Aggression in the Nursing Home:
Nurse Aide Perceptions, Appraisal and Management

by

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A Master's Research Project

Presented to
Oregon Health Sciences University
School of Nursing
in partial fulfillment of
the requirements for the degree of
Master of Science
March 1992

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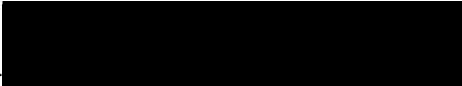

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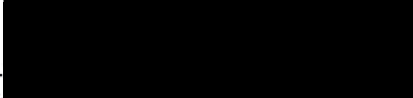

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Acknowledgements

I would like to thank my research committee Beverly Hoeffer, Terri Harvath and Joanne Rader for their excellent contributions to this study. Their efforts, both individually and collectively, have made my first research project a great learning experience. The knowledge and skill I have gained came from their patience, expertise and sensitivity.

I would like to thank the participants - the resident, his family and the Nurse Aides - for their time and valuable data. They have enriched my understanding of a complex phenomena and reassured me of a continuing commitment to quality of life in the nursing home. Thanks too, to the facility's suppport throughout the study.

Thank you to the Juan de Fuca Hospital Foundation, for their financial support of my entire master's program; Jessie Mantle, Jeanette Funke-Furber and Jack Howard for their faith in my scholarly abilities and my friends here and in Victoria for patiently seeing me through.

Finally, in memory of my mom, dad and brother, their love lives on in my every day.

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Chapter I

INTRODUCTION

The ever-increasing number of elderly in the community and in institutions has raised the study of this group to a high priority. Not only did Murphy and Hoeffer (1987) find that geriatric mental health is a growing subspecialty in Psychiatric and Mental Health Nursing, but Fagin (1986) placed issues regarding the elderly as a high priority on the research agenda for nursing. McBride (1990) further stated that one of psychiatric nursing's agenda's for the 1990's should include concern about the structure of discrete caregiving acts, the managing of aggressive behavior being one example.

One of the major problems facing nurses in nursing homes today is the management of the cognitively impaired, aggressive resident. Ryden (1988) cited 22 studies between 1984 and 1988 in the broad area of behavior problems. Those specifically related to aggression (n=14) have examined the nature of the aggressive resident, the nature of the caregiver, the context in which the aggression occurs, and the interventions to reduce aggression. In studies related to staff characteristics and/or perceptions of the problem of aggression, all levels of staff and different disciplines are usually included. This study will focus only on the Nurse Aide (NA) and will seek to understand: a).how NAs perceive the presence or absence of aggression during one caregiving activity; b).what the NA attributes the cause of that behavior to be; and c).what meaning the NA gives to the experience. The NA is the

person who is in closest physical contact with the resident and thus most at risk for aggressive responses, yet she/he is the least formally prepared staff member to deal with the problem of aggression.

Research conducted to date has focused more on resident and staff in isolation than on the interactive process of the resident and the staff person during the aggressive incident. As professionals we have numerous theories on what contributes to aggression but have less information about how non-professional NA's perceive the interaction and how this perception affects their management of aggressive behavior. Solutions to the effective management of aggression may lie in understanding "lay" perceptions of such incidents. The elder who suffers dementia is handicapped in telling us what to do to help. The NA is our closest link to the situation.

Gaining knowledge about the problem from the NA's perspective could lead us to identify three possible points of intervention: a) the labelling of aggression, b) the attribution of cause and c) the management of the aggression. Perceptions which are found to feed the aggression could then be dealt with from a more informed perspective, and positive perceptions could be reinforced and "sold" on a peer level. In this sense, knowledge becomes power; however, it is important to know what needs to be learned.

Significance

Incidence and Prevalence

Data on incidence of aggression and assault on staff did not begin appearing in the literature until the 1980's and the majority of the reports were from psychiatric settings (Lion, Snyder, and Merrill, 1981). Only recently has aggression and assault in the Nursing Home population been addressed. The percentage of nursing home residents who are aggressive varies widely in the literature. Investigations to detect the incidence of aggression have found that, although the occurrence is high, it is not always reported (Petrie, Lawson, & Hollender, 1982; Sternberg, Wheilihan, Fretwell, Bielecki &Murray, 1989; Winger, Schirm and Stewart, 1987; Zimmer, Watson & Treat, 1984). In a recent study by Ryden et al (1991) investigators found that 86.3% of 124 residents in their sample showed some form of aggression. Of those who were aggressive, 68.5% were on psychotropic medication. Meddaugh (1987), through review of incident reports, found 30 aggressive incidents by 10 (14%) residents in a thirteen week period. Zimmer et al., (1984) reported that 8% of 1,139 residents in 42 skilled nursing facilities exhibited aggressive behaviors. However, Petrie et al., (1982) reported 55% of 222 patients admitted to a geriatric psychiatry unit displayed aggressive behavior. Irrespective of the percentages, when aggression occurs it is a major concern because of its impact on residents, families, staff and the health care system.

This investigator and colleagues initiated an annual one-week count of aggressive incidents in a facility of between 450 and 510 residents. Aggression was defined as "intention to do verbal and/or physical harm to self or other"; nineteen aggressive behaviors were listed for the count. Over a three year period the least number of reported incidents in one week was 1109 (N=481) and the most incidents was 1946 (N=510). Granted, these were subjective reports based on caregivers perceptions, however, if one perceives aggression, one responds accordingly. This alarming number of perceived acts of aggression emphasizes the importance of understanding these perceptions and learning how we might influence them in a positive direction.

Impact on Residents

Aggressive residents, who are usually cognitively impaired and dependent in activities of daily living (Meddaugh, 1987; Winger & Schirm, 1989; Zimmer et al, 1984), are at risk of losing even more control by the use of common interventions such as chemical and physical restraint (Ryden, Bossenmaier, & McLachlan, 1991; Travis & Moore, 1991). Nurses have tremendous impact and control in the Nursing Home since they are the primary caregivers. They hold important knowledge critical for the development of intervention strategies though often they do not realize the power of this knowledge. They also tend to be the gate-keepers for use of psychotropic medication. It is the nursing staff whose

tolerance dictates the amount of psychotropic medication used, and who can instigate discontinuance by the physician.

The current trend in care of the institutionalized elderly is a move away from the use of restraints. In order to do this in a thoughtful and creative manner, more must be learned about the phenomenon of aggression so that restraint use can be minimized (Rader, 1991; Rader & Donius 1991; & Werner, Cohen-Mansfield, Braun & Marx, 1989).

Aggressive elders are also at risk of becoming socially isolated (Beck, Baldwin, Modlin, & Lewis, 1990; Meddaugh, 1991)). Continued social deprivation can lead to depression and/or physical decline. The growing numbers of cognitively impaired elderly in the Nursing Home (70 to 90% - Reichel, 1989) and the strong relationship between cognitive impairment and aggression (Cohen-Mansfield, Billig, Lipson, Rosenthal & Pawlson, 1990) suggest that the problem will not go away. Non-aggressive residents often live in fear of being harmed and are perplexed as to why aggressors are not sent to a "more appropriate place".

Impact on Families

The second group affected by aggression are the families of the aggressive elders. They often suffer embarrassment and fear, particularly of retribution from the victims, by way of lawsuits or expulsion from the nursing home. The emotional pain of seeing this side of their loved one takes it's toll with the result that the family may decrease visits or be in constant conflict with staff over care issues. Families of non-

aggressors fear for their loved one and besiege staff to do something to make the facility safe.

Impact on Staff

Costs for staff can include burn-out, absenteeism, and high staff turnover related to psychological stress and physical injury (Beck et al., 1990). Lanza's study (1983) on staff who were victims of assault in a Veteran's neuropsychiatric hospital found that staff minimized the effects of the assault. They often blamed themselves for the assault and saw it as an occupational hazard. Thirty percent of staff in the study acknowledged emotional, social and biophysiological reactions of both short and long-term duration. These tendencies to under-report, minimize, deny and feel guilty are found consistently across disciplines (from psychiatric resident to Nurse Aide) and in various settings (e.g., acute and chronic psychiatry, acute general hospitals and nursing homes). Staff at all levels complain of limited, if any, training to handle the assaultive or aggressive client. (Chaimowitz & Moscovitch, 1991; Cooper & Mendonca, 1989; Jones, 1985; Lion et al, 1981; Negley & Manley, 1990; Roberts, 1991).

Impact on Health Care System

The final group affected by aggressive behavior are the facilities themselves. Organizations, in general, have been found lacking in the support they offer to their staff in the form of preventive training, policy-making, post trauma counselling and follow-up. Lanza and Milner (1989), in their study at a Veteran's Hospital in Massachusetts, estimated

the cost of patient assaults on staff, per year, at a figure of $38,000. Nine factors were included in their estimate: staff costs, police costs, victim costs, nursing administration time, employee assistance program, personnel service time, safety officer time, training costs, and "disturbed behavior committee" costs. They believed their figure to be in the direction of under-estimation.

Staff burn-out and experiences of aggression from residents are correlated with subsequent resident abuse by staff (Pillemer & Bachman-Prehn, 1991). This too is of great concern to facilities. Finally since no extra reimbursement exists for handling this kind of resident there is real danger that facilities will refuse admission to these types of elders because of the risks outweighing the benefits (Rohrer, Buckwalter & Russell, 1989).

Review of the Literature

There is an impressive body of literature in the broad area of behavioral problems in the elderly. Aggression is a major dimension of that cluster of behavioral problems. Ryden (1988), in her review of the literature on behavioral problems in dementia, found that of 22 studies, 14 included aggression and five were focused on aggression alone. The single phenomenon of aggression has become more visible in the literature over the past two years with Meddaugh, Ryden, Beck and Baldwin conducting on-going nursing research in the area. This review of literature will cover findings on: a.) the characteristics of aggressive residents; b.) the perceptions and responses of nursing home staff to

this population and c.) the nature of attributing cause to aggressive behavior.

Aggressive Resident Characteristics

The factors of pre-morbid personality and lifestyle were identified as important considerations in the wandering population (Dawson & Reid 1987; Rader, 1987). Personal history gleaned from family can lead to explanations of present behavior though often aggression does not exist before the mental impairment. It is still critical to know of pre-morbid aggressive behavior patterns in order to fully determine causality, though it is not easy to access this information (Ryden et al., 1991).

Most researchers report that the aggressive resident suffers from some degree of cognitive impairment. In a study of 408 residents of an urban nursing home, Cohen-Mansfield et al., (1990) found that aggressive behaviors were strongly correlated with dementia, cognitive decline and severe functional impairment. This group also seemed to be perceived as having more pain or recent surgery. In this study there was a high correlation between aggressive behavior and use of major tranquilizers. This group of aggressive residents did not have more physical disease than the non-aggressive residents. Zimmer et al., (1984) found dementia in 66.5% of the population reported to be aggressive while only a few had an actual psychiatric diagnosis (e.g.,. personality disorder, schizophrenia, bi-polar affective disorder). The issue of psychiatric diagnosis in elderly nursing home residents is debatable since very little is done in the way of establishing accurate

diagnosis (Rovner and Rabins, 1985). Aggressive elderly who are sent from the nursing home to psychiatric facilities due to their unmanageability either suffer from paranoid delusions and have a clear sensorium or have some form of dementia (Petrie et al, 1982; Tardiff, 1982).

In Meddaugh's (1987) descriptive study of staff abuse in a 72 bed skilled nursing facility, "there were no abusers with a clear sensorium" (p. 51). When Winger & Schirm (1989) studied factors associated with behavioral problems in long term care their subjects had to sign informed consent. Subjects with behavior problems may have been eliminated since 40% of 172 potential subjects showed cognitive dysfunction, could not sign informed consent and were therefore excluded from the study. Clearly, this circumstance is a major barrier for those who wish to study this population, as many cannot represent themselves.

Marx, Werner and Cohen-Mansfield (1989) did a study of 24 nursing home residents known to have high levels of agitation and cognitive impairment. The study occurred over a period of three months with 1000 observations made for each resident. The observations included the number of times the resident manifested an agitated behavior and the distance the resident was from the closest person in the environment. The investigators found a relationship between aggressiveness and touching which suggested that these residents interpreted the touch as a violation of their personal space. These were similar findings to those of Ryden and Bossenmaier (1988).

Meddaugh (1991) did an inductive study that examined the interaction of 15 aggressive residents with their caregivers. Data were collected by observing each resident for a total of 15 hours over a five week period. All residents were cognitively impaired, over 65 years, had no psychiatric diagnosis, were English speaking, had been in the nursing home one month or more and had at least one significant other in their life. Interestingly, she found limited documentation of aggressive incidents on the chart. When asked why this was, staff said it was just part of their job. Triggers to aggressive behavior identified in this study were: social isolation, lack of choice over daily living activities, inconsistent caregivers leading to inconsistent daily personalized routine and lack of diversional activity.

Caregiver Perceptions and Responses to Aggression

Studies in this area include various levels of nursing staff in the nursing home: Registered Nurse (RN), Licensed Practical Nurse (LPN) and Nurse Aide (NA). Since each of these groups brings a different frame of reference to the care they provide, given their roles , knowing the subject's position is important when interpreting study findings.

Agitated behavior often precedes an act of aggression. Cohen-Mansfield has studied agitation in nursing home residents extensively. In her 1986 study, professional nurses' attributions of causality for agitation included: the elder's frustration at loss of control especially during caregiving (e.g.,. bathing); invasion of their personal space; mental confusion; attention seeking possibly from loneliness; depression; past

history; phases of the moon; constipation; hearing impairment and being restrained.

Glasspoole and Aman (1990), in their study of RN and LPN's attitudes, knowledge and happiness working with the elderly population, found that aggressive behavior and calling out were the most exasperating problems for the staff. They recommended more training to handle such problems. Bernier and Small (1988) looked at the effects of disruptive behavior on staff and on other residents. Of the 66 nursing staff who participated in the study, 68.2 % were unlicensed. The number of residents in the study numbered 44. Whereas aggression was very problematic to the staff, the residents found "wandering into wrong room" as the most disruptive behavior. Staff, on the whole, were more disrupted by residents than other residents. It would seem that staff and resident may not perceive disruption in the same way. Certainly their experience of the environment is different. Perhaps because residents are in the home 24 hours a day they are able to build a tolerance for particular disruptions and they do not have to interact closely with the disruptive residents.

Meddaugh (1987) studied a 72-bed skilled nursing home where 26 of the 97 female staff experienced abuse from 30 residents. Meddaugh collected her data retrospectively from charts and incident reports. The residents who abused staff were all cognitively impaired, highly dependent on their caregiver, tended to be male and had fewer visitors than non-abusers. Certain characteristics of the abused staff

member were also identified. The abused staff were: usually less educated; younger rather than older; more often LPNs (more than RNs and NAs); and were full-time staff rather than part-time staff. This was a descriptive, retrospective study which looked at incident reports, however, these records were not complete and details were lost. Still, these findings support the belief that incidents often occur without proper documentation. Further information from staff by way of an interview may have provided further clarity to these findings.

Burgio, Butler and Engel (1988) investigated nurses' attitudes toward the efficacy of behavior modification and the use of psychotropic medication to handle aggressive behavior. They did not define "behavior modification" so the results were based on what that term subjectively meant to each nurse. RN's and LPN's were interviewed by means of a scale developed specifically for the study and two general findings were of note. First, LPN's supported use of behavior modification more than did the RN group and second, LPNs were more positive about the effects of psychotropics. Since no information was provided on the LPN and RNs' knowledge level of behavior modification and psychotropic drug use it is difficult to judge the validity of the findings. All staff acknowledged a need for training in the handling of behavior problems.

Sternberg et al. (1989) suggested that behavior can only be disruptive in the context of a relationship, that is, someone must be "disrupted" by it. They postulated that it is the perception of the severity of the disruptive behavior, more than the disruptive behavior per se, that

critically affects the decision making of the care provider. Sternberg et al. examined disruptive behaviors (aggression as one only) in acute and long term care. One difference in the sample was that 61-67% of the acute care providers had a RN education level or above in contrast to 19% in the long term care setting. The investigators found that behaviors deemed disruptive were identified according to the level of the staff persons responsibility and the degree to which staff were in close physical proximity to the patient. Thus, RN's and LPN/NA's perceived behavior quite differently and in accordance with their own roles. Since the NA is usually providing direct physical care, she/he is more likely to encounter aggression but may paradoxically make less of an issue of it as it becomes the norm. This finding is similar to that of Bernier & Small (1988) in relation to residents' increased tolerance to aggression. This variation in perspective from different levels of staff can lead to difficulty coming to agreement on consistent intervention strategies.

Beck et al (1990) studied caregivers' perceptions of aggressive behavior in the nursing home population. The sample consisted of 22 participants who worked in a skilled care facility of 114 beds and 19 who worked in Veteran's Administration long term care units totalling 50 beds. Sixty-eight percent of the caregivers (comprised of 21 RN's and 20 NA's) stated that residents were physically aggressive and 95% cited verbal aggression. New staff were more likely to experience aggression. Incidents tended to occur more often during clothing changes and dressing. Attribution of causality as identified by staff included: family

members (22%), residents wanting things done their own way (12%), unfulfilled requests (10%), illness (7%), homesickness (7%), medication (5%) , and other (2%) (e.g.,. confusion, restraint, nervousness, being a new resident, inability to communicate with family, disliking roommate). The methods most commonly used to calm the resident included talking in a comforting manner, reasoning with the resident and questioning the behavior. These investigators suggested more teaching about communication strategies was warranted. They also recommended that further research be conducted to address the relationship between staff perception of the resident's behavior and the actual behavior exhibited. How the interaction style or communication technique of the staff member affects the resident's behavior (or vice versa) remains to be explored.

Attribution of Causality

In relation to causality, Meddaugh's (1990) recent work uses the theory of reactance and suggests that aggressive behavior stems from limited choices, institutional constraint and caregiver interactions with the resident in the Nursing Home. The aggressive behavior then, is an attempt to gain control over these limiting factors (Meddaugh, 1990).

Ryden et al. (1991) adapted Lanza's (1983) model, "Origins of Aggression", to depict internal and environmental origins for potential aggression leading to three manifestations: defused, expressed and unexpressed behavior. In this study they found that internal variables (mental status, physical dependency, and psychotropic drug use) played less of a role in aggressive behavior than external variables (specific

nursing home, the time and location of incidents of aggression, events preceding the behavior and the use of physical restraints).

Harvath (1986), in her study of family caregivers, found that caregivers who attributed cause of behavioral problems to cognitive impairment better tolerated the situation and generated more effective management strategies than caregivers who personalized the aggression. In addition, those caregivers who found the behavior meaningful and identified it as a form of communication were able to reframe the situation and be more successful in handling it.

In summary, studies show a high rate of aggressive incidents with a low rate of written documentation. NAs are the staff in closest contact with the resident yet research from their perspective is limited. Staff vary in their perceptions of the problem and these perceptions are influenced by the staff member's role, their level of education, their personal characteristics, and their tolerance to resident aggression. There are both internal and external factors which impact on the attribution of causality and finally on the interventions utilized to handle the aggressive or potentially aggressive resident. The interactive process of the resident and the NA warrant further investigation as Beck and colleagues suggest. This shift to the NA's perception of that process will be the focus of this study.

Conceptual Framework

For the purposes of this study aggression is conceptualized as a form of communication common to all people. It can be both constructive

and destructive in nature and it is employed in order to gain dominance and mastery over self, others and/or the environment (Brooks, 1967). The operationalized definition of aggression is: "hostile action (verbal or physical) directed toward the other person, object or toward self" (Ryden, 1986).

The conceptual framework for this investigation draws primarily on attribution theory. The theory was initially conceived by Heider (1958). He held that people perceive events as having causes and that the locus of the cause could be either in the person or in the environment (Frieze et al., 1979). If causation rests with the person, another aspect important to perception (and, thus, response) is whether the act was intentional or not. Heider used the term "naive" to reflect the "lay person's" perspective. A central assumption of this theory is that in understanding naive or common-sense ideas about why people do the things they do, one can better predict the behavior and emotional reactions of people (Frieze & Bar-Tal, 1979).

In this study, NAs represent the "lay person's" perspective. With only four months or less training for their job, they deal with very complex people whose aggressive behavior often does not make sense to the them. As professionals who are supervising and directing the NAs, nurse clinicians need to know more about the NA's "naive" assumptions of the elders' aggressive acts. In applying attribution theory to the problem of aggression, three major issues are of concern: what precedes the attribution (e.g., personal characteristics, background, motivation); what

is the the explanation of the attribution and what are the consequences of the attribution? The literature suggests that most aggression in the elderly occurs in people with dementia (Cohen-Mansfield et al., 1990; Meddaugh, 1991; Ryden et al., 1991). However, to the extent that NAs do not read the literature, they may be left to their own devices to attribute causality. An understanding of their attributions, then, is crucial to facilitating their care of elderly persons displaying aggressive behavior. If the NA attributes an aggressive act to be intentional (personal causality), she/he may respond punitively. If the act is viewed as part of the dementing process and therefore not intentional (impersonal causality), the response may be more empathic.

In summary, this conceptual model leads to the belief that solutions to handling aggression may come from outside the resident and lie in the context of the situation. If people's perceptions of the interaction are inherent in the outcome, then it behooves us to study those people. Clearly the perception of the NA and our understanding of how she/he responds is integral to our designing intervention strategies that will prevent or lessen the impact of aggressive acts. This study is a small step in that direction. It focuses only on the NA and seeks to understand: a).how NAs perceive the presence or absence of aggression during one caregiving activity; b).what the NA attributes the cause of that behavior to be; and c).what meaning the NA gives to the experience.

Research Questions

The research questions for this study are as follows:

Research Question One: Is there congruence between what the NA labels as aggressive behavior and the operational definition?

Research Question Two: When the resident's behavior is labelled aggressive to what does the NA attribute the cause?

Research Question Three: How does the NA describe the experience of caring for an aggressive resident?

Chapter II

METHODOLGY

Aggressive behavior was operationally defined as hostile action (verbal or physical) directed toward the other person, objects or toward self (Ryden, 1986). Physical behaviors included grabbing, holding, slapping, scratching, biting, kicking, punching, hitting, pinching, pulling, spitting and throwing objects. Verbal abuse included name calling, swearing and insulting. Verbal abuse was considered a subjective report, depending on the caregivers' frame of reference or perception (e.g.,, swearing may offend one person but not another). Threatening gestures (e.g.,. waving a fist) were also included. The investigator, in her role of participant-observer, used this operational definition to make her own classification of the behavior that occurred when the NA and resident interacted during a caregiving activity. It was therefore possible that the NA might identify absence of aggression when in fact by definition it existed, or vice versa.

Design

This was a qualitative study using participant-observation and in-depth interview techniques to describe NA perceptions of aggressive behavior. The investigator observed each NA during a caregiving activity, then on the same shift, at the NA's convenience, the investigator conducted a private guided interview (Appendix B) with the NA. The resident cared for was the same man in each situation. This resident was chosen because he had a history of aggressive behavior with the staff.

The interview took place in a quiet, private area and was audiotaped. The investigator sought to discover the personal meanings NAs attached to aggressive acts that occurred during caregiving activities. Transcripts from the interviews were analyzed and categorized into conceptual meanings to better understand the NAs' conception of aggressive acts, their attribution of causality and their experience of the situation.

Setting

This study took place in a 130 bed non-profit religiously affiliated nursing facility in a rural town in the Pacific Northwest. The unit under study was a secured 25 bed "flex" unit designed primarily for cognitively impaired residents, some of whom wandered.

The nursing home has two Clinical Nurse Specialists (CNS) one in Gerontology and one in Mental Health, resulting in a high level of in-service education and on-going research activity. The facility trains its own NAs who then must qualify, through state examination, to become Certified Nursing Assistants (CNA). All staff at the facility receive inservice education. Staff on this unit receive no special training and are not specifically selected for the unit. Consequently, it is likely that the sample drawn for this study is representative of NA staff in the entire facility.

Sample Description

The resident (referred to as C__) chosen for the study was selected because he consistently expressed aggressive behavior toward caregiving staff and occasionally toward other residents, since his

admission seven months prior to this study. C__ had a well-documented history of hitting, pinching, biting, holding, grabbing, pulling hair, threatening and swearing. Additionally, this investigator had witnessed incidents in which C__ exhibited aggressive behavior as previously defined. The behavior was documented on chart records and incident reports were filed. In addition, the two CNS' have received consultation requests for these concerns. C__ had Alzheimer's Disease with severe apraxia, agnosia and poor language comprehension (receptive and expressive). His aggression typically occurred during caregiving activities (toileting, dressing, and bathing). He was six foot four inches tall and had a physically commanding and impressive appearance. However, he could not follow simple commands and could not initiate his own care. Previously, he had been cared for by a loving and committed family. Staff generally found him difficult to care for due to his resistiveness to caregiving acts. The involvement of only one resident controlled for the variation in approach which can occur with different residents.

The six NAs in the study were all Caucasians and female. All the NAs had Certified Nursing Assistant training and their work experience varied from three months to eleven years. Two NAs worked part-time in the facility and their experience with C__ was limited. The other four NAs worked full-time and had cared for him many times during the seven months since his admission.

Sampling Technique

In this study purposive sampling technique was used to identify NAs familiar, in varying degrees, with the care of this resident. NAs were identified based on their availability and in some instances on the recommendation of the RN. It was hoped that the participants would have a similar range of experience with the resident and a wide range of effectiveness, however, due to scheduling difficulties and reluctance to participate these criteria were not consistently met. Seven NAs were asked by telephone or in person to be in the study and six agreed - two on days, two on evenings and two on nights. This allowed for comparison across shifts. Since the interviews were to occur on their own time a nominal fee was paid to each participant. The person who declined was not comfortable with the investigator-observation part of the study.

The same explanation was given to each NA:

> "C___ has been identified by NA's as presenting problems in daily caregiving. In order to understand your experience I would like to become more familiar with what happens at these times, therefore, I would like to be with you to observe one caregiving activity (e.g., bed/tub bath). Later on your shift, at your convenience, I would like to interview you about your experience. During the interview I hope to learn more about your thoughts, feelings and experiences looking after C__. You do not have to participate and you may withdraw at any time."

Once the NA agreed to take part in the study the consent was explained in person and then signed.

Human Subjects Protection

Consent forms were devised for both the resident and the NAs (Appendix A). Included in the consent form for the NA was the fact that the investigator is required, by law, to report any abusive behavior by staff. No inappropriate behavior by staff was observed. Consent to do the study was received from the Nursing Home Research Review Board at the hospital where the study took place and the University Human Subjects Committee where the investigator was a graduate student.

Since the identified resident had severe dementia, making his informed consent unattainable, family consent was received for the resident's participation in the study. This investigator sought assent from the resident prior to accompanying the NA in the caregiving activity. He did not indicate that he objected to the investigator's presence.

NA confidentiality was protected by having the interviews marked by subject number so that no identifying data was on the audiotape. Any names mentioned during the interview were removed from the transcription. The audiotapes were erased after the transcriptions were checked for accuracy.

Procedure

This investigator accompanied the NA during the caregiving act, in the role of participant-observer. In order to maintain consistency, the caregiving act was morning care on days, HS (hour of sleep) care on

evenings and routine care given on rounds on nights (changing incontinence pants). Each NA instructed the interviewer when to arrive for the caregiving activity on her shift and each NA chose the time most convenient for her to have the interview. Time of convenience to staff was critical in order to maximize her ability to focus on the interview. A limitation of this approach was that interviewing immediately after the activity may have elicited more emotion than at a later time. In contrast, NAs who had more time between interview and activity may have reflected more on what transpired. It was not possible to determine whether the timing of the interview affected the results.

In the role of participant-observer, the investigator took direction from the NA so that the interaction was observed under naturalistic circumstances. Two NAs had the investigator assist them during care while the other four had her observe; they had assistance from another NA or in one situation the NA did all the care herself. Following the observation the investigator made brief notes indicating whether or not aggression occurred as defined by the the operational definition, the nature of the aggression and how the NA handled the situation. Also noted were any comments about how the NA worked with the resident. These notes were used as reference points during the interview. To control for bias in data gathering, the investigator made note of her beliefs before data collection and made every attempt to be open to the relevance of what else was happening at the moment. (Corbin, 1986).

Data Collection Instrument

The interview began with an explanation by the investigator of the audiotape and in general terms the questions, including that all the NAs would be asked similar questions. The time was noted so that the interview would be completed in the half hour. The original questions were expanded during the first interview and remained essentially unchanged for subsequent interviews. A brief demographic sketch was also collected (Appendix B). NAs were asked a broad opening question followed by more specific probe questions (Appendix B). The interviews were conducted in a quiet private area and were audio taped.

Analysis Strategies

The audiotapes were transcribed and reviewed for accuracy. The transcriptions were the raw data used in the analysis. Qualitative exploratory analysis was utilized to search the transcript for themes that may explain the meaning of the behaviors for the NA. Analysis occurred in four phases, however, the phases did not necessarily occur chronologically since analysis was a fluid activity.

Phase one. Each interview was analyzed sequentially, significant passages were highlighted and initial codes were formulated to identify important and emerging themes. This list of codes was collapsed into major themes and data to support the themes were compared across interviews.

Phase two. The collapsed codes were linked to developing theoretical notions and conceptualized into primary and secondary

concepts. Based on the data, each concept was defined and different dimensions of the concept were explored across interviews.

Phase three. Up to this point analysis was broad and encompassed all the interviews. Next, each interview was analyzed independently to discover how particular concepts were expressed (e.g. behavior, causality and outcomes). This process gave information on how each participant was similar to or different from the other in relation to these concepts. It helped to identify negative cases and exemplars.

Phase four. During phase four relationships between and among the concepts were identified in general and then specifically in each interview. Hypotheses regarding the relationships between concepts were examined according to their applicability across situations and across NAs. A tentative model was developed based on the conceptual interactions.

Limitations

The greatest limitation in this study was its small sample size. A larger sample would have enhanced generalizability. The NAs interviewed were typical of the facility, however, there were no males included. There were differing degrees of effectiveness in the sample, however, the findings may have been enhanced if the NAs had been selected based on their perceived degree of effectiveness or difficulty in working with this resident (e.g., one NA per shift who worked well with him and one NA per shift who experienced difficulty working with him). This may have elucidated "styles" more clearly. Finding time on the shift

when the NA could be interviewed proved to be difficult since their schedule is so structured and time was limited to one half hour for days and evenings and 20 minutes for nights. Though all questions were covered with the night shift NAs a further ten minutes may have provided more detail.

This nursing home is considered to be a leader in the care of institutionalized elderly and so staff may not be reflective of less resourceful homes. The NAs interviewed were quite sophisticated in their appraisals (e.g. knowing C__'s behavior stemmed from his cognitive impairment). Other NAs in different nursing homes may have offered different appraisals.

Finally, this was the first time this investigator had undertaken qualitative research and hence she is a novice in this methodology. However, collaboration with, and guidance from nurses familiar with this methodology compensated for this lack of experience.

CHAPTER III

RESULTS AND DISCUSSION

Conceptual Model

The purpose of this study was to examine NAs' perceptions of caregiving to an aggressive resident. The results section focuses primarily on research questions two and three - the attribution of causality and the NA's experience of caring for an aggressive resident.

Research question one was to address actual aggressive behavior which occurred during the caregiving situation observed in the study. However, since only two situations contained any aggressive behavior as operationally defined there was insufficient data to pursue the question in depth. Hence, analysis of the data resulted in the development of a conceptual model that explains how the NA's perceptions are formed and how these perceptions, in turn, influence her management of aggressive behavior. The differences in management of aggressive behavior seem to be reflected in the following concepts: caregiving philosophy; appraisal of the situation; mutuality (NA relationship with the resident); "tricks of the trade" and finally the occurrence or non-occurrence of aggressive behavior. An overview of the model (Figure 1) is given followed by an analysis of each concept individually.

Each NA has her own philosophy of caring for aggressive residents and this philosophy influences how the NA appraises the

situations where aggression may occur. The appraisal of the situation influences and ,in turn, is influenced by the degree of mutuality that develops e.g., the quality of the NA's relationship with the resident. Mutuality enhances the NA's ability to recognize triggers for aggression in the situation. She then utilizes "tricks of the trade" developed primarily through experiential learning. These intervention strategies may or may not be effective in averting or managing the aggressive behavior. Based on the feedback she receives from her actions she may adjust her "tricks of the trade" for better results and be willing to try a variety of strategies given her appraisal at the time. Mutuality is central because it acts as a mediating factor in each situation. The richer and deeper the mutuality, the more "tricks of the trade" the NA collects and the more likely she is to anticipate a potentially aggressive action and to handle it effectively. The behavioral outcome of her "tricks of the trade" influences her appraisal of the situation and in turn contributes to her caregiving philosophy, and the mutuality that develops. The cycle continues as illustrated in Figure 1.

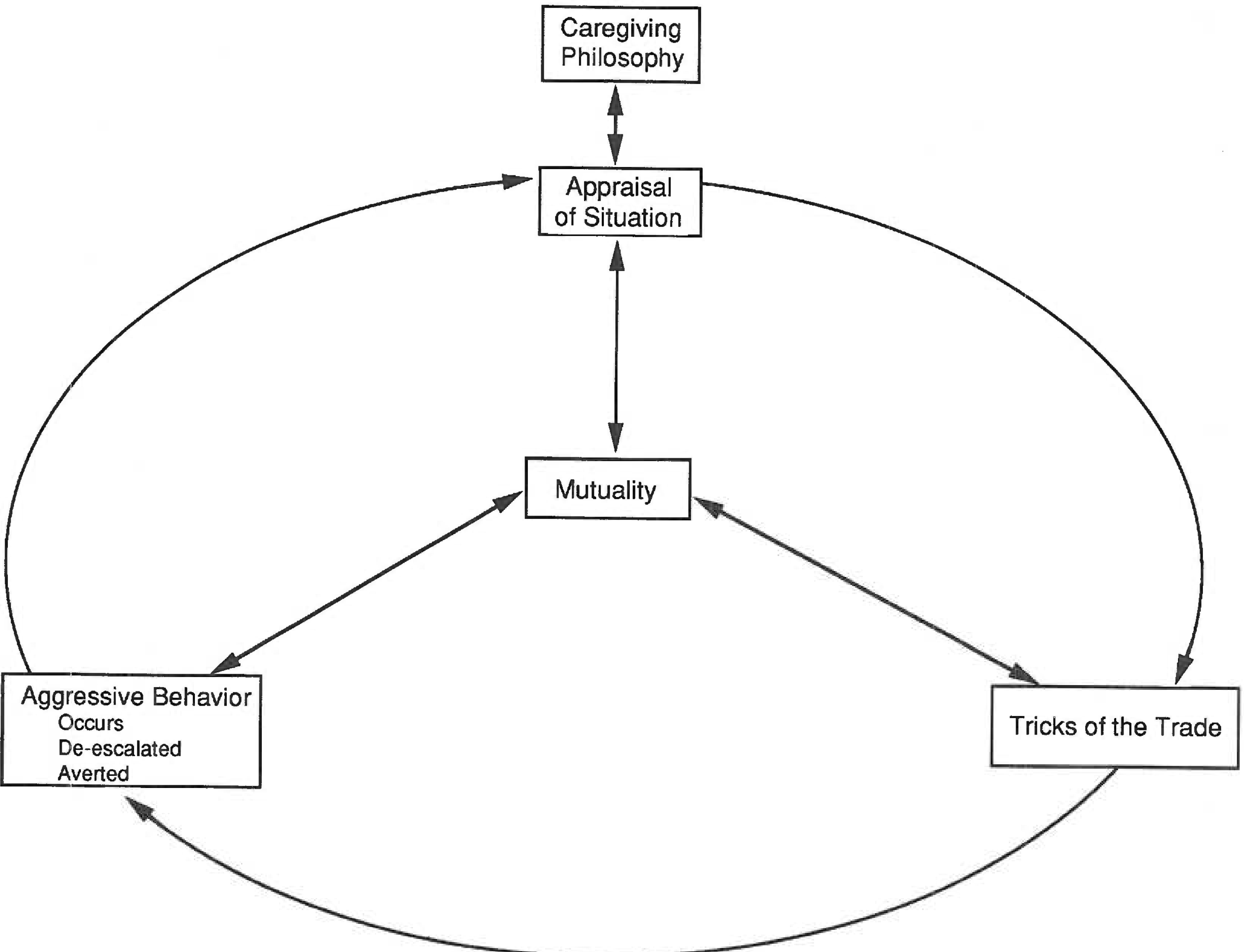

Figure 1. Nurse Aide's management of potentially aggressive behavior in a caregiving situation.

Concept Descriptions

The following section will define and elaborate on each concept presented in the model as it evolved from the data.

Caregiving Philosophy

Caregiving philosophy is defined as the beliefs, values and thinking the NA carries into her job. This concept is important because it involves the unique characteristics the NA brings to her work and it influences how she approaches working with a potentially aggressive resident. It is the internal code that colors how she appraises the situation:

> I think it has to be a certain kind of people that can work with someone like that. . . . there's going to to be the kind of people that are going to be impatient and not willing to take the time. . . . they can't take care of a person like that. You need to have patience, you need not to be the kind of person that's going to be afraid all the time. It's not their fault if they don't have the patience or even mental capacity to care for someone like him.

Caregiving philosophy can change over time and with experience but it remains at the core of the NA's management of aggressive behavior.

The NA's caregiving philosophy includes four components: 1) her attitude about her job; 2) the amount of flexibility she exercises within the confines of the job; 3) how she thinks about the care she provides; and 4) how she feels about caring for aggressive residents.

Work Attitude

There appeared to be three general types of work attitude about caring for a potentially aggressive resident: The job as a challenge: "It's a challenge for myself to see if I can really help them". The job as a mission: "I feel good taking care of him, he is such a needy person". Or the job as a must: "It is something I have to do, it is not the highlight of my shift, I know I have to do it" (caring for an aggressive person). These attitudes go into the room with the NA and affect how she appraises the situation and what interventions she uses.

Flexibility

The second component of NA caregiving philosophy was the NA's ability to be flexible within the confines of her job. Though the observed caregiving task was the same on each shift, the way in which each NA accomplished the task and the priorities she set varied. The variations seemed related to the NA's degree of flexibility. Some NAs remarked that rushing the resident created aggression and so they worked according to his timetable. One NA did him first and another left him to last. Time could not be given strict limits:

> Sometimes it'll take you maybe an hour and a half to get one person to take a shower or something. It just takes time, you can't rush into anything.

Another said:

> My attitude with time, as far as him or anybody, is I do what I am capable of doing.

The degree to which NAs are flexible can also be related to the differing demands of their shift and resistance from colleagues to change routines. One NA stated that C__ was consistently resistant if she tried to change his pants while he was in bed; however it was not a problem if he was sitting and then standing. The night shift's main contact with C__ was to change his pants if he was incontinent. The idea of getting him up to do this would counter the goal of not waking him too fully. In order to lessen C__'s opportunity for aggression, the night shift had lessened the number of times they changed him during their shift but had not come up with an alternate method of handling his incontinence. Shift routines and staff's support of those routines can encumber the NA's attempts to be flexible

Thinking

The way in which the NA thought about or analyzed her caregiving practices was a component of her philosophy. Some NAs showed an impressive degree of reflective thinking while others thought more in a rote fashion. NA thinking differs from appraisal in that it relates more generally to the way in which the NA grasps all aspects of the situations around her and reflects upon them (e.g., the way in which she thinks). Caring for a cognitively impaired resident who can be aggressive is a complex task; hence, some NAs described giving considerable thought to their interventions, including evaluating the outcomes on an on-going basis. One NA watched C__ consistently pull his shirt off as soon as she pulled it over his head. She decided that she mussed his hair while

putting the shirt on and so began to smooth his hair as she went over his head. The result was that C__ stopped pulling off his shirt.

A recurring dilemma was the fact that C__ took a long time coming to a standing position due to his apraxia. One NA watched as a peer followed the advice of the resident's daughter and gave C__ his cane before getting him to stand. He stood quite readily. She explained, "He caught on, sometimes an old thing that you remember just clicks in". These analyses foster creativity and innovation.

The ability to be reflective, that is, think in ways that were more complex assisted the NA to be more creative and innovative in working with the resident.

<u>Emotional Reaction to Aggressive Behavior</u>

How the NA reacted emotionally to aggression in general and her personal experience with aggressive behavior influenced her caregiving philosophy. Background personal experiences were not sought in this study, however, most NAs had taken care of other aggressive residents.

The interview question on feelings often met with a pause as if perhaps this was a question seldom posed, or as if the acknowledgement of negative feelings wasn't safe. When one NA was asked how she felt after the resident hit her she said:

> I didn't feel angry like, you know, I'm going to hit you back type of thing. I really couldn't answer that question.
> I didn't really feel any specific way. It was just part of my job and I dealt with it.

One NA stated that after C__ hit her:

> I just felt pain, I will admit I got angry. But then I know how C__ is as I've seen him hit other people too. It's something I have to do.

Being fearful was a common feeling among the NA's. This seemed influenced by the size and strength of the resident:

> Part of it is his size and his strength. He is very, very strong. If he becomes difficult, it can be frightening.

As some NAs got to know the resident, their fear seemed to lessen:

> At first I was a little scared of him. I think he is easier to take care of than some of them. . . . You can get him to smile or laugh.

One NA suggested that a little fear was good because it kept the person alert to the potential for aggression.

Appraisal of the Situation

The concept of appraisal is defined as the NA's explanation as to why the behavior occurs in the caregiving situation, what it means and whether it is intentional. Appraisal could be empathic where the NA perceived the situation from the resident's stance or it could be defensive where the NA perceived the situation from the stance of protecting herself from the resident. The data supports two different types of appraisal previously discussed in the literature: attribution of causality and attribution of meaning.

Attribution of Causality

The NAs attributed the aggressive behavior to a variety of causes, including physical, environmental, unmet needs, caregiver's actions and unknown cause. Having knowledge of how caregiving affected the resident made it more likely that the NA could avert the aggressive behavior.

Physical causes. Some of the NAs reported that C__'s aggressive behavior was caused by: pain, fatigue, incontinence, Alzheimer's dementia, and medication. Some of these causes were reversible, hence, the NA felt she had some control over the situation. For example, in handling the fatigue it was important that the resident did not get over-tired because then he would tend to resist getting ready for bed:

> You really have to be watchful and get him to bed at
> his best time. . . . it is not always the same time.

Night shift stated that if he did not get his night medication (Mellaril) they expected him to be agitated. They noted a distinct improvement when he was switched from Serax to Mellaril, as did the other shifts. Specifically, he was better able to follow their directions. As one NA put it, "He has dramatically calmed down".

One NA explained the resident's tight grabbing as a primitive reflex resulting from the brain damage of Alzheimer's disease. Though this cause could not be reversed grabbing was often not seen as aggressive by the NAs due to the explanation given it:

> I don't think he's grabbing at a person . . . to hurt them. He's

just always holding onto something.

Unmet need. At times the behavior was viewed as the result of an unmet need, suggesting that the resident's behavior was his way of communicating that he needed something. For example one NA stated:

> He reaches for something that isn't there; he just wants to get a hold of something; he might just want someone to talk to.

Facial expressions were mentioned as a means to identify his needs:

> You can tell when he's in pain, it's very obvious . . . (by his) facial expressions. He limps more, he creases his brow, sometimes he even says 'ouch or damn that hurts'. I mean you hear him say that quite often.

The need may even extend to the resident's family. One NA reported:

> They (family) want him to be mobile. . . They're seeing him go downhill and it's like the last thing he has. His mind is gone and now the last thing that he has is his mobility and he's losing that and I'm sure that's very hard to accept.

In this example the NA felt that sometimes the resident was pushed to walk against his will. She would walk him only as far as he was willing to go.

Those NAs who saw the behavior to be the result of an unmet need tended to intervene to meet the need. Rather than addressing the aggressive behavior per se, they would try to address the underlying need they thought was contributing to the the behavior. These NAs

seemed to work more effectively with the resident and expressed more positive outcomes.

Caregiver's actions. NAs were clear about certain things that triggered the aggression, e.g., rushing the task, insisting a task be done when C__ was resistant, being loud, giving too many directions at once and washing his genital area. Many of the triggers were under the control of the NA. When the NA appraised her own actions as a trigger to aggression she was more able to avert or de-escalate aggressive behavior by altering her actions:

> You have to go real slow and calm with him. Regardless of how agitated you get, you can't show it. . . . so you keep calm because he'll pick up on it. . . . he starts swinging.

Because the NA's actions were under her own control she could use her style of caregiving as part of her "tricks of the trade".

Environmental causes. Some NAs attributed the aggressive behavior to environmental causes, for example, noise on the unit or hot weather on summer days. Although environmental causes were not always under the control of the NA (e.g., weather), some NAs used their appraisal of environmental causes to intervene with C__ to reduce his agitation. For example, one NA recommended:

> If the radio or television is on shut them off. I think it helps him when things are quiet when you try to get him to do something... I've found that if no one else is in there, that you put on a radio station that's real calm music and sometimes he'll calm down too.

Several NAs reported that hot weather was a problem in the summer, describing how it decreased the resident's energy and created irritability. One NA said that on a hot day after the meal C__ would become very tired. If she did not get him ready for bed before his fatigue surfaced she had a difficult time because he could not follow directions and did not want to be bothered. Her appraisal of how the weather affected C__ became a critical factor in helping him cope on hot days.

Unknown cause. In some situations, the cause of the aggressive behavior was perceived as unknown. When the cause was unknown the NA was left without knowledge of what the resident was trying to communicate and without approaches that might circumvent the aggression. For example, when asked why this resident was more aggressive than other residents one NA answered "I don't know, I have no idea". NA's who could not hypothesize the cause of the behavior were often guarded and watchful for possible aggression:

> We need to watch out for ourselves but also take care of him at the same time.

An unknown cause and a defensive stance were associated with the NA's having fewer tricks of the trade to draw on for caregiving. Though being watchful is important, being too guarded may block the NA's ability to interpret complex or subtle messages from the resident.

Attribution of Meaning

The second type of appraisal identified in this study is the attribution of meaning. This concept involved the NA's interpretation of

the resident's behavior. Giving meaning to the behavior often stemmed from the NA's caregiving philosophy and her knowledge of the resident. It was an interpretation based on an empathic relationship of "walking in his shoes". Attribution of meaning tends to be more abstract than attribution of causality. It is also very dependent on the establishment of mutuality whereby the NA has a meaningful relationship with the resident.

One clear example was given in relation to the resident's striking out during bathing of his genital area. The NA believed the resident was protecting his modesty and so defended himself against violation.

> It's a natural instinct (to ward off a stranger). To him everybody, no matter how long you've worked with him, is a stranger... In his mind someone he doesn't know is trying to violate him.

This "meaning" made the striking out logical and without intention to do personal harm. Rather than the resident being viewed as an aggressor, he became a victim of his perception and engendered the NA's empathy. The resident was communicating fear and the NA saw her role as calming his fears.

Attribution of cause and attribution of meaning provided useful insights to the NAs and gave a course to their actions. Cause was usually a more direct and concrete observation, something that could be changed or dealt with (e.g.,. changing the resident when he was incontinent lessened the possibility that he would become agitated). The

causes tended to be more common knowledge and were shared by many staff.

Attribution of meaning, however, came from the individual NA's appraisal, based on her unique relationship with the resident and her knowledge of him as an individual. Attribution of meaning was influenced by the NA's caregiving philosophy and the degree of mutuality between the resident and the NA. The observational and analytical skills of the NA plus her ability to connect with the resident directly affected the richness of her appraisal. One NA said very little when she was with the resident preferring that he talk on while she listened. Another NA responded to C__'s conversational tones and words which she felt had implied meaning even though most of what the resident said did not make any sense. Both felt their own tactic pleased the resident and provided him with respect. This suggests that there may not be a single best way to handle aggressive behavior. Instead the NA's sense of connection with the resident, no matter what form it takes, seems crucial.

Attribution of Volition

Intentional versus non-intentional aggression. During the interviews with NAs, they were asked whether they thought C__'s aggressive behavior was intentional. In response to that question, all the NAs denied that C__'s behavior was intentional. For example one NA stated:

> Take him in stride, don't ever take his aggression personally. At first I did (take it personally) but I don't now. Having other

> people yell at me . . . you know it's not you, it's them, that they don't understand what we're doing. That we're trying to help them.

However, on closer examination of the language used by some NAs to describe C__'s behavior, an implicit element of intentionality was detected. For example:

> He *tries* to hit us, just *trying* to push us away
>
> He can be very stubborn if he *wants* to be (emphasis added)

It is as if the NAs knew they were supposed to say C__'s behavior was unintentional and yet, at least to some degree, they believed it was volitional. When the NA's language implied that C__'s behavior was intentional, she tended to assume a more defensive posture when providing care to him. Although this defensive stance was helpful to some NAs (e.g., helped them protect themselves), it seemed to interfere with the quality of their relationship with C__. The task rather than the relationship became the goal for care.

In contrast, when the NAs use of language suggested their claim was not intentional, they tended to be more empathic in their appraisal of C__'s behavior. Those appraisals seemed to contribute positively to the NA's relationship with the resident. Sometimes the task was abandoned to preserve the relationship.

Nature of Appraisal

Empathic versus defensive appraisals. Empathic appraisals were appraisals seen from the resident's side of the experience, whereas defensive appraisals were appraisals seen from the NAs own experience

and position. Empathic appraisals led to greater mutuality by way of "knowing" the resident and this knowledge led to a wider variety of "tricks of the trade" (interventions) that could be used during caregiving. The broader the number of "tricks of the trade" the less likely it was that aggression occurred.

If on the other hand the appraisals are narrow in scope (e.g., seen primarily from the NA position of being at risk for injury) then the appraisal may lead to a more defensive stance. The defensive stance will focus more on protecting self and therefore focus away from "reading" the message of the resident. This approach tends to be one-sided and therefore limits the degree of mutuality in the relationship. The task rather than the relationship becomes the goal for care. When the task becomes the focus, the opportunity for aggression is higher because as one NA commented "pushing the resident" (to do a task) will result in him "pushing back".

Mutuality

The concept of mutuality is defined as the interactive quality of the relationship between the NA and the resident. Hirschfeld (1983) defined mutuality as the caregiver's "ability to find gratification in the relationship with the impaired person and meaning in the caregiving situation, . . . and the caregiver's ability to perceive the impaired person as reciprocating by virtue of his/her existence"(p. 26). Developing a good relationship with a resident can be complicated by the resident's cognitive impairment. The NA must often infer meaning from a resident's confused language and

behavior. Likewise because of receptive language impairment, the resident often must make inferences from the NAs non-verbal behavior. Mutuality arises from the beliefs and values of the NA together with her appraisal of the resident and the situation.

This concept is more elusive than the others. Quotes such as "I enjoy working with this resident" or "he's my favorite resident" were few because this resident was difficult and often the NA did not know what to expect from him. Even those who had many tricks of the trade had been hit or nearly hit. This is not the kind of situation one enjoys. Still, the ways in which NAs spoke of the resident did communicate a sense of the degree to which they liked him (e.g., "I like working with him . . . he's "a sweet guy"), felt emotional warmth toward him and wanted the best for him. Hence, the essence of the relationship or the mutuality was expressed in the warm and personal connection that the NA felt with the resident rather than the words per se.

Those who had limited mutuality conveyed ideas rather than feelings. They cared but on a less connected level. They were not invested personally as much as professionally. The degree of mutuality varied for each NA, depending on how she felt toward the resident. If aggression set up feelings of fear, anger or frustration, these feelings became blocks to the development or strengthening of mutuality. Those NAs who were empathic tended to resolve their negative feelings early and developed a relationship with the resident while those who were more defensive still struggled with mutuality.

Interestingly, an increase in the number of times the NA had given care to C___ did not necessarily lead to increasing mutuality, as one might expect. Some NAs had only cared for him on a few occasions, yet they had many tricks of the trade based on thoughtful appraisals and creative approaches. Others who worked with him routinely were perplexed by his behavior at times and had fewer tricks of the trade. The nature of their relationship was one of guardedness and distance in order to remain safe.

If the caregiving was brief with minimal opportunity to interact, the NAs had less information to use and fewer tricks of the trade: "We are not here during the day to see what his day was like." NAs on nights preferred he slept through their care because once he was fully awake he would get agitated. However, this circumstance offered little opportunity to get to know him. Previously he used to wander on nights:

> I just thought he was a cute man . . . I never had any problems when he got up and wandered around. I could always get him back to bed . . . I'd ask him about his job or playing football.

The mutuality stemmed from these conversations and so too did the interventions.

More influential than number of times the NA looked after C__ was the NA's activity with the resident. Specifically, the amount of care he required on her shift. A kinship of sorts developed while she was with him giving care and this provided her with opportunity to learn his idiosyncrasies:

> I've sort of tuned into him.
>
> I've gotten to learn what makes him tick.
>
> He's not a mean person, he really likes people and likes people to talk to him and it helps him and it helps us.

Mutuality was not always deepened by the degree of satisfaction the caregiver felt. Satisfaction was based on the goal set by the NA. If the goal of caregiving was to get in and out of his room without any aggressive incidents this might be better accomplished with minimal interaction, "Just do it and get it done with and leave him alone". However, if the goal was not just to accomplish a task but was to develop a relationship with the resident, the mutuality was strengthened. This sometimes meant that the task was abandoned in order to preserve the relationship. For example if the resident adamantly refused to have his teeth brushed the NA would not force the issue:

> One evening not getting their teeth brushed is not going to hurt them. Maybe you'll be a little bit more thorough next time. If it's going to mean . . . they're not going to sleep well or they're just going to be really frustrated it isn't worth it.

Mutuality then involved an advocacy role as well. This type of independent decision-making contributed positively to NA satisfaction.

The interaction of the NA's caregving philosophy and her appraisal of the situation contributes to the degree of mutuality in the relationship. The NA decisions on how to handle aggressive behavior

and what "tricks of the trade" best suit the occasion are an outcome of the reciprocal relationships between these factors. In order to understand the depth of mutuality and its influence, time must be spent listening to what the NA says and feels about her relationship with the resident.

Tricks of the Trade

"Tricks of the trade" are strategies or approaches utilized by the NA to handle the aggression or potential aggression of one resident. The term "tricks of the trade" implies that the NA learned her approaches on the job while she cared for the resident or from others who cared for him. Though some of these approaches may have been taught in the classroom, the "bedside" experience of the NA with the resident more clearly shaped the "tricks of the trade".

This experiential learning became obvious when the NA's responded to one particular interview question asking how they learned to deal with aggressive behavior and what they thought could be included in CNA training on this subject. Most NA's stated that they did not learn to care for aggressive people during their CNA training. As one NA said, "Graduate from your class and then welcome to the real world".

All NAs said that generalities could not be made and that since every resident is unique the NA must learn by caring for the specific resident. Learning could occur by watching someone care for the resident or by sharing tricks of the trade among one and other.

A new NA said:

> I just watched and then decided what I would do
> with him, because I could tell what they were
> doing . . . wasn't working too well.
> I'll probably learn more as I work with him more.

Sharing tricks of the trade was common, "We all kind of learned together, when he came. And our nurses report always helps . . . and we'll share ideas then". She acknowledged that there were things written down in his chart but usually the sharing was oral.

Some NAs suggested that students be assigned an aggressive resident during CNA training for two reasons: a) to learn skills, and b) to be screened for their capabilities in caring for this type of resident. Most saw themselves as hands-on learners and felt the classroom was not the appropriate milieu for learning bedside skills. Instead they preferred learning on the job. They all agreed that no general principles could be taught even though some of their "tricks of the trade" were commonly held beliefs. It is interesting to note that none of the NAs interviewed mentioned the professional staff as a source of direction and guidance in handling this very complex gentleman's care.

Many examples of "tricks of the trade" were described and these related to the caregiver's style or were approaches found to be effective and therefore shared among the NAs.

Caregiver's Style

A caregiver's style could be translated into a "trick of the trade" depending on how cognizant the caregiver was of the relationship between her behavior and the resident's aggression. Some NAs utilized their behavior as a management strategy while others did not make the connection. The following quote suggests it can be a critical factor in whether aggression occurred:

> The approach is the main, the most important thing. The people he has is a very big factor. It takes a certain kind of people to be able to work with him.

Examples of NA behavior that could trigger the aggression were: rushing or pushing the resident (e.g. "If you start pushing him he'll push back"); talking too loud or too much; or asking too many questions. One NA who was struck by the resident for no apparent reason said maybe she had asked him too many questions. Some NAs would not go in alone to care for C__ while others believed that it was better to care for him alone except if help was required during transfers. The "group" approach may have been related to a "safety in numbers" philosophy.

Not all NAs focussed on the caregiver's style, but those who did were adamant that NA behavior played a critical role in whether or not the resident got agitated, thus increasing the potential for aggression.

The less the NA associated her approach with the resident's reaction, the fewer tricks of the trade she seemed to have and the more perplexed she seemed to be about how to manage the aggression. It is

as if this lack of understanding of cause and effect rendered the NA more powerless in the situation. As a result, approaches aimed at containing the behavior rather than preventing it were more frequently used.

Commonly Shared Approaches

Even though there was no one right way some interventions were commonly used:

> If I can tell he's going to be uncooperative from the beginning, and angry, I'll just leave for awhile and come back.
>
> Be easy and go slow with him

Several NAs said that only one person should give directions to the resident and these should be brief and clear. When doing activities of daily living such as brushing his teeth, using a washcloth or coming to a standing position, NAs found that getting C__ started with the action was often necessary before he could take part.

The problem of C__ "grabbing" and holding onto the NA (an action was vice-like and had the potential of being injurious if not handled effectively) stimulated a variety of creative approaches.

> I go through the arm (of his shirt) and hold his hand so I can bring his arm through it without him grabbing.
>
> I never let him get me around the wrist . If I let him get a hold of my hands I can slip out.
>
> He's got a big jar of licorice. Hand him some of that or I usually stick it in his mouth and then he has to take his hand (off) to take it out of his mouth.

Give him a towel (to hold onto).

NAs knew that trying to pull away once he had a hold made him grip tighter and all said they would wait until he relaxed his grip.

These tricks of the trade were shared among the NAs, sometimes at their report, at an orientation to the resident, or just informally when one NA helped another. There were strategies written down on the front of C__'s chart but only two NAs mentioned them. Others said there was nothing written down. This observation further confirms that NAs are more oriented to "hands-on" learning. Written communication, care plans or classroom examples may be less instructive given the nuances of the situations they encounter at the bedside.

Aggressive Behavior

Aggression was operationally defined as hostile action (verbal or physical) directed toward the other person, objects or toward self (Ryden, 1986). The study intended to examine the congruence between the NA's definition of aggressive behavior and the operational definition however there were only two occasions where aggression occurred. In the three other observations (two NAs were observed in the same activity) aggressive behavior was averted.

During the caregiving situations where aggression occurred operationally both NAs denied that the behavior was truly aggressive. On both occasions it was very hot. In one situation where C__ swore at the NA she explained that her drying his sore ankle triggered his response, the swearing was his expression of pain. Rather than be

defensive this NA apologized for hurting him and acknowledged his discomfort. This NA also used much reassurance in a kindly voice and made eye contact frequently. C__'s hostile mood switched quickly to laughter and the Na smiled with him. It appeared that the "trick of the trade " here was to match C__'s mood and acknowledge his pain and fear.

On the second occasion C__ was tired and irritable. He was verbally abusive at times and he did swing out but did not actually strike the NA. The NA was able to calm him with her reassuring voice and gentleness and she successfully de-escalated the situation. She had wanted to use C__'s cane as a prop to help him come to a standing position, however, this was a new technique and her helper did not agree with the strategy. She appraised C__ as overtired and said the NA helping her was going faster than she would have on her own:

> I had a different idea of doing things than the other
> NA did and I think it could have gone smoother.

It was clear while observing, that the two NAs had different styles and so appraised the resident's needs differently. Most NAs preferred to do caregiving on their own until it was time to have C__ get into or out of bed. As this NA explained when one NA helps another, the helper's work gets behind and they may not always want to take the extra time. When asked how the experience was, this NA said:

> Well, overall it was average. He wasn't overly aggressive
> or anything. He can be but he wasn't even though

at bedtime it might have appeared that way. That was typical for me. It's unusual for it to go real smooth at bedtime.

During the course of the other observations the NAs used various "tricks of the trade" to handle C__'s behavior. Their caregiving philosophy became apparent in the strategies they chose. One NA gave him licorice to hold and chew on while she dressed him in order to avert him grabbing the clothing or her wrist. Another NA found that having C__ stand beside his bureau where he could investigate articles there while she washed and dressed him from behind worked very well. She could not be hit and he was distracted by the items he chose to hold. This approach came from careful observation and trial and error. This kind of appraisal and evaluation did reduce opportunity for aggressive behavior benefitting the resident and the NA.

Night shift had three NAs go in to do the caregiving - one to hold his hands close to his chest, one to talk to him and one to change his pants. They found that if C__ were sleepy when they went in he would be easier to change; he was sleepy and he showed no resistance to their care thus reinforcing their appraisal. Since they reported him to be aggressive 50% of the time they chose to have three NAs go in at all times for safety purposes.

NAs who had many tricks of the trade reported less difficulty with caregiving. They also based their strategies on their own interactions, taking into account how their behavior affected the resident's. When the list of tricks of the trade was short, it was often because a set routine was

in place and the caregiving activities were circumscribed. Those with fewer tricks of the trade were often more perplexed by the behavior and used fewer appraisal skills. The quality of mutuality was also not as rich. These NAs reported more aggressive incidents.

Chapter IV

CONCLUSIONS and IMPLICATIONS of STUDY for THEORY, PRACTICE and RESEARCH

Theoretical Implications

The conceptual framework for this study was attribution theory. That theory states that If we can understand how people attribute cause to a situation we may be better able to predict the outcome. The study explored NA's perceptions of behavior that occurred during caregiving to a resident known to be aggressive.

The importance of attributing a cause to the behavior and thus understanding and predicting the behavior was validated. NAs identified the locus of cause as either in the person (e.g., he didn't understand what was being done and so resisted taking part) or in the environment (e.g.,. noise or weather). Those NAs who were able to identify cause and give meaning to the behavior were also better able to intervene and perhaps avert the aggression. Sometimes though, no cause could be identified. Those who were perplexed by the cause of the behavior tended to be more defensive and limited in their caregiving approach. This is consistent with the findings of Harvath (1986) in her study of family caregivers.

Attribution theory also holds that attribution of intention is critical to how people behave (Frieze et al, 1979). All the NAs in this study indicated that the aggression was not intentional nor personally directed toward them, although they did say that the behavior held meaning and

that the aggression was intended to stop the caregiving activity. Since none of the NAs indicated direct intentionality (although some eluded to it) a comparison of outcomes was not possible. Taking the aggression personally may be more common in family caregivers since they have a longer history with the resident.

Attribution of causality involves "categorization of information, judgements and evaluation" (Frieze & Bar-Tal, 1979, p. 4). There was strong support for the complexity and importance of thinking that goes into attribution of causality. The ability of the NA to do this cognitive work was variable. Some NAs collected minimal information, did not connect their own actions with the resident's behavior and evaluated only whether or not aggression occurred. Others collected detailed information, had varied and creative "tricks of the trade" and set goals involving the relationship rather than the behavior. Perceptions seemed to depend not so much on the number of experiences with the resident but on the depth and reflection of those experiences.

Attribution theory speaks of the lay person's perspective. Though NAs were seen to be "lay" because of their limited training some were quite capable of managing complex problems. The study supports the investigation of these skilled caregivers' methods of problem solving.

A surprise finding of this research was the importance of the concept of mutuality. The depth of the mutuality played an important role in the attribution of cause and enhanced the quality of the interventions and outcomes. This finding supports other studies done with family

caregivers where mutuality eased certain aspects of role strain (Archbold, Stewart, Greenlick & Harvath, 1990).

The interaction of the concepts in this study deserve further investigation to see if they hold true in a larger sample. The question of what risk factors for aggression might be identified would have impact on hiring practices and training programs. The issue of how NAs learn is important for educators to understand because it is unlikely that we will ever see an all-RN staff in the nursing home.

Implications for Practice

In this study, NAs stated that they did not learn how to care for an aggressive resident in their initial training nor do they believe that the classroom is the place to learn. Instead they saw themselves as learning by experience and from other successful peers. The success of their peers seems to stem from their observational and analytical ability, as well as a philosophy of care that highly values the relationship with the resident. As these three activities interact the NA collects many "tricks of the trade"; the more tricks she has the less likely she will experience aggressive behavior.

In the hiring interview, it would behoove us to learn what the NA's caregiving philosophy is and how she has handled a particular aggressive incident. This may alert the interviewer to the risk factors involved in this NA's approach to aggressive behavior (e.g., what are her attributions of causality) and where her training should be directed.

Since training on the job and supervision are limited commodities, it would probably be wise to start with those NAs having problems and have their learning occur by observation of a successful NA. RNs might spend more time at the bedside with these NAs and their residents so that a comprehensive assessment of the problem could occur. During the hands-on activity, the RN could identify the potential of the NA to learn to work with aggressive residents, for example, assessing if the NA is abrasive, conflictual, fearful etc. Also in having a peer act as a role model the RN is valuing the talents of her NA staff and providing job satisfaction not to mention teamwork. Taking the opportunity to share expertise would also lead to expanding peoples' skills and place value on the problem solving process. It is important to realize that the NA working with an aggressive resident must be watchful for escalating behavior. However, being too guarded may block the NA's ability to interpret complex or subtle messages from the resident. If expertise is not available within the facility then an external consult might be requested.

Programs have been developed to train staff in the management of aggressive behavior (Mentes & Ferrario, 1987; Crandall, 1986; Robinson, Spencer & White, 1989). Although this clearly responds to a felt need, it appears that understanding NAs perceptions of the aggressive behavior is warranted before teaching intervention strategies. Otherwise we risk a mismatch of need and intervention through application of a generic program.

It seems clear that NAs do not use documented careplans as much as word of mouth. Certainly the Clinical Nurse Specialist would be in a perfect position to set up the learning experiences and evaluate their impact. The goal of which would be to enhance the NAs philosophy, appraisal skills and mutuality thus increasing her tricks of the trade. The role of the professional nurse in problem solving may need more attention too, especially since they were not mentioned as resources by the NAs in this study. It may be that the NA sees herself as a lone worker and not a member of a team.

This study also brought to bear the role of the family. They often hold important clues to management strategies and need to be included. This would have three benefits: NAs would learn positive approaches from people who really know the resident and knowing the resident as a person may lead to enhanced mutuality; the family would feel involved in the caregiving; and both groups might come to a better understanding of the other's dilemmas. Hopefully, the more expertise brought to bear on the situation the more the resident will benefit.

We must also investigate what types of support are required by staff in order to deal with the psychological stress that comes with aggression. The emotions triggered by an aggressive resident can have an impact on the relationship. NAs who are frightened might avoid getting close to the resident; those who get angry might withdraw their warmth from the resident. When emotional response to aggression is not dealt with on a unit, NAs may avoid evaluation of their feelings and the

impact of those feelings on the residents. Examples of staff support include: on-site peer support groups; external Employee Assistance Programs and or incident review meetings (Dawson, Johnston, Kehiayan, Kyanko & Martinez, 1988). Emotional support for nursing home staff will directly effect resident care.

Finally, at the system level, it seems important that we re-evaluate the tasks of each shift and the inherent problems of shift routines. In the days when custodial care was the goal of a nursing home, turning and changing the resident was a critical activity. Now residents are up for long periods during the day and there are numerous incontinence products to protect skin. Perhaps the routine of frequently waking, changing and turning residents on nights should be re-evaluated. Imagine the continual trauma to the cognitively impaired resident who feels attacked every night when staff go in to change him. Staff and resident become victims of a shift routine. Establishing mutuality on a shift where the only encounter with residents is rapid and potentially traumatic is difficult, yet we have identified that mutuality is one key to the handling of aggression. Hence a paradox exists. Perhaps we should wait for the resident to alert us to his discomfort before disturbing him to make him comfortable. The professional staff will need to take the lead in changing the system.

This study points to approaches which are meant to prevent or de-escalate incidents of aggression - approaches which come directly

from the bed-side caregiver. Since many NAs do handle aggressive residents effectively it becomes clear that the task is not impossible.

Future Research

A question for future research remains: What are the foundations for building deep and rich mutuality between the resident and NA? If NA philosophy and appraisal are integral to mutuality how might we foster these? Is there a point at which too much mutuality is a problem (e.g., the NA becomes too involved? Perhaps having a long list of tricks of the trade is critical but not enough to deal with the problem of aggression in the elderly nursing home resident. Teaching interventions is manageable but how do we teach people to develop a meaningful relationship with the resident? One appears to depend on the other.

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Abstract

Title: Aggression in the Nursing Home:
Nurse Aide Perceptions, Appraisal and Management

Author: Ann-Marie Monahan

Approved: ____________________________________
Beverly Hoeffer, RN., DNSc., Advisor

This study examined the issue of aggressive behavior in an elderly nursing home resident from the Nurse Aides' (NA) perspective. Using a qualitative exploratory study design the investigator observed six different NAs providing the same type of care to the same resident. During a guided interview NAs were asked their perceptions of the behavior displayed, their attribution of the cause of the behavior and the meaning they gave to the experience.

Analysis of the data resulted in the development of a conceptual model that explains how the NA's perceptions are formed and how these perceptions, in turn, influence her management of aggressive behavior. The differences in management of aggressive behavior seem to be reflected in the following concepts: caregiving philosophy; appraisal of the situation; mutuality (NA relationship with the resident); "tricks of the trade" and finally the occurrence or non-occurrence of aggressive behavior.

Each NA has her own philosophy of caring for aggressive residents and this philosophy influences how the NA appraises the situations where aggression may occur. The appraisal of the situation influences and, in turn, is influenced by the degree of mutuality that develops (e.g., the quality of the NA's relationship with the resident). Mutuality enhances the NA's ability to recognize triggers for aggression in the situation. She then utilizes "tricks of the trade"

developed primarily through experiential learning. These intervention strategies may or may not be effective in averting or managing the aggressive behavior. Based on the feedback she receives from her actions she may adjust her "tricks of the trade" for better results and be willing to try a variety of strategies given her appraisal at the time. Mutuality is central because it acts as a mediating factor in each situation. The richer and deeper the mutuality the more "tricks of the trade" the NA collects and the more likely she is to anticipate a potentially aggressive action and to handle it effectively. The behavioral outcome of her "tricks of the trade" influences her appraisal of the situation and in turn contributes to her caregiving philosophy, and the mutuality that develops. The findings have important implications for nursing practice even though the study is limited by its' small sample size. Firstly, NAs come into their job with a caregiving philosophy which needs to be elucidated in the hiring interview as it gives clues to the NA's future management of aggressive behavior. NAs consistenly reported that "tricks of the trade" were learned at the bed-side in an experiential way. Nurse educators need to recognize this preferred style of learning and make programs compatible to this delivery method. Finally the concept of mutuality is critical to successful outcomes. This means that all those involved in the nursing home, family included, must make the system complimentary to that relationship.

The identification of concepts in this study suggests that further exploration of NA beliefs and behaviors may lead to more successful management of aggression in the Nursing Home.

Appendices

Appendix A

Consent Forms

Oregon Health Sciences University
Informed Consent
Nurse Aide

Title
Working with Difficult Residents - Caregiver Perceptions and Attribution of Causality

Principle Investigator
Ann-Marie Monahan, RN. BSN. (Master's Student)
Phone: (503) 238-7601

PURPOSE

Ann-Marie Monahan, a master's student in the School of Nursing, is doing a research project designed to understand how Nurse Aides, working in a Nursing Home, perceive particular behaviors in elderly residents during a caregiving activity.

PROCEDURE

If I agree to participate in the study, Ann-Marie will accompany me during a caregiving activity (e.g., toileting) and later that shift will ask me questions in private about the experience from my personal point of view. This interview will be tape recorded. The interview will take about 15 to 30 minutes. The tape will be destroyed following transcription and my identity will be protected.

RISKS AND DISCOMFORTS

Information shared in the interview will be used in the study; however my identity will be protected. Should Ann-Marie discover resident abuse she is required by law to report this to the Director of Nursing. However, she would discuss this with me at the time.

BENEFITS

I may not benefit directly from participating in this study, but the information may help other people in the future. Participation gives me an opportunity to share my experience of working with this resident.

CONFIDENTIALITY

Neither my name nor my identity will be used for publication or publicity purposes.

COSTS

There are no monetary costs involved for me as a participant.

COMPENSATION

Since the interview time is not available during my regular work day it will occur during my meal break or in the half hour after my shift and I will be compensated with a five dollar stipend.

LIABILITY

It is not the policy of the Benedictine Nursing Center to compensate or provide medical treatment for human subjects in the event that the research results in physical injury.

The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. Should I suffer any injury from the research project, compensation would be available if I establish that the injury occurred through the fault of the University, its officers or employees.

Ann-Marie has agreed to answer any questions I may have. I may refuse to participate in this study or withdraw at any time without affecting my relationship with this agency or the Oregon Health Sciences University. I will be given a copy of this consent form. My signature below indicates that I have read the foregoing and agree to participate in this study. If I have further questions, I may call Dr. Michael Baird at (503) 494-8014.

-- ---------------------------------------

Participant's Name Date Witness' Name Date

Oregon Health Sciences University
Informed Consent
Resident's Family

Title

Aggression in the Nursing Home - Caregiver Perceptions and Attribution of Causality

Principle Investigator

Ann-Marie Monahan, RN. BSN. (Master's Student)
Phone: (503) 238-7601

PURPOSE

Ann-Marie Monahan, a master's student in the School of Nursing, is doing a research project designed to understand how Nurse Aides working in a Nursing Home perceive particular behaviors in elderly residents during a caregiving activity.

PROCEDURE

If I agree to my father's participation in this study Ann-Marie Monahan will accompany, on separate occasions, six Nurse Aides while they do one caregiving activity (e.g., toileting) with my father. There will be no change in the way care is given to him as Ann-Marie will be an observer only. Ann-Marie will seek assent from my father before going along.

RISKS AND DISCOMFORTS

My father may feel more distracted with an extra person in attendance, but there should be no other risks or discomforts.

BENEFITS

My father will not benefit directly from participating in this study, but the results of the study may help other people in the future.

CONFIDENTIALITY

Neither my father's name nor his identity will be used for publication or publicity purposes.

COSTS

There are no monetary costs involved for my father as a participant.

LIABILITY

It is not the policy of the Benedictine Nursing Center to compensate or provide medical treatment for human subjects in the event that the research results in physical injury.

The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. Should my father suffer any injury from the research project, compensation would be available if I establish that the injury occurred through the fault of the University, its officers or employees.

Ann-Marie has agreed to answer any questions I may have. I may refuse participation in this study on behalf of my father or withdraw him at any time without affecting our relationship with this agency or the Oregon Health Sciences University. I will be given a copy of this consent form. My signature below indicates that I have read the foregoing and agree to my father's participation in this study. If I have further questions, I may call Dr. Michael Baird at (503) 494-8014.

-- --------------------------------------

Daughter of Resident Date Witness' Name

Appendix B

Demographics

Questionnaire

DEMOGRAPHICS

Date ________________ Shift_______________

Caregiving Activity

____

Experience with C ____________________

Status FT_____ PT ___________ On-Call_________
Other_____________

Sex F____ M____ Months_______ Years ______ as NA

Time at BNC ________ Time elsewhere __________ as NA

MRP IV QUESTIONS - REV 7/10

___ agree it didn't occur **___agree it did occur**
___didn't occur but labelled **___ did occur not**
labelled

Intro Question

Would you tell me about your experience of looking after C__ today. What was it like for you?

1. Were there any of C__'s behaviors that made caring for him hard for you?

2. How would you label these behaviors?

3. I'll name each behavior you mentioned and I'd like you to tell me what you think caused the behavior **OR** I saw the following behaviors what caused them?

4. What do you think accounts for C__ being ________ to care for today?

5. How does that make a difference?

a) anything you did?

6. Was there any point at which you thought he might be getting difficult to manage?

7. What was going on then?

8. Is there anything that makes C__ more difficult to care for?

9. How do you feel about looking after C__. Do these feelings change and if so when? e.g., before, during, after.

10. If you were orientating a new NA what advice would you give them about looking after C__?

11. Have you ever looked after C__ when he was difficult? What did he do?

b)Why did he do this?

c)How did you feel?

12. Have you ever experienced C__ being a________ at times?

b) what did he do? and Why?

13. How was it for you that I went with you for caregiving?

14. What should we teach NA's about caring for resident like C__.?