

A VIEW FROM THE FRONTLINES:
PERSPECTIVES OF CERTIFIED NURSING ASSISTANTS ON
PROMOTING AUTONOMY AMONG THE ELDERLY IN LONG TERM CARE

by

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**“A VIEW FROM THE FRONT LINES: THE
PERSPECTIVE OF CERTIFIED NURSING
ASSISTANTS PROMOTING AUTONOMY AMONG
THE ELDERLY IN LONG TERM CARE”**

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ABSTRACT

Title of Thesis: A VIEW FROM THE FRONT LINES: PERSPECTIVES OF
CERTIFIED NURSING ASSISTANTS ON PROMOTING
AUTONOMY AMONG THE ELDERLY IN LONG TERM
CARE

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The purpose of this study was to explore the phenomenon of the “lived” experience of promoting choice and autonomy for the elderly in long term care facilities as experienced by Certified Nursing Assistants. Study participants included five CNAs who were employed in three nursing facilities on the Eastern Shore of Virginia.

Participants were interviewed in different settings using a guided interview which was audiotaped. The interviews were transcribed and the resulting narratives were analyzed for data that was pertinent to the subject. Units of data were coded and organized, using the qualitative data analysis computer program QSR NUD.IST 3.0.4. Six category themes emerged from the data: (1) motivation, (2) environmental support

and non-support, (3) resident characteristics, (4) the nursing process, (5) conflict, and (6) patient's rights.

The results of the study indicated that the CNAs brought to their roles the positive attributes of affection and sympathy for the elderly. They described many strategies used for "mutual goal setting," and for ensuring that their clients received responsive, sensitive care. All participants expressed the belief that "there's always a way" to provide for resident's choice, even within the constraints of a regimented institutional setting.

The CNAs were concerned about the stresses imposed on their work by environmental factors which included short-staffing, loss of teamwork, and inadequate educational preparation. They also described how resident safety and quality of life could be compromised by Patient's Rights requirements, even while maintaining that the right of elderly residents to autonomy should not be abridged.

PREFACE

“The nurse’s aide came into my room and told me it was time for me to go to the dayroom for breakfast. When I told her I would take breakfast in my own room, she said I had to go to the dayroom with the other patients. It was part of the routine, and besides, it would be good for me to get out and be with other people. She said it was part of my ‘therapy.’ I continued to protest, but I let her take me to the dayroom. When she left me there and I looked around and saw all those sick, sad-looking people, I shouted that if somebody didn’t take me back to my room, I would be sick. That got their attention”

-excerpt from a conversation
with an 80-year-old patient
in a Skilled Nursing Facility

This account of a conflict given by an assertive, but temporarily dependent, woman mending from a fractured hip marked the start of a long journey of inquiry. At the time of this incident all patients admitted to the facility received a thorough explanation of the concept of “patient’s rights.” They were assured that while they resided on the unit their civil rights and choices in matters large and small would receive the respect of the staff. These assurances were not only institutional policy; they were required by law. Awareness of the discrepancy between the promise of respect for autonomy and the reality of an elderly person’s lived experience was unavoidable.

The elderly in long term care---whether in skilled nursing units, rehabilitation centers, or nursing homes--- face many challenges to their sense of being in control. Pressures may come in the form of gentle encouragement, firm insistence, or even outright bullying. They may come in the form of benevolent advice: “It’s for your own good; it will help you get well,” or appeals to rules: “These are doctor’s orders...” or

“It’s the routine here.” Such pressures from staff members may come from an understanding that the concept of “patient’s rights” implies more than a simple acquiescence in every matter. “Pushing” patients may encourage them to achieve an eventual independence that at first seems beyond their reach. A firm refusal on the part of staff may be the most caring response to a request that may lead to injury for a client unable to anticipate consequences.

Therapists, doctors, theorists, and nurses all have interesting views concerning the issue of protecting and promoting autonomy for institutionalized elderly people. This study, however, represents an attempt to listen to those who spend the most time with residents, have the most genuine daily interactions with them, and understand the issues involved in promoting autonomy and “patient’s rights” most personally and directly: Certified Nursing Assistants.

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This work could never have been completed without the encouragement and assistance of many people, and I wish there were space to acknowledge each by name.

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I would also like to thank thesis committee members Dr. Elizabeth Rankin and Mary DiBartolo for their forbearance and for their incisive suggestions. I hope that they will be pleased to see how their thoughtful comments were taken to heart and have improved the final product.

For the Certified Nursing Assistants who have inspired me in various workplaces and whose participation enlivened this study, I am extremely grateful.

For my husband Johnny, who supported me with endless patience and humor, and with faint hope of ever seeing this project reach its conclusion, I am thankful.

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CHAPTER I

The Problem

The 20th century has seen the emergence of the field of bioethics, the recognition of universal principles to guide decision making, in response to the proliferation of new medical technologies that seem to offer the power to transform, extend, and even create human life. One fundamental ethical principle, “respect for persons,” states that individuals should be treated as autonomous agents and that persons with diminished autonomy should be entitled to protection. The ability of an individual to exert control over his own life appears to be an intrinsic human need and in fact comprises one definition of what it means to be human.

For the profession of nursing, advocating patient autonomy has always been an important goal and one which presents many complex and challenging aspects (Castellucci, 1998). In caring for persons with reduced capabilities, nurses may recognize inequalities of power and inevitable conflicts between their goals and decisions and those of their clients. In acute care settings such as hospitals, these conflicts are easily managed because acute problems are generally well defined and reversible and the goals of the caregiver and client are easily determined and agreed upon.

For the institutionalized elderly, however, respecting choice and autonomy is more challenging. The problems of the elderly are frequently not curable and generally involve social and emotional as well as physical dimensions. While the issue of autonomy may be more complicated when it pertains to the elderly, it is also an issue of

greater importance, because the extent to which it is encouraged or denied may determine whether aging is considered successful.

The human need for autonomy is challenged by the very factors that contribute to an elderly person's admission to the long term care environment. Each individual admitted into institutional life has been brought there by loss: the death of a spouse, the loss of social supports, the loss of health or physical function, and the loss of competence or ability to maintain a home. With each of these traumatic losses, the realm in which control over one's own life and environment may be exercised is further diminished. The residents of long term care institutions are thus vulnerable to depression and a sense of loss of control even before entering the facilities (Ryden et al., 1999). This disorienting experience has been compared to that of homelessness (Insley, 1999).

The institutional community that these elderly people join is itself a factor that reinforces this debilitating sense of loss of control. Admission processes may seem to probe and remove the semblance of a private identity, transforming an individual with a rich personal history to a patient largely identified by a medical diagnosis (Lidz & Arnold, 1990). A new resident may be randomly assigned to share a room with a total stranger. Space limitations may limit the addition of personal possessions which may signify "identity" and "home." This unfamiliar setting has its own rules and culture, and is peopled by inhabitants who may be unlike any the new resident has ever encountered. The institutional routines already in place and the uniformed and authoritative staff may prove daunting to a vulnerable and solitary newcomer (Gerber, 1995). Chronic staff shortages impose limitations on the abilities of staff to offer choices or to implement the choices that a resident may voice. The need to comply with the standards of multiple

certifying and reimbursing agencies may further contribute to the sense that the nursing home is a decision-free environment. The individual learns to recognize a hierarchy of authority, and must ask permission for even routine activities. The long term care environment has much in common with prisons, mental institutions, military training schools, and other “total institutions” whose purposes are served by limiting individuality and autonomy (Thomas, 1996).

Thus, admission to a nursing home occurs as an elderly person is relinquishing independence, home, mobility, and other privileges of full adulthood and brings the person into an environment that compounds this sense of loss of control and autonomy. At the end of the twentieth century, there is recognition and concern for the need for special protection of autonomy for the institutionalized elderly. But there are also demographic trends, health care trends, and financial considerations which complicate and limit society’s ability to support the elderly person’s right to autonomy.

An emerging awareness of how basic human rights for institutionalized elderly might be compromised has led to a consideration of the issues in recent years and to legislation to ensure protection of these rights. First, the Omnibus Reconciliation Act of 1987 (OBRA 1987) linked Medicaid reimbursement to a demonstrated accommodation of residents’ right to dignified and respectful treatment, responsiveness to individual needs, consideration of personal interests, and the right to be a decision maker. The Patient Self Determination Act of 1990 (OBRA 1990) further required that nursing home residents be given choices regarding their care and be informed that their right to make decisions would be supported. This act required hospitals, nursing homes, and hospice agencies to advise clients and their families at the time of admission of their right to

accept or decline treatment, to execute advance directives, and to retain their basic civil rights. Further, these agencies were mandated to document this communication in the medical record. By the end of the 1990s, Joint Commission Accreditation standards reinforced the intent of patients' rights legislation by including an emphasis on demonstrated respect for patient rights in survey processes.

The 21st century will bring unprecedented numbers of elderly Americans into long term care as the "boomer" generation ages. While the number of Americans aged 65 and older is projected to increase 13.5 percent between 2000 and 2010, a decrease of 1.2 percent in the number of those aged 18 – 44 is projected for the same period (U.S. Census Bureau, 1999). Smaller family size, more two-career families, and increased mobility have all reduced the number of caregivers available to help the elderly remain in their own homes or with their own families. Feeding tubes, new medications, and dialysis have turned previously fatal conditions into merely chronic ones. These advances that add years to lives may also take care-giving beyond the ability of families to manage at home. As a result, long term care is the fastest growing segment of health care. Those surviving to age 65 have at least a 25 percent chance of living in a nursing home (Kincade Norburn, Nettles-Carlson, Soltys, Read, & Pickard, 1995). While in most cultures families naturally provide culturally sensitive, individualized care to their own elderly members, long term care institutions will be relied upon to fill the void created by changes in American society.

Health care reform, with its emphasis on controlling costs, has imposed its own pressures on long term care. The Balanced Budget Act of 1997 has restricted reimbursements on a system already stressed by managed care changes

(Aaron & Reischauer, 1998; Weinberg, 1998; Simpson, 2000). Agencies have attempted to manage costs by reducing nursing labor costs as much as safety allows. Some common strategies have included minimizing staff, reducing the numbers of licensed and professional nurses, and relying more upon unlicensed assistive personnel to provide care to the elderly.

Thus, long term care institutions today face the daunting task of caring for greater numbers of the elderly with increasingly complex problems, with more attention to accommodation of autonomy for less reimbursement. In this stressed environment, the role of the Certified Nursing Assistant (CNA) assumes tremendous importance. CNAs are used as an inexpensive labor source to supplement the work of professional nurses in long term care.

CNAs typically provide most of the daily care and most of the interpersonal interactions of the elderly in long term care. CNAs might be considered “the least of these” in the hierarchy of nursing home staff, at least in terms of compensation and status. Nevertheless, they wield considerable influence and power in the arrangement of the daily lives of residents because it is in the realm of daily living that residents most experience choice (Tolley, 1997). It is important to realize that in reality, the work of CNAs includes caring not only for bodies but also for the minds and spirits of those in their care; there is an expectation that they will serve as a suitable substitute for residents’ own families (Tulloch, 1990). Their job training and job descriptions might lead them to expect that their role is limited to providing simple assistance with routine activities of daily living and physical care. Within their role, however, is the capacity for instilling hope, restoring independence and autonomy, and protecting self-esteem and

integrity. It is essential that these important features of the CNA role be examined, appreciated, and supported by the best efforts of the nursing profession.

Purpose of the Study

It is the purpose of this study to explore the concept of autonomy from the perspective of Certified Nursing Assistants employed in a variety of long term care settings serving the elderly. Since their role in promoting autonomy for the residents of long term care agencies can be significant, it is important to discover how they view their role. Professional nurses who are charged with educating CNAs must understand the genuine issues CNAs face in the workplace in order to provide experiences and strategies that prepare them for reality. Professional nurses who have the responsibility for delegating work to CNAs must understand the barriers CNAs will face in their efforts to promote the exercise of autonomy within the constraints of an institution with many rules but limited staff and resources. Those who are accountable for the quality of life for elderly residents in long term care should be attentive to the issues which necessarily arise in this environment to undermine the basic human right of self-determination.

This study proposes to provide an opportunity for CNAs to speak for themselves about their experiences and the promotion of autonomy for the elderly in long term care. These, after all, are the workers “on the front lines,” who interface most directly and most often with the elderly.

Significance of the Study

In spite of the growth of alternate sources of community care for the elderly, such as home health and adult daycare, nursing home placement will undoubtedly continue to increase. As nursing homes become a fact of life in American culture, it is important to

ensure that they are becoming institutions in which people may live out their days with the best support society knows how to provide. This study seeks to support this process of learning how to promote autonomy as part of successful aging within institutions.

There are as many societal pressures impacting the CNA workforce as there are pressures driving the movement of the elderly into institutions. Because the demand for CNAs in nursing homes seems insatiable and because the educational requirements are fairly minimal, training programs for CNAs are often presented as a solution in the current welfare reform movement (Morgan, 1998). The 80 hours of training required for certification can transform an unskilled, minimally educated welfare recipient into an employable CNA quickly and inexpensively. Long term care employment may be the most readily available opportunity for poor women, especially in rural areas. Within the domain of nursing knowledge is the awareness of the need for meaning, satisfaction, and a sense of effectiveness and empowerment in one's work (Beaulieu, Shamian, Donner, & Pringle, 1997). Therefore it seems incumbent on the nursing profession to examine how these important caregivers are prepared for their roles and supported in finding meaning, satisfaction, and a future in their work.

The long term care institution brings together the growing population of our most vulnerable citizens and growing numbers of our most minimally trained, overworked, and underpaid health care workers. The place where these two important groups come together is an important and relevant area for study.

CHAPTER II

Review of the Literature

There has been abundant research in recent decades examining protection of the rights of dependent elderly people in institutions. Literature which explores the concept of autonomy as it particularly relates to the elderly in nursing homes will first be reviewed. Next, this chapter will focus on the large role that CNAs play in the process of promoting autonomy in long term care, and will examine the ways in which CNA training, attitudes, and experiences impact the right to self-determination for the elderly. This literature review will highlight the factors which should be explored from the perspective of CNAs, in order to determine which factors seem most important in encouraging this population of workers to promote autonomy for the elderly and which interventions can best support their efforts? Finally, a conceptual framework for understanding the various factors which influence the process of promoting autonomy will be presented.

Autonomy and the Elderly

The publication of Vladek's Unloving Care: The Nursing Home Tragedy in 1980 helped to expose the scandalous conditions endured by the elderly in many nursing homes at the time. This landmark study led to an examination of public policy, a prolonged public exploration of threats to the rights of institutionalized elderly, and eventually to legislation designed to protect these rights.

Legislating protection of the right to autonomy for nursing home residents and actually ensuring this right in daily nursing home life may be two entirely different matters. The difficulty of supporting autonomy does not necessarily reflect on the

intentions of caregivers, but may arise from the complexity of caring for individuals with physical and cognitive disabilities without controlling them. Hofland (1990) described the delicate task caregivers of the elderly face in long term care as they balance one ethical principle against another. For example, the protection of an individual's right to autonomy must be weighed by careful consideration of the rights of other residents (justice), the need to protect an individual from harmful choices (beneficence), and the fact that respect for autonomy risks justifying benign neglect or abandonment (non-maleficence). Thus, autonomy must be recognized as only one value among many. At times over-riding an elderly person's expressed choices may be ethically justified.

Collopy (1990) described the various challenges to autonomy that might occur in long term care institutions in terms of six different polarities: 1.) decisional vs. executorial, 2.) competent vs. incapacitated, 3.) authentic vs. inauthentic, 4.) immediate vs. long range, 5.) positive vs. negative, and 6.) direct vs. delegated. The elderly may be capable of articulating their informed decisions, but must frequently rely on others to execute these choices. Those who are charged with assisting the elderly in nursing homes may have difficulty determining whether controversial choices of residents are the result of sound judgment or not, or are to be considered within character or inauthentic. Often caregivers choose to over-ride a resident's choice in order to assure that a greater good or greater freedom will be ultimately achieved; for example, bullying a resident into accepting unwelcome treatments may be justified because doing so will lead to greater health or eventual independence. "Positive autonomy" is described as care that constitutes control, while "negative autonomy" is non-interference that constitutes

neglect. The elderly may for various reasons choose to yield their direct autonomy to trusted others as “delegated autonomy.”

Most ethical decisions concerning autonomy involve tension between the elements of these polarities. These distinctions provide a useful vocabulary for discussing the range of dilemmas faced by caregivers attempting to determine and to serve the best interests of the elderly people for whom they care. When the elderly are cared for by family members, as is traditional in most cultures, caregivers may be guided by intimate knowledge of an individual’s authentic self, values, and best interests. In long term care settings, however, many of these determinations are likely to be made by CNAs who may or may not have the time, ability, or familiarity with the residents to whom they are assigned to determine and support residents’ choices.

Castellucci (1998) discussed four requirements for individual autonomy: free action, authenticity, effective deliberation, and moral reflection. Free action implies that an individual has access to all the information necessary to make decisions without coercion or pressure. Authenticity suggests a consistency between decisions and the values and beliefs and the lifelong patterns of action and thought of the individual. Effective deliberation requires the provision of time and space for careful consideration and introspection, and moral reflection implies a satisfaction with the morality of decisions and with outcomes. These aspects of autonomy are reminiscent of the concept of “integrity,” a developmental stage to be achieved in old age. Erikson (1964) stated that a failure to achieve “integrity” would result in “despair.” Indeed, Castellucci describes much research that demonstrates a clear relationship between perceived loss of control and autonomy in the elderly and increased stress, depression, fatigue, isolation,

and mortality---all symptoms of despair. Elderly people who have been hastily admitted to a nursing home after an abrupt crisis or sudden loss, without adequate provision or time for informed decision making, are at significant risk for despair and its accompanying symptoms. Thoughtful action by nursing home personnel may ameliorate these effects of loss of autonomy.

Attitudes

The importance of CNAs in the lives of nursing home residents can hardly be overstated since they provide 80 to 100 percent of the care residents receive. Many studies, however, have articulated a commonly held assumption that these caregivers are rude, uncaring, and unmotivated, are incapable of delivering compassionate, high quality care, and are uncommitted to their jobs but incapable of securing any other work (Bowers & Becker, 1992). There is concern that negative or stereotyped attitudes towards the elderly would undermine any inclination to view residents as individuals and to expend any effort to assist them in executing their unique choices.

Roop (1987) was among the first researchers to test the relationship between level of nursing training and attitude towards the institutionalized elderly. Comparing attitudes towards the elderly among CNAs, LPNs, and RNs who worked in long term care, Roop found that there was indeed a correlation between lower level of nursing education and less favorable, more stereotyped attitudes towards the elderly, and suggested that the poorer attitudes of CNAs might be related to a knowledge deficit. Exploration of the importance of caregiver attitudes toward the elderly has been repeated by other researchers over time (Bowers & Becker, 1992; Kincade Norburn, Nettles-Carlson, Soltys, Read, & Pickard, 1995; Vance & Davidhizar, 1997). Questions as to whether

CNAs bring *a priori* less favorable attitudes to their work, and whether there are aspects of the work which alter and undermine attitudes over time are still being debated. CNAs who work in long term care may enjoy being associated with the nursing profession and involved in work which benefits others. On the other hand, they may be discouraged by the fact that residents do not generally improve as a result of their efforts and may not express appreciation for their work. In addition, the work may be repetitive, boring, and physically difficult.

In this study, CNAs will be asked to describe their own attitudes toward the elderly and toward their work, and will be asked about their past experiences with elderly people. It is possible that their responses might reveal something of the affective background that CNAs bring to the task of promoting autonomy.

Educational Experiences

There is much research concerning the effectiveness of providing in-service education directly to non-professional health care workers. One rationale for this intervention is provided by the research on “attitude.” If level of educational preparation is a variable that determines attitudes, perhaps the provision of specific gerontological education might improve attitudes and consequently improve the quality of care CNAs provide to the elderly. Examples of specific topics that might be offered as in-service education include normal physiologic changes of aging, developmental stages, and residents’ rights legislation and its impact on nursing home situations.

Brainard and Townsend (1995) conducted such a targeted intervention in a Veterans’ Hospital whose patient population was mostly elderly. Because this federal agency was exempt from OBRA 1987 requirements that nursing assistants be trained and

certified, the researchers assumed that the nurses' aides had never received education specific to the needs of their elderly population. A one-day seminar provided information about cultural stereotypes of aging, demographic trends, physiological and psycho-social changes in aging, and nursing strategies for providing appropriate care. The test instrument was a simple quiz administered before the seminar-intervention, immediately afterwards, and again after two months. As expected, there was a mild but measurable increase in gerontological knowledge on both post-tests.

The truly significant change came in the attitudes of the nursing assistants whose supervisors observed new enthusiasm for their work and increased motivation. The researchers noted that the nursing assistants may have benefited as much from the opportunity to be together to share their experiences, frustrations, and ideas with each other as from the educational experience. The researchers noted:

The job of a NA [nursing assistant] is difficult and routine, and at times boring, and lacking in recognition and opportunities for advancement. Improved self-esteem, job satisfaction, and recognition may come to the nursing assistant through this type of educational experience. This, in turn, may translate into improved patient care for our aging veteran population. (Brainard & Townsend, 1995, p. 40).

Kincade Norburn, Nettles-Carlson, Soltys, Read and Pickard (1995) conducted similar educational seminars for assistive personnel in a nursing home, and emphasized the support group aspect through exercises designed to improve communication and collaboration. Participants were encouraged to brainstorm approaches to problem situations with elderly residents and to suggest ways of supporting staff members who

were bearing the brunt of a difficult interaction. The same serendipitous group effects reported by Brainard and Townsend were noted. In addition, the researchers observed:

These seminars were an important first step toward “empowering” bedside caregivers....The participants often shared feelings and at times the sessions seemed cathartic. Some participants spoke directly of their faith (“This is part of God’s work.”) and their personal motivation for service (“That could be my mother.”), while also expressing frustration about the low pay and physical and emotional exhaustion. We believe that in these seminars participants felt listened to and validated as important people in the lives of the residents. (p. 42).

Kincade Norburn et al. (1995) and Vance and Davidhizar (1997) added affective sensitization experiences to didactic programs offered to CNAs. These interventions included having participants attempt to eat meals while wearing varnished eyeglasses to simulate deteriorating vision, and having them eat pureed foods with fingers splinted and padded with cotton. Participants imagined the experience of loss---common for the elderly---through values assessment and reminiscing. Both groups of researchers reported that their interventions provided support, increased motivation, and fostered empathy. The participating CNAs were enthusiastic and appreciative. CNAs were noticeably more willing to contribute their ideas to the process of care planning in their agencies.

In each of these studies improvement in the attitudes of participating CNAs was observed, regardless of whether the program was purely didactic or involved group support or sensitization experiences. This improvement in attitude was noted to extend to

quality of care and individualization of care planning. It is difficult to determine whether improved attitudes were due to the educational component or to the fact that time and space were provided for participants to talk about their work with each other and develop a sense of teamwork, cooperation, and camaraderie. Some of the issues that this study proposes to address, therefore, are CNA perceptions regarding the value of educational experiences as well as the role of teamwork and group support in helping CNAs foster autonomy and individualized care.

Environmental Factors

Some nurse researchers have questioned whether there are limits to the value of the best supportive, knowledge-based programs for CNAs, given the institutional barriers to autonomy that exist in long term care. Roberto, Wacker, Jewell and Rickard (1997) designed an experiment to determine whether education provided to CNAs in the area of OBRA-mandated residents' rights was effective. The researchers presented eleven scenarios of typical patient's rights dilemmas that might occur in a nursing home to a sample of 145 nursing home staff members.

The researchers found that the majority of participants answered most questions about the cases appropriately. What the researchers did not expect was the participants' frequent noting of a discrepancy between the correct way of dealing with a tricky situation and the way the situation would most likely be handled in the respondent's own institution. This underscores the difficulty of implementing one's knowledge of residents' rights in some nursing home settings.

Roberto et al. (1997) suggest that the constraints of the environment, for example working under a "task-oriented medical model" without access to the rationale behind

specific care plans, may limit CNAs' ability to put what they know about the importance of supporting residents' choices into practice. Additional barriers exist as well: the CNA recognizes that respecting residents' choices means spending extra time with residents to help make and execute choices of attire, activities, meals, etc. But the CNA also knows there might be penalties for falling behind in scheduled work and for not completing assigned tasks.

Bowers and Becker (1992) compared the work practices of newly hired CNAs and experienced CNAs. The new CNAs struggled to organize their work in a way that accommodated the residents' individual preferences. The stress on these workers was great as they tried to provide care within the constraints of considerable workload and limited time. Their adaptive responses, ultimately, were either to quit (which 90 percent of the new CNAs did), or to conform to the work routines observed in their experienced co-workers. Bowers and Becker observed:

More experienced NAs often increased the efficiency of rounds by sequencing patients according to a plan that did not (could not) take account of individual patient needs. The rooms were entered in a patterned sequence, and residents were fed, bathed, and put to bed in a preplanned, predictable order, often regardless of individual preferences. Using this style of organization meant that call lights would not be answered while "rounds" were being conducted. Resident behavior that deviated from the predictable order, such as an unusual request from a resident, was often discounted or ignored... (p. 363)

These adaptations which enabled CNAs in some facilities to simply survive, are certainly counterproductive when viewed through the lens of promoting autonomy for the elderly.

This study, therefore, will ask CNAs to describe factors within the nursing home that may interfere with their ability to promote resident autonomy.

Control and Creativity

Mattiasson and Andersson (1995) devised a complex study which focused on the emotional climate present in long term care settings. Staff in several different nursing homes were asked to rank their facilities in terms of ten different aspects of the quality “creativity” (i.e., challenge, idea support, trust, freedom, playfulness, risk taking, etc.). The participants were then asked to respond to case studies which would measure their experience and judgment concerning patient autonomy. The researchers found that autonomy was more likely to be supported by staff from nursing homes rated most creative and innovative. Mattiasson and Andersson concluded that an institutional environment that allows flexibility and creativity and encourages innovation and problem solving by staff would encourage individualized treatment of residents as well. They acknowledged that their study draws its conclusions from rather indirect measurements, and they encouraged future researchers to continue the investigation using qualitative methods that address the question of how a nursing home resident might express himself within nursing home care.

The concept of the “creative organization” has much in common with “locus of control” as a concept predictive of both staff satisfaction and respect for resident autonomy. CNAs who feel that they have been empowered with discretionary judgment, and who feel that their concerns and observations are valued, may in turn encourage decision making among residents. Beaulieu, Shamian, Donner and Pringle (1997) devised a study that demonstrated that in long term care nurses who were provided

empowerment in the form of opportunity, information, resources, supplies and support would demonstrate a high level of job commitment and job satisfaction. The researchers concluded that “leaders in long term care who wish to increase work effectiveness could do so by modifying the organizational structures rather than trying to change the nurses’ personal characteristics” (p. 36). They suggested many strategies for altering the environment, and suggested that in exchange for providing employees with an empowering work environment, employees would in turn “engage heart and mind in their work.” How pertinent and how important this concept seems in light of the fact that the worker most at risk for burn-out and short job tenure and whose work most directly affects the emotional well-being of the elderly, is the CNA.

These studies suggest that any problems resulting from an increased reliance on rapidly trained unlicensed assistive personnel might be addressed by a consideration of the emotional needs and the emotional climate of these workers. CNAs who are given an opportunity to participate in problem solving may respond well to the challenges of promoting autonomy with enthusiasm and creativity. Therefore, this study will seek an understanding of CNA perceptions regarding the environment in which they work and whether it allows them the satisfaction of empowerment, creativity, and problem solving.

Barriers to Empowerment within the Environment

When Kincade Norburn et al. (1995) planned their educational program for long term care nursing assistants, they did so with the goal of enabling the CNAs to share their direct knowledge of specific residents and needs with the professional staff who planned care. The researchers were astounded by the resistance of the professional staff to the idea of including CNAs in the regular interdisciplinary team meetings where discussions

about planning of care and individual residents occurred. They reported that the existing planning conferences focused on meeting federal regulations and produced computer-generated care plans that allowed no space for the observations and contributions of CNAs. The process in place focused on an interventionist medical model more appropriate for an acute setting than for addressing the daily life issues of the nursing home resident. Eventually, separate planning meetings were initiated which could include CNAs. As a result, useful, individualized, and “radically different” sorts of care plans were generated.

The study of Kincade Norburn et al. (1995) raised questions about the attitudes of professional nurses towards CNAs and the effect these attitudes might have on CNAs. Recent changes in health care will require that professional nurses place more nursing responsibility in the hands of CNAs and rely more upon their judgment. In the past, clinical expertise was the benchmark of good nursing practice, but in long term care the most important skill in the future may be guiding the work of CNAs and structuring the environment so that CNAs can work effectively (Salmond, 1997). Kerfoot (1996) writes that the emerging health care climate requires a “paradigm shift” from old models of totalitarian, top-down leadership to a more collaborative and empowering model. Edwards (1997) however describes the historical difficulty that the professional nurse has experienced in giving up power to the nurses’ aide. In the earliest days of professional nursing, Florence Nightingale worked hard to distinguish the new professional nurse from the untrained and underclass handywoman nurse who had traditionally provided care to the poor, to prisoners, and to the incurable. It has always been in the interest of the profession to maintain this wide and respectable distinction, to retain for itself the

right to perform specific skills and pronounce certain judgments, and to limit the role of the “untrained” nurse to less prestigious, less skilled work.

CNAs today can be seen as heirs of a tradition of withholding the satisfactions of empowerment and respect, yet these are the individuals who care for the greatest number of elderly. Health care reform may pit this innate tendency toward “professionalization” in nursing against an urgent need to expand the capabilities and the role of the CNA.

This study will seek to discover whether CNAs who are working in long term care facilities feel that their direct knowledge of individual residents is valued and solicited by professional nurses. Do supervisors empower CNAs, and does the work environment allow CNAs to experience personal growth and being part of a team? It seems reasonable to expect that if CNAs are provided opportunities to exercise judgement, to experience empowerment and personal growth, and to work collaboratively with other team members then they will in turn provide elderly residents with scope for empowerment, mutual goal setting, and personal growth.

Cultural Practices

The ability of a CNA to deliver respectful and individualized care may be circumscribed by factors larger than her own attitudes, training, or even the work environment. Our American culture imposes certain expectations on the practices of care-giving institutions that may have basis in neither nursing science nor common sense. Nursing home bathing norms and mealtime routines provide examples of how cultural practices may prevent CNAs from treating residents as individuals and accommodating their preferences.

Skewes (1997) wrote that frequent and regular bathing of residents is time-consuming and difficult and is stressful for both resident and caregiver. It is a leading cause of disability for staff, is suspected of contributing to dry skin conditions, and is of exceedingly limited value in maintaining health and well-being in the elderly. Skewes attempted to modify the bathing routine to only every other day in her institution. The standard of a daily bath was so enculturated in the minds of staff members, however, that they felt they were not doing an adequate job if residents were not bathed every day. The families of residents felt they were “not getting what they were paying for” (p. 48). Reimbursement for nursing home care by third-party payers may be linked to the standard of the daily bed bath and the twice-weekly shower or tub-bath regardless of its actual value.

Mealtime routines are an area of similar difficulty. They are established to comply with the standards of regulatory agencies and third party payers. Consequently, mealtimes are stressful for staff and residents and chronic weight loss is a pervasive problem in many nursing homes (Van Ort & Phillips, 1995). Time pressures may compel staff to feed patients who could, if given attention, guidance, and adequate time, feed themselves (Mattiason & Andersson, 1995). Rethinking some of these practices might result in any number of acceptable and beneficial changes which might promote individual autonomy and enable residents to experience self-efficacy and resultant self-esteem. Some strategies are allowing residents to choose food items, portions, and mealtimes, supplying favorite foods, and altering utensils and the environment to facilitate eating. Such changes, however, may be difficult to incorporate into

well-established nursing home routines (Kane, Freeman, Caplan, Aroskar & Urv-Wong, 1990).

In this study, CNAs will be asked to suggest changes to nursing home routines that might improve the lives of elderly residents. Presumably, they would be aware of the existence of many minor institutional barriers to residents' right to self-determination and would be in a position to recommend sensible changes.

Conclusion

Clearly, CNAs who provide physical care and promote autonomy for large numbers of residents in a stressful environment face a daunting if not impossible task. Numerous questions arise. How do they view the challenges that exist in their work? What elements do they identify as most supportive? What barriers to autonomy exist? Do facilities recognize the importance of supporting resident autonomy, and make this responsibility "do-able?" Do CNAs find educational experiences useful in promoting autonomy? What attitudes do they bring to their work? Are they able to find satisfaction in their work, and are they able to see themselves continuing in their jobs in the future? These questions raised by the review of literature will be addressed in this study.

Theoretical Framework

While this study is concerned with the elderly person's experience of loss, particularly the loss of autonomy that accompanies nursing home admission, its focus is on the role of the CNA in promoting autonomy for the elderly person. As a newly admitted resident attempts a restoration of a sense of equilibrium, identity, and self-determination in this strange new environment, the interactions with primary caregivers,

typically CNAs, are pivotal in either restoring and supporting autonomy or enforcing a sense of loss.

King's Systems Interaction Model provides a framework which merges the understanding of an elderly resident's life in a long term care institution with the responsibilities and purposes of nursing care givers. This model is useful in organizing all of the variables that impact the transactions between nursing and clients where these human needs may be either met or thwarted (King, 1981).

King's model provides definitions of nursing, health, the environment, and person. *Nursing* is defined as "goal-oriented nurse-client interactions whereby each perceives the other and the situation, and through communications, they set goals, explore the means to achieve them, agree to the means, and their actions indicate movement toward goal achievement" (King, 1981, p. 13). In a nursing home, professional nurses may not have opportunities for genuine daily interactions and goal setting with residents, but must nevertheless be attentive and responsible for the ways in which CNAs carry out these interactions as "nurse extenders." King (1981) defines *health* as the achievement of maximum potential for daily living and the ability to function in social roles. *Illness* or lack of health would be marked by "a deviation from normal...an imbalance in a person's biological structure...psychological make-up, or a conflict in a person's relationships" (p. 5). In a long term care environment, health may appear different from its manifestation in acute settings since a decline in abilities is a natural and expected part of aging; here, *health* suggests an ability to adapt to such changes without undue distress and to maximize the remaining capacity to function in adult roles. King's definitions of *person* and *environment* refer to each other: a *person* is

“an open system interacting with the environment” and *environment* is “that with which or with whom the person interacts” (p. 10).

King’s “Theory of Goal Attainment” addresses the “significance of patient involvement in the care process as well as in the decision-making process, the importance of collaboration, and the humanity of the nurse-patient encounter” (Meleis, 1991, p. 328). In fact, according to King, the goal of nursing is to enable clients to attain their goals, and the significant nursing problem is non-mutual goal setting. Among King’s explicit assumptions is this: “Incongruities may exist between the goals of health care givers and recipients. Persons have the right to either accept or reject any aspect of health care” (King, 1981, pp. 143-144).

King’s theory is useful in providing a framework for the provision of autonomy within the long term care institution. Obviously it is not applicable to nursing home residents who are comatose or cognitively impaired to the extent that self-determination to any degree is impossible. Mutual goal setting is certainly “the crux of the matter” for nursing home residents experiencing diminishing choices.

King did not develop diagrams to depict the relationships among her central concepts, but her theory suggests and supports the linkages depicted in Figure 1. This model, “Factors Affecting the Outcomes of Interactions between Nursing and Elderly Clients in Nursing Homes,” illustrates the relationships among the different variables which affect goal achievement. It visually brings together CNA factors that serve as barriers or facilitators to autonomy with those resident characteristics that also may hinder or help the resident in his goal attainment. The CNA factors will be further

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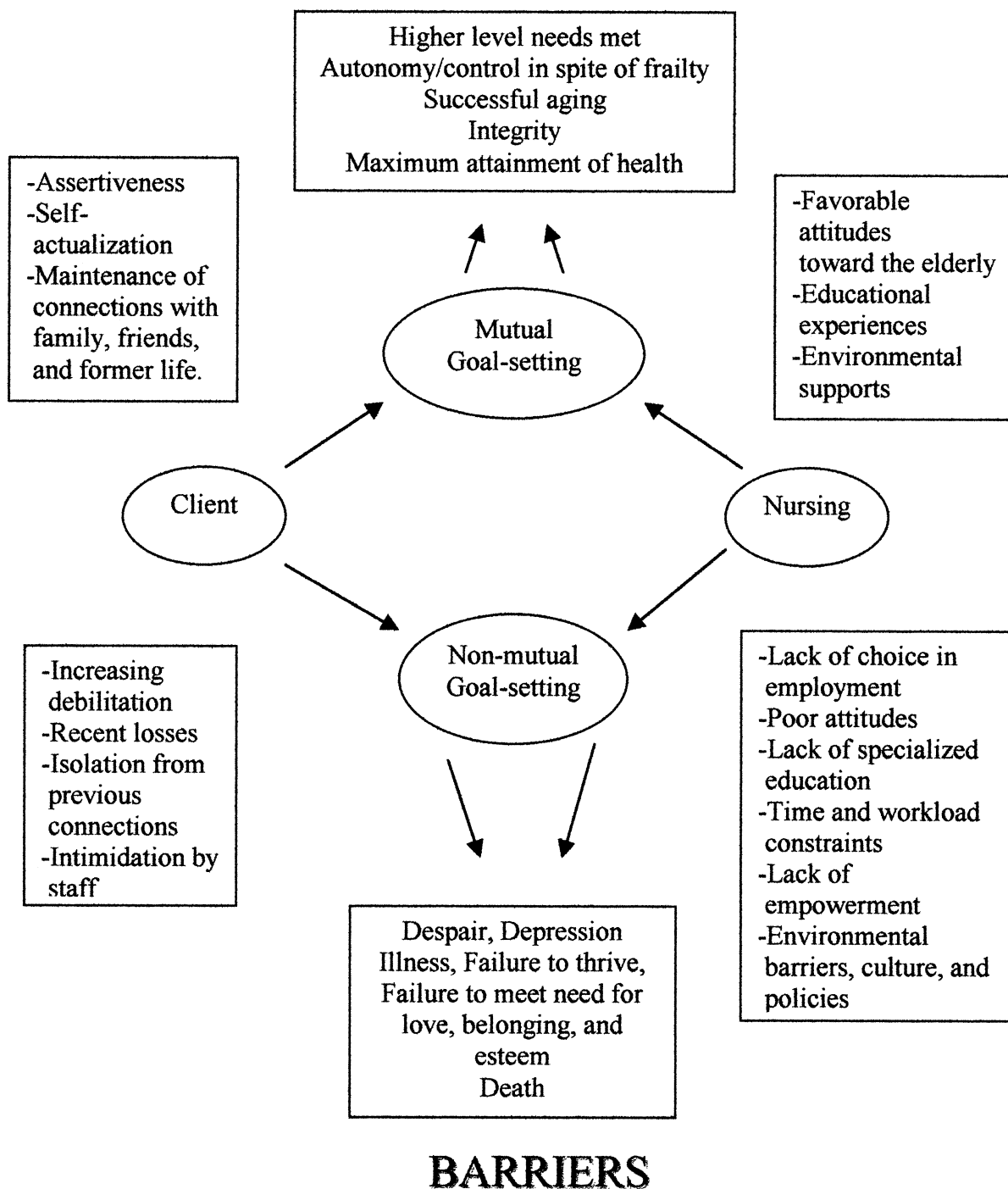


Figure 1. Conceptual model of factors influencing interactions between nursing and elderly clients in long term care.

explored in this study through interviews. The CNA perspective may provide validation for this model or may suggest additional factors operating in the long term care setting.

Research Question

The research question to be explored is “How do CNAs perceive the issue of autonomy for residents in long term care facilities, and how do they describe the factors that facilitate or hinder its promotion?”

Assumptions

1. It is assumed that promoting autonomy is a subjective experience that can be described (Polit & Hungler, 1999, p. 11).
2. It is assumed that in exploring the experience of promoting autonomy, patterns and themes may emerge from the narratives of study participants, from which meanings may be derived and the experience understood (Polit & Hungler, 1999, p. 11).

Definition of Terms

Autonomy: the quality of being self-governing and self-determining, of exercising choice without external coercion; the state in which control of decision making is retained by the individual, who is considered to be a moral agent. Self-determination and autonomy are synonymous.

Certified Nursing Assistant (CNA): health care worker who provides limited nursing care under the direction and supervision of a licensed professional nurse. Nursing activities within the scope of the

practice of CNAs include monitoring vital signs, providing assistance with activities of daily living, and managing the environment in which nursing care is provided. Federal legislation (OBRA 1987) mandates a certification process for these workers, requiring the completion of a standard 80-hour training program and successful completion of a competency exam.

Phenomenology: “An approach to thinking about what the life experiences of people are like...what people experience in regard to some phenomenon and how they interpret those experiences” (Polit & Hungler, 1999, p. 246).

CHAPTER III

Methodology

Research Design

The multiple issues raised by the preliminary review of literature could be contained in one large question posed to CNAs who are charged with promoting autonomy for the elderly, and that question is simply “What is it like?” The simplicity of this question belies the complexity of the interaction between human beings involved in the collaborative process of determining and meeting goals. These individuals, shaped by diverse conditions in a variety of settings, bring to this transaction unique personal histories and experiences which influence their perceptions and purposes. To attempt to measure or objectify this complex transaction would limit an understanding and unnecessarily sacrifice richness and intricacies of meaning. Thus, a qualitative approach was chosen for this study.

An assumption of qualitative research is that the reality of much of human experience is subjective. Many who share an experience will perceive it in different ways, and all of their perceptions represent valid but diverse aspects of the same phenomenon. Language is what makes these varying perceptions real and enables others to comprehend their meaning.

This descriptive, qualitative study seeks to explore the experience in question using phenomenology, an approach which seeks to derive meanings that reflect relatively enduring conditions. To borrow from the vocabulary of the ethnographer, the *emic* (insider’s) perspective is sought. It is hoped that CNAs, provided an opportunity to reflect on different aspects of their work with the elderly, will reveal “essences” of the

lived experience of promoting autonomy for the benefit of those on the outside of that phenomenon. From their descriptions, patterns and themes may emerge to help outsiders understand the CNAs' experiences helping the elderly to retain a sense of autonomy in their lives.

Instrumentation

Instruments used in this study were a Demographic Data Questionnaire (Appendix D) and an Interview Format (Appendix E). The Demographic Data Questionnaire was designed to describe the range of backgrounds of the participants.

The Interview Format instrument contained nine open-ended questions that evolved from a consideration of the literature that was reviewed. The questions were designed to encourage the participants to share their perspectives on the factors that seem to influence the promotion of autonomy. For instance, the first questions attempted to assess the CNAs' attitudes towards the elderly and towards the work of providing care for them. Some questions asked participants to discuss any specific gerontological education they may have received and explore their understanding of the need to support autonomy. Some questions pertained to barriers and facilitators to elderly autonomy within the environment. Other questions explored the concepts of empowerment, creativity, and teamwork as the literature suggested that these factors could affect a CNA's ability or willingness to help residents implement their decisions.

In many ways, this study design departed from the typical method of qualitative research. The questions asked of participants were highly focused; therefore, the study lost some of the flexibility and elasticity that is considered a strength of a qualitative study. The questions were not altered as the study proceeded despite the fact that some

themes achieved saturation fairly readily. Occasionally CNAs would make intriguing statements which might have been profitably pursued but were instead dropped due to time constraints or to minimal relevance to specific questions. The long term care facilities that had offered cooperation for this study had been shown the Interview Format in advance. Because they had been told that the interviews would closely adhere to these questions, it was necessary to leave certain CNA statements unexplored.

This study was also limited by the researcher's intuitive sense that CNAs would be unable or unwilling to be involved in a lengthy interview process; therefore the interviews were relatively brief. There was no expectation of an intense involvement in the interview process for lengthy periods of time, nor was there an expectation of continuing contact with study participants. Questions were limited to what the researcher felt could be addressed in approximately 30 minutes. It was felt that this time limitation would encourage participation. Participants were told that the interview would be limited to these questions but that further elaboration of any responses might be sought. They were informed that they would be free to stop the interview or decline to answer any questions at any time. Participants were asked to review and sign a consent form (Appendix C) which explained the nature of the study and assured protection of confidentiality. This consent form contained information about the study as well as the names and phone numbers of the researcher and thesis chair. A copy of this form was given to each participant to keep.

Participants

The population for this study was a voluntary sample of Certified Nursing Assistants employed in long term care facilities on the Eastern Shore of Virginia. After

the study proposal received the approval of the Committee on Human Research of Salisbury State University (Appendix A), the directors of nursing in the five agencies were contacted and provided information about the proposed study. Three of the nursing directors enthusiastically invited the researcher to make presentations at staff meetings to solicit participants. The other two agencies initially expressed interest, but subsequent resignations of both directors of nursing precluded further involvement in those sites at the time of the study. Cooperating facilities included a large non-profit, Medicare-certified nursing home, a private-pay church-affiliated retirement community (which includes many levels of care including skilled and hospice care), and an in-hospital 13-bed skilled nursing facility.

At staff meetings, the researcher described the background of the study, answered questions, and distributed a sign-up form to the CNAs who were present at each of the three meetings. The CNAs were assured that confidentiality would be protected and that their employment would in no way be affected by their participation. For their participation they were offered a \$5 gift certificate at a local business as compensation for time and inconvenience. The sign-up sheet requested phone numbers as well as “best time to call” so that convenient sites and times for interviews could be arranged.

The results of the sign-up sheet distribution were interesting because they revealed something of the nature of CNA turnover and lifestyle. Only half of those CNAs who voluntarily signed up to participate could be reached at the phone numbers they had listed. One CNA’s phone number became unlisted, one CNA moved away, one CNA worked two different jobs and the researcher’s hope of ever reaching her was eventually extinguished. Of the five CNAs who were eventually interviewed, two had

resigned from their facilities between the time of the presentation and the time an interview could be scheduled.

Procedures

CNAs who expressed a willingness to participate in this study were contacted by phone to arrange a convenient and suitable site for the interviews. Although two directors of nursing had offered the use of private sites within their facilities for interviews, participants invariably preferred alternate sites which included their own homes, the home of the researcher, or the office in the local Hospice agency at which the researcher worked.

When the participant and the researcher met for the scheduled interview, time was taken to establish a sense of privacy, comfort, and rapport. The purpose and the procedures were explained. The consent form and the demographic data form were read carefully and filled out. The interview was then formally begun with the researcher asking prepared questions from the Interview Format (Appendix E). The entire interview was audiotaped. At the conclusion of the interview, each participant was offered the opportunity to add any additional thoughts “for the record.” The researcher explained that the audiotapes would be transcribed and a copy would be mailed to the participant for her approval. Participants were encouraged to make any additions or changes to the transcriptions that they liked.

Each interview and demographic data form was identified only by a number; no other identifying information would link a particular individual with an interview. The signed consent forms and the tapes were to be kept in a locked cabinet. In the transcriptions of the audiotapes, any specifically identifying information was deleted.

The researcher explained to each participant in advance that some of the directors of nursing were interested in the results of the study, but that they would be given only the final report in which selected quotations from participants would be pooled. No administrative personnel in the different facilities were aware of the identity of any of the participants. No participant expressed uncertainty about confidentiality, but several suggested that fear and mistrust might have caused other CNAs to decline to participate. Most of the CNAs were interested in the results of the study and requested that a copy be sent to them. Several expressed appreciation for the chance to talk about their work and stated that they had enjoyed being part of a research study. The two CNAs who had resigned from their jobs in nursing homes voluntarily extended the length of time of the interview to more than an hour; both seemed to use the interview as an opportunity to bring closure to their experiences. One stated that the interview questions were interesting and that the interview was helpful to her; the other CNA expressed the hope that the study might help to bring about change. At the conclusion of the interviews, gift certificates and certificates of appreciation were given to each participant.

Data Analysis

The tape-recorded interviews were transcribed verbatim and recorded in narrative form. A copy of the transcription was mailed to each participant along with a letter of appreciation, which included an additional request to examine the document for accuracy.

Using a word processor, the researcher divided the narratives into text units, each containing a distinct thought about the experience of working with the elderly or supporting patient rights. Initial notes coding each unit were made in the margin of the text. At this point a retired professional nurse with expertise in geriatric nursing and

experience in nursing home administration was asked to read the transcriptions (after signing a confidentiality statement) and to add her own coding suggestions to the text.

The qualitative data analysis computer software program QSR NUD.IST 3.0.4 – Nonnumerical Unstructured Data Indexing, Searching, Theorizing (Richards and Richards, 1995) was used. This program was useful in helping to list the text unit codes and organizing them into broader categories for data indexing.

The transcriptions were returned to the participants for their approval and the researcher assumed that the absence of a reply indicated that the participants found the transcriptions to be accurate and reliable representations of the interviews. On two occasions, the researcher contacted participants in the course of data analysis in order to clarify points made in the interviews and learned that the transcriptions were considered satisfactory. The reading of the transcriptions by the second nurse provided peer debriefing, which helped to establish trustworthiness of both the data and the researcher's interpretations. In some cases, new codes were added as a result of this valuable second opinion. One coded transcription was shared with one of the CNA participants who felt that the codes summarized the statements she had made about her experiences.

The rigor of the methodology of this study, as for any qualitative study, is a matter of some subjectivity. The participants have been described and are considered credible informants regarding the experience of promoting autonomy, since their daily work requires constant immersion in this experience. It is felt that the condition of transferability is satisfied by this study, and that CNAs working with the elderly in a variety of other nursing facilities would recognize commonalities of the experience which participating CNAs described. It must be noted that "elite bias" may be a factor in this

study; the CNAs who volunteered to participate in the study may represent the most articulate, most accessible members of their group. They may bring more positive attitudes towards the elderly and greater commitment to their work than is typical of the CNA population at large, since their demographic data reveals much longer job tenure than what the literature describes. Nevertheless, the themes which they describe are those which would likely be recognized and experienced universally by CNAs who work with the institutionalized elderly. It is hoped that consistency and confirmability are ensured by the audit trail that was established in the course of this study. The trustworthiness of this study may ultimately be confirmed or challenged at a later time, when this study is presented to participants and to administrators in the facilities who expressed an interest in the final results.

CHAPTER IV

Results

This chapter presents the data that were collected during interviews with five CNAs who have provided care to elderly in long term care facilities on the Eastern Shore of Virginia. Demographic data concerning those CNAs who chose to participate in this study are presented for descriptive purposes only. The collected interview data initially yielded 64 codes; these codes led to the recognition of 6 theme categories composed of 12 subcategories with distinct nuances within each subcategory. The theme categories are (1) motivation, (2) environment, (3) resident characteristics, (4) the nursing process, (5) conflict, and (6) patient rights. These categorizations are presented in Table 1. It is hoped that the ordering and the discussion of these codes, sub-categories and categories will convey a sense of the complexity of the world in which CNAs attempt to provide care and support autonomy for elderly people.

Demographic Data

The demographic data collected at each interview are presented in Table 2. CNAs who participated in this study represented diversity in their educational backgrounds, ages, and time spent in long term care. All the participants were female and all were employed by one of the long term care facilities on the Eastern Shore of Virginia. Two of the participants signed up for this study at a staff meeting within their facilities but resigned their positions before the actual interview was conducted. They nevertheless wished to contribute their perspectives to this study.

Table 1

Category themes, subcategories, and codes

Category theme	Subcategory	Codes
Motivation	Extrinsic (11)	salary, praise, gratitude
	Intrinsic (53)	love for elderly, interest in nursing, nurturing role, pride, satisfaction, & uplift, personal connections
Environment	Supportive (18)	teamwork, education, approval from superiors
	Non-supportive (96)	non-support from superiors, broken promises, stressful changes, short staffing, loss of teamwork, burnout, vicious cycle, nature of work, physical difficulty, repetitious, low pay, co-worker conflict, inadequate educational preparation
Resident characteristics	(37)	not in right mind, depressed or experiencing loss, unmotivated or lazy, insisting on rights
Nursing Process	Assessing (75)	compassion and sensitivity, intuition, experience, and knowledge
	Planning (13)	establishing mutual goals, choices
	Implementing (56)	establishing trust, teaching, coaxing, advocating, flexibility, meeting them halfway (doing for them what they would do for themselves if able)
	Evaluating (2)	coming to an agreement about experience

Note. Numbers in parentheses indicate number of participant statements corresponding to subcategories.

Table 1 (continued)

Category themes, subcategories, and codes

Category themes	Subcategories	Codes
Conflict	Strategies (93)	teaching, negotiating, allowing time and space, bending the rules, yielding, using humor, benevolent deception, finding a way, calling in a coworker, relinquishing to the charge nurse, insisting
	Emotions (20)	sadness, detachment
Patients' Rights	Support (19)	fundamental human right, "if in right mind"
	Hassles (15)	practical difficulties, compromise safety, balanced by responsibility

Table 2

Demographic Data

Question	Response	Frequency	Percentage
1. Age	between 31 and 40	3	60%
	between 51 and 60	1	20%
	more than 61 years	1	20%
2. Gender	female	5	100%
3. CNA training	through nursing home program	2	40%
	community college program	2	40%
	“grandfathered in”	1	20%
4. Years in current work setting	between 1 and 3 years	1	20%
	between 9 and 12 years	1	20%
	between 13 and 20 years	2	40%
	other (29 years)	1	20%
5. Years working with elderly	between 2 and 5 years	1	20%
	more than six years	4	80%
6. Formal education	less than a high school diploma	1	20%
	high school graduate	3	60%
	some college	1	20%

Theme categories

Hundreds of significant statements were extracted from the narrative transcriptions and were organized in six main themes: motivation, environment, resident characteristics, nursing process, conflict, and patient rights. The study was limited by the short and intense time planned for the actual interviews. The questions which guided the interview had been formulated directly from issues emerging from a preliminary literature review. Because the interview was so directly guided, the data naturally tended to fall into these themes, rather than being generated by a free ranging exploration by interviewer and participant that may have revealed less expected aspects of the phenomenon of fostering autonomy. Some categories such as *motivation* and *client characteristics* were readily saturated and others, such as *patient rights practical problems and environment* remain to be explored further in future studies.

Motivation

The theme category “Motivation” contained all the text codes which seemed to explain what brought the participant into this sort of work and what was found to be rewarding, enjoyable, and satisfying about the role. This theme provided information about the question of CNA attitudes toward the elderly and towards the job, and was of interest because the preliminary review of the literature suggested that attitudes would influence the sort of care that residents would receive, particularly whether CNAs would make the effort to provide individualized care.

From the data several subcategories of motivators emerged which were *extrinsic* to the actual work of caring for an elderly resident. One CNA stated that the job paid “very, very well” in the setting in which she first began to work, and that her husband had

encouraged her to train for the job because “we needed the money.” This statement is somewhat surprising because CNA wages are generally considered to be minimal, but as a family’s second income the pay may be rewarding and over-time opportunities abound. Several CNAs indicated in different ways that their work rewarded them with praise from their fellow staff members and gratitude from residents and their families. For example, one CNA told how a physical therapist had introduced her to a peer as “one of our valuable CNAs,” and stated that “Well, it made me feel pretty good!” Another CNA stated that “just the patients saying ‘thank you’ means everything, you know.”

Most of the motivation for these participants seemed to be *intrinsic*, that is, rewards are an inherent part of the job of working with the elderly for these CNAs. They described how they enjoyed personal relationships with the elderly that seemed an extension of prior relationships with elderly family members, or filled a void when such relationships were absent. One CNA enjoyed the nurturing aspects of her work, which built on her experiences mothering her own children rather than on her experience relating to family elders. The CNAs expressed respect for the elderly: “There’s a lot of wisdom and just, life’s experience in general that you can learn from them.” All of the participants enjoyed personal connections with both the residents and their family members. “It’s connecting with them also, as another person. That’s important to me.” Many CNAs considered their clients to be friends: “We know they enjoy...interacting with us and having companionship with us. And we sit down and get into their conversation at night. Those we do enjoy.”

Some CNAs were attracted to this work because of a desire to be part of nursing and found that this level of involvement was satisfying. “When I was in high school, I

always wanted to be part of nursing...” was a common statement. The CNAs did not necessarily aspire to go further: “Everybody always tells me, ‘Why don’t you go on a little further, try to become an RN or LPN?’ but I’m just satisfied where I’m at.” They took pride in developing expertise and acquiring knowledge and experience: “I feel I have a lot of expertise. I can really get it done.” One CNA described being a leader among CNAs: “I feel I am an asset to the other CNAs...I go out there and help them; I don’t leave them stranded out there by themselves.”

Most of the CNAs described uplifting aspects of their jobs: “You can’t be in it for the money. It’s more than a job. It’s a calling. It’s a ministry.” They described seeing how their efforts had made a difference to others: “If you can...help somebody do something ten times better than what they think they can do, it enlightens you, it brightens you up then.”

Environment

This large category included all references to elements of the workplace which affected the ability of CNAs to care for the elderly to their own satisfaction. *Environment* includes the other people in the work setting, resources, changes and the nature of the work. Subcategories were *supportive* elements, those which facilitated the promotion of autonomy and other CNA tasks, and *non-supportive* elements, those which were barriers to conscientious work, which interfered with a CNA’s ability to provide appropriate, sensitive, and individualized care.

Supportive elements included teamwork, approval and support from administration, and educational support. Teamwork was the most frequently mentioned

support, and was experienced as both side-by-side collaboration with other CNAs: “on our wing...we always work together as a team. Rarely does anybody go in a room by their self...” and as cooperation and mutual appreciation among all levels of staff: “Used to be, the nurses would thank you personally. At the end of your shift, they’d say, ‘Thank you, girls, for all your help.’ Everybody was in there together..it’s teamwork. With the nurses, with the CNAs, with everybody.” CNAs infrequently mentioned the value of specific continuing education: “we had a lot of inservices and workshops..that teaches you different things, because you really don’t learn all that in school.”

Discussion of *non-supportive* elements yielded many codes and it is doubtful whether data in this subcategory achieved saturation. Stressful changes in health care seem to have an effect on all the features of the environment. CNAs frequently mentioned non-responsiveness and broken promises from superiors as a frustration which had a definite impact on resident care. When CNAs would mention concerns about residents to nurses, they would be frustrated by a lack of response, even when they understood that the nurses worked under significant pressures. For example, “I went right to the nurse with that [patient concern] and I told her and she said, ‘Yeah, uh-huh.’ And that ‘yeah, uh-huh’ was it. That was it. ‘Yeah, uh-huh.’” Many CNAs expressed a weary discouragement by frequent promises of improvements that never occurred: “You feel like you’re being lied to when they tell you that, ‘Oh, we’ve hired five or six new workers and they’ll be here in two weeks.’ Well, the two weeks hasn’t got here yet, and that’s been three years!”

Chronic short staffing was cited as contributing to a vicious cycle of loss of teamwork and increased difficulty for those CNAs who remained on the job. This

element had a clearly stated effect on CNAs ability to deliver care that respected the choices and the right of elderly residents. About a co-worker who had become exhausted by the work, one CNA stated, “I could see a difference in the care she’s giving because she’s just simply tired....I mean, you work five days a week with no help, you have your day off, and the phone rings. ‘Can you come work today?’ That ruins your vacation, that ruins your day off.” One participant described how trying to deliver responsive care to residents in an understaffed unit took its toll: “You find yourself going beyond the boundaries...maybe pulling a muscle yourself, on trying to help them out. You know they’re impatient, by waiting for help. Well, you just don’t have the help.”

Some difficulties are accepted as simply part of the nature of the work: low pay, burnout, and physical difficulty. One of the participants expressed a consciousness that even in supportive environments the work could be overwhelmingly sad and wearying. “...and the next thing you know, you’ll have another resident pass away, and you stop to think....I promised myself that if I ever got to the point that I was so totally unhappy with seeing...then it was time to change careers. Because I don’t feel like I would be offering them any positive aspects. And sometimes it becomes very repetitious too, and that’s discouraging.” Another stated, “I didn’t know what it was doing to me physically, emotionally, and mentally. I’ve been doing this for twenty-some years and it was wearing me down. No. I’m not going back.”

Many comments highlighted the inadequacy of CNA educational preparation in preparing new CNAs for the realities of the workplace, and referred to a lack of practical experience and meaningful clinical time as a cause of high turnover among any newly hired CNAs, whom the respondents regarded as their “lifeline.” One CNA described the

newly certified employees: “A lot of them come and then they don’t stay two or three days. And then they say they were not prepared for this. They didn’t know old people could haul off and knock your head off...the first time they get bit or kicked or punched, that’s the end of it...I think in CNA classes they should be taught that this is what they can expect....Don’t send them through the program and take their money and then they’re not prepared for what they got to face when they come in a nursing home.” When asked whether the CNA students acquired clinical experience in nursing homes, the CNA said, “Well, they *do* go down the hall with us, but they don’t do anything, they just observe. But when it comes down to them doing it, they’re just not prepared....They don’t know a single thing.”

Both the review of literature and the comments of the CNAs who participated in this study indicate that a shortage of well-prepared CNAs leads to short staffing which contributes to a vicious cycle of over-work for those CNAs who remain on the job, who then succumb to exhaustion and burnout. The consequences of inadequate numbers of CNAs clearly affects the ability of institutions to respond to their residents’ need for autonomy.

Resident characteristics

All of the CNAs discussed how the individual characteristics of the residents they served influenced the ways in which the CNAs responded to them. When residents were *not in their right mind*, or confused, the CNAs felt that extra patience and tolerance were called for. Acknowledgment that the elderly were frequently *dealing with loss or depression* evoked compassion: “You think about it. You take them out of their home,

you place them in unfamiliar surroundings, and they just feel useless. They can do but so much, and they know it.” But when clients were *insisting on their rights*, CNAs felt the clients needed an explanation of the reason for a request, which typically was for the resident’s benefit: “If ambulation was the issue, I would constantly reinforce that ‘this is to help you.’” Sometimes such residents were a source of frustration: “They feel like, ‘I can do it because it’s my right. I don’t want to get out of bed, it’s my choice. I don’t have to.’ And we have people like that. We have some strong elderly people sometime. It’s hard to work with them.”

Many of the CNAs comments described residents who appeared to be *unmotivated, lazy, or giving up*. These residents were a source of concern, and the response of the CNAs was to seek reasons for the behaviors and to provide encouragement and motivation, for example, “[We had] this big woman...we were practically lifting her...she wouldn’t even turn herself over. We thought it was just laziness. Well, they changed her medicine. I think what it was with her was depression, basically. They changed her medicine and a couple or three days she was like a new person.”

The nursing process

This is an extremely broad category that describes the “how” of the CNA experience in transactions with elderly residents. Subcategories are composed of *assessing, planning, implementing, and evaluating*---aspects of providing care which are part of the vocabulary of all nurses.

In *assessing*, CNAs described how they determined the needs and goals of the residents, using *compassion* (sensitivity), *intuitive skills* (listening hard), *experience*, and

actual nursing knowledge of physical problems. Assessing was described as both an intuitive skill and one which years of experience would help to develop. With experience, a CNA could learn to understand even residents' non-verbal communication: "You've got to really pick at the details...sometimes there're underlying issues...that you just can't see on the surface. So they might be upset about something else and just trying to incorporate it into their ambulating or something...you've got to listen and pay attention to what's going on." CNAs recognized their important role in observing changes in residents that nurses may not notice: "If they have a decline, you would be the first to key in on it, because they're more apt to tell you because they see you around so much....They're a little withdrawn to tell the nurse...but where they *would* talk more to me because I'm there all the time with them."

Planning is the process of *offering choices* and *establishing mutual goals*. All of the CNAs were skillful at providing opportunities for the exercise of choice for elderly people: "As far as getting up in the morning, ask them, 'What would you like to wear today?' instead of saying, 'You're going to put this on today.'" Another CNA stated, "There're things you know they can't have, maybe you can kind of like, you know, suggest other things."

The subcategory *implementing* reveals the great variety of ways that CNAs help residents obtain their goals and choices. It includes *establishing trust*, *teaching*, *coaxing and encouraging*, *advocating*, *looking for a way* (persistence, flexibility, and creativity), and *meeting them halfway* (stepping in the gap, doing for residents what they would do for themselves if they were able). As CNAs and clients became more familiar with each other, comfortable and mutually agreeable patterns of behavior were established which

appeared to work for both people. For example, one CNA described her approach to helping residents get started in the morning: “There are some others...that you might really have to coax them out of bed, and just sit down and talk to them...and help them get oriented....Some of them, you can say a little joke or something right off the bat and they’ll be more responsive to that than to “this is what we’re going to do now.” The ways that CNAs accomplished their tasks while accommodating their clients preferences and individuality seemed to involve remarkable artfulness, and highlighted the importance of stable, long term relationships in accommodating preferences of the elderly.

Evaluating showed how the CNAs determined whether their interventions were satisfactory to their elderly clients. Numbers of statements which exemplified this subcategory were limited, perhaps because long term relationships with clients did not require the same level of evaluation as in short term settings. The following is an example of one CNA’s conscientious effort to make certain that her interventions were satisfactory to her clients: “And I do let them know that if they ever do have a problem with me to please let me know, and then I will go ahead and make sure I change it in some way and make it better for them.”

Conflicts

Participants described a variety of situations which led to conflict with residents. These conflicts invariably involved an ethical conflict between competing values. Sometimes safety for residents would be compromised, sometimes there was conflict over the necessity of following rules or therapeutic recommendations. Participants expressed the belief that there is always a way to arrive at a mutually agreeable solution

to conflicts, and they described many *strategies*: *teaching, negotiating, allowing time and space, bending the rules, yielding, using humor, "benevolent deception," finding a way, relinquishing the situation to a co-worker or superior*, and, when necessary, *insisting*. Generally, careful communication resolved conflicts: "As long as you explain to them, and treat them like adults, you'd be amazed, most of the time they do understand and you really don't have too much of a conflict. Explanation is a good key, and communicating."

When difficulties arose, CNAs justified the use of pragmatic but ethically questionable responses when the outcome was resident satisfaction: "A lot of times you have to turn your head for things like, if they're forbidden to have salt...and the first thing they'll ask for is salt, and you may go out of your way to find just maybe a little package of salt and that little pack will go a long way and means a lot to them." *Benevolent deception* involved putting off the request of a confused patient: "'Okay, Ma'am, but we won't be able to carry you today. We'll see about tomorrow.' And probably it won't be on their minds tomorrow." One CNA described an elaborate deception in her facility designed to distract a confused resident from the hope that waiting cars would take her on outings: She was taken to windows that had been "disguised" to look rainy, and told, "Oh, man, you don't want to go out there. It's raining out there, it's cold out there..."

For resolving conflicts teamwork was an extremely useful resource. CNAs recognized that cognitively impaired residents might be satisfied by another CNA when the efforts of the assigned CNA were rejected: "She may listen to me for an hour, then I come back to her in the next 15 minutes, she don't want to hear anything I have to say. She may listen to the next person." When difficult situations arose, CNAs could always

call upon the nurses to assume responsibility or provide guidance: “Go to the charge nurse, pass it on to her. That’s what we’re told to do.”

Insistence was necessary when safety was compromised, and also when resident choices were irresponsible or affected the community in a negative way. This insistence upon holding residents accountable for responsible behavior may seem coercive, but in a certain sense it can be interpreted as upholding the resident’s adult status as a responsible member of the community. In other words, with residents’ rights go responsibilities. One CNA described her response when a resident was overheard discussing the confidential circumstances of other residents with friends over the phone: “So I tried to explain to her on the next occasion that those people have rights also....Because like I say, ‘Think about if the role was reversed and it was you and you wouldn’t want anybody to know what you was going through...and somebody came in and invaded your privacy.’ And she kind of got thinking about it.”

Occasionally when they reached the limits of their ability to work out solutions, CNAs revealed that they experienced powerful emotions of *regret* or *sadness*. An awareness of the enormous losses that elderly clients may have experienced and an awareness of the limitations of institutions to meet human needs was acknowledged: “I know that they need a lot of caring like love and attention. Sometimes we’re not able to give all that.” At other times, the CNAs strongly sympathized with their clients, and were torn by conflicting demands of promoting autonomy and acting with beneficence: “I said, ‘I don’t like getting Mr. ___ up because he’s contracted and he don’t want to get up.’ And [the nurse] said, ‘Well, that’s the doctor’s order and we have to do this.’ I said, ‘But it’s hard for me. I don’t like to do this. The man’s in pain and it bothers me.’”

Residents' rights

Most CNAs expressed a belief that residing in a long term care facility did not limit a person's civil rights or the right to make decisions in his own best interests. Every participant stated in effect, that "To me, [resident rights mean] the same rights as everyone else has, you know. Just because they're old, don't neglect their rights....They might not have their right mind, but their rights are basically the same." These CNAs shared a basic assumption was that their job included ensuring that residents' rights were respected.

Some CNAs have found that recent residents rights legislation has led to policies that have resulted in a proliferation of *hassles* for staff, absurdities, and actual threats to resident safety. While a belief in residents rights is unquestionable, considerable doubt exists about the wisdom of some resident rights regulations. The CNAs provided examples of the unintended consequences of regulations designed to reduce the use of restraints, including protective rails on beds: "Because of 'patients' rights' they have the right to fall out of bed and break a hip when it could be prevented. For CNAs that's the biggest gripe. Not that we want them restricted...we don't want to tie them down. But you've got somebody who doesn't know the bed perimeters...you can't even put a rail on the bed to keep them from falling out of the bed?" While bed rails can be used if responsible family members provide written permission, apparently it is uncommon for the nursing home to procure this permission. Instead, other measures are used in an attempt to prevent injury to resident at risk for falls: "They've put mattresses down on the floor so we can break our necks stepping on them to wait on the patient. Have you ever tried working on somebody with a mattress on the floor?"

Another area of difficulty is a patients' rights policy that prohibits making room changes for residents without first obtaining documented permission from responsible family members for all residents involved. Formerly this was a matter within the purview of CNAs. When a conflict between residents was observed, CNAs could accomplish room changes without difficulty. "Now then, 'patients' rights' have stepped in and you have to get this family member and another family member and the responsible party to all agree that they can be moved to another room. And the nurses aren't going through all that hassle. So they stay where they're at. But that was one little hands-on thing that we used to be able to accomplish, was that we could pair people up that got along. And you shouldn't have to live with somebody that you're not compatible with." In some ways, these regulations limit the ability of CNAs to make judgments and carry out actions for the benefit of residents. They limit the power of CNAs to respond to the individual needs they observe among residents

The OBRA 1990 requirement that newly admitted residents to long term care be informed of their rights has had another unintended consequence for CNAs. Cognitively impaired residents may appeal to these rights as an excuse for anti-social behaviors. As one CNA stated, "Residents' rights! They can know that by heart! They know 'residents' rights' by heart!... 'Well, I know my rights, and my rights is that I can sleep in my clothes if I want to.'" Residents' refusals to be changed out of wet or soiled clothes, to participate in therapeutic activities, or to assume responsibility for their own actions create ethical conflicts for CNAs, who are responsible for finding the way to respect autonomy while practicing beneficence and maintaining a safe, healthful environment for other residents.

This chapter has summarized the themes that resulted from the interviews with CNAs who shared many experiences and thoughts concerning the promotion of autonomy for the elderly in long term care. A more complete list of CNA statements which exemplify each subcategory is found in Appendix F.

CHAPTER V

Discussion

The Certified Nursing Assistants who participated in this study showed that their work involves creativity, resourcefulness, continual adaptation, fulfillment, and genuine caring. The “conceptual model of factors influencing interactions between nursing and elderly clients in long term care” (Figure 1) had predicted mention of barriers to autonomy in the form of poor attitudes toward the elderly, ignorance of special needs, and resentment derived from low status, limited opportunity and low pay. However, none of these negative themes could be extracted from the data generated by these participants.

Attitudes

The CNAs in this study seemed to have remarkably positive attitudes about their work and about elderly people in general. They indicated that their work with the elderly was a source of interest, pride and satisfaction. A participant’s description of the CNA role as “a calling, a ministry” highlighted the fact that this role incorporates emotional and spiritual dimensions as well as physical ones. It has been suggested that the CNAs face an impossible task when expected to meet the needs of residents in all three dimensions (Bowers & Becker, 1992). As part of a “formal group,” CNAs complete a large number of physical tasks as efficiently and economically as possible for extrinsic rewards. CNAs also serve in a “primary group” role, however, and there is an expectation that they will meet emotional needs, motivated by bonds of affection like family members. This combination role may seem impossible, but the CNAs in this

study strove to fulfill it. As one CNA stated, “you got to *make* a little time, especially if you see them getting down and depressed.”

Most germane to this study, all participants expressed an understanding of the importance of expanding the opportunities to exercise choice for elderly people and described the many ways that they were able to do so. They indicated that given adequate time, nearly any difficulty faced in the process of “mutual goal setting” could be surmounted. These positive attitudes seemed to contribute to the often expressed belief that “there is always a way” to support residents’ right to autonomy.

Environment

CNAs in this study described many environmental factors which, when present, facilitated their efforts to help the elderly remain autonomous. They described teamwork, supportive superiors, and educational experiences in the form of inservices, “because you really don’t learn all that in school.”

The CNAs also described many features at work in the long term care environment which interfere with supporting individual autonomy. One was a growing demand for “institutionalized caring” in the form of burgeoning regulations that dictate specific and documentable actions. Another was the legislated mandate for residents’ rights that may pit the value of individual freedom against common sense and safety issues. Yet another was the overwhelming pressure to reduce labor costs imposed by managed care and by health care reform. While the first two elements increased the demands placed on long term care givers, the third element guaranteed that staffing would be held at minimal levels. As several CNAs indicated, this set up a vicious cycle in which the facilities already enduring extreme stress would lose workers to burnout and

exhaustion. As a result, retention of remaining workers would become more difficult and recruitment of new workers, nearly impossible.

According to the CNAs, this stressed environment affected the nursing home resident in many ways. Nurses became less responsive to voiced concerns, CNAs delivered only the basics, the physical needs of residents were treated in an assembly-line manner and emotional needs were met only coincidentally. Because providing individualized care and promoting autonomy are tasks which require the luxury of time, patience, and persistence, these tasks may not receive priority during times of short staffing. In addition, short staffing may undermine those motivating factors that CNAs described as intrinsic to their work. The only CNAs who could realistically be expected to continue in this environment are those whose chief motivation is salary, who are unable to secure employment elsewhere.

The reduced staffing that has accompanied recent health care changes has led to other problems, according to the CNAs. Loss of a stable group of workers has resulted in a loss of teamwork, contributing to loss of camaraderie and loss of mutual support and appreciation. Fewer CNAs in a setting for elderly people mean fewer workers to share heavy physical tasks, which may contribute to neglect of residents' needs and requests. It also reduces the human resources available to resolve conflicts that occur in the processes of mutual goal-setting.

CNAs expressed concern about the unrealistic and inadequate educational preparation of newly hired CNAs. Research has demonstrated that newly hired CNAs, overwhelmed by the difficulty of learning to manage workloads in the long term care setting, may either quit or learn to work in ways that ignore individual resident needs or

preferences (Bowers & Becker, 1992). This failure of CNA educational programs thus contributes directly to high staff-turnover in long term care, and indirectly to the diminishment of autonomy for elderly people.

Resident characteristics

The CNAs in this study discussed the importance of taking into account the differing characteristics of the residents in their care as they went about their work. Residents who were cognitively impaired, or like “a two year old, mentally,” were given much latitude, and when conflicts occurred, were treated with tolerance and accommodation. CNAs also recognized depression and suffering among residents, and responded with sympathy and extra attention. CNAs occasionally had to deal with residents whom they considered lazy, unmotivated, or stubbornly insistent on their “rights.” Unmotivated residents received extra teaching, coaxing, and exhortations to help themselves and reach their potential. Those residents who used “rights” in order to resist complying with routines created ethical dilemmas for the CNAs. They sought to balance respect for autonomy with the principles of beneficence (was the resident’s well-being at risk?) and justice (were other residents or the environment affected by the resident’s behavior?) as they decided whether to yield to the resident’s rights or insist on compliance.

Accounting for individual circumstances and characteristics is a time- and energy-consuming process for CNAs, but it shows a resistance to stereotyped attitudes and is extremely important for promoting autonomy.

The nursing process

When asked how they were able to help old people have their own way, CNAs in

this study revealed the varieties of ways they determined what elderly residents wanted, and how they went about helping them to achieve their goals. In nursing it is often difficult to find the way to assist clients without assuming control. Many of the CNA statements indicated that they recognized the importance of providing only as much support as residents needed to accomplish their goals. At times they offered substantial encouragement and support---to the point of bullying--- recognizing that this would ultimately help residents retain or regain control and independence.

Conflict

Remarkably, the participants in this study felt that all conflicts that arose in the course of trying to assist residents could be resolved in a way that was satisfactory to both resident and CNA. Sometimes a simple intervention such as teaching, negotiating, or talking it out was effective, especially when the CNA pointed out that compliance would ultimately lead to a goal desired by the resident such as getting stronger, becoming more independent, or returning home. Sometimes the CNAs used the slightly unethical tactic of “benevolent deception,” with cognitively impaired residents, making misleading or untruthful statements in order to satisfy those who persistently made unreasonable or impossible requests. Their fabrications seemed to fit in with the resident’s own idea of reality, seemed to provide satisfaction for the moment, and therefore seemed easy to rationalize. In matters perceived to be trivial, CNAs did not hesitate to yield to the choices of residents or even to bend the rules. They were aware that this was one powerful way of helping residents retain their sense of autonomy in spite of losing control in many areas of their lives.

The CNAs described many circumstances in which the wishes of residents were overridden without regret or hesitation. These situations generally involved safety, regulations, or the rights of other residents. The fact that CNAs held residents responsible for appropriate behavior implies that a realm exists in which the elderly---whatever their circumstances or limitations---may still exercise significant choice as moral agents. The strategy of “insisting” also highlights the determination of CNAs to maintain an environment in which civility is practiced and the rights of residents are protected.

Residents’ rights

CNAs unanimously expressed the belief that admission to a nursing home did not at all negate an elderly person’s right to act autonomously. This belief was generally qualified by “if they have their right mind.” Like many ethicists, the CNAs realized that the right to autonomy assumes that a person is competent to make choices of behalf of himself.

CNAs recognized that legislation and regulations designed to protect and promote resident autonomy have had unintended consequences. For example, efforts to reduce the use of restraints have apparently resulted in an increase in injuries for residents. The recent redefining of bedrails as “restraints” has led facilities to develop outrageous strategies to protect confused residents from falls, which makes the work of CNAs much more difficult and puts *them* at risk for injury. The difficulty of arranging for room changes for incompatible residents was also mentioned as a consequence of legislation. These and other recent changes were meant for the protection of residents’ rights. Paradoxically, they instead seem to limit the ability of CNAs to respond to the specific

needs of individual residents. An inability to address individual needs is characteristic of institutions that fail to support autonomy.

Significance

This study was significant because it provided a forum in which CNAs could speak for themselves and share their valuable perspective on a situation of growing concern to the public. The data generated in this study supported the relationships established in the conceptual model. The data also highlighted the factors in the long term care environment that have a negative impact on the promotion of autonomy. Such situations as chronic short-staffing, loss of teamwork, inadequate educational preparation, and the unintended consequences of residents' rights legislation have serious implications for long term care residents .

Implications for nursing

The concerns that CNAs expressed in this study about their workplace environment and the pressures it imposed on their relationships with residents should be closely attended to by nursing administrators and policy makers in long term care. Growing numbers of elderly will depend on the adjustments that might be made to highly stressed system. It is unlikely that funding will ever be adequate to staff institutions to the extent that they actually approximate family settings with family affective bonds and truly individualized care. But what possibilities might mitigate the present situation?

The major strength of the workplace environment cited by CNAs was teamwork when it was present. An absence of teamwork was demoralizing and debilitating. The effects of the absence of teamwork were discernable to family members, visitors, and inspectors alike; obviously residents would experience the effects as well. Its impact on

the ability to provide individualized care and support patient choice is apparent.

Without teamwork, CNAs had difficulty responding in a timely manner to the needs that residents expressed. Without teamwork, a CNA could only rely on her own limited, and possibly inadequate, resources of strength and creativity to meet the diverse needs of elderly residents. Those nurses who help to structure the environment in which CNAs work should give thought to the ways in which teamwork can be fostered and CNAs can be encouraged to help support each other.

Another source of concern that CNAs cited was the lack of realistic educational preparation for newly hired orientees. Typically, professional nurses provide the training and arrange clinical experiences for CNA students. It is suggested that successful working CNAs might be recruited to help provide instruction in practical matters such as how to organize the work, how to negotiate the difficult situations with patients, and how to manage time. It would be worthwhile for nursing administrators and educators to work together to prepare CNAs for the reality of the workplace and to support them once they are there.

Other concerns that this study highlighted were the practical consequences that residents' rights regulations have had in long term care. For example, many nursing facilities are struggling to come up with solutions that both comply with residents' rights regulations and promote resident safety. Placing protective mattresses on the floor around resident beds and even allowing residents to sleep on mattresses placed directly on the floor are ways that nursing homes have attempted to prevent injuries while avoiding the appearance of restraints. Obviously these solutions introduce their own problems for staff and for residents.

CNAs from different nursing facilities indicated that their facilities interpreted the regulations in different ways. For example, one CNA stated that the use of any bedrail was considered a restraint and required substantial documentation as well as written permission from a resident's family. Another facility's policy seemed to state that while the use of four rails on a bed to protect a resident from falls was considered a restraint, the use of two or three rails was not. Since this issue seems so important for both resident safety and resident autonomy, a careful examination and questioning of the intent of the regulation is called for.

Limitations of the Study

This study was limited by the small number of long term care facilities in which the researcher was invited to seek participants. Although data saturation occurred in many categories, the CNAs revealed significant differences in the cultures of their particular facilities and widely varying ways that autonomy might be supported or hindered in each one. CNAs from other facilities on the Eastern Shore would have broadened the range of experiences that were discussed.

This study was further limited by the very focused design of the interview guide, which confined the comments to narrowly defined subjects. A more open-ended instrument might have elicited perspectives on entirely unsuspected CNA concerns.

CNAs who agreed to participate in a study were likely to be CNAs who are confident, successful and articulate. Therefore, a perspective on the less positive and less favorable aspects of the CNA experience was lacking in this study. It is likely that a perception of risk prevented some CNAs from participating and produced guardedness in others. It is also possible that participant responses to questions were influenced by an

awareness of the social desirability of purely favorable, positive remarks concerning the support of autonomy for the elderly.

It is not unlikely that the researcher, by virtue of being an outsider, might have presented a barrier to trusting, candid sharing of experience. The structure of the interviews (the setting, the audiotape equipment, etc.) might also have seemed intimidating and presented a barrier to open communication.

Future Research

In one facility, the researcher was invited to meet with CNAs immediately after a staff meeting in order to describe the proposed study and invite participation. No supervisor was present, and in this small and safe-seeming group setting, the CNAs became engaged in a rather free-wheeling, synergistic (and unfortunately, un-tapeable) discussion of their experiences with resident rights. It would be interesting to use a focus group like this one to generate spontaneous ideas. CNAs who might have found an individual interview too risky or too intensive could contribute freely in a group of their peers.

It would be interesting to further explore the concept of “teamwork” in order to learn more about ways CNAs experience it and the uncomplicated (and inexpensive) ways that institutions might foster it. Acknowledging the fact that much of the work of CNAs cannot be accomplished in the absence of teamwork is an important admission for long term care administration. It would be interesting to explore the perceptions of nursing home administrators regarding the importance of many such CNA concerns.

It would be worthwhile to encourage CNAs to describe the educational experiences that were most helpful in preparing them for success working in a long term

care facility. The critical period of time in which a new CNA is first learning the reality of work in a long term care facility is a time when many decide to quit, and is an area for further exploration. Do successful CNAs feel their educational experience provided useful practical preparation? Can they identify aspects of the orientation process that were helpful? How does the environment support a new CNA? What are the lessons a new CNA learns from her co-workers about the importance of allowing for resident autonomy?

During their interviews CNAs occasionally made statements which could not be explored at the time due to the researcher's determination to keep the interview focused. One such issue emerged when a CNA was asked if she experienced the satisfaction of personal growth in her work. She stated that she did, and then spoke of the potential for growth for residents:

I don't see how there's any personal growth for a person in a long term care facility. I think that once they've reached the point of coming to a long term facility, they basically know that it's just a matter of time before they pass away....There is no growth.

This may be a common perception of those who care for the elderly in nursing homes. One of tenets of nursing is that living involves continuous growth and change and that human beings retain the ability to grow in various ways until death. It would be interesting to learn how those who shape the environment of the elderly in long term care view the possibilities for growth, and how their beliefs influence their practices.

Conclusion

CNAs who participated in this study provided a great deal of insight into the complexity of their role. They are the personnel in long term care who are closest to residents and their decisions and actions determine whether or not residents of nursing homes experience autonomy.

During these interviews CNAs have described many different factors that influence them in this role of promoting autonomy. It is apparent that the hiring of more CNAs in every long term care facility would significantly improve the quality of life for residents. It is clear that short staffing is frequently unavoidable and that it takes an enormous toll on CNAs and residents alike. There are many actions that can be taken to support both new and experienced CNAs in their work that would alleviate many of the pressures in long term care settings.

Perhaps the most important step to be taken to support the rights of elderly people is to provide an environment that is supportive of the CNAs who care for them. When CNAs are given the freedom to experience the satisfactions of decision-making and empowerment, they will in turn maximize these opportunities for the people with whom they work. When supervisors take CNA observations and concerns seriously and treat them with respect, CNAs will in turn respond to elderly residents with attentiveness and respect. And when a system recognizes that this group of workers represents the very heart of caring in long term care facilities and values them accordingly, then perhaps all the elements that support CNAs' ability to promote autonomy for the elderly will be in place.

APPENDIX A:
Committee on Human Research
Statement of Approval



**Statement of Approval
Committee on Human Research**

Date: March 17, 2000

To: Barbara Kellam, Ann Snyder

Title: A View from the Front Lines: Perspectives of Certified Nursing Assistants on Promoting Autonomy among the Elderly in Long Term Care.

The Committee on Human Research has considered the above application and, on the basis of available evidence, records its opinions as follows:

- 1) The rights and welfare of individual volunteers are adequately protected.
- (2) The methods to secure informed consent are fully appropriate and adequately safeguard the rights of the subjects (in the case of minors, consent is obtained from parents or guardians.)
- (3) The investigators are responsible individuals, competent to handle any risks which may be involved, and the potential medical benefits of the investigation fully justify these studies.
- (4) The investigators assume the responsibility of notifying the Committee on Human Volunteers if any changes should develop in the methodology or the protocol on the research project involving a risk to the individual volunteers.

The application is considered to be: ☒ Exempt, ☐ Expedited, ☐ Full Committee provided that no names are used.

Sincerely,

Francis I. Kane
Committee Chair

APPENDIX B:

Letter to Long Term Care Facilities

P.O. Box 215
Franktown, VA 23354
September 30, 1999

Name
Title
Institution
Address

Dear Ms. xxxxxx,

I am enrolled in Salisbury State University's Graduate Nursing Program and am currently involved in planning research for a thesis. My interests are in the field of geriatric nursing, and I am hoping to explore the concept of promoting autonomy for the elderly in long term care. My observation is that CNAs provide the most direct care to the elderly. Their work may at times be repetitive and physically difficult and may in many ways seem unappreciated and unrewarding; nevertheless, the interactions between CNAs and their clients make a profound difference in the quality of life for the elderly in long term care. I've tentatively named my study "A View from the Front Lines: Perspectives of Certified Nursing Assistants Promoting Autonomy among the Elderly in Long Term Care."

This is a qualitative study which proposes to explore the subject of autonomy from the perspective of CNAs. I would like to conduct individual personal interviews with subjects who have been informed of the nature of this investigation and volunteered their participation. The interviews would be audiotaped and would last approximately 30 minutes each. These would be arranged for the convenience of the CNAs, and each CNA would be offered a gift certificate valued at \$5.00 to compensate for her time. A list of proposed open-ended questions is attached for your perusal. It is the nature of an exploratory study to seek further elaboration of some responses, but I would not expect to deviate very far from these questions. In addition, I will request some basic demographic information from each participant, (see attached); like the interview itself, this information will remain confidential. Each interview will be identified by a coded number, and no other information will link a particular interview with an individual. I am seeking participation not only from (your institution) CNAs but also from CNAs from other agencies serving the elderly on the Eastern Shore. This is by no means for comparative purposes but rather to broaden the range of experiences discussed and to make this convenience sample more cross-sectional.

I hope that this study will reveal interesting and common themes in the responses of CNAs. Did their educational experiences emphasize the importance of accommodating the individual preferences of their elderly charges? What factors do they identify in the long term care environment and culture that promote autonomy? What barriers inhibit it? Do CNAs recognize the inherent occasional conflicts between resident's wishes and institutional routines and policies? How do they decide between taking time to allow for individual patient choice and completing work assignments efficiently?

The issues involved in caring for the elderly are important ones for professional nurses who plan care and provide supervision of aides. These issues are interesting and important ones to me. If granted permission to seek interviews with (your institution) CNAs, I would be happy to make a presentation on the subject (the importance of "self-determination" for the elderly) to your staff, I would be pleased to share the results of the study, and I would certainly gratefully acknowledge your assistance!

Most sincerely,

Ann M. Snyder, R.N.
757-442-4118

Enclosures

APPENDIX C:

Consent Form

CONSENT FORM

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In signing this document, I am giving my consent to be interviewed by Ann Snyder, a student at Salisbury State University, under the direction of Dr. Barbara Kellam, Associate Professor, Department of Nursing, Salisbury State University, Salisbury, Maryland. I understand that I will be part of a research study that will focus on the experiences and perceptions of Certified Nursing Assistants working in long term care.

I understand that I will be interviewed in a quiet setting at a time convenient to me. I will be asked some questions about my experiences working with elderly people. The interview will last approximately 20 – 30 minutes and will be audiotaped.

I understand that I was asked to participate in this study because I am employed as a Certified Nursing Assistant at _____, a long term care facility on Virginia's Eastern Shore.

This interview was granted freely. I have been informed that the interview is entirely voluntary and that even after the interview begins, I can refuse to answer any specific questions or decide to terminate the interview at any point. I have been told that my answers to questions will not be given to anyone else. I have also been informed that my participation or non-participation or my refusal to answer questions will have no effect on any aspect of my employment. I have been told that any information that I provide will be kept confidential, that all documents will be identified with code numbers rather than names, and that after the study has been completed, materials will be stored in a locked cabinet for one year before being destroyed. The results of the study may be shared with long term care agencies, but my responses will be pooled with those of other participants to maintain anonymity.

This study will help develop a better understanding of the experiences of Certified Nursing Assistants and factors that might prove helpful to them and to their patients. However, I will receive no direct benefit as a result of participation. As a means of compensating for any fatigue, inconvenience, or monetary costs associated with participating in this study, I have received a gift certificate valued at \$5.00 for granting this interview.

I understand that the results of this research will be given to me if I ask for them and that Ann Snyder is the person to contact if I have any questions about the study or about my rights as a study participant. Mrs. Snyder can be reached through a collect call at (757)442-4118.

Date

Participant's Signature

Interviewer's Signature

This form has been adapted from Nursing Research: Principles and Methods, 5th Ed. By Denise Polit and Bernadette Hunglar, 1995. Philadelphia. J. B. Lippincott and Co., p. 128.

APPENDIX D:
Demographic Data Instrument

DEMOGRAPHIC DATA

1. What is your age?
 - a. less than 20 years
 - b. 21 – 30 years
 - c. 31 – 40 years
 - d. 41 – 50 years
 - e. 51 – 60 years
 - f. more than 61 years
2. What is your gender?
 - a. female
 - b. male
3. How did you receive your training as a Certified Nursing Assistant?
 - a. high school vocational education program
 - b. community college training program
 - c. workplace on-the-job training
 - d. other, please specify _____
4. How many years have you worked in your current work setting?
 - a. less than 1
 - b. 1 – 3
 - c. 4 – 8
 - d. 9 – 12
 - e. 13 – 20
 - f. more than 21 (please specify) _____
5. How many years have you worked in long term care with the elderly?
 - a. less than 1
 - b. 2 - 5
 - c. 6 or more
6. What is the extent of your formal education?
 - a. less than a high school diploma
 - b. high school diploma or G.E.D.
 - c. some college
 - d. college graduate

APPENDIX E:
Interview Format

INTERVIEW FORMAT

1. What made you choose to work with old people in this nursing home? How do you feel about the work you do?
2. How do you feel about old people? Do you think they have any special needs? If so, how did you learn about what these special needs are?
3. Were you ever encouraged to let old people “do for themselves” as much as they can? If so, how was this advice conveyed to you? Why do you think it’s important to let old people make decisions and choices whenever they can?
4. At work, in what ways are you able to help old people have their own way? What are some things that make it hard? If one of the people you are caring for expresses a wish to do something that conflicts slightly with nursing home rules, what do you do? How do you feel when you’re not able to help a resident do something that you know is important to him?
5. What is it at work that encourages you the most to make residents feel good about themselves? How?
6. If you see that a resident needs something that you can’t provide, what do you do about it?
7. How does your work help you experience
creativity? problem solving? personal growth? being a valued
member of the team?
8. Do you plan to be doing the same work in 5 years? Why or why not?
9. What changes would you make to make life better for old people in nursing homes?

APPENDIX F:
Theme categories, subcategories,
and participant statements

Theme Category	Subcategory	Participant Statements
Motivation	Extrinsic	<p>When I first took my training we needed the money and in [] they paid very well. Very, very well.</p> <p>I think it was a physical therapist, he was introducing me...he said, "This is one of our valuable CNAs." Well, it made me feel pretty good.</p> <p>So I would say it benefits you as a person because just the patients saying "Thank you" means everything, you know. "Golly, been thanked!"</p>
	Intrinsic	<p>I always loved being around the elderly. I just love them...just love being around old people, taking care of them.</p> <p>I don't care what kind of energy you may have, when you get to your job, once you see one of those folks, when you walk in, and their face lights up cause they're so used to seeing you it makes you feel good all over.</p> <p>Cause you see, I had never actually been around a lot of old people, cause both sets of my grandparents was dead when I was born, so I missed out on that. And being around them, like you know, it seems like it's making up for it, and I just love being around them.</p> <p>I have a lot of respect for older people. There's a lot of wisdom and just, life's experience in general that you can learn from them.</p> <p>Everybody always tells me, "Why don't you go on a little further, try to become an RN or LPN?" but I'm just satisfied where I'm at.</p> <p>Well, when I was in high school, I always wanted to be part of nursing, not knowing what part I want to do.</p>

Theme Category	Subcategory	Participant Statements
Motivators (continued)	Intrinsic	<p>I guess being a mom, I also feel like I'm nurturing them in some way.</p> <p>I feel I have a lot of expertise. I can really get it done.</p> <p>I think my skills have increased.</p> <p>I feel I am an asset to the other CNAs.</p> <p>I've said, you can't be in it for the money. It's more than a job. It's a calling. It's a ministry.</p> <p>Then you feel good about the point that they've helped enough that they can go back in their home and function for themselves....</p> <p>If you can go along and help somebody do something ten times better than what they think they can do, it enlightens you, it brightens you up then.</p> <p>It's a lot of the family members that come in that you get really close to.</p> <p>And we kinda do little extra things for them cause we know they enjoy...interacting with us and having companionship with us. And we sit down and get into their conversation at night. Those we do enjoy.</p> <p>It's not so much a matter of helping them, it's, I guess, connecting with them also, as another person. That's important to me, and I know that they have something that they can give to me, and I have something that I can give to them...so it's like a partnership.</p> <p>When I come back, it was like, "You were off yesterday, and we missed you."</p>

Theme category	Subcategory	Participant Statements
Environment	Supportive elements (teamwork, approval from superiors, educational support)	<p>But I can say, within our facility we have teamwork. Our teamwork is great. It's great.</p> <p>On our wing...we always work together as a team. Rarely does anybody go in a room by their self. We always go together. If there are three of us working, three would go in a room, maybe there'll be a heavy person and one not. The one does the one not and the other two does the heaviest.... But on the <i>other</i> wings, they won't even help each other.</p> <p>Of course it [teamwork] makes a difference. Families notice the difference, and that's why they always ask if their family member can go to [a particular unit]. Inspectors knew, visitors noticed the difference. Families noticed. Teamwork made the difference.</p> <p>Used to be, the nurses would thank you personally. At the end of your shift, they'd say, "Thank you, girls, for all your help." Everybody was in there together...it's teamwork. With the nurses, with the CNAs, with everybody.</p> <p>You don't have to give a reward or anything, but just say, "I think you did a good job...appreciate what you're doing, Miss." A little appreciation goes a long way.</p> <p>Well, we had a lot of inservices and workshops...that teaches you different things, because you really don't learn all that in school.</p>

Theme category	Subcategory	Participant statements
Environment	Non-supportive (non-responsive superiors, broken promises, stressful change, short-staffing, loss of teamwork, vicious cycle, nature of the job, burnout, low pay, physical difficulty repetitiveness, inadequate preparation, co-worker conflict)	<p>It goes in one ear and out the other...I went right to the nurse with that [patient concern] and I told her and she said, "Yeah, uh huh." And that "yeah, uh huh" was it. That was it. "Yeah, uh huh."</p> <p>And you feel like---and I know this is going on the record---but you feel like you're being lied to when they tell you that, "Oh, we've hired five or six new workers and they'll be here in two weeks." Well, the two weeks hasn't got here yet, and that's been three years!</p> <p>But it's the findings that they find once they get there. Everything that may have been promised to them at first, they don't get that. And that's not an incentive to keep them there. And then they just venture on. I mean, it's like, we were promised this, we didn't get this.</p> <p>We used to have a supervisor who would tell us, "Now if you feel like you're getting to that point, you go to the break room and just take a few minutes to sit down and get yourself straight." But you know what happened. Somebody saw we were sitting down and complained and after a while they wouldn't let us use the break room to take breaks. So is it any wonder when your workers get a little snappy with the patients? Another time we had this administrator who got it in his head that we were socializing among ourselves and wasting time. So the word came down, he didn't want to see us walking down the halls in groups of twos and threes, talking or laughing. He broke that up....</p>

Theme categories	Subcategories	Participant statements
Environment, continued		<p>And they were good nurses, good caring nurses that wouldn't mind pitching in to help you out, but you no longer have them. And then you find yourself dealing with people that's just coming in, not because of the caring, just simply because of a paycheck. And you don't have the team anymore.</p> <p>I mean, they move on to somewhere else, that pays more money. Cause the money is less for all the work that you have to do. A lot of time they expect you to carry your workload on and another person's [in times of short staffing] and you still get your same salary.</p> <p>It's just to get the people in there and then keep them together....one person starts straying because they're doing two peoples' workload and it's not enough money, and then the next person and where you used to have teamwork, you no longer have the team members.</p> <p>And you find yourself going beyond the boundaries,...maybe pulling a muscle yourself, on trying to help them out. You know they're impatient, by waiting for help. Well, you just don't have the help.</p> <p>And one of them,...I could see a difference in the care she's giving because she's just simply tired....I mean, you work five days a week with no help, you have your day off, and the phone rings. "Can you come work today?" That ruins your vacation, that ruins your day off.</p>

Theme categories	Subcategories	Participant statements
Environment, (continued)		<p>And that's what's putting the wear and tear on me. It's just one nurse and myself....for four hours, for [a lot of] people. She's passing all the meds. You've got two-hour turns. And a lot of these are total care people. I mean, it's hard to try to do these turns and to try to, you know, free her up enough from passing meds...to do these turns and it's really hard on you. Then, <i>she</i> may be relieved and go home at seven, another nurse comes on, but that still leaves just me for another four hours. And it's putting wear and tear on you.</p> <p>They have this policy...seven occurrences and you're out the door. Every occurrence is a punishment. You can be sent home for three days. And they have sent people home for three days when we didn't have enough help on the floor.</p> <p>Like, wow. I didn't know what it was doing to me physically, emotionally, and mentally. I've been doing this for twenty some years and it was wearing me down. No. I'm not going back.</p> <p>...and the next thing you know, you'll have another resident passes away, and you stop to think....I promised myself that if I ever got to the point that I was so totally unhappy with seeing...then it was time to change careers. Because I don't feel like I would be offering them any positive aspects. And sometimes it becomes very repetitious too, and that's discouraging.</p>

Theme categories	Subcategories	Participant statements
Environment (continued)	Non-supportive elements	<p>I used to get a lot of flack, if I was in with a resident, just talking...or waiting while they were getting to the end of their conversation and I got rung twice...when I got out of the room, the other CNAs were like, "Where <i>were</i> you?"See, it's not so much pressure coming from the residents, it's pressure coming from the other workers who don't want to spend time....And there's times, too, when I don't want them to be rung. I'm sort of possessive, you know. I want to make sure that I take care of my people and that they're happy and satisfied before I leave my shift.</p> <p>A lot of them come and then they don't stay two or three days. And then they say they were not prepared for this. They didn't know old people could haul off and knock your head off...the first time they get bit or kicked or punched, that's the end of it.... I think in CNA classes they should be taught that this is what they can expect, and then they can choose whether they want to stay in the program or not. Don't send them through the program and take their money and then they're not prepared for what they got to face when they come in a nursing home.</p> <p>[Don't students get practical clinical experience?] Well, they <i>do</i> go down the hall with us, but they don't do anything, they just observe. But when it comes down to them doing it, they're just not prepared.... They don't know a single thing.</p>

Theme categories	Subcategories	Participant statements
Resident characteristics	Not in right mind, depressed, dealing with loss, insisting on rights, unmotivated, lazy, giving up.	Well, most of what we deal with there does not have mind enough to...you know, you're dealing with a two year old child mentally. You know, you're taking care of somebody that's really not there.
		It's times that they may be a little confused at this point in time, and then in the next five minutes they may be starting to make a little sense.
		They're ready to sell her house....She says, "The day my house is sold, I'm no longer dressing myself, I'm no longer walking, I'm no longer feeding myself, I will not do anything for myself." She just made her mind up, that's it....I guess it was a trauma, I mean, to sell your home, but they have to do it, to pay her way there. Medicaid won't kick in until everything you got is gone. So I mean, they have to do it.
		The main concern I have with them, a lot of them are lonely, and they get to the point where...they figure they're unwanted, maybe by family members, or a lot of them don't have a lot of family members left, they may be the only one.
		For one thing,...they lost control of a lot of things that they used to have control of.
		You think about it. You take them out of their home, you place them in unfamiliar surroundings, and they just feel useless. They can do but so much and they know it.
		They feel like, "I can do it because it's my right. I don't want to get out of bed, it's my choice. I don't have to. And we have people like that. We have some strong

Theme categories	Subcategories	Participant statements
Resident characteristics (continued)		<p>elderly people sometime. It's hard to work with them.</p> <p>If ambulation was the issue, I would constantly reinforce that "this is to help you."</p> <p>Some of them just lack motivation. [We had] this big woman...we were practically lifting her,...she wouldn't even turn herself over. We thought it was just laziness. Well, they changed her medicine. I think what it was with her was depression, basically. They changed her medicine and a couple or three days she was like a new person.</p> <p>My biggest struggle ...was that...they didn't have to do cause they were paying for it...I told them the truth. "You realize that if you don't use your body parts...eventually some day you might not have them to use..."</p>
The nursing process	Assessment (compassion, intuition, experience, knowledge)	<p>It's like a built in instinct. Cause you also note their body signs. And verbally listen. Listen very hard.</p> <p>It takes years to...mull it out, on how to approach your patient....It's not there right off the bat....I can honestly tell you that I was very uncomfortable probably for the first good year that I was a CNA, only because I was very unsure of myself.</p> <p>I've always found that most of the time when they didn't want to do, there is a reason. The only other time that I would run into something like that is if ...something was medically wrong.</p>

Theme category	Subcategory	Participant statements
Nursing process (continued)	Assessment	<p>You've got to really pick at the details... sometimes there're underlying issues... that you just can't see on the surface. So they might be upset about something else and just trying to incorporate it into their ambulating or something...you've got to listen and pay attention to what's going on.</p> <p>And if they have a decline, you would be the first to key in on it, because they're more apt to tell you because they see you around so much. If you say, "I notice you're not doing this today..." and they'll say, "Well, I really don't feel that well today." And if I was to say, "Well, I'll go get the nurse..." it would be like, "No, don't bother <i>her</i>." They're a little withdrawn to tell the nurse...but where they would talk more to me because I'm there all the time with them.</p> <p>Especially with a stroke person, you have to watch them how they eat, how they swallow, and really, how they're chewing....</p> <p>But if I notice...it continues into the next day then it's time to go and probe a little bit further. "Are you not feeling well? Did something happen...?"</p>
	Planning	<p>As far as getting up in the morning, ask them, "What would you like to wear today?" instead of saying, "You're going to put this on today."</p> <p>"Get up for lunch, and if you don't feel like getting up for supper, we'll let you stay here." We give them a choice like that...and if they don't want to go to the dining room, I guess sometimes we just leave them alone.</p>

Theme category	Subcategory	Participant statements
Nursing process (continued)	Planning	<p>We might not go ahead and settle everything in a five-minute conversation. This might be an ongoing process...to go ahead and come to that mutual agreement.</p> <p>There're things you know they can't have, maybe you can kind of like, you know, suggest other things.</p>
	Implementing (establishing trust, teaching, coaxing and encouraging, advocating, looking for a way, meeting them halfway)	<p>And that usually gives a lot of relief to them, knowing they can go ahead and share with me how they want something done.</p> <p>A lot of them may have...an outside friend that comes in...You know what I'm saying? You see and you don't see. And a lot of them appreciate that, too, that you don't go opening your mouth about what you have seen...Turning your head the other way!</p> <p>Sometimes you have to cue them. You verbally cue them into doing a thing. Keep talking to them...you know, "Mr. So-and-so, you need to eat in order to get strong." And you need to help them some....I begin to talk to them...and then if they feel they don't want to feed themselves, well, I help them get started. I sit beside them to see if they'll eat. And they'll eat. They'll start but then they'll get tired. And when they get tired, I'll pick up the spoon and begin to feed them.</p> <p>There are some others...that you might really have to coax them out of bed, and just sit down and talk to them...and help them get oriented...some of them, you can say a little joke or something right off the bat and they'll be more responsive to that than... "This is what we're going to do now."</p>

Theme category	Subcategory	Participant statements
Nursing process (continued)	Implementing	I have sometimes gone in [to an IDT meeting] and ask about how he's doing and I will figure out the very interest of the patient.
		Sometimes you kind of got to make a little time, especially if you see them getting down and depressed.
		Always...let them do as much as they can for themselves because there's going to come a point in time when they are unable to do anything for themselves, and then that's where you play a big part.
		[About walkers] ...And sometimes they'll say, "Oh yes." Especially if you put a little pouch or something in the front of it. And we find they'll take it.
Conflicts	Evaluating	...they get into the tub of water, and when I take them out and I'll ask them, did they like it. And they say, "It was wonderful. I had no idea it was going to feel like this."
		And I do let them know too that if they ever do have a problem with me to please let me know, and then I will go ahead and make sure I try to change it in some way and make it better for them.
	Strategies (teaching, negotiating, allowing time and space, bending rules, yielding, yielding, humor, "benevolent deception," relinquishing, insisting)	As long as you explain to them, and treat them like adults, you'd be amazed, most of the time they do understand and you really don't have too much of a conflict. Explanation is a good key, and communicating.

Theme category	Subcategory	Participant statements
Conflicts	Strategies	<p>I'd see this lady in the hallway with no cane, no walker, just holding on to the railing, and as soon as she'd see me coming she'd get the biggest smile on her face, because I'd go up to her and I'd say, "Do you know why I'm here?" And she'd say, "Yes!" Then I'd give her a hug...and she was more than cooperative.... "I know I'm not supposed to go...without my walker." And I'd go, "Uh huh!"</p> <p>There's always a way of avoiding conflict and confrontation.</p> <p>And if they're still confrontational towards you, you might ask if somebody else could come in and stay with them and take over, and then come back.</p> <p>So we try to encourage her. I say, "Ms. So-and-so,... would you mind using your walker please?" I say, "This is a nice little thing, ooh, I'd like to have one of these." And sometimes they'll say, "Oh, yes." [But] it don't always work. So you just have to follow them around, make sure...they can't walk but so far in the facility, so we'll just say, "We're going to walk with so-and-so, cause she wants to be up without her walker." So that's fine.</p> <p>But otherwise I would usually back off and let them tell me what they want and how it's going to proceed.</p> <p>And if they absolutely refuse, then yes, I will do it.</p> <p>Making sure they're out for breakfast by 8:00...yeah, I know! I sidestepped those things!</p>

Theme categories	Subcategories	Participant statements
Conflicts		<p>There's always a way of working out everything. Always. It might not be be crossing the "t" actually, the way they would like to have it done, but there's always a way of coming to something that they'd be satisfied with, always.</p> <p>A lot of times you have to turn your head for things like, if they're forbidden to have salt. No salt, no added salt, and the first thing they'll ask for is salt, and you may go out of your way to find just maybe a little package of salt and that little pack will go a long way and means a lot to them.</p> <p>Go to the charge nurse, pass it on to her. That's what we're told to do.</p> <p>Depends on what it is. If it's something that you know got to do with rules and regulations, you automatically take it to the charge nurse. But for most smaller things we can pretty well take care of it ourselves.</p> <p>With an Alzheimer's patient, you don't push an Alzheimer's patient. You just have to kind of go with the flow with them. Go this minute and do it or not do it. And the next minute you can come back and they're fine and let you do it. Why all the hassle when you can just wait a little while, go do somebody else and then come back to them?</p> <p>She may listen to me for an hour then I come back to her in the next 15 minutes, she don't want to hear anything I have to say, she may listen to the next person.</p> <p>We take it to the charge nurse and tell her, "Would it be a problem for her to have it just for today?"</p>

Theme category	Subcategory	Participant statements
Conflict		<p>I go, "Okay." You know, you just have to agree with them. "Okay, ma'am, but we won't be able to carry you today. We'll see about tomorrow." And probably it won't be on their minds tomorrow.</p> <p>We have a lady that likes to go outside...so I tell her, I say, "Oh, man, you don't want to go out there. It's raining out there, it's cold out there. Yes, ma'am, it's raining." So we disguise our windows because every time she sees a car coming and it's waiting for someone, she thinks it's someone coming to pick her up....and every time she looks out, "Ooh, the weather's bad outdoors, Ms. ____, you don't want to go out there."</p> <p>One of our patients loved to smoke. So we used to take them [to another area of the facility used for psychiatric patients]. One particular patient went over there and she had, like, a breach of confidence when she came back. She got on the phone and she told different people she saw this one and she saw that one....So I tried to explain to her on the next occasion that those people have rights also....Because like I say, think about if the role was reversed and it was you and you wouldn't want anybody to know what you was going through...and somebody came in and invaded your privacy. And she kind of got thinking about it.</p> <p>I said, "I'm not going to give you the drink of water until you say 'please.'" "I don't need the water." "Here, take the water." If she had to say "please" she didn't want it. So of course naturally I had to give her the water, but she didn't want to say "please." "I don't have to say 'please' to you."</p>

Theme category	Subcategory	Participant statements
Conflicts	Emotions	<p>“I don’t like getting Mr. ____ up because he’s contracted and he don’t want to get up.” And she said, “Well, that’s the doctor’s order and we have to do this.” I said, “But it’s hard for me. I don’t like to do this. The man’s in pain and it bothers me.”</p> <p>And it’s kind of hard to tell them “Well, the doctor says you can no longer smoke because of your health.” They don’t understand this. And it makes it hard for you, because they’re looking at you as the enemy cause you’re taking the side with the doctor.</p> <p>I know that they need a lot of caring like love and attention. Sometimes we’re not able to give all that.</p> <p>It came my day to have her, and when I went in to her, she says to me, “I don’t understand why God’s letting me live. I’m ready to go. I don’t want to live.... Would you take that chair and hit me over the head real hard and kill me? Nobody would know it, I’d be cold and nobody’d know it.” I said, “Honey, I’d know it.” I flew out of there, I sat down and I cried and I cried and I cried.... That almost did me in.</p> <p>We’re doing all we can.... We do it all week again, and then, [if] they’re really not helping themselves then we have to step in. They need to really do it for themselves, too.... If the therapy they’re getting’s not doing them any good, then there’s no need for them to stay....</p>

Theme category	Subcategory	Participant statements
Residents' rights	Innate right	<p>They have their rights, what they want to do. If they're in their sound mind they have their rights.</p> <p>Let them do the thinking for as long as they can, for themselves. And when they can't speak for themselves, then you step in to help them speak. I think you should let them use their minds as long as they can.</p> <p>To me [resident rights mean] the same rights as everyone else has, you know. Just because they're old, don't neglect their rights. They might not have their right mind, but their rights are basically the same.</p> <p>There's always a way of being able to make sure that you don't take away from their rights....not necessarily conforming with certain distinctive rules or whatever....There is always a way. There's absolutely nothing that can't be worked out.</p> <p>Oh, I'm big on "resident rights." I believe that they have the right to choose, to make decisions, to have control.</p>
	Hassles and practical problems	<p>[The CNA said] "There's no reason that you can't help do something for yourself."....And she reported her for talking to her like it. There's so little you're allowed to say to them at all.</p> <p>I mean, these "patient's rights" things is going overboard....nobody wants to see an old person abused in any way. But the state ties your hands sometimes, that something that's good for them, like a rail on a bed, or a restraint when it's absolutely necessary... But when it's absolutely necessary, we should be allowed to do it.</p>

Theme category	Subcategory	Participant statements
Resident's rights (continued)	Hassles	<p>Now then, "patient's rights" have stepped in and you have to get this family member and another family member and the responsible party to all agree that they can be moved to another room. And the nurses aren't going through all that hassle. So they stay where they're at. But that was one little hands-on thing that we used to be able to accomplish, was that we could pair people up that got along. And you shouldn't have to live with somebody that you're not compatible with.</p> <p>Because of "patient's rights" they have the right to fall out of bed and break a hip when it could be prevented. For CNAs that's the biggest gripe. Not that we want them restricted...we don't want to tie them down. But if you've got somebody who doesn't know the bed perimeters...you can't even put a rail on a bed to keep them from falling out of the bed?</p> <p>We've got five or six that the families have come in there and they have had to document it and they have stressed "<i>I want them to have rails on their bed.</i>" And so, they've got rails....There's very few that have rails. They've put mattresses down on the floor so we can break our necks stepping on them to wait on the patient. Have you ever tried working on somebody with a mattress on the floor?</p> <p>"Resident's Rights!" They can know that by heart! They know "Resident's Rights" by heart!.... "Well, I know my rights, and my rights is that I can sleep in my clothes if I want to"</p>

Theme category	Subcategory	Participant statements
Resident's rights	Hassles/ problems	My biggest struggle with being here was to start off with, that what everybody did or didn't do, they didn't have to do cause they were paying for it....I told them the truth. "You realize that if you don't use your body parts...eventually some day you might not have them to use..." And I'd ask them, "Why don't you want to go ahead and wash your own face?" And they'd say, "Well, I'm paying"....And I'd say, "Well, I agree with you, you are paying. But are you unable to do it today?"

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