the small number of males who were in the sample. However, the two male participants did not report any problems with mangers or LPNs. Mark said,

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I don't have problem with them . . . I don't care about them if they are on duty or not . . . No, I am not scared from them maybe because I am a man. I know other staff, they are too scared from them, but I don't know why.

Jordan provided a different view about working with casual staff and considered them a joy to work with:

Honestly, casual staff for me, I don't get stressed. I actually enjoy casual staff because it's like a vacation. And there is stress 'cause casual staff doesn't know the routine, and they don't know whose shower it is, and who to get up, and this and that. So there is a little bit more stress because you're in charge more, but it's a different kind of stress because it's a work stress. It's not a co-worker stress, which I find a lot more stressful than just a regular work stress.

Another example related to the definition of physical violence. Male participants provided a different interpretation of what physical violence means. Also, they talked about the benefits of masculinity when working as a HCA. Jordan stated,

I've had people slap me before, but I don't really consider that physical abuse. If I'm getting punched in the face, that's abuse. For a female, it's probably a lot different than it is for a man . . . You know slapping like this, for me, that's not bad. It's like if you give a real good punch you know? A good thing about being a guy in this job is that we are physically bigger than a female, and . . . I believe we control situations better just because we are bigger . . . We're just better.

It is noticeable that the two male participants' perspectives were little bit different from female perspectives; for example, what is the meaning of physical violence for male and female?

Challenging work environment. All participants agreed that the workplace environment is a significant source of generating or increasing stress among HCAs. A challenging work environment was mentioned several times by the participants as a source of stress. Workload and work pace were mentioned as the major sources of stress as well as working short-staffed, being overworked and underpaid, having an unequal resident-staff ratio, lacking time, and doing additional work beyond the job description

were perceived as an additional sources of stress. The following quote from Joe

supported these ideas:

> It's a very hard job. It's really hard. It's not just physical hard. It's so hard
> because the workload. There are too many residents for one person. You have not
> enough time for the resident for what you actually have to do. Everything is
> rushing, and you have no time to spend any minute with them to talk. They are
> residents, here should be a home for them and not just something they're in. . . .
> It's not a bad job if you like it, but you have to be really in your mind. You must
> be right to work hard by yourself and being under stress, working under stress,
> and rush, rush, rush.

Further, Mark shared his experience on working short-staffed:

> I remembered one day I was working on the 2nd floor, and we are supposed to
> work four workers until 7 and then five after 7 . . . One of the workers called in,
> and they did not cover his shift so we stay three from 3 till 7 until the night girl
> comes. Then we divided resident between us, which [was an] overload because
> each one get at least three or four residents more, which is not really bad for me.
> At 9 pm the night girl went home sick, and they did not cover her, and the LPN
> that day asks three of us to finish the job. . . . Just imagine three staff doing the
> job of five. . . . We cannot do anything because it is not the residents' problem; it
> is our problem, and we need to manage that.

> Moreover, accessibility to resources, shortage of equipment, not having a break or

not having a physical space for a break, and doing extra work, such as cooking for

residents, were discussed by the HCAs as sources of stress. Jill talked about her

experience of not having a break and how she managed that:

> We don't get a break. We get paid for our break. So we sit down when we can,
> but you don't get a break where you can leave the cottage, or leave and just be
> away from it. . . . There's doors that are open to the back . . . I just put a pillow in
> so I can hear the bed alarms or whatever go off, and I have a quick puff and go
> back in.

The harsh work environment, with no break and conflict between policy and what

actually happens, was discussed by many HCAs. Chloe, a casual staff, shared her

experience about policy conflict when she worked with other regular staff:

I know it's wrong . . . I do it out of fear of my co-workers because if I am defiant and I say, "No we should do what's right," it will be harder to work with them. It will be more difficult to do my job because my work environment will become a less favourable place because they will start to not like to work with me. They will start saying things about me, and so I go along with what's wrong because of fear.

Chloe added:

Subsequent stress that will come from that harsh work environment . . . There's another stress for you, the challenges between following policy and going along with what actually happens with other staff members. Definitely it is a conflict, and that's a stress for sure.

Kat talked about the notion that HCAs are the frontline, and they should have more to say about their work. She also described her feelings during meals, where many residents need to be fed, and there are insufficient staff members to help them. Kat stated,

We are the frontline; we are right there in the front; we are the ones, and we know that they just scratched themselves. We usually know how they scratched themselves; we know how they are reacting to a medication. We are doing all this stuff one-on-one. Whereas, the other nurses, they only come in once in a while, and they only get the information from these people because of us, but yet we are not recognized as being a nurse. It's really, really hard. Some of the residents have to wait, and sometimes you are feeding two at once.

Kat added:

Sometimes we try and sit them out at the same table and feed them, but it's definitely not enjoyable for them because we are just quickly trying to feed them. I think a lot of the time, they don't get the proper nutrition or the fluids because they don't get the time to eat it and if they are slow, either we are rushing to the next thing so.

The challenging work environment was a significant source of work-related stress among HCAs. Workload and work pace were seen as the primary sources of stress at the workplace. By controlling the stressors on the work environment, HCAs' work-related stress level will decrease and work productivity will increase.

Furthermore, there was no fixed staff-resident ratio across the three facilities. There were differences in staff-resident ratio with those differences depending on the

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floor, shift, and the site. As noted earlier, on the regular floor, the average ratio on the

morning shift was one staff to six to eight residents, while on the evening shift, the ratio

was one staff to 12 to 17 residents. On the other hand, in the cottages, the average

morning ratio was one staff to six residents, and one staff to 12 residents for the night

shift. Iliana said,

> Usually I have about a 13 to one ratio; I'm taking 13 people on. It is like the first floor, it's manageable. If you can time manage, it's not stressful at all, but on the second floor, it is a little more people, a little more behaviour. Like I said, if you have an understanding with your resident, you agree on times when things will get done, it's very manageable; it all has to do with your communication.

Theme 3: How Stress Affects/Changes Workers' Lives

The third theme identified by participants' reflected the effects of stress on their

lives. Three subthemes emerged: (a) physically draining /exhausting; (b) mentally

hard/emotionally drained; and (c) affects my life/affects my work.

Physically draining/exhausting. More than two-thirds of the participants

reported physical consequences associated with frequent exposure to stressful situations

at work. Examples included pain throughout the body (e.g., back, neck, shoulder, and

foot), muscle aches, physical exhaustion, indigestion, weight gain, and high blood

pressure. The following are some comments made by HCA participants:

> I do get high blood pressure when I get stressed. I can feel it, and then I get a headache. (Linda)

> Muscle pain. Back pain, shoulder pain, headache. Sometimes, when I feel really bad, I get stomach problems because of not eating, because I have no break. Everywhere hurts. (Lena)

> Stress can manifest so differently in everybody, but for myself, physically, I find that I'm exhausted, my body hurts, [and] I'm getting injuries. I have to have a massage like every two weeks just to de-stress. Yeah, my body physically is in a lot of pain. By the end of that day, you will be exhausted, but I think you just get so used to it too; it's just a constant disappointment. (Kat)

Although all of these signs and symptoms are important according to the participants,

back pain and shoulder pain were the most frequently reported physical consequences

due to the physically demanding job. Jill commented,

> I have headache, shoulder spasm, neck pain, and back pain. Shoulder spasm is the one thing that I find is almost chronic with me now as I'll get shoulders and neck pain. Part of it is, you know, the heavy lifting and stuff like that; turning people and finally weight gain.

The following is Jill's comment about her change in activity patterns:

> Before I started in this field, I was a dedicated runner; I went to the gym like five days a week. In 2005 when I first started into this field, I was probably 40 pounds lighter. So in the last like nine years, I've probably gained 40 pounds from this like just being more inactive. I mean I was running half marathons; I was competitive in lots of sports and stuff, and then when I went into this field and stuff, that's when I started smoking again.

> Participants described the HCA job as being physically demanding, as it included

lifting, bending, grabbing, and pulling. The following is Chloe's comment about the

mechanism of injury at work:

> You know how they teach you in back care training to use your legs, use this and whatever. Sometimes, you're in situations where you can't do that, and you have to reach, and bend, and grab, and pull, and you can't always do it. So you're going to use your back; you can't avoid it, but there is value in the, "It's Your Move" kind of training.

Indeed, working as an HCA in ALFs is physically draining, exhausting, and demanding,

which participants identified as sources of work-related stress.

Mentally hard/emotionally drained. Participants talked about psychological and

emotional consequences and ramifications associated with work-related stress and their

impact on psychological well-being. Examples included emotional exhaustion and feeling

drained, intervals of depression, anger, anxiety, restlessness, changes in mental acuity,

feeling sad and unhappy, changes in sleep patterns (e.g., sleep pattern disturbance: either

sleeping too much or sleeping less), and irritability. The following are some examples

from participants of the psychological and emotional consequences within and after the

stressful situations. Mary commented,

> It will bring me to tears at home. I'll be sitting at home, and I'm so stressed out
> about work, and it only happens every once in a while, where I'm like really
> overly stressed, like for instance that time when [the site manager] moved me
> floors. She didn't say anything to me, and I come into work, and I see it on the
> sign-in sheet. I was just furious, so stressed out. Like my anxiety, I was shaking,
> like it was the worst for me.

Sue said,

> It definitely does make you more anxious. It's so much a mind thing that it turns
> into a physical stress, not just a mental stress, which at that point, you need to do
> something about it to resolve it if it's going to be so persistent.

> Changes in sleep patterns were mentioned by many participants, such as tossing

and turning before going to sleep, insomnia, nightmares, and over sleeping. Alayna said,

> I work till 10:30; I'm working, working. . . Then I get home, and . . . I can't relax
> you know when I get home; I just can't lie down and go to sleep. I have to stay up
> for a little bit. . . . Then I'm up until like two in the morning, and then I'll finally
> go to sleep, and then I'll sleep till probably 12:00, and I get up and go to work, so
> I'm on a very weird schedule.

Lena added: "I get nightmares. It is nightmares and not feeling well, and sometimes, it's

getting up at night." Indeed, working as an HCA in ALFs is mentally hard and

emotionally draining, which was also seen as a source of work-related stress.

Affects my life/affects my work. The last subtheme was how work-related stress

affects the personal and professional life of an HCA. Withdrawal or isolation from social

life, being easily distracted, and shouting and yelling are some examples of personal

consequences as reflected by Lena's comment:

> I'm really grumpy. Every little thing makes me explode on that day. I cannot be a
> normal person. I'm stressed. I'm running around. I'm busy and try to work out the
> stress. Spread it out, yeah. My husband, actually he has to deal with this, with all

my stress because I bring it all to him. I push it to him. I do it here consciously, but it's going all the stresses to him. He said, "Come on. Have a sit. Why you do this? You're running around and cleaning here and doing this." I need something to do so I can stress release. He had to deal with it.

Kat commented,

If I was going to put it in the percentage, how much it affects my home life; I would definitely put it high, 80 to 90%. It totally affects me, so when I come home after say, a day of short working with casuals, it's so physically and mentally exhausting. By the time I get home, I don't want to do anything. I don't want to be with my kids, I don't want to spend time with my husband, I don't want to go back to work. Everything is really dark and gloomy and overwhelming.

Professional ramifications of work-related stress were also mentioned by the participants.

and focused on the quality of resident care and poor performance. As an example, Jordan

said,

If you're stressful your brain is thinking about what is causing you the stress, so that could affect you. That does affect you giving resident care. . . . You have that on your mind, and what you should be focused on is the resident and what you're doing for the resident or residents, but you've got all this in your head, and you keep thinking about that, and that's when mistakes happen and stuff like that.

Work-related stress has many professional and personal consequences that affect the

quality of life and work productivity of the workers.

Theme 4: How HCAs Cope

Work-related stress was considered an individual phenomenon with regard to how

participants perceived and dealt with stress, as were the coping mechanisms were varied

across the sample size. This finding led to this fourth main theme. Three subthemes

emerged from this main theme, which included (a) Venting and social support; (b) chill

out; and (c) stress courses.

Venting. Venting is an important coping strategy used by participants and defined

as talking about the situation and release your feelings and opinion to someone. "Let it

go," "venting," "I can't bottle them up," and "get it off my chest" were words used by participants to describe how they coped with their work stress. Strategies such as seeking social support and talking to somebody were mechanisms used to address their interrelated stress by buffering the negative effects of stress and were also important in building a healthy work relationship. Coping mechanisms such as talking to co-workers, family members, friends, and sometimes LPNs and management helped individuals cope with their stressful experiences. Mary said,

> I talk about it to almost anyone that will listen. If I'm at work and someone has done something that has stressed me out, I will start talking about it with other workers, usually ones that I trust, ones that I feel I can share those things with. I process my stress by getting it out, by talking about it, getting other people's opinions, seeing what they think about the situation, and then formulating my decision about what I should do. I was raised to talk, so I spit it out.

Mark spoke about managing stress as an inner power of the individual and having the ability to cope with stress. Also, he talked about seeking social support from his co-workers or his wife. Mark said,

> I don't think there is anything at work to help me to manage my stress. I think it is inside. You need to know how to deal with that, which I really, some days, I don't know what to do . . . just struggling and facing the situation alone. Talking with other staff and get their opinion is really helpful, and I think it decreases my stress. I talk to my friends on my break or when I go outside to smoke. I think it helps little bit, but not too much. When I go home, I give my wife like a report what happened, and sometimes [she] give me ideas.

Coping with work-related stress was dealt with differently but social support was the most common strategy used.

Chill out. Chill out is getting away from the stressful situation, become quiet or calm, or getting busy. Eleven participants talked about taking time to "chill out" as a mechanism for relieving stress. Getting away from the situation, relaxing, being busy with different things, taking a short break after the stressful experiences, reading, writing,

walking, shopping, doing family activities, taking a bath, having a massage, or watching

a movie were mentioned as mechanisms to relieve or reduce work-related stress. Linda

said,

> I usually kind of take a time out. I'll sit down and read for a bit or just chill out, like sit there and take a breather. . . . At home, I'll come home, have a beer, and read or have a bath. Reading is my big thing. That's my stress release.

Another example was provided by Kat as to how she decreased or released her stress:

> At the moment, I try not to be reactive, but usually after work when I go home, I try and read, I try and pray, I talk to my husband, I have a bath, I watch a movie, just kind of relax my mind. I usually like to talk about it, get it worked out.

Sue talked about avoiding and trying to get away from the stressor:

> I need to pay off my student loan, and it's really a matter of just do it and push through and kind of almost avoid that person. If I have to speak to them, it's going to be very short and sweet, and that's basically it. That's not exactly the best way to deal with it. If I find I have a problem with somebody and it's just continuous and they just have a problem with me, then I will have a chat with them "Okay, what am I doing to piss you off, and what can I do to not piss you off?"

> Additionally, one participant reported that sex was the best way to reduce or

relieve stress, and she explained that sexual activity could reduce stress by taking a

person's mind off the stressful situation. Other participants reported that doing exercise

or going to the gym was a helpful way to relieve or reduce stress. Examples of exercise

included walking, running, and playing baseball, soccer, or tennis. Jordan shared his own

experience with doing exercise:

> I'm very athletic, I do lots of exercise. When I'm not at work, or if I come home from work, I go for a run, or play tennis, or just do something athletic . . . go for a jog. When I'm at work, I'll kind of just take a deep breath and just kind of stand and relax and just mellow out for a minute or two, and then I'm pretty good.

The tendency for calling in sick because of work-related stress was frequently reported. All participants reported this as a strategy to reduce or avoid stress. Judy explained why she calls in sick:

> Lots of times, if there are things going on or just if you're having a problem with a co-worker, you think about that, and then you're not looking forward to going to work. So the best thing you can do is call in.

Joe gave another reason for calling in sick, which she connected to the lack of future opportunities and professional development:

> I feel like that every day. I wake up and I'm like, [expletive deleted] work, I don't want to go. It gets stressful because it's the same thing and that's what gets to you. . . . There is no challenging, no career development, and you're stuck. You feel like you're just stuck in a hole, you can't get out.

However, Mary talked about the difficulty of calling in sick nowadays:

> I used to call in, but now we can't use our sick days or our personal day because we have to bring in a doctor's note, which I think is ridiculous after one day. I don't want to lose out on a full 12-hour night shift if I'm not sick. Like I got a runny nose, watery eyes, and I'm still going to go to work because. I know it doesn't seem right because these are people that you are taking care of. You have to pay twenty dollars for each doctor's note. And in our AUPE book, technically [the employer] is supposed to pay you back. I've gotten three doctor's notes in the two and a half years, so that's sixty dollars they owes me that has not paid me. So I don't bother calling in a lot of times. Like if I got a bad back I'll push it through and do what I've got to do.

> Many coping behaviours were revealed by the participants, such as drinking

alcohol, smoking tobacco or marijuana, eating too much, sleeping more than normal, or

taking specific drugs like Percocet, a narcotic pain killer used to treat acute pain such as

back pain, and Ativan, used to treat anxiety disorders. Linda said,

> I'll emotionally eat, if I'm stressed. I'll feel it. . . . I don't even eat really but when I do eat, it's bad because that's what makes me feel better, but it doesn't in the end. It just makes you feel gross. It affects the way I react.

Alayna talked about her own mechanism to decrease stress and about other co-workers:

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I'll go for a cigarette. I do know one girl, and she does do marijuana, and I've heard she does do it on the job so. I know a girl who is abusing the drugs, but she does take a lot of prescription drugs for herself . . . like narcotics. I think she was taking the Tylenol number fours and the Percocet. Like, if I just take one Tylenol number three, it makes you feel like you're . . . like you know, it does affect you.

Joe talked about her aggressive coping behaviours for stress:

I usually tend to smoke a lot, or I actually do get sometimes physical and just punch a wall or something, or bite myself. I got other, a whole bunch of them, but I don't want to say, so, I'm good.

Coping behaviours varied among participants, and they ranged from calling in sick to drinking alcohol or smoking. Coping behaviours and mechanisms were an individual choice and were selected based on what participants found could relieve or reduce stress. Twelve participants noted that their coping behaviours and mechanisms were effective and helped them to relieve or reduce stress. Sue commented,

I definitely feel like I can confide in my boyfriend. I feel I'm very good about being confidential. I'll say, "Oh today was such a tough shift, so and so did this." And it really does help me; talking is really a very good tool to just kind of get it off your chest, and then after that I feel so much better.

Finally, using counselling services was mentioned by many participants. Unfortunately, more than half of the participants did not know about this service or if their workplace provided it or not. Kat said,

I've used medication, and I've used counseling for sure to help. I haven't accessed anything through work though. . . . I've heard they have a counseling service. . . . I don't know if it's through the union or if it's through the workplace. I don't know if it's specific to the site, but I've heard that there is something there, but I've used my benefits for counseling, I paid for counseling myself.

Stress courses. All 14 participants stated that they never completed any courses or attended lectures about workplace stress or stress management at their workplace. Five participants took part in such courses in their basic training program or at the colleges, but not at their work location. Iliana said,

> Just the basics I was taught when I was doing my PCA course. They taught us how to manage stress, how to help, or how to leave a situation that's stressful, and they taught us a lot of the situations we would be put in, and trust me, we were put in those situations, but I didn't receive any training in [facility] about stress.

Moreover, more than half of the participants would prefer to have courses or lectures about work-related stress and how to deal with difficult situations. Participants felt that such courses would be helpful and one way to decrease the stress level by knowing the sources of stress and how to manage stress at workplace. Mary added:

> I think it well be helpful to have such courses. I think if we were having different coping mechanisms, learning from other people's experiences and helping each other like in a class room of ten or whatever, it would really be helpful. I do remember when I took my course [HCA course] two and a half years ago, there was a section about how stressful your job can be and all this stuff, but I don't really remember it. Like, it would be nice to get a refresher on that: things you can do, people you can talk to.

Courses and lectures about work-related stress and how to deal with it were seen by participants as a way to be prepared for the workplace environment.

Theme 5: Ideal Workplace

In addition to the four main themes that were generated from the analysis a fifth theme was generated to address what the ideal workplace looks like from the HCAs' point of view. A good working environment should be a source of joy to the employees and give them the initiative to be more productive. When I asked participants about the ideal workplace, their comments varied. Many criteria for an ideal workplace were mentioned, such as management support and recognition, good team work, appreciation among all levels of workers, increased staff numbers, regular meetings, in-service education about work-related stress and stress management, physical space for staff (e.g., lounge room), organizing and prioritizing work, and communication. Lena said,

My recommendation for the whole system is to try to make it better for the worker. It means, not decrease the staff. I would put more in, so there is more staff available. Then, a couple of days or nights go in the field and see what they're doing there anyways. I think the manager has no idea. They should go and see what's going on, how the workload is, and what we're doing there. Everything is fine on paper, but they don't know the work for sure. Go just in to see what they're doing and how they have to deal with different residents, what's going on at night, what's going on in the day.

Judy added:

Actually, I think if they had meetings . . . a monthly meeting. I think if you have a meeting once a month with management and staff, everybody could talk about things that they are having problems with, and maybe things would change. At least, you could talk once a month and get it all out in the open, where now we don't.

A main point from almost all participants was that workplace relationships between workers and supervisors or managers are so important and can make employees more committed and productive at their work. Kat talked about the ideal workplace:

The first thing that comes to my mind is just teambuilding, just do some teambuilding work together, don't have this hierarchy, don't have these different levels, be like we are a team. I'd like to be approachable, I'd like to let my staff know I'm approachable, I'd like to be there to support them however I could. I would like to see just a healthy environment all around, just none of this back-talking, picking, gossip, slander, like all of that is just so unhelpful.

Kat added:

If I was the manager, I'd just do a lot of teambuilding, and even just rewarding my staff, giving incentives to them to let them feel like you are important, you are valued. Here is a box of donuts today or whatever, just something, a pat on the back; you are doing a great job. I'd also make sure the floor had the residents move in that I knew exactly what I was getting, and I'd want them to collaborate with my team as staff. I'd want to know how is this working, how are these residents? Like, I would probably bring them into disciplinary meetings, not leave them on the outside and just keep people on there that aren't doing the frontline care with them, right. I'd want to know how we can help you and [what they would] like. It's all relationship.

An ideal workplace and good work environment are required to eliminate and decreases stress levels among HCAs. Many criteria for an ideal workplace were

mentioned, such as support and recognition, team work, appreciation, and physical space for staff.

Chapter Summary

In this chapter, a detailed discussion of the research results based on participants who were interviewed in this study was included. From three different ALFs, two male and 12 female participants were interviewed using a semi-structured interview. Descriptive statistics were calculated to identify the demographic characteristics of the participants. The female participants ranged in age from 20 to 49 years with an average of 33 years; male participants ranged in age from 36 to 38 years with an average of 37 years. Each had between 2 to 17 years of accumulated experience as an HCA. Thematic qualitative analysis was used to analyse data in this study. Data analysis produced agreement on four major themes: (a) the meaning of work-related stress, (b) genesis of work-related stress, (c) how do HCAs cope, and (d) stress affects/changes my life. Nine subthemes were identified, and these along with the major themes are listed in Table 3, such as identifying work-related stress, challenging work environment, and chilling out. Discussion of the meaning of the research results compared with the literature will be presented in chapter five.

Chapter 5: Discussion, Implications, Recommendations, Limitations, Dissemination,

and Conclusion

This qualitative study utilized a descriptive, exploratory approach based on semi-structured interviews to describe, understand, and explore the experience of work-related stress among 14 health care aides (HCAs) in assisted living facilities (ALFs). The first three chapters focused on the background and problem statement, the literature review, and methodology. In Chapter Four, I provided the analysis and results related to work-related stress among HCAs. In this chapter, I present a discussion of the findings in relation to the literature. Implications and recommendations for future research, limitations, and research dissemination are also included.

Discussion of the Findings

Demographic Data

The sample consisted of two male and 12 female participants, for a total of 14 participants. The average age of participants was 34 years and the age range was between 20 to 49 years. The average age of males was higher than females; the average age for females was 33 years and for males it was 37 years. The accumulated experience working as an HCA, for both male and female participants, was between two and 17 years, with an average of seven years. The HCA participants worked an average of nine hours daily and 34 hours weekly. Twelve participants were born in Canada and two born in other locations. Ten participants held an HCA certificate and four did not. Moreover, HCA participants preferred to work part-time and evening shifts more than other positions or shifts. Although this is a small sample, given that there is a lack of information about the characteristics of the Canadian HCA workforce in ALFs, the demographic information

generated in this study has provided some indication about this population in Southern Alberta.

Training

The literature highlighted the inconsistency of the title, diversity in the training and standardization, and job description in Canada and internationally. Study findings about training revealed that HCAs are unregulated and not recognized as a profession in Alberta; also, they do not have a standard educational requirement. Berta et al. (2013), CNA (2008), Cummings et al. (2013), and Demone (2011) stated that there is no consistent training requirement for HCAs entering the workforce, no national standard for education and training of HCAs in Canada, and training varies from province to province. The participants in the current study focused on the importance of standardized education to ensure HCAs provide high-quality care to residents. These findings were congruent with the *Workforce Strategy for Continuing Care in Alberta 2012 to 2017* report by ACCA (2012; see also Demone, 2011). Further, the findings showed that ALFs provide in-service education courses for HCA, but fewer than half of the participants received instruction about work-related stress during the HCA course. This finding was similar of CNA (2008) and HPRAC (2006), both of whom stated that many HCAs are trained by employers, while others receive formal training in colleges. No such training was provided at the workplace for participants in this study; many of the participants pointed out the potential value of such courses.

The Main Themes

Many studies showed that work-related stress is one of the major sources of life stress. Work-related stress has become a global epidemic (Collins, 2006), and work-

related stress is on the increase (Palmer et al., 2004). One third of North American

workers are affected by stress, and it has been described as a substantive problem for

workers and employers (Patrick & Lavery, 2007). DeVries and Wilkerson (2003)

reported that stress is fast becoming the most common cause of worker ill health and

disability and turnover. Work-related stress is a highly individualized phenomenon and

can vary widely, even in the same situations for different reasons. Four main themes were

identified in this research: (a) the meaning of work-related stress, (b) genesis of work-

related stress, (c) how HCAs cope, and (d) stress affects/changes my life (see Chapter

Four, Table 3).

        The meaning of work-related stress. All participants found it hard to describe

their perception of work-related stress; this may be because stress is an experience related

to a subjective feeling. In other words, what is a stressful event for one may not be for

others. Two participants found it difficult to define work-related stress because English

was not their native language. If you do not have words to describe or explain what work-

related stress is in your native language, it will be hard to manage and relieve stress in

this situation and hard to identify it. The participants defined stress from physical,

psychological, and emotional perspectives that they then connected to their work

environment which was congruent with CCOHS (2012b) when they defined work-related

stress as "the harmful physical and emotional responses that can occur when there is a

conflict between job demands on the employee and the amount of control an employee

has over meeting these demands" (para. 2). Also, participants' definitions aligned with

the definition of stress provided in a few articles and reports. The European Agency for

Safety and Health at Work (as cited in Milczarek et al., 2009) has adopted this definition:

"work-related stress is experienced when the demands of the work environment exceed the workers' ability to cope with (or control) them" (p. 14). The stress level as reported by all the participants was high. The stress level rate was measured on a scale of 1 to 10, where 1 reflected zero stress and 10 was the maximum stress. On bad days, the stress level reported by participants ranged from 6 to 10, with an average of 8.

Participants described the signs and symptoms of being stressed out according to their belief, awareness, and personal experiences. Physical, psychological, and emotional signs and symptoms were noted by participants, such as headaches, muscle aches, insomnia, anxiety, and depression. These signs and symptoms were reported many times in different research and reports (CCOHS, 2012b; Griffiths et al., 2009; NIOSH, 2008), even though the research represented by these authors was not focused on HCAs.

Furthermore, 40% of the participants were not satisfied with their job. This low dissatisfaction level was quite interesting given the number of factors that had been identified as contributing to work-related stress; however, not all factors apply to all people. Dissatisfaction among HCA participants was connected to organizational factors, such as leadership style and lack of decision-making opportunities (Barling et al., 2005; CCOHS, 2012b; HSE, 2014); work environment, such as workload and work pace (CCOHS, 2012b; NIOSH, 2008); and lack of appreciation from management, supervisors, residents, and residents' families (CIHI, 2006; Giver et al., 2010). Berta et al. (2013), Church et al. (2004), and Sengupta et al. (2012) claimed that HCAs represent the lowest-paid jobs, which they connected to job dissatisfaction. However, the results from the current study revealed that HCA participants were satisfied with their wages and considered HCA work as financially rewarding compared to other jobs.

Genesis of work-related stress. There are many sources of work-related stress. In the current research study, participants identified two main categories of stress. The first category comprised behaviours, attitudes, and situation stressors from residents and thier families, leadership, and other co-workers. This was congruent with the literature that identified many sources of work-related stress, such as: (a) lack of appreciation, threat of violence, role conflict, and role ambiguity (CCOHS, 2012a; NIOSH, 2008); (b) lack of managerial supports, work-related violence, and bullying (HSE, 2014); (c) organizational role stress, organizational justice, poor leadership, work-family conflict, harassment and discrimination, and workplace aggression (Barling et al., 2005); and (d) not being recognized or respected by others (ACCA, 2012).

The second category was the challenging work environment. The work environment was seen as having a part in generating or increasing work-related stress among HCAs. Working short-staffed, overworked and underpaid, high resident-staff ratio, lack of time, and doing additional work not listed in the job description were mentioned as the major sources of work-related stress. The findings reported in my study correlated with the findings of the literature review, such as: (a) workload, shiftwork and hours of work, and lack of skills and training (CCOHS, 2012b; NIOSH, 2008); (b) work schedules, physical work environment, and workplace safety (Barling et al., 2005); and (c) working heavy workloads with short hours (ACCA, 2012). These results supported previous studies and reports about work-related stress, even though those literature sources were not specifically focused on HCAs.

The rate of violent incidents experienced by health care workers is now recognized as a serious health priority (WHO, 2014). Workplace violence toward health

care workers continues to grow, and "between 8% and 38% of health workers suffer physical violence at some point in their careers. Many more are threatened or exposed to verbal aggression" (WHO, 2014, para. 1). According to the Workers' Compensation Board of British Columbia (2005), violence-related injuries claims "account for an average of 7.5% of all claims in the health care industry" (p. 46). According to the literature, one can assume there are some particular sources of stress related to HCAs, such as being underpaid, having a high resident-staff ratio, providing direct care to elderly all the time, and workplace violence. Workplace violence is much more than physical assault. CCHOS (2012a) has defined it as:

> [Workplace violence as] any act in which a person is abused, threatened, intimidated or assaulted in his or her employment. Workplace violence includes: threatening behaviors . . . verbal or written threats . . . harassment and bullying . . . verbal abuse . . . [and] physical attacks. (para. 1-2)

People who are working in the health care field are more likely than those in other jobs to experience workplace violence. HCAs are at high risk of workplace violence because of the nature of their job, in provide the most direct care to residents who are elderly and may have dementia (King, 2008; Lerner et al., 2011). Violence or aggression from residents was identified by participants as a source of work-related stress. These findings are closely related to research reported by Gates, Gillespie, and Succop (2011), WHO (2014), and WorkSafe BC (2005) when they identified violence or aggression as a major source of stress at the workplace, and health care workers, nurses, and HCAs are experiencing the highest rates of violence at workplace (Gates et al., 2011). Three kinds of residents' violence were identified, which included physical, verbal, and sexual. All participants reported at least one kind of violence or aggression; however, physical and verbal were the most frequently mentioned. Thirty-eight percent of health workers

suffer physical violence in their workplace in general (WHO, 2014). Although I am unable to compare my results with these figures, it is noteworthy that 10 of 14 participants reported physical violence, whereas six reported sexual violence, which was more than the average of sexual violence in health care fields. Further, Fudge (2006) estimated that 50% of health care workers experience physical assault during their careers, while Thomas (2010) claimed that 62% of new nurses reported verbal abuse.

I assumed that negative experience from violence coupled with inadequate training about violence would also influence the stress level and job satisfaction. HCAs in this study reported numerous examples of violence in the workplace and inadequate training either about violence or work-related stress. This means they are at a high risk for workplace stress, which often results in many consequences to their personal life and work life. In addition, the results revealed there were many feelings and emotions associated with acts of violence, such as anger, job dissatisfaction, feeling uncomfortable, feeling unsafe, low self-esteem, and being scared about future violence, which was comparable to Gates, Fitzwater, and Succop's (2003) results on violence among emergency department nurses who experienced anxiety and feeling unsafe after a violent situation.

Furthermore, Kelloway, Sivanathan, Francis, and Barling (2005) identified poor leadership as a source of work-related stress that had negative effects on workers' performance, efficacy, and individual well-being. This literature was compatible with the findings from the current study when participants identified interactions with their supervisors and managers as a source of work-related stress. Participants talked about situations that generated the work-related stress, such as bad relationships with

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supervisors, lack of control, lack of involvement in decision-making, aversive behaviour, leadership style, and lack of support and lack of respect.

Finally, HCAs identified two categories of work-related stress. The first category is controllable sources, which are possible for HCAs to control within their sphere of responsibility in the workplace or which can be managed by the employer, such as workload, work pace, and physical space for breaks, or employers might be able to influence attitudes of LPNs towards HCAs. The second category is uncontrollable sources, which are hard to control or manage, such as families' attitudes and behaviours, as one cannot control what families do, and disease progress if the resident has dementia.

Stress affects/changes my life. Participants identified three major consequences of work-related stress. The first included physical consequences, such as back pain, headache, neck pain, shoulder pain, and muscle aches; back pain and shoulder pain were the most frequently reported physical consequences. The explanation could be related to the nature of work, which includes lifting, bending, and pulling.

Second, there were mental and emotional consequences, such as emotional exhaustion and feeling drained, depression, anger, anxiety, restlessness and irritability, feeling sad and unhappy, and changes in one's sleep pattern. These findings were similar to the literature about work-related stress in the health care field (CCOHS 2012b; HSE, 2014; NIOSH, 2008). This literature identified many physical results from work-related stress such as heart disease, back pain, gastrointestinal disturbances, and psychological effects including anxiety and depression.

The third consequence was that work-related stress interfered with personal and professional life; this included withdrawal or isolation from social life, being easily

distracted, spreading the stress, decreased quality of resident care, and poor performance.

These findings were similar to those of Bickford (2005) and Griffiths and colleagues

(2009), who identified that work-related stressors have multiple origins, and can impact

employees, employers, and community, and have a negative effect on the health of

employees and on workplace productivity. Also, these results were congruent with the

NIOSH (2008) report, which clarified that the quality of patient care provided may also

affect health care worker stress.

How HCAs cope. Work-related stress was considered an individual phenomenon

based on how participants perceived and dealt with stress. Thus, reactions and coping

strategies were different across the group of participants. Researchers have identified a

number of coping mechanisms that can reduce or eliminate the negative effects of work-

related stress, which include degree of control, emotionality, social support, and an

individual's coping mechanisms (Gillespie, Walsh, Winefield, Dua, & Stough, 2001).

Several steps have been identified to reduce work stress, which include taking

responsibility for improving physical and psychological health, avoiding pitfalls by

identifying negative attitudes and unhealthy habits that add to the stress, and learning

better communication skills to enhance relationships with others (J. Segal, Smith,

Robinson, & R. Segal, 2012). Coping strategies could be healthy or unhealthy. Healthy

coping strategies include changing the situation by avoiding the stressor, altering the

stressor, changing the reaction by adapting to the stressor, or accepting the stressor.

Unhealthy coping strategies include smoking, drinking, sleeping too much, or

procrastinating (M. Smith & R. Segal, 2014). Working in a stressful workplace such as

ALFs, dealing with difficult and stressful situations on a daily basis, and having little

support forced HCAs to use many coping mechanisms or a combination of strategies to reduce work-related stress. HCAs in this study seemed to be using a combination of coping strategies more than one single strategy. HCAs identified many coping mechanisms, such as:

1. Venting and seeking social support. Participants highlighted the importance of having someone to confide in and seeking social support, which was consistent with AbuAlRub's (2004) research on job stress, job performance, and social support among hospital nurses, which showed that perceiving social support from coworkers increased job performance and decreased work-related stress. My findings indicated that perceived social support from coworkers decreased the level of reported job stress.

2. Avoiding stressful situations. This response from participants was consistent with other research that found avoidance was a coping mechanism to reduce stress (Chang et al., 2006; V. Lambert, C. Lambert, & Ito, 2004).

3. Absenteeism (calling in sick). Eriksen, Bruusgaard, and Knardahl (2003) identified that the lack of an encouraging and supportive culture in the workplace was a predicting factor for absenteeism and calling in sick among Norwegian nurses' aides.

4. Leisure, which included relaxing, taking a short break, reading, writing, walking outside, shopping, watching a movie, sexual activity, playing sports. These findings were congruent with research by Trenberth and Dewe (2002) who reported on the importance of leisure as a means of coping with work-related stress.

5. Behavioural mechanisms were used to cope with work-related stress, such as drinking alcohol, smoking cigarettes or cigars, smoking marijuana, eating too much, sleeping more than normal, or taking prescription drugs like Percocet and Ativan. These findings were consistent with Rowe and Macleod Clark's (2000) literature review of why nurses smoke. They found that many nurses smoke to decrease their stress level due to working environment. Further, Seyedfatemi, Tafreshi, and Hagani (2007) reported that Iranian nursing students used smoking and drinking as coping strategies to decrease their stress level.

Educational Implications

The pressures on HCAs at ALFs continue to mount. The findings from this study could serve as a reference to explore the directions of health education in the HCAs' sector. I examined how HCAs in ALFs experience work-related stress, the sources and consequences of stress, coping with stress, and the consequences of stress. This was the first study in Canada to focus on HCAs in ALFs using a descriptive, exploratory, qualitative design. This study is important because it provides new insights and new knowledge about HCAs' work life. The findings in this study have demonstrated the value of training programs and in-service education before entering the HCA field and this program need to be consistent and standard. Such programs and education would be helpful to better prepare HCAs as to what to expect in the actual working field and how to deal with stress. Thus, future research about the effectiveness of training programs and in-service education is needed.

Policy Implications

An important recommendation for policy makers and managers of ALFs would be to consider what HCAs described as the ideal workplace. Many criteria for an ideal workplace were discussed by HCAs, such as management support and recognition, regular meetings, and in-service education about work-related stress and stress management. Training programs for ALF managers are recommended, which would include courses about leadership position and leadership style. Leadership style has much to do with decreasing work-related stress. It would be helpful if managers learned how to be proactive leaders. Many approaches to leadership style can be learned, and skills learned through such training could help a leader encourage and empower their staffs.

HCAs talked about how physical space for staff (e.g., lounge room), working as a team, and appreciation among all levels of workers could make the workplace less stressful. Therefore, it is suggested that more in-service education is needed to promote these ideas and create a healthy work environment. Physical space for staff to have breaks and relax and having a comfortable work environment can play an important role in decreased stress levels and increased employee satisfaction.

The challenging work environment and poor working conditions, such as staffing levels and workload, were emphasized as a source of work-related stress. HCAs reported that work-related stress affects their ability to provide safe and high-quality care. As working conditions can affect the ability to deliver a high quality of care and also affects HCAs' sense of safety in ALFs, interventions to improve working conditions could decrease the stress level among HCAs, increase safe practice, and also aid in providing a high quality of care. Interventions such as increasing staff numbers and reducing long

shift hours would be helpful. However, there are many structural and organisational

factors that cannot be controlled such as resources, hiring process, staff-resident ratio,

and placement of residents. The increasing number of aging persons, the inter-related

increased demand on health care systems, and the expansion of ALFs has resulted in an

increasing demand for HCAs. My final recommendation is specific to policy makers. As

was presented in the literature, the HCA position is an unregulated job (i.e., not licensed

or governed by a regulatory body). Therefore, I suggest it is better for HCAs to be part of

a regulatory body like other health care professions, in order to standardize the HCA

training program and certification, as well as the job title of HCAs across the country.

Recommendations for Future Research

The unique nature of work-related stress experiences and the associated coping

mechanisms make the study of work-related stress a daunting undertaking. The

complexities inherent in ALFs and the nature of HCAs' work further complicate this

challenge. Thus, the importance of further research about this marginalized worker group

is clear. In this study, I have used two theories related to stress, which include (a) the

transactional model of stress and coping (Glanz, Rimer, & Viswanath, 2008; Lazarus &

Folkman, 1984) and (b) the job demands-resources model (Demerouti & Bakker, 2011;

Schaufeli & Taris, 2014). These theories discussed three phases: appraisal of stress,

coping, and outcome of stress, further research that focuses on these different phases

among a larger health care aide population would generate additional information. For

example, this study provided glimpses into some of the experiences of work-related stress

encountered by HCAs in ALFs. Future research could focus on HCAs in different

settings like long-term care or hospitals and include more male participants. This

qualitative study focused on describing and exploring the experience of work-related stress among HCAs in ALFs in Southern Alberta. The study design was descriptive and exploratory with participants from three sites in Southern Alberta, thus further study in other geographic areas that builds upon these understandings is recommended. The current study findings would be beneficial for future quantitative and qualitative research. As little is known about HCAs in Canada, further research in Canada to investigate work-related stress among HCAs at the provincial and national level is required. A national survey of HCAs could build an understanding of the demographic profile of the Canadian HCA workforce. One more point needs to be added: Violence, in general, and sexual violence, specifically, was reported by HCAs in this study; future research is needed to address this issue.

Limitations of the Research Study

There were several limitations in the study. Selecting participants for interviews was one limitation because participants were likely to have strong views of work-related stress, and by using inclusion criteria, the participants did not represent all workers. Although the findings from this study were innovative and achieved a rich description of work-related stress and coping mechanisms, they cannot be generalized. However, the findings could be transferable to similar settings. Moreover, my own work experience as an HCA may have had unintentional effects on the research process and interpretation of the findings.

Although the findings may reasonably represent the knowledge and views of the HCAs who participated in this research, the findings cannot be generalized to the experiences of other HCAs in other ALFs in Alberta or across Canada. Another limitation

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was the small geographical area of this study. Finally, more male participants might have provided different insights and experiences not presented by this study's participants.

Research Dissemination

Research findings will be disseminated to interested participants upon request as outlined in the informed consent (see Appendix E). Participants were given the option of requesting a copy of the final thesis; in the consent form, participants provided the information by which they could be contacted. Further, short presentations or summaries will be provided for each ALF site. Furthermore, I intend to present my findings at relevant conference. Finally, it is my intent to publish the findings; articles will be submitted for publication to academic journals.

Conclusion

The exploratory nature of this study has offered an in-depth understanding into how HCAs in ALFs experience work-related stress. Creating a healthy work environment for HCA represents a priority for not only maintaining an adequate HCA workforce, but also for providing high-quality care to clients while increasing HCA safety. HCAs need to be aware of the work-related stress and appropriate coping strategies they could use at their workplace. This could be accomplished by utilizing the free counseling services provided by the facilities or even in-service education. This study identified the sources of work-related stress faced by HCAs who work in ALFs, the coping mechanisms, and the effects on their personal and professional lives. Further research, both qualitative and quantitative, with a larger sample size is needed to better understand this marginalised group of workers.

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Appendix A: Poster 1

University of Lethbridge
Faculty of Health Sciences

PARTICIPANTS NEEDED FOR RESEARCH

You are invited!

Have you been working as a health care aide in the Lethbridge area for 1 or more years?

If so, I would like to talk to you

I am a graduate student at the University of Lethbridge looking for volunteers to take part in a study about stress in the workplace.

Each interview will be about 60 minutes.

Participants must have identified English as a language of communication at work.

Participation is voluntary, and your privacy will be protected.

If interested, or for more information please contact:

Mohammed Al-Hassan, Graduate Student, Faculty of Health Sciences, [email address] or [phone #].

Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]	Mohammed Al-Hassan [email address] [phone #]

Appendix B: Poster 2

ARE YOU A HEALTH CARE AIDE?

ARE YOU INTERESTED TO KNOW MORE ABOUT WORK-RELATED STRESS?

If yes, you are INVITED!

I am a graduate student at the University of Lethbridge looking for volunteers to take part in a study about stress in the workplace.

Have you been working as a health care aide in the Lethbridge area for 1 or more years?

If so, I would like to talk to you

Each interview will be about 60 minutes.

Participants must have identified English as a language of communication at work.

Participation is voluntary, and your privacy will be protected.

If interested, or for more information please contact:
Mohammed Al-Hassan, Graduate Student, Faculty of Health Sciences, [email address] or [phone #]
Thank you for your time and consideration.
Sincerely,

Mohammed Al-Hassan

Appendix C: Interview Guideline

Start

- Why did you become a HCA?
- Did you receive any training for this role? Do you believe the training program is important? Why?
- How did you find this job as HCA? What benefits were offered to you at this facility?
- How satisfied are you as a HCA with your current job?
- What are some of the reasons HCA (you) continue to work in your current position?
- Do you know your job description (role)? What?

Experience and Level of Stress

- Do you get stress out from this job? Why?
- From scale of 10 (where 1 is no stress and 10 severe stress) where are you?
- How do you know if you stress or not?
- Can you define what work stress mean to you?
- Do you know the sings of stress? If yes can you tell what?
- In the past few months, have you experienced stress in any situation in your job as a HCA? If yes, please describe the situations. Can you give me more examples?

Probe,

- Has your experience of work stress changed over time?
- What makes the situation difficult?
- What emotions did you experience following this difficult situation?
- How did you cope with this difficult situation?
- Was your strategy effective for you in this difficult situation?
- If your strategy was not effective, what could you have done differently?

Causes

What contributes to your stress at work?

Probe,

- Are there any causes of stress that are unique to this job/facility?
- Do you think HCA have different stress from other jobs? Why?
- As a HCA, what situations, in general, are sources of stress for you in your job?
- What factors increase stress for you in your work?

- What factors decrease stress for you in your work?
- How you define workload, what did mean by workload
- Describe the relationship between stress and performance.

Coping strategies

- How do you handle stress?
- What helps you to manage your stress at work?

  Probe,

  - What personal strategies do you employ to manage your work stress?
  - In what way do these strategies help you to manage stress?
  - Is there anyone in your work environment that you can share your experience of stress with? If yes, can you please describe a time when you did this? Are there any types of support (emotional, informational, appraisal, role modeling, or instrumental) that you do not receive from anyone?
  - How has social support been important to you in managing your stress? Give specific examples.
  - What aspects of your work and work environment help you to manage your work stress? How?
  - What activities do you generally engage in to decrease stress?
  - What you can do to prevent stress? Individual level?
  - What strategies can your organization do that be helpful in decreasing stress in your job? What are the organizational strategies can be done to prevent stress?
  - *Why should organizations be concerned about stress at work?*
  - Did you receive any training about stress or coping with stress in the past? Where and for how long? Did you take any continuing education classes in past 2 years?

Consequences
- *What are the major physical consequences on your health from work stress? The behavioral consequences? The psychological consequences?*
- How does the stress you experience at work affect you? Professionally? Personally?
- Are there any other comments regarding this subject that you may want to add? Please elaborate.

Appendix D: Ethics Approval Documentation

CERTIFICATE OF HUMAN PARTICIPANT RESEARCH
University of Lethbridge
Human Subject Research Committee

PRINCIPAL INVESTIGATOR: Mohammed Al-Hassan

ADDRESS: Faculty of Health Sciences
University of Lethbridge
4401 University Drive
Lethbridge, AB   T1K 3M4

PROJECT TITLE: Work-related Stress among Health Care Aides: A Descriptive Exploratory Study

INTERNAL FILE: 2013-074

INFORMED CONSENT: Yes

LENGTH OF APPROVAL: November 12, 2013 – August 30, 2014

The Human Subject Research Committee, having reviewed the above-named proposal on matters relating to the ethics of human research, approves the procedures proposed and certifies that the treatment of human participants will be in accordance with the Tri-Council Policy Statement, the Health Information Act, and University policy.

Susan Entz, Ethics Officer   _November 12, 2013_
Human Subject Research Committee   Date

University of
Lethbridge

Faculty of Health Sciences

Study Title: Work-related stress among Health Care Aides

Dear Participant,

You are invited to take part in a study about "Work-Related Stress among Health Care Aides". This study is being conducted by Mohammed Al-Hassan, a student in the University of Lethbridge, under the supervision of Dr. Judith Kulig from the Faculty of Health Sciences. A research study is a requirement to obtain a Master's degree. The purpose of this study is to know how Health Care Aides (HCAs) feel about work stress in Assisted Living Facilities. I am interested in what factors add to work stress and what HCAs do to manage workplace stress.

This study will require you to share your feelings about work stress in an interview. The interview will be 60 – 90 minutes. The interview will be audio recorded with your permission. If you prefer not to be audio recorded, I will ask permission from you to take notes. Please know that your sharing is voluntary and your response is private. The interview will be done wherever you prefer (e.g. in your home or a private meeting room). You have the right to withdraw your consent and discontinue at any time. You have the right to refuse to answer any questions. If you experience any bad feelings or discomfort, I will provide you with contact information for counseling services if you request it.

If you reveal abuse, I am legally obligated to report this information to the police, and to the Protection for Persons in Care office at [contact information]**.**

All data will be destroyed at the end of the study. Your name will not be given to anyone nor appear in any documents released from this study, unless you reveal abuse. Several steps will be taken to protect your privacy. All the audio-recorded files or interview notes will be destroyed once they have been transcribed. The transcribed interviews will not include your name. Participants can request a pseudonym to be used in replacement of your actual name, or a randomly generated number will be used instead. The results of this study will be published in a master's thesis and may be

published in scientific journals or presented at scientific conferences. In any publication or presentation, no individual data will be identified, but rather an anonymous aggregate of the data will be presented.

The transcribed interviews will be kept in a locked filing cabinet and on a password-protected computer, and only the researcher will have access to the interviews. A copy of the transcript for review will be given to you. You can delete any information that you do not want to share, and you can add comments too.

There are some questions that can be considered mildly distressing by some, and you do not have to answer any questions that make you feel uncomfortable. In this case, I will turn off the recorder and try to reduce any discomfort you may be experiencing. If for some reason you do not want to continue with the interview, I will end the interview at that time. If you want to continue or re-schedule for another time, we will proceed in that way. I will make sure that you have the supports you need before I leave. If you feel you need more help, I will provide you with a list of counseling services that might be helpful.

There is no cost related to your involvement in this study. There are no benefits to be in this study aside from sharing your feelings, thoughts, and opinions. There is a possible benefit for you to increase the knowledge of work stress among HCAs: knowledge that may be used to improve work place and your life. Highlights of the findings will be available; if you want to receive this summary, you may indicate this on the following page. If you have any questions about the study, please feel free to contact my supervisor, Dr. Judith Kulig, or me. If you are not satisfied with how this study is being conducted, or if you have any questions about the study, please contact the Office of Research Services at the University of Lethbridge [contact information].

Thank you for your time.

Sincerely,

Mohammed Al-Hassan	Judith Kulig Ph.D.
Graduate Student / Primary Researcher	Faculty of Health Sciences Nursing Program
Faculty of Health Sciences	Office: M3071 (Markin Hall)
University of Lethbridge	[contact information]
[contact information]	

I give my consent to participate in this research.	Yes ❑ No ❑
I recognize that if I reveal abuse in the workplace, that it will be reported to police.	Yes ❑ No ❑
I give my consent to have the interview audio-recorded.	Yes ❑ No ❑
I request to review my copy of the transcribed interview and to edit it as I see fit prior to it being included in the analysis.	Yes ❑ No ❑
Upon completion of the study, I hereby request to receive a summary of the results.	Yes ❑ No ❑

Your signature below means that you voluntarily agree to participate in this research

study.

_____   _____

Signature   Date

_____   _____

Signature of Researcher   Date

[Note: A copy of this consent will be left with the participant and a copy will be retained

by the researcher.

Contact information for transcribed interview and/ or summary of the findings

Email or mailing address: _____

University of Lethbridge

Faculty of Health Sciences

Appendix F: Demographic Information Sheet

Research Title: "Work-related stress among Health Care Aides"

Date:

Gender:	Male ❏	Female ❏	

Age:

Education Level:

How long have you been working in this position:

Employment Status:	Full-time ❏	Part-time ❏	Casual ❏

Working Shift:	Day ❏	Evening ❏	Night ❏

How many hours working per day/ per week:

How long have you lived Canada?

Do you consider English as your first language?

Previous Occupation:

Work assignment (Cottage, regular floor):

Frequency of changes in work assignment (daily, weekly, monthly):

pseudonym:

Appendix G: Safety Protocol

This protocol includes:

1. The participants have the free will to decide where they would prefer to be interviewed after the agreement between the researcher and the participant,

2. The consent form will be read at the beginning of the interview,

3. Participants will be informed at the beginning of the interview of the researcher's duty to report disclosure of abuse,

4. No interviews will take place in public spaces or in working sites as others could overhear,

5. Participants will be informed regarding the protection of the data,

6. Participants will attend only one interview to reduce the risk of discovery,

7. Interviews will not exceed 2 hours,

8. The investigator will not leave the site of the interview with any of the participants,

9. Participants will be advised not to use any names and to be vague when discussing problems with specific staff or supervisor,

10. All identifying information of the participants will be removed and all the interview rooms should be with closed doors,

11. Participants will be reminded of the availability of a counselor,

12. Only the researcher knows who participated in the study,

13. Paraphrasing will be used instead of direct quotation

Note: This protocol adopted and developed from:

Langford, D. R. (2000). Developing a safety protocol in qualitative research involving battered women. *Quality Health Research, 10*(1), 133-142 doi:10.1177/104973200129118192

Paterson, B. L., Gregory, D., & Thorne, S. (1999). A protocol for researcher safety. *Quality Health Research, 9*(2), 259-269. doi:10.1177/104973299129121820