

Liminality in Ontario's long-term care facilities: Private companions' care work in the space 'betwixt and between'

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Abstract

Nursing, personal care, food and cleaning are publicly funded in Ontario's long-term care facilities, but under-staffing usually renders all but the most basic of personal preferences superfluous. This individualization of responsibility for more personalized care has resulted in more families providing more care and opting to hire private, private companion care. With direct payment of companions becoming a growing but largely invisible facet of care, exploring companion's roles is important. Using a six site rapid ethnographic study in long-term care facilities (i.e. observations, documents and key informant interviews (n = 167)), this paper argues that private companions occupy a liminal space between policy, family and market, and their role within institutions and in private homes may be the missing link in the care work chain in the sense that it can at once be classified as formal and informal and draws on their own and others paid and unpaid labour.

Keywords

Private companions, informal and formal care, long-term care, care work, gender

Introduction

As you enter the foyer of a publicly funded long-term care facility (LTCF) in Canada's largest city, you will see many older adult residents with someone who is younger, more agile and usually racialized. These private companions, usually women, may be seated beside the resident or pushing their wheelchair. Companions may be conversing with fellow companions, but the residents are not usually part of the conversations; some residents may be dozing, while others may be awake but silent.

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In terms of positioning, families, estates and legal guardians pay privately for companions' work as it is not included within publicly funded long-term care. As for the contexts within which companion care increasingly has been sought, austerity measures have limited public funding for staff and supplies, neo-liberal expectations about individual responsibility and lower taxes have been enacted, and provincial staffing intensity is far below expert recommended levels. As a result, there is less social engagement, residents are not getting sufficient attention and violence towards staff and other residents is increasing (Banerjee et al., 2012; Daly et al., 2011; Shaw, 2004).

All companions care directly for residents but importantly they are not employees of LTCF. Companions' employment circumstances are generally of two sorts: they are agency employed or work independently. Agency companions infrequently enjoy benefits or job security but are covered by statutory programs such as worker's compensation and employment insurance. If families and guardians adhere to labour laws, then private companions are covered by statutory programs; however, when companions are paid in cash then they are usually denied even the most basic of statutory protections. In addition, most facilities do not check whether proper labour laws are followed for companions working on their premises and thus liability for injury remains unclear.

'Agency' companions are more likely to be wearing badges and medical scrubs. Those who work directly for families are likely to be wearing street clothes. Companions provide different combinations of social and emotional care as well as body work for residents, which involves toileting, washing the body and assisting with eating. Even though some companions may dress like the staff and do much of the same labour, when you enter the units where the residents live, what distinguishes companions from staff is the one-to-one attention companions are paid to provide. While staff members hurry from one resident to another or are busy with paper and computer screen work, the companions' work is neither rushed nor officially recorded in the LTCF statistics.

According to Sweeney (2009: 570), '[l]iminality denotes a time/space where subjects are "betwixt and between", neither "in" nor "out" and separated from familiar space, routine, temporal order or hegemonic social structures'. Stretching back more than a century, 'liminality' was first used by Van Gennep (1909) to refer to transitional periods or rites of passage in ancient cultures. Turner (1969) re-theorized it to include any period of change, especially to rites of passage. Recent cross sector and cross-disciplinary work has expanded the notion of liminality to involve subjects who are in spaces that are between two worlds, whether through choice, circumstances or a combination of the two (Giladi, 2010; Sweeney, 2009).

This paper investigates how private companions are positioned in the provision of care in residential LTCF in Ontario. Using qualitative data, this paper argues that private companions occupy a liminal space in public policy, in workplaces where they are workers without formal employment relations, and within familial relations. The role played by companions within institutions and in private homes may be the missing link in the care work chain in the sense that it can at once be classified as formal and informal and draws on their own and others paid and unpaid labour. The paper is organized in the following way. After documenting Ontario's LTCF context and some empirical and theoretical gaps in our knowledge about private companion's work in LTCF, we introduce the study's method and its theoretical focus. We found that companions working in LTCF inhabit at least three liminal spaces marked by invisibility in public policy and regulation, within organizational policies

and practices, and within familial relationships. We conclude that the liminality of companions working in LTCF raises important theoretical, policy and praxis questions.

The Ontario LTCF context

LTCF for older adults are highly regulated and highly gendered sites of care in Ontario – Canada's most populous province. The majority of residents are women as are the majority of workers. The work receives low pay relative to hospital work and is performed under difficult working conditions, which include care responsibilities for a large number of residents per shift and the conduct of physically and emotionally arduous tasks. Ownership in the sector is divided amongst for-profit chains and stand-alone facilities, non-profit religious and secular facilities, and public facilities run by the local municipalities. The state publicly funds nursing and personal care for more than 100,000 residents per year across 78,210 beds. There is a co-payment for accommodation, but the food and the care is publicly funded based on a needs assessment model. There is high union density of about 80% across the sector. Twenty-four hour availability of nursing care defines these facilities. The work is hierarchical and task based (Daly and Szebehely, 2012) registered nurses have oversight of personal support workers (PSWs) and do hands-on care only for more complex medical cases; licensed practical nurses do medications and recording but little other hands-on-care; the majority of the body work is performed by PSWs. It is the bodywork of PSWs, that most closely resembles the work of companions, and in many cases companions have trained as PSWs and may be employed as PSWS elsewhere. In other ways, the work of companions is more expansive than that of PSWs, as they provide a much more significant amount of social care that, in the Ontario context, tends to be associated with the informal care of volunteers, students and families/friends.

Retirement Care Homes are privately paid residences and are for those who cannot or do not need to gain admittance to LTCF. Tenants can receive publically funded home care if they qualify, though this is individual and limited. People can purchase 'packages' of care for which they pay the retirement home if they need assistance with activities of daily living and with other supports. Prior to new legislation being introduced, it was landlord tenancy legislation that governed the sector despite the fact that increasing numbers of older adults who resided in homes required higher intensity levels of care. Retirement homes are not under obligations to have 24h nursing care available, which distinguishes the levels of care available and helps to explain some of the differences in the resident population. However, there are long waiting lists for publicly funded nursing homes (Bronskill et al., 2010).

Private companions: The literature

As yet there is scant literature that directly examines private companions' work in LTCF as the majority of studies focus on the paid work of nurses or support staff employees, or migrant care workers working in private homes (Shutes, 2012; Williams, 2011; Bourgeault et al., 2010). This dearth provides us with an opportunity to explore companions' work in terms of theoretical and empirical gaps. It is important that we understand where companions 'fit' because, as Lyon and Glucksman (2008, 102) argue, 'analysis of formal and informal, paid *and* unpaid forms of the same labour activity has rarely been incorporated within the same research, and remains a key challenge for the contemporary sociology of

work'. In response to what they identify as a theoretical gap in studies of work (Esping-Andersen, 1990, 1999; Gershuny, 2000; Gershuny and Sullivan, 2003), Lyon and Glucksman (2008) provide an 'economic sociology' approach to analysing care work by applying their 'total social organization of labour' model. They provide four countries as archetypes with respect to funding care work for older adults. Their model delineates intersections between the state and public, family and community, voluntary and not-for-profit, and market and for-profit. They place companions within the familial care realm based on the studies that have reported on programs for migrant care workers to come and live with families to provide care in private homes. Their archetypes do not easily accommodate institutional care and they argue that institutional care is less relevant. Within the existing archetypes – with the boundaries drawn between state, market, voluntary sector and households – it is challenging to locate companions who are either independent or agency workers, and who work in publicly paid facilities but are paid privately.

There have been other exciting advancements in the care work field, which have moved us from dichotomous thinking of work classified as either paid *or* unpaid, to seeing how these categories are blended and messy (Ungerson, 1999). For instance, Baines (2006) shows that while paid workers sometimes volunteer their own time, the gendered organization of care work in the social services sector makes it more likely that women will be conscripts to volunteer care in their work environments that make it increasingly hard to provide quality care while still on the clock. Most studies consider those providing formal and informal work as distinct. For instance, with a focus on informal care work, Twigg (1989: 53) develops three 'models of carers' to show how social care agencies conceptualize relationships with them: carers as resources, carers as co-workers and carers as co-clients. She addresses how social care agencies working with the elderly classify carers; however, her analysis nevertheless limits informal carers to kin, friends and neighbours who provide care. Moreover, while the model considers the 'intermingling' of formal and informal sectors (Twigg, 1989: 61), it does so without challenging the space in-between formal and informal care provision or without directly considering private companions who perform paid care work on behalf of families.

There is another divide between studies that consider either care in private homes or institutionalized 'homes' or give most attention to one. Unlike most studies, Lanoix's philosophical paper (2010) focuses on both and the relational care developed by family care providers and health care practitioners, nonetheless her work leaves the dichotomies between paid and unpaid work largely intact. Castle et al. (2008: 233) point out that there is little empirical research examining the use of agency staff hired by the facility. Their study finds that high use of agency nurse's aids was generally associated with lower quality. While they examine the use of agency staff, their approach is limited to those hired as 'temporary caregivers used by nursing homes to fill available positions' (Castle et al., 2008: 232) and excludes caregivers from agencies hired directly by families.

Literature about companions caring in residential settings appears first during the late 1970s in North America; despite its long history there are few references to this care in the academic literature. Where references are made to private companions in the literature, these are not necessarily well developed. For instance, an American legal opinion from 1979 talks about how American nursing homes can limit their liability from being considered to be the employer (Vaccaro and Seletsky, 1979). Cartier (2003: 293), for instance, who examines how neoliberal reforms have led to the redefinition and relocation of health services, observes that 'what is not widely known is that residents of substantial means in such

facilities not uncommonly hire their own supplementary caregivers to provide regular attention'. This observation is unelaborated. Beyond the limited literature, there are scattered references to private companions in some industry-oriented and popular literature. Furrow (1997) suggests private companions paid for by families can be seen as a resource for facilities that can lead to savings (and thus profits) – apparently reflecting a perspective in line with Twigg's (1989) model of carers as resources. Hamermesh (1998) considers policies for policing private duty personnel. Lahm (2005) identifies a trend with non-medical home caregivers moving into facilities to provide older adults with the level of care they could receive at home. Overall this sparse literature tends to prioritize perspectives friendly to industry; it is not well suited to providing insight into the perspectives or experiences of private companions or frontline workers who interact with them in LTCF.

Dergal's (2011) doctoral dissertation examines families' use of private companions in Toronto nursing homes from families' perspectives. The study found that families hired private companions who were mostly women and immigrants to perform a range of activities, including 'assisting with activities of daily living, toileting, feeding, escorting to activities and providing social support', and to address 'quality of care' including concerns about 'inadequate staffing, unmet residents' needs, overburdened family members and suboptimal nursing home environment' (Dergal, 2011: ii). Noting the challenges of conducting research on this topic because few companions were included as interviewees, the research is largely about companions without adding their voice (Dergal, 2010). Recently, Outcault (2013) has interviewed a small number of private companions, their clients and other key informants about companions' roles in home care and, in a more limited way, in LTCF in British Columbia. Companions offer 'visiting and conversation, reading, outings and walks, music, art, respite and palliative care'; moreover, 'they provide no personal care with the exception of feeding assistance' (Outcault, 2013: 93). Finally, that study notes that companions can play a positive role without highlighting sufficiently any tensions or contradictions inherent in their privately paid role providing work that overlaps with that of paid staff in publicly funded care settings. While the findings contribute to our understanding of private companions' work, because very few companions working in facilities were interviewed it does not necessarily capture the range of care that companions provide and it ignores the significance of gender.

In summary, the theoretical care work literature requires refinement to accommodate private companion's place in the care of older adults, particularly within publicly funded institutional care; as well there are few empirical studies that directly examine private companions working in LTCF or that identify the complex interplay of relations between facility staff and management, family, residents, companions, volunteers and students. Ironically, a literature review of private companions yields more studies focused on animal companions (see Dono, 2005; Katsinas, 2000; Le Roux and Kemp, 2009; Prosser et al., 2008; Reynolds, 2006) or robot companions (see Robinson et al., 2013; Sharkey and Sharkey, 2012) than people.

Method and methodology

This mixed methods convergence model study (Creswell and Plano Clark, 2007) involved three aspects. First, we conducted a population survey of all 871 publicly funded LTCF and privately funded retirement homes across Ontario. The e-mail survey ($n = 279$; response rate

of 32.1%) used a tailored design (Dillman, 2007). We performed analyses with Excel and SPSS 19 and have included selected descriptive statistics in this paper.

Second, we conducted comparative, qualitative ‘rapid’ ethnography case studies of informal care in six large (100+ bed) publicly funded and non-profit LTCFs located in a large urban city in Ontario. Sites were selected using a most-similar case design (Yin, 2014). The use of rapid ethnography to understand workplace conditions, labour processes and care work (Baines and Cunningham, 2013; Szebehely, 2007) is a rich method that accommodates the complexity of LTCFs. The case studies were conducted on secure, locked units and public spaces. These non-profit sites were either non-denominational or held religious affiliation. Some of the homes contracted out services to for-profit operators (e.g. food, laundry, management). Three of the sites also had retirement homes under their organizational umbrella. In addition to document and policy analysis, each of six field case studies involved week-long rapid ethnographic observations; we conducted key informant interviews with formal care workers (i.e. nurses, PSWs, managers, dietary and housekeeping staff) and informal care providers (i.e. private companions, family, students and volunteers). In general, the residents on these units were too cognitively impaired to consent to an interview. In one instance, we were able to interview a resident with a family member present. During interviews, we asked about the quantity, quality and duration of informal care; health and safety; the division of labour; work organization and staffing intensity; and what worked well and what was most challenging about the work. In total we conducted 167 key informant interviews generally lasting between 60 and 120 min each. We also conducted in excess of 1000 h of observations on the units and in the facilities’ common spaces between 7 am and 11 pm that were recorded in researcher field notes. Most often, there were two researchers observing on the unit or within the home’s common spaces such as main foyers where concerts were held. When we observed in dining room spaces, we recorded the activity using dining room work maps that are a diagrammatic version of our field notes.

Finally, we conducted a policy analysis of Ontario government legislation; we identified staffing and informal care regulations and identified who was and was not included in the regulations. This paper presents findings from our survey, key informant interviews, field notes and policy analysis.

Feminist political economy (Armstrong and Armstrong, 2005; Armstrong et al., 2001) and francophone ergonomic work analysis (Messing, 1998) guided our study’s design. Using these frameworks drew our attention to the intersections between paid and unpaid work, the gender division of labour, the health and safety of performing certain tasks and the importance of the external policy context for understanding roles and responses. After developing a thematic coding list, we used NVivo and a constant comparative method for coding the interviews and the field notes. We used the theory to guide our thematic analyses of the verbatim transcribed key informant interviews and the researcher generated field notes.

Findings

This section presents our findings with respect to how companions exist in a liminal space within the public policies governing the care of older adults living in facilities, as workers in the facilities and within the context of family relationships.

Liminality in the policy realm

There are two pieces of legislation that govern older adults' congregate living arrangements: publicly funded facilities are governed by the *Long-term Care Homes Act*, 2007 (LTCHA) and privately funded ones by the *Retirement Homes Act*, 2010 (RHA). This paper is focused on companions who work in LTCF and are governed by the LTCHA. The comparison with RHA is useful for what is missing from the LTCHA. We found that, despite working with and for residents in LTCF, companions are not recognized as workers in Ontario's LTCHA.

The LTCHA specifically identifies three different categories of people who perform functions in LTCF. The first are 'staff' and this includes those who are directly employed; those who are under direct contract with the facility or those under contract between the facility and an 'other third party' employment agency. Nursing homes directly employ nurses and PSWs, a physician Medical Director, a Director of Nursing Care and Administrators. Direct care staff is required to receive training in abuse recognition and prevention, mental health care including care for those with dementia, behaviour management, and restraint minimization, palliative care. Nursing homes are further required to limit temporary, casual or agency staff in order to provide a 'stable and consistent workforce' and to 'improve continuity of care to residents' Section 74 (1). Agency staff work at the home because of a contract held between the home and an outside agency. Individuals hired from an agency by the facility are also treated as staff, meaning that they must also follow staff obligations as laid out in the legislation. Companions are not included in this category as they are not hired by the facility.

'Volunteers' comprise a second category of worker. In nursing homes, there must be an orientation for volunteers, to provide them with information about the residents' bill of rights, zero tolerance of abuse and neglect, the home's mission statement, fire safety and infection control practices Section 77 (a-g). Homes also require police checks.

The third category is 'family and friends' and, though not mentioned specifically, private companions tend to be lumped into this category in terms of their treatment in practice. As part of the required nursing home Resident's Bill of Rights, every resident can meet privately with family, friends or persons of importance, and these people are entitled to attend annual meetings with staff of the home. There is an added provision in the legislation for a Family Council for each home to provide assistance, information and advice at the time of admittance, about rights and obligations of the *Act*, to help resolve disputes, to plan activities for residents, to review inspection reports, financial statements and the home's operational, advise the ministry about the home, report any concerns to the home's Director, and any other powers in the regulations.

Nursing homes have an obligation to ensure that staff and volunteers are screened and have the proper skills and qualifications to work there. In addition, the act outlines what educational requirements qualified personal support programs must meet:

- (i) 'the vocational standards established by the Ministry of Training, Colleges and Universities;
- (ii) the standards established by the National Association of Career Colleges, or
- (iii) the standards established by the Ontario Community Support Association. The training must be at least 600 hours consisting of a combination of class and practice based learning' (MOHLTC, 2010).

LTCF are also obligated to ensure that no staff or volunteers work in the home unless they have received training in a list of areas including but not limited to the residents' bill of

rights, zero tolerance of abuse and neglect, injury prevention and infection prevention and control 65(1 a-j). There is no such obligation with respect to screening for skills and qualifications with respect to private companions who are simply lumped in with family and friends in the LTC Act.

In contrast, retirement homes are less regulated than the publicly funded LTCF. Despite fewer regulations, the *RHA* lists family members and a *person of importance* in its retirement home legislation. Moreover, this is done in relation to allowing them to receive information with the resident's consent. It is also intended to prevent staff from threatening families or the person of importance with retaliation against a resident. The *RHA* (63) also includes the category of 'external care provider', defined as

a person who provides care services to a resident of a retirement home and who is not the licensee of the home, the staff of the home or a volunteer with respect to the home...This includes any organization or *individual* that provides care.

Thus, while there is explicit legislative reference to private companion care in the *RHA*, they are unacknowledged in the LTCF regulations. In other words, the legislation provides no explicit boundaries around the work, the qualifications, or the requirements made of private companions. As the next section shows, there are very informal boundaries around the care that companions provide within and between different facilities. This lack of formal legislative recognition is highly problematic because private companions provide care work in more than two-thirds (68.1%) of the facilities that responded to our survey.

Liminality in the practice realm

Companion's relationships with facility management were complicated because they lacked status as employees, family members or volunteers. For instance, management did not view companions as a part of the care team and witnessed a great deal of turnover. This quote illustrates some of the tensions.

The problem is it's hard to manage them because private duties are changed like gum. Like today it's someone, next week it's someone else, the week after it's another person. Some family members are so volatile that at the blink of an eye they're gone. So it does get challenging in terms of some family members and their philosophy in terms of who they're bringing in. You know, they may not even have the proper background but, you know, we're not recruiting these people. (Site 1 Manager)

We found that while many homes had companions, they lacked policies to address or limit the types of care provided by companions. More than one-third (32.3%) of the homes we surveyed had no rules governing what care companions could provide. When asked what types of issues companions needed to report to staff, one companion noted: 'We need to report right away because otherwise is going to be our fault' (Site 4, Companion). In interviews, we asked whether companions were trained or told the rules when they arrived at the facility. Reflecting the policy and procedural void in which companions operate, another companion retorted that: 'Well other girls will tell you the rules and all that' (Site 5, Companion). As this quote highlights, another companion noted that she did not know where the line was in terms of what she could and could not do because the policies were not made clear.

A; ... the private workers... there's a couple that are really good but most of the private care-givers they don't bother... They don't get involved with any of the other staff. They're there for

that person and that's it. You know, if somebody wanders into one of the rooms they'll take them out. But it's not teamwork here. It's people like me and there's the private worker and then there's the staff... sometimes it's worked where there's been somebody, a staff that's alright with people helping and it works out good. But I don't know legally where I stand if somebody... like I say, if I'm helping somebody and they fall.

I; What would happen?

A; I don't know. You know, like no one has ever said 'Really you shouldn't do that because...'

So I think they need extra help. That's what I feel. (Site 1, Companion)

In some instances, there were policies; however, these were circumvented depending on the companion or the resident. For instance, homes may have had rules that prevented companions from providing bodywork; despite this, companions did provide it under the direction of the family.

Informal rules were a real source of tension. In one workplace, when conflict arose between staff and companions, staff would sometimes impose arbitrary policies, such as banning caregivers from the dining spaces or enforcing rules to speak only English on the floor. One companion explained that she was no longer allowed in the dining space because she wasn't needed to help feed her resident. When her resident didn't require help, she would assist another women. The companion thought that she was being punished for doing the staff's work by being kicked out of the dining room. She noted that no words had been exchanged so she wasn't really sure why the policy was imposed.

Management also imposed arbitrary and new policies in ways that confused not only companions but staff as well. One companion noted that when she started at the facility she only introduced herself to the residents but not to the staff. She described how one of the staff recently approached her after three months of being there to ask questions:

...she said 'Who are you working with? Who are you working for? What's your name?'... I said 'You're asking my name now after all these months?'...She said 'We want to know everybody in here now, who comes in, who goes out.'...It's pretty recent...it's not that I'm afraid to give you my name but I've been here all the time and nobody came and said 'Who are you? Are you somebody trustworthy?' So it was kind of a little bit, you know... (Site 5, Companion)

Staff, too, had a precarious relationship with companions, reflecting their ambiguous positions. At times staff described companions as helpful: 'it's an extra hand' (Site 4, PSW). Praise was always qualified by the staff's assessment of the companion's personality; how understanding the companion was of the PSWs' workload; how much the companion helped to solve problems or whether the companions reported on them to the families. One PSW reported the following:

...sometimes they [companions] are very helpful but sometimes they are annoying because they're telling you what to do. 'How come you didn't do this, you didn't do that?' I know they're concerned about their [residents] but we have a lot of things. They should know that we have other duties too. Instead of them helping us sometime they're giving us a problem. But not all of them... because they have limitations that they can't use the lifts. I think they're not allowed to give bath too. (Site 4)

Some staff also felt that companions improved the quality of residents' lives and alleviated the depression of being in the home. One noted that people with companions tended to live longer than those without one. One manager noted that: '...there's all sorts of issues that

come in with private duties but the reality is it does help Belmont and some residents do benefit from having an extra person with them' (Site 1).

One companion described the relationship with the frontline staff as being different than the one with management. This same companion felt part of the frontline staff: '...when we have a problem we can resolve right away...We are a good team. I am a part of the team of course' (Site 4) However, this feeling of belonging was exceptional. Most companions expressed a feeling of uncertainty and generalized distrust coming from staff.

One of the main challenges involved the complex interactions between staff and companions that resulted in companions complaining to families. These interactions resulted in families complaining to management, with staff then feeling watched, blamed and often powerless. Surveillance was a surprisingly big issue. When we asked if the private companions 'spy' on the staff, one companion said it happens 'all of the time'.

The thing with the companions they're close to the families, right? So anything they tell to the families because the families don't know what's going on. So they tell that to the families, the families will tell the RN. It's like complaints. So sometimes that thing happen. So instead of finding ways to solve the problem they make it bigger. (Site 4, PSW)

Companions felt the resentment of staff when they crossed a sometimes 'invisible' line.

... [When her resident's] seat mate at the table need (sic) someone to help her I sometimes help. But I don't know if that's a good one or a bad one. But I told them I also have...because I do the feeding program. I attended the feeding program here too so I'm aware of that too, you know, how to feed them. I don't know. But sometimes the mentality people, oh I try to take my work or whatever. Like I don't know if they think I'm making them mad because I'm the one who is helping them. I don't know. I feel like they don't appreciate what you do. (Site 4, Companion)

One companion noted that she was hired to take the resident outside for walks and to do some feeding. Staff frequently noted that they were envious of companions being able to spend time on the more pleasurable work and from being excluded from less pleasant and heavier work. When that same companion was asked what made her work difficult she noted that there were conflicts related to who should do what.

... the hardest thing is that when I came the morning he was not prepared. He was not prepared and sometimes the PSW ask me 'You should do that.' I said 'How come? I am alone. Only one person. I can't help to pick him up and take him to the bathroom. I am not allowed.' She lift him. She said I would come back. I was wait, wait, wait. She didn't came. And finally I tried to get him out of bed and put him in the chair and I took him to the dining room because we were late so we stayed there for a long time. And I took him in... [she] said 'You took [name].' I said 'Yes.' And the nurse was there too. The nurse said 'You should not do that. You should wait for somebody to come.' But some PSWs said '[do it] yourself'. (Site 5, Companion)

Finally, even though many companions held PSW qualifications, they lacked the protections felt by PSWs whose work tends to be protected by unions and provided with benefits. In contrast, the work of a companion is precarious. As one noted: '[i]f that person pass[es] away it takes a long time for you to pick up something' (Site 5, Companion). Most companions made sure to have more than one resident that they cared for in the building so once someone passed they could still come in to the building to solicit more work from other families wanting private care.

Liminality in the familial realm

The reasons families decided to hire companions were complex. Some decisions were based on structural issues. For instance, the acuity in LTCF has been increasing; despite its rise public funding has not kept pace and there is widespread acknowledgement that there are too few staff to provide more than minimal levels of care (Armstrong et al., 2009; Armstrong and Daly, 2004; Daly and Szebehely, 2011). One family member spoke for many when she noted that the staffing intensity was inadequate.

So up until I'd say a year ago my mom was having pretty much around the clock care that we were providing so there were no issues. There were no problems. We didn't have to really interact. If something arose, you know, the caregiver would contact the doctor, always me on a daily basis. So I didn't really see that. But now that we have withdrawn private companions now I really do see the reality and it's frightening not only for my mother but for every single resident in this nursing home. And I know, well I'm surmising but I believe that they do staff according to how many private caregivers are doing the job that they have to do. And that's why we do have a private companion because they weren't handling her as if she was a human being. Not all. Some. Some were very open and giving and loving and caring and handled her with dignity but I would say that the vast majority do not, are angry, are overworked... (Site 4, Family Member)

Some family members expressed resentment. They blamed the under-staffing on the facility, not the government, and felt that they were subsidizing the overall care of others by paying for private care. '...even now I must say that the staffing in this nursing home is based on people like us who provide personal care' (Site 4, Family Member).

In some cases, residents brought with them the private caregiver that they had when they were still in their own homes. The care gap between the level of care that facilities are funded for and the residents' needs meant that some families scraped together everything that they could in order to provide the additional care. In some cases, parents may have had funds in savings that could cover the additional costs. Some families used remaining retirement funds to provide personal care within a facility with 24-h care. Other resources such as time and energy were also important and in many instances the hiring decision was related to a lack of time. The competing demands of careers and other family obligations, combined with geographic and/or emotional distance amongst families, may preclude them from providing regular social care, from doing bodywork, or from running errands. Dual-income families may have money but not time. Families sometimes hire companions to provide the one-on-one care that they cannot be or do not want to provide. Thus, personal circumstances certainly factored in to families' hiring decisions. With people living longer with increasing medical complexity, the expense of private care meant that wealth was a determinant of hiring.

With the worsening of Alzheimer's and Dementia, families described how some residents developed challenging behaviours or needed care during dining, and facilities 'suggested' that families should hire personal carers. This put many families in awkward positions. Even families with wealth, who had opted for 24 h a day private care, found that over time the cost was prohibitive.

... because we can afford it we pay for the room and board and for a long time my mother had money put away for herself and we hired, we had to hire private companions. She needed somebody on a one-to-one basis; otherwise she would be left alone. She needed the social

interaction. So we had somebody 24 hours a day. Gradually we cut out the night and just recently for financial reasons we had to cut out, um, she had a private companion here from eight in the morning until noon and then again from five to seven. So somebody gets her up in the morning and then somebody gets her into bed again. But she's pretty much left alone between twelve and five and if we were to continue providing that... actually [if] we were providing eight o'clock in the morning until eight o'clock at night care... it would cost a grand total of \$100,000 a year. (Site 4, Family member)

Social and emotional care was an important theme. Some families hired someone to visit and take the resident outside or to recreation events such as concerts and crafts for 1 or 2 h per day. With residents who had dementia and Alzheimer's, moving slowly with patience and without competing distractions, certainly explained some of the cachet of hiring companions for families who had the means to afford it. In many cases, families hired companions to provide care that they could not do or would not do. One companion reported that:

...he doesn't have any time to come. He comes for a visit maybe once in six months, sometimes... once a year only... We communicate at least twice, three times a week because he is a lawyer and he said 'I am so busy.' I feel awkward when I am calling the person that's so busy. At least she's okay and I can manage by myself. It's okay. I said 'No need to call.' But if she has a concern, I have a concern that really needs the family to know then I will call. (Site 4, Companion)

Families hired companions because they identified a care gap and they could not or would not provide the care themselves. In most instances, it was families with wealth who hired caregivers; however, we heard stories of families that scraped together everything they could in order to pay for the care. In more than one instance, we spoke with families who had scaled back or who were no longer able to afford companion care. These stories were often framed with guilt and worry.

The relationships with families were equally complex to those with facility management and staff. Because some companions were hired directly by the family, they often established close relationships. One companion noted: 'I treat his family like my family' (Site 4, Companion). Another companion echoed the voices of others when she noted that: '[w]e have... constant communication' (Site 3, Companion). When companions were hired through an agency, they usually do not interact directly with families. Companions report to an agency administrator who then communicates to families. It seems that agencies fear that families will hire good companions directly if they are allowed to communicate with them. The personal relationships that developed between companions and residents existed in the liminal space between worker and friend, and sometimes resulted in companions performing care work for which they were not paid. An exchange about hours reveals one of the forms that this volunteering took:

I; So you come at 8:30 and you do feeding from 8:30 to 9:30. And then 9:30 to 11:30 is supposed to be your free time?

A; Free time, yeah. I'm not working that hour.

I; You're not working. Do you leave?

A; No. I stay with her.

I; You stay?

A; I will stay with her if I am not going somewhere that's necessary, that's important. I just leave her to the nurses' station if I go to the bank and that's it. If I have my doctor's appointment then I phone up to tell her [the nurse] that I have my doctor's appointment... if it's just two hours.

Three hours, I need to call somebody to work with her. I don't want to leave her alone for long hour. No. Because even you talk to the family if she don't have anybody, yeah, they [the nurses] will assist her. But it's different if you are there so that you know what happen to her. ...So my free time I like to stay with her. We just sit down together, watch TV, put on the TV... she has a lot of CDs so I put it on. You know, she is sleeping. . . I am not going to leave her. I love her very much. (Site 4, Companion)

In this particular case, the companion did most of the resident's body care and feeding care. She was paid to simply spend time with the resident at other times when not doing these tasks. Nonetheless, as this exchange illustrates, her free time was indistinguishable from her work time, because she had split shifts and did not work close to home. Many companions kept hours that ranged from 8 a.m. to 8 p.m., sometimes for as many as six days per week. This strategy was done as a way of securing their own employment, and often reflected the fact that they cared for more than one resident in a day.

Companions often spoke about other residents that they had previously cared for and whom they still cared about. They noted that residents would often ask them to come to visit them afterwards. There was usually a desire on the part of the companion to do so; however, work hours, distance and other factors prevented them from doing so.

Families relied on companions to be their eyes and ears and to do things that they could not. Companions talked about how they cultivated this feeling. One companion wanted the daughter to increase the hours. She told us: 'And I said to the daughter I think she needs more help because the people here they cannot be 24 hours with her because they have some other residents too' (Site 5, Companion). Another family member worried about what care would be missed without a companion: 'I thought imagine if you didn't have a companion, those people never get downstairs. They never get outside, never feel the sun on your face. Nothing. And for her that was really important' (Site 4, Family Member).

Families did a significant amount of unpaid care work in the form of coordinating and scheduling companion care. Many had assumed that this form of unpaid care work would diminish once their family member had entered a publicly funded care facility. In our interviews, we heard the opposite, as daily communication, coordination of activities and supplies, and mediating between management, staff and companions took the place of care work families previously performed at home.

Discussion and conclusions

Lyon and Glucksman look at non-homologous work practices to argue how '[w]ork that is formal and work that is informal overlap with paid and unpaid work respectively' (103). Theirs is a laudable goal worthy of pursuit and their archetypes do much to advance our thinking about care work. Nonetheless, their current conceptualization requires refinement because it fails to take account of several issues. First, while the model is ostensibly about all elder care the analysis largely ignores institutional care because, they note, there has been a 'move away' from institutions. They provide the example of Italy where costs and culture make institutionalization less attractive; however, their cursory review of institutional care lacks important context. For instance, policy makers do argue that home care is preferred and better, but this can be an economic rather than an absolute argument. In most countries the focus on home care has not curbed the high demand for institutional care, which remains so because some care needs are not and cannot be met in home care settings because of the acuity on the one hand and the inadequacy of the home environment on the other.

The higher public sector costs of institutional care result in policy makers limiting space leaving many people without sufficient choice between home and institution (Bronskill et al., 2010). Limited space also results in only the most acutely ill gaining a spot. In some countries and regions there has been greater public sector investment in home care; however, it may be at the expense of public funding resulting in a degradation of institutional care quality.

Second, because of the author's focus on the macro level, what is missing from their model is the extent to which modes of provision intersect *within* a given care setting. While they do account for women's labour market participation and do acknowledge that women provide the majority of informal care, meso configurations of care and ones that are largely class based are not captured. Regional jurisdictions within countries may differently fund and allocate resources between home and institutional care. Thus, they argue that there are big differences *between* countries but there may be just as many differences *within* countries. Furthermore, how does household wealth impact the care configuration within a country? This is important to consider because insufficient public home care funding requires additional private payments; this is a class issue as not everyone can afford to pay privately for care.

Third, they provide the example of home care in Modena, Italy to argue that hiring personal assistants allows for the practical maintenance of a familial care ideal (106). This example excludes decisions to hire companions made not to uphold familial care ideals as much as to extend staffs' care capacity when austerity measures limit staffing and care allotments (Shutes, 2012). Hiring companions may then represent privatization (Ungerson and Yeandle, 2007) and a re-alignment from more to less generous welfare state provision or represent an artefact of a residual approach to the provision of publicly funded care. The authors classify the paid care work of companions as informal because they consider migrant workers privately employed in homes by families to extend 'the continuity of family care' (108). This raises the question of whether paying for private assistants' care can be classified within familial care, especially when done for payment and/or when offered in a residential facility where care may otherwise be publicly funded.

Finally, the model's focus on funding and delivery (provision) but not on regulation is problematic because it is the latter that represents the state's role determining scope of practice and mode of provision. As a result of these omissions the formal/informal, paid/unpaid dichotomies that the authors hope to transcend are re-created within the structured boundaries they have drawn between the modes of provision. For instance, they have limited the market care category to for-profit companies. Companions – who may be directly employed by one family or by a few families as independent contractors or employed by for-profit agencies – are nonetheless bound to the family but not to the market in their model. With the state's changing funding and regulatory roles, companions may in fact straddle the liminal space between family (household) and market.

In summary, the care work literature requires refinement to accommodate private companion's place in the care of older adults, particularly within publicly funded institutional care. These issues with Lyon and Glucksmann's model are underscored by empirical gaps in the literature. There are few empirical studies that directly examine private companions working in LTCF or that identify the complex interplay of relations between facility staff and management, family, residents, companions, volunteers and students. We would argue that companion care, particularly when provided in residential settings, requires additional study to expand our empirical and theoretical understandings.

As a starting point, our study found that too few staff meant that families were paying out of pocket for private care for services that were supposed to be publicly funded. Most families had neither the time nor the skills to make up for the deficit. But, our research shows that the work of companions is 'officially' invisible. The legislation is silent on companion's labour despite the high numbers of companions providing care. In every facility the scope of their practice and the types of policies to address what they can and cannot do, as there are neither common standards nor common job descriptions. In many cases there are no organizational policies. Companions are not directly supervised, and facilities hesitate to intervene directly with companions, choosing instead to deal with families when there is a problem. Many work for an agency but agency work is precarious, and tightly controlling of the relationship with the family. Being hired directly by the family may involve cash payments and rarely includes even statutory benefits.

Thus, private companions are in spaces that are in-between. They are paid workers but not employees where they work. They are invisible in terms of organizational rules but often have rules applied to them. Companions are also liminal in a regulatory sense. Whereas the LTCHA enforces screening for qualifications, training and criminal history of staff and volunteers, there is no obligation to screen companions. Sometimes they are employed by formal agencies and have statutory benefits but rarely extended health benefits, but many times they are employed directly by families and lack even the most basic of statutory benefits. Within LTCF, management accepts companions' work because Ontario's resident's bill of rights stipulates that every resident can meet privately with family, friends or persons of importance. Unions and staff often accept their work due to understaffing and the extent to which it is 'help', though it can negatively affect their own work organization. Families 'need' their work because of under-staffing resulting from rationing of care and their own inability to provide the care that the state has downloaded back to individuals. The hurried nature of paid care work – where there is always too much to do – may explain staff's seeming tolerance with having people paid to do very similar and in some cases the same labour as their unionized work.

Existing ways of comparatively theorizing care work do not adequately account for the causes, contradictions and conditions of liminality for companions. We need models that can better account for the blurry lines between formal and informal, paid and unpaid care work. To date this has not been taken up in the LTCF research except in descriptive ways. There is a growing body of research that documents the nature of informal home care, but almost no research documenting informal care in LTCF unpaid *nursing home care* (by family, volunteers or students), or the other wage labour of privately private companions.

The notion of liminality allows us to highlight the spaces in between informal and formal, paid and unpaid and to begin to theorize the forces that shape this kind of work and the nature of relations within it. Addressing these spaces has importance for theory, practice and policy. Especially as companion care represents more informal care in formal care settings. Furthermore, we need studies to enable us to better understand the intersecting and contradictory funding, delivery and regulatory roles held by the state, voluntary organizations, households and markets. But, in doing so we should better account for how care differs between private homes and institutions, how class and other social locations make a difference within countries and how some people are marginalized within systems that are insufficiently staffed.

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Conflict of interest

None declared.

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