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Experiences of moral distress by privately hired companions in Ontario's long-term care facilities

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Abstract

Purpose—To explore long-term residential care provided by people other than the facilities' employees. Privately hired paid "companions" are effectively invisible in health services research and policy. This research was designed to address this significant gap. There is growing recognition that nursing staff in long-term care (LTC) residential facilities experience moral distress – a phenomenon in which one knows the ethically right action to take, but is systemically constrained from taking it. To date, there has been no discussion of the distressing experiences of companions in LTC facilities. This paper explores companions' moral distress.

Design—Data was collected using weeklong rapid ethnographies in seven LTC facilities in Southern Ontario, Canada. A feminist political economy analytic framework was used in the research design and in the analysis of findings.

Findings—Despite the differences in their work tasks and employment conditions, structural barriers can cause moral distress for companions. This mirrors the impacts experienced by nurses that are highlighted in the literature. Though companions are hired in order to fill care gaps in the LTC system, they too struggle with the current system's limitations. The hiring of private companions is not a sustainable or equitable solution to under-staffing and under-funding in Canada's LTC facilities.

Value—Recognizing moral distress and the impact that it has on those providing LTC is critical in terms of supporting and protecting vulnerable and precarious care workers and ensuring high quality care for Canadians in LTC.

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Introduction

This paper addresses the everyday realities of privately hired paid "companions" in long-term care (LTC) homes in Southern Ontario, Canada. It outlines constraints that they experience with regard to carrying out their work in light of LTC under-staffing and under-funding. The work of companions is virtually invisible from a systems perspective. In other words, it is unseen, undocumented, and unaccounted for (Daly et al., 2015). Companions are a distinct, under-studied care group with different care provision requirements, different employers, and different frameworks for care than other workers in LTC facilities (Daly and Armstrong, 2016). Because their work differs from that of facility staff, it is worth exploring the ways in which moral distress can also affect companions. This conversation is valuable for companions, but also for residents, other workers, and families, as moral distress has been shown to have negative effects on care (Pijl Zieber et al., 2008). In what follows, the authors argue that while the role of paid companions has been introduced in order to fill care gaps in the LTC system, companions also struggle with the current system's limitations. The independent hiring of private companions brings with it certain benefits, but is not a sustainable or equitable solution to the problems of under-staffing and under-funding in Canada's LTC facilities. Indeed, it is an indicator of a system under stress.

Background

Moral distress

The concept of moral distress was introduced in nursing literature in the 1980s. Much of this literature explores nursing in acute care contexts (Elpern, 2005; Zimmerman et al., 2005). There is growing recognition that nursing staff in LTC residential facilities also experience moral distress (Green & Jeffers, 2006; Pijl Zieber et al., 2008; Edwards et al., 2013). Moral distress is defined as a phenomenon in which one [presumes that one] knows the ethically right action to take, but is systemically constrained from taking it (Epstein & Delgado, 2010). Pijl Zieber et al. (2008) suggest that constraints may come in the form of: limited human and health care resources; competing values of cost and care within the health care system; policies and regulations; tensions between families, staff members, and management; and the isolation of care providers. This phenomenon reflects cases where the ethical duty is apparent, but the nurse is unable to fulfill it. For example, in order to meet the facilities' need for efficiency, and to cope with the limited number of care providers, a nurse may not provide a resident with the necessary degree of social or emotional support. Recent research suggests that LTC nursing staff in Western Canada experience moral distress at least daily or weekly and that increased time spent at the bedside increased their level of moral distress (Pijl Zieber et al., 2016). This is particularly noteworthy for companions who spend the majority of their time at the bedside or providing direct care to residents.

Moral distress is said to have a lasting effect of "moral residue" (Webster & Bayliss, 2000) that workers carry with them. This residue reflects the strain experienced when workers have to repeatedly act against their values. Moral distress and moral residue can also accumulate over time (Epstein & Hamric, 2009). This "crescendo" of distress can lead to numbness to ethically challenging situations, a sense of powerlessness, burnout, and abandonment of the

profession (ibid). Recognition of moral distress and its impacts is critical in terms of supporting and protecting all those who provide LTC.

LTC in Ontario and the use of private companions

In Ontario, LTC facilities are heavily regulated and the funding allocated for nursing care must be spent on staff. This includes registered nurses (RNs), licensed practical nurses (LPNs) and personal support workers (PSWs). There is a requirement that at least one RN be on duty at all times to provide medical care, but there is no minimum staffing level and most of the direct body care is provided by PSWs (Daly & Szebehely, 2012; Estabrooks et al., 2015). While the complexity of residents' needs have increased, funding and staffing have not kept pace (Armstrong & Daly, 2004; Bowers, Esmond, & Jacobson, 2000; Ontario Council of Hospital Unions, 2014). Increases in for-profit service delivery and New Public Management approaches (Baines, 2004) to work organization in the public sector have put increasing pressure on employees (Daly, 2015). As noted in other jurisdictions, RNs and LPNs are particularly vulnerable to moral distress due to their extensive training and education regarding patient care combined with limited decision-making power in the workplace (Pijl Zieber et al., 2008). Feeling rushed and overwhelmed with tasks may make for stressful working conditions, but it can also lead to guilt, anxiety, and distress associated with not being able to provide an ethically satisfactory level of care.

There is very limited discussion in health services research about the role of companions and unregulated workers in LTC facilities. As a result, little is known about the moral distress that these workers may experience. Companions can be considered vulnerable care providers because they are disproportionately women, people born outside of Canada, and people from lower socioeconomic status groups (Daly et al., 2015). They sometimes work without any form of employment contract. Their work is precarious in terms of pay, benefits, hours, and job security (Daly and Armstrong, 2016). Some companions are trained PSWs and are hired through agencies, but there is a wide range of preparation for the job. Some families hire companions who were former nannies, neighbours, community members, or individuals who responded to classified ads. This study revealed that in some cases, families that are concerned about a facility's limited resources hired companions to act as a source of surveillance.

Literature from Canada's prairie provinces suggests that unregulated care aides in LTC and nursing homes experience the same workplace characteristics that precipitate burnout in nursing and allied health professions (Estabrooks et al., 2015). With fewer staff employed in LTC homes in Ontario, leaner budgets, and more demanding task-oriented care schedules, companions are hired to supplement facilities' care for residents (Daly et al., 2015). Their tasks typically involve conversational visits, walks, reading, assistance with feeding, and accompanying residents in other activities. However, what families ask them to do may vary and there is no single government or employer policy on what they are or are not allowed to do (Daly and Armstrong, 2016). Companions work *within* LTC institutions, but are not unionized, regulated, nor employed by the institutions themselves (Daly et al., 2015). These workers occupy a complex position in terms of addressing the needs of the resident and the family/employer, while working alongside the LTC staff, LTC management, and the policies

and regulations of the facility. The following section outlines the methods used to explore these issues.

Methods

The data presented in this article come from a CIHR-funded study conducted to explore gender in relation to long-term residential care provided by people other than the facilities' employees (Principal Investigator: Tamara Daly). This research was designed to address the roles of formal and informal care provision in LTC. The researchers conducted weeklong team-based rapid ethnographic case studies (Yin, 2014) in seven Southern Ontario non-profit LTC facilities to better understand the division of labour between formal and informal care workers. A growing number of studies have successfully used rapid ethnographies to understand workplace conditions, labour processes, and care work (Baines and Cunningham, 2011; Szebehely, 2007).

This method involved immersing the research team in the environment to conduct interviews and detailed field observations. Individual semi-structured interviews (n=203) were conducted with managers, workers, families, companions, and volunteers. While one or two team members conducted interviews, two to three other team members recorded their observations in public spaces within LTC facilities (for instance, dining, recreation, and other common spaces). This was done over six days between the hours of 7am and about 11pm at each of the seven sites. Participants were asked questions related to: shifts in the division of labour between facility employees and informal care providers, the ways in which workloads and occupational health and safety are affected by the care performed by these other workers, and staff intensity when accounting for work performed by informal carers. Thirty companions were interviewed. Most of them were female, most were racialized (Galabuzi, 2006) or people of colour, and many were born outside of Canada. Interviews were digitally recorded, transcribed verbatim, and thematically coded and analyzed using the constant comparative method (Creswell, 2009; Glaser, 1965) and NVivo data management software.

Feminist political economy (FPE) (Armstrong & Armstrong, 2005; Mutari, 2000) guided both the research design and thematic analyses of the key informant interviews, work observation field notes, and policy documents. This framework was chosen because of its focus on the intersections of formal and informal labour, divisions of labour, matters of gender and race, and the conditions in which care work is performed. Given this focus, FPE is well suited to explore formal and liminal labour – predominantly performed by women – in LTC facilities. In terms of research design, FPE determined the area of inquiry: care work. As feminist political economists, the authors are concerned with who provides care to vulnerable individuals and how their labour is valued or devalued and seen or unseen. FPE also informed the methods chosen. Because feminists have historically understood the personal as political (Hanisch, 1969), qualitative in-depth interviews and field observations were used to understand the experiences of these workers and how their everyday realities fit within and reflect/challenge broader systems. FPE informed the types of questions asked during interviews, which are described above. In the thematic analyses, using FPE meant paying particular attention to the broader context for care work. This meant considering

these experiences within facilities, within provincial regulations, and within current political and economic regimes. Feminist political economists also ask, “who benefits from current arrangements?” (Armstrong & Armstrong, 2005) and so this analysis also included attention to matters of power and [in]equity.

The FPE framework is known for its engagement with the tension between structure and agency (Vosko, 2002). This is particularly appropriate for exploring the concept of moral distress since moral distress results from the desired actions of an individual agent and the structural constraints that prevent them from taking said action. In other words, moral distress provides a concrete example of this tension at work. Because FPE situates individuals’ experiences within social, economic, and political contexts, the analysis of these findings links the macro policy level with the meso facility level and the micro level of individual worker experience. It reveals how neo-liberal restructuring to reduce costs, increase control over the work force, and – in many cases – produce profits, influences everyday care work. FPE also stresses the need to include all workers and to examine both power relations and the gendered nature of the workforce.

The research team held meetings to discuss observations twice at each site and once after each week was complete. After reviewing the transcripts and field notes the team generated a list of codes and prominent themes, which was amended over several weeks. For this particular article, the first author performed secondary coding related to the theme of moral distress.

Limitations

The data were collected in a major urban centre in Southern Ontario. As a result, the findings may differ from the experiences of paid companions in rural Ontario or in other provinces. Moral distress may vary based on site and facility policies, as well as provincial and federal regulations. Sites with more staff or clearer regulations around companions’ work may find that workers experience less moral distress. The following section outlines the findings from this study.

Findings

The nature of companions’ moral distress may differ from that of nursing and PSW staff. Companions are typically responsible for only one resident at a time. As a result, they can work at a slower pace. They have more time to do what other workers see as enjoyable parts of the job. This considerably reduces their risk for distress when compared with formal staff who must manage a far more significant caseload. Many companions in this study reported that they generally enjoy their work. However, it appeared that companions were distressed by many of the same phenomena as the nurses and PSWs, including: limited human and health care resources; competing values of cost and care within the health care system; Ministry and management level policies and regulations; tensions between families, staff members, and management; and the isolation of care providers.

Limited health and human resources: Cost vs. care

The most common theme reported by staff and companions was that the facilities did not have enough staff and the staff did not have enough time and/or nursing resources. Almost all of the participants in our study, including companions, spoke about the increasing pressure on health professionals in LTC to compensate for low staffing levels by performing more tasks more quickly. The tension between cost and quality care has been well-documented in literature on health care restructuring (Armstrong & Armstrong, 2010; Fine, 2006; Tudor Hart, 2006) and its impacts are addressed in the literature on the relationship between low staffing levels and the potential for moral distress (Austin et al, 2003; Cocco et al, 2003; Corley, 2002). LTC staff members have large numbers of residents, with greater care needs, and less time to spend with each of them. One companion spoke about how she was hired to walk with a resident because he would otherwise become aggressive. The PSWs did not have time to take him for the walks required to keep him calm:

> A: [I was hired] mostly for hitting because PSW cannot spend an hour on resident [sic].
>
> I: They don't have the time?
>
> A: Or half hour.
>
> I: Or even half an hour. Right.
>
> A: She cannot afford the time. The girls try their best, but the time is the crucial time. You have no time for this
>
> (Site 4, Companion 1).

Many companions spoke about watching the nurses and PSWs race around and about how they tried to help minimize the staff's burden and stress. Several of them talked about finding it difficult to see residents go without the attention they require:

> "They need more staff so you're just running to get your work done. At the end of the day [residents are] the ones who suffer because attention they don't get [sic]. And I think to say 'How are you?' or give a hug means the world to them… For me, observing throughout my years working in nursing homes, I think that's what's missing. More people to give them that. More staff to give them that. And like for him if you go and talk to him you will hear it so that's attention he needs and he's crying out for attention. But you need the staff to do that, to fill that need"
>
> (Site 2, Companion 5).

Because companions are hired to provide care for a single resident, they cannot address the needs of other residents. This companion emphasized that additional facility staff is required in order to provide adequate relational care. Other companions also spoke to the need for more staff:

> "I think [they are] short on staff. Like fourth floor it's very tough floor. Those girls sometimes, you look at leaving time, her shirt is wet because she run fast to manage everything on time for the supper, for changing [diapers], for everything. Probably two more person on the fourth floor that would be blessing. That would be blessing.

> That would be miracle. That would be much, much better for all residents because it's a very tough floor… I hope get more staff but I don't know. Everybody struggling with everything"
>
> (Site 4, Companion 1).

When asked for follow up about her comment on the need for more PSWs, another companion said:

> "Yes. I think so. At this point in time people are aging, including myself. We are aging and I think that for [LTC work] it's a very hard and technical job and a job that is really stressful especially if you're not prone to dealing with this situation. I think they really need extra staff. And I always said in this job, in this field of work they should always have two people that work together"
>
> (Site 5, Companion 4).

In sum, the tension between cost and care has led to fewer staff members in LTC facilities and, in turn, a more hurried and stressful work environment. This environment has implications for the work of private companions. In response to experiencing a sense of helplessness with regard to the limited staff and the high needs of residents, companions frequently take on work and responsibilities. While this is sometimes framed as something that they do not mind doing, is at the behest of the families, or are happy to help with, many companions also say that they do so because they feel badly for the staff and the residents and thus feel compelled to intervene. The following section outlines how taking on these additional tasks can also be distressing.

Policies and regulations: The sliding scope of companions' care work

Many employers lack a specific job description for companions and this can lead to tension and confusion. As noted earlier these individuals are hired for companionship purposes and for some care duties. A large number of companions reported that they frequently perform personal care work including bed baths, changing diapers, and other tasks typically done by PSWs or nursing staff. Conversely, a number of companions spoke about being unable to perform necessary tasks or duties because of liability. This tension reveals the failure of governments and facilities to provide a defined scope of practice for paid companions, with the scope varying by institution or even amongst companions within the same facility. Their scope is defined primarily in terms of what others can do, rather than by any government or professional regulations specifically about their labour. One companion who spoke about performing bed baths for her resident said:

> "It's not because I don't like the way [the nurses do it], no it's not that. I like to help them also because so many patients they are doing. One PSW they are doing 12 or 7 or whatever, how many people, right? So the way they wash is different from the private [companion]"
>
> (Site 1, Companion 1).

In other words, this companion felt inclined to perform personal care duties because there is not enough time or enough staff to provide longer, more comfortable and attentive baths for residents. Another companion echoed this sentiment with regards to shaving a resident:

> A: Yes. Because sometimes they use the blade and then he get cuts. I feel bad so I say leave it, I'll do it because with them sometimes they're always... they cannot do it slowly because they have lots of residents to take care and he's not the only one. With me at least even I shave him for half an hour I'll do it because I'm only with him.
>
> I: And you can take your time?
>
> A: Yes
>
> (Site 6, Companion 3).

In addition to these concerns about quality of care for residents, companions can also experience distress because they are unable to perform actions understood as outside the scope of their responsibilities. In these cases, policies around task distribution act as a decision-making constraint. Several companions discussed times when they had to leave their resident in pain or discomfort because in some facilities companions are prohibited from transferring residents in and out of bed without a PSW or nurse present to assist. When this happens, they must wait until one of the staff becomes available. This type of scenario becomes particularly distressing when there is an emergency:

> "For example, [resident] needed to go to the hospital. I cannot go right away to the nurses because the nurse is only one and she went to the other side [of the facility]. It was so tremendous, uh, staff, no staff. So I am looking for the nurse. Even I am paging. So [the resident] was already – and even I know how to insert the oxygen, I cannot do it because that's not my jurisdiction, so I have to wait – but she was already, like, blue"
>
> (Site 1, Companion 5).

In this type of scenario, there is a discrepancy between what the companion feels she ought to do and what she is able to do. In cases like this one, or when there is the potential for a resident to fall, companions can become distressed because of the limitations on their ability to act and because of their potential legal liability. One participant offered an example of this:

> "So each of these [residents] are individuals too and the people inside you can see that some just need that hug or to hold the hand. This one lady is very anxious so every day I go when I'm here... and I shouldn't… This is another thing I want to bring up. I don't work for [the LTC home] so it's difficult sometimes to engage with the other residents because really if something was to happen, you know, I don't know if I'm legally... you know, if I was holding somebody's hand and they fell, you know. This is the stuff you have to be careful about"
>
> (Site 2, Companion 4).

Institutional policies can make it challenging for companions to address residents' needs. In this quotation, the companion explains that she has a bit of time to provide small acts of care and affection for other residents in the facility. She sees that these residents have emotional needs that are unmet, but she is often unable to provide this care because of her potential liability in the event of an accident. This sentiment was echoed by other companions, who

said things to the effect of, “suppose I feed another resident I’m not responsible for and that resident chokes on food, I’m responsible.” This presents a real challenge for companions who consistently encounter residents in need of a care provider’s attention. In the field observation notes of this study, multiple team members commented on the painfulness of watching particular residents sob or scream day after day and being unable to intervene. Experiencing this sentiment for months or years could certainly take an emotional toll on companions. To avoid this toll, some companions made particular care decisions. For instance, one companion discussed walking a resident on her own, knowing that she really ought to have additional support, because no one else was available to help her walk the resident and the alternative was the resident not getting a walk that day. Performing this type of task alone can leave companions feeling isolated in their work and cause tension with formal workers.

Stuck in the middle: Isolated companions

Though physicians, nurses, PSWs, companions, families, and other care providers work in teams, collaboration can sometimes be challenging. A lack of satisfactory collaboration with physicians is cited as a source of distress for nurses (Pijl Zieber et al., 2008). Similarly, a lack of collaboration with nurses and other health professionals can be a source of distress for companions, especially given that companions are not part of the formal care team and are excluded from most decision-making. Though some companions in this study had excellent relationships with the care teams, several felt isolated in the workplace and had limited power to make decisions or take action about treatments. This was particularly true if the employees saw them as spies for the family. Their work is often very solitary and focused directly on the needs of the resident.

Given the considerable variability of a companion’s role noted earlier, it can sometimes be difficult to determine who is responsible for particular tasks. Despite being in the facility solely for their resident, the companion is present to witness the care provided by the LTC staff. As an observer who holds a stake in the quality of care provided to their resident, companions are well positioned to note the strengths and shortcomings of the homes that they work in. They sometimes share these observations with the family that employs them or with the nursing staff.

The Director of Care at one of the sites described this relationship in the following way:

> A: I would say more like the private caregivers feel that they... they have ownership over the resident. It’s their resident. ‘It’s mine. I’m here to care for him. You’re not capable to do it. I know the resident better than you do. You are staff.’ So then they would try to give directions to our staff how to care for that resident.
>
> I: Do the staff get upset?
>
> A: Oh yeah, of course because we are the professionals. We know how to do it. You don’t come to tell me. But there are situations when, yes, we embrace that suggestion and we might use it if it’s not something that really is off the... But family going around and trusting us, I would say that mostly they still go with the private caregivers

(Site 3, Director of Care).

This comment reveals a tension between those who are clinically and medically trained to care for older adults and those who are paid to provide the attention and affection that, because of time constraints and limited staffing, these professionals are unable to provide. This can be distressing for companions who may not have the same education or formal training as other staff, but have expertise regarding the temperament, needs, and preferences of the particular resident they care for. When companions do notice something concerning, they often feel conflicted about whether or not to speak up, and to whom. One companion said:

> A: No. You just keep quiet. You should keep quiet because when you talk [it's] going to go back to you. Sometimes what you see, what you hear, just leave it there. That's the best policy.
>
> I: And is that your philosophy?
>
> A: It's my philosophy. But maybe if it's like wrong, wrong, wrong, wrong you have to open your mouth and at risk to those who really like the things [sic]
>
> (Site 6, Companion 3).

When asked about whom to speak with when there is a concern, another companion said:

> A: As a private companion, my first priority is my primary [resident], you know? So anything I see like something, you know, it's not right, I tell the nurse. If I tell the nurse and no actions at all, then there's the time that I tell to the son…
>
> I: So you would try first to speak to a staff member if there was an issue, if you had an issue?
>
> A: Yes.
>
> I: And then, if you didn't get a response that you liked, then you would go to the family member?
>
> A: Yes. Because sometimes [the staff] say I'm not a family member. That's what they say. I'm not a family member so I have no right to ask them to do this, to do that.
>
> (Site 6, Companion 4).

These quotations reveal companions' unique position in which they must provide care, as well as navigate issues of trust and tensions between family members and facilities' staff. While they are employed by the family and ultimately accountable to them, companions must also foster a continued relationship with the nursing team they interact with each day. If this relationship is not amicable or companions are unable to effectively communicate their concerns, it can have negative implications for their day-to-day working conditions.

Discussion & Conclusion

Nurses sometimes experience moral distress because of "the various conflicting loyalties demanded by the profession" (Pijl Zieber et al., 2008, p.42). Paid companions have to

balance the needs, wants, and values of the same stakeholders that nurses do, with additional weight given to those of the family that employs them. They also stress about relations with employees of the facility. Companions do not necessarily report to the facility's management team, nor are they formal members of the staff. They do not have a union or professional association to support them or to turn to. This lack of systemic outlets for their concerns may increase their level of moral distress and put them at added risk for its negative impacts. They may also be less likely to voice their concerns because of their precarious employment, fearing repercussion from family members or facility staff. Despite having a role that was created to fill care gaps in the LTC system (Daly et al., 2015; Daly and Armstrong, 2016), the shortage of formal staff and funding, workplace isolation, and other systemic barriers create challenges for companions as well.

The data collected both confirmed and extended the researchers' thinking about FPE conceptions of care work and moral distress. Through a FPE lens, these gaps can be seen as indicative of systemic priorities guided by a neo-liberal market approach and a failure to recognize the skills involved in care. Often invisible in the assessment of traditional women's work, human connection and emotional support are cut when efficiency, cost cutting and/or profit-seeking, and task-oriented workdays become the norm. The responsibility and costs of care for older adults is shifted from the state to residents' families and the companions they employ. Companion work is seen as non-essential in the public health system and is not accessible for lower-income families. This reinforces traditional FPE critiques of neo-liberalism and its negative impact on carers and health services. Companions have relatively low pay, no job security or union protection, and they have no power in the work hierarchy except as potential family spies. The optional nature of their care reveals the value that is ascribed to the type of work that they provide – a type of care that is both gendered and non-clinical/biomedical. Care work has historically been, "denigrated as a low-level job, yet also lauded as 'special' work, involving the supreme virtues of 'love' and 'care'. The roots of this tension… lay in the fact that it is largely performed by women" (Twigg 2000, p. xii) and the fact that 'care' has often been treated as emotional and conceptually distinct from 'work' (Ungerson 2005). These conditions are not unique to paid companions in Canada. In the United Kingdom and Europe, there is also a trend towards low-wage, non-professional, precarious, commodified care relationships (Christensen 2010; Guldvik et al. 2014; Ungerson 2003). The care structures vary amongst and within these countries, but privately hired, unregulated care work is becoming increasingly common.

This research identifies sources of moral distress for paid companions. Similar to nursing staff, companions' moral distress resulted from limited resources for publicly-funded care; competing values of cost and care within the health care system; policies and regulations that simultaneously affect companions and exclude them; tensions between families, staff members, and management that leave them caught "betwixt and between" (Daly et al., 2015); and their isolation from care providers employed by the facility. The distress was evident in the sheer number of challenges expressed by companions as they attempt to navigate this highly complex landscape of care. The distress experienced by companions may differ from that of the PSWs and nursing staff and it does not necessarily have identical implications, but the systemic barriers that create their problems are the same. The shortage

of staff, time, and resources impact their work and their care, as does the undervaluing of emotional labour and social support so long associated with women's work. Moral distress can thus lead to negative outcomes and experiences for both formal and liminal care workers in LTC facilities. These outcomes are of interest because they reflect the health and working conditions of those who care for vulnerable citizens during a time of dependency. This issue is increasingly pressing as unregulated companions become more and more common in LTC facilities across Canada. Given the little attention that companion work has received, this is a novel area of study that merits further exploration.

In order to address the moral distress experienced by companions, both their work and their working conditions must be made visible. This must be made visible to the families that employ them, to the facilities in which they work, to the policy makers who regulate LTC, and to the public. There is a need for a larger public conversation about the increasingly complex care needs of Canadians in LTC and the resultant reliance upon families, rather than the state, to bear the costs of care. Additionally, attention should be paid to the reliance upon women, often immigrant women, to provide care at reduced pay. When assessing LTC funding and staffing levels, policy makers must be cognizant of the invisible labour that takes place in these facilities and the fact that reliance upon unregulated, privately hired workers is not sustainable nor does it necessarily result in adequate quality care. Policy makers should listen to frontline care workers who have expressed that they require more staff and more time in order to provide high quality relational care (Armstrong, 2016). Long-term care facilities can aim to reduce companions' moral distress by having companion-specific policies. This could include, for example, implementing background checks and basic training, including companions in staff meetings and memos, and providing clear conflict resolution protocols for resident-family-companion-staff care teams. Future research on LTC should count and account for privately hired companions as part of the labour force. Indeed, their employment offers a telling indicator of gaps in care and of attitudes towards care work.

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