Blurred boundaries: how paid careworkers and care managers negotiate work relationships

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The Australian population is ageing. In 2006 an estimated 2.7 million Australian residents were aged 65 and over, 13 per cent of the population (Australian Institute of Health and Welfare 2007, p. 82). The Australian Bureau of Statistics (2004) predicts this proportion will double by 2051 when those aged 65 and over will make up 26–28 per cent of the total population. As the population ages, increasing numbers of older Australians will need support to stay at home.

Since the 1980s government policy has focused on enabling people to live more independently in the community rather than in residential care, resulting in ‘the growing provision of community care options to support people in their homes for as long as is reasonable’ (Australian Institute of Health and Welfare 2007, p. 78). We have witnessed a shift from an era where family care for older people was the norm, with state support for some residential care, to the present where the state supports a comprehensive range of home and community services to support older people and their families.

Growth in home and community services has been matched by growth in the workforce providing these services. The community services workforce is one of the fastest growing sectors of the workforce in Australia. Employment in non-residential care services (which includes home care services) expanded faster than any other community services industry between 1996 and 2001 (Meagher & Healy 2005).

This chapter reports some findings from a project that collected
and analysed the views of those at the frontline of community aged care work: the paid careworkers themselves. The project aimed to investigate the experiences of agency managers in managing careworkers, and to document and analyse the careworkers’ descriptions of their work.

Paid careworkers in Australia

What do we know of the workforce that provides social care (or community services) in Australia? The care workforce overall is predominately female and is ageing. In 2006, 87 per cent of workers in community service industries were female, similar to 2001 (88 per cent), but much higher than in the total workforce (45 per cent). In 2006, 14 per cent were aged 55 and over, up from 10 per cent in 2001, and the ageing of the care workforce was most evident in those sectors of community services that deliver aged care (Australian Institute of Health and Welfare 2007, p. 334).

Careworkers earn lower hourly incomes, on average, than those they work beside in non-caring occupations in community service industries. Further, male careworkers receive, on average, a higher hourly rate of pay than female careworkers (Meagher & Healy 2006, p. 92). A relatively high proportion of careworkers work part-time. In 2001 well over half (54.6 per cent) of all careworkers in community service industries were working part-time, compared with 30 per cent of workers in similar occupations in the labour market overall (Meagher & Healy 2006, p. 62).

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1 Data on the home care workforce is not able to be separated out from data on the workforce in non-residential care services overall, which includes a wide range of welfare activities from drug and alcohol rehabilitation to adoption and child welfare services. Further, data about workers in non-residential care services are often combined with data on other community service industries, such as child care and residential aged care. Thus, the figures presented in this section give a summary overview of social care or community service workers, and so approximates rather than specifies the profile of the home care workforce.
In addition, there are few opportunities for promotion, a paucity of training opportunities, no formal training or educational level required in many jobs, and little formal recognition of prior knowledge or experience, paid or unpaid. In 1996 a significant minority (44.3 per cent) of all careworkers reported having no qualification at all; this rate fell to 38.5 per cent in 2001. Overall in 2001, 13,871 or 7.3 per cent of careworkers in the community services industries held a bachelor degree or higher, but worked in an occupation classified as an associate profession or as intermediate service work. Thus, some workers are formally overqualified for their jobs, indicating a lack of employment opportunities in higher-skilled job categories in caring occupations (Meagher & Healy 2006, pp. 36–37).

What do we know of the experiences of careworkers?

What does research tell us about the experiences of careworkers working at the frontline of care? And more specifically, what have careworkers told researchers about their work?

When careworkers are asked what makes for good care, it is the centrality of relationships with those for whom they care that is singled out (Aronson & Neysmith 1996; Piercy 2000; Twigg 2000). Careworkers enjoy their work and consistently report very high levels of job satisfaction (McLean 1999; Szebehely 2005; Twigg 2000). The most satisfaction comes from the aspects of their work over which they have the most control, activities that produce rewards for their efforts, such as improving their clients’ quality of life, making people happy and helping them feel part of the community, keeping older people comfortable, and seeing them make progress (McLean 1999; Fleming & Taylor 2006). What careworkers like most about their jobs is the autonomy and freedom of working alone and the opportunity to exercise judgements in relation to how they can best meet the individualised needs of the older person (Szebehely 2005; Twigg 2000). Careworkers’ sense of themselves as caring individuals, committed to their elderly clients’ wellbeing, was found for many
careworkers to be a central feature of their personal and work identities (Rasmussen 2004).

Wærness found that although the careworkers she studied enjoyed their work and were committed to those they were caring for, they also realised that the values they bring to their work and the skills they draw upon were devalued in the public sphere (Wærness 1987). Several later studies confirmed these findings, and researchers have expressed concern that the frontline knowledge that carers possess regarding the centrality of relationships in supportive home care is devalued by employers, and that instrumental tasks are given priority (Aronson & Neysmith 2006; Szebehely 2005).

What careworkers like least about their work is those aspects over which they have little control, for instance, working under conditions where there is little flexibility to change the care they are providing, where there is not enough time to complete tasks, and where there are insufficient resources for them to provide the care they would like to provide. Under these conditions careworkers will do all that they can to provide what they judge to be good care, including 'breaking the rules' and working unpaid overtime. Job satisfaction and enjoyment decline when careworkers have less time to spend with older people and as tasks become more instrumental (Aronson & Neysmith 2006; McLean 1999; Szebehely 2005). Careworkers express legitimate concerns at how this is reflected in the poor rates of pay and the generally held views of care work as a low status profession (Fleming & Taylor 2006; McLean 1999; Szebehely 2005).

The relational and emotional labour central to care work has been further sidelined with moves to managerialism and market models of care, which has increased the standardisation of services. Careworkers report increasing difficulties in meeting the varying needs of the care recipients (Aronson & Neysmith 2006). Home care workers themselves bear the costs as they strive to respect relationships while attempting to offset the impact of efficiency-driven care (Aronson & Neysmith 2006; Rasmussen 2004; Szebehely 2005).
In the remainder of the chapter, I examine the findings from a research project that explored the endeavours of careworkers and managers to organise and provide care to elderly people in their own homes. The managers and careworkers sought to provide care based on ‘caring’ principles, which privilege the formation of relationships with those receiving the service over instrumental, task-oriented, managerialist principles.

The research project: method and participants

The study reported here was conducted with careworkers and care managers employed by the Benevolent Society of New South Wales. The Benevolent Society is a non-profit provider of home care services for the aged and those with disabilities, and for their carers.² The Benevolent Society has been involved in aged care since the 1950s and has managed a number of large aged care residential facilities in Sydney. In more recent times, the aged care section of the organisation has expanded and, paralleling the trends in aged care policy described above, the majority of the aged care budget of the Benevolent Society now goes toward providing home care for older people.

Prior to the commencement of the study, ethics clearance was given by the Human Research Ethics Committee of the University of Sydney. Initial approaches were then made to the Chief Executive Officer of the Benevolent Society. She was very supportive of the research and invited the researcher to the monthly meeting of the senior managers of the aged care section to talk about the research. There were eight managers at this meeting. Detailed descriptions of the proposed research, with draft focus questions, were distributed, and comments and feedback were sought. Permission was sought to interview the managers at the meeting and to have them assist in recruiting careworkers for the study. The researcher promised to

² The Benevolent Society also provides a range of other social care and welfare services, including child and family welfare services, alongside its aged care work.
provide a draft report to inform all participants of the main findings, and to organise focus groups to discuss the findings, check for accuracy and enable feedback and further input from all those who had participated.

All eight managers agreed to be interviewed and to assist in recruiting careworkers. It was also agreed that the Benevolent Society would pay the careworkers for the time they spent on the research, out of the budgets from the branch offices. The researcher addressed several large gatherings of home care workers, explained what the research was about and recruited volunteers who were willing to be interviewed. The participants who volunteered to be part of the study were those who were interested in the research and willing to talk about their work, so were a self-selected rather than a representative sample.

Between July 2004 and February 2006, 34 people were interviewed, 22 careworkers and twelve managers and care coordinators. Two interview schedules were developed, one for careworkers and one for care coordinators and managers. These questions had been developed early in the planning stages of the project and were modified in response to feedback from the managers. A number of focus questions were devised to use as ‘discussion starters’. The questions were further modified over the course of the study as the participants introduced issues of interest and concern to them that had not been initially considered. Questions for managers focused on how they organised the provision of care, whereas the questions for careworkers were more oriented to their day-to-day work with older people. The researcher conducted all the interviews. Each interview lasted approximately one hour. The interviews were conducted at four Benevolent Society offices located throughout metropolitan Sydney. The interviews were audio-taped and transcribed and the data was coded utilising QSR International’s NVivo software.

In October 2005 a draft report was distributed to all those who had participated in the research. Four focus groups were organised. Two focus groups were conducted with the care managers (one with six
and one with three participants), and two with careworkers (one with seven and one with eight participants). Focus group participants were asked to comment on the draft report and to discuss some questions that the researcher devised from the themes documented in the draft report. These sessions were also tape-recorded and their feedback was incorporated into the final report. The final report was submitted to the Benevolent Society in March 2006 (Mears 2006).

The careworkers and care managers who participated in the study fitted the profile of careworkers outlined earlier. They were mostly women aged from 30 to 60, the average age being the mid-50s. They had worked for the Benevolent Society for periods ranging from three months to ten years, most for at least five years. The majority of the careworkers were employed as permanent part-time workers, working up to twenty hours per week. A few were employed as casuals called to ‘fill in’ when the permanent part-time careworkers were sick or unable to work. All the care coordinators and managers were employed full-time. The participants were based in four offices in metropolitan Sydney.

For most of the participants, home care was a job they had come to later in life. A significant proportion of the careworkers were ‘older workers’, that is, they were over 45 when first appointed. This was not a ‘first job’ for any of the people interviewed. They came with a wide range of previous work experience, both paid and unpaid. Those interviewed were highly skilled, with long careers and varied paid work experience in a wide range of jobs. About a quarter had worked in white-collar jobs, for instance, in banks and building societies or as teachers, and one had been a pathologist. The majority had worked in a range of blue- and pink-collar jobs, in offices, as hairdressers, running small businesses, in shops and in clubs and hotels. Approximately one-third of the careworkers in this study had some past work experience in human services, mostly as nurses or nurse aides. Some had previously worked in nursing homes. The wide range of past paid work experience was an unexpected finding. In some instances there were continuities between their past work
experience and their present work, for example, from working in hospitals and nursing homes to working as careworkers. However, for the majority of the participants in this study taking on care work was a major change from their previous paid work.

One of the most striking findings of this research was that all the women who were interviewed, both the care managers and the careworkers, had extensive experience as informal, unpaid carers for elderly and disabled relatives. A significant number were still caring for family members, and so combining paid and unpaid care work. The only exception was the one man who participated in the study.

There are no Australian statistics tracking the informal caring responsibilities or the past caring histories of paid careworkers, so it not possible to determine whether this finding applies across the sector or is unique to participants in this particular study. For several of the careworkers, it was their experience of informal care that had influenced their decision to take on paid care work. This was work they understood and were confident they could do well. As one participant expressed it:

I cared for my mother-in-law when she was dying, seven or eight years ago. And when she passed away, I thought, ‘That is a job I think I might like to do’ (Ann, careworker, aged 52).

The research project: results

Providing good care

What did the care managers and careworkers see as making a good careworker? There was a high level of agreement between the two groups in their answers to this question. The careworkers possessed the ‘way of thinking’ Wærness describes as the ‘rationality of caring’:

In order to solve specific problems in the everyday world of care, we require a way of thinking, which is contextual and descriptive, rather than formal and abstract. The concept of
the “rationality of caring” suggests that personal knowledge and a certain ability and opportunity to understand what is specific in each situation where help is required, are important prerequisites to be able to provide good care (Wærness 2007, p. 4).

When listing the skills, knowledge and qualities that made for a good careworker, they drew heavily on their experience and knowledge accumulated as informal carers. Indeed, they frequently referred to family care as the model for good care. For example, one careworker explained,

I care for these people as I would care for my own Mum (Pat, careworker, aged 40).

They all spoke at length of the ability to form good working relationships with people as being central to the provision of good care. Their responses add to existing empirical evidence that ‘both the providers and recipients of paid care agree that the characteristics and quality of the relationship between the carer and the careworker is both an expression and means of good care’ (Meagher 2006, p. 35).

The practice of participants in the study was underpinned by principles of social justice. They spoke of respecting human rights, listening carefully to people, providing individualised care, and responding in ways that enhanced quality of life and empowered the older person. Particular personal qualities that they believed were required of a good careworker were kindness, patience, tolerance and empathy, with an affinity for, and an interest in, older people. Specific skills were good communication skills, being adaptable and flexible, and being able to work alone, unsupervised. Both the careworkers and the care managers used the term ‘professional careworker’ to describe a careworker who held the principles and possessed the personal qualities and skills described above. They also used this term frequently to describe a careworker who could successfully negotiate boundaries (as discussed in the next section). Care managers and careworkers all spoke of being strongly motivated
by a desire to work with older people in an industry where personal relationships were valued and where they could make a difference to people’s lives. Several spoke of experiencing the effects of managerialism on the organisations they had been working for and said that they had deliberately chosen care work because it involved working with people in a satisfying way. As one participant put it:

I worked for a bank for a long time and I got sick of being told to sell fries with that, to sell more and more services, when people came in for their withdrawals. I just got tired of that. I wasn’t interested anymore. I wanted to work with older people (Carol, careworker, aged 54).

All the participants reported high levels of job satisfaction. The high levels of job satisfaction and commitment were further reflected in their plans for their future working lives. The majority of the participants in this study wanted to stay working for the Benevolent Society into the foreseeable future, as the following quote illustrates:

I love this type of work. At this stage I haven’t got any plans to do anything different (Bernadette, careworker, aged 45).

Both the care managers’ and the careworkers’ accounts of their practice were underpinned with what Tronto talks of as an ethics of care. She suggests a fourfold conceptualisation of care that encompasses: attentiveness, responsibility, competence and responsiveness (Tronto 1993, pp. 127–34).

Transcending boundaries

Deborah Stone has argued that:

when care ‘goes public’ worlds clash, the values, feelings and interactions that make up the relational essence of care in the private sphere are sometimes devalued, discouraged and even forbidden in the public world. Caregivers and the people they care for are pressured by the norms, rules and policies of the public world to make care conform to the image of work that predominates in the public world. At the same time, they strug-
gle to sustain the meaning and value of care as they know it in their more intimate relations (2000, p. 90).

Careworkers inevitably become very close to the older people they are caring for. Julia Twigg found that, as a consequence, workers attempt to put boundaries on the extent of this closeness; and this applies both to the physical aspects of carework and the emotional ones. Care, with its unbounded ethic of love and its powerful undertow of emotional connectedness, contains the potential to engulf the worker. Setting limits on this is a necessary part of surviving the job (2000, p. 212).

Care managers and careworkers are constantly negotiating the boundaries between work relationships and personal relationships or friendships. These are fraught negotiations with constant merging, clashes and overlaps of personal/private lives with work/public lives. The boundaries are indeed far from clear. The care managers and the careworkers in this study had put a lot of time and thought into developing caring relationships. Much of the time in all the interviews was spent discussing these issues.

Care managers were concerned that the careworkers would breach boundaries and ‘break the rules’ in ways that may lead to abuse and exploitation of the careworker or the older person. The careworkers acknowledged the managers’ concerns. However they were confident they could successfully negotiate these boundaries and provide, in their judgement, good care, with some guidance from care managers and with clear and transparent policies and guidelines.

**Care managers’ perspectives**

Where is the dividing line between a friendship and a work relationship? The care managers expressed the dilemmas succinctly, the careworkers are employed because they care, but they don’t want the careworkers to care too much. They seemed to recognised that, as Twigg puts it, ‘care work is intrinsically about emotions … the cold careworker, even if super efficient, can never be a good carer.
Getting attached to clients was an occupational hazard as well as a source of pleasure. Strong feelings were inevitable’ (2000, p. 166).

A large part of the care managers’ work involved ensuring that the careworkers were able to separate their work lives from their private lives, as illustrated by the following quote from a care manager:

   Everybody struggles with this in this field because you are going in every single day of the week and of course you develop a relationship. We are looking for people who have this ability to be able to be empathetic, understanding, be warm in what they do without actually giving completely of themselves. That is a very difficult balance. I probably have three staff members who do that amazingly well and if I could bottle it I would because you see the others will struggle with it. And that is how we sell ourselves as a relationship-based service (Sandra, care manager, aged 37).

They spoke of how important it was that careworkers possess the skills and ability to negotiate the complex boundaries between personal and professional relationships.

   So it is a huge skill to professionally care for someone in a way that is loving and compassionate and then extricate yourself. And that is what we are asking people to do (Barbara, care manager, aged 58).

The danger, from the care managers’ perspective, was that the closer the relationship between older person and the careworker, the greater the chance that the worker would be exploited by the older person. One way to prevent this was for care managers to visit the older person regularly, monitor the situation closely, and ensure the careworkers were not taking on caring loads that were too heavy. Also, the needs of the clients may change and the careworkers simply may not realise that they are taking on too much.

   We visit them regularly. We see what problems the careworkers have with them. Just generally as the clients deteriorate as they do. They can go for periods where they are stable. And if it is a
good relationship with the careworker and the client, either that remains stable or the careworker is taking on more and more work and because they like the clients and they don’t realise they have taken on too much until they get very tired and very worn out (Ruth, care manager, aged 60).

The care managers spoke of the possibility of careworkers burning out because they were too involved with the clients. Caring about one’s clients made a good careworker and if you advised people not to become involved with their clients then they were not going to be very good careworkers.

There seems to be this dilemma that is not settled. How can you actually be human and be emotional, but still cut people off at a certain point without burning out? People are either throwing themselves completely into it or doing an unnatural thing where they are not feeling for people because they are too scared that they are going to cross those boundaries (Sandra, care manager, aged 37).

Care managers found they were constantly advising careworkers to keep a distance between themselves and the client. Careworkers are not paid to be on duty all the time.

We always tell the careworkers you have to keep your distance. You give a lot of emotional commitment but you’ve got your life and it is not good to try and live their lives all the time. So I try to get the girls to always keep it professional (Elizabeth, care manager, aged 56).

The care managers’ accounts illustrated a high degree of respect for the careworkers and their ability to deal with these dilemmas. They were relying on the careworker to behave appropriately. There was general agreement among the care managers that most careworkers will learn through experience how to deal appropriately with these issues.

It depends on the careworker. I’ve seen some careworkers that learn pretty quickly. You will usually find within the first three months they will struggle with these issues and you
need to talk to them about it. And they will understand. They usually won’t understand until they are actually in a situation (Effie, care manager, aged 53).

As one care manager observed, most of the careworkers were mature women with extensive past experience to draw on. Her view was that careworkers draw on past experience and learn quickly to deal with these dilemmas.

Most of our careworkers are middle aged. They are sensible. I give them the benefit of the doubt. They usually find the first time they’ve given a phone number and they have a client who is calling them in the middle of the night. They learn. It is the best way to learn. You are never going to stop them anyway (Anita, care manager, aged 50).

A consistent theme that emerged here was the importance of transparent supervision of the careworkers, with good lines of communication between care managers and careworkers to enable discussion and resolution of any problems in regard to these dilemmas.

**Careworkers’ perspectives**

Caregivers who participated in Stone’s study said that ‘their training, their employers and their professional norms all discourage “getting too close,” “getting too attached,” or “getting too emotionally involved” with the people they care for’ (2000, p. 99). Twigg also found that the ‘emotional reward of helping, the warmth of interpersonal exchanges and freedom and autonomy of the job [conflicted with] the emotional strain and the need to set limits’ (2000, p. 129). Careworkers who participated in the Benevolent Society study reported similar experiences and conflicts. They found themselves negotiating and renegotiating professional and personal boundaries every time they were at work. Over time, and with experience, they had learnt to impose, negotiate and maintain boundaries that enabled them to do their work and provide good care.

Central to their struggles and negotiations was the clash of values
between care as understood in the private sphere, as personal, warm, compassionate, flexible and emotional, and the values of a professional in the public sphere, expected to ‘create’ distance and work to consistently applied rules. One careworker described her struggle in the following terms:

When I first started I wanted to do everything for everybody. But now, four years later, I’ve learnt that boundaries are very important. You’ve got to stop somewhere. I’ve learnt the hard way. When I first started I thought about the job all the time but you realise that you can’t take care of everybody or solve everyone’s problems (Fiona, careworker, aged 46).

Some of the careworkers, like the workers in Stone’s study (2000), spoke of ‘caring by the book’, that is, closely following the rules to prevent any problems arising:

Sometimes you tend to go very much by the book, follow the rule. The guidelines that we’ve been given strongly emphasise the problems that could be caused if you go outside the boundaries, outside the guidelines. So I do everything I can within the boundaries. I don’t want to step outside them (Jennifer, careworker, aged 34).

However, they all spoke of breaking the rules at some time or other:

We are never supposed to give our home numbers out to people. But of course we all break the rules and there are certain people we will give the number to and there are certain people you won’t. The genuine people will never ring you unless they have to. It is awful really when you are told not to give your phone number out to anybody. And then as I’ve said to one coordinator, “You’ve got my home number. You ring me on my home number. What is the difference?” Because it may only be, “Could you pick me up a bottle of milk or something?” And how much easier and time saving is that? (Meg, careworker, aged 53).

The following story is an interesting case study in negotiating these boundaries with different care managers. In this case, the boundaries
and rules were changed when the care manager changed. The situation and the ways the careworker broke the rules are almost identical, except that there was a different care manager supervising the careworker in the second instance.

I had a lady in hospital last year and she was in for six weeks. No family at all. There was another lady in the ward with her that I also know. She told me that this lady was turning her underwear inside out to wear, because the hospital doesn’t do washing. She was bed-bound. She couldn’t get up and rinse her underwear herself, so I went there and I took them home and washed them. And I got in so much trouble. I said, “Well, I’m sorry but I’ve done it” (Brenda, careworker, aged 50).

She continues with the story and describes a similar situation and making similar decisions, but running the scenario by a different care manager:

I had the same situation this morning. The coordinator rang me this morning and asked me if I’d been to see this lady in hospital. I said “No, I’m going to go this afternoon”. And I thought, “Oh well, I’ll try it, while she’s on the phone”. I said “Have you got a problem with me taking home any clothing that she’s got to wash?” And she said to me, “No, and if you haven’t got time to do it, drop them into the office this afternoon and I’ll take them home and do them”. So it was a completely different story (Brenda, careworker, aged 50).

Brenda had no difficulty justifying her behaviour in providing good care to her client. She was quite comfortable with her transgressions and felt she had behaved responsibly and looked after her client’s best interests.

That is my duty of care as the careworker to this person. That’s the way I looked at it. If I had to I would have stayed in the hospital and washed them in the basin in the hospital, but it was just easier for me to take them home, dry them and take them back the next day (Brenda, careworker, aged 50).
She clearly felt far more comfortable with the way the second care manager had handled the situation and felt her own judgment and decisions were vindicated and supported. This was a far more satisfactory resolution from her perspective:

It just makes you feel so much better. I mean you’re not worried about ringing the coordinator. I’m not going behind her back doing things. Before I was doing things on my own and thinking, “I’ll just take the consequences when they come”. But now I’m not frightened to do that. I find it very easy (Brenda, careworker, aged 50).

Points of tension between managers and careworkers

Care managers and careworkers had different views about how one drew the boundaries between personal and work lives and about how one built and maintained professional relationships between careworkers and the person being cared for. The care managers spoke of having to be constantly vigilant, putting a lot of time and energy into explaining the nature of the desired professional working relationship. By contrast, the careworkers stated that they understood where the managers were coming from, found their guidance useful, but spoke of learning through their own experiences. They felt they were able to negotiate this difficult terrain, learn from their experiences and become better at negotiating professional relationships over time.

You do learn to put up barriers … as you lose a client the next one that comes in you try and just keep that little tiny tissue paper between you. Not a wall, but just a little tissue paper there. You do have to draw a line in certain things (Jan, careworker, aged 57).

The role of policies and guidelines

The care managers and careworkers interviewed for this research were experienced and knowledgeable providers of care. In formulating policy they took on board frontline knowledge of the
centrality of relationships and the secondary importance of tasks in supportive home care (Twigg 2000). Over time, the care managers have developed a range of detailed and transparent policies to cover most contingencies. The policies were pivotal in providing guidance to careworkers, while at the same time enabling careworkers to make professional judgments based on their ethic of care. The care managers saw the development and refinement of policies as a continually evolving process. Once the policies are developed they are ‘tweaked’ as needed to cover contingencies as they arise. They emphasised that all staff needed to be involved and made aware and continually updated on current policies:

We have a whole range of policies that cover the whole range of care areas that basically fit the job descriptions. Policies include anything from how to pay for shopping, to what to do when the client isn’t home. There is a whole range of policies that we are quite strict about adhering to and we use the team meeting process to make sure the policies are understood (Mary, care manager, aged 52).

They were continually explaining the underlying rationale and stressing the importance of adhering to these policies. One example, as outlined below, is ensuring older people are given receipts for any money they give the careworker. The care managers were aware that this can be time-consuming and inconvenient for the careworker, but ultimately the process ensures that all money is accounted for so there can be no confusion or accusations of exploitation.

I make a point of adhering to the policy. The policies are there to protect the careworker from being compromised or put into a position where they are doing more than they are paid for. I think careworkers are resistant because it is a hassle sometimes. It is a hassle. It is easier to say, “I’ll bring the change back”, and not get the clients to sign, and the clients will say, “I trust you”. And you’ve got to go through this rigmarole, “This is the policy. I have to give you a receipt”. Sometimes you have to go over things a million times and it
seems laborious and eats into your time. Sometimes you are pressed for time. You are rushing. The coordinator tells you to fill out the log as you go. But when you are on a rush, as a careworker you haven’t got time. So there are all those bits of paperwork that are necessary (Eva, care manager, aged 45).

One of the rules that the care managers expect the careworkers to follow very closely is the rule that all changes to the care plan must be passed by the care managers. The care managers stressed, over and again, the importance of the careworkers running any changes by them, or at the very least, ensuring the care managers are kept updated and informed if changes are made.

I maintain and review the care plans every three months to make sure that things are working well. I make sure that the clients really know me, so that they have the confidence to ring me in case anything goes wrong. Often they tell their problems to the girls, and then the girls come in and tell me. I would like to minimise that (Maria, care manager, 45).

A major preoccupation of the care managers was putting in place a framework that would protect and enhance the rights of both the workers and the recipients of care, and protect both groups from violence, abuse and exploitation, while providing good care where relationships were central and consistent with the overall aims of the Benevolent Society, an organisation where care managers and careworkers aimed to provide a relationship-based service.

Conclusion

Care managers and careworkers had different views on how relationships should be formed and negotiated day-by-day. The managers felt they were continually reiterating rules about appropriate boundaries, and spending a substantial amount of time supervising and scrutinising relationships between careworkers and older people. The majority of the careworkers were well aware of the managers’ concerns, and spoke of numerous ways they
negotiated working relationships with older people, day-by-day, not infrequently breaking the rules to provide what they judged to be good care. This took them into a realm of potential conflict with the care managers, and reflects what Twigg calls ‘an unbounded element in carework’:

that derives from the importation into it of an ethic of love that derives primarily from the bonds of the family. This is something that workers find hard to resist and they find themselves caught between the personalised demands of this ethic of care—reinforced by emotional bonds that develop over time, particularly in response to personal dependence—and the conditions of waged labour in an increasingly hard nosed and cost pressured sector (Twigg 2000, p. 178).

This study demonstrates that, although it is not easy to negotiate these blurred boundaries, it is clearly possible. There were points of tension in this negotiation for both care managers and careworkers. Negotiating the boundaries between personal and work lives, and forming working relationships with the older people they were caring for, was not straightforward. All the participants acknowledged the importance, to both the careworker and the older person, of building and sustaining these relationships. However, as the careworkers and the care managers were continually emphasising, this is a working relationship and one which requires that boundaries be put in place to limit the nature and extent of the caring work and the degree of emotional involvement.

What made the work satisfying for the careworkers was that they enjoyed forming ongoing, productive, working relationships with their clients. They reported high levels of job satisfaction and were committed to working in the sector for as long as they could. As well, support that is based on strong relationships between worker and client, relationships that are respectful and positive, has been demonstrated to be beneficial in decreasing vulnerability in community care clients. Marsh reports that:
research demonstrates that positive relationships which mirror everyday social relationships are highly desired between elderly people and formal care providers and result in fewer physical symptoms and increased longevity. Consequently strong professional relationships between workers and clients should be viewed as a strength to be harnessed, not a weakness to be avoided (2007, p. 38).

This study found that, rather than advising the careworkers to remove any emotion or personal relationships from their care work and be totally task-oriented, the care managers in this organisation acknowledged the centrality of relationships in care provision and set in place mechanisms to enable these relationships to flourish, while protecting the rights and wellbeing of both the careworker and the person receiving care. As Joan Tronto has argued: ‘Care is a central concern of human life. It is time we began to change our political and social institutions to reflect this truth’ (1993, p. 180).

References


