Faculty Publications   Social Work, College of

2009

Prevention of Elder Mistreatment in Nursing Homes: Competencies for Direct-Care Staff

Dana DeHart
University of South Carolina - Columbia, dana.dehart@sc.edu

Jennifer Webb

Carol Cornman

Prevention of Elder Mistreatment in Nursing Homes:

Competencies for Direct-Care Staff

Dana DeHart, PhD

Jennifer Webb, MA

Carol Cornman, RN, PA

Abstract

Existing training on elder mistreatment in nursing homes focuses on detection and reporting of abuse, with little training specifically targeted toward prevention of mistreatment before it occurs. We used qualitative interviews with nursing home staff, policymakers, and related professionals to identify training needs. Based on participant accounts, we drafted a number of competencies essential for caregiver training to prevent mistreatment in nursing homes. Competencies include those dealing with: definitions and policies; risks for mistreatment; communication and respect; and development of a cooperative working environment. Competencies are discussed along with illustrative examples, and implications for practice and policy are addressed.

KEYWORDS: elder abuse; elder mistreatment; elder neglect; nursing homes; long-term care; prevention.

Introductory Note

Dr. DeHart is Research Assistant Professor and Ms. Webb is Staff Writer for The Center for Child & Family Studies at the University of South Carolina's College of Social Work. Ms. Cornman is Director of The Office for the Study of Aging at the University of South Carolina's School of Public Health. Please address all correspondence to Dr. DeHart at The Center for Child & Family Studies, College of Social Work, University of South Carolina, Columbia, SC 29208; e-mail: dana.dehart@sc.edu; phone: 803-777-7867.

Introduction

There is growing interest in elder mistreatment in nursing homes and the role that

staffing and staff training may play in prevention of such mistreatment (Allen, Kellett, &

Gruman, 2003; Payne & Fletcher, 2005). There are nearly 17,000 nursing homes in the

United States with a total of 1.6 million residents, and numbers are expected to

quadruple to 6.6 million residents by 2050 (USCB, 2002; U.S. House of Representatives

Committee on Government Reform cited in NCEA, 2006). The direct-care staff who

have the most contact with nursing home residents are certified nursing assistants

(CNAs). Under the supervision of other medical staff, CNAs assist residents with

activities of daily living, such as helping to eat, dress, bathe, and use the toilet. These

jobs typically require a high school diploma and 75 additional hours of training, and are

characterized by low pay, high physical and emotional demands, and limited opportunity

for advancement (USDoL, 2006). The increasing elderly population, financial pressures

on hospitals to discharge patients from short-term care, and high turnover rates among

CNAs render employment in long-term care settings a fast-growing occupation in the

United States (USDoL, 2006). Development of quality training programs for CNAs and

other nursing home staff is thereby an essential aspect of preventing elder abuse and

neglect.

Existing Research on Mistreatment in Facilities

It has been noted that there are no reliable data on the prevalence of abuse or neglect

in nursing homes (Hawes, 2002), but that forms of mistreatment in nursing homes are

analogous to those found in domestic settings, including physical and sexual assault,

neglect, inappropriate restraint, financial abuse, isolation, verbal threats, and subtle mistreatment such as denying personal choice (Nerenberg, 2002). Data on abuse in nursing homes indicate that physical abuse may be the most common type reported (USAoA, 2003), but that unreported abuse may be serious and widespread (Hawes, 2002). Hawes' testimony to the United States Senate Committee on Finance (2002) reviews findings from multiple studies of nursing home residents and staff. Collectively, these data indicate that about half of residents self-report being abused and roughly handled, and about one-third report witnessing abuse of others. The vast majority of residents report experiencing or witnessing neglect. Approximately half of staff self-reported committing psychological or verbal abuse, and 10-17 percent report enacting some form of excessive restraint or physical abuse of residents.

Role of Training in Preventing Mistreatment

The United States Department of Labor's *Occupational Outlook Handbook* (2006) notes that work of nursing aides often involves unpleasant tasks such as changing soiled linens, and that patients cared for may be disoriented, irritable, or uncooperative. Goodridge, Johnston, and Thomson (1996) note that CNAs experience "multiple stressors that underscore the highly interpersonal nature of caregiving" (p.49). These authors found that nursing assistants were, on average, physically assaulted by residents 9.3 times per month and verbally assaulted 11.3 times per month. Among reasons cited by CNAs for frustration in their jobs was lack of knowledge about managing conflict (Braun et al., 1997). It is also possible that CNAs lack understanding

of power differentials, boundaries, and privacy issues that come into play in coping with perceived "problematic" resident behavior (Clough, 1999; Nerenberg, 2002).

Numerous authors have asserted that staff training is key in prevention of elder mistreatment in nursing homes (Hawes, 2002; Joshi & Flaherty, 2005). Aide registry directors, ombudsmen, and CNAs agree that inadequate training is one of the most significant contributors to such mistreatment (Hawes, Blevins & Shanley, 2001). Based on available literature, Nerenberg (2002) posits that training for caregivers might address interpersonal skills, managing difficult situations, problem-solving, cultural issues that affect staff-resident relationships, conflict resolution, stress reduction, information about dementia, and witnessing and reporting abuse.

To date, most existing CNA training on elder mistreatment focuses on detection and mandatory reporting of abuse. Little training focuses specifically on the prevention of elder mistreatment. We have conducted the current study to identify competencies for CNA training to prevent mistreatment from occurring.

Methods

We utilized qualitative personal interviews with nursing home staff, policymakers, and related professionals to identify training needs for elder mistreatment prevention among CNAs. Although an exhaustive sampling of different types of service providers, policymakers, advocates, and investigators was beyond the scope of the project, our sampling was conducted with consideration of the varied "actors" and perspectives involved in elder services. Project staff worked with members of SC's Adult Protection

Coordinating Council—a twenty-two member entity representing public agencies, private organizations, and gubernatorial appointees working in adult protection—for recommendations regarding potential interviewees. We obtained a statewide sample to achieve balance with consideration of factors including individual position descriptions, years of experience on the job, urban/rural locale of work setting, and facility type (e.g., corporate, limited-liability, state-owned, hospital-owned).

Prospective participants were contacted via phone or letter and provided with a brief description of the project; then, interested parties were scheduled for in-person interviews. Several persons opted for phone/email correspondence due to scheduling conflicts. Each participant received IRB-approved informed consent and assurance of confidentiality. Interviews were conducted by the first author, were digitally recorded, and were approximately a half-hour in length. Interview prompts addressed the type of work performed by the interviewee, available training on elder mistreatment, examples of types of mistreatment that occur in nursing homes, perceived motivations for mistreatment, steps that might be taken to prevent mistreatment, types of training needed, and other things that the interviewee felt would help prevent mistreatment in nursing homes. All interviewees were offered a $25 gift card as a thank-you for participation, though some participants declined these due to workplace regulations on accepting such incentives.

Interviewees included several nursing home administrators, a director of nursing, two registered nurses, a licensed practical nurse, nine CNAs, a psychologist, a social worker, several ombudspersons, two regulatory investigators, two law enforcement

officers, and an elder law attorney, all working in or specializing in long-term-care

settings. Fifty-seven percent of interviewees were White and the remainder were African

American. Eighty-eight percent of interviewees were female.

Interview transcripts were analyzed using the ATLAS/ti qualitative-analysis software and

a grounded-theory analytic approach (Strauss, 1987). ATLAS/ti allows the researcher

to mark computerized text passages in a manner akin to underlining text in a book.

Passages can be annotated, tagged with commentary, or labeled with codes (e.g., "

sexual abuse," "stressors," "cultural issues"). The passages, codes, and commentaries

can be sorted into networks and hierarchies, providing a fertile context for identifying

themes and perceiving associations between variables.

Findings

Based on participant accounts, we were able to identify a number of competencies

essential for caregiver training to prevent mistreatment in nursing homes. These might

be generally described as those dealing with: definitions and policies; risks for

mistreatment; communication and respect in relationships with residents; and

development of a cooperative working environment. Each competency is listed below,

along with a brief explanation and illustrative accounts provided by participants in our

study.

Definitions and Policies

Competency: Define and give examples of different types of mistreatment that occur in nursing homes, including neglect and quality of life issues, psychological abuse, physical abuse, financial abuse, and sexual abuse.

Participants gave their impressions of the prevalence and examples of types of abuse. Their accounts imply that CNAs need training on subtle forms of abuse in particular, such as neglect and dignity issues, psychological coercion, rough handling, retaliatory physical abuse, and petty theft.

Participants indicated that, although physical abuse was the most frequently *reported* type of mistreatment, the majority of mistreatment that occurred involved neglect or quality-of-life issues. Examples included caregivers failing to answer call buttons, not changing or turning residents as called for in the care plan, not taking time to feed residents properly, failing to monitor or check on resident well-being, and not putting needed items within reach (e.g., dentures, ice, television remote). Participant accounts illustrate precursors and consequences of such omissions.

> *The feeding issue is always a problem, particularly if they can't feed themselves…it would take an hour to an hour and half to feed [the resident] and not force feed her. Or [the CNA could] just say, "to hell with it" and go to Ensure or put in a stomach tube—a gastric.*

In some nursing homes, pervasive neglect could contribute to overall noise and disorder.

You see the staff outside smoking cigarettes and little old ladies wandering the halls just looking for somebody.

The noise levels—all of it is from people that are repeatedly asking for help or for things that they need and being ignored….They know that they can't ask for it one time and it be delivered to them, so they get into a habit, and the noise level abounds, and the staff just shut it out.

Even seemingly minor omissions could have adverse effects on resident dignity.

I go to take them to an activity or something, and their aide doesn't care about how they look before they're leaving. Like maybe they had a meal, and [the CNA] didn't even bother to take their clothes protector off.

They don't feel respected when their food is cold, their aide is mean, their nurse won't give them their medicine.

Participants felt that psychological abuse was the next most frequent type of mistreatment in nursing homes. This included caregivers cursing at residents, threatening them, teasing or otherwise demeaning residents, withholding food or medicine, and isolating residents or confining them to their rooms. The threats, withholding, and isolation sometimes appeared to be ill-suited attempts to manage behavior perceived by caregivers as problematic.

I had a little lady…crying and she's clearly in pain. She doesn't normally act like this… This lady's clearly in pain and jerking, and [the CNA] just take[s her] sweet

time [telling a nurse that medication is needed], "Well, I'll do it. I'll do it as soon as you be quiet."

They have someone that spits a lot…They just make [the resident] eat in their room, sit in a corner somewhere—especially [residents] that gag and spit. Really, nobody wants to hear that when they eat, but you can't just push them back [into a corner].

Other times, psychological mistreatment was overtly malicious.

[CNAs will tell residents], "Well that's why they brought you here—you're just a mean person." And, "No, they're not coming back to see you."

It would blow you away at what people will do—cut their hair without their permission—just for kicks.

Much of the physical mistreatment described by participants included rough handling during transfers and bathing or retaliatory slapping.

[The CNA] was scrubbing into raw, raw flesh (bedsores). That was abuse.

I know someone who spit food in [a CNA's] face, and before the [CNA] knew what they did, [the CNA] popped them.

I call it reflex abuse when you have a patient who's combative or strikes a staff member, and it's kind of a slap—like, you know, a kindergarten situation where [the CNA] retaliates immediately.

Participants indicated that stealing was the most common type of financial abuse, although financial fraud was perceived to be on the rise.

They steal mostly money and food. Like [the resident's] family might bring them their favorite thing—a Three Musketeers or something…and [the CNA] will take their food.

We had a CNA to steal a check out of sequence out of a checkbook and write the check to herself and cash it.

I've had a poor little lady come to me…They were in her Bible, and they stole her money [out of it]…She had $17, and all she wants to do is come downstairs for bingo, and get a honey bun…That's what she looks forward to on Mondays and Fridays—that high-priced honey bun in that canteen machine. She's prideful that she has that little bit of money to go get her honey bun, and they took her money.

One participant explained how handling one's own personal spending money was a quality-of-life issue for residents.

I tell my residents, "Please, just keep it in the bank until it's time for you to get it." And it's so aggravating, because they don't want to keep going to the little bank down there, "Can I have a dollar? Can I have a dollar?" They want to have a

couple of dollars in their pocket just like they did when they weren't in a nursing

home.

Albeit rare, participants did describe incidents of sexual abuse in nursing homes, including several cases of staff-to-resident sexual assault and sexual taunting of residents by CNAs.

It's fairly common for [female CNAs] to talk to female residents…and tell them explicitly, "Your husband's not dead," or whatever, "I went out with him last night we had sex with him."

Competency: Identify organizational, state, and federal policies around documenting and reporting elder mistreatment in nursing homes.

Although most CNAs receive some basic training on definitions and reporting policies regarding abuse and neglect, reiterating these foundation concepts is an essential component of any comprehensive mistreatment prevention training. In addition, participants emphasized the need to document resident complaints and misunderstandings and incidents of incomplete care.

Always when a resident is picking at you, always report it. Report it to the nurse, make sure they document that, make sure they pass is down from one shift to the next shift….Because it's like your word against her word or him. If you go in there and a resident hits you, you leave—you report it to the nurse. And then you always take somebody in there with you.

Cover your butt with your paperwork so that in case something comes after it, you've documented you've taken care of it and whether or not it changes.

Your staff has to feel comfortable enough to report on their co-workers….It's not tattling, it's your reputation….It's their responsibility to first of all, to protect the patient and second of all, to get someone to pay attention.

Risks for Mistreatment

<u>Competency: Identify workplace contexts (e.g., staffing and oversight) that create a risky climate for mistreatment in nursing homes.</u>

This competency is especially important for administrators and supervisors. Some of the most frequently mentioned contributors to mistreatment risk involved workplace climate. Participants repeatedly mentioned understaffing (i.e., staffing to regulatory minimums) and lack of supervision.

If administration is never seen on the floor, making rounds, continuously during the day, watching to see what's going on, talking with your families, with your patients…that sets up the first hurdle…I think if you're out there and being present, then you are supporting correct behavior and taking care of the negative stuff as it comes up. But if you're in your office, hemmed in with all the things that you know you've gotta take care of everyday, and you're never out there, they know that no one's watching.

Participants also noted that facilities with many cases of mistreatment tended to suffer from a broader array of quality-control issues and were frequently those that lacked corporate oversight.

> *Some of the other facilities…that you knew you had a history [had] not only stacks of complaints about abuse, but complaints about everything else.*

Competency: Identify worker attitudes and behaviors that create a risky climate for mistreatment in nursing homes.

Staff contributors to risk ranged from unintentional rough handling or failure to tailor care to the resident's condition to reflexive or retaliatory aggression to intentional malicious or predatory behavior. Participants hypothesized that motivations included staff "cutting corners" to save time, being burnt-out or desensitized to residents as individuals, carrying stress or inappropriate disciplinary habits from home into the workplace, performing for co-workers, and needing to prove one's own power or control over residents.

Several participants mentioned situations in which caregivers apparently "showed off" for co-workers via mistreatment directed at residents.

> *I think sometimes they get caught up in something that sounds exciting and really don't realize particularly the psychological abuse that it would do to a resident.*

Participants also mentioned situations in which mistreatment stemmed from caregivers' needs to demonstrate control over residents or over other staff. This

sometimes resulted in situations escalating beyond managing behavior and crossed a line into the caregiver relishing upset of the residents.

> *What I found with a lot of staff was not that their initial reaction was all that bad to aggressive behavior on the part of the residents, is that they carried it one step further. They didn't know when to quit once they had it under control.*

> *[A resident threw something] at one of the staff members and hit her, then she ran outside and threw a rock through the staff member's window…At that point [the staff] sort of piled on her to get her under control. Up to that juncture, they were doing okay, but then they proceeded to beat the crap out of [the resident].*

Competency: Identify resources and coping strategies for addressing personal stressors (e.g., financial difficulties, family problems) so that these do not carry over to create mistreatment risk in the workplace.

Many participants mentioned poverty, addiction, and violence in caregivers' own lives as possible sources of mistreatment risk.

> *They could come from home and just been beat up by their boyfriend, and they come in here and are expected to provide proper caregiving to an elder person that doesn't have cognitive capacity. It's a bad situation set-up.*

> *CNAs, if they've got family violence issues at home, they'll bring them to work, if they have financial issues, they'll bring them to work, if they have health issues or if they're single parents…they bring [those sort of issues] to work with them.*

<u>Competency: Identify resident vulnerabilities that increase the risk of their being mistreated.</u>

Given these varied motivations for mistreatment, participant descriptions of victim characteristics touched on diverse factors. Residents who were quiet, disoriented or unable to communicate, or isolated from family support (e.g., fewer visitors) were described as more vulnerable.

> *The less visitation, the more likely the CNAs are not going to see them as real people.*

Conversely, residents who were perceived as noncompliant, combative, rude, demanding, or manipulative were also described as vulnerable.

> *I think what it is, they get tired of the little old lady that comes to the desk constantly…I can see them getting frustrated, especially if it happens day after day after day.*

> *Come into the nursing home, and you will have people that are going to spit, kick, cuss and bite…you need to know that that comes along with the territory.*

> *We all are manipulative to get our needs met, and so that's part of being able to survive in a nursing home. It's not necessarily a bad thing. But you hear that all the time, "Well, that patient's just manipulative."*

Finally, various medical conditions were said to increase risk.

Urinary tract infections…it causes them to be uncomfortable, so then without the ability to express themselves, they may strike out. They may yell out. They may do other things that people misinterpret as aggressive behavior. A lot of times with our diabetics, with fluctuating blood sugars, we will find that there is an exacerbation of behaviors. Psychiatric patients--if you have that situation and you don't have the appropriate medications on board or psychiatric treatment on board, then you've got the potential for abuse.

Communication & Respect in Relationships with Residents

Competency: Identify verbal and nonverbal communication strategies to build rapport with the nursing home resident.

This might include pleasant tone of voice, nonthreatening physical approach, and conversation to build trust. Participants noted that abrupt treatment could be disconcerting to residents.

You want somebody coming in your bedroom, shake the covers back and say, "Time to get up." What's you gonna come up doing? Swinging, yelling, you know what I'm saying?

A lot of them think that you raising your voice at them, that you're gonna kill them. That's their main word, "You gonna kill me." And you just gotta just wait until they get to know you.

You gotta lower your voice, be calm with them and be patient….especially when they don't know you.

Competency: Identify strategies to engage the nursing home resident in his or her own care.

This might include listening and providing choices, talking through procedures with the resident, and addressing resident complaints with the resident and his or her family.

Let them make a choice what they want to eat, what they want to wear…Just don't pick their stuff out. Take them to the closet, let them find out what they want to wear.

A lot times…the nurses or the assistants talk to each other, and the patient is the third party there…[The resident's] whole mood and behaviors are ignored because [the CNAs] are engaged with each other and not with the person.

We have a resident, wouldn't eat breakfast. Nobody would figure why. You know why? 'Cause her daughter said, she never ate breakfast. Duh! Here you've been trying, "Eat, eat, eat, eat, eat." And she's like, "No, no, no, no, no."

If they give you any kind of feedback, just go back and check and make sure that…everything is okay…with that resident. And just basically continue to do like a public-relations type of thing.

<u>Competency: Differentiate appropriate and inappropriate responses to resident behaviors that are perceived as problematic.</u>

Participants noted that mistreatment may arise when workers react poorly to resident behaviors such as noncompliance with care needs, disrespect toward staff, and physical aggression.

> *It's, "If you don't do this, I'm gonna do that" from staff to a patient. "If you don't behave, I'm not gonna come back in here. I'll take your call light away from you."*

> *Some older mens is kind of fresh and sometimes you had an aide that got offended by it and said, "No, I'm not going to take care of him, 'cause he's fresh."*

Examples of appropriate responses include coming back later if a resident does not want to cooperate, offering choices of when or how a bath is given, and asking for help if a resident behaves aggressively.

> *Bathing is always a very traumatic time for a lot of people…the staff may try to verbally, "It's okay, everything's okay." And you hear them talking over the patient. You know, the patient still is afraid and scared and it's not helping them…[The staff] really they needed to stop that and do something else, or back out of that situation and let that patient…calm down and feel safe again.*

> *It gets real sticky as far as what can you do and how far can you go and when do you do it and at what point do you back off. I kind of look at those things when something becomes a danger to someone, then you might have to get a little bit*

more aggressive with making sure the care is done--like you can't have someone sitting in [their own] stool.

[If] we know that this patient is combative and could hurt one of us, they'll give us two aides to manage that patient.

Competency: Identify verbal and nonverbal strategies to reduce conflict and establish safety for staff and residents.

Empathy and active listening on the part of direct-care staff can help residents feel that they have been heard and understood, lessening their frustration or anger.

Someone might be coming out of the kitchen...they'll say, "That meal sucked," and will be cussing about the meal. And instead of a staff member saying, "Oh, I'm sorry you didn't enjoy the meal" or even just to try to de-escalate the situation, you'll have your staff start to say, "Well, you don't have to eat it. You don't have to come here."

[The resident] is in the corner with his cane getting ready to hit somebody....I went up...and I said, "Oh, Mr. So-and-so, sorry you're having a problem. Let me see if I can help work it out for you, come on let's get a soda, sit down and tell me what's wrong." No problem.

Competency: Identify age-related conditions that may impact compliance and strategies for communicating with persons who have diminished capacity.

Participants recognized that CNAs need training about dementia and practical information about daily care for residents with dementia and other age-related conditions.

> *I came in one day, and there was a little man out here with a bucket and a mop…The staff member had come up and then started chastising him…gave him the bucket, for urinating in the corner. [The staff member] was making [the resident] clean it up. And I'm thinking this [staff member] might think that, "Well if he does that, I'll make sure he cleans it up and then that will teach him not to do it again."…Someone's not going to learn not to urinate in the corner. They wouldn't be here anyway if they were able to not urinate in the corner.*

> *[The CNAs] don't understand dementia…"Well, [the resident] knew how to do it yesterday, but they can't do it today so they're just faking it, just to piss me off."*

> *The woman did not respond [to the CNA's instructions], but she was standing on the side where the woman could not hear. In her frustration, she thought the woman was being noncompliant with care so she started trying to physically make her do the things.*

> *The staff needs to know pain, stiffness, seeing/hearing loss and all of the above affects mood and compliance. Depression is a big one for staff to understand.*

Competency: Identify generational issues that impact resident behavior (e.g., racism, expectations regarding social interaction).

Racism, sexism, and cultural and generational differences will become apparent during daily care activities. Direct-care staff must learn to expect these issues and be prepared to respond appropriately.

> *The way some of the residents talk…like when the some of the older White people say "nigger" or some of the Blacks saying "cracker." And some [of the younger CNAs] just don't know how to handle that. But then you have to look back at how [the resident] was raised in their day.*

> *A lot of people that are hired these days don't seem to have a lot of social constraints when it comes to what they say. I'm finding that foul language is just a part of the norm in society, but when you introduce it into an elderly patient's room whose mother would have died if they had said that, it's frightening for them.*

Competency: Describe the inherent power differential between vulnerable adults housed in a nursing facility and the staff working in that facility and implications of this for mistreatment risk.

Staff must understand that residents depend on them for many of their basic needs. This gives staff a great deal of power, which must be used responsibly.

> *One of the basic things that we teach in orientation is, you know, "Well he hit me first, so I was hitting back." That's never acceptable…It's part of your job to take it and walk away. But you're not allowed to fuss, you're not allowed to swear,*

you're not allowed to do anything…other than just trying to catch the arm while it's in motion to defend yourself…I said, "We're smart enough to get out of the way."

Competency: Describe the CNA's role as a customer service provider that assists the nursing home resident in maintaining activities of daily living.

As service providers, CNAs have the responsibility to treat residents with respect.

When I first got here, I was trying to give a cup of coffee to someone…and someone said to me, "Don't do that. They'll now expect it everyday."…Gosh, these people, all they want is a cup of coffee and a cigarette.

[The residents] don't get half of what they need and even less of what they want…

I just feel [like CNAs should] do what [the residents] want to be done. Because I feel like…[the residents have] done did their time of working. They done did their time of doing things. They're on a vacation. Treat them like they're at the Ritz Hotel.

[The residents] are our employers in a way, so we wouldn't have a job without them.

Competency: Justify the importance of knowing the nursing home resident as a person and individualizing care.

If a caregiver has a good relationship with a resident, the caregiver will be more likely to respect residents' choices and desire to have control over their lives, and the risk of mistreatment will decrease.

> *Caregivers are often noted as forcing the residents to be on the staff's schedule, not on the individual's needs or desires.*

> *People come in thinking they're going to treat a condition instead of a person. And when you lose that initial sensitivity to that with someone that raised children and worked in our community, [the CNAs] don't see the person anymore, but they see someone that's a diabetic or a stroke person.*

> *We encourage people to bring in pictures, show us what they used to do, talk to us about their history. "Can you bring a picture in of when your mom was a young lady? So that the staff can relate back to when they were young and vital, involved in the community?" And it's a lot harder to mistreat someone that you know a lot about than it is a stranger.*

Competency: Share core values related to caregiving, including concern for humankind, compassion and empathy, protecting those who cannot protect themselves, and respecting the elder's right to privacy, dignity, and self-determination.

Participants agree that keeping in mind these core values can help direct-care staff be cognizant of details that affect residents' dignity.

This is their home, number one. So when you approach, like somebody come to my house, they not gonna just walk in my house…Knock on the door, address who you are. Let them know, I'm coming in.

Just saying, "Because I said so" is an abusive thing…These folks are not children. These are people that have had full lives, even if they're demented now.

Grooming to me is important, too, because I feel that…if they was able, they would have did their nails…[The residents] come in with food under their fingernails, and [feces] under their fingernails, and long toe nails…Come on! If they could have cleaned it, they wouldn't live like that.

You hear stuff down the hall, "Mister So-and-so, come in here and get your diaper changed." You don't say that in the hall…[CNAs] don't realize how it's coming across as being dignity issues.

Development of a Cooperative Work Environment

<u>Competency: Identify strategies for communication among staff around the nursing home resident's needs, the care plan, and changes in behavior or condition.</u>

Good communication within the care team can help keep the CNAs knowledgeable about the care plan and reasons for certain requirements (e.g., turning a resident every few hours to prevent pressure ulcers). Direct-care staff may also be the first to notice any changes in a resident's behavior or condition. They should be encouraged to communicate any concerns to their supervisor or the nurse on duty.

When there's a change in the resident's condition, sometimes they aren't modifying the care plan.

It's good for a caregiver to insure that each individual is receiving the care that's actually documented in their care plans. I've seen caregivers take a group and do the same daily routine, and that's not appropriate depending on the resident's condition.

The CNAs may not know…the significance [of the care plan requirements]….The CNAs need to know what they're supposed to do and how it ties in to meeting the goals. So if I'm a CAN and you're telling me you got to turn and reposition Miss Jane Doe every two hours, well, fine and good. If I can, I'm gonna do it, but if there's an emergency with this patient or this happens, you know, I may skip a turn or two. But [I'll be more conscientious] if you say to me, "She has severe diabetes…and we're really concerned about her developing pressure ulcers and so…turn and reposition her every two hours because if you don't, then she's going to develop a pressure ulcer."

Competency: Justify teamwork as part of a supportive work environment, including appreciation and respect among coworkers, pride in one's work, and cooperative efforts to promote quality service.

A positive work environment lowers the risk of mistreatment. Direct care of residents is difficult, and it's not a job that should be done alone. Administrators, nurses, aides, non–direct-care staff, families, and residents must work together to provide quality care.

I don't ever want to hear somebody say that, "This is not my resident." When you walk in this door, these are every one of our residents.

The families may have valuable information to contribute and because they're not being told exactly what's going on, they're not able to really give the nursing home feedback.

We promote team so much and I do orientation with the housekeeping and dietary [staff] too, and I say,…nobody passes call lights….You think you're too big to go in the room and the only thing that person probably want is their TV Guide or a Kleenex or a glass of water, which anybody can do….But if they want more than that, then you go get the nurse or the CNA.

Competency: Identify strategies for offering or requesting assistance from coworkers when conflicts or heavy workloads pose risk of mistreatment.

Participants recount examples of asking for or offering help and indicate the positive results from this give-and-take approach to teamwork.

Even if I walk in, and that resident start cussing me, I go back out. I report it to the nurse. Then when I go back again, I ask somebody to go with me.

One of the floors I worked on we really had a…close knit thing, and we always would work together…Just us actually saying, "Okay, well I'm finished feeding Miss Lisa, now do you need me to help feed somebody else?" I mean this person

has a heavier load. You're helping that person out…That's a big stress buster, if you're there for one another.

Sometimes you get hit. Sometimes you get cussed out. Sometimes you get spit at. Sometimes you get kicked…but if you got another aide that you're comfortable working with, they'll kind of intervene. Because when that patient hit me in my eye, it's just like a reaction, and all [my coworker] did was just grab me. I told her, I said, "I'm okay." She said, "Well, you need to go out the room, because you don't know how you're gonna react."

Sometimes it is a very hard call because sometimes it's like when your working in a place like this is, you're my friend, you my buddy, you're supposed to look out for me…But if I can stop somebody from doing something that is going to cause them to end up in jail, I will. But if [the other CNAA] can't sit and be sensible and human about it, then…I'll go get the director of nursing.

Conclusion

Based on what we have been told by the participants in this study, there is much training to be done on prevention of mistreatment. Direct-care staff members need certain competencies to do their jobs well. In many instances, mistreatment results from misunderstanding, thoughtlessness, heavy workloads, and a lack of skills and knowledge. Training on the types of mistreatment will increase CNAs' awareness of what constitutes mistreatment. Understanding the risk factors for mistreatment helps staff be conscious of their own actions when many risk factors are present. Once CNAs

are aware of the increased risk for mistreating a resident who pinches, for example, they are prepared and are less likely to retaliate thoughtlessly.

Communicating with residents and responding appropriately to behavior that is perceived to be problematic or difficult to manage are skills that can be taught. Building relationships with residents should be a top priority for direct-care staff. As the participants in this study point out, it is much more difficult to mistreat someone you know and care about than someone you see as just another body requiring care. If direct-care staff share core values related to caregiving and they are able to build relationships with residents, they will be able to see past the series of tasks to be completed. They will be able to see residents as individual human beings deserving of respect and care.

A cooperative work environment is also crucial to preventing mistreatment. Frustration and feelings of being overwhelmed are common to direct-care staff, who have difficult jobs. Support from coworkers and administrators and good communication and teamwork can help alleviate these negative feelings and create a safer environment for residents and staff alike. Teamwork has to be instilled not just through training, but also through modeling and coaching.

With the competencies we have identified from this study, direct-care staff may be equipped to care for nursing home residents respectfully in a supportive work environment. The risk for mistreatment will be reduced, and the quality of care will rise. From these competencies, we are developing training curricula for direct-care staff and managers. We hope these competencies and the accounts provided by our

interviewees can contribute to everyday practice in a variety of other ways. For instance, our findings may prove useful in routine supervision, drafting of quality assurance or assessment criteria, or development of professional standards. Because our study was conducted in the Southeast, researchers may wish to examine generalizability of findings in other locales. Also, because our focus was on mistreatment in nursing facilities, researchers may investigate whether constructs are equally applicable to residential treatment facilities or community settings. Program developers might explore different techniques of implementing training around such competencies; for instance, training could be delivered by supervisors, peer trainers, or training teams. Finally, we hope these findings may inform those working in related fields regarding nature and dynamics of mistreatment, thereby facilitating development of collaborative community responses to addressing elder abuse and neglect.

References

Allen, P.D., Kellett, K., & Gruman, C. (2003). Elder abuse in Connecticut's nursing homes. *Journal of Elder Abuse & Neglect, 15*(1), 19-42.

APA Online (2006). Elder abuse and neglect: In search of solutions. Washington, DC: APA.

Braun, K.L., Suzuki, K.M., Cusick, C.E., & Howardcarhart, K. (1997). Developing and testing training materials on elder abuse and neglect for nurse aides. *Journal of Elder Abuse & Neglect, 9*(1), 1-15.

Center for Advocacy for the Rights and Interests of the Elderly (no date). Abuse prevention. Philadelphia, PA: CARIE.

Clough, R. (1999). Scandalous care: Interpreting public enquiry reports of scandals in

      residential care. *Journal of Elder Abuse & Neglect, 10*(1/2), 13-27.

Goodridge, D.M., Johnston, P. & Thomson, M. (1996). Conflict and aggression as

      stressors in the work environment of nursing assistants: Implications for

      institutional elder abuse. *Journal of Elder Abuse & Neglect 8*(1): 49-67.

Hall, B.L. & Bocksnick, J.G. (1995). Therapeutic recreation for the institutionalized

      elderly: Choice or abuse. *Journal of Elder Abuse & Neglect, 7*(4): 49-60.

Hawes, C. (June, 2002). Elder abuse in residential long-term care facilities: What is

      known about prevalence, causes, and prevention. Testimony to the U.S. Senate

      Committee on Finance.

Hawes, C., Blevins, D. & Shanley, L. (2001). Preventing abuse and neglect in nursing

      homes: The role of the nurse aide registries. Report to the Centers for Medicare

      and Medicaid Services. College Station, TX: School of Rural Public Health,

      Texas A&M University System Health Science Center.

Joshi, S., & Flaherty, J.H. (2005). Elder abuse and neglect in long-term care. *Clinics in*

      Geriatric Medicine, 21(2): 333-354.

Meddaugh, D.I. (1993). Covert elder abuse in the nursing home. *Journal of Elder Abuse*

      & Neglect, 5(3): 21-3.

National Center on Elder Abuse (2006). Nursing home abuse. Washington, DC: NCEA.

Nerenberg, L. (May, 2002). Special research review section: Abuse in nursing homes.

      National Center on Elder Abuse Newsletter. Washington, DC: NCEA.

Payne, B.K., & Fletcher, L.B. (2005). Elder abuse in nursing homes: Prevention and

resolution strategies and barriers. *Journal of Criminal Justice, 33*(2): 119-125.

Strauss, A. (1987). Qualitative analysis for social scientists. Cambridge: Cambridge

University.

United States Administration on Aging (2003). National Ombudsman Reporting System

Data Tables. Washington, DC: U.S. Administration on Aging.

United States Census Bureau (2002). Industry statistics sampler: NAICS 62311 Nursing

Care Facilities. Washington, DC: USCB.

United States Department of Labor (2006). Occupational Outlook Handbook, 2006-07

Edition. US Department of Labor, Bureau of Labor Statistics.