

AN INTERVENTION FOR DIGNITY-ENHANCING CARE
IN PERSONAL CARE HOMES:
THE DEVELOPMENT OF A RESPECTFUL CARE TRAINING
PROGRAM FOR NURSING ASSISTANTS

BY

Jo Ann Egilson

A Practicum submitted to the Faculty of Graduate Studies
In partial fulfillment of the requirements for the degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
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Abstract

This practicum examines the concept of dignity as a standard of care in personal care homes. As a standard of care, the meaning of dignity ought to be clearly defined and operationalized so that caregiving staff and institutional systems understand their role(s) in contributing to (or undermining) the personal dignity of residents of personal care homes (PCH).

A literature review identified two primary components to dignity: an external component described as *worthiness* and an internal component described as *self worth*. The intervention in this practicum was directed toward the external component to dignity. The intervention encouraged caregiving staff to provide *respectful care* as a means to communicate to residents that they are valued, *worthy* individuals whose lives matter to those around them. Respectful care has the potential to buffer the challenges and indignities that residents may face from the many debilitating chronic illness(es) that tend to precipitate their admission(s) to PCHs. Further, respectful care can have a positive effect on the internal component to dignity – the resident's sense of *self worth*.

In this practicum, staff training in respectful care was identified as an intervention to enhance resident dignity. A Respectful Care Training Program was developed, and implemented with a group of thirty-three nursing assistants who were working or training in Assiniboine Region personal care homes. The training was delivered in a 6-hour format over the course of one day and focused on improving participants' skills in empathy and respectful staff-resident interactions, while overcoming barriers to respectful care such as resident conflict, and problem behaviors associated with dementia.

A participatory approach to the training, attempted to build skills for participants to implement in their workplaces following the training.

The results of the evaluation component of the training program identified high levels of participant satisfaction with the content, delivery, and effectiveness of the training program in helping increase sensitivity and display respect toward residents following the training.. The results also indicated that though the majority of participants displayed high levels of empathy and positive attitudes before and after the training program, barriers to respectful care do exist in the workplace; these include staff burn out, heavy workloads, conflict with residents, abuse of staff by residents and dignity diminishing care of residents by staff.

The results of the evaluation of the program were mixed showing slight levels of improvements in participants' empathy and attitudes following the training and slight decreases in the amount of conflict with residents reported following the training. The slight variations in measures may indicate that the measurement instruments were not sensitive enough to detect the level of changes or that more training in these areas is required to result in significant change.

The general findings of this practicum indicate that though training is one approach to enhance resident dignity, organizational policies must also address systemic barriers to dignity-enhancing care such as staff shortages, heavy work loads and work place stress.

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Ah, but a man's reach should exceed his grasp, Or what's a heaven for? . . . Robert Browning

Chapter 1

Overview

1.1 Statement of the Problem

Residents¹ of personal care homes (PCHs)² by their citizenship as Canadians, have their right to dignity protected by the *Canadian Constitution (1982)* as stated in the *Charter of Rights and Freedoms*. Further to this, the promise of personal dignity is a standard within the various *statements of residents' rights* that are displayed in PCHs to guide the behavior of those who live and work there.

If the enhancement and protection of personal dignity is a standard of quality care within the PCH context, then it is apparent that the meaning of dignity ought to be clearly defined and operationalized so that caregiving staff³ understand their role in contributing to (or undermining) the personal dignity of residents. The people who reside in PCHs tend to be the frailest elderly who often do not have the personal or social resources to advocate for systemic change. The PCH social worker is challenged to advocate for dignity enhancing care and to intervene in situations where a resident's dignity has been violated. If the caregiving staff have the potential to enhance personal dignity or to violate it, then it is a role of social work to plan interventions with staff to minimize violations of personal dignity and to maximize interactions that enhance the personal dignity of residents.

The term *dignity* has been described in the literature as a component of quality care and quality of life, and as a social norm and moral framework. It is a complex state of being that is personally held and socially influenced. *Dignity* has been described as “pride, self-respect, quality of life, wellbeing, hope and self esteem. While most of these terms refer to internal states of mind, dignity is distinctive in that it also has an external component based on the perception of one’s worthiness of honour and esteem from others” (Chochinov, Hack, McClement, Kristjanson, & Harlos, 2002, p.441).

For the purpose of this practicum the terms *worthiness* and *self worth*, together capture the essence of the concept of dignity because they include both the external and internal components of dignity. An individual has his/her sense of worthiness acknowledged if he/she experiences the external components of dignity - positive, respectful interactions with others. These external components help the individual develop a positive sense of *self worth* which is the inner component of dignity (see Table 1).

Throughout the practicum report, the term “respectful care” will refer to caregiving approaches that communicate to residents that they are valued, *worthy* individuals whose lives matter to those around them. A respectful philosophy of care that guides the quality of staff-resident interactions can serve to buffer the challenges and indignities that residents may face from the many debilitating chronic illness(es) that tend to precipitate their admission(s) to PCHs. At the very least, respectful care approaches must help residents maintain their personal dignity, if not to enhance it, and must help deter disrespectful interactions that have the potential to diminish resident dignity and self worth.

Table 1: Internal and External Components to Dignity

1. The external component to dignity in the PCH context:

WORTHINESS

The acknowledgement of resident worth by positive respectful interactions with others:

“Respectful Care”-

These interactions enhance opportunities for Residents to be independent, to have choices, to experience privacy, to feel positive about their image and to experience an overall sense of worthiness or respect in the eyes of their caregivers.

Respectful care strengthens: ----->

2. The internal component to Dignity:

The resident’s sense of SELF WORTH

This inner component is strengthened by the external component. The Resident’s self worth is thereby buffered by **“Respectful Care”** in the face of external threats to self worth such as the personal losses associated with the onset of disability and/or symptoms of progressive illness.

WORTHINESS + SELF WORTH =

AN ENHANCED SENSE OF DIGNITY

The resident’s sense of dignity can be kept intact when he/she feels empowered, safe, valuable, and worthy in the respectful care environment.

Both the literature and personal care home facilities have identified staff training as an important factor in improving the quality of care and quality of life of residents in personal care homes. Many personal care homes in Manitoba and across Canada face staff shortages such that hiring practices have evolved over the last number of years where a significant number of untrained nursing assistants have been hired to provide direct resident care. Nursing assistants are the front line workers who most frequently interact with residents in personal care homes. It is vital that they have the knowledge and skills required to communicate respect to residents while they provide for physical care needs.

Staff shortages and heavy workloads are barriers to staff training programs. Staff who attend training programs must have their work shifts filled by other staff in order that resident care needs are met. This places increased cost on the facilities for staff coverage, and also places limitations on the staff who request the training. If they cannot be replaced to attend training, then they cannot attend the training unless they choose to attend on a day off. This usually means that the staff who participate in training opportunities are the minority of staff, rather than the majority. This barrier places a double bind on staff and facilities and limits the potential for a respectful philosophy of care to be fully developed or supported in personal care homes.

Enhancing resident dignity is a complex, multi-faceted task that requires staff with advanced interpersonal skills. The personal care home context challenges staff to provide respectful care on a daily basis. Challenges such as heavy workloads, staff shortages, and lack of time to complete care tasks, are made more difficult to cope with

when staff are faced with physical and verbal abuse by some residents with cognitive impairments.

Nursing assistants require skills in conflict management and dementia care if they are to overcome risk factors that are barriers to respectful care. In order to attain these skills, staff require support from the organization through incentives that encourage and facilitate attendance at training opportunities. At the same time they require the organizational support necessary to reduce staff shortages and to reduce the stress of the personal care home environment to tolerable levels.

Training programs must be shown to be effective in improving staff knowledge. Further, training programs must be shown to be effective in encouraging new skills that are implemented on the job after the training is completed. Facilities can be encouraged to invest in intensive training programs for staff, if they are satisfied that training outcomes will bring positive change to staff-resident interactions and quality of care.

1.2 Purpose of Practicum

The purpose of this practicum was to implement an intervention to enhance resident dignity by developing, implementing and evaluating a training program for nursing assistants. The development of the training program was guided by the following parameters:

1. The training program would enhance the knowledge of participants in providing respectful care, while providing them with useful skills that would be implemented after the training was completed.

2. The duration of the training program would be provided within a reasonable time frame in order that it be feasible for staff to attend, while ensuring resident care needs were met.
3. The training program would engage the support of the regional health authority to support staff attendance through whatever incentives available.
4. A measuring tool would be developed to evaluate the effectiveness of the training program in improving attitudes and subsequent respectful interactions with residents. This measuring tool would also identify future training needs.
5. A report would be provided to the regional health authority describing the training program, the results of the program evaluation, and recommendations for future revisions/use of the training program.

This practicum was an opportunity for me, as a social worker who is employed in a personal care home to intervene at the level of the larger system. The opportunity to train a sample of personal care home nursing assistants in order to enhance the dignity of residents was an important step towards fostering a respectful care philosophy in the personal care homes where the nursing assistants worked. The limitation to this intervention was the small sample size; the participation of all staff would be required to truly foster a respectful philosophy of care. However, this was a valuable opportunity for partnership with the regional health authority to encourage their future use of training programs as a method to enhance resident dignity in all personal care homes.

Chapter 2

Practicum Setting and Objectives

2.1 Practicum Setting

The training program was implemented in Assiniboine Health Region – which is located in the south west portion of Manitoba. The primary site for implementation of the training program was East View Lodge Personal Care Home. The Neepawa Resource Centre was a secondary site for one session of the training implementation.

East View Lodge PCH is located in Neepawa, MB and operates under the direction of Assiniboine Regional Health Authority. It is a long term care facility which provides care to 124 older adult residents who require assistance with activities of daily living due to problems associated with the onset of chronic illness and/or disability.

This setting was chosen for a training site because the student's area of specialization is in the long term care environment. Also, it is the student's workplace as facility social worker, and one goal of the practicum was to attempt to implement systemic changes in the workplace to benefit residents' dignity. It was hoped that the training program, if shown to be effective in educating staff on dignity enhancing care, would become part of the orientation program for new staff, and be given to current staff at intervals as refresher training and as part of a continuing quality assurance program. The training program was not limited to employees of East View Lodge PCH. Nursing assistants, who were training, recently hired, or working in Assiniboine Region in personal care homes were invited to participate in the program.

Personal care to residents in personal care homes is provided primarily by nursing assistants, under the supervision of registered nurses and licensed practical nurses. Over a number of years staff shortages have resulted in some personal care homes hiring untrained nursing assistants. The formal job requirements include a grade 12 and the successful completion of a certificate in Health Care Aid from a recognized community college program. The nursing assistant's job tends to be task oriented with heavy workloads, and frequent staff shortages (Goodridge, Johnston & Thompson, 1997). This leads to a coinciding high turn over of staff resulting in the need for frequent hiring of new staff.

Untrained staff are required to enroll in a certificate program or they can challenge the credit after a certain number of hours worked. It is important that staff have advanced interpersonal skills to meet the challenges of the job, and the needs of the residents. Untrained staff are less likely to have had specific training or experience in providing respectful care, or in dealing with high conflict situations, or residents with unique problems associated with dementia. These skills should not be left to be acquired "on the job". The fact that there are greater numbers of untrained nursing assistants highlights the importance of a respectful care training to be provided as part of an orientation program or as an ongoing program of staff development to ensure dignity enhancing care.

2.2 Intervention Objectives and Goals

For social workers in the PCH setting, interventions occur at the interface of three separate but interdependent systems - residents, staff, and the institutional environment;

these three variables interact in complex ways; at times, the personal dignity of residents is supported; at other times dignity is violated. The ecological perspective guides social work practice in PCHs – the knowledge that the relationship between people and their environments “is characterized by continuous reciprocal exchanges, or transactions, in which people and environments influence, shape, and sometimes change each other” (Germain, 1991, p.16).

Compton and Galaway (1994, p.6) refer to Rein’s description of the function of a radical casework approach in social work – it is “not merely obtaining for clients social services to which they are entitled or helping them adjust to their environment, but also trying to deal with the relevant people and institutions in the clients’ environment that are contributing to their difficulties”. Social workers in personal care homes are challenged to advocate for resident dignity by intervening in the system itself; it is the systemic problems of PCH living that creates the largest challenge to resident dignity – abuse of care and power, ageism and paternalism, the nature of caregiving and institutionalization. These are environmental barriers to dignity which can create more problems for residents than their own personal challenges of disability and illness.

The role of social work in PCHs includes helping staff become sensitive to approaches that impact personal dignity and investigating ways to improve policy and address the inflexibilities of a system that creates the conditions where dignity is violated. The practicum, by focusing on a definition of dignity enhancing care, and by the development of a “Respectful Care Training Program” that is based on this definition, attempted to address *some* of the personal and systemic problems that are barriers to residents’ dignity.

The practicum attempted to foster the knowledge and skills that are required to provide for resident dignity by implementing a staff training program. The objectives and goals of the intervention are summarized as follows:

Objective # 1

Based on a review of the literature on *Dignity*, to develop, deliver, and evaluate a “Respectful Care Training Program” for nursing assistants that emphasizes skill development for providing respectful care for residents in nursing homes.

Goals

- a) To identify core curriculum to develop a Respectful Care Training Program.
- b) To identify training methods for improving participant empathy, sensitivity to the quality of staff-resident interactions, and skills in conflict resolution, dementia care, abuse prevention and advocacy.
- c) To review current training programs that focus on the identified core curriculum, and to incorporate material from these training programs into the Respectful Care Training Program.
- d) To engage the regional health authority to encourage nursing assistant participation in the program.
- e) To assess the trainees’ attitudes and knowledge prior to the training program to develop a baseline for comparison.
- f) To implement the training program with a group of nursing assistants who work in personal care homes under the direction of the Assiniboine Regional Health Authority (ARHA).

- g) To evaluate the training program's effectiveness in influencing staff attitudes and behaviors towards residents following the training program and to answer the following questions.
- i. Is the program effective in increasing empathy of participants for residents?
 - ii. Is the program effective in improving the ability of participants to meet the resident's requirements for the enhancement of personal dignity?
 - iii. Is the program effective in increasing the sensitivity of staff regarding caregiving approaches that enhance vs. diminish resident dignity?
 - iv. Is the program effective in reducing the frequency of participant conflict with residents?
 - v. Is the program effective in prompting staff to respond to problem behaviors in a respectful way?
 - vi. Is the program effective in prompting staff to intervene in abusive situations?

Objective # 2 To engage the participants in identifying methods for improving respectful care as well as barriers to respectful care and to elicit their cooperation in seeking solutions to these.

Goals

- a) To encourage a participatory approach to learning where participants share strengths and best practices.

- b) To encourage an experiential approach to learning where participants can share what they have learned during the training and the feelings associated with their experiences.
- c) To incorporate participant feedback into a final report that will be made available to participants who request it.
- d) This feedback will include participant satisfaction with the training program, suggestions for program improvements and perceptions regarding organizational barriers to respectful care and solutions to these.

Objective # 3 To engage the regional health authority to support the training of personal care home staff as an intervention to enhance resident dignity and as a method to foster a respectful philosophy of care in personal care homes.

Goals

- a) To work with the regional health authority to implement the program and assist with recruitment of participants.
- b) To provide the regional health authority with a practicum report that describes the training program curriculum and the findings from the program evaluation.
- c) To provide the regional health authority with recommendations for program revision, the potential for future use of the training program and future staff training requirements.
- d) To provide the regional health authority with participants' perceptions regarding organizational barriers to respectful care.

The training program was designed to improve staff empathy for the situation of residents, and the connection that personal dignity has with the residents' experience of privacy, independence, respect, choice, sense of worth and belonging. The training focused on sensitivity training through role plays, and the development of staff skills in conflict resolution and dementia care. The training identified specific risk factors such as conflict, dementia, and work stress and attempted to develop concrete skills that staff could use to deal with these following the training. It was hoped that a positive outcome of this intervention would include the reduction of the frequency of staff-resident conflict. Abuse recognition and prevention was a focus of the training. By identifying what constitutes resident abuse, and by emphasizing the staff's responsibility in preventing and reporting abuse, it was hoped that the incidence of staff-resident abuse would be reduced, and that participants would advocate for residents to ensure that staff-resident abuse is not tolerated.

Systemic problems that the staff identified as barriers to dignity enhancing care were a focus of discussion during the training program. Participants were asked to identify what they perceived as solutions to these issues and to make recommendations for change.

It is important to point out that systemic barriers to respectful care were not a focus of the intervention. This is one of the limitations of the practicum in enhancing respectful care for residents in personal care homes. Though staff training is an important component to improving resident dignity and has the potential to make a difference in the lives of residents, it cannot reduce all risk factors associated with the

conditions that detract from resident dignity. The limitations of the practicum will be discussed further in Section 2.3.

2.3 Limitations and Boundaries to the Intervention

The overall guiding principle that precipitated the practicum intervention is the standard of resident dignity which is strived for by the implementation of a respectful philosophy of care within the personal care home environment. There were many limitations to the chosen intervention (staff training) as a method for ensuring the dignity of residents.

First of all, there was no attempt in this intervention to measure resident satisfaction or the residents' perception of personal dignity before and after the training program. For the purpose of this practicum, the approach to improving resident dignity was based on information from the literature, and residents did not participate in evaluating the effectiveness of the intervention. It would be an important next step for future research to incorporate resident perceptions in the evaluation of an intensive staff training program.

Second, this intervention was focused on a relatively small sample of participants. Dignity is such a complex state of being, that it would require overall systemic changes in the personal care home context for a significant improvement in resident dignity to occur. Therefore, this intervention alone could not possibly stimulate such a global change in the environment. Rather it was hoped that participants would be encouraged to make a difference in the lives of residents, one interaction at a time, and to serve as role models for their colleagues who were unable to participate in the training program at this time.

Changes in the participants' ability to provide for resident dignity were measured by the *participants' perceptions* of their abilities and of improvements in their abilities following the program. The participants' perceptions of their abilities were undoubtedly affected by social desirability, their own personal values, and other extraneous factors such as workload and burn out which are barriers to respectful care which could not possibly be addressed by this training program alone. The practicum report and dissemination of findings to the regional health authority, if providing incentives for additional training opportunities, will have more lasting benefits to resident dignity than the training program itself due to the limitations and boundaries of the intervention discussed thus far.

2.4 Educational Objectives and Goals of Student

Objective #1

To understand the standard of personal *dignity* in the context of residential life in nursing homes by a thorough review of the literature on this topic.

Goals

- a) To use the knowledge gained through the literature review to identify how the caregiver relationship can enhance vs. diminish resident dignity.
- b) To identify caregiver skills that are required to enhance resident dignity and to identify methods for transferring these skills to PCH staff.

Objective # 2

To gain experience in the development, of a staff training program, and to improve on current skills.

Goals

- a) To develop the curriculum for the training program.
- b) To elicit facility participation in evaluating the course content and relevancy to the context prior to implementing the curriculum.
- c) To revise the curriculum as deemed necessary.

Objective # 3

To gain experience in the implementation of a staff training program, and to improve on current skills as a presenter and program facilitator.

Goals

- a) To independently facilitate the training program with some assistance from facility staff in setting up training sessions and recruiting participants.
- b) To engage the participation of the trainees.
- c) To assess participant comfort levels with course content and experiential learning methods.
- d) To identify areas where improvements in presentation methods are required.

Objective # 4

To gain experience in the evaluation of a staff training program, and to improve on current skills in evaluation and the development of measurement tools.

Goals

- a) To elicit feedback from participants on course content, and presentation methods following the training program using a participant satisfaction questionnaire.
- b) To undertake a personal analysis of strengths and weaknesses in relation to the training program development, delivery and evaluation and to identify opportunities for improvements of these.
- c) To analyze data gathered from pre-post-test instruments and to analyze what this data means.
- d) To evaluate the pre-post-test instruments for their effectiveness in measuring change and to identify how these instruments could be improved.

Objective # 5

To gain hands on experience in transferring social work theory into practice/service interventions through the implementation of a training program.

Goals

- a) To transfer the theory from the literature review into a planned social work intervention with measurable objectives and outcomes in the form of a training program with an evaluation component built in.
- b) To evaluate the intervention and make future recommendations for social work practice in personal care homes.

Objective # 6

To identify problem areas where future social work interventions are required in the personal care home context.

Goals

- a) To identify the current participant perceptions of staff to resident and resident to staff conflict and to identify potential interventions.
- b) To identify current participant perceptions of resident to staff and staff to resident abuse that exists in the personal care home environment and to identify future strategies to address these.
- c) To identify the current participant perceptions of work stress in the personal care home environment.
- d) To identify the participant perceptions of barriers to respectful care.
- e) To identify additional social work interventions in personal care home systems that will enhance the dignity of residents.

The personal student objectives and goals will be evaluated in Chapter 7 of this report.

Chapter 3

Literature Review

3.1 Dignity in Personal Care Homes

This chapter describes some of the literature relevant to the practicum. First, it is used to explore a definition of dignity that is relevant to residents in personal care homes. The literature points out the importance of dignity to the quality of life for residents in PCH and identifies factors that serve to sustain or diminish personal dignity. Risk factors and barriers to dignity enhancing care are identified; as well, conditions and interventions that serve to overcome these barriers are discussed. The literature review suggests core components to be included in the “respectful care” training program for nursing home staff.

Prevalence

Who are the people that are, or will be affected by the presence or absence of dignity in the PCH setting? According to Statistics Canada (2003), in the year 2002, four million Canadians (12.7 % of the Canadian population) were sixty-five years or older. According to Holosko and Feit (1990), there is a one-in-four chance that a person over the age of sixty-five will spend some time in a PCH. The demographics of an aging population in Canada would indicate that the issue of dignity in PCHs will affect at minimum one in four people who reach the age of sixty-five years and older.

The likelihood of admission to PCH increases dramatically with age - in Manitoba, there are approximately nine-thousand PCH beds with an average age at admission of eighty-five years of age (Centre on Aging as cited in Manitoba Health,

1999). The number of people eighty-five years and older is increasing rapidly; this cohort is the fastest growing population group in Manitoba and was estimated to increase from fifteen-thousand people in 1991 to twenty-two thousand people in 2001 (Manitoba Health, 1999). Within Canada, it is projected that this cohort will double in size from 1993 to 2016, and will grow fivefold by 2041 (George, Norris, Nault, Loh & Dai as cited in Novak, 1997).

The people who reside in PCHs tend to be the frailest elderly. Characteristics and conditions that have been connected with admission to PCHs include: age eighty-five or over, living without a spouse, having a recent hospital admission, requiring help with one or more problems of daily living (Shapiro & Tate as cited in Novak, 1997), and approaching the last four years of one's life (Montgomery, Kirshen, & Roos as cited in Novak, 1997). The PCH population is primarily female in gender with females outnumbering males by two to one (Health Canada, 1995).

The Importance of Dignity

How important is the issue of dignity within the PCH context? The importance of maintaining dignity and integrity throughout the life cycle is a value position, but most of the developed countries emphasize the importance of dignity for all people (Gotesky & Laszlo, 1970). Life without dignity has been described by terminally ill people, as life not worth living (Chochinov et al., 2002).

Dignity becomes more important to an individual as aging occurs, because of the person's fear that the final days of life may bring indignities such as dependency and vulnerability (Moody, 1998). Moody also suggests dignity is a societal value reflected in different forms such as human rights, age based entitlements and, more controversial

issues, such as euthanasia. Many authors argue that dignity is a moral norm that can serve to uphold the rights of the frail elderly to humane treatment and quality of life (Bemis, 1991; Carter, 2002; George, 1998; Jonas-Simpson, 2001; Martin & Post, 1992; Pullman, 1999). According to George (1998), dignity is an absolute necessity if quality of life is a goal rather than mere existence. The importance of dignity is immeasurable if it is required to make life worth living, to uphold human rights, and to achieve quality of life.

3.2 The Problem of Definition

Gotesky and Laszlo (1970) identify three general features of dignity – “(1) its vagueness in most current usage, (2) its generally acknowledged importance (whenever a wrong has been committed, a primary emphasis has been the violation of human dignity), and (3) its universal relevance: dignity is considered to be an essential condition for the good life of all persons, wherever they may live” (p. v).

In spite of the importance and relevance of dignity, a universally accepted definition is absent from research literature; however, there is agreement that the meaning of this concept must be clarified (Chochinov et al., 2002; George, 1998; Johnson, 1998; Moody, 1998). Chochinov et al. found that the term dignity overlaps conceptually with terms such as “pride, self-respect, quality of life, wellbeing, hope and self esteem. While most of these terms refer to internal states of mind, dignity is distinctive in that it also has an external component based on the perception of one’s worthiness of honour and esteem from others” (2002, p.441). The terms *worthiness* and *inner worth*, seem to capture the essence of the concept of dignity.

On the surface, this definition (dignity as inner worth) seems to be straight forward. However, the autonomy vs. dependency debate creates an added dimension of complexity to the concept of dignity because it raises the question - what constitutes worthiness? Autonomy – the freedom to act according to one’s own will – is a condition that is highly valued in western society (Bemis, 1991). The intense value placed on autonomy, can cause those who have autonomy to be viewed as more worthy of respect than those who are dependent. This conflict brings into question whether dignity is inherent to an individual based on humanity, or if worthiness and respect must be earned by one’s contributions to society. Some writers point out that this conflict can result in a *non-person status* being extended to the frail elderly due to their dependence on others for care, leaving them at risk of being denied their right to dignity (Bemis, 1991; Martin & Post, 1992; Smith, 1992). Most agree that a person is worthy and valuable simply because of his/her status as a human being regardless of his/her capacity for autonomy (Bemis, 1991; Pullman, 1999).

Part of the difficulty in defining what dignity means is that it is an extremely complex and personal condition. George describes dignity as dialectic in nature - it is “highly personal, and usually socially developed and sustained” (1998, p. 45). By this she means that dignity is both inherent to the individual **and** bestowed by others. A person is worthy because he/she is human; conversely, an individual’s sense of honor and esteem is influenced by the way that others communicate their respect and value for the person. Johnson (1998) agrees that it is the *acknowledgment* of a person’s humanness that defines dignity, and it is therefore important that this respect be communicated.

The concept of dignity has multiple layers of meaning that on the surface seem to contradict one another. Moody (1998) refers to conditions of dignity as polar opposites- dignity is perceived to be enhanced by the presence of feelings of respect, honor, decorum, privacy, power, equality, personhood and/or autonomy; in contrast dignity is perceived to be at risk when a person feels disrespected, humiliated, exposed, vulnerable, objectified and/or dependent. Dignity is a unique concept in this respect – it can be sustained, or diminished and has contradictory emotions attached to it depending on its security or its vulnerability.

Dignity as a Component of Quality of Life and Quality of Care

Quality of life is defined as the capacity to meet the demands of the environment while perceiving a sense of well-being (George, 1998). How is dignity related to quality of life? George points out that a positive self regard mediates between stressful life events and perceived well-being; in other words, if one experiences a state of dignity, or worthiness, this condition helps the person perceive life as having quality, even in the absence of the capacity or resources to meet environmental demands (George, 1998; George, 2000). George stresses that dignity is an essential component to quality of life (1998).

The assessment of quality is defined as “a judgment concerning the process of care based on the extent to which that care contributes to valued outcomes” (Donabedian, 1982, p.3). Dignity has been described as a benchmark of quality of care in PCH; rather than focusing on body care and completion of daily routines, the focus should be on maximizing privacy, dignity and choice (Nolan, 1999). In other words, if perceived dignity is a valued outcome that defines quality of care, then efforts that succeed in

supporting dignity also help to achieve quality of care and hence, quality of life. The standard of dignity can be achieved in spite of the fact that residents in personal care homes face illness related challenges that impact their independence and their capacity to meet environmental demands.

Some writers suggest that the way to improve the quality of care of older people is to create a culture of positive care that values older people (Nolan, 1999; Nolan, Davies & Grant, 2001). In other words, helping a resident feel valued and worthy is a method to promote dignity, a major component to quality of care and quality of life. According to George, the probability of quality of life is greatest when “individuals have a sense of self-dignity and members of the social environment convey the message that one is deserving of dignity” (1998, p. 47).

Dignity as a Social Norm and Moral Framework

Dignity is described as a moral framework that can serve as a guide for behavior that supports the rights of the frail elderly to humane treatment and quality of life (Bemis, 1991; Carter, 2002; George, 1998; Jonas-Simpson, 2001; Martin & Post, 1992; Pullman, 1999). Bemis (1991) refers to Kantian ethical theory to support this argument – human life is irreplaceable and therefore has an intrinsic worth; being human by definition implies a right to dignified treatment, and acknowledgment of this inner worth by others. Carter (2002) also refers to Kantian theory to conclude that the governing rule of dignity is morally right and can be applied to every situation to guide behaviors and decision making by practitioners and caregivers.

Pullman (1999) suggests that treating a resident without respect and dignity is morally wrong and potentially defined as abuse of the individual. This implies that the

morality of caregivers with respect to dignity, might mean the difference between dignified or non-dignified treatment of residents in PCH. Martin and Post (1992) point out that the moral reasoning of paid caregivers has not been studied and is not understood. Can the morality of dignity be taught to caregivers, to ensure dignity enhancing care? Or should staff hiring and staff evaluation policies require that certain morals be part of the belief system and values of future and present staff to guide dignity enhancing care?

Martin and Post (1992) suggest that paid caregiving for persons with dementia may require a special form of self concept and ego strength that is based in the belief that all humanity has an inherent worth or dignity. Whether or not the moral of dignity can be taught, is unclear and further research is required to answer this question. However, if dignity enhancing care is considered by society to be morally right, then policies and procedures that serve to uphold dignity enhancing care can be justified and actions that serve to diminish dignity can be condemned. At the very least, the standard of personal dignity can be strived for, if not always achieved.

3.3 Diminished Dignity

Abuse of Care

Resident abuse is defined as any act of commission or deliberate omission that results in physical injury, and/or harm to mental health and well-being (Health Canada, 1995). Resident abuse diminishes personal dignity, by conveying disrespect and evoking feelings of shame, fear, hopelessness and worthlessness. Much of what constitutes behaviors that diminish dignity can be described as abuse or neglect, whether it be

physical, psychological, or neglect. Examples of actions that are demeaning to residents include: name calling, yelling, insulting, intimidating, ridiculing, ignoring, isolating from others, and excluding from decision making (Health Canada, 1995).

A study conducted on behalf of the Ontario College of Nurses found that, of 804 registered nurses and 804 nurses aids surveyed, over half had witnessed one or more incidents of abuse by nursing staff, mostly involving older persons (College of Nurses of Ontario as cited by Health Canada, 1995). Respondents believed that abuse was triggered by uncooperative clients (64%), overworked nurses (56%), nurses' lack of knowledge (31%), nurses' personal problems (25%) and abusive clients (5%). Types of abuse witnessed were: roughness (31%), yelling and swearing (28%), offensive/ embarrassing comments (28%), or hitting/shoving (10%). Victims were primarily female (54%), disoriented (57.7%), requiring assistance to move (32%), confined to bed (32%).

This study indicates the type of abuse of care that occurs in the PCH context as well as the staff's perspective on causes. It is interesting to note that two of the triggers for abuse were attributed to characteristics of staff (i.e. their problems or lack of knowledge); two other triggers were attributed to resident characteristics (i.e., lack of cooperation or abusiveness); while an additional trigger was identified as problems within the environment (i.e., overwork).

Nolan (1996) suggests that the failure to bestow frail older people with full status as human beings underlies much of the institutional abuse that exists. The four most common forms of abuse in PCH include infantilization (treating older people as children), depersonalization (lack of consideration of personal identity), dehumanization

(treating older people as having no human value), and victimization (theft and abuse of property) (Kayser Jones as cited in Nolan, 1996).

3.4 Risk Factors for Diminished Dignity

Dependence and Dementia

Many residents in PCH have some form of physical or cognitive disability that affects their behavior, their ability to communicate, and/or the degree to which they can independently meet their daily needs. Residents with perceived behavior problems, communication difficulties, cognitive impairments, and social impairments are at high risk for abuse (Health Canada, 1995).

Cognitive impairment in the elderly refers to any illness that exhibits symptoms of dementia. "Dementia refers to over 70 diseases that cause a grouping of symptoms which result in progressive deterioration of brain cells, particularly those responsible for memory and thought" (Jones, 1999, p. 2). There are many behavior problems that are associated with dementia; these can include wandering, undressing (causing staff to re-do the previously completed work of dressing the person), failing to comply with routines, and/or aggression.

The symptoms of dementia cause vulnerability to physical and emotional harm; this harm can occur due to the person's own impairments in judgment or due to the actions of others (Martin & Post, 1992). According to these authors, the caregiver has great power over the resident with dementia because of the lack of judgment and self control related to the dementia, and due to the fact that the caregiver may be required to make decisions for, and try to control the person with the dementia.

Caregivers are at times frustrated by the constant demands of the person and/or have difficulty dealing with the potentially dangerous behavioral symptoms of the dementia (Martin & Post, 1992). Under these conditions, some staff will interact with residents in ways that are abusive, and may do so believing that their actions are justified.

It is important to note as these conditions are reviewed, that abuse can never be justified; however understanding the type of conditions where abuse occurs, can help in understanding where interventions must be applied to prevent future abuse and demeaning actions by caregivers.

Chochinov et al. (2002) notes that increased levels of dependence, both cognitive and functional, serve as factors that can undermine dignity. It is an accepted fact that most residents in PCH require help with some aspect of personal care, such as bathing, toileting, dressing, etc. Lillestro (1997) explores the feelings of violation felt by clients who receive intimate care from staff who are by definition *non-intimates*; feelings of objectification and humiliation are described - these feelings are related to the routine transgression of body boundaries during personal care. According to this study, negative feelings are made worse by: 1) having vast numbers of staff provide personal care, 2) by having staff attend to parts of self care that clients are able to do independently (this was perceived to be caused by staff being rushed), and 3) by the perception that the staff focus more on needs of the body than the person's feelings.

Lillestro suggests that the medical system is organized in ways which standardize care and treatment approaches in an effort to provide quality care, yet this can lead to impersonal care that makes the person feel objectified and violated. Accepting help with personal care has been described by residents as one of the most difficult parts of life in

PCH. Therefore, it is worth exploring ways to buffer this personal assault on resident dignity and to sensitize staff to approaches that make personal care the least harmful experience possible for residents.

Gender

Personal risk factors for abuse include advanced age and female gender (Beaulieu & Belanger, 1995). Because of the predominantly female workforce in PCH, and the fact that 71% of the PCH population are women (Health Canada, 1995), the abuse that occurs in PCH is primarily the abuse of women by women (Jack as cited in Aitken & Griffin, 1996). Aitken and Griffin (1996) suggest that female aggression is poorly understood and is rarely discussed in Western culture; it is a taboo topic because it goes against gender role stereotyping of women as non-violent, feminine and caring. Neysmith (1995) points out that the issue is not so much one of gender; rather the issue is related to the power differentials between resident and staff, both of whom are likely to be female. However she also suggests it *is* relevant that the staff who work in a PCH setting that has low status, low pay and high stress, are women. One thing is clear from this discussion – future research should investigate the role that gender plays in the abuse of care in PCH.

Characteristics of Caregivers who Abuse

Personal characteristics of caregivers that have been linked to the abuse of residents in PCH include: the experience of a life crisis, a dysfunctional relationship or problems related to alcohol, drugs, or mental illness; also, some socio-economic factors such as poverty, job dissatisfaction, and/or lack of social supports have been identified as risk factors (Beaulieu & Belanger, 1995). According to these same authors, there is usually a complex mix of these factors that play a part in abuse.

Ageism and Caregiver Attitudes

Ageism has been associated as a contributing factor to abuse and neglect; ageism refers to pervasive negative attitudes and stereotypes which lead to discrimination based on age (Pittaway, Westhues, & Peressin, 1995). The older victim can internalize these negative attitudes and perceive the abuse as deserved or as a consequence of their situation (Vinton as cited in Pittaway et al., 1995). This type of thinking can create a sense of hopelessness, and a barrier for residents to report abuse that occurs to themselves or others.

Negative attitudes and stereotypes about individuals who have dementia can cause caregivers to feel justified in ignoring the words, actions, or needs of those who have dementia (Jonas-Simpson, 2001). This author proposes that even the most severely impaired can communicate needs to care providers, and a positive connection can be made by the perceived effort to understand. An individual with dementia must be spoken to as an equal in order to feel “valuable as a human being, deserving of dignity, worth and voice” (Jonas-Simpson, 2001, p. 206). Caregiver attitudes that assume a person with dementia does not understand what is going on, can lead to dignity diminishing care. Persons with dementia are at high risk for having their dignity violated because of these negative attitudes.

The prevalence of illnesses that cause dementia is very high in the population who live in PCH because the risk for dementia increases greatly for people over the age of 85 years. It has been estimated that 50% of the population who is over 85 will develop dementia, and 60% of the current PCH population suffers from symptoms of dementia (Jones, 1999). Improving caregiver attitudes and understanding of residents with

dementia, is therefore an extremely urgent requirement to providing dignity enhancing care.

Paternalism

Paternalism (sometimes referred to as beneficence or limited paternalism) is defined as interference in the autonomy or free choice of another individual with the intent to help or benefit the person; this is also referred to as acting in their best interest (Bemis, 1991). According to Childress (1982), paternalism is justified when there is impairment in the decision making capacity of an individual and there is potential harm to the individual or others related to this impairment; also the benefit of intervention must outweigh the potential harm associated with non-intervention and the least restrictive intervention should be used.

Childress gives an example of unjustified paternalism and its consequences: “a professional’s refusal to acquiesce in [sic] a person’s wishes, choices, and actions, where no one else is harmed, and merely because the professional disagrees with the values of the patient’s life plan . . . is a profound affront to dignity and independence” (1982, pp. 68-69).

According to Bemis (1991), the elderly are at high risk of unjustified paternalism, because of the likelihood of others presuming their incompetence to make safe decisions. The more dependent a person is on the help of others due to physical or cognitive challenges, the more likely it is that unjustified paternalism will be applied (Carter, 2002). In other words, those who are at highest risk of having personhood and dignity undermined are residents who have lost the capacity to decide or are wrongly judged to have lost this capacity. Future research must find ways to include this group of people in

studies on dignity; research methods that can overcome communication barriers must be found if this group cannot verbalize their own issues due to physical and/or cognitive challenges.

Characteristics of the Environment

Clough (1996) has analyzed the characteristics of the tasks in personal care that might create the conditions where staff provide care in a dignity diminishing or abusive way. He found that: 1) the work exposes staff to the pain of others, and they struggle with the desire to reduce this pain; 2) the work is physically demanding, repetitive, and inflexible with tight schedules; and 3) it is stressful working with a large group of residents attempting to balance many needs with scarce resources.

Twigg (2000) raises the issue of care work as “bodywork” and the negative emotions that this type of work can evoke in both workers and clients. Care workers find some aspects of their jobs demeaning; this can include 1) dealing with human waste, 2) transgressing personal boundaries by seeing clients’ nakedness and 3) being required to touch clients in intimate ways in order to provide personal care. This author found that care work is usually delegated to the lowest paid staff, and is hidden from others because, if witnessed, it is further demeaning to both care worker and client; care work deals with aspects of life (dependence and deterioration) that society with its emphasis on independence and youth does not want to acknowledge. If staff do not feel good about themselves, or the work that they do, these feelings can potentially impact the dignity of residents.

The Low Status of Caregiving

Caregiving has historically been viewed as a woman's role, based on the view that it is a natural feminine ability with no special training required and no economic value (Nay, 1998). Nursing in PCHs is given lower status than nursing in hospitals because curing has more status than "caring" People who live in PCHs require chronic care, rather than cure. It is important to find ways to provide recognition to those who work in care homes that their roles are important to residents and to society.

According to Nolan (1999), the first step towards residents and staff having more positive views of the system and themselves is to remove the public perception and stigma from personal care homes that imply they are last resorts or failures of other alternatives. The same author suggests that institutional care must be perceived by society as valuable and as a quality component of long-term care that helps elderly people live meaningful lives. A teaching nursing home where practitioners from all fields can attend as a necessary part of their training, would help to raise the profile and status of long term care for those who live and work there. Staff need to feel valued and supported if high quality of care is to be attained (Nolan, 1999).

The Nature of Institutionalization

Many features of institutionalization affect resident's values, choices and world view (Lidz, Fischer, & Arnold, 1992). These authors, in their study on the effect of institutionalization on autonomy, found that the PCH environment has many of the features which constitute a "total institution" : 1) entry rituals such as history taking, labeling people as residents, and placing them in identical rooms can impact individual identity; 2) daily activities occur in the presence of a large group, and violations of

privacy are common; 3) contact with the outside world is minimal; 4) residents are often excluded from making plans, and must ask staff permission for routine activities; 5) daily activities are tightly scheduled by staff, with little variation permitted, ensuring the “routine” is maintained; and 6) an authority hierarchy exists where the staff’s view dominates if there is a difference of opinion between staff and resident.

This study recommends a “minor revolution” to promote the autonomy of residents by reducing the use of restraints, improving privacy, increasing flexibility of scheduling and staffing, and modifying staff training and job descriptions. A greater emphasis on autonomy should occur rather than focusing on the values of institutional efficiency and emphasis on body care (Lidz, Fischer & Arnold, 1992).

Burnout and Powerlessness

The organization itself can play a part in creating (or not preventing) the conditions which foster abuse. These conditions include poorly supported and trained staff, high workloads, and funding issues that impact quality of care (Beaulieu & Belanger, 1995). Nay (1998) refers to complex care demands and staffing shortages that create the conditions where staff tend to work in more controlling ways, in order to meet job requirements with the resources available to them. According to the same author, when the demands of caring exceed staff resources, the staff cope by focusing on routines and professional distance rather than individualized care. The approach to caring has a direct impact on sustaining or diminishing resident dignity.

Nolan (1996) refers to the problem of *rust out* in staff which occurs due to the highly repetitious nature of, and the difficulty attributing any value or meaning to the work. As a consequence there is risk that the staff will detach themselves emotionally as

a way of coping with boredom. Implementing ways to develop positive relationships between staff and residents can be mutually helpful – staff will attribute more positive meaning to their work, and residents will feel valued by staff. In other words, both staff and residents require dignity in their lives – they both need to feel valued and worthy for who they are and for what they do.

Individuals functioning within a group may feel a sense of powerlessness because they feel forced to act in certain ways to ensure belonging and prevent exclusion from the group; group norms can set standards as to how one should behave within the organization (Henderson, 1996). Under these conditions, staff may believe that it is a greater disloyalty to report another staff member than it is to fail to protect a resident from abuse. Interventions that would help to prevent diminished dignity of residents in PCH must take into account the barriers of organizational pressures.

Institutional Power Structure

The power differential between staff and residents is a problem that can impact dignity (Clough, 1996). This author suggests that often abuse is linked to attempts by staff to control the behavior of residents; staff may feel that this abusive action is justified by claiming the intent was “good”. Residents feel a sense of powerless simply by virtue of their situation where they rely on others to meet their basic needs and staff have the power to increase or to minimize these feelings by the way that they interact with residents. Residents are particularly vulnerable because they feel too intimidated or are unable to complain or leave the situation. Power is endemic to the PCH environment; staff must be sensitive to this in order to place a priority on finding ways to ensure residents have choices available to them and that these choices are respected.

3.5 Conditions that Strengthen Dignity

Dignity Conserving Repertoire

A study of terminally ill patients, by Chochinov et al. (2002) identifies perspectives and practices that can strengthen a person's sense of dignity; these are referred to as a *dignity conserving repertoire* and include the following: continuity of self, role preservation, legacy, maintenance of pride, hopefulness, control, acceptance, and resilience. Living in the moment, maintaining normalcy, and seeking spiritual comfort are practices that are identified as ways to strengthen dignity.

Chochinov et al. suggests that these perspectives and practices can be supported with *dignity conserving care* provided by health care professionals. According to this study, staff can give patients the opportunity to participate in decisions about their care or assist them to contribute something that might serve as a lasting legacy for their families. These are examples of ways to assist patients in feeling an enhanced sense of dignity. Staff can also assist patients to maintain a familiar routine, focus on the present and/or have access to spiritual practices.

The study by Chochinov et al. also suggests that illness concerns such as level of dependence and symptom distress can interact with relationship concerns to have a negative impact on dignity; however, the presence of a strong dignity conserving repertoire can help to buffer these effects; conversely if the person has a weakened dignity conserving repertoire, then there is a higher likelihood this person will experience a diminished sense of dignity related to illness or relationship concerns (Chochinov et al.,

2002). This study suggests that interventions at the level of strengthening the person's dignity conserving repertoire can assist to enhance dignity when illness concerns and relationship concerns cannot be improved.

Relationships

Relationship concerns can detract from, or enhance a person's sense of dignity depending on the quality of the relationship: these characteristics are referred to as *social dignity inventory* and refer to levels of social support, care tenor and the sense of being a burden to others (Chochinov et al., 2002). Helping a patient feel he/she is not a burden or that he/she does matter are ways of strengthening dignity through positive care relationships.

In this study, patients described many situations where family, friends, and health providers served to enhance or diminish their dignity. This research suggests that the quality of the relationship between care-provider and care-receiver can affect patients' dignity in positive or negative ways. It also supports the idea that dignity is an inner quality, as well as a reflection of social relationships and the effect these relationships have on an individual's resilience and well being.

Quality of Staff-Resident Relationship

According to Donabedian (1982) the process of care is divided into two major components: technical care and the interpersonal relationship between the worker and the client; the relationship is the means to the provision of technical care, but it can also in itself be therapeutic or harmful. The worker's behavior in this relationship must be governed by the client's feelings and by social and ethical rules. Moody, (1998) points

out that social services must be sensitive to the fact that the way in which the services are provided (rather than just the service itself) can sustain or violate dignity.

Gubrium (2000) suggests that it is impossible to be invulnerable to the social relationships that we share, as they become part of who we are. We see ourselves in the reflection of the way others view us which can be positive or negative. Nolan (1996) agrees that it is the interpersonal relationship that is the means to quality of care and the provision of privacy, dignity and choice. The same author suggests that failure to thrive can occur when residents cannot find meaning in their lives and have no attachments with others; meaningful relationships with staff who are perceived to care about residents help affirm the individual's worth and dignity.

Caring and respect for personhood

Respect for the uniqueness of each individual is referred to as respect for the personhood of residents. This personal respect is one way of acknowledging the dignity of residents – their worth and value. One way to implement respect for personhood is through data collection of social history, preferences, interests, family background, hopes and dreams (Coker, 1998).

Howell (as cited in Martin & Post, 1992) suggests that caregivers must possess the following characteristics if they are to cope with the great difficulties of caregiving: 1) a belief in the value of every living person; 2) a willingness to form a relationship rather than holding clients at a professional distance; 3) satisfaction in providing care tasks; 4) ability to work as a team member; 5) ability to stand up to neglect or abuse; 6) the belief that the work is worth doing; and 7) a compassionate sense of humor.

According to Nay (1998), a study of residents' perceptions of positive caring found the following to be important: 1) reducing residents embarrassment and feelings of being burdensome; 2) recognizing residents as unique and letting them know they matter; 3) appearing interested and involved with residents; and 4) responding to needs. Negative methods of providing personal care were also identified: 1) appearing uninterested; 2) being rough and dictatorial; 3) appearing unhappy and in a rush; 4) making residents feel they are a bother; and 5) treating residents like children or "like a number". Though both positive and negative approaches to care are viewed as *providing care*, the outcomes to residents are different and related to whether care is positive and enabling, or disempowering.

Privacy

Chochinov et al. (2002) refers to levels of privacy as relationship concerns that can enhance or detract from personal dignity. The PCH environment, with large groups of residents and staff, tends to violate personal privacy in many ways. Staff must be sensitive to the resident's need for privacy in order to overcome barriers to dignified care. Knocking before entering a room is a way to ask permission to enter, and to ensure the person is prepared for company. Ensuring doors are closed during personal care, and being sensitive to the resident's feelings when intimate care is provided, are examples of ways to support privacy and dignity.

Communication

Johnson (1998) proposes that dignity for the dying is best defined as "an interactive process among the dying and their caretakers . . . (as they) engage in humanizing communication aimed toward understanding the final needs and wants of the

client” (p.337). Dignity is ambiguous because it means different things to different people, and the only method to understand unique needs is via communication aimed for mutual understanding. In the PCH context, improved communication between residents and caregivers is an important way to promote dignity.

Enhancement of Autonomy and Perceived Control

Autonomy and dignity are two conditions that are very much interrelated (Bemis, 1991). Independence in function and decision making is highly desired by individuals, and is admired by those who regard the independence of others. Autonomy is a condition that induces feelings of worthiness, and earns positive esteem from others. Though residents may not be capable of complete independence, caregivers can facilitate their participation in choices as much as possible. From choosing the clothes that they want to wear, to developing their own daily routine, residents should have control over their own lives.

3.6 Interventions to Enhance Dignity

Dignity as a Moral Framework and a Philosophy of Care

The medical model of acute care when transferred to the PCH context inadvertently serves to dehumanize and devalue elderly people. Participatory models of care must be implemented in nursing homes where the approach is *caring with* rather than *caring for* residents (Nay, 1998).

Quality care must be defined with standards that are realistic and achievable – Nolan (1999) identifies these standards as privacy, dignity and choice; he suggests that a focus on residents’ status as human beings and the importance of therapeutic intimacy and personal investment by staff in the lives of residents, is key to achieving the

standards of quality. A philosophy of care must be developed which holds that the ultimate standard is to ensure the dignity of residents at all times. The ethic of dignity should guide every interaction between staff and residents.

Training

The literature supports the education of caregivers as a method to foster dignity (Cox & Parsons, 1993; George, 1998; Moody, 1998). The literature discusses the importance of caregivers' showing respect for older persons (Ebenstein, 1998; Ingersoll-Dayton, 2000), due to the frail elderly's susceptibility to feel undignified and demeaned by others (Moody, 1998; Heumann, McCall & Boldy, 2001; Neysmith, 1999). Jones (1999) speaks of the most important element in the supportive PCH environment - the people who interact with the residents (staff, family, and co-residents), as holding the power to be agents of help or harm. "The beliefs, attitudes, and language of caregivers shape the life of the person and therefore there is a direct relationship between the caregiver's level of education, skills, and judgment and the care-receiver's quality of life" (Jones, 1999, p. 27).

Training staff is an approach to changing attitudes and prejudice towards older people and is recommended as an abuse prevention strategy (Beaulieu & Belanger, 1995). Training must also address issues of therapeutic intimacy, and the development of positive staff-resident relationships that communicate caring (Nolan & Keady, 1996). The same authors suggest that training is not a one time event but must be a planned program of staff development.

Skog, Grafstom, Negussi and Windbladd (1999) observe the success of a training program which focuses on a human dignity perspective; they found that it is possible to

teach a humanitarian approach to care, but that it takes time. The participants in this study received a year of special training to fully develop this philosophy of care. Just as it takes time to build relationships with residents, it takes time for staff to become more sensitive to the fact that residents with dementia are human beings behind the symptoms of their disease. However, after the knowledge is attained, staff can take on advocacy roles and act as mentors to pass on their knowledge to other staff (Skog et al., 1999).

Innes, (1999) and Chapman and Kerr (1995), have developed eighteen to twenty hour "person-centred care" training programs that address the caregiving challenge of dementia. These programs can be delivered in one-day workshops over three to four days, or over a period of eight to ten weeks, by completing two to three hours per week. The programs focus on methods to overcome the tendency to treat residents with dementia as "non-persons" or objects. The use of social histories help staff understand the past history, strengths and interests of the resident rather than seeing only the symptoms and problems of the present.

Goodridge, Johnston, and Thompson (1997) suggest that the provision of well-planned appropriate education for staff can have a positive impact on staff attitudes toward residents and ability to manage conflict. They suggest that education, directed at nursing assistants who provide the majority of direct care to residents, needs to be on the agenda of PCH. These same authors (1997) evaluated a one-day training program called *Ensuring an abuse free environment – a learning program for nursing home staff*. This program was developed in 1991 by the Coalition of Advocates for the Rights and Interests of the Elderly (CARIE) in Philadelphia. The CARIE program was delivered at Riverview Health Centre, Winnipeg in 1995 and was well received by the participants

(Goodridge, Johnston, & Thompson, 1997). A pre-post research design found that nursing assistants were less likely to agree that elderly were like children following the program. Also, a decline in self-reported nursing assistant-resident conflict was shown in the post-test findings.

The same CARIE program was implemented in nursing homes in the United States and evaluated by Pillemer and Hudson (1993). They found that staff reported reductions in resident aggression toward themselves following the training which was seen as a possible indicator for staff having learned to avoid or defuse conflicts before a resident became aggressive.

The curriculum of the CARIE (1991) program focuses on recognition of abuse and its causes as well as sensitizing staff to the role that work stress plays in abuse. A video presentation gives an example of an abusive situation and invites participant discussion. Stress reduction techniques and strategies to manage challenging behaviors of residents are practiced through role plays and discussions. The program attempts to sensitize staff to the challenges that residents face associated with illness, losses, and living in a personal care home. By developing empathy, staff can understand the root causes of difficult behaviors rather than taking them personally. The CARIE (1991) program was revised in 1999 and re-named *Competence with compassion - An abuse prevention training program for long term care staff* (CARIE, 1999). The revised version provides more specific skills for conflict management and engages participants in role plays to practice these skills using a typical work situation. Also, the video in this package is followed by a module that analyzes the feelings of the victim, and what

stressors led to the abusive situation. Participants are asked to brainstorm ideas that would have prevented the situation, and how staff could have interacted differently.

Thomson and Burke (1998) evaluated a three hour training program that was offered to all nursing assistants at Riverview Health Center in Winnipeg in 1996. The course content included: reflection on important things in one's life, and the emotions associated with the losses of these; simulating experiences of residents by having participants act out scenarios from the perspective of residents and reflect on feelings evoked by the experience; and an overview of changes associated with normal aging. The study supported the theory that experiential education that places the learner in an experience of another at a personal level helps to change attitudes.

Nolan and Keady (1996. p. 336) observe that the successful training should:

- Be matched to need;
- Be seen as relevant,
- Actively involve staff in the design, content and delivery of the programme,
- Be given a priority by management;
- ... and should have:
 - Skill variety: there is a focus on varied knowledge and skills
 - Task identity: training is linked to a clear purpose
 - Task significance: training and the subject of the training are seen as important
 - Autonomy: staff must be able to implement what they have been taught
 - Positive feedback: should be given to staff by peers and management.

3.7 Social Work Role in Abuse Prevention

Improving work atmosphere and the social health of staff are preventive strategies to reduce staff burnout and conflict as causal factors in abuse; staff involvement in the development of codes of ethics and in detection and intervention protocols are necessary if this intervention is to be successful (Beaulieu & Belanger, 1995). The social work role in PCH is guided by ethical responsibilities as defined in the *Social Work Code of Ethics*

to advocate for change in the best interest of the client and for the overall benefit of society. This responsibility is limited by certain conditions, one of which includes respecting the client and acting so that the dignity, individuality and rights of the person are protected (Canadian Association of Social Workers, 1994). Social workers must participate in strategies for the prevention of abuse in PCH to ensure that the dignity and personal rights of residents are protected.

A system of checks and balances must be developed to ensure abuse of power is not tolerated within the PCH environment (Beaulieu & Belanger, 1995). Legislation is required for serious breaches of dignity whereas less severe forms require intervention within the specific environment; the best intervention is consciousness raising – teaching caregivers respect for dignity, to overcome indifference and ignorance (George, 1998).

Legislation has been passed in Manitoba, in the form of the *Protection of Persons in Care Act (2001)*. Under this Act, social workers, and all staff in PCH are required by law to report all incidents of resident abuse that occur. Social workers must be involved in raising staff awareness of what this Act means, and how it is implemented. Part of the social work role includes helping staff understand what types of acts or omissions constitute abuse of care. By raising awareness on what constitutes abuse of care, it is hoped that 1) abuse will be prevented and 2) when abuse occurs, it will be reported and dealt with.

3.8 Summary of the Literature

The authors referred to in the literature have provided a composite definition of dignity. Dignity is a personal concept that is measured by the presence and absence of certain conditions. Dignity is the acknowledgement of the inner worth of all humanity. It is a concept that is personal and social, important to quality of life, and affected by the quality of social relationships. For residents in PCH, the quality of the staff-resident relationship has a direct effect on residents' dignity. Dignity is violated by abuse, humiliation, and disempowerment, just as it is supported when residents feel that they are cared for and do matter. Having autonomy helps to ensure dignity, but for those who are vulnerable and dependent, the moral norm of dignity must guide the behaviors of caregivers to acknowledge that all people have an inner worth or dignity, regardless of their abilities or contributions.

The intervention for this practicum was guided by the literature review. The literature review on *Dignity* helped to identify staff training as one method to enhance resident dignity. It also identified core components to be included in a training program to enhance dignity: empathy training, sensitizing staff to the quality of staff-resident relationships and skill development in conflict resolution, dementia care, abuse prevention and advocacy.

The practicum activities consisted of the development, implementation and evaluation of a training program that focused on sensitizing staff to the importance of a positive staff-resident relationship and a respectful approach to provide dignity enhancing care. The program attempted to challenge negative attitudes and prejudice, while identifying approaches to improve staff-resident relationships. At the same time, the

training program informed staff that abuse is a violation of dignity that requires a personal and group effort to prevent. Overcoming organizational barriers to respectful care was also a focus of the training.

Chapter 4 describes the curriculum development in depth, and the design and implementation of the Respectful Care Training Program.

Chapter 4

Design and Implementation of the Training

The first part of this chapter describes the design and content of the training program. The second part of this chapter describes the implementation of the training program, the recruitment of participants and the evaluation component built in to the delivery of the training. The participant sample is described and data gathering methods and instruments are identified.

The training was provided to three groups of nursing assistant participants over three separate one-day sessions. The three groups were comprised of trained and untrained nursing assistants and student nursing assistants nearing graduation. The evaluation component to the training program was intended to measure the effectiveness of the training in providing participants with skills they could implement in their workplace after the training was completed.

4.1 Dignity and Curriculum Development

The intervention for this practicum was guided by the literature review. The literature review on *Dignity* helped to identify staff training as one method to enhance resident dignity (Cox & Parsons, 1993; George, 1998; Moody, 1998). It also identified core components to be included in a training program to enhance dignity: empathy training and sensitizing staff to the quality of staff-resident relationships (Nolan and Keady, 1996); the importance of a respectful relationship (Ebenstein, 1998; Ingersoll-Dayton, 2000); skill development in conflict resolution (Goodridge, Johnston, &

Thompson, 1997); the importance of a respectful approach to dementia care (Jonas-Simpson, 2001); and abuse prevention and advocacy (Beaulieu & Belanger, 1995).

The core components to the training program and their relationship to dignity and respectful care are illustrated in Table 2. As illustrated in this table, respectful care is the means to enhance resident dignity. Barriers to respectful care are also barriers to resident dignity. In order to provide respectful care, and enhance resident dignity, these barriers must be overcome.

Staff provide respectful care to residents when they have empathy for residents and are sensitive to their situations and the feelings that are associated with these situations. Residents tend to experience a sense of worthiness or dignity when they feel understood and valued by their caregivers. Barriers to respectful care and resident dignity include staff insensitivity, impersonal care, and treating residents like children or objects. The intervention to address the barrier of insensitivity is identified as empathy training.

Similarly, staff deliver respectful care when they encourage resident independence, choice, privacy, and positive self image. Residents experience dignity when their independence, choice, privacy, and self image are maximized. The training curriculum therefore included activities where these concepts were emphasized.

Respectful care is provided when residents are protected from abuse. Interventions to overcome barriers to this form of respectful care include training in abuse recognition and staff advocacy.

Table 2: The Means to Respectful Care and Dignity

Expected Relationship between Staff and Resident Objectives		Expected Relationship between Barriers and Interventions	
<p>1. Staff Objective: Respectful Care</p> <p><i>The means to Respectful care is:</i></p>	<p>2. Resident Objective: Enhanced Dignity</p> <p><i>The means to enhanced dignity is:</i></p>	<p>3. Barriers to Respectful Care/ Enhanced Dignity</p> <p><i>Factors that can cause diminished dignity/disrespectful care:</i></p>	<p>4. Interventions to Encourage Respectful Care/ Enhanced Dignity</p> <p><i>Methods to overcome barriers:</i></p>
<p>a) Staff empathy for residents where staff understand the residents' situations and the feelings associated with different situations.</p> <p>b) Staff sensitivity to the quality of interactions with residents.</p>	<p>a) Feeling understood and respected.</p> <p>b) Experiencing positive interactions with caregivers and feeling valued as a person.</p>	<p>a) Staff insensitivity toward residents.</p> <p>b) Experiencing impersonal care; being treated like children or objects.</p>	<p>a) Empathy training where staff place themselves in the resident's situation.</p> <p>b) Sensitivity training where staff learn connection between r approach to care and resident feelings/dignity.</p>
<p>c) The encouragement of independence, choice, and privacy for residents.</p>	<p>c) Having maximum independence, freedom of choice, privacy of body and space.</p>	<p>c) When staff are rushed or limited by routines to the extent that they do for residents what they are able to do themselves.</p> <p>When privacy is violated.</p> <p>When choices are limited.</p>	<p>c) Address work-load issues, and/or inflexible routines.</p> <p>Teach staff the importance of independence, choice and privacy for residents.</p>

Table 2 continued

1. Staff Objective	2. Resident Objective	3. Barriers	4. Intervention
<p>d) Ensuring physical appearance of residents is appropriate.</p>	<p>d) Feeling that one's physical appearance is suitable to the occasion.</p>	<p>d) When residents are made to wear inappropriate clothing or unwanted "aids" such as "bibs" or incontinent wear.</p>	<p>d) Teaching staff the importance of self image, and embarrassment that residents may feel if dressed a certain way.</p>
<p>e) Ensuring residents are free from all types of abuse.</p>	<p>e) Feeling safe and free from abuse.</p>	<p>e) Abuse of residents by staff; Ignorance that certain behaviors are deemed abusive; Staff who allow abuse of residents to occur without intervening or reporting.</p>	<p>e) Training in abuse recognition; zero tolerance for abuse. Staff advocacy to intervene if witnessing abuse. Reporting abuse to appropriate authority.</p>
<p>f) Ensuring care is provided to residents with problem behaviors with caregiving approaches that reduce the likelihood of staff becoming targets of abuse by residents.</p>	<p>f) Being approached in a manner that is non- threatening, and is given choices and personal space.</p>	<p>f) Abuse of staff by residents; Staff taking problem behaviors personally, rather than identifying source of abusive behavior.</p>	<p>f) Training staff in conflict resolution skills and care plan development to reduce the incidences where staff are victims of abuse.</p>
<p>g) Ensuring care is provided to residents with dementia in ways that communicate respect while coping with the symptoms of dementia.</p>	<p>g) Being treated with respect while care is provided for symptom relief.</p>	<p>g) Problem behaviors of residents with dementia. Staff resentment toward residents with behavior problems. Staff approaching residents with problem behaviors in a disrespectful way.</p>	<p>g) Training staff to understand residents with dementia and how to cope with problem behaviors in a respectful way.</p>

And finally, respectful care can be provided to residents with behavioral problems and dementia so that they too can experience dignity and a sense of worthiness when interacting with caregivers. The training curriculum therefore included skill development in conflict resolution and dementia care that emphasized methods for defusing conflict and responding to problem behaviors in the most respectful ways possible while maintaining the safety of staff and residents.

Examples of training programs that address these issues were also identified by the literature review, and information from some of these training programs was used in the development of the training curriculum (Astill-McNish, 1984; CARIE, 1999; Chapman, Jackson, & McDonald, 1999). See Appendix A for the complete package of Respectful Care Training Program (2003) overhead presentation and handouts.

4.2 Training Objectives

The training objectives for the Respectful Care Training Program are summarized as follows:

- 1) Participants will understand what **dignity** means in the life of a PCH resident.
 - a) Participants will identify resident dignity as a philosophy of care that should guide the quality of staff interactions with residents.
 - b) Participants will learn how nursing assistants have the opportunity to support or undermine dignity, based on their approach to resident care.
- 2) Participants will enhance their level of **empathy** for residents as a skill to help them provide dignity enhancing care.

- a) Through role play, and discussions of scenarios, participants will place themselves in the resident's situation to understand how residents' sense of worth can be damaged by negative interactions and enhanced by positive interactions
- 3) Participants will recognize all types of staff-resident abuse, and will understand risk factors that can create the conditions where abuse can occur.
 - a) Participants will understand their role in advocacy for residents, abuse prevention and duty to report abuse.
 - b) Participants will understand it is their *responsibility* to enhance rather than diminish the dignity of residents and to intervene if they witness others who diminish the dignity of residents.
- 4) Participants will develop increased skills in conflict management and stress reduction as methods to minimize risk factors for dignity-diminishing care.
- 5) Participants will understand the causes of problem behaviors for residents with dementia.
 - a) Interventions with residents with dementia will focus on methods that defuse conflict and maximize choice and dignity. Person-centered care that focuses on the person rather than the illness or behaviors will be encouraged to address the challenge of dementia as a risk factor for dignity-diminishing care.
- 6) Participants will identify organizational barriers to respectful care – e.g., workloads, routines.
 - a) Participants will be asked to brainstorm ways to overcome organizational barriers. Participants' suggestions will be incorporated into recommendations to management as an outcome of the training program.

4.3 Training Program Resources

The training program was developed by incorporating material from a number of sources. The empathy training portion of the program was adapted from "A sensitization program for Geriatric nurses" (Astill-McNish, 1984). This author suggested a role play activity to build staff empathy for the power differentials between staff and residents, and for the feelings associated with having a disability and requiring help:

Participants who are in the role of "residents" acquire disabilities such as blindness, deafness, one sided paralysis and/or dementia by using props and role play skills. Participants who are in the role of "staff" proceed to assist the "residents" to have tea and a snack. Following the role play, participants share their experience with the group in more detail in terms of how the disability affected their dignity, and whether the staff interaction served to buffer the impact of their disability, or may have worsened it (Astill-McNish, 1984). This role play is summarized in Appendix B.

Relevant poetry written by a registered nurse and submitted for use in the training program was included in the handouts for participants. One of the poems is reproduced below with permission from the author (Chute, 2003, unpublished).

Loneliness

He works hard
has a family
supports his town
and becomes an important person
in his community.
In time he grows old
and his body becomes weak.
His loving wife is gone
and his family has moved away.
He is now dependent on others
for basic needs, wants and companionship.
Pass me a kleenex
help me move
pour me some water
help me put on my sweater
He is always asking for help.

Can't he do it himself?
Maybe
Or maybe
what he really wants is
a little time when he is not alone.
When he can see a smiling face,
feel a caring touch
and hear a friendly voice.

Written by Kathy Chute, 2003

The imagery in this poem identified some of the feelings associated with being dependent on others, and how every interaction with caregivers, even if it is only related to a response for a request for help, is an opportunity for the resident to have human contact and have loneliness reduced. The imagery in this author's poetry was a useful tool in building empathy, as the reader could experience the resident's innermost feelings and his longing for caring contact (see Appendix C for additional poems used in the training program).

A video presentation by Elder Communications (1997), called *Preserving resident's dignity – For staff members in long term care*, was shown to participants as a method to sensitize them to interactions and approaches to enhance dignity. Content from the video was summarized on overheads and on handouts given to participants to refer to following the training program.

The video identified five categories – care of physical appearance, independence, freedom of choice, privacy and respect. Within each of these categories, examples were given that depicted ways in which different caregiver approaches can enhance or diminish a resident's dignity (see Appendix D).

Using scenarios based on the five categories identified in the video, participants were asked to experience dignity from the perspective of residents, by participating in role play scenarios (see Appendix E). These role plays were developed with the assistance of a panel of experts (two registered nurses and a nursing assistant) from the facility in order to use scenarios that were relevant to the PCH context. This activity was intended to help participants understand how residents feel when staff enhance dignity vs. diminish dignity. The participants were given some scenarios in which “staff” provide personal care to a “resident”. With each scenario, the “staff” first interact with the “resident” in a way that diminishes dignity. Then, the “staff” interact with the “resident” in a way that enhances dignity. The scenarios describe ways to do this. The participants all have a turn at being a “resident” and a “staff”. Following the scenarios group discussion focused on the following:

- 1) How did it feel as “residents” when you were:
 - a) Respected?
 - b) Disrespected?
 - c) What indignities did you experience?
- 2) How did it feel as Staff A in the disrespectful role toward residents?
 - a) What were the contributing factors?
 - b) Did this justify the behavior?
- 3) How did it feel as Staff B who sometimes had to stand up for residents’ rights in spite of routines, or partner’s behaviors?

Groups were asked to analyze personal feelings associated with diminished and enhanced dignity and to try to imagine how it would feel to be a resident in the situation of these circumstances.

Abuse recognition and prevention were components of the training program (see Appendix A). Participants were provided with overheads and handouts depicting definitions of various types of abuse with specific examples. The training curriculum

also included the presentation of a video *At the End of the Day* produced by the Centre for Advocacy for the Rights and Interests of the Elderly, (CARIE 1999). This video was part of the training program: *Competence with compassion: An abuse prevention training program for long term care staff* (CARIE, 1999).

Participants watched the video enactment of a situation involving staff to resident physical abuse. The participants were asked to identify the conditions that set the stage for the abuse (a resident with dementia who is agitated and non-compliant with taking medication; a nurse working over time under stress from work and home). The participants were also asked to identify what could have been done differently to avoid the abusive situation.

Stress was identified as a barrier to respectful care, and the training attempted to help participants identify useful techniques that were helpful in reducing stress or helpful in coping with stress. The importance of care for the caregiver in order to maintain the health and energy required to fulfill work and personal responsibilities was emphasized (see Appendix A).

A conflict resolution technique called "RETHINK" was utilized from the CARIE program (as noted above; see Appendix F). Participants were asked to apply this model to some case scenarios, which were later brought forward for class discussion. The RETHINK acronym refers to:

1. Recognizing anger and learning to relax;
2. Explaining the situation from the other person's point of view;
3. Thinking how one might be contributing to the problem;
4. Hearing what the other person is saying;
5. Including I- statements to avoid blaming the other person,
6. Negotiating to work things out to everyone's satisfaction, and
7. Kindness (CARIE, 1999).

The components of the curriculum, which focused on dementia care were adapted from a training program by Chapman, Jackson, and McDonald (1999) called *What Behavior? Whose problem?* This training program identified potential triggers for problem behaviors such as residents who: do not understand care task and experience fear or anger, have difficulty coping with the noise of the institution; have pain or unmet emotional needs; have difficulty coping with change; and/or experience isolation or disorientation. This program identified specific tips for interacting with a resident with dementia (see Appendix G). This information was presented using overheads and handouts. Participants were given opportunities to bring forward difficult scenarios and problem behaviors for the class to discuss and attempt to come to a consensus on a respectful approach to cope with the identified behavior.

Two poems describing residents experiencing dementia were submitted by a registered nurse for use in the training program and are reproduced with the permission of the author in Appendix C. The imagery in these poems, *Confusion* and *Power of a Smile* (Chute, 2003, unpublished), helped describe the residents' perceptions of staff interactions and how these perceptions though real to the residents, are not congruent with reality due to the symptoms of dementia (see Appendix C). In these poems, the resident is able to understand a kind approach and feel safe and accepted, just as the resident is able to understand when he/she is being treated like a child or is being disciplined. These poems helped to emphasize the fact that residents with dementia have the capacity to feel emotions, and can understand a friendly approach, when all other levels of understanding may be altered by the disease. Using the imagery of poetry,

participants were shown how to enhance the dignity of residents with dementia by using a positive approach that communicates unconditional acceptance.

4.4 Pre-implementation Program Review Process

The training program was reviewed by representatives from the nursing home who gave feedback on relevance to staff, complexity level of the material, and training methods. The client care coordinator, a health care aid and registered nurse reviewed the scenarios and role plays and gave feedback for minor revisions. Also a representative from the student's practicum committee reviewed the full design of the program prior to implementation. Revisions were made prior to the implementation of the training program. Appendix A contains the handouts and overheads used in delivering the program.

4.5 Training Methods

The format for presentation of the training program consisted of a variety of methods to meet the learning needs of a broad group of participants. There was some lecture material in the form of presentation and overheads. A limitation to this format is the possibility that the material might be perceived as boring and participants could lose interest. To overcome this limitation, participants were encouraged to ask questions during the lectures to increase their understanding. Also, lectures were starting points for group discussion where participants were invited to give examples from their own experiences and workplaces to demonstrate knowledge of the material. The participants were divided into small groups to brainstorm and summarize ideas on flip chart paper to

bring back to the larger group for discussion. This also encouraged more discussion from participants who were reticent to speak up during the larger group interaction.

Scenarios consisted of case study type descriptions of hypothetical interactions between staff and residents and were used as starting points for discussion. For example, students were asked to respond in alternate ways to make abusive scenarios examples of dignity enhancing care. Also, participants were asked to give feedback on ways they could intervene with other staff if they witnessed an interaction that diminished the dignity of a resident.

Participants were encouraged to discuss staff responsibility in abuse prevention and to identify barriers to these interventions. The participants also had an opportunity to submit these ideas as part of a follow up survey that was completed three to four weeks following the training program.

Because the objectives of the training program included skill development and behavioral change rather than simply understanding the material, participatory methods of teaching were utilized. According to Alspach (1994) role playing is the enactment of true-to-life situations to teach process skills or to develop attitudes rather than conveying factual content. Role playing is a useful tool to improve the participants' empathy for what is deemed respectful and disrespectful interactions with residents. It was hoped that by enhancing empathy for residents' perceptions of interactions, participants would become more sensitive and aware of interactions around them that enhance or diminish dignity. It was useful for participants to try out new behaviors and to experience difficult situations rather than simply talking about them. Opportunities for group discussion followed the role plays so that learning experiences were shared with the group.

A limitation to this method of teaching is some apprehension by group members who have not used this method of learning. Participants were encouraged to work in groups of two or three, in non-threatening contexts rather than in front of the class.

4.6 Recruitment of Training Participants

The training was open to employed nursing assistants (trained and untrained), and nursing assistant students in Assiniboine Regional Health Authority (ARHA).

Recruitment of participants required the help of officials from local nursing homes in the Assiniboine Health Region and the Assiniboine Community College (ACC) in Brandon.

It was important to seek the assistance of the ARHA and ACC, because of the logistics of rescheduling shifts if nursing assistants chose to attend during a work day, and to seek permission to have students attend during a regular class day. (This was one of the most difficult parts of the recruiting process due to staff shortages – to re-schedule nursing assistant shifts so that they could attend the training).

A letter was sent to the Regional Health Authority (RHA) and ACC officials summarizing the content of the program, the evaluation component, and the targeted group of participants. This letter was a follow-up to telephone conversations inviting the participation of ARHA nursing assistants and ACC students (see Appendix H).

The Education Coordinator for the Assiniboine RHA and Client Care Coordinators from the personal care home in Neepawa and surrounding areas were given information about the program, to inform their staff and seek volunteers. Trained and untrained employed nursing assistants were recruited from nearby personal care homes in Neepawa, Minnedosa and Carberry. In total, twenty-two regional employee nursing assistants attended the training – ten were untrained and twelve were trained.

The ARHA provided incentives to their employees who chose to attend the program during a regular work day, if their shifts could be covered. These participants could apply for an unpaid leave from their shift for the day of the program and receive wage replacement from education funding. Eight participants took advantage of this incentive.

Recently hired nursing assistants who had unused orientation days were allowed to use the training program as orientation time, and were paid to attend as if it were a regular work day. Nine participants were recruited using this incentive.

The remaining five nursing assistants volunteered to attend the program during non-work hours. Incentives to attend the training with pay were important and successful in recruiting participants to the program; the majority of employee participants (17) were paid to attend through these incentives and it is unlikely that they would have attended on their day off.

Incentives were also important in recruiting the student participants. If the students had been invited to attend on a voluntary basis, a much lower level of participation would likely have occurred. However, the facilitator from ACC arranged for the Neepawa nursing assistant class to attend the training during one of their regular class days, during their final week of class prior to their graduation. There were eleven student nursing assistants who attended the training program. One of these participants did not complete the follow up evaluation and therefore, data from this participant was not included in the evaluation of the program.

No volunteers were turned away, and therefore the sample consisted of all who chose to attend with the exception of some nursing assistants who were unable to attend

because of scheduling problems. Two of the untrained nursing assistants did not complete the follow up evaluation and therefore, data from these participants were not included in the evaluation of the program.

Table 3: Participant Sample and Evaluation Response Rates

Participants	# Student nursing assistants Group A	# Untrained nursing assistants Group B	# Trained nursing assistants Group C	Total # participants
# completed training	11	10	12	33
# completed evaluation component	10	8	12	30
evaluation response rate	91%	80%	100%	91%

The student nursing assistants (Group A) attended the training session at the Neepawa Resource Centre. The nursing assistant employee participants (Group B and C) attended one of two training sessions offered at the East View Lodge site. Groups B and C were mixed during the training and participant data were separated afterwards to comprise Group B and C for comparison purposes.

All participants who attended the program had taken time from their work, personal, and/or school time to attend the training program. In order to make the day more enjoyable and to acknowledge the participants for their time and interest, the facility provided lunch for the sessions that occurred at East View Lodge and local businesses were encouraged to donate self-care items for free draws as an incentive for participation. Draws were made for door prizes at the end of the training sessions.

Participants were informed that the program was part of a pilot project to develop a dignity enhancing care training program as part of the requirements for a student

practicum. A consent form was signed by all participants to participate in the research study and to complete all surveys and tests as part of the evaluation of the practicum (see Appendix I for a copy of the consent form). They were informed that their feedback would be considered for future revisions and use of the training program.

According to the literature, the length of training programs can vary from one hour modules (Chapman & Kerr, 1995; Innes, 1999) to ongoing staff development programs and intensive year-long programs (Skog, Grafstom, Negussi & Windbladd, 1999). The training program implemented in this practicum was limited to a six-hour, one-day session. The reason for limiting the training to one day was to enable all participants to complete the entire training session. Difficulties in re-scheduling work shifts, and limitations on the amount of education dollars available to compensate for lost work time, meant that it would be next to impossible to have the same group attend sessions on different days. There was sufficient material included in the curriculum of the training program to require the duration of a full day of training.

In order to keep the attention of all participants and keep the course content manageable, six hours of training was the maximum that was considered feasible. There was a 15 minute morning and one half hour lunch break scheduled, in addition to the six hours training time. Participants had the option of having an afternoon break or finishing earlier in the afternoon. They were free to access refreshments (snacks and beverages) throughout the day, as desired.

There was a great deal of material to cover in six hours, however by breaking the training into components, it was felt to be manageable within the time frame. The effectiveness of a time-limited educational format was assessed from the perspectives of

the participants and student. The participants had the opportunity to evaluate the duration of the training in the participant evaluations. During the delivery of the program, the student noted whether all material was covered in the time allowed with adequate time for discussions and questions. In some cases, discussions were quite extensive, and the student felt that some of the content may have been rushed in order to accommodate the group learning experience. At times it was a judgment call whether discussion should be facilitated further or interrupted in order to move on to the next topic.

The training was provided to the three groups in separate one-day sessions. Because of work schedules, Groups B and C were mixed for the training, but data was separated afterwards in order to compare the effectiveness of the training program with trained and untrained staff. In total, 30 participants completed all aspects of the training and evaluation – Group A- ten nursing assistant students; Group B -eight untrained staff and Group C – twelve trained staff. The participants were separated into these groups for data analysis in order to compare differences in initial baseline knowledge, and differences in skills learned, used and retained following the training program. It was hoped that any differences observed might determine which groups would most benefit from the training program in future. Also, it allowed an examination of whether future training needs might differ among the three groups. It was felt that this information may be helpful when planning types of future training opportunities and identifying future trainees if resources are scarce, such that all staff cannot receive training.

4.7 Descriptive Results

All training participants were female which reflects the primarily female work force in personal care homes. Training sessions were held on three separate days and attended by three separate groups.

The student nursing assistant participants (Group A) were enrolled in the Assiniboine Community College Comprehensive Health Care Aide (CHCA) course, and were nearing their graduation. This group of participants attended the training as a mandatory part of their course because it was held on a regular class day. Eleven participants attended the training program and ten completed all surveys associated with the evaluation component of the practicum. Their ages were distributed across all age categories with 50% between the ages of 18 to 25 years. The remainder of the group was between the ages of 26 and 55.

The majority of Group A (70%) had “worked” in personal care homes less than six months as part of their training program practicum. Many had worked in personal care homes within Assiniboine region during their student practicum. Some of these participants were hired by nursing home facilities following the completion of their studies. The remainder of the group (30%) had been employed at nursing homes between six months and five years. Following the training program and the completion of their CHCA course, the majority (60%) of participants experienced an increase in the number of shifts worked, probably due to recent employment opportunities. The remainder (40%) experienced a decrease in the number of shifts worked. It is important to be aware of the increased frequency in the number of shifts worked by the majority of participants in Group A, when analyzing follow-up data. The increase in frequency of shifts worked

may coincide with increases in participants' reports of incidents such as conflict or abuse following the training.

A second group of participants (Group B) consisted of ten untrained nursing assistants who worked in the personal care home in Neepawa or surrounding personal care homes in Assiniboine Region. Ten participants attended the training but two participants did not complete the follow-up survey to evaluate the training program. Evaluation feedback was therefore limited to eight participants from this group. The majority of Group B (70%) had worked in personal care homes for less than one year with the remainder working for more than one year. These eight participants were more evenly spread across age categories with 25% between the ages of 18 – 25; 50% between the ages of 26 and 45; and 25% over age 46.

A third group (Group C) consisted of trained nursing assistants who had a Health Care Aid certificate and had worked for a period of time in the personal care home in Neepawa or surrounding personal care homes in Assiniboine Region. This group consisted of twelve participants who attended the training and completed the evaluation component. The majority of this group (58%) was between the ages of 36 and 55, with 25% between ages 18 and 35 and 6% over 55 years. The majority of this group (75%) had worked in nursing homes for more than three years with the remainder having worked between one and three years.

4.8 Design for Evaluation Component

The evaluation component of the training program was developed as a method to identify strengths and weaknesses of the training program and where future

improvements are required. First it was necessary to develop a baseline measure of the participants' knowledge of the curriculum, and their perceived ability to provide respectful care. Second, it was necessary to identify any change in their knowledge, perceived ability, and actual behaviors following the training and whether these changes might be attributed to the training. By comparing information gathered before and after the training program, the effectiveness of the training was evaluated. The evaluation information was also important in assessing needs for future training.

Data was collected through the completion of a pre-test - post-test – follow-up survey design. The pre-test was given to participants three to four days prior to the training so that it was completed and submitted the morning(s) of the training program session(s). See Appendix J for a copy of the pre-test. The pre-test gathered information from participants regarding their:

- age, work experience and education;
- ability to provide for residents' dignity;
- assessment of organizational support;
- capacity for empathy;
- perceived workload;
- attitudes toward residents;
- reported frequency of conflict with residents;
- reported frequency of abuse of staff by residents;
- reported frequency of staff-resident abuse; and
- ability to intervene with residents with dementia in a positive way.

A short post-test and participant evaluation was completed the same day as the program, at the end of the training. The post-test repeated some of the questions from the pre-test that focused on participants' perceived ability to provide for resident dignity and attitudes towards residents (see Appendix K for post-test). The post-test was intended to measure any immediate change in participants' self evaluation of their ability to provide for resident dignity and any change in their attitudes toward residents immediately following the training. These results were then compared to the same sections on a follow up survey completed 3-4 weeks following the training to note if these changes were retained over time.

The follow-up survey was mailed out three weeks following the first training session and participants were asked to complete it and mail it back in a self-addressed stamped envelope. The follow-up survey was sent with a cover letter reminding participants that they had consented to participate in the training and the follow-up survey and to return the survey as soon as possible (see Appendix L for a copy of the follow-up survey and cover letter).

It was necessary to phone half of the participants to remind them to return the surveys; six participants required a second reminder before the surveys were returned. Three surveys were not returned in spite of additional reminders.

The follow-up survey included a number of the questions asked in the pre-test survey and this enabled a pre-test-follow-up comparison of responses to these questions. Additional, open-ended questions were also asked on the follow-up survey to encourage more detailed feedback. The focus of these questions was how the training had changed the participants' sensitivity to the quality of staff-resident interactions and their ability to

deal with conflict and residents with dementia. They were asked if the training program had caused them to change the way they interacted with residents, and the way they intervened if they witnessed dignity diminishing care.

The measurement instruments were developed by adapting instruments referred to in the literature and by adapting instruments that had been used to measure the effectiveness of other programs (CARIE, 1999).

The pre-test questionnaire was divided into ten sections and the follow-up survey was divided into eleven sections. Both instruments contained questions which gathered information about the participants. In the pre-test, information was obtained on participants' work history, age, and education. In the follow-up survey, information was gathered regarding changes in the frequency of work experience since the training program. This was important to know, when analyzing changes in the sections where frequency of conflict and abuse were recorded as these differences might be attributed to changes in the frequency of work shifts.

A series of five questions that measured participants' self-rated ability to provide for resident dignity were included in the pre-test, post-test and follow-up survey. These questions focused on five categories of needs that comprise resident dignity. These needs, as identified in the literature review, include physical and emotional needs, choices, privacy and independence. Respondents were asked to answer each question by choosing one of the following responses:

1- Not much ability; 2- Some ability; 3- Adequate ability; or 4 - Not required for the job. This section was intended to indicate any differences in the participants' self-evaluated ability to provide for resident dignity following the training program.

The pre-test and follow-up survey included some questions to measure perceived organizational support for resident dignity. These questions were developed to measure the participants' perceptions of organizational support for staff in providing for residents' physical, and emotional needs as well as coping with job stress and accessing training. Respondents were asked to answer each question by choosing one of the following responses: 1- *No support*; 2 - *Very little support*; 3 - *Some support*; or 4 - *Adequate support*.

It was expected that there might be some improvements in the perception of organizational support for training, following the training program, because of the support given to participants to attend the training program. In contrast, it was expected that this measure might demonstrate a perceived decrease in organizational support for coping with job stress following the training because the training occurred just prior to the onset of summer holidays. It was expected that after the training there would be an increase in job stress related to staff shortages that generally occur over the summer holidays.

An empathy scale was included on both the pre-test and follow-up survey. This scale consisted of eleven questions intended to measure the participants' self-rated potential for empathy toward residents and the presence or absence of conditions that tend to reduce empathy such as burn out. The questions were developed from the constructs that make up the *Empathy Construct Rating Scale (ECRS)*, as described by La Monica (1981), and from some questions on the instrument that was used to evaluate the CARIE program (1999). Participants were asked to respond by choosing numbers on a Likert scale from strongly agree to strongly disagree. Items were scored to measure

changes in self-rated empathy following the training. These are the items or questions posed as statements describing the degree to which the participant perceived herself:

- experiencing burnout;
- able to handle conflict;
- being critical of residents with behavior problems;
- having a positive attitude toward residents;
- treating residents impersonally;
- being sensitive to residents needs;
- understanding the frustration of residents;
- taking problem behaviors personally;
- resenting residents with heavy care; and
- caring about what happens to residents.

This section of the pre-test and follow-up survey was intended to measure the effectiveness of the empathy training as well as any changes in barriers to empathy such as degree of burnout experienced.

The next section of the pre-test and follow-up survey contained three items designed to measure the workload of participants in terms of adequate time to complete tasks and adequate numbers of staff to provide care. It was expected that participants might experience a higher degree of perceived workload following the training program as the training coincided with the onset of vacation and staff shortages, and with the students starting new jobs. Perceived workloads were measured before and after the training as it was important to know if higher workloads were being experienced following the training. This was important as workloads have been identified by the

literature as a barrier to respectful care. Higher workloads experienced following the training could also potentially be a barrier to participants retaining new skills learned during the training program.

A series of eight questions to measure caregiver attitudes towards residents was adapted from *An Attribution Toward the Elderly Scale* as cited by Lucas, (1991). According to Lucas, “*attribution* is defined as the process of inferring characteristics to the cause of behavior of an elderly person” . . .while, “attitude is defined as the organization of beliefs about an elderly person which would cause a health services professional to act positively or negatively towards an elderly person” (1991,p.17). These questions were included in the pre-test, post-test and follow-up survey. It was hypothesized that following the training program, respondents’ scores would indicate an increase in positive attitudes and a decrease in negative attitudes towards residents.

This scale was adapted and extended to measure participants’ perceptions regarding residents’ overall need for dignity. The concept of dignity for residents was operationalized by the following: (1) right to respect; (2) right to be treated as an adult; (3) the importance of outward physical appearance; (4) the need for privacy; (5) the need for relationships; (6) the need for activity; (7) the need to feel safe and cared for; (8) the need for a sense of belonging and acknowledgement by others; (9) the need for control over personal space; and (10) the desire to be independent. Following the training program, respondents’ answers were compared to determine if the findings indicated a more positive attitude towards residents and an increased understanding of the residents’ right to overall dignity. A higher score in this section indicates a more positive attitude towards residents and a greater understanding of the residents’ need for dignity.

The pre-test and follow-up survey included a series of questions to measure the frequency of conflict with residents, the frequency of resident to staff abuse, the frequency of staff to resident abuse witnessed by participants, and the frequency of resident abuse by participants. These questions were adapted from the CARIE training program (1999). Abuse is defined as an act that causes physical or psychological pain to another person (Pillemer & Moore, 1989). Respondents were asked to report first on actions they observed other staff commit and then on actions personally taken. It was expected that it would be easier for staff to comment on abuse that they had witnessed rather than abuse that they had committed.

The confidentiality of responses was emphasized and questions did not ask for identifying information about a specific abusive incident, in order to encourage participants to be truthful. However it was expected that some of the responses would be influenced by social desirability, hence the two-part questionnaire that allowed participants to comment on the actions of others before their own.

It was important to measure changes in conflict, and in participants' reports of abuse following the training. A reduction in reported conflict and participant to resident abuse after the training might be a possible outcome of improved conflict resolution skills. In contrast, an increase in reports of abuse might also indicate a higher degree of sensitivity to the different types of abuse.

The pre-test and follow-up survey included questions intended to measure the participants' ability to provide respectful care to residents with dementia. This concept was measured by four questions adapted from *Penn State Mental Health Caregiving Questionnaire*, as described by Spore, Smyer, and Cohn, (1991). The questions describe

scenarios where residents with dementia display problem behaviors. Participants are asked to select the intervention that they would carry out if caring for this resident. The original test was designed to measure nursing assistants' knowledge of three problems – depression, agitation, and disorientation as well as behavioral approaches for dealing with these. The adapted questions focus on behavioral interventions for agitation and disorientation.

The answer that is deemed to be correct indicates that the respondent has the ability to perceive meaning behind behaviors of residents with dementia, and to intervene in ways that maximize choice and defuse conflict. Incorrect answers indicate that the respondent: is taking the behaviors personally by blaming the resident or treating the resident like a child; is choosing interventions that remove choices and indicate power differentials; or has chosen an intervention that may work temporarily but has not anticipated the meaning or problem behind the behaviors in order to prevent it from occurring again. A higher score in this section indicates a greater ability to respectfully provide care for residents with dementia. Because dementia is a barrier to respectful care, and the training course emphasized skill development in dementia care, it was important to develop a measure that allowed for an assessment of the ability to respectfully care for residents with dementia.

Questions from the measurement instruments were reviewed by the same panel of experts that reviewed the training program (a registered nurse, a nursing assistant and the facility Client Care Coordinator who is also a registered nurse). They were asked to provide feedback and suggestions for revisions. This was an important step in evaluating the instruments prior to implementation as this panel of experts provided feedback

regarding the face validity of the measurement tools, ensuring that questions were relevant to the nursing home context and were measuring what they were intended to measure. Some changes were recommended by this panel. For example, in the preceding concept, the panel of experts was asked if the identified correct response measured what it was supposed to measure – the ability to perceive meaning behind behaviors of residents with dementia, and to intervene in ways that maximize choice and defuse conflict. Questions were revised accordingly. The pre- test was completed by a volunteer nursing assistant to ensure that questions were understandable, and that the length of the survey was manageable. With this feedback, as well as feedback from the student's committee members, the survey was revised accordingly to reduce the overall length and any overlap of questions or concepts.

During the training program, feedback on organizational barriers to dignity enhancing care were identified during class discussions and recorded on flip chart paper. In the same way, participants recorded feelings that were associated with the empathy building exercises. This feedback was intended to be analyzed in the evaluation section of the practicum report to indicate themes in the areas of organizational barriers and experiential learning.

Immediately following the training a course evaluation was given to all participants to evaluate the training program. This evaluation was completely anonymous with no identifying data included in the questionnaire. Participants were asked to complete the evaluation honestly as their feedback would be helpful in identifying the strengths and weaknesses of the program.

The course evaluation elicited responses to the following topics: complexity of curriculum, opportunities to ask questions, comfort levels, and achievement of their learning goals. Participants were asked to identify what learning goals were not achieved, if any, and what they found most and least helpful during the training. As well, participants had the opportunity to rate the training and the presentation methods of the presenter on a scale of 1 - 10.

Chapter 5 consists of the results from participants' surveys. These results are summarized and analyzed to identify the effectiveness of the training program in changing attitudes and behaviors of participants.

Chapter 5

Evaluation of the Training

5.1 Introduction

The pre-test results for each group of trainees served as baseline data to be compared with the post-test and follow-up survey and to compare groups to one another. Each component of the pre/post-test was analyzed for trends and the degree of change in the following areas:

- participant-rated ability to provide for resident dignity;
- perceived organizational support for resident dignity;
- participant-rated capacity for empathy towards residents;
- participant attitudes towards residents that can impact (positive vs. negative) caregiving approaches;
- frequency of conflict with residents in past month before training and at follow-up;
- frequency participants witness staff interactions with residents that diminish dignity in past month before training and at follow-up; and
- frequency participants reports interacting with residents in ways that diminish dignity in past month, before training, and at follow up.

In order to compare results among groups of trainees, any differences in time that elapsed from pre-test to follow-up among groups of trainees will be described and accounted for. As well, differences in perceived workload and frequency of shifts among groups of trainees will also be identified.

5.2 Frequency of Shifts and Perceived Workload

Follow-up surveys were completed by all participants over the same two-week time period. Surveys were mailed to participants the same day, and 30 of 33 surveys were returned within a two week period. The time that elapsed between pre-test and follow-up surveys for Groups B and C was between three to four weeks, for a mean of 3.5 weeks. The time period between pre-test and follow-up surveys for Group A was between two to three weeks for a mean of 2.5 weeks.

In order to adjust all groups to a comparison period of 4 weeks at follow-up, all data referring to frequency of reports at follow-up were adjusted using the method outlined in Table 4. Data adjusted using this method included participants' follow-up mean scores which measured the average frequency of the following: (1)working short-staffed; (2)experiencing conflict with residents, (3)abuse of participants by residents, and (4)resident-abuse by staff and participants.

Table 4: Method for Adjusting Frequency Reports at Follow-up.

<p>1. Group B and C's average elapsed time from pre-test to follow-up was 3.5 weeks and was adjusted to 4 weeks as follows: : $\frac{4 \text{ weeks}}{3.5 \text{ weeks}} = 1.14$</p> <p>a) Therefore frequency data for groups B and C were adjusted upward by multiplying data by 1.14.</p> <p>2. Group A's average elapsed time from pre-test to follow-up was 2.5 weeks and was adjusted to 4 weeks as follows: $\frac{4 \text{ weeks}}{2.5 \text{ weeks}} = 1.6$</p> <p>a) Therefore frequency data for Group A were adjusted upward by multiplying data by 1.60.</p>

Adjusted data are noted in each table. There were types of data that could not be accurately adjusted and these consisted of percentages or actual numbers of respondents that reported a response category, where each category covered a range of scores.

It is important to describe the contexts before the training and at follow-up in terms of the frequency that groups worked and their perceptions of workload. Heavy workloads can be barriers to respectful care and therefore fluctuations in workload have the potential to affect some of the outcomes or expected outcomes of the training program.

Group A experienced an increase in the numbers of shifts worked since the training program. For example, prior to the training program, 50% of participants had worked between '6 and 20 shifts', and in the two to three week period following the training, 80% had worked these amounts. The actual number of shifts at follow-up would be 1.6 times the reported amount (as in Table 4) given the reporting period was only a partial month.

This increase may also be a result of participants graduating from their training course and having more time to accept shifts, and/or recently having been hired by local facilities. If this is the case, not only did their number of shifts increase, but also their roles changed from students to employees and this may have affected the stress they experienced in the time period since the training as well as their potential for implementing new skills learned during the training.

In comparison, Group B and Group C appear to have experienced a decrease in the number of shifts worked since the training program. For example, in the month prior to the training program, 100% of Group B (n=8) reported working between '6 and 20

shifts', and in the three to four week period following the training, 63% (n=5) reported working these amounts. However the actual number of shifts at follow-up would be 1.14 times the reported amount (see Table 4) given the reporting period was only a partial month for Group B (i.e., the decrease in number of shifts worked may have been influenced by the decrease in reporting period from one month before training to a mean of 3.5 weeks at follow-up). Also, reduced shifts may have been influenced by new, trained staff being hired in their facilities over this period of time reducing the number of shifts available for untrained staff.

For Group C, in the month prior to the training program, 100% of participants (n=12) reported working between '6 and 20 shifts', and in the three to four week period following the training, 84% (n=10) reported working these amounts. The decrease in number of shifts worked may have been impacted by vacations, as one participant reported this to be the case. It is important to keep in mind that, similar to Group B, the actual number of shifts at follow-up for Group C would be 1.14 times the reported amount (see Table 4) given the reporting period was only a partial month for Group C (i.e., the decrease in number of shifts worked may have been influenced by the decrease in reporting period from one month before training to a mean of 3.5 weeks at follow-up).

Perceived workload was operationalized by participants' perceptions of having enough time to complete all tasks, and the frequency that participants worked short-staffed at pre-test and follow-up. The perception of having adequate time to accomplish all tasks was measured before and after the training with the majority of participants reporting being somewhat short of time at follow-up (see Table 5).

Table 5: Perceptions Re: Adequate Time to Complete Tasks at Pre-test and Follow-up.

Question	Mean Scores ¹ for Participant Groups					
	Group A (n = 10)		Group B (n = 8)		Group C (n = 12)	
	Pretest	Follow-up	Pretest	Follow-up	Pretest	Follow-up
In general, do you have enough time to accomplish all tasks assigned during your shift?	1.8	2.5	2.9	2.5	2.8	2.8

Notes: ¹Mean scores based on responses where 1 = more than enough time, 2 = just enough time, 3 = somewhat short of time, and 4 = very short of time.

Group A's perception of workload changed from having 'just enough time' to complete tasks before the training towards being 'somewhat short of time', at follow-up. This change may be attributed to the change in role from student to employee experienced by the majority of participants in Group A at follow-up. As students at pre-test, participants were working as "extra staff", with fewer expectations placed upon them as compared to working as employees at follow-up. In comparison, Group B and C's perception of workload did not change following the training from being 'somewhat short of time' at pre-test.

The frequency that participants reported working 'short-staffed by one person' and/or 'short staffed by two or more persons', was measured at pre-test and follow-up (see Table 6). All groups experienced an increase in workload at follow-up as measured by the frequency that they worked short-staffed. For example, on average Group A reported working 'short-staffed by one person' between two and five times in the month following the training as compared to once in the month preceding the training.

Table 6: Frequency Working Short-staffed at Pre-test and Follow-up.

In the past month ¹ how often have you	Participants' Mean Scores ²					
	Group A (n = 10)		Group B (n = 8)		Group C (n = 12)	
	Pretest	Follow-up	Pretest	Follow-up	Pretest	Follow-up
1. Worked short-staffed by one person?	0.88	2.4 ¹	1.50	1.56 ¹	1.42	2.28 ¹
2. Worked short-staffed by two or more persons?	0.33	1.12 ¹	0.25	0.72 ¹	1.00	1.32 ¹

Notes: ¹Scores adjusted upward for all groups at follow-up to increase post comparison period to one month; Group A adjusted by 1.6 and B and C by 1.14.

²Mean score is based on responses where 0 = never, 1 = once, 2 = 2-5 times, 3 = 6-10 times, and 4 = more than 10 times.

On average, Group B reported a very small increase in working short-staffed at follow-up whereas Group C reported a larger increase. Group C, on average, reported working 'short-staffed by one person,' between two and five times in the month following the training as compared to once, on average, in the month preceding the training.

At follow-up all groups reported on average having worked 'short-staffed by two persons' at least once which was up slightly from the pre-test reports. These results are most likely accounted to the onset of summer vacation which occurred in the month following the training. Historically, the problem of staff shortages is exacerbated by the onset of holidays.

In summary, high workload was analyzed for its role as a barrier to the delivery of respectful care related to the training program. Workload is influenced by having time to complete tasks, and having adequate staffing to complete tasks. On average, there was a

somewhat higher perceived workload reported at follow-up as compared to pre-test based on the frequency that participants worked short staffed.

Overall, Group B and C experienced a slight decrease in shifts worked at follow-up, while Group A experienced a significant increase. At follow-up, all groups reported being 'somewhat short of time' required to complete tasks. This was an increase in perceived workload for Group A whereas there was little to no significant change in this perception reported by Groups B or C.

Therefore workload appeared to have increased in terms of the frequency that participants reported working short-staffed whereas perceived workload did not change for Groups B and C as they reported being 'somewhat short of time' at follow-up and at pre-test. The fact that the perception of workload did not change significantly at follow-up is thought-provoking. It may be indicative that working short-staffed has become a somewhat "normalized" part of the general working experience. If this is the case, staff may have developed coping mechanisms in terms of making some tasks a priority, and leaving others that are not deemed essential. This coping method could be a barrier to respectful care if it results in lower quality of staff-resident interactions because of "rushed" care.

5.3 Participants' Perceptions Regarding the Ability to Provide for Resident Dignity

The participants from all groups rated their ability as 'adequate' in meeting resident dignity as measured by the following categories: their ability to meet residents' physical and emotional needs; their ability to respect residents' choices and privacy; and their ability to encourage residents' independence (see Table 7).

Table 7: Participants' Perceptions Regarding Ability to Provide for Resident Dignity at Pre-test, Post-test and Follow-up.

Participants' Perceived Ability	Mean Scores ¹								
	Group A (n = 10)			Group B (n = 8)			Group C (n = 12)		
	Pre-test	Post test	Follow-up	Pre-test	Post test	Follow up	Pre-test	Post test	Follow up
1. To meet residents' physical needs.	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
2. To meet residents' emotional needs.	2.9	2.9	3.0	3.0	3.0	3.0	3.0	3.0	3.0
3. To respect residents' choices.	3.0	2.9	2.8	2.9	2.6	3.0	2.8	2.9	2.8
4. To protect residents' privacy.	3.0	3.0	3.0	2.9	3.0	3.0	3.0	3.0	2.9
5. To encourage residents' independence.	2.9	3.0	3.0	2.8	2.9	2.9	2.8	2.8	2.8
Summed Mean²	14.8	14.8	14.8	14.5	14.5	14.9	14.6	14.3	14.5

Notes: ¹Mean score is based on responses where 1 = not much ability, 2= some ability and 3= adequate ability.

²Summed mean score is based on 5 items where score can vary from 5 (least ability) to 15 (adequate ability).

There was no change at all in participant perceptions before and after the training regarding their ability to meet residents' physical needs. There was some slight variation in participants' perceptions of ability to meet the other four categories of needs, but the change was so slight that it is difficult to assess if it was significant.

The lack of variation in scores before and after training could be attributed to a number of factors none of which can be substantiated with the given information. First, the training program may have had no effect on participants' abilities to provide for residents' needs or their perceptions of this. A second possible reason for the lack of

variation in scores may be that most participants were skilled in meeting the needs of residents in all five categories. In addition, participants' may have rated themselves so highly at pre-test that there was little room for improvement following the training.

There also may have been a problem with the instrument itself. Perhaps there was a lack of variation in the rating scale in terms of the degree of ability to provide for residents' needs. For example, rather than rating abilities from 'not much ability' to 'adequate ability', it may have been more accurate to have the choices increase by intervals from 'not much ability' to 'excellent ability'. Related to this, social desirability may have been a factor in participants having difficulty describing themselves as having inadequate ability to do tasks related to their paid employment. And finally, the lack of variation in scores may be attributed to assigning incorrect categories to measure the presence of dignity enhancing care. In other words, the criteria chosen to measure dignity may not have had criterion validity in terms of measuring the concept that was intended to be measured.

The lack of variation in findings illustrates how difficult it is to define an elusive concept such as dignity with criteria that are tangible enough to measure. There is a need to develop a measurement tool that can accurately measure caregivers' success in meeting the standard of dignity enhancing care. Adding a component to the measurement tool to incorporate the residents' opinions of their caregivers' abilities to provide for resident dignity may be one approach to improve validity. It would be interesting to apply the measuring tool used in this research to gather the opinions of residents and compare these to participants' perceptions.

5.4 Perceived Organizational Support for Resident Dignity

Perceived organizational support was operationalized to include the following four criteria: support to provide for residents' physical and emotional needs and support for staff to cope with job stress and to access training (see Table 8).

Table 8: Perceived Organizational Support for Resident Dignity at Pre-test and Follow-up

Participants' Perceived Organizational Support	Mean Scores ¹					
	Group A n = 10		Group B n = 8		Group C n = 12	
	Pretest	Follow-up	Pretest	Follow-up	Pretest	Follow-up
1. For staff to provide for residents' physical needs.	4.0	3.8	3.6	3.8	3.5	3.3
2. For staff to provide for residents' emotional needs.	3.7	3.4	3.6	3.3	3.1	2.6
3. For staff to cope with job stress.	3.7	3.4	3.8	3.1	2.8	2.4
4. For staff to access training.	3.7	3.3	3.6	3.6	2.5	3.2
Summed Mean²	14.8	13.9	13.5	13.4	11.9	11.5

Notes: ¹Mean score is based on responses where 1 = no support, 2 = very little support, 3 = some support, and 4 = adequate support.

²Summed mean score is based on 4 items where score can vary from 4 (no support) to 16 (adequate support).

It was important to measure the level of perceived support for respectful care from the organization before and after the training. Some of the factors which are barriers to respectful care are beyond the control of participants. For example working short-staffed in a stressful environment may make it difficult for staff to provide for

assistance and training opportunities may be methods to cope with some of the barriers to respectful care. However, accessing training and employee assistance programs often requires the support of the organization.

Although there was a slight decline between pre-test and follow-up, Group A reported the highest level of organizational support for resident dignity (pre-test mean of 14.8 for this four-item summed scale with a comparative follow-up mean of 13.9).

In comparison, Group C had significantly lower perceptions of organizational support for resident dignity before training and at follow-up than the other two groups with a slight decrease in this perception at follow-up. However, it's important to note that their perception of organizational support for accessing training increased following the training (pre-test mean score 2.5 on this item with a comparative follow-up score of 3.2 based on responses where 2 = 'very little support' and 3 = 'some support'). It is difficult to assess whether this group perceived more support from the organization to access training as a result of incentives to attend the training program, or if this was a perception of increased support generally that participants' may have attributed to the training itself.

In comparison, Group A, who had graduated and started work since the training program, identified a slight reduction in the amount of organizational support for training (pre-test mean score 3.7 on this item with a comparative follow-up score of 3.3 based on responses where 3 = 'some support', and 4 = 'adequate support').

Scores for Group B indicated 'some support' to 'adequate support' from their organization on all four items of the scale. There was no significant difference from pre-

test to follow-up (mean of 13.5 at pre-test and 13.4 at follow-up on the summed scale score).

5.5 Participants' Capacity to Express Empathy for Residents

The capacity to have empathy or to be in tune with the feelings of residents was measured by eleven questions posed as statements. Respondents were asked to express their level of agreement using a 4-point agree-disagree scale. Results are shown in Table 9. The participants' capacity for empathy was measured according to the participants' level of burnout, capacity to handle conflict, and ability to understand and care for residents with heavy needs and behavioral problems.

The summed mean scores were very high for Groups A and B at pre-test and at follow-up indicating a high degree of empathy for residents, with little variation before and after training. In comparison, the summed mean score for Group C was somewhat lower than A and B at pre-test, and improved the most (the summed mean for Group C increased from 31.0 at pre-test to 34.0 at follow-up on an 11-item summed mean scale with minimum and maximum scores of 11 and 44 respectively).

At follow-up, on average Group C 'mildly disagreed' with the statement: *I don't often feel burned out from my work*. This response may indicate that these participants experienced higher levels of burnout following the training than at pre-test when on average, they 'mildly agreed' with this statement. In comparison Group A and B on average 'mildly agreed' with this statement before and after the training, indicating lower levels of burnout than Group C at follow-up.

Table 9: Capacity for Empathy at Pre-test and Follow-up.

Participants' Level of Agreement with the Following Statements	Mean Scores ¹					
	Group A (n = 10)		Group B (n = 8)		Group C (n = 12)	
	Pre-test	Follow-up	Pre-test	Follow-up	Pre-test	Follow-up
1. I don't often feel burned out from my work. ³	2.8	2.8	3.3	2.9	2.5	2.2
2. I handle conflict well.	3.6	3.3	3.4	3.6	3.0	2.9
3. I am not critical of residents who have behavior problems. ³	3.7	3.3	3.3	3.5	2.5	3.3
4. I display a generally positive attitude toward residents.	3.9	4.0	3.5	4.0	3.9	4.0
5. I don't treat residents more impersonally than I would like to treat them. ³	3.7	3.2	3.0	2.6	2.7	2.5
6. Job stress is not making me somewhat less sensitive to residents' needs. ³	3.4	2.6	3.3	3.3	2.0	2.3
7. I understand how frustrated residents must feel when they must wait for their care.	3.8	3.8	3.9	4.0	3.7	3.8
8. I don't take it personally when a resident lashes out at me in anger. ³	3.7	3.5	3.4	3.5	2.9	3.3
9. I am not resentful of residents who need frequent heavy care. ³	3.8	3.8	3.9	3.9	3.2	3.6
10. Sometimes I take the residents' problems home with me.	1.5	1.6	1.4	2.0	1.5	1.5
11. I do care very much what happens to one or another resident. ³	4.0	3.8	4.0	3.0	3.2	3.9
Summed Mean²	37.9	36.1	36.1	37.1	31.0	34.0

Notes: ¹Mean score is based on responses where 1 = strongly disagree, 2 = mildly disagree, 3 = mildly agree, and 4 = strongly agree.

²Summed mean score is based on 11 items where score can vary from 11 (low level of empathy) to 44 (high level of empathy).

³Negatively worded items in the original scale are reworded in a positive direction for presentation purposes; thus a higher score on the scale indicates greater capacity for empathy.

At follow-up Group C 'mildly agreed' with the statement, *I am not critical of residents who have behavior problems*. This compares to a pre-test score where the mean response was between 'mildly agree and mildly disagree' (a mean response of 2.5 at pre-test increased to a mean response of 3.3 at follow-up where 2 = 'mild disagreement' and 3 = 'mild agreement' on a 4 point agree-disagree scale). These results suggest that Group C demonstrated an increase in capacity for empathy following the training, as measured by being less critical of residents with problem behaviors.

Group A's mean score for this item at pre-test indicated 'strong agreement' and their score was in 'mild agreement' range at follow-up (pre test mean score of 3.7, and comparative follow-up score of 3.3 where 3 = 'mild agreement' and 4 = 'strong agreement' with this item on a 4 point-agree-disagree scale). Group B's mean score for this item between pre-test and follow-up increased slightly from 3.3 to 3.5.

At follow-up, all groups agreed less strongly with the statement *-I don't treat residents more impersonally than I would like to treat them*. For example, Group A's mean response for this item decreased from 'strongly agree' to 'mildly agree' at follow-up (with a mean score of 3.7 for this item at pre-test and a comparative follow-up score of 3.2 where 4= 'strongly agree' and 3 = 'mildly agree'). In comparison Group B 'mildly agreed' at pre-test and there was a decline in the mean score at follow-up (3.0 at pre-test to 2.6 at follow-up where 2= 'mild disagreement' and 3 = 'mild agreement'). Group C decreased slightly in the mean response score for this item, moving from 'mild agreement' range at pre-test to a mean score that was mid-way between 'mildly disagree' and 'mildly agree' at follow-up (pre-test mean score of 2.7 with a comparative follow-up score of 2.5).

This variation may be indicative of a decrease in capacity for empathy as measured by this item. Or, perhaps, this change in level of agreement may be attributed to the fact that the training program created a greater awareness of the importance of a personal approach to care, and how this is communicated. Thus, participants could have been rating their behavior differently because they understood the difference between personal and impersonal care, more clearly, after the training.

Before and after the training, Group C on average 'mildly disagreed' with the statement, *job stress is not making me less sensitive to residents' needs*, indicating that this group on average identified job stress as a barrier to their sensitivity to residents. Their level of disagreement was only slightly less at follow-up.

In comparison, Group A agreed less strongly with this statement at follow-up (a mean response of 3.4 at pre-test decreased to a mean response of 2.6 at follow-up with 2 indicating 'mild disagreement' and 3 indicating 'mild agreement' on a 4 point agree-disagree scale). This may be indicative of higher workloads following the training, or a higher level of awareness regarding the negative effect that stress can have on staff sensitivity. Group B on average 'mildly agreed' with this statement before and after the training with absolutely no variation in level of agreement (3.3 mean score at pre test and follow-up). Group B reflected the most positive response to this item at follow-up; that is, they expressed a higher level of agreement with the statement that job stress was not affecting their ability to be sensitive to residents' needs.

Before and after the training all groups on average agreed 'mildly' to 'strongly' with the following items: handling conflict well, displaying generally positive attitudes towards residents, understanding how frustrated residents feel when they must wait for

care, not taking it personally when residents lash out, caring what happens to residents, and not being resentful of residents who require heavy care. Group C's scores indicated an increase in empathy between pre-test and follow-up on the last two items.

Before and after the training all groups disagreed with the statement: *sometimes I take the residents' problems home with me*. Though this item was intended to measure empathy by indicating the degree to which staff show concern about residents during non-work hours, it is obvious that participants make an effort to leave their work concerns at work. This may also be indicative of healthy stress management by participants. In future, this question can be omitted from the scale, as it does not appear to measure the concept of empathy.

The following points provide a summary of the results from the eleven item empathy measure.

- All groups demonstrated fairly high levels of empathy before and after training as their summed mean scores were closer to the higher end of the scale (44) than the lower end (11).
- Groups A and B demonstrated the highest levels of empathy before and after the training as measured by the items in this scale. There was no significant difference noted between these two groups.
- While Group C demonstrated the lowest levels of empathy of the three groups at pre-test and follow-up, the difference at follow-up is modest due to an increase in Group C's summed mean score after the training (increasing from 31.0 at pre-test to 34.0 at follow-up on this eleven item scale).

- As indicated above, Group C demonstrated the greatest improvement in levels of empathy following the training. This was related to increased levels of agreement at follow-up with the following statements: not being critical of residents with behavior problems; caring what happens to residents; not taking it personally when residents lash out; and not being resentful of residents who require heavy care.
- At follow-up, all groups agreed less strongly with the statement *-I don't treat residents more impersonally than I would like to treat them.* This may be indicative of greater empathy in terms of participants' wanting to treat residents more personally, and understanding the importance of doing so.
- At follow-up, on average Group C 'mildly disagreed' with the statement: *I don't often feel burned out from my work* (at follow-up mean score of 2.2 indicated a greater degree of disagreement with this statement than the pre-test score of 2.5 on a 4 point scale where 3 = mild agreement and 2 = mild disagreement). In comparison Group A and B on average 'mildly agreed' with this statement before and after the training, indicating lower levels of burnout than Group C at follow-up. Thus, in comparison to Groups A and B, Group C may have a greater need for empathy training to buffer the higher stress and burnout that these participants reported experiencing.

5.6 Caregiver Attitudes

A series of seven statements was developed to measure the attitudes that participants have towards residents in the following areas:

- The need to be treated like adults;
- The importance of appearance, privacy and independence; and
- The need to be considered worthy individuals who want to live meaningful lives.

In the absence of these positive attitudes, caregivers are more likely to treat residents like children, to neglect to maintain their privacy, independence and appearance; they may also inadvertently communicate to residents that they are not valued and are not living meaningful lives.

All groups demonstrated a high degree of positive attitude as measured by this scale, with all summed mean scores closer to the high end of the scale (28) as opposed to the lower end (7). The summed mean scores for this scale indicate a slight improvement in attitudes at follow-up for all three groups with all groups scoring fairly similarly in terms of positive attitudes towards residents (see Table 10). Variations in the mean scores for this attitudinal scale indicate that Group C has the most positive attitude toward residents both at pre-test and follow-up although there was very little difference in the average scale scores for Group C and Group A.

Group B reported a slightly greater improvement in attitude from pre-test to follow-up, however their average score was also the lowest at pre-test and remained somewhat below the other two groups at follow-up (mean scale score of 22.8 as compared to 23.5 and 24.3 for Groups A and C respectively). This variation in attitudinal mean scores may be related to the formal training that the trained participants from Group C and the student participants from Group A share (i.e., health-care-aid certificates). Although the difference is not large, the variation may indicate that Group B would

benefit most from training that included material on developing positive attitudes towards residents.

Table 10: Caregiver Attitudes at Pre-test, Post-test and Follow-up

Participants' Level of Agreement with the Following Statements	Mean Scores ¹								
	Group A (n = 10)			Group B (n = 8)			Group C (n = 12)		
	Pre-test	Post test	Follow up	Pre-test	Post test	Follow up	Pre-test	Post test	Follow up
1. Residents are not like children, needing discipline from time to time. ³	3.4	3.4	3.2	3.4	3.4	3.5	3.3	3.8	3.7
2. Personal appearance is important to most residents.	3.4	3.9	3.7	3.4	3.9	3.9	3.8	4.0	3.8
3. Most residents don't like being excluded from conversations with staff. ³	3.4	3.6	3.2	3.3	3.4	3.1	3.6	3.2	3.5
4. Most residents would rather do their own personal care than accept help.	3.5	3.6	3.4	2.9	3.4	3.1	3.0	3.4	3.5
5. Most residents are not just passing the time until they die. ³	2.5	3.3	2.6	2.8	3.1	3.3	3.3	3.4	2.9
6. Most resident would be embarrassed to wear open-backed clothes, bibs and incontinent aids.	3.0	3.7	3.3	2.8	3.1	2.4	3.3	3.8	3.5
7 Most residents don't like it if you touch/move their belongings without asking. ³	3.2	3.6	3.3	3.1	3.3	3.6	3.5	3.1	3.4
Summed Mean²	23.1	25.7	23.5	21.1	23.6	22.8	23.5	24.6	24.3

Notes: ¹Mean score is based on responses where 1 = strongly disagree, 2 = mildly disagree, 3 = mildly agree, and 4 = strongly agree.

²Summed mean score is based on 7 items where score can vary from 7 (least positive attitude) to 28 (most positive attitude).

³Negatively worded items in the original scale are reworded in a positive direction for presentation purposes; thus a higher score on the scale indicates a more positive attitude.

It is important to recognize that the variations in summed mean scores among the three comparison groups are very modest and therefore may not be considered significant enough to suggest differences in training requirements among the three groups based on this scale alone. The very small variation in scores before and after training could be attributed to a number of factors none of which can be substantiated with the given information. First, the training program may have had little effect on participants' attitudes towards residents; as attitudes are formed over life experiences, they can be difficult to influence or change with one training program. A second possible reason for the small variation in scores may be that most participants demonstrated very positive attitudes, and there was little room for improvement following the training. The lack of variation in scores may also indicate that the tool is not sensitive to changes in levels of positive attitudes among participants and/or it may indicate that more training is required before significant levels of improvements in attitudes would occur. The results could have been influenced by any of these factors or a combination of these. At the same time, it is encouraging to note that there was a larger increase in scores between pre-test and post-test and that follow-up scores were higher than those reported at pre-test. This trend in scoring seems to suggest that the training program had a small but noticeable impact on influencing attitudes towards residents.

5.7 Frequency of Conflict with Residents

The frequency of conflict with residents was measured to indicate if there was an improvement in conflict resolution skills following the training. Conflict is a barrier to

respectful care, and it is important to reduce conflict as a method to promote respectful care.

Participants from Groups A, B and C were asked to identify the frequency that they had experienced conflict with residents in the month before the training and the month following the training. The frequency of conflict reported at follow-up expressed as a mean score was adjusted to ensure the comparison period was the same for all participants using the method previously described in Table 4 (adjustment factor is 1.6 based on average of 2.5 weeks at follow-up as compared to 4.0 at pre-test). However, it is important to note that the percentage of participants who indicated response categories at follow-up was not adjusted using this method, so the analysis of any variations in these percentages must allow for the shorter reporting period at follow-up (i.e., percentages at follow-up would likely show a somewhat higher frequency).

Eight categories of conflict were included within this measure including conflict over: the quality of food; residents complaining too much; residents wanting to go outside; residents unwilling to eat; residents unwilling to dress; residents unwilling to comply with personal hygiene; and/or unwilling to comply with assistance with toileting. An additional category of "other" was offered as a choice so that all types of conflict would be reported. All categories of conflict are listed in descending order in the Tables according to the frequency that participants reported these categories.

Group A (see Table 11) reported a significant increase in conflict following the training (mean scale score of 7.8 at pre-test increased to 12.3 as adjusted for time differences at follow-up). This increase needs to be interpreted cautiously as the

adjustment factor is quite large (i.e., 1.6) and this increases the possibility of error in such calculations.

Table 11: Frequency of Conflict in Past Month for Group A at Pre-test and Follow-up.

Category of Conflict	Frequency and Percentage of Responses Group A (n = 10)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1.Residents' unwillingness to eat.	(1) 10%	(2) 20%	(6) 60%	(1) 10%	(2) 20%	0	(7) 70%	(1) 10%
2.Residents' unwillingness to dress.	(2) 20%	(4) 40%	(4) 40%	0	(3) 30%	(3) 30%	(4) 40%	0
3. Residents' personal hygiene.	(4) 40%	(2) 20%	(4) 40%	0	(3) 30%	2 20%	(5) 50%	0
4. Quality of food.	(4) 40%	(3) 30%	(3) 30%	0	(5) 50%	(3) 30%	(2) 20%	0
5. Residents wanting to go outside the home.	(5) 50%	(1) 10%	(3) 30%	(1) 10%	(4) 40%	(2) 20%	(2) 20%	(2) 20%
6. Residents complaining too much.	(5) 50%	(4) 40%	(1) 10%	0	(4) 40%	(3) 30%	(2) 20%	(1) 10%
7. The toileting of residents.	(8) 80%	(1) 10%	0	(1) 10%	(9) 90%	0	0	(1) 10%
8. Other:	(8) 80%	(1) 10%	0	(1) 10%	(7) 70%	0	0	(1) 10%
Summed Mean²	7.8				12.3³			

*Number of respondents for each response category shown in parentheses.

- Notes:
- ¹Responses where 0 = never, 1 = once, 2 = 2-10 times, and 3 = 10 or more times.
 - ²Summed mean score is based on 8 items where score can vary from 0 (no conflict) to 24 (frequent conflict).
 - ³Mean score adjusted upward for Group A by 1.6 at follow-up to increase post comparison period to one month.

However, the increase in the frequency of conflict may also be attributed to the increased frequency in working and/or changes in roles from students to employees experienced by the majority of the participants in Group A at follow-up. For Group A,

conflict was reported in all categories with the most conflict identified in three categories (1) 'residents unwilling to eat' (60 % of participants [n= 6] at pre-test and 70% of participants [n=7] at follow-up reported conflict occurring in this category two to ten times in the past month, with 10 % [n=1] reporting it more than ten times in the past month at pre-test and follow-up); (2)'residents unwilling to dress' (40% [n=4] at pre-test and 30% [n=3] at follow-up reported conflict occurring in this category once in the past month, with 40% of participants [n=4] at pre-test and at follow-up reporting conflict occurring in this category two to ten times in the past month; and (3)'residents unwilling to comply with personal hygiene' (40% of participants [n=4] at pre-test and 50% of participants [n=5] at follow-up reported conflict occurring in this category two to ten times in the past month, with 20% [n=2] reporting it happening once in the past month at pre-test and follow-up).

In comparison Group B, (see Table 12) reported a very slight decrease in conflict following the training (summed mean scale score of 7.0 at pre-test was reduced to 6.3 at follow-up with summed mean scores based on 8 items where score can vary from 0 indicating 'no conflict' to 24 indicating 'frequent conflict'). While this is encouraging, the decrease is so small it cannot be considered significant enough to conclude that the training program had an impact on conflict resolution skills. However, the frequency of responses in the different categories of conflict may be useful in identifying where future interventions can be directed in order to reduce conflict.

Table 12: Frequency of Conflict in the Past Month for Group B at Pre-test and Follow-up.

Category of Conflict	Frequency and Percentage of Responses Group B (n = 8)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1 Residents wanting to go outside the home.	(3) 37.5%	(2) 25%	(3) 37.5%	0	(1) 12.5%	(3) 37.5%	(4) 50%	0
2.Residents' personal hygiene.	(2) 25%	(2) 25%	(4) 50%	0	(2) 25%	(3) 37.5%	(3) 37.5%	0
3.Residents' unwillingness to eat.	(2) 25%	(2) 25%	(4) 50%	0	(3) 37.5%	(3) 37.5%	(2) 25%	0
4. Residents complaining too much.	(4) 50%	(1) 12.5%	(3) 37.5%	0	(6) 75%	(1) 12.5%	(1) 12.5%	0
5. Quality of food.	(4) 50%	(2) 25%	(2) 25%	0	(5) 62.5%	(1) 12.5%	(2) 25%	0
6. Residents' unwillingness to dress.	(4) 50%	(2) 25%	(2) 25%	0	(6) 75%	(2) 25%	0	0
7. The toileting of residents.	(5) 62.5	(1) 12.5%	(2) 25%	0	(5) 62.5%	0	(3) 37.5%	0
8. Other:	(5) 62.5%	(1) 12.5%	(2) 25%	0	(7) 87.5%	0	(1) 12.5%	0
Summed Mean²	7.0				6.3³			

*Number of respondents for each response category shown in parentheses.

Notes: ¹Responses where 0 = never, 1 = once, 2 = 2-10 times, and 3 = 10 or more times.

²Summed mean score is based on 8 items where score can vary from 0 (no conflict) to 24 (frequent conflict).

³Mean score adjusted upward for Group B by 1.14 at follow-up to increase post comparison period to one month at follow-up.

For Group B, conflict was reported in all categories with the most conflict identified in three categories: (1) 'residents wanting to go outside the home' (37.5% of participants [n=3] at pre-test and 50% of participants [n=4] at follow-up reported conflict occurring in this category two to ten times in the past month with 25% [n=2] and 37.5% [n=3] reporting it happening once in the past month at pre-test and follow-up respectively); (2) 'residents unwilling to comply with personal hygiene' (50% of

participants [n=4] at pre-test and 37.5% [n=3] at follow-up reported conflict in this category occurring two to ten times in the past month, and 25% [n=2] and 37.5% [n=3] reporting it happening once in the past month at pre-test and follow-up respectively); and (3) 'residents unwilling to eat' (50% of participants [n=4] at pre-test and 25% of participants [n=2] at follow-up reported conflict occurring in this category two to ten times in the past month, with 25% [n=2] and 37.5% [n=3] reporting it happening once in the past month at pre-test and follow-up respectively).

Group B reported significant reductions in the frequency of conflict at follow-up in the following two categories (in order to compare overall frequency of conflict in a given category the percentages in the columns under responses 1-3 are summed): 'residents complaining too much' (from 50% [n=4] at pre-test to 25% of participants [n=2] at follow-up reporting one or more occurrences in the past month); and 'residents unwillingness to dress' (from 50% [n=4] at pre-test to 25% of participants [n=2] at follow-up reporting one or more occurrences in the past month). The analysis must take into account the slightly shorter reporting period at follow-up (mean of 3.5 weeks at follow-up vs. 4 weeks at pre-test for Group B), though it is unlikely that a half week would have caused this level of decrease.

Similar to Group B, Group C reported a slight decrease in conflict following the training (summed mean scale score of 7.3 at pre-test was reduced to 6.7 at follow-up with summed mean scores based on 8 items where score can vary from 0 indicating 'no conflict' to 24 indicating 'frequent conflict'). This decrease is not large enough to be considered significant (see Table 13).

Table 13: Frequency of Conflict in Past Month for Group C at Pre-test and Follow-up.

Category of Conflict	Frequency and Percentage of Responses Group C (n = 12)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1 Residents' unwillingness to eat.	0	(5) 42%	(6) 50%	1 8%	(3) 25%	(3) 25%	(6) 50%	0
2. Residents wanting to go outside the home.	(2) 17%	(5) 42%	(5) 42%	0	(3) 25%	(3) 25%	(6) 50%	0
3. Residents' personal hygiene.	(3) 25%	(4) 33%	(5) 42%	0	(8) 67%	(2) 17%	(2) 17%	0
4. Quality of food.	(4) 33%	(5) 42%	(3) 25%	0	(7) 58%	(3) 25%	(2) 17%	0
5. Residents complaining too much.	(6) 50%	(2) 17%	(4) 33%	0	(7) 58%	(2) 17%	(2) 17%	1 8%
6. Resident's unwillingness to dress.	(8) 67%	(3) 25%	(1) 8%	0	(6) 50%	(5) 42%	(1) 8%	0
7. The toileting of residents.	(8) 67%	0	(2) 17%	(1) 8%	(7) 58%	(3) 25%	(2) 17%	0
8. Other:	(10) 83%	(1) 8%	(2) 8%	0	(9) 75%	(1) 8%	(2) 16%	0
Summed Mean²	7.3				6.7³			

*Number of respondents for each response category shown in parentheses.

*Percentages in this table and elsewhere in the report may not add to 100% due to rounding.

Notes: ¹Responses where 0 = never, 1 = once, 2 = 2-10 times, and 3 = 10 or more times.

²Summed mean score is based on 8 items where score can vary from 0 (no conflict) to 24 (frequent conflict).

³Mean score adjusted upward for Group C by 1.14 at follow-up to increase post comparison period to one month.

For Group C, conflict was reported in all categories with the most conflict identified in the same three categories as group B: (1) 'residents unwilling to eat' (50% of participants [n=6] at pre-test and at follow-up reported conflict in this category occurring two to ten times in the past month, with 42% [n=5] at pre-test and 25% of participants

[n=3] at follow-up reporting it occurring once in the past month; one participant reported conflict occurring in this category more than ten times in the past month at pre-test; (2) 'residents wanting to go outside the home' (42% of participants [n=5] at pre-test and 50% of participants [n=6] at follow-up reported conflict in this category occurring two to ten times in the past month, with 42% [n=5] and 25% [n=3] reporting conflict once in the past month at pre-test and follow-up respectively); and (3) 'residents unwilling to comply with personal hygiene' (42% of participants [n=5] at pre-test and 17% of participants [n=2] at follow-up reported conflict in this category occurring two to ten times in the last month with 33% [n=4] and 17% of participants [n=2] reporting conflict once in the past month at pre-test and follow-up respectively).

The most frequent conflict at pre-test and follow-up for Group A and C was reported in the category 'residents unwilling to eat'; as well Group B reported frequent conflict in this area. This may highlight the need for specific ethical training in the care of residents who refuse to eat. Groups B and C experienced significant levels of conflict with residents wanting to go outside the home which was less of a problem for Group A.

Some improvements in terms of reductions in the frequency of conflict at follow-up were identified in some categories (in order to compare overall frequency of conflict in a given category the percentages in the columns under responses 1-3 are summed). For example, Group C reported less frequently having conflict with residents over personal hygiene at follow-up (from 75% of participants [n=9] at pre-test as compared to 33% [n=4] at follow-up reporting one or more occurrences in the past month). This reduction is large enough that it cannot completely be attributed to the reduction in reporting period at follow-up.

The overall frequency of conflict over quality of food decreased at follow-up in terms of a reduction in the frequency that groups reported the occurrence of this category of conflict one or more times in the past month (from 60% at pre-test to 50% at follow-up for Group A; from 50% at pre-test to 37.5% at follow-up for Group B; and from 66% at pre-test to 42% at follow-up for Group C). Conflict over food quality is difficult to attribute to any change in behavior of nursing assistants and is more likely due to other factors.

5.8 Abuse of Staff by Residents

Abuse of staff by residents with cognitive impairments has been identified as a barrier to respectful care. It was important to measure if the training program had the effect of reducing the frequency of reports of abuse of participants. It was also important to examine the extent to which participants experience abuse in the workplace at the hands of the people for whom they provide care, and what types of abuse are most prevalent. Six categories of abuse were integrated to create a staff abuse scale. Participants were asked to report the frequency they were abused by residents in the past month. Categories included types of physical and verbal abuse and threats of physical abuse, as well as an 'other' category to include additional types of abuse not included in response categories. Results for Group A are found in Table 14.

The degree of increase in summed mean scores at follow-up for Group A indicate a significant increase in the frequency that this group reported being abused by residents at follow-up as compared to at pre-test (from 4.0 at pre-test to 7.5 at follow-up on a 7 item scale where 0 refers to no abuse and 21 to frequent abuse). The summed mean scores indicating frequency of abuse of staff by residents that was reported at follow-up

was adjusted to ensure the comparison period was the same for all participants. This increase needs to be interpreted with caution as the adjustment factor is quite large (i.e., 1.6) which increases the potential for greater error with such calculations. However, it is important to note that the frequency of reports as measured by percentages was not adjusted using this method.

Table 14: Frequency of Abuse of Staff by Residents in past Month for Group A at Pre-test and Follow-up.

Category of Abuse	Frequency and Percentage of Responses Group A (n = 10)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1. Was pushed, grabbed shoved or pinched.	(1) 10%	(5) 50%	(4) 40%	0	(4) 40%	(2) 20%	(4) 40%	0
2. Was insulted or sworn at.	(2) 20%	(4) 40%	(4) 40%	0	(3) 30%	(3) 30%	(4) 40%	0
3. Was threatened.	(4) 40%	(4) 40%	(2) 20%	0	(4) 40%	(1) 10%	(5) 50%	0
4. Was actually hit or had something thrown at self.	(6) 60%	(3) 30%	(1) 10%	0	(5) 50%	(2) 20%	(3) 30%	0
5 Was hit or attempted to be hit with an object.	(10) 100%	0	0	0	(3) 30%	(2) 20%	(5) 50%	0
6. Was kicked or bitten.	(10) 100%	0	0	0	(6) 60%	(4) 40%	0	0
7. Other incidents.	(9) 90%	0	(1) 10%	0	(9) 90%	(1) 10%	0	0
Summed Mean²	4.0				7.5³			

*Number of respondents for each response category shown in parentheses.

Notes: ¹Responses where 0 = never, 1 = once, 2 = 2-10 times, and 3 = 10 or more times.

²Summed mean score is based on 7 items where score can vary from 0 (no abuse) to 21 (frequent abuse).

³Mean score adjusted upward for Group A by 1.6 at follow-up to increase post comparison period to one month.

The two categories of abuse that were most frequently reported by Group A are listed in descending order by the percentages of respondents who indicated these

categories: (1) 'being pushed, grabbed, shoved, pinched' (40% of participants [n=4] reported this category of abuse occurring two to ten times in the past month at pre-test and at follow-up, with 50% [n=5] and 20 % [n=2] reporting it once in the past month at pre-test and follow-up respectively); and (2) 'being insulted and sworn at' (40% of participants [n=4] reported this category of abuse occurring two to ten times in the past month at pre-test and follow-up, with 40% [n=4] and 30% [n=3] reporting it once in the past month at pre-test and follow-up respectively). The decrease in frequency of reporting at follow-up, in terms of percentages of reports, was probably influenced by the shorter post comparison period of 2.5 weeks vs. pre-test comparison of 4.0 weeks. In other words, because the follow-up percentages were not adjusted to reflect the shorter reporting period, the actual percentage of participants experiencing abuse at follow-up would most likely be higher than what is shown in this report.

It is important to note the increase in frequency and severity of physical abuse that occurred at follow-up with 50% of participants [n=5] from Group A reporting being 'hit or attempted to be hit with an object' two to ten times in the past month at follow-up compared to none reporting this category at pre-test; and 40% [n=4] reporting being 'kicked or bitten' once in the past month at follow-up compared to no reports in this response category at pre-test. This increase occurred in spite of percentages of responses not being adjusted for the smaller post comparison period (2.5 weeks vs. 4.0 weeks). One premise for this trend may be that Group A, as new employees who are likely caring for residents not well known to them, may have required a more thorough orientation regarding specific residents with behavioral problems and specific training in approaches that are most effective with these residents. A question that could be posed, in further

research is whether abuse of staff by residents occurs at a higher frequency in the first few months of employment and if this is related to inadequate orientation and/or not understanding the special needs of some residents. In comparison, Group B reported a slight decrease in the frequency of being abused by residents at follow-up (see Table 15).

Table 15: Frequency of Abuse of Staff by Residents in Past Month for Group B at Pre-Test and Follow-up.

Category of Abuse	Frequency and Percentage of Responses Group B (n = 8)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1. Was insulted or sworn at.	(3) 37.5%	(1) 12.5%	(3) 37.5%	(1) 12.5%	(1) 12.5%	(4) 50%	(2) 25%	(1) 12.5%
2. Was threatened.	(4) 50%	(2) 25%	(1) 12.5%	(1) 12.5%	(4) 50%	(3) 37.5%	(1) 12.5%	0
3. Was pushed, grabbed shoved or pinched.	(4) 50%	(1) 12.5%	(3) 37.5%	0	(5) 62.5%	(1) 12.5%	(2) 25%	0
4. Was actually hit or had something thrown at self.	(6) 75%	0	(1) 12.5%	(1) 12.5%	(7) 87.5%	0	0	(1) 13.5%
5. Was hit or attempted to be hit with an object.	(6) 75%	0	(2) 25%	0	(7) 87.5%	0	(1) 12.5%	0
6. Was kicked or bitten.	(6) 75%	(1) 12.5%	(1) 12.5%	0	(7) 87.5%	(1) 12.5%	0	0
7. Other incidents:	(7) 87.5%	(1) 12.5%	0	0	(8) 100%	0	0	0
Summed Mean²	4.6				3.9³			

*Number of respondents for each response category shown in parentheses.

Notes:

¹Responses where 0 = never, 1 = once, 2 = 2-10 times, 3 = 10 or more times.

²Summed mean score is based on 7 items where score can vary from 0 (no abuse) to 21 (frequent abuse).

³Mean score adjusted upward for Group B by 1.14 at follow-up to increase post comparison period to one month.

The mean summed score for Group B, at pre-test was 4.6 and decreased to 3.9 at follow-up on a 7 item scale where 0 refers to no abuse and 21 to frequent abuse. Though

it is encouraging to observe a decrease in the frequency of abuse of participants in this group, the decrease is too slight to be considered significant, or to conclude that the training in dementia care and conflict resolution was effective in reducing the abuse of staff.

The three categories of abuse that were most frequently reported by Group B are listed in descending order by percentages and numbers of respondents who chose these categories: (1) 'being insulted and sworn at' (37.5% of participants [n=3] at pre-test and 25% [n=2] at follow-up reported this abuse occurring two to ten times in the past month, with one participant reporting this abuse occurring more than ten times in the past month at pre-test and follow-up; and almost all participants experiencing this abuse to some degree at follow-up with 50% [n=4] reporting being subject to this abuse once in the past month at follow-up, as compared to 12.5% [n=1] at pre-test); (2) 'threats of abuse' (50% [n=4] reported the occurrence of this abuse one or more times in the past month at pre-test and follow-up [responses 1-3 are summed to determine the number of participants experiencing this abuse one or more times in past month]); and (3) 'being pushed, grabbed, shoved, pinched' (50% of participants [n=4] reported this abuse occurring one or more times in the past month at pre-test as compared to 37.5% [n=3] at follow-up). Some of these participants (37.5% [n=3] and 25% [n=2] experienced being 'pushed grabbed shoved or pinched' two to ten times in the past month at pre-test and follow-up respectively. Though verbal abuse is the most frequent category of abuse experienced before and after training by Group B, physical abuse at the hands of residents is also a significant problem faced by these participants.

Table 16 shows the frequency and percentage of abuse by residents as reported by Group C at pre-test and follow-up. The three categories of abuse that were most frequently reported by Group C are listed according to the percentages and numbers of respondents who indicated each category. These are: (1) 'being insulted and sworn at' (58% of participants [n=7] at pre-test and 50% [n=6] at follow-up reported experiencing this abuse two to ten times in the past month with the majority of the remaining participants experiencing this abuse at least once in the past month at pre-test and follow-up - 25% [n=3] and 42%[n=5] respectively); (2) 'being pushed, grabbed, shoved, pinched' (at pre-test 25% [n=3] reported experiencing this abuse between two and ten times in the past month and 17% [n=2] reported experiencing this more than ten times in the past month; in comparison at follow-up, 67% [n=8] reported experiencing this abuse two to ten times in the past month, with 17% [n=2] experiencing it at follow-up once in the past month);and (3) 'threats of abuse' (42% of participants [n=5] reported experiencing this abuse two to ten times in the past month at pre-test as compared to 33% [n=4] at follow-up; also, 33% [n=4]and 17% of participants [n=2] reported experiencing this abuse once in the past month at pre-test and follow-up respectively).

The percentage of participants in Group C who reported experiencing physical abuse is much higher than that of Group B, but verbal abuse is the most frequently reported abuse experienced by both groups. In comparison, the percentage of participants from Group A that reported physical abuse and verbal abuse is high in both categories.

Table 16: Frequency of Abuse of Staff by Residents in past Month for Group C at Pre-test and Follow-up.

Category of Abuse	Frequency and Percentage of Responses Group C (n = 12)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1. Was insulted or sworn at	(2) 17%	(3) 25%	(7) 58%	0	(1) 8%	(5) 42%	(6) 50%	0
2. Was pushed, grabbed shoved or pinched.	(4) 33%	(3) 25%	(3) 25%	(2) 17%	(2) 17%	(2) 17%	(8) 67%	0
3. Was threatened.	(3) 25%	(4) 33%	(5) 42%	0	(6) 50%	(2) 17%	(4) 33%	0
4. Was actually hit or had something thrown at self.	(5) 42%	(4) 33%	(3) 25%	0	(5) 42%	(4) 33%	(3) 25%	
5. Was hit or attempted to be hit with an object.	(8) 67%	(2) 17%	(2) 17%	0	(8) 67%	(3) 25%	(1) 8%	0
6. Was kicked or bitten.	(11) 92%	0	(1) 8%	0	(12) 100%	0	0	0
7. Other incidents:	(11) 92%	0	(1) 8%	0	(12) 100%	0	0	0
Summed Mean²	5.5				5.7³			

*Number of respondents for each response category shown in parentheses.

- Notes:**
- ¹Responses where 0 = never, 1 = once, 2 = 2-10 times, 3 = 10 or more times.
 - ²Summed mean score is based on 7 items where score can vary from 0 (no abuse) to 21 (frequent abuse).
 - ³Scores adjusted upward for Group C by 1.14 at follow-up to increase post comparison period to one month.

When compared to Groups B and C, Group A has a lower summed mean score on this scale at pre-test (4.0 to 4.6, and 5.5 for Groups B and C respectively on a 7 item frequency of abuse scale ranging from 0 to 21). However, at follow-up, the opposite trend occurs. Group A's summed mean score is the highest (at 7.5 as compared to 3.9 and 5.7 for Groups B and C respectively). Group A therefore experienced the highest increase in the frequency of abuse by residents at follow-up.

For Group A, the increase in abuse may be related to the increase in shifts worked associated with new jobs, and/or inexperience and/or ineffective training in the area of conflict resolution. The variation could also be related to the fact that the adjustment factor used to adjust the follow-up reporting period to one month is quite large (i.e., 1.6) which increases the potential for greater error. However, it is important to note that the frequency of reports as measured by percentages was not adjusted using this method, and if adjusted, would be higher. For Groups B and C there was no significant change in the level of abuse experienced at work at follow-up to attribute to the training program.

This analysis portrays the prevalence of the issue of staff abuse in personal care homes. The abuse of staff by residents is a frequent occurrence in the workplace experienced by most participants. It was not addressed by the training content in conflict resolution provided within the Respectful Care Training Program. Abuse of staff, therefore remains a significant barrier to providing respectful care and is an important area of intervention for future training and organizational abuse policies.

Staff who face frequent abuse in the workplace eventually begin to feel that this is just 'part of the job.' However frequent physical and emotional harm can lead to a sense of powerless and disenchantment with the workplace, such that the potential for the staff to provide respectful care is significantly reduced. Staff must feel supported by the organization to find solutions to this issue. Staff have the same need for dignity as residents, which means they need to feel valued rather than disempowered by intolerable workplace conditions.

Encouraging the reporting of abusive incidents and ensuring that psychiatric assessments of residents (who are identified as having problem behaviors) and follow-up

is done to assist in symptom relief and care plan development is one step toward a solution. The dissemination of care plans to the frontline workers is the second step to providing staff with the information they need to respond to residents in ways that are deemed most effective in preventing resident agitation and aggression toward staff. Intensive training in dementia care and conflict resolution should be mandatory for all staff to help increase their ability to prevent incidents of abuse, and to help de-escalate incidents once agitation and aggression is evident.

However, in the event that prevention strategies are not successful, staff need to feel supported in coping with the side effects of the abuse by having opportunities to debrief and share experiences in a safe environment. Training programs such as the Respectful Care Training Program do offer staff a forum to share strengths, best practices and coping strategies to build strength for coping within a stressful workplace. However, in order for interventions that focus on support and teambuilding to be helpful, these programs must be accessible to all staff, and given at regular intervals.

5.9 Staff-Resident Abuse as Witnessed by Participants

The frequency that participants witnessed the abuse of residents was measured for two reasons – to assess if their sensitivity to the presence of abuse increased following the training, and if they intervened when witnessing abuse following the training. The latter point will be assessed in section 6.2 - *Participants' Perceptions of Impact of Training Program* later in this report (when participants are asked if they intervened when witnessing dignity diminishing care after the training program). The importance of

abuse recognition and advocacy skills was emphasized during the training program to enhance respectful care.

Table 17 shows the frequency and percentage of abuse of residents as witnessed by Group A in the past month at pre-test and follow-up.

Table 17: Frequency Participants Witnessed Staff-Resident Abuse in Past Month for Group A at Pre-test and Follow-up.

Category of Abuse	Frequency and Percentage of Responses Group A (n = 10)							
	Pre-test				Follow-up			
	0	1	2	3	0	1	2	3
Responses¹								
1 Treated a resident as a child	(4) 40%	4 40%	(1) 10%	(1) 10%	(5) 50%	0	(4) 40%	(1) 10%
2. Talked about a resident's private matters in front of others	(5) 50%	(2) 20%	(2) 20%	(1) 10%	(3) 30%	(3) 30%	(4) 40%	0
3. Provided care in a rough manner.	(7) 70%	(2) 20%	0	(1) 10%	(3) 30%	(1) 10%	(5) 50%	(1) 10%
4 Physically forced a resident to accept care.	(8) 80%	0	(1) 10%	(1) 10%	(6) 60%	0	(3) 30%	(1) 10%
5. Yelled at a resident in anger.	(8) 80%	(1) 10%	0	(1) 10%	(6) 60%	(2) 20%	(2) 20%	0
6. Confined a resident in room as disciplinary measure.	(8) 80%	0	1 10%	(1) 10%	(6) 60%	(3) 30%	(1) 10%	0
7. Insulted or swore at a resident.	(8) 80%	1 10%	0	(1) 10%	(8) 80%	(2) 20%	0	0
8. In participant's opinion unnecessarily restrained a resident.	(9) 90%	0	0	(1) 10%	9 90%	(1) 10%	0	0
Summed Mean²	4.4				9.4³			

*Number of respondents for each response category shown in parentheses.

Notes: ¹Responses where 0 = never, 1 = once, 2 = 2-10 times, 3 = 10 or more times.

²Summed mean score is based on 10 items where score can vary from 0 (no abuse) to 30 (frequent abuse).

³Scores adjusted upward for Group A by 1.6 at follow-up to increase post comparison period to one month.

The summed mean scores indicate the frequency participants from Group A witnessed the abuse of residents by staff. The mean score at follow-up was adjusted by 1.6 to ensure the comparison period was the same for all participants. Group A reported witnessing a significant increase in the frequency of staff-resident abuse at follow-up (pre-test summed mean of 4.4 increasing to 9.4 at follow-up on a 10 item frequency scale where 0 refers to no abuse and 30 to frequent abuse). This increase in mean score at follow-up needs to be interpreted with caution because of the adjustment factor being so great (1.6), as it increases the potential for greater error with such calculations. It is important to note that the percentage of participants who reported each response category at follow-up was not adjusted using this method, so the analysis of any variations in these percentages must allow for the shorter reporting period at follow-up.

There are two categories of abuse not listed in Table 17 because there were no incidents of these categories of abuse witnessed by participants in Group A. These categories include: “denying a resident food or privileges as part of punishment” and ‘physical abuse (hitting, grabbing) of a resident in anger’.

The two most common categories of abuse witnessed by Group A include the following: (1) ‘treating a resident as a child’ (60% of participants [n=6] reported this abuse one or more times in the past month at pre-test as compared to 50% [n=5] at follow-up); and (2) ‘talking about a resident’s private matters in front of others’ (50% of participants [n=5] reported this abuse one or more times in the past month at pre-test as compared to 80% [n=8] at follow-up) .

There were significant increases in witnessing the following categories of abuse at follow-up: (1) ‘providing care in a rough manner’ (30% of participants [n=3] reported

witnessing this abuse one or more times in the past month at pre-test as compared to 70% [n=7] at follow-up); and (2) 'talking about a resident's private matters' (50% of participants [n=5] reported witnessing this abuse one or more times in the past month at pre-test as compared to 70% [n=7] at follow-up); and (3) 'yelling at a resident in anger' (20% of participants [n=2] reported witnessing this abuse one or more times in the past month at pre-test as compared to 40% [n=4] at follow-up).

This increase in reporting by Group A could be attributed to actually witnessing more abuse due to more frequent shifts, and/or being more sensitive to the presence of abuse after the training. Since the percentage of reports was not adjusted higher for the shorter reporting period at follow-up (2.5 weeks vs. 4.0 weeks), the actual percentages for a month follow-up period might well have been much higher. This may indicate participants are more aware of the effect that various types of abuse have on residents' dignity and are more likely to report it in a survey format.

In Table 18 Group B's results show an increase in the summed mean at follow-up although the change is insignificant (pre-test summed mean of 3.6 increasing to 4.3 as adjusted by 1.14 at follow-up on a 10 item frequency scale where 0 refers to no abuse and 30 to frequent abuse). The following category of abuse is not shown in Table 18 because none of the participants in Group B reported witnessing this abuse – 'physically abusing a resident in anger such as hitting, grabbing, and pushing'.

Table 18: Frequency Participants Witnessed Staff-Resident Abuse in Past Month for Group B at Pre-test and Follow-up.

Category of Abuse	Frequency and Percentage of Responses Group B (n = 8)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1. Provided care in a rough manner.	(4) 50%	(1) 12.5%	(3) 37.5%	0	(4) 50%	(3) 37.5%	(1) 12.5%	0
2. Talked about a resident's private matters in front of others	(5) 62.5%	(2) 25%	0	(1) 12.5%	(4) 50%	(1) 12.5%	(3) 37.5%	0
3. Physically forced a resident to accept care.	(5) 62.5%	(2) 25%	(1) 12.5%	0	(4) 50%	(2) 25%	(2) 25%	0
4. Treated a resident as a child.	(6) 75%	0	(2) 25%	0	(4) 50%	(1) 12.5%	(3) 37.5%	0
5 Insulted or swore at a resident.	(6) 75%	1 12.5%	(1) 12.5%	0	(6) 75%	(1) 12.5%	1 12.5%	0
6. Yelled at a resident in anger.	(6) 75%	2 25%	0	0	(7) 87.5%	(1) 12.5%	0	0
7. Confined a resident in room as disciplinary measure.	(7) 87.5%	0	1 12.5%	0	(7) 87.5%	0	1 12.5%	0
8 In participant's opinion unnecessarily restrained a resident.	(7) 87.5%	(1) 12.5%	0	0	(7) 87.5%	(1) 12.5%	0	0
9 Denied a resident food or privileges as part of punishment.	(7) 87.5%	(1) 12.5%	0	0	(8) 100%	0	0	0
Summed Mean²	3.6				4.3³			

*Number of respondents for each response category shown in parentheses.

Notes:

¹Responses where 0 = never, 1 = once, 2 = 2-10 times, 3 = 10 or more times

²Summed mean score is based on 10 items where score can vary from 0 (no abuse) to 0 (frequent abuse).

³Scores adjusted upward for Group B by 1.14 at follow-up to increase post comparison period to one month

The three most common categories of abuse witnessed by participants in Group B include the following: (1) 'providing care in a rough manner' (50% of participants [n=4]

reported witnessing this abuse one or more times in the past month at pre-test and at follow-up); (2) 'talking about a resident's private matters in front of others' (37.5% of participants [n=3] reported witnessing this abuse one or more times in the past month at pre-test as compared to 50% [n=4] at follow-up); and (3) 'physically forcing a resident to accept care' (37.5% of participants [n=3] reported witnessing this abuse one or more times in the past month at pre-test as compared to 50% [n=4] at follow-up). Though there appeared to be increases in the frequency of witnessing abuse at follow-up, with the small number of participants (n=8) the increase appears to be the result of increased reporting for that category by one participant and therefore is not significant.

However, it is significant that Group B identified 'rough care' as a category of abuse that occurs frequently with 50% of participants [n=4] witnessing this occurrence one or more times in the past month at pre-test and at follow-up. Three participants reported witnessing 'rough care' two to ten times in the past month at pre-test and one had witnessed this abuse two to ten times at follow-up.

As indicated in Table 19, Group C reported a slight increase in mean scores from 4.8 at pre-test to 5.4 at follow-up with the follow-up score adjusted by 1.14 on a 10 item frequency scale where 0 refers to no abuse and 30 to frequent abuse. The variation is not great enough to be significant. Table 19 summarizes the results for Group C; the following categories of abuse were not shown because none of the participants reported witnessing these- 'denying a resident food or privileges as part of punishment' and 'physical abuse by hitting or grabbing a resident in anger'.

Table 19: Frequency Participants Witnessed Staff-Resident Abuse in Past Month for Group C at Pre-test and Follow-up.

Category of Abuse	Frequency and Percentage of Responses Group C (n = 12)							
	Pre-test				Follow-up			
Responses ¹	0	1	2	3	0	1	2	3
1. Yelled at a resident in anger.	(2) 17%	(3) 25%	(7) 58%	0	(10) 83%	(2) 17%	0	0
2. Treated a resident as a child.	(5) 42%	(5) 42%	(1) 8%	(1) 8%	(5) 42%	(2) 17%	(4) 33%	(1) 8%
3. Talked about a resident's private matters in front of others.	(5) 42%	(3) 25%	(3) 25%	(1) 8%	(6) 50%	(3) 25%	(2) 17%	1 8%
4. Confined a resident in room as a disciplinary measure.	(6) 50%	(5) 42%	(1) 8%	0	(6) 50%	(4) 33%	(2) 17%	0
5. Physically forced a resident to accept care.	7 58%	(3) 25%	(2) 17%	0	(7) 58%	(4) 33%	0	(1) 8%
6. Provided care in a rough manner.	(7) 58%	(2) 17%	(2) 17%	(1) 8%	(12) 100%	0	0	0
7. Insulted or swore at a resident.	(8) 67%	(2) 17%	(2) 17%	0	(9) 75%	(2) 17%	0	(1) 8%
8. In participant's opinion unnecessarily restrained a resident.	(12) 100%	0	0	0	(10) 83%	(2) 17%	0	0
Summed Mean²	4.8				5.4³			

*Number of respondents for each response category shown in parentheses.

Notes:

¹Responses where 0 = never, 1 = once, 2 = 2-10 times, 3 = 10 or more times.

²Summed mean score is based on 10 items where score can vary from 0 (no abuse) to 30 (frequent abuse).

³Scores adjusted upward for Group C by 1.14 at follow-up to increase post comparison period to one month.

The four most common categories of abuse witnessed by participants at pre-test for Group C included the following: (1) 'yelling at a resident in anger' (83% [n=10] reported witnessing this abuse one or more times at pre-test as compared to 17% [n=2] at

follow-up); (2) 'treating a resident as a child' (58% of participants [n=7] reported witnessing this abuse one or more times in the past month at pre-test and follow-up); (3) 'talking about a resident's private matters in front of others' (58% of participants [n=7] reported witnessing this abuse one or more times at pre-test as compared to 50% [n=6] at follow-up); and (4) 'confining a resident in room as disciplinary measure' (50% of participants reported witnessing this abuse one or more times in the past month at pre-test and follow-up). The significant reduction at follow-up in reporting 'yelling at residents in anger' is impossible to account for with the data available.

A comparison of the three groups indicates some trends:

- There were no reports by participants from any group having witnessed physical abuse of residents in terms of 'hitting or grabbing in anger'.
- 'Treating residents like children' and 'talking about residents private matters' were the most frequently witnessed abuse reported by all groups.
- There was a marked increase at follow-up in the frequency that Group A reported having witnessed abuse of residents. This may be related to the training program; or the increased number of shifts worked; or the adjusted follow-up score; and/or may be related to the fact that they are new to the workplace and may be more sensitive to the issues of abuse and may have a lower level of tolerance for what they define as abuse. It does appear that participants from Group A, are more sensitive to the presence of staff-resident abuse at follow-up than Group B or C as indicated by the higher frequency of reporting (adjusted scale of 9.4 at follow-up as compared to 4.3 and 5.4 for Groups B and C respectively on a 10 item frequency scale where 0 refers to no abuse and 30 to frequent abuse). Although

Group A worked more frequently after the training program than they did before (due to employment), they did not work more frequently than Groups B and C overall in the month following the training. While this issue needs more careful examination, it may suggest that more emphasis needs to be placed on abuse recognition in training programs for staff with more experience.

- In support of the hypothesis discussed in the previous bullet, there were some specific differences among groups in the frequencies that they reported 'rough care'. At follow-up, 70% [n=10] of Group A reported witnessing 'rough care' one or more times in the past month whereas 42% [n=5] of Group C reported witnessing this category one or more times in the past month at pre-test with no reports at follow-up. Group B identified 'rough care' as a category of abuse that occurs frequently with 50% [n=4] witnessing this one or more times in the past month at pre-test and at follow-up. Three participants from Group B witnessed this occurrence two to ten times in the past month at pre-test and one witnessed this abuse two to ten times at follow-up. The differences in the percentages between certain categories of abuse raises questions. For example, Group C reported no occurrences of rough care at follow-up in spite of observations by Groups A and B that it does occur. Does this difference indicate varying tolerance levels for what is deemed 'acceptable' abuse, or different definitions for what constitutes 'rough care'? Is abuse tolerated if it is committed in order to get the task done? For example, forcing care when a resident refuses to comply or providing care in a 'rough' manner when rushed? Staff who have worked longer in a facility may be more at risk of losing sensitivity such that they define *rough*

care at a higher threshold than a person who is new in their job. Even though 'rough care' may be considered somewhat 'less forceful' than other forms of physical abuse, or 'justified' if in the process of providing care, it is a form of physical abuse that cannot be tolerated. These are areas which should be further examined. It may suggest the importance of on-going sensitivity training as a buffer to the high levels of stress and burnout that has been identified as a barrier to respectful care

In summary, this analysis portrays the frequency of staff to resident abuse in two comparative one month time periods. During this time, the abuse of residents by staff was witnessed by most participants. This analysis highlights the issue of staff-resident abuse as a continued priority for intervention in terms of future training and organizational abuse policies.

5.10 Frequency of Staff-Resident Abuse by Participants

Participants were asked to report the frequency that they committed resident abuse or acted in ways that would diminish the dignity of residents. Because of social desirability, and the risk that participants would underreport, it was first asked that participants report abuse they had witnessed. This was discussed in the previous section of the report.

Information on the frequency of abuse committed by participants was important to the analysis for two reasons. First, it was important to assess if reports of participant abuse increased or decreased following the program. However, it is difficult to interpret changes in that increased reports could simply indicate a heightened sensitivity to these

actions, whereas lower reports might indicate that the training influenced participants to change their behaviors. Nevertheless any reports of such incidents remain a concern.

Second, if the training did not result in changed behavior, the next question is why?

As anticipated all groups reported a much lower level of abuse targeting residents at pre-test and at follow-up than the level of abuse they had reported witnessing other staff commit. The summed mean scores were extremely low both at pre-test and follow-up for all groups. on an 11 item frequency scale where 0 refers to 'no abuse' and 33 refers to 'very frequent abuse'. The results using this scale were as follows:

- Group A reported a summed mean score of **0.2** at pre-test and **0.5** at follow-up adjusting for the decrease in reporting period by adjustment factor, 1.6. This indicates a *very* slight increase in reports at follow-up.
- Group B reported a summed mean score of **2.3** at pre-test and follow-up adjusting for the decrease in reporting period by adjustment factor, 1.14, indicating *no variation* in scores at follow-up.
- Group C reported a summed mean of **1.8** at pre-test and **1.5** at follow-up adjusting for the decrease in reporting period by adjustment factor, 1.14. This indicates a *very* slight decrease in reports at follow-up.

These summed mean scores are so low and so marginally different that variations up or down are not significant in this analysis. It may be more helpful to organize responses into numbers and percentages of respondents who reported each category of abuse at pre test and follow-up.

A percentage of Groups A, B and C reported participating in abusive behaviors towards residents at pre-test and at follow-up. The seven response categories of behaviors reported by participants are summarized in the bullets below:

- The most frequently reported abusive behavior was ‘talking about residents’ private matters in front of others’: Group A did not report this behavior at all. One participant (12.5% of Group B) reported talking about private matters once in the past month at pre-test and one participant (12.5% of Group B) reported doing this two to ten times in the past month at pre-test. At follow-up, two participants (25% of Group B) reported talking about private matters once in the past month. Three participants (25% of Group C), reported this behavior once in the past month at pre-test, and three (25% of Group C) reported doing this between two and ten times at pre-test. At follow-up this was reduced to two participants (17% of Group C) reporting talking about residents once in the past month and two (17% of Group C) reporting this between two and ten times at follow-up. A higher percentage of participants from Group C reported this behavior at pre-test and at follow-up, than participants from Group B
- The next most frequently reported abusive behavior was ‘physically forcing a resident to accept care.’ All groups reported this behavior, with one participant (10% of Group A) reporting having done this two to ten times in the past month at pre-test and once at follow-up. One participant (12.5% of Group B) reported forcing care once in the past month at pre-test and at follow-up. Two participants (17% of Group C) reported forcing care once in the past month at pre-test and one participant (8% of Group C) reported doing this two to ten times at pre-test. At

follow-up there was an increase in reporting for Group C with one more participant than at pre-test reporting forcing care once in the past month at follow-up (25% of Group C) and one participant (8% of Group C) reporting forcing care between two to ten times during this time period. A higher percentage of Group C reported forcing care than Group A or B at pre-test and at follow-up.

- The next most reported category of abuse, was 'treating a resident as a child' with a greater percentage of Group B (25% [n=2] reporting doing this one or more times at pre-test and follow-up, as compared to Group A or Group C (10 % of Group A [n=1] who reported treating a resident as a child at follow-up and 8% of Group C [n=1] reported behaving this way with residents at pre-test.
- 'Confining a resident to room as a disciplinary measure' was reported by three participants (25% of Group C) at the frequency of one or more times at pre-test with two participants (17% of Group C) reporting this at follow-up. Groups A and B did not report this at all.
- Twenty –five percent [n=2] of Group B reported 'knowingly neglecting a resident's needs' once in the past month at pre-test and one or more times at follow-up. One participant from Group C reported neglecting a resident once in the past month at follow-up, and Group A did not report neglecting a resident at all. A higher percentage of Group B reported this category both at pre-test and follow-up as compared to Group C or Group A.
- Two participants (12.5% of Group B and 8% of Group C) reported 'insulting or swearing at a resident' at pre-test, with no participants reporting this at follow-up.

- One participant (12.5% of Group B) reported 'providing care in a rough manner' once in the past month at pre-test, and one participant (8% of Group C) reported this behavior two to ten times in the past month at pre-test. One participants (8% of Group C) provided care in a rough manner once in the past month at follow-up.
- The following categories were not reported by any participants: 'yelling at a resident in anger', 'unnecessarily restraining a resident', 'denying a resident food or privileges', and 'pushing, or grabbing a resident in anger'.

Within each category of abuse, the percentage of participants reporting the behavior is relatively low. It is important to keep in mind however, that these figures could be affected by underreporting due to social desirability. This may be a factor when one considers that these reports are much lower than participants' reports of abuse they had witnessed others commit in the previous section of this report. In addition, though the reports are small, the analysis does indicate that staff-resident abuse does occur in personal care homes, with a negative impact on dignity of residents.

Because of the small numbers of participants, these results may not accurately reflect the actual prevalence of this problem, however they do indicate that the problem exists and further interventions are required. The results are mixed and therefore do not indicate that the training program was effective in reducing the frequency of abuse and/or increasing the sensitivity about the presence of abuse.

5.11 Ability to Provide Respectful Care to Residents with Dementia

Dementia has been identified as a barrier to respectful care, because of the risk that caregivers will treat residents with dementia like children, or attempt to 'take control'

of the resident in his/her best interest. Residents with dementia have the capacity to sense when caregivers are treating them in a controlling or demeaning way. The Respectful Care Training Program therefore included information on approaches to dementia care that focused on communicating respect for the resident while coping with the symptoms of dementia such as problem behaviors.

A series of four scenarios was designed to form a measurement tool in the pre-test and follow-up survey. These scenarios depicted problem behaviors displayed by residents with dementia. A series of 5 multiple choice interventions was provided as response sets, one of which was the most respectful intervention. Each correct choice was awarded one point, thus the score for this scale was a maximum of 4 and a minimum of 0.

This 'correct' intervention defused conflict, while providing respect for the resident. Participants also had the option of choosing an 'other' category and explaining how they would actually intervene, if the response set did not include the intervention of choice. As long as the participant described a positive intervention, one point was given for the correct answer. The scenarios and correct responses are summarized in Table 20, and are also included in Appendix J in the last section of the pre-test questionnaire.

Table 20 Scenarios for Respectful Approaches to Dementia Care

1. The first scenario described a resident who was swearing at staff. The correct response was to ignore the swearing and ask her what was wrong or some other positive response from the 'other' category.
2. The second scenario described a disoriented resident who was found in another resident's room rummaging through belongings. The correct response was to approach the resident in a friendly manner and distract by asking him to go for a walk or some other positive response from the 'other' category.
3. The third scenario described a disoriented resident sitting in a noisy public area who was banging on a table top. This behavior happened most frequently at busy times of the day. The correct response was to assist her to sit in a less stimulating area or some other positive response from the 'other' category.
4. The fourth scenario described a resident who was physically abusive to staff when they attempted to help him. The correct response was to ask his permission to provide care and keep a safe distance until he is willing to accept help or some other positive response from the 'other' category.

Because of the small number of scenarios, the pre-test-post-test results for this measure were analyzed for all groups together. If one combines all participants who responded there is a possibility of 120 correct answers (30 participants \times 4 correct answers each). Results for each scenario are summarized next.

1. **Scenario 1:** Twenty-seven of 30 participants (90%) chose a positive intervention at pre-test and 20 of 30 participants (67%) chose a positive intervention at follow-up. The second most frequent response was to 'tell

resident to stop behavior and leave the room'. Two individuals chose this answer at pre-test and eight chose this at follow-up. It is apparent that the correct response rate for this question dropped significantly at follow-up. This may be indicative of perceived time pressures being experienced by staff at follow-up. For example, it takes more time to ask a resident what is wrong, and to listen and empathize than it does to leave the room and come back later. Thus, the fact that eight respondents chose a more negative intervention at follow-up as compared to two at pre-test may be indicative of coping mechanisms under duress rather than a disregard for the most respectful and positive intervention. A second possibility is that respondents were choosing the intervention that they would actually use, rather than the one that is the 'right' answer.

2. **Scenario 2:** Twenty-eight of 30 participants (93%) chose a positive response at pre-test and 27 of 30 participants (90%) chose a positive intervention at follow-up. This question had a high positive response rate at pre-test and post-test indicating little room for improvement for this intervention.
3. **Scenario 3:** Twenty-four of 30 participants (80%) chose a positive response at pre-test and 27 of 30 participants (90%) chose the positive intervention at follow-up. The second most frequent response was 'other' with various negative interventions suggested. This question had high positive response rates at pre-test and follow-up with some improvements noted at follow-up.
4. **Scenario 4:** Twenty-one of 30 participants (70%) chose this at pre-test and 20 of 30 participants (67%) chose a positive intervention at follow-up. The most

common negative response was 'avoid the behavior by leaving the resident alone as much as possible except for necessary care'. Four individuals chose this answer at pre-test and seven chose this at follow-up. The second most common negative response was 'always have two staff present so one can hold him while the other provides care'. Three participants chose this answer at pre-test and two chose this at follow-up. This may be indicative of some of the actual negative approaches that are used in the workplace to cope with abusive residents: isolation and forcing care. Forcing care is often done 'to get the job done'. Residents who are non-compliant with care can cause increased stress for staff to cope with, when working in an environment where time is limited. The negative responses to this question reveal an area where more training is required to reduce potentially abusive interactions with residents with dementia and the conflict that is inevitably associated with these negative interventions.

Out of 120 possible positive interventions for all participants in the series of four questions, one-hundred positive responses were chosen at pre-test and ninety-four were chosen at follow-up. The frequency that participants chose the positive response at pre-test was 83% as compared to 78% at follow-up. Clearly there is no evidence from this measure that the training was effective in providing participants with respectful dementia care skills.

However, it must be pointed out that participants had high levels of dementia care skills as assessed by this measure at pre-test and a major change at follow-up was unlikely. Nevertheless, the slight decline in positive responses is disappointing.

Possible reasons for this decline were the barriers identified, such as working short-staffed and shortages of time identified at pre-test and at follow-up. These barriers may have prevented participants from implementing new skills. The question in each scenario asked participants: *'what would you do in this situation?'*

In the first and last scenarios, the most frequent negative interventions that were identified by respondents appeared to be interventions intended to avoid further conflict while saving time, rather than the most positive interventions which may have been more respectful, but also more time-consuming. This may be indicative of the realities of the workplace, where staff cope as best they can with the resources available, sometimes at the expense of respectful care.

Chapter 6 consists of a summary of participant satisfaction and participants' perceptions of the effectiveness of the training program in helping implement new skills in respectful care in their workplaces.

Chapter 6

Participant Satisfaction and Perceptions

6.1 Perceived Satisfaction on Day of Training

Immediately following the training a satisfaction survey was given to all participants to evaluate the training program and to elicit their responses to the following topics: complexity of curriculum, opportunities to ask questions, comfort levels, and achievement of learning goals. Participants were asked to identify what learning goals were not achieved, if any, and what they found most and least helpful during the training. As well, participants had the opportunity to rate the training and the presentation methods of the presenter on a scale of 1 - 10. The satisfaction surveys were analyzed for similarities and a summary of the participants' responses are organized in the discussion that follows.

It is important to point out that the questionnaire was completely anonymous and participants were asked to complete the evaluation honestly as their feedback would be helpful in identifying strengths and weaknesses of the program. Because of the anonymity of surveys, and the fact that participants from Groups B and C attended the training program together, it was impossible to separate results from satisfaction surveys for Groups B and C. Therefore, the analysis will refer to Groups B and C together (n=22) with some references to results from Group A (n=11). Often results will be analyzed for the entire group (n=33).

Participants on average were satisfied with the length of the training. The majority (n=27, 82%) of the 33 participants felt the length of the training was just right.

Two participants from Group A found the training too long while four participants from Groups B and C felt it was too short in terms of too much content to cover in too little time.

Similarly, participants were satisfied with the level of complexity of training content, the amount of time given for questions, and indicated they were comfortable with the topics. The majority of participants (n=26, 76%) found the content 'easily understandable' with one participant from Group A finding it 'somewhat difficult'. Participants were unanimous in describing the training as having 'just the right amount of time' allotted for asking questions and *all participants* reported being 'very comfortable' or 'somewhat comfortable' with the topics discussed. The last point is important feedback as the student had expected some of the participants to feel uncomfortable discussing sensitive topics such as resident abuse, and the roles that staff have in preventing this.

While the majority of participants (n=29, 88%) felt 'very comfortable' or 'somewhat comfortable' with the role plays, it is important to note that four participants from Group B and C felt 'a little uneasy' with this method of learning. No one from Group A reported any discomfort with role plays. This may indicate that Group A had more experience in this method of learning and/or may have had a higher comfort level with each other having spent ten months together during their training course. It is important to ensure participants are comfortable with role-playing to enhance the effectiveness of this method as a training tool in building empathy. Participants who feel more comfortable with the role plays are more likely to tune into their feelings and benefit from this form of empathy building exercise.

While the majority of Group A (n=7, 64%) identified role plays as the most helpful part of the training, Group B & C identified 'role plays' (n=5, 23%) as second in importance to 'sharing experiences' (n=6, 27%). Group B and C were comprised of nursing assistants from different PCHs and they may have found it helpful to share problems and solutions with each other. This highlights the importance of giving nursing assistants opportunities for peer support by arranging interfacility training.

All participants identified 'all' or 'some' goals as having been achieved during the training. Goals that were identified as not achieved included 'when to report minor issues' (n=1, 3%); and 'dealing with difficult situations' (n=1, 3%).

There were several reasons cited by respondents for having participated in the training program with some of the participants listing more than one reason. The following reasons are listed in rank order for all groups: 'mandatory to course' for Group A or 'part of job orientation' for Group B (n=9, 27% of all participants); 'improving empathy and respect' (n=7, 21% of all participants); 'improving skills and knowledge to use in workplace' (n=7, 21% of all participants); 'improving quality of interactions with residents and staff', and 'to avoid abusive situations' (n=6, 18% of all participants); and 'to share experiences and problem solve difficult situations' (n=5, 15% of all participants).

The participants described some components of the training that they felt were least helpful. Two of the participants (6%) identified some of the role plays as not applicable. Though it was not many participants who identified this as a problem, it is important to keep in mind the importance of screening role plays to make sure they are relevant to the context. One participant (3%) felt it would have been more helpful to

have participants from a larger variety of places. One participant (3%) identified that the people who most needed the training did not attend. One participant (3%) found the scenarios were degrading to staff, as it implied that staff had abused or were disrespectful to residents. This concern highlights the sensitivity of the topic area and the risk that some of the participants may take it as a personal slight to their reputation as a caregiving staff. This is consistent with the literature that speaks of *abuse in PCH* as a taboo topic, which can only be addressed by raising awareness and breaking the silence.

The average rating for the training program was 8.7 and the average rating for the presentation methods and presenter was 9.1 on a scale of 1-10 with 1=poor and 10=excellent. Overall, these are positive ratings that indicate the perceived quality of the training program, the presentation methods and the facilitation techniques used by the presenter.

6.2 Participant Perceptions of Impact of Training at Follow-up

At follow-up, participants were asked to identify if the training program had increased their skills in the following areas: being sensitive to the quality of staff-resident interactions, communicating respect to residents, understanding the meaning behind problem behaviors associated with dementia care, using conflict resolution strategies, reducing stress with new coping strategies, and recognizing and intervening in resident abuse.

Participants felt that the training had improved their sensitivity to the quality of staff-resident interactions. Fifty three percent of all participants (n=16) responded that the training had improved their sensitivity 'very much' with the majority (60%, n=18)

responding that it had improved their sensitivity 'somewhat'. Only 1 participant felt it had not helped at all. One respondent indicated that the role-plays helped her become "more aware how a resident might see us." A second participant identified that actually doing the activities of the role play helped her understand the feelings of a resident under those circumstances.

The results were also positive in terms of respondents indicating the training program had helped them interact with more respect with residents. Fifty percent of all participants (n=15) indicated it had helped 'very much'; 33% (n=10) indicated it had helped 'somewhat'; and four indicated it had not helped because they had always shown respect to residents.

Some respondents indicated the training had helped them:

- "allow more privacy;"
- "apply more respect when handling personal items of residents;"
- "be more patient and understanding;" and
- "be more aware of verbal approaches to show respect."
- One respondent indicated that giving respect is time consuming because "sometimes it's quicker to help a resident than to give them time to be independent."
- Another respondent explained that after participating in the role plays, "I realize what they are going through."
- Another respondent said that she had tried to be "more patient and try harder to find solutions to their problems" since the training.

- While another referred to the training, “It made me think of what I’m doing and how I’m doing it.”

At follow-up, on a scale of 1-10 with 1 = poor success and 10 = excellent success, the following mean scores refer to participants’ average ratings for the training program’s success in:

- | | |
|--|-----|
| a) Improving most participants attitude toward residents: | 8.4 |
| b) Helping most participants develop empathy for residents: | 8.6 |
| c) Encouraging most participants to provide respectful care: | 8.9 |

These ratings are encouraging as they indicate that the majority of participants perceived the training to be effective in improving the attitudes, and empathy, of most participants and in encouraging most participants to provide respectful care.

Almost all participants reported that the training had helped them understand the meaning behind problem behaviors of residents with dementia (63% or n=19 reported being helped ‘somewhat’ and 33% (n=10) reported being helped ‘very much’). Only 1 participant responded that the training ‘did not help at all’.

- One of the respondents identified that the training had helped her realize that people with dementia may respond more to how something is said, rather than what is said: “How you approach a person is very important (tone of voice etc.), as the person might not understand what is being told to them.”
- Another participant indicated she watched the resident’s actions to try and understand the problem in order to respond to what the resident really wanted, if he or she was unable to explain this.

- A third respondent felt that more training on site is required to improve these skills.

Sixty-three percent (n=19) identified the training as helping 'somewhat' to provide useful conflict resolution skills, and 33% (n=10) said it had helped 'very much'. Only 1 respondent felt it had not helped at all. Another participant felt that she had identified an effective coping method during the training: "sometimes leaving the situation is helpful as it relieves stress on both sides."

The training was identified as not providing five (17%) participants with any useful stress reduction skills. However, the majority of respondents (63%, n=19) indicated that the training had helped 'somewhat' in this area, and four (13%) said it had helped 'very much'. In spite of the number indicating the training had not helped, this component to the questionnaire elicited the most feedback; many identified the positive coping mechanisms they had implemented since the training to deal with stress. These include the following strategies for coping:

- "Not to worry about things I can't get done in a certain time frame because it will get done."
- "Working things out at work, never taking it home."
- "Knowing we are recipients of their anger; I don't take things personally."
- "Staying calm and thinking a problem over before taking action."
- "I keep a daily journal to let my frustrations out."
- Several participants found it useful to take a time out under stressful circumstances and to ask a co-worker to cover the situation until stress levels were reduced.

- Several also mentioned the importance of self-care like bubble baths and doing things for yourself that you enjoy.

Forty-seven percent of respondents (n= 14) felt the training had helped them 'somewhat' in recognizing abusive staff-resident interactions while 43% (n=13) felt it had helped them 'very much'. Three respondents indicated the training did not help at all because they were able to recognize abusive interactions before the training. Some respondents indicated that they were more aware of the negative effect that unfriendly approaches have on residents: "when staff are moody or speak sharply, or don't speak at all to residents, this dampens the mood of residents."

Respondents were asked if they had witnessed staff-resident interactions that they would define as diminishing the dignity (self worth) of residents, since the training program, and if so, what did they do about it. Four respondents (13%) indicated having seen this happen 'many times' and 50% of respondents (n=15) indicated that they had seen it happen 'a few times' since the training. Eleven respondents had not witnessed dignity diminishing care since the training. The respondents who had witnessed the abuse consisted of six student respondents (60% of Group A), four untrained participants (50% of Group B) and nine trained participants (75% of group C) The rates of witnessing dignity diminishing care seemed to increase in frequency with the numbers of shifts worked. In total 19 participants witnessed abuse since the training which is 63% of all respondents.

Of the nineteen participants who had witnessed abuse, four indicated that most of the time they 'reported it to the appropriate authority', thirteen 'intervened with the staff person' themselves and five 'did nothing'. As indicated, the number of responses (n=22)

exceed the number of individuals reporting, because some gave more than one response to different incidents (i.e., intervened one time and did nothing another time).

Overall, the majority of participants (59%, or 13 of 22) who observed abusive interactions chose to intervene with the staff person themselves; in 23% of cases (n=5) nothing was done and in 18% of cases (n=4) the incident was reported to the appropriate authority. It is encouraging to observe, that the majority of participants who reported witnessing abusive interactions attempted to intervene to prevent further abuse. However, it is important to understand what barriers to advocacy exist by examining the reasons given by the five respondents who chose to 'do nothing' to intervene. These are listed as follows and may reveal areas where further development of advocacy skills is required:

- "Management would not follow up on situations due to low staffing levels, not wanting to risk losing what staff we have."
- "I have to work with these people on a daily basis, and they would know who lodged the complaint making for a *very uncomfortable* working situation."
- "I'm not very assertive and I don't like the way I'm handling things."
- "The degree of infraction was too light to cause confrontation."
- "I was on orientation and felt it wasn't my place."
- "I took over later to change the direction of the action."

6.3 **Barriers and Solutions to Respectful Care: The Participants' Perspective**

Participants were asked to identify barriers to respectful care, during the training and at follow-up on their follow-up surveys. They were also asked for solutions to these barriers in terms of what they believed the organization *should do* to improve respectful care. They were also asked to answer the question: *what can you do to improve respectful care for residents where you work?*

a). Barriers

The participants identified many barriers to respectful care. These are organized into themes and described in the following discussion.

- Workload issues were a very common theme identified by participants as a barrier to respectful care. Many sub-themes were included in this theme such as:
 - ❖ Time constraints, rushed care, staff shortages, and job stress.
 - ❖ Lack of time to spend with residents was identified as a major problem by most participants, with one respondent summing this up as follows, "Time schedules always takes priority over respectful care."
- Lack of team work and poor communication were also identified as barriers to respectful care, as was untrained staff.
- Negative attitudes were identified as a barrier to respectful care. This category included issues with:
 - ❖ "Staff who won't change ways or attitudes and side with each other."

- ❖ “Staff who are moody, and choose not to practice respectful care.”
- ❖ It was suggested that, “some people should not be in this line of work, but are here because of being short staffed.”

b). Organization’s Responsibility

The participants identified many areas where the organization must take responsibility to support the respectful care of residents. Most of these categories are related to addressing the barriers that were identified in the previous section. The participants identified the following organizational responsibilities:

- Some respondents felt that workload and job stress needed to be addressed.
 - ❖ Increasing staff ratios so that there are more staff to provide for resident needs.
 - ❖ Hiring more casual staff to address staff shortages.
 - ❖ Helping staff cope with stress.
- Other respondents suggested less rigid time schedules:
 - ❖ “So residents don’t feel so rushed and staff are able to give choices.”
 - ❖ One respondent suggested that “rather than running schedules by the clock: it would be better to specify average times for waking and assisting residents in the morning.”
- Some respondents suggested training.
 - ❖ “Mandatory training for staff.”
 - ❖ “Making training accessible to all staff.”
 - ❖ “More training programs similar to this one with role-playing to improve empathy.”

- Some respondents felt that supervision and leadership is required to develop respectful care.
 - ❖ “Supervisors working alongside staff members on random occasions, setting examples and giving constructive criticism.”
 - ❖ “Leadership in order to build better teamwork among staff.”
- Other respondents suggested tougher disciplinary action and abuse prevention policies.
 - ❖ “Any staff who mistreats a resident should not be allowed to work.”
 - ❖ “One incident should not be tolerated.”
 - ❖ “Clamp down on reports of workers being mean to residents; and give suspensions rather than verbal warnings.”
 - ❖ Abuse prevention in terms of a better system for reporting and following up on complaints of situations lacking respectful care.
- Some respondents suggested that the organization must support staff in providing for residents with dementia in terms of “special care plans for residents with dementia and behavior problems.”
- Other respondents suggested that the organization must support residents who are lonely by encouraging social interactions.
 - ❖ “Find more volunteers to help provide social interactions with residents who have families who live far away.”
 - ❖ “Private rooms and more homey spaces to visit with families.”

c). Staff Responsibility

Participants indicated that there are endless ways they personally take responsibility to promote respectful care. They try to enhance respectful care in areas that they have personal control over. Many of these methods are described below in the words of the participants:

- Many suggested the best approach to care is to set an example for other staff, so that they will follow your role model. Some respondents explained,
 - ❖ “I try to set an example by treating each resident as if he or she were my mother or father.”
 - ❖ “I continue to provide an example of respectful care by tactfully providing others with an alternative way of doing things.”
 - ❖ “I speak up more often to make it happen.”
 - ❖ “I exercise respectful care and hopefully others will learn by my example.”
- Ensuring a resident’s privacy is protected, was identified as another way to provide respectful care. Participants suggested:
 - ❖ “I make sure residents are comfortable with personal care given.”
 - ❖ “Make sure doors are closed, and curtains drawn when doing personal care.”
 - ❖ “I never discuss a resident in front of other staff or other residents.”
 - ❖ “Only discuss residents with other staff if it concerns their care.”

- Helping residents accomplish goals, maintain appearance and include in care processes were identified as respectful care approaches that empower residents:
 - ❖ “Focusing on the person” and “giving them complete attention” was described as a way to communicate respect to residents.
 - ❖ Another respondent indicated, “I include residents more in conversations.”
- Many respondents spoke of the importance of making every moment that you have to spend with a resident, *count*:
 - ❖ “I do the best I can with the amount of time I have with residents.”
 - ❖ “I talk to residents as often as possible even while I’m working.”
 - ❖ “I try to talk and interact with residents when I have time - a lot of residents have family far away or no family and they love the company.”
 - ❖ “I take time to get to know them better.”
- The importance of empathy was described by many participants as a skill in giving respectful care:
 - ❖ “Put yourself in their shoes and act accordingly.”
 - ❖ “Realize these residents were once like us and how would we like to be treated if we were in their situation.”
 - ❖ “I keep in mind a resident is someone’s mother, father, grandparent – I try to treat them as I would want my parents treated.”

- Self care was also described as a personal method for staying healthy in order to have the strength to provide respectful care.
 - ❖ “Do something nice for yourself once a week to relieve stress.”
 - ❖ “I take only the number of shifts that I can handle to reduce stress and help me provide the best care I can for my clients.”
- Advocacy in abuse prevention was another approach identified to enhance care.
 - ❖ “Report staff and make sure follow-ups are done on a timely basis.”
 - ❖ “I remind staff that residents are not children and should not be treated as children.”

The summary of participants’ responses indicates that most participants are supporting respectful care in their workplace(s), using the methods promoted in the Respectful Care Training Program. Interacting with residents, protecting privacy, practicing empathy, acting as advocates and role models are excellent first steps to a respectful philosophy of care in nursing homes. However, the participants also identify, that this philosophy requires the support of the organization to achieve. Support for staff training; adequate staffing levels; abuse prevention and follow-up investigations when abuse is reported; all of these are equally necessary components to achieve respectful care and require the support of the organization.

A few respondents indicated that there are times they feel it is hopeless and that there is nothing that any one person can do to make respectful care happen. These respondents are correct in one aspect: it takes all staff and the organization as a whole to ensure that a respectful philosophy of care is promoted and achieved. However,

respectful care must start with each staff individually and with the organization's support, respectful care as a philosophy of care, will grow and flourish.

Chapter 7 of the practicum report consists of an analysis of student learning as an outcome of the practicum activities, a summary of all learning goals that were achieved, and implications for future interventions and use of the training program.

Chapter 7

Student Learning, Implications and Conclusion

7.1 Achievement of Student Learning Objectives

Overall, the student learning objectives were generally achieved. One primary objective was to understand what dignity means to residents, and to determine if it is a standard of care that can be accomplished in personal care homes. An extensive literature review revealed the many layers of the meaning of dignity and how this concept applies to residents who live in personal care homes.

I was able to accomplish secondary learning goals related to this primary objective by using the knowledge I gained in the literature review to identify ways to intervene at the level of the general system in order to enhance the dignity of residents. I did this by identifying how the caregiver-resident relationship, if strengthened, can be used as a buffer to enhance resident dignity. A respectful relationship between staff and residents has the potential to enhance dignity by strengthening the residents' sense of external worthiness and internal sense of worth.

A second primary objective was to gain experience in the development of a staff training program as an intervention to enhance resident dignity. I met this objective by developing a Respectful Care Training Program and implementing it with a group of nursing assistants as a pilot project. In order to do this I met related secondary goals by planning a curriculum that was based on the dignity literature. I identified skills that were required to provide respectful care: empathy, sensitivity to the quality of the staff-resident relationship, and skills in conflict resolution, abuse recognition and dementia

care. I found information and programs in the literature and put together a 6 hour curriculum that covered the components that were identified to be important for enhancing dignity. When the program was implemented, however, the limited time format was a factor, and throughout the training delivery, I felt that more time was required to cover all subject areas adequately.

A third primary learning objective was to develop skills in implementing a training program. I met this objective by organizing three training sessions for nursing assistants with the cooperation of regional health authority and community college officials. I learned how important it is to have all stakeholders involved in the development and implementation process. The RHA offered monetary incentives to staff participants (orientation pay or education funding), while the community college ensured attendance by having student participants attend the training during class time. The incentives provided by these organizations helped to improve attendance which was one of the most important components to the pre-implementation process. Having all stakeholders part of the program implementation, ensured that the program was offered to as many participants as was possible at the time. It also served to raise awareness about the training program, in the event that it would be considered for future use. These incentives also seemed to be a method to communicate to the participants that their organizations valued them and were investing in them as staff in order to enhance their skills and improve resident care. The importance of empowering and supporting staff became more evident as the barriers to respectful care were identified by participants.

A fourth primary learning objective was to identify barriers to respectful care and areas for future social work interventions. Workloads, time limitations and the frequency

that participants work short-staffed were obvious barriers to respectful care. The frequency that participants experience abuse from residents, and have difficulty coping with problem behaviors were also identified as significant barriers to respectful care. Participants identified that organizational support is required to address these barriers, if a respectful philosophy of care is to be achieved.

A fifth primary learning objective was to develop skills in facilitating. I did this by identifying training methods that were conducive to group learning. I met my related secondary learning goal which was to ensure that the approach to learning was participatory at all times; my primary role was a facilitator, engaging participants to share their strengths and knowledge with each other. In doing this, I observed an unanticipated benefit – participants identified that sharing with others was one of the best components of the Respectful Care Training Program. The supportive group learning experience provided the participants with the opportunity to share best practices and contribute peer support. The participants later identified ‘sharing experiences with others’ as one of the most helpful parts of the training program.

Many participants expressed that the role plays and discussions of scenarios, were helpful in developing empathy. I also felt that this was the best method for improving sensitivity of participants for residents’ situations and feelings, as participants were able to demonstrate increased understanding of the feelings associated with having a disability as well as the contrasting feelings that correlate with positive vs. negative resident-staff interactions. During discussions, most participants indicated they would not want to live in a care home because they worried that their own dignity would be diminished by the lack of privacy, the inflexible routines, the lack of choices and independence. By placing

themselves in the residents' situations, the participants developed a greater sensitivity to residents' feelings. During the role plays, participants indicated that they were able to actually *feel* the indignities associated with disrespectful care in contrast to the calming empowering effect of a respectful interaction.

Recruitment, implementation and evaluation issues, that are important to keep in mind for future use of the Respectful Care Training Program, are summarized in the bullets below:

- Involving the RHA in the recruitment process and participation incentives.
- Including a variety of participants from different facilities in future training.
- Ensuring scenarios are relevant to the context by screening with facility representatives.
- Using role plays that encourage participants to take on resident roles in a way that is as authentic as possible, in order to build empathy.
- Building comfort levels of group members with each other and training methods.
- Utilizing the group learning forum as a supportive environment for sharing best practices and peer support.
- Increasing the amount of time devoted to each component of the training.
- Collecting participant satisfaction and evaluation measures to help identify strengths and weaknesses of the training.

Participant satisfaction was evident at the time of the training, as participants communicated verbally and nonverbally (with smiles) their general sense of enjoyment and appreciation with the session. Throughout all three sessions, I perceived a high

degree of enthusiasm from the participants with the training program. Overall I felt most participants left the training feeling more empowered to be role models, leaders and advocates in their facilities and that they would enhance dignity one interaction at a time, benefiting many residents.

A final primary learning objective was to develop skills in evaluating a training program and developing measurement instruments. This was the area of greatest learning for me, and one where there remains much more to learn. I learned how difficult it is to operationalize an intangible concept like dignity. The measures that were developed indicated that participants demonstrated good empathy skills and positive attitudes, with some improvements at follow-up. The measures also indicated that staff-resident conflict such as the abuse of staff by residents, and resident abuse by staff does exist in the PCH environment. In this sense, the measures were helpful in identifying where future interventions must be applied, though not as helpful in measuring the effectiveness of the training program. The positive feedback from participant satisfaction questionnaires and their responses to follow-up questions (regarding the effectiveness of the training in helping participants develop greater empathy and sensitivity) were much more encouraging. These evaluation measures indicated that the training program was very effective in developing empathy, improving attitudes, and encouraging participants to communicate respect toward residents.

7.2 Effectiveness of Training Program

Overall, the majority of participants reported high levels of satisfaction with the Respectful Care Training Program in terms of course content, training delivery and presentation methods. Participants gave consistently high ratings that substantiated the quality of the training program, presentation methods and facilitation techniques used by the presenter.

Overall, the participant responses at follow-up indicated that the training program was effective in improving the attitudes and empathy of most participants and in encouraging most participants to provide respectful care. The pre-test-post-test-follow-up survey results indicated a slight increase in positive attitudes for all groups. Though the variation at follow-up was small in comparison to pre-test, it was encouraging to note that there was a larger increase in scores between pre-test and post-test and that follow-up scores were higher than those reported at pre-test. This trend in scoring seems to suggest that the training program had a small but noticeable impact on influencing attitudes towards residents.

There was a similar improvement in levels of empathy at follow-up for Groups B and C as indicated by the empathy measure. Observations made by the student during the training sessions, supported these findings as participants were observed to have a greater sensitivity towards the situations and feelings of residents as shown by group discussions following participation in role plays.

A second positive outcome of the training was the appreciation by participants for the opportunity to share experiences in a supportive context. The training program offered participants a forum to share strengths, best practices and coping strategies.

Participants showed enthusiasm and positive attitudes throughout the training sessions, as observed by the student.

The evaluation measures require some revisions, as they did not appear sensitive enough to accurately indicate the levels of change in participants' attitudes or empathy; i.e., the level of change shown by the measures was much lower than the level of change that was observed by participants and the student facilitator. The lack of variation in findings as indicated by these measures illustrates how difficult it is to define somewhat intangible concepts such as attitude, empathy and dignity with measurable criteria. There is a need to develop a measurement tool that can accurately measure caregivers' success in meeting the standard of dignity enhancing care. Adding a component to the measurement tool to incorporate the residents' and/or family's opinions of caregiving may be one approach to improve validity.

7.3 Report to RHA

A report will be sent to the RHA regarding the effectiveness of the training program and its future use with staff in nursing homes. It will be suggested that the training program, with some revisions, has the potential to promote a respectful philosophy of care to enhance resident dignity, if it is made accessible to all staff.

Additional content on dementia care and conflict resolution must be incorporated into the present training program to respond to the levels of conflict, staff and resident abuse that occurs in the workplace as indicated by participants over the two consecutive one month reporting periods before and after the training.

The revised training program should be given at orientation and as refresher training to all staff at one year intervals. Incentives for training would ensure that all staff can participate in the Respectful Care Training Program to ensure its effectiveness in creating a philosophy of care that promotes resident dignity. The training program must focus on participatory training methods that create a supportive environment for staff to share experiences and engage in peer support.

The report to the RHA will also emphasize that training cannot address all barriers to respectful care. The organization must address workload, staff shortages, and effective implementation of abuse policies if a respectful philosophy of care is to be achieved.

7.4 Conclusion

Dignity, as a standard of care in personal care homes, can be supported by ongoing staff training in empathy, and an emphasis on the quality of the staff-resident relationship. Training in respectful care has the potential to help buffer indignities that residents in personal care homes face as a result of chronic, debilitating illnesses. In addition, training staff in conflict resolution and dementia care has the potential to help staff deal with problem behaviors associated with dementia and to reduce the incidence of the abuse of staff by residents which are barriers to respectful care. Training on its own however, cannot address systemic barriers to respectful care which include staff shortages, heavy workloads, rushed care, and stressful working conditions.

Future social work interventions in personal care homes must include the following strategies:

- Making recommendations to the RHA for the need for ongoing staff training programs to enhance empathy, staff attitudes towards residents, and to improve the quality of staff-resident interactions. This training would be more effective if it was mandatory, and part of an on-going quality assurance program, such as the orientation of new staff, and regular refresher training for existing staff.
- Advocating for staff support programs to help cope with stress. Participants identified how helpful it is to share experiences with others, and it may be helpful to develop inter-facility support networks for nurses and nursing assistants to share strengths with staff from other facilities in the region.
- Continuing to emphasize resident abuse prevention policies and ensuring staff understand their responsibility in preventing and reporting abuse.
- Reducing the incidence of resident-staff abuse and staff-resident abuse through training and the development of individual care plans to address problem behaviors.
- Continuing to emphasize the importance of respect and dignity as a philosophy of care.
- Engaging all stakeholders in addressing barriers to respectful care, by involving all levels of the system, from the RHA to management, to staff, to clients. Everyone must work together to build a respectful philosophy of care in nursing homes. This endeavor requires the commitment of all involved if it is to be successful in enhancing resident dignity.

Endnotes

1. The people who live in PCHs will be referred to as *residents*
2. In this study, *PCHs* will be used to refer to institutions which by definition, care for older people who need long-term assistance with activities of daily living due to the effects of chronic and/or progressive illness(es) and/or the loss of social supports
3. The term *staff* will refer to nurse's aids who provide the majority of direct personal care to residents of PCHs.

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Appendix A

Respectful Care Training Program Presentation

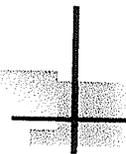
Overheads and Handouts

Respectful Care Training Program

- Welcome Everyone!
- Congratulations for taking the time to participate in the Respectful Care Training program!
- You are participating in a program to promote respectful care of residents in the personal care home where you work.

Agenda – Respectful Care

- **0900.** Coffee
- **0915 -** Introductions - Ice Breakers-
The work we do – Coping with stress
- **10:15** Attitudes and Empathy
Dignity
Video Presentation- "Preserving residents' dignity"
Role plays
- **12:00** Lunch
- **12:30** What is Abuse
Video presentation "At the end of the day" - Discussion
Managing Conflict/
Dementia care-scenarios
- **14:45** What do you feel you learned today?
- **15:00** Evaluations, Draw, and Wrap up



Get acquainted and decorate your nametag.

Participants divide into groups of three or four. On flip chart paper will answer questions:

1. What do we have in common?
2. What's different about us.
3. Examples of categories to compare: hobbies, job, favorite color.

Get creative! Do all of you put ketchup on macaroni?
Decorate your nametag to reflect who you are.

Introduce each other

In groups of two, ask each other:

- Name?
- Where do you live?
- What are your hobbies?
- What color would you choose that describes how you are feeling?

Now, introduce your partner to the group!

Group Agreement

- On flip chart paper, facilitator will record group rules as participants answer the following question:
- What do you need to happen here to feel comfortable to share, and to have a good learning experience?

Ground Rules

- Participants have the right to be heard without being interrupted.
- Comments, questions, suggestions or concerns raised by participants will not be repeated outside this room.
- Your participation is voluntary and if you prefer to refrain from any part of the training, you have the right to withdraw at any time.
- Lets have fun today as we learn.

Personal/Group Goals

Record on flip chart paper:

- What do you think you will get out of this training program?
- What do you hope to get out of this training program?
- What do you feel you have learned today? (This will be recorded at end of day)

Objectives - Empathy

1. Participants will develop **empathy** for residents.
2. Through role play, and discussions of scenarios, participants will place themselves in the resident's situation to understand how residents' sense of worth can be damaged by negative interactions and enhanced by positive interactions

Objectives – Understanding our role in Dignity of residents

3. Participants will understand what **dignity** means in the life of a PCH resident.
4. Participants will learn how nursing assistants have the opportunity to support or undermine dignity, based on their approach to resident care.

Objectives - Abuse prevention and advocacy

5. Participants will recognize all types of staff-resident abuse, and will understand risk factors that can create the conditions where abuse can occur.
6. Participants will understand their role in advocacy for residents, abuse prevention and duty to report abuse. Participants will understand it is their *responsibility* to enhance rather than diminish the dignity of residents.

Objectives - Coping with conflict and stress

7. Participants will develop skills in conflict management and stress reduction.
8. Participants will understand the causes of problem behaviors for residents with dementia. Interventions with residents with dementia will focus on methods that defuse conflict and maximize choice and dignity.

Objectives – Addressing organizational barriers to dignity

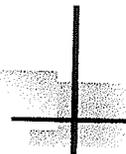
9. Participants will identify organizational barriers to respectful care – e.g., workloads, routines
10. Participants will be asked to brainstorm ways to overcome organizational barriers. Participants' suggestions will be incorporated into recommendations to management as an outcome of the training program.

Evaluation Component

- This training program will be evaluated for its effectiveness in teaching the concept of dignity, and changing negative attitudes, and behaviors that threaten resident dignity.
- Participants have completed the pre survey which will be compared to a test that will be completed at the end of the day, and a post test that will be completed 3-4 weeks from today.

Your answers are confidential.

- It is important that participants complete these tests honestly. Tests will be coded so that pre-tests can be matched with post tests. There will be a master list that matches participants' names to a code. There will be no other identifying information on the test.
- These tests will be destroyed after results of the training are tabulated, and the final report will not refer to any participant by name.



Ice breaker

- Group leader will ask a question. In pairs each person will answer the question and discuss.
- Let's get moving. Participants divide into two groups and form two circles one inside the other with inner circle facing outer circle.
- For every new question the outside circle will move one partner to the right so that the group forms different pairs.
- The group will come together to discuss the questions.

Questions

1. What do you like best about your job?
2. What do you like least about your job?
3. When you need care, would you want to live in a care home? Why?

Record on flip chart: the rewards and challenges of the job; the challenges of living in PCH

Introduce - The work we do

Exercise: Break into groups and have each group brainstorm one of the following categories recording responses on flip chart paper:

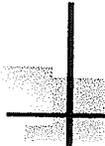
- Changes and losses due to aging and/or disability
- Stresses at work/stresses at home
- Stress of being a resident in a PCH
- Resident behaviors that stress or challenge us: it is very difficult when a resident is . . .
- Qualities of the ideal staff person.

(Adapted from CARIE, 1999)

Resident challenges

Changes and losses due to aging and/or disability:

- Impaired vision, hearing, taste, smell
- Decline in energy
- Change in appearance
- Change in sleeping patterns
- Role changes; changes in support systems
- Impaired mental function
- Loss of identity, work, family, home, possessions
- Residents have many needs associated with changes and losses; it is important to know who they are (their unique identity) rather than their physical needs alone



Resident stress

Stress of being a resident in PCH

- Lack of control or choice regarding daily activities
- Lack of privacy
- Pain and disability associated with illness
- Being dependent on others for daily care
- Conflict with staff or other residents
- Stigma associated with aging and being in PCH

Our challenge is to help residents exercise their rights to the fullest capacity possible and to help buffer the organizational stresses faced by residents

Our influence on resident stress

Q: How do staff increase a resident's stress?

- Being rushed
- Poor attitude or indifference toward residents
- Difficult dispositions or personalities of staff
- Staff don't take the time to stop and listen
- Staff forget to do what they promised
- Residents are made to do something they don't want to) dress, eat, do activities, bathe.

(Adapted from CARIE, 1999)

Stress is a two way street

- It works both ways, we (staff and residents) can irritate each other
- It is important for us to put ourselves in residents' shoes and identify the things that may upset them

Resident behaviors that challenge us when they are:

- **Aggressive**
- **Asocial**
- **Confused**
- **Controlling**
- **Defensive**
- **Demanding**
- **Dependent**
- **Intolerant**
- **Never satisfied**
- **Resistant**
- **Rude**
- **Ungrateful**
- **Wandering**
- **Manipulative**
- **Repetitive**
- **Uncooperative**

(Adapted from CARIE, 1999)

The challenges of the job

- We come to a work environment that is less than ideal.
- We are trying to cope with residents who are dealing with their own stressful issues, who may be fearful, angry, resentful etc.

Our own stress

Stresses at work and home:

- We work in an environment that places many demands; we are all stressed by demands at home but are expected to “leave our problems at the door”

(Adapted from CARIE, 1999)



Stress

- What is stress?
- What are your symptoms of stress?
- What coping skills can we use on the job to reduce stress?

Stress – physical symptoms

- We experience stress when we experience a threat to our well being and are unsure how to deal with it.
- Physical signs: rapid, pounding heart beat, dry throat and mouth, feeling excited/keyed up/nervous, sweaty palms, neck, upset stomach diarrhea, vomiting, fatigue, trembling, headache, eating too much or too little, problems sleeping, pain, tightness in neck and back muscles.

Stress- Emotional symptoms

- Frustration, moodiness, irritability, angry outbursts, loss of temper;
- Feeling overwhelmed, upset over little things, having trouble making decisions, breaking into tears easily; depression, poor concentration.
- Feeling defensive, experiencing strained relationships, complaining, criticizing.

Question-How might others know we are stressed?

- Being abrupt
- Being argumentative
- A "too bad" approach with others
- A "why bother" approach with situations
- Blowing up
- Avoiding tough situations
- Doing hurtful things to people
- Reduced productivity creativity

Q: How might stress indicators contribute to abuse?

- Losing temper = striking or hitting a resident
- Raising one's voice = saying something hurtful
- Forgetting to do important things = not leaving call bell in reach

The Challenge of Providing Good Care

- 
- Residents are coping with many changes and losses
 - We all have stress--at home and at work--that requires self-awareness
 - Residents must deal with the daily routine of institutional living and possibly isolation
 - Staff face many pressures on the job
 - Some behaviors of residents can influence staff reactions

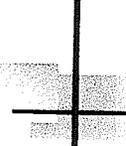
Abuse can happen if these issues are not adequately addressed!

Life style strategies to cope with stress

- **What do you do that helps you stay healthy physically and emotionally?**
 - Eat a well balanced diet
 - Reduce or eliminate caffeine
 - Get enough sleep
 - Exercise regularly (1/2 hr. 3-4 times week)
 - Schedule leisure activities
 - Develop a hobby
Do not rely on cigarettes, alcohol or drugs
 - Look for humor: People who take time to laugh live longer healthier lives.
- Do something to unwind between work and home
- Learn about meditation and relaxation exercises and build them into your life
- Seek professional help if your stress-related symptoms don't go away e.g. EAP
- **Take time to look after your self.**
When you are *too busy* to look after yourself, this is when you need it the *most!*

Sharing On the job strategies -

- **Share with the group/partner, (if you feel comfortable), a situation where you felt your stress getting out of hand.**
- **What did you do that helped? Facilitator can start with personal experience.**
 - Walk away from situation
 - Ask a co-worker for help
 - Count to ten
 - Take three deep, slow breaths
 - Sit down (this is especially helpful if you cannot leave the resident's room)
 - Discuss the problem with a co-worker or supervisor
 - Repeat a saying in your mind that helps you to stay calm (a prayer, a song)
 - Limit over time
 - Remember, it is often the situation that is the problem, try not to personalize
 - Work with your supervisor to rotate assignments of residents whose care is difficult
 - Schedule time off



Let's make stress reduction a priority!

- Share with the group or partner one self care strategy that you will do this week.
- Let's list them:
- Partners – Can you check in with your partner that she/he followed through? Can you remind your partner that she/he deserves some TLC?



We need to feel valued too

- We need to feel recognized for the challenging work we do, and the home life we balance with our work life.
- Tell each other what a good job we are doing. Sometimes we are too busy to be nice to our colleagues.
- Right now, lets list some of the wonderful things we and our colleagues do every day!

Qualities of the ideal staff person

- On time
- Pleasant
- Compassionate
- Willing to do extra things
- Gentle
- Efficient
- Not rushed
- Takes time to talk/listen
- Meets all residents needs
- Respectful
- Treats residents with dignity

(Adapted from CARIE,1999)

The work we do

- We are expected to be kind, considerate, efficient, always ready to do whatever is needed and willing to go out of our way to do a good job.
- Of course the “perfect resident” or “perfect staff” is unrealistic since perfect people have no needs – we as human beings all have needs.
- We will all have bad days – this is when we need the support of the people around us and our self care strategies.

(Adapted from CARIE, 1999)

Attitudes

Where do we get our attitudes about aging?

Exercise: Each participant will recall one positive and one negative experience with an elderly person and recognize what impression that experience had on his/her attitude about old people. Share this with the group

(Astill-McNish, S. (1984). A sensitization program for Geriatric nurses. Canadian Nurse, 80, (3), 21-24.

Attitudes

- For example: Old people are active, productive, good teachers with time and patience, wise, influential, proud, loving and caring.
- Can these characteristics be generalized to all old people?

(Adapted from Astill-McNish, 1984)

Attitudes

- What negative attitudes toward older people come about as a result of negative experiences?
- For example: Old people are seen as lonely, frightened, helpless, angry, bitter, sick, confused and a burden to others.
- Attitudes such as these can influence the way that we interact with older people.

(Adapted Astill-McNish, 1984)

Empathy by Role play:

"Come to Tea in the Day room"

Participants will experience what it is like to be a resident and will understand the use/abuse of power through structured behavior of staff in an institution.

(Adapted from Astill-McNish, 1984)

Empathy – roles and props

- Instructions: Participants will act as a group of residents, with two or three participants acting as staff in custodial role.
- Props: Bibs, restraints, string, opaque tape, straws and "tea".

(Adapted from Astill-McNish, 1984)



Empathy exercise- challenges

- Participants are individually assigned to wheelchairs or geriatric chairs.
- They are provided with “deficits” -one lens covered to imitate blindness in one eye associated with one sided stroke; centre of both lenses covered for cataracts; one arm and leg on same side tied to wheel chair to imitate one- sided paralysis.

(Adapted from Astill-McNish, 1984)

Empathy as "Residents"

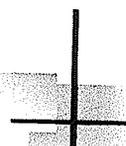
- Participants are seated around the table and served lukewarm tea (so they don't burn themselves) and cookies. Tea should be sipped through a straw.
- Participants who are blind will try to feed self, and staff will take turns helping and encouraging residents with their "meal".

(Adapted from Astill-McNish, 1984)

Empathy as "Staff"

- "Staff" can be innovative in managing their patients by feeding them, isolating them if they act out, taking them to the bathroom (if they are on a "bladder routine") and playing "nice" (loud) music for them so they can enjoy themselves.

(Adapted from Astill-McNish, 1984)



Empathy exercise - discussion

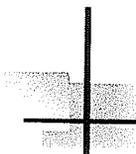
- After 10 -15 minutes “release” the participants and discuss the feelings that resulted from this activity. Who was in control?

(Adapted from Astill-McNish, 1984)

Dignity– Whose responsibility?

**Video Presentation: Elder Care Communications (1997).
Preserving Residents' Dignity- for Staff Members in Long
Term Care , Cincinnati, Ohio.**

Exercise: Following the video, break into groups and each group will answer the following questions, recording on flip chart paper:



Dignity

- What is dignity?
- What do residents need to maintain dignity?
- How can staff help them maintain dignity?
- What do staff do that diminishes dignity?

What is Dignity?

- The maintenance and enhancement of residents' sense of self worth.
- A basic human right that does not need to be earned, but should be inherent to all people.
- A social norm –Even when physical and mental abilities wane, people still have right to dignity.
- Staff and external forces have a powerful impact on the dignity of residents

What residents need for dignity:

- Care of physical appearance
- Independence – self sufficiency
- Freedom of Choice
- Privacy
- Respect

How to enhance dignity- Physical appearance:

■ **Physical Appearance :**

Residents value a Positive self image – taking care of appearance is important – e.g.. clothing, makeup.

DO:

Encourage resident to wear clothes he/she feels is suitable to the occasion - as what the resident wants to wear

- **Give personal care in manner resident chooses,**

DON'T:

- **Neglect to help resident remove food from face and hands after eating**
- **Dress residents in clothes they would not feel comfortable in, simply because it is easier for staff to put on – e.g.. hospital night gown, open back clothing**

How to enhance personal dignity- Independence:

- **Independence:**

Residents want to do as much for themselves as possible within the limitations of their illness/disability

DO:

- **Remove barriers from physical environment that hinder independence**
- **Offer to help and if the resident refuses pleasantly accept the residents choice.**

DON'T:

- **Take over for the resident simply because it's faster to do it yourself.**

How to enhance personal dignity- Freedom of choice

■ **Freedom of Choice:**

Residents want to make their own decisions about daily activities- how to spend the day, what to wear, what to eat, where to go

DO:

- **Encourage residents to choose types and times of daily activities.**
- **Facilitate resident council meetings as a forum for resident group decision making**

DON'T:

**Give residents the message that staff feel they know what's best.
Treat residents like a child, or like an old, sick person**

- **Discussion: are rules and routines for the convenience of staff or for the safety of residents?**
- **Does the organization deny residents choice, in the name of efficiency?**

How to Enhance Personal Dignity- Privacy

■ **Privacy:**

Residents want to maintain acceptable body boundaries, and the privacy of belongings, home and personal information

DO:

- **Knock on door to resident's room**
- **Get permission to enter**
- **Clothes door/draw privacy curtains before beginning care**
- **Safeguard modesty during toileting, bathing and other personal care**
- **Accommodate confidential phone calls and visits**
- **Refrain from touching belongings without permission**
- **Keep confidential information to yourself**

DON'T:

- **Walk into the tub room to get supplies when a resident is being bathed**
- **Leave a resident exposed during care**
- **Talk about a resident in front of other residents**

How to enhance personal dignity: Respect

DO: **Respect-**

A resident needs to feel valued by others and acknowledged for the unique person he/she is.

- Address residents as he/she prefers- If you don't know preference then address by Mr., Ms. Mrs. etc.
- Include residents appropriately in conversations
- Ask residents for their opinions and demonstrate that their opinions matter to you
- Focus on the residents physically **and emotionally** during caregiving activities

DON'T:

routinely use "bibs"

Discussion:

- Are rules and routines for the convenience of staff or for the safety of residents?
- Does the organization, at times, deny residents choice, in the name of efficiency?
- What can we do about this?
- Whose responsibility is it to ensure that all residents' dignity is protected? Is it the resident, the organization, the staff, or . . .?

Enhancing or Diminishing Dignity?

How many of these feelings do we as staff have the power to influence and how?

- Feeling respected by others or disrespected.
- Feeling proud or humiliated.
- Feeling that privacy will be protected or that there is the chance one will be physically exposed.
- Feeling safe or vulnerable.
- Feeling competent to make choices or knowing others have the power to make choices for you.

Enhancing or Diminishing Dignity?

- Feeling valued as a human being or treated as an object
- Having the rights and privileges of an adult or being treated like a child
- Feeling independent or totally dependent
- Feeling that life has meaning or that life has no meaning
- Feeling hopeful or hopeless
- **Discussion**
We are social beings – the way we view ourselves is influenced by the way others view/treat us.

Role play scenarios

Role Plays

Objective: to attempt to understand how the resident feels when staff enhance dignity vs. diminish dignity

- Divide participants into groups of 2 or 3 and distribute some scenarios in which staff are providing personal care to a resident. The participants will role play these scenarios. One participant in each group will act as a resident, and the other one or two will act as staff. With each scenario, the "staff" will first treat the "resident" in a way that diminishes dignity. Then, the "staff" will treat the "resident" in a way that enhances dignity. Scenarios will describe ways to do this. The participants will have a turn at being the resident.
- Groups will write down feelings associated with diminished and enhanced dignity. Try to imagine how you would feel if you really were in the situation of the resident.

Process points – Residents

"Residents": As you participate as a "resident" in the role play, think about:

- How does body positioning affect your sense of vulnerability?
- How does tone of voice/body language affect how you perceive the care from the staff, the respect they have for you, and whether you can place your trust in them?
- How does it feel to know you have lost control of a bodily function, or that you have lost your memory, or that someone else is making you do something you don't want to? What if this were true?
- How do you know that the staff care about you? Are your needs just a "job" to them?
- How is your sense of worth impacted by the positive and negative interactions with staff?
- Do you think you might dread the help of some staff, and look forward to the help from others based on your past experience with them?

Process points – Staff

"Staff" -As you participate as a "staff" in the role play, think about:

- What is your tone of voice/body language when you tell the resident what to do and/or talk about the resident to a colleague
- Compare this to the tone of voice/body language when you ask permission from the resident, or apologize to the resident for being late?
- Can you understand why the resident is embarrassed, or lashes out at you, or refuses to follow the routine?
- Does your approach influence the resident's behavior/feelings?
- How have you harmed the resident's dignity? How have you enhanced it?
- We need to be sensitive to the potential effect that staff behavior can have on resident's feelings and behaviors.
- If you were the resident, which staff would you want to look after you?

Scenario 1 – Resident’s point of view – Respect for person

- Scenario I: Materials required: hospital bed, sheet, hospital gown
“Resident”:

You are a female resident (Mrs. Jones) who has pulled a call bell to get assistance to be toileted. You are lying in bed waiting for someone to answer. You have been waiting for fifteen minutes now, and your bladder is very sore. By the time staff come to help you, you have accidentally voided in the bed. You are feeling **very** ashamed about this. As the staff enter you say in a frustrated voice, ***You’re too late now, I couldn’t hold it!***

Respond to the staff as you feel fit. Take note of the emotions that their responses cause you to feel. We will be sharing this later

Scenario 2 –Resident’s point of view – Respect and dementia

Materials required: hospital bed, sheet, hospital gown

Scenario 2A: You are a female resident (Mrs. Smith) You have Alzheimer’s disease and do not remember where you are but you know you are lying in bed. You are wakened as two strangers walk into your bedroom. They approach you and try to take off your nightgown. You are terrified and if they don’t tell you why they are there, you will “fight” them off. Act out how you feel.

Take note of the emotions that their responses cause you to feel. We will be sharing this later

Respond to their interaction with you. Do they do anything to make you less fearful, so that you will accept help? Respond accordingly.

Scenario 3 -Resident point of view – Freedom to choose

Materials required: Wheel chair, robe, towels.

You are Mrs. Johnson and today is your bath day. You have been sitting in your wheelchair for most of the day. Your back is sore and you are in no mood for a tub bath. You are tired of being told what to do and when to do it. When the nurse's aide comes in to take you to the tub room you respond rudely: "**You stupid little girl, you can't make me take a bath.**" You are prepared to hit her if she tries to force you.

Does she say something that makes you more angry, or does she say something that helps you feel understood. Respond to her interaction accordingly.

Take note of the emotions that her response causes you to feel. We will be sharing this later

Scenario 4 -Resident point of view – Physical appearance

Materials required: wheel chair, night gown left open at back , toast and margarine, "Bib"

You are a resident named Mr. Olson. You no longer have the use of your hands due to ALS - Lou Gehrig's disease. The nurse's aid has just finished helping you with your toast. You are painfully aware that there is margarine on your face, and that your gown is open at the back, leaving you bare. The "bib" is still around your neck. You cannot clean yourself, fix your gown, or take off that dreaded "bib."

You ask her to take you back to your room so you can wash and get dressed, because you know your friend Jim is coming to visit, and you couldn't bear to be seen like this.

Does she answer your request in a way that makes you feel better or worse about your situation?

Take note of the emotions that the response cause you to feel. We will be sharing this later

Scenario 5 – Resident point of view -Privacy

Materials required: wheel chair, sling, commode

You are Mrs. Murray, and you have recently moved into a personal care home.

You share a room with another resident. You are a large person, and when you ask to be toileted, the sling for the lift machine does not fit around you. Your room mate is watching the nursing assistants struggle to adjust the sling, and you are feeling very embarrassed about the situation.

One of the nursing assistants says "She's too big to fit in this. What are we going to do now?"

This makes you even more embarrassed but you are afraid to say anything.

Does the other nurse aid do anything or say anything to make you feel better? Respond accordingly.

Take note of the emotions that their responses cause you to feel. We will be sharing this later

Scenario 6 – Resident point of view - Independence

Materials required: wheel chair, night gown, face cloth,

You are Mr. Antonio and you have Parkinson's disease. You are very slow at doing your self care, but if given the time, you can do it. You are in front of the sink washing your face with the cloth, when a nurse aid comes into your room to help.

Does she interact with you in a way that makes you feel good about your abilities or does she make you feel badly?

Take note of the emotions that her responses cause you to feel. We will be sharing this later

Scenario 1A- Staff point of view

"Staff" A:

You enter Mrs. Jones room. Her call bell has been ringing for about 15 minutes, and she is frustrated.

You enter the room **without saying anything** to the resident. No matter what she says, you do not answer her or look her in the eye.

You approach the resident's bed, turn off the call bell and pull the sheet back in an **abrupt** fashion.

You reach out and lift the resident's gown as you begin personal care. You say loudly:
You've wet the bed! Now I'm going to have to change you **and the bed!**

You mutter to yourself in an angry tone: ***Jenny and Jane were supposed to be doing this end of the hall – where are they anyway?***

Scenario 1B – Staff point of view

Staff B

You knock at the door before entering Mrs. Jones room. Her call bell has been ringing for about 15 minutes, and she is frustrated.

You ask, **Can I come in Mrs. Jones?**

Tell her **who you are** and **apologize** for taking so long to answer the call bell. Make sure your tone of voice is gentle and sincere.

When you find out she has voided in the bed:

- Give her the **choice** of whether she wants to go to the toilet or get into clean clothes
- Take responsibility for what has happened even though you were busy with another resident. Don't give any excuses for what has happened.
- Tell her it's not her fault this has happened and that you will try to answer the call bell more quickly next time.

Scenario 2A staff point of view

Staff A: You are going to help Mrs. Smith who has Alzheimer's disease, with her AM care. In the past, she has been resistant to care.

You enter her room, walk up to the bed quickly, and reach for the sheet.

When she pushes your hand away, you respond sternly "Stop it" that's not nice to hit like that! I will hit you back if you try to hurt me!

You proceed to pull down the sheet. Mrs. Smith responds accordingly.

Take note of the emotions that her responses cause you to feel. We will be sharing this later

How do you feel when she lashes out at you? Do you think she doesn't like you?

Scenario 2 B Staff point of view

Staff B: You are going to help Mrs. Smith who has Alzheimer's disease, with her AM care. In the past, she has been resistant to care. You knock on the door and say, Good Morning Mrs. Smith. I am here to help you.

You notice she looks frightened, so you take your time and talk to her in a kind voice before entering her personal space.

Tell her your name.

Tell her you are there to help her get up.

Wait until she is calm before you go any closer to her.

If she doesn't calm down, tell her in a gentle voice that you will come back in a little while to help her.

Smile at her as you leave the room.

What thoughts are going through your mind? Are you worried she might hurt you? Do you dread working with her? Do you understand why she is resistant to care?

Take note of the emotions that her responses cause you to feel. We will be sharing this later

Scenario 3A -Staff point of view

Staff A:

You are behind schedule today, and you know that Mrs. Johnson will be stubborn about her bath. She is cognitively well, but can be difficult.

You enter her room with towels in your arms when Mrs. Johnson says, "*You stupid little girl, you can't make me take a bath.*"

If you don't bath her, it will be up to the next shift which could cause some resentment. You know she might hit you if try to force her. You answer: "***No wonder no one around here likes you. You better not hit me or I might hit back!***"

What thoughts are going through your mind? Are you worried she might hurt you? Do you dread working with her? Do you understand why she might be resistant to her bath? Do you take her comment personally?

Take note of the emotions that her responses cause you to feel. We will be sharing this later

Scenario 3B -Staff point of view

Staff B:

You are behind schedule today, and you know that Mrs. Johnson will be stubborn about her bath. She is cognitively well, but can be difficult

If you don't bathe her, it will be up to the next shift which could cause some resentment. You enter her room with towels in your arms when Mrs. Johnson says, *"You stupid little girl, you can't make me take a bath."*

You ask her, *"I know you dread your bath every week. How can I help to make it better for you?"*

You are prepared to negotiate with her. And she responds . . . Give her the opportunity to choose bath time: *"When would you like your bath? I could check with the nurse, when we could fit it in later."*

Ask yourself, if Mrs. Johnson has the right to refuse her bath. Is a bath worth fighting over? Do you understand why she refuses her bath?. Is she angry at you, or something else?

Take note of the emotions that her responses cause you to feel. We will be sharing this later

Scenario 4A-Staff point of view – Physical appearance

Staff A:

You are helping Mr. Olson finish eating his toast.

It is time for your break, and you are **very** tired.

Mr. Olson's face is greasy, and his gown is untied. He does not have the use of his hands to clean himself. He asks you to take him to his room to get washed and dressed. You know that he has guests coming and that he does not like to be seen in his gown. You quickly take his dish away, and roughly pull off his bib.

You tell him **"I don't have time for that right now. It's coffee time. I'll be back to help you after my break. Your company usually doesn't come until after 10"**.

Notice: the look on his face. Do you feel guilty about leaving him. Are you pressured that if you miss your break, other staff will be angry?

Take note of the emotions that his responses cause you to feel. We will be sharing this later

Scenario 4B-Staff point of view – Physical appearance

Staff B:

You are helping Mr. Olson finish eating his toast.

It is time for your break, and you are **very** tired. Mr. Olson's face is greasy, and his gown is untied. He does not have the use of his hands to clean himself.

He asks you to take him to his room to get washed and dressed.

You know that he has guests coming and that he does not like to be seen in his gown.

You know that it is your turn for a break. If you don't go now you might miss it. You know that Jim's appearance is important to him. You re-tie his gown and decide to check with the nurse if you can take your break a little later. Ask Jim: **Do you want help to wash your face?** If he says yes, gently wipe Jim's face, and re-tie his gown.

You say: **Let's go and get you ready for you day! You must be looking forward to your company.**

Are you pressured that if you miss your break, other staff will be angry?

Take note of the emotions that this situation causes you to feel. We will be sharing this later

Scenario 5B – Staff A Point of View -Privacy

- Staff B
 - Staff B You are helping Margaret to the toilet with the mechanical lift. She is new to the nursing home, and is sharing a room with another resident who is watching the interaction from her bed.
 - As you try to get the sling on Margaret you realize it is too small. As you try to adjust it,
 - **Staff A:** your partner says in exasperation: "***She's much too big to fit in this. What are we going to do now?***"
 - **Staff B:** you realize that this comment may be hurtful for Margaret, but your are afraid to confront your partner. You reply. "***We should get a larger sling.***"
- What feelings are you experiencing right now, for not standing up for Margaret? Is your relationship with your partner more important than protecting the residents feelings?

Take note of the emotions that this situation causes you to feel. We will be sharing this later

Scenario 5A – Staff A Point of View -Privacy

Staff A: You and your partner are helping Margaret to the toilet with the mechanical lift. She is new to the nursing home, and is sharing a room with another resident who is watching the interaction from her bed.

- As you try to get the sling on Margaret you realize it is too small.
- You are behind getting residents up. You know that all you need is a larger sling but,
- **You** say loudly in exasperation: "***She's much too big to fit in this. What are we going to do now?***"

How pressured are you by the routine of the care home that you would make a rude comment to a resident? What feelings are you having right now?

Take note of the emotions that this situation causes you to feel. We will be sharing this later

Scenario 5B – Staff A and B Point of View -Privacy

Staff A and B. Staff A and partner Staff B are helping Margaret to the toilet with the mechanical-man lift. She is new to the nursing home, and is sharing a room with another resident who is watching the interaction from her bed.

Staff B closes the privacy curtain.

Staff A says in exasperation: "*She's much too big to fit in this. What are we going to do now?*"

Staff B apologize to Margaret for the problems you are having, and after leaving the residents' room, talk to your partner about the rude comment in a private area.

What should Staff B say?

What does Staff A say? Is she apologetic or defensive? Does her excuses justify what has happened?

How can Staff B retain the friendship of Staff A while doing the right thing? (be respectful as you give constructive criticism)

What feelings do both of you have as staff B confronts her friend? Does Staff A argue with you that this is "no big deal". Will Staff B suffer for advocating for Margaret? Will staff A feel she has been put down by her friend? ***Take note of the emotions that this situation causes you to feel. We will be sharing this later***

Scenario 6A – Staff Point of View -Independence

Staff A: You quickly enter Mr. Antonio's room. He has Parkinson's disease and is extremely slow at doing self care. You have left him fifteen minutes ago by the sink and are disappointed to see, he hasn't finished washing his face, and hasn't even started brushing his teeth.

You tell him:

We have to hurry or you will miss breakfast. You will have to brush your teeth later.

You take the face cloth from his hand and roughly wash his face.

You quickly push him in his wheel chair to the dining room.

How pressured are you by the routine of the care home? Can he have his breakfast later? Does he prefer to do his own care, even if it takes a long time?

Take note of the emotions that this situation causes you to feel. We will be sharing this later

Scenario 6B – Staff Point of View -Independence

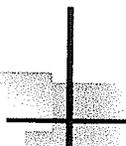
Staff B: You knock at Mr. Antonio's door before entering. He has Parkinson's disease and is extremely slow at doing self care. You have left him fifteen minutes ago by the sink and notice he hasn't finished washing his face, and hasn't even started brushing his teeth.

You tell him: **Mr. Antonio, breakfast is in five minutes. I see you are a little behind this morning? Would you like me to help you?**

Give him the choice of having breakfast later, or brushing his teeth later, or letting you help him. If he asks you to wash his face, do so gently. If he wants to continue on his own, tell him he's doing a great job for sticking with it and you will get him a tray when he is done.

Does it take extra time to negotiate with him? Does it make you feel good to see him doing his own self care? Will it cause more work to order the tray, and can you fit this in your schedule? How pressured do you feel in this situation, that it is easier to do this yourself than encourage his independence?

Take note of the emotions that this situation causes you to feel. We will be sharing this later

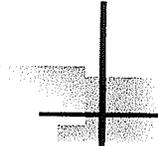


Group discussion

- How did it feel as residents when you were:
 - Respected?
 - Disrespected?
 - What indignities did you experience?

- How did it feel as Staff A who was disrespectful to residents? What were the contributing factors. Did this justify the behavior?

- How did it feel as Staff B who sometimes had to stand up resident's right in spite of routines, partner's behaviors etc.?



Abuse

Objective:

to review definitions of abuse and to identify specific examples of types of abuse that happen to some residents in personal care homes.

Questions

What comes to mind when you hear the word abuse?

Give specific examples from your work place for the following categories of abuse.

- Physical
- Sexual
- Psychological
- Active Neglect
- Passive Neglect

Physical Abuse

The infliction of injury, unreasonable confinement or punishment with resulting physical harm.

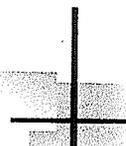
Examples

- Hitting, slapping, beating, punching shoving spitting striking with object pulling/twisting, squeezing, roughly pinching, scratching, tripping, biting, burning, using overly hot water, using cold water, improper use of restraints, improper use of medicine

Indicators that Physical Abuse May Have Occurred:

- Bruises, skin tears, swelling, limbs out of place, change in walking, scratches, irritation of genitalia, burns, withdrawal, unexplained depression, change in behavior, denial of situation, unusual fear

Adapted from CARIE, 1999



Psychological Abuse

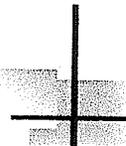
- **The threat of injury, unreasonable confinement and punishment, or verbal intimidation and humiliation which may result in mental anguish such as anxiety or depression.**

Examples

- Resident told to have bowel movement in diaper rather than toileting
- Leaving resident on bedpan for an extended period of time
- Threatening the resident with punishment if she/he does not behave

- Talking to resident as if she/he was a child
- Talking about resident as if she/he was not there
- Yelling or screaming,
- Using demeaning language or ridicule
- Confining resident unnecessarily
- Prohibiting free choice
- Not allowing to participate in activities
- Using silence
- Ignoring resident's questions, comments
- Exposing resident with no precautions for privacy

Adapted from CARIE, 1999



Indicators that Psychological Abuse May Have Occurred

- ❑ Recent or sudden changes in behavior
- ❑ Seemingly unjustified fear
- ❑ Unwarranted suspicion
- ❑ Unwillingness to communicate
- ❑ Denial of situation
- ❑ New or unexplained depression
- ❑ Lack of interest
- ❑ Change in activity level

Adapted from CARIE, 1999



Sexual Abuse

- **Sexual contact that results from threats, force or the inability of the person to give consent, including but not limited to assault, rape and sexual harassment.**

Examples

- Male resident fondling a confused female resident
- Staff member intimately touching resident during bathing
- Any sexual activity that occurs when one or both parties cannot or do not consent

- *Indicators that Sexual Abuse May Have Occurred:*
- Scratches, tears, irritation and swelling around genitalia
- Changes in sitting or walking ability
- Abnormal discharge
- Psychological indicators, including withdrawal, depression

Adapted from CARIE, 1999

Financial Exploitation

An improper course of conduct with or without informed consent of the older adult that results in monetary, personal or other benefit, gain or profit for the perpetrator or monetary or personal loss for the older adult.

Examples

- Stealing or helping oneself to any of the resident's possessions without permission
- Not treating reports of theft seriously
- Borrowing from one resident for another resident without permission
- Not returning proper change to resident after making purchases
- Forcing resident to tip
- ***Indicators that Financial Exploitation May Have Occurred***
- Missing clothes
- Missing valuables
- Missing food or other personal belongings
- No spending money

Adapted from CARIE, 1999

Active Neglect

- **The willful deprivation of goods or services which are necessary to maintain physical or mental health.**

Examples

- Not assisting a resident whom you know needs help with feeding
- Purposefully withholding food, or other items
- Knowingly postponing incontinent care to take a break
- Not delivering mail or messages promptly to a resident
- Sitting at the nurses station and ignoring a call
- Just about anything that an individual postpones or does not do because of some personal activity such as a break or personal call.

Adapted from CARIE, 1999

Passive Neglect

The deprivation of goods or services which are necessary to maintain physical or mental health, without conscious intent to inflict physical or emotional distress.

Examples

- Forgetting to keep the water pitchers full so residents can drink freely
- Not adhering to facility safety precautions
- Telling a resident you will return in 5 minutes and forgetting to do so
- Leaving a resident on the toilet and forgetting to return
- Forgetting to put in a resident's dentures
- Forgetting to help a resident with feeding
- Leaving someone unattended due to high number of residents in the area

Adapted from CARIE, 1999

Indicators that Neglect (Active or Passive) May Have Occurred

- Loss of weight
- Dirt under fingernails, matted hair, body odor, or heavily soiled or stained clothing
- Reduced ability to walk
- Skin breakdown
- Psychological indicators including withdrawal, sudden or unexplained changes in behavior, new or unexplained depression, or agitation, anger, demanding behavior

Adapted from CARIE, 1999

Process Points

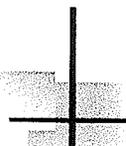
- How many of these examples of abuse are examples of what dignity is **not**?
- Resident Abuse diminishes dignity, whereas abuse prevention protects dignity of residents.

Reporting Abuse

- It is your responsibility to actively prevent abuse, and report it when it occurs.
- You are a resident advocate –you may be the resident’s only voice and hope if he/she cannot speak for him/her self.
- According to the Protection of Persons In Care Act, we **must report** all abuse, or we are breaking the law.

Consequences of not Reporting Abuse

- The situation could worsen
- The resident could be seriously injured
- The person who is being abusive could abuse other people
- If it is discovered, that you knew about the abuse, and did not report it, you could be held legally accountable.



Residents at risk of abuse

Behavioral problems- Residents who:

- Abuse others
- Insult staff or other residents
- Show demanding or critical behaviors
- Don't want won't accept help from staff

Communication deficits-Residents who:

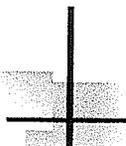
Can't verbalize they have been abused

Cognitive/social impairments-Residents who:

- Would not be expected to notice if things were missing, etc.
- "Undo staff help"

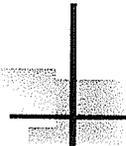
Staff who may react abusively

- Have high stress in personal lives
- Have high stress at work – too much overtime, working short, not getting along with co-workers
- May take things personally
- May have poor supervision
- May abuse Drug/alcohol
- May tend to miss breaks/lunch etc.



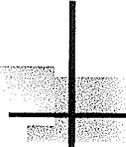
Staff at risk for being abused

- Tend to rush residents who are cognitively impaired
- Approach agitated residents with a loud, overly cheerful manner
- Do not use calm, friendly, non-verbal approaches
- Are rough in giving care
- Are impatient
- May appear “threatening” to residents



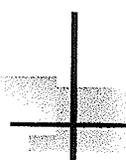
At the End of the Day

- Video Presentation "At the End of the Day" Centre for Advocacy for the Rights and Interests of the Elderly (CARIE 1999)
- Participants will watch video and summarize key aspects of how abusive situations can develop and escalate.



Questions

- What contributed to the abuse?
- Not knowing what issue is worth pursuing with resident and when
- Real issue is control not the medication. Residents often have very little control when dependent on caregivers
- How many times was Lillian told what to do vs. given a choice?
- How did Alice's stress contribute to the abuse?
- Sometimes staff need to get help to defuse a conflict. Who can you turn to when you get into conflict?



Conflict Management- RETHINK

Recognize when you are angry, learn to **Relax**

Explain the situation from the other person's point of view

Think about how you may be contributing to the problem.

Hear really hear what the other person is saying.

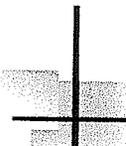
Include "I" statements. Use sentences that begin with I.

I feel _____ when you _____.

Negotiate to work things out to everyone's satisfaction

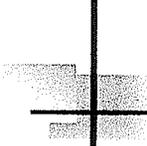
Kindness can be shown even when expressing anger.

Adapted from CARIE, 1999.



Questions for Groups

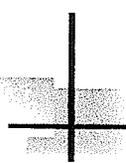
- Recognize anger – what are your body's signals?
- Relax – what strategies can we use to help calm ourselves?
- Explain/empathize – what is the point of view of the other person- have you ever been in that situation? How can we understand how the other person is feeling? Ask? Imagine?
- Think – how do we sometimes cause conflict to escalate? Do we need to take responsibility that our approach may have caused a negative reaction?
- Hear – listen to what the person is saying to understand what is causing the anger? Encourage communication and sharing. How can we do this?
- I- statements are ways of sharing our feelings. How can this help the situation?
- Negotiate: the goal is to end the conflict in peace, not who wins How do we decide on a compromise?
- Kindness – we can disagree as long as it is done with respect- How can we show the other person we still care even though we disagree with the immediate conflict? Tone of voice, focus on problem not person, humor?



Scenarios

Lets problem solve some conflict situations using

- RETHINK – distribute scenarios to groups:
- Role plays “Put yourself in their shoes” Appendices 1-6 are attached at the end of the presentation.
- What situations have you experienced where you didn’t know how to respectfully deal with the situation? Let’s discuss as a group.



Dementia Care:

What is dementia?

- It's a word that describes a variety of illnesses that cause cognitive impairment. Illnesses such as:

Alzheimer's disease

Korsakoff's disease

Creutzfeldt-Jacob disease

And many others

Lewy Body disease

Vascular dementia

Huntington's chorea

- Most types of dementia involve impairment in cognition such as memory, concentration, and/or problem solving.
- These symptoms affect the individual's ability to function and interact with others.
- Dementia often causes difficulty in communicating. The individual with dementia may not understand the meaning of interactions with others, or cues from the external environment.

Adapted from Chapman, Jackson, and McDonald, 1999

Challenging Behavior

What causes challenging behavior – is it the disease?

- Or is it the individual's responses to environmental factors and/or worker responses?
- Key point: the behavior of people with dementia is not an inevitable consequence of the disease process- their behavior is a response to others and a changing environment.

Adapted from Chapman, Jackson, and McDonald, 1999

Challenging Behaviors –Whose problem?

Is this behavior challenging: a person walks about and is restless. Think about the three settings below and whether this behavior would be seen as a problem in that setting:

- In a busy acute medical ward
- In a safe and secure environment with room to roam
- In an open nursing home next to a busy road

Adapted from Chapman, Jackson, and McDonald, 1999



People with dementia are unique individuals

- **Individual routines are based on a lifetime of experience and are extremely important to people**
 - **In the care home, it is the very routines that might trigger problematic behaviors-**
 - **Personal care:** Not understanding intimate caring tasks, which can lead to embarrassment or resistance with care
 - **Mealtimes:** Lots of back ground noises and/or the poor eating habits of others, may cause a resident to react with agitation, or disgust
 - **Evening:** after a busy day, we may experience a headache, or a surge of stress and tension – this may be the same experience of the person with dementia – that they are unsettled related to a tense day

Key point: Challenging behaviors are not always a problem for the person with dementia – when do behaviors become problems for staff?

Adapted from Chapman, Jackson, and McDonald, 1999

What affects the way we behave? Pain

- PAIN how would you react or behave if you had a severe tooth ache or an acute abdominal pain and couldn't explain this verbally?
- Would you:
 - become irritable, or aggressive, moan, shout or scream for help, isolate yourself, try to walk off?

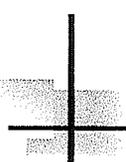
Adapted from Chapman, Jackson, and McDonald, 1999

Fear affects behavior

■ FEAR:

- What might your reaction or behavior be if you thought someone was about to harm you and you were unable to communicate verbally?
- irritable, resistive, uncooperative, aggressive, physically or verbally, restless, agitated, emotional upset or tearful.
- What if you were expecting a family member to arrive, and they were unusually late- would you worry, or pace?

Adapted from Chapman, Jackson, and McDonald, 1999



Emotional needs affect behavior

- Emotional needs:
 - we all need to be loved, wanted and respected.
 - If those needs remain unmet, then we might become angry or irritable, blame others, become withdrawn, sad, unhappy, clingy or over-familiar with others

Adapted from Chapman, Jackson, and McDonald, 1999

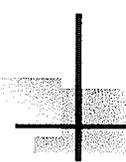
Coping with change affects behavior

- Coping with change:

How would you react if you moved from your home for the first time in 10 years to a town a distance from where you have been born and raised?

-isolated, disoriented

Adapted from Chapman, Jackson, and McDonald, 1999



Coping with New Experience

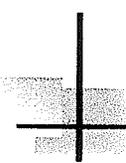
What if you were invited to a night out in a club where you find no familiar faces? The atmosphere is busier, darker, smokier and noisier than you are used to. How would you feel?

Anxious, intimidated, insecure, want to leave, wonder if people are friendly?

Adapted from Chapman, Jackson, and McDonald, 1999

Society Rules and Roles

- Because we live in a social group we expect others to live by social rules such as:
 - To be polite and courteous to others,
 - Not to interrupt when someone else is speaking
 - Not to be aggressive or anti-social to others
 - To have civilized eating habits and good table manners
 - Appropriate toileting habits (correct places, discrete)
 - Appropriate sexual behavior, (where to dress/undress, expression of sexual feeling).
- How do we react when people with dementia do not conform to social rules – do we judge them, have difficulty tolerating their differences?
- Key Point: we need to be tolerant and not judge the person with behavioral challenges as a bad person just because the behavior is not socially acceptable.
Adapted from Chapman, Jackson, and McDonald, 1999



Environmental Challenges to dementia:

- Lack of hominess and comfort
- Corridors that lead to locked doors
- A lack of signs to help orientation
- Noisy crowded sitting areas
- Lack of personal belongings
- Confined or restricted areas
- Hostile, unfriendly atmosphere

Key Point: In order to understand behavior, it is important to look at the situation through the experience of the person with dementia.

Adapted from Chapman, Jackson, and McDonald, 1999

Staff approaches that challenge dementia

- Assuming the person will not understand you, so you do not explain what you are going to do with personal care – this may provoke an aggressive response
- Scolding someone with dementia will make the situation worse instead of better

Key Point: Any show of hostility, disrespect, abruptness, rudeness, impatience, infantilisation, or total disregard for the person's individual needs is likely to increase the risk of being confronted by challenging behavior.

Adapted from Chapman, Jackson, and McDonald, 1999

Organization approaches that challenge dementia

- Inflexible routines – routines that are based more on staff needs than on the individual needs of the person with dementia – this may cause the individual to rebel.
- Task oriented care – is the physical care more important than how the resident is feeling?
- Lack of appropriate activities, stimulation, or relaxation – physical energy must be constructively challenged or the energy may fuel a challenging behavior

KEY POINT: How does task oriented care suggest that efficiency is more a priority than respect for individuality, and choice?

Any examples for discussion?

Adapted from Chapman, Jackson, and McDonald, 1999

Mr. Jones – case study

- Mr. Jones is very frightened and suspicious about being in a care home. He needs to have his clothes changed because he has been incontinent. He is embarrassed and doesn't really know, or trust anyone yet. How would you approach Mr.. Jones?
- Should two or three staff approach Mr.. Jones?
- If the staff try to help without explaining intent, what might happen?

Adapted from Chapman, Jackson, and McDonald, 1999

Tips for interacting with someone with dementia:

DO:

- Have a Friendly approach
- Be Calm, and confident
- Introduce yourself and let the person see you
- Get down to the person's level
- Use eye contact
- Reassure the person that you are there to help them and not to harm them
- Give person choice – do they respond better to certain approaches?
- Adapt your approach to the individual
- Document what works and share this with others

Adapted from Chapman, Jackson, and McDonald, 1999

DON'T

- Don't rush in – if your first approach does not succeed give the person a few minutes
- Don't approach from behind
- Don't stand over people
- Don't make sudden actions or movements that could be misconstrued as threatening
- Don't speak over the person, but include in conversation

Tips for interacting with person with dementia:

SHOW RESPECT-

- Always speak to the person with dementia as a unique individual human being, even if you believe they probably do not understand what you are saying – the person may have brief moments of complete clarity, or may understand your tone if not your words
- Recognize and respect the person's social identity, for who they were, rather than who they are now
- Always explain what you are going to do – that you are not going to hurt them or harm them in any way
- Put yourself in their shoes and ask:
 - How would I feel or respond in this situation?
 - Would I like this?
 - Would I like my mother or father to be treated like this?

Adapted from Chapman, Jackson, and McDonald, 1999

Reducing frequency, severity and duration of challenging behaviors

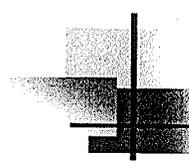
- De-fusing situations that may be caused by a behavior
- Approach in calm, confident relaxed manner
- Distract – this can be used to divert attention away from whatever may be contributing to their challenging behavior
- Touch – holding hand may reassure, however some people may find this an invasion of personal space – so use caution
- Remove trigger for behavior if known
- Respond to their need – try to find out what is wrong and resolve the problem if possible
- Listening or sharing time with person –to give reassurance and support
- Try new ideas- a new approach may not work the first time
- Give constructive activities: e.g. give a person who rummages in other's rooms a box of old clothing to rummage through

Adapted from Chapman, Jackson, and McDonald, 1999

Discussion

How would you approach person with dementia who is:

- Rummaging in other residents' room?
- Looking for lost children?
- Walking away from you with another resident's belonging?
- Other ideas to discuss?

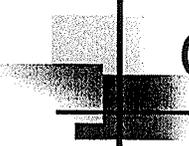


Wrap up, draw, Evaluations

- Check in time:
 - where are you at-
 - what color describes how you feel right now?
 - How is your energy?

What did you learn today – Have we identified organizational barriers to respectful care?

- write down what you have learned and put in blank envelope and hand in. Did you reach your learning goals?
- Post test and training program participant evaluation
 - Make sure same number as pre- survey is on test and place in envelope and hand in.
- 3-4 weeks from today, you will receive a follow up survey.
 - Please make sure you complete these and return.



Congratulations

- Let's draw for self care products. These items were donated by the following local businesses:

ANGIE'S CUTTING EDGE
BEYOND THE GARDEN GATE
HARRIS PHARMACY
MARYKA'S THERAPY CLINIC AND DAY SPA
NEEPAWA PHARMACY
NEW SHADOWS FITNESS CENTRE
SEARS
WHITE'S FUNERAL HOME

- You are all winners today for helping develop a respectful care training program.
- Thank you for your participation!

Resources

- Astill-McNish, S. (1984). A sensitization program for Geriatric nurses. Canadian Nurse, 80, (3), 21-24.
- CARIE. (1999). Competence with compassion: An abuse prevention training program for long term care staff. Centre for Advocacy for the Rights and Interests of the Elderly: Philadelphia, PA.
- Chapman, A., Jackson, G. and McDonald. C. (1999). What Behavior? Whose problem?
Dementia Services Development Centre, Stirling Scotland: University of Scotland.
- Elder Communications. (1997). Preserving Resident's Dignity – For staff members in long term care.
Cincinnati, Ohio: Elder Care Communications.

Appendix B

Empathy Exercise

<p>Activity: Come to Tea in the Day room</p>
<p>Props: Bibs, restraints, string, opaque tape, straws and “tea”.</p>
<p>Objectives: The participants will experience what it is like to be a resident and will understand the use/abuse of power through structured behavior of staff in an institution.</p>
<p>Instructions for participants and description of context: Some participants will act as a group of residents, with two or three participants acting as staff in custodial role. Participants are individually assigned to wheelchairs or geriatric chairs. Participants are seated around the table and served lukewarm tea (so they don’t burn themselves) and cookies. Tea should be sipped through a straw.</p>
<p>Disabilities: Participants who are in the “resident” role are provided with “deficits” -one lens covered to imitate blindness in one eye associated with one sided stroke; centre of both lenses covered for cataracts; one arm and leg on same side tied to wheel chair to imitate one-sided paralysis. Participants who are blind will try to feed self, and staff will take turns helping and encouraging residents with their “meal”.</p>
<p>Staff role(s): Be innovative in managing the “residents” by feeding them, isolating them if they act out, taking them to the bathroom (if they are on a “bladder routine”) and playing “nice” (loud) music for them so they can enjoy themselves</p>
<p>Participant debriefing and analysis of experience: After 10 -15 minutes “release” the participants and discuss the feelings that resulted from this activity. The participants are asked to identify who was in control during this role play).</p>

Adapted from Astill-McNish, 1984

Appendix C

Poetry to Enhance Empathy

1. Confusion

2. The Power of a Smile

Confusion

Through a haze they wander
in a world all their own
days gone by
still on their mind.

“Who is this approaching,
are they friend or foe?”
It is hard to tell
through the mist of confusion.

“There is something wrong.
I can tell by the nagging.
“Is it a thought, a pain, or a memory?
I don’t know but something is wrong.”

They wander aimlessly
getting into this and that
making a mess
irritating others.

“No don’t touch me,
you are so irritating
always telling me no
just leave me alone.”

“Don’t you understand
I am tired and anxious?
I must get this done
I can’t leave this mess.”

They can’t say these words
for they do not know
what is irritating them
they just know something is wrong.

They only know if we
treat them like naughty children
or treat them kindly and gently
like an adult who knows no better.

By Kathy Chute, 2003,
Unpublished works. Reproduced with the permission of the author.

The Power of a Smile

Very confused
lost in his own world
wandering
into others belongings he creeps
“Get out of there that is mine.”
Blame cannot be placed
one is confused
the other protective
hold out your hand
to the confused
speak softly
and smile
they smile back
and are easily taken to a safer place.
So use the power of your smile.

By Kathy Chute, 2003,
unpublished works.
Reproduced with the permission of the author.

Appendix D

Providing for Resident Dignity

1. Care of physical appearance

Residents value a positive self image – taking care of appearance is important – e.g. clothing, makeup.

DO:

- a) Help resident dress in clothes he/she feels is suitable to the occasion - and what the resident wants to wear
- b) Give personal care in manner resident chooses.

DON'T:

- a) Neglect to help resident remove food from face and hands after eating
- b) Dress residents in clothes they would not feel comfortable in, simply because it is easier for staff to put on – eg. hospital night gown, open back clothing

2. Independence: Residents want to do as much for themselves as possible within the limitations of their illness/disability

DO:

- a) Remove barriers from physical environment that hinder independence
- b) Offer to help and if the resident refuses pleasantly accept the resident's choice.

DON'T:

- a) Take over for the resident simply because it's faster to do it yourself.

3. Freedom of Choice: Residents want to make their own decisions about daily activities- how to spend the day, what to wear, what to eat, where to go

DO:

- a) Encourage residents to choose types and times of daily activities
Offer to help and if the resident refuses pleasantly accept the residents choice.
- b) Facilitate resident council meetings as a forum for resident group decision making

DON'T:

- a) Give residents the message that staff feel they know what's best.
- b) Treat residents like a child, or like an old, sick person

4. Privacy: Residents want to maintain acceptable body boundaries, and the privacy of belongings, home and personal information

DO:

- a) Knock on door to resident's room
- b) Get permission to enter
- c) Close door/draw privacy curtains before beginning care
- d) Safeguard modesty during toileting, bathing and other personal care
- e) Accommodate confidential phone calls and visits
- f) Refrain from touching belongings without permission
- g) Keep confidential information to yourself

DON'T:

- a) Walk into the tub room to get supplies when a resident is being bathed
- b) Leave a resident exposed during care
- c) Talk about a resident in front of other residents

5. Respect- A resident needs to feel valued by others and acknowledged for the unique person he/she is.

DO:

- a) Address residents as he/she prefers- If you don't know preference then address by Mr., Ms. Mrs. etc.
- b) Include residents appropriately in conversations
- c) Ask residents for their opinions and demonstrate that their opinions matter to you
- d) Focus on the residents physically and emotionally during caregiving activities

DON'T:

- a) routinely use "bibs"

Adapted from video produced by Elder Communications, 1997

Appendix E

Scenarios for Role Play Activity

Scenario 1 – Resident’s point of view – Respect for person

Materials required: hospital bed, sheet, hospital gown

As “resident”, you are a female resident (Mrs. Jones) who has pulled a call bell to get assistance to be toileted. You are lying in bed waiting for someone to answer. You have been waiting for fifteen minutes now, and your bladder is very sore. By the time staff come to help you, you have accidentally voided in the bed. You are feeling very ashamed about this. As the staff enter you say in a frustrated voice, *You’re too late now, I couldn’t hold it!*

Respond to the staff as you feel fit. Take note of the emotions that their responses cause you to feel. We will be sharing this later

Scenario 2 –Resident’s point of view – Respect and dementia

Materials required: hospital bed, sheet, hospital gown

As “resident” you are a female resident (Mrs. Smith) You have Alzheimer’s disease and do not remember where you are but you know you are lying in bed. You are wakened as two strangers walk into your bedroom. They approach you and try to take off your nightgown. You are terrified and if they don’t tell you why they are there, you will “fight” them off. Act out how your feel.

Respond to their interaction with you. Do they do anything to make you less fearful, so that you will accept help? Respond accordingly. Take note of the emotions that their responses cause you to feel. We will be sharing this later.

Scenario 3 -Resident point of view – Freedom to choose

Materials required: Wheel chair, robe, towels.

As “resident”, you are Mrs. Johnson and today is your bath day. You have been sitting in your wheelchair for most of the day. Your back is sore and you are in no mood for a tub bath. You are tired of being told what to do and when to do it. When the nurse’s aide comes in to take you to the tub room you respond rudely: *“You stupid little girl, you can’t make me take a bath.”* You are prepared to hit her if she tries to force you.

Does she say something that makes you angrier, or does she say something that helps you feel understood. Respond to her interaction accordingly. Take note of the emotions that her response causes you to feel. We will be sharing this later

Scenario 4 -Resident point of view – Physical appearance

Materials required: wheel chair, night gown left open at back , toast and margarine, “Bib”

As “resident” you are a resident named Mr. Olson. You no longer have the use of your hands due to ALS - Lou Gehrig’s disease. The nurse’s aid has just finished helping you with your toast. You are painfully aware that there is margarine on your face, and that your gown is open at the back, leaving you bare. The “bib” is still around your neck. You cannot clean yourself, fix your gown, or take off that dreaded “bib.”

You ask her to take you back to your room so you can wash and get dressed, because you know your friend Jim is coming to visit, and you couldn’t bear to be seen like this.

Does she answer your request in a way that makes you feel better or worse about your situation? Take note of the emotions that the response cause you to feel. We will be sharing this later

Scenario 5 – Resident point of view –Privacy

Materials required: wheel chair, sling, and commode

You are Mrs. Murray, and you have recently moved into a personal care home. You share a room with another resident. You are a large person, and when you ask to be toileted, the sling for the lift machine does not fit around you. Your room mate is watching the nursing assistants struggle to adjust the sling, and you are feeling very embarrassed about the situation. One of the nursing assistants says “She’s too big to fit in this. What are we going to do now? This makes you even more embarrassed but you are afraid to say anything.

Does the other nurse aid do anything or say anything to make you feel better? Respond accordingly. Take note of the emotions that their responses cause you to feel. We will be sharing this later

Scenario 6 – Resident point of view – Independence

Materials required: wheel chair, night gown, face cloth,

You are Mr. Antonio and you have Parkinson's disease. You are very slow at doing your self care, but if given the time, you can do it. You are in front of the sink washing your face with the cloth, when a nurse aid comes into your room to help.

Does she interact with you in a way that makes you feel good about your abilities or does she make you feel badly? Take note of the emotions that her responses cause you to feel. We will be sharing this later

Appendix F

RETHINK – A Conflict Resolution Strategy

R.E.T.H.I.N.K. A Conflict Resolution Strategy

Recognize when you are angry, learn to **Relax**.

Explain the situation from the other person's point of view.

Think about how you may be contributing to the problem.

Hear really hear what the other person is saying.

Include "I" statements. Use sentences that begin with I.

I feel _____ when you _____.

Negotiate to work things out to everyone's satisfaction

Kindness can be shown even when experiencing anger

Adapted from CARIE, 1999

Appendix G

Tips for Dementia Care

Tips for Dementia Care

DO:

1. Have a friendly approach
2. Be calm, and confident
3. Introduce yourself and let the person see you
4. Get down to the person's level
5. Use eye contact
6. Reassure the person that you are there to help them and not to harm them
7. Give person choice – do they respond better to certain approaches?
8. Adapt your approach to the individual
9. Document what works and share this with others
10. SHOW Respect
 - a. Speak to the person with dementia as a unique individual human being, even if you believe they probably do not understand what you are saying – the person may have brief moments of complete clarity, or may understand your tone if not your words
 - b. Recognize and respect the person's social identity, for who they were, rather than who they are now
 - c. Always explain what you are going to do – that you are not going to hurt them or harm them in any way

DON'T:

1. Don't rush in – if your first approach does not succeed give the person a few minutes
2. Don't approach from behind
3. Don't stand over people
4. Don't make sudden actions or movements that could be misconstrued as threatening
5. Don't speak over the person, but include in conversation

Adapted from Chapman, Jackson, and McDonald, 1999

Appendix H

Letter to RHA Regarding Training Program

Respectful Care Training Program Summary – to be implemented in.

Principal Researcher and Program Facilitator: Jo Ann Egilson BSW
University of Manitoba, Faculty of Social Work advisor: Dr. Brad McKenzie

As a partial requirement to complete a Masters degree in Social Work, I am developing a “Respectful Care” Training Program for nursing assistants. The training program will be implemented in a one-day session with 6 hours of course content delivered in an eight hour day.

The goals of the Respectful Care Training Program are

1. Participants will understand what **dignity** means in the life of a PCH resident. Also, participants will learn how nursing assistants have the opportunity to support or undermine dignity, based on their approach to resident care. Specific examples of approaches that support or undermine dignity will be discussed. There will be opportunities to role-play these scenarios.
2. Participants will develop empathy for residents. Through role play, and discussions of scenarios, participants will place themselves in the resident’s situation to understand how easily dignity can be undermined by staff interactions and how residents’ self esteem and sense of worth can be damaged by dignity diminishing care.
3. Participants will recognize all types of staff-resident abuse, and will understand risk factors that can create the conditions where abuse can occur. They will understand their role in advocacy for residents, abuse prevention and duty to report abuse. They will understand it is their responsibility to enhance rather than diminish the dignity of residents.
4. Conflict, stress, and resident dementia are risk factors for abuse of residents; coping with these risk factors will be a primary focus of the training. Participants will develop skills in conflict management and stress reduction techniques. They will understand the causes of problem behaviors for residents with dementia. Interventions with residents with dementia will focus on methods that defuse conflict and maximize choice and dignity.
5. Participants will identify organizational barriers to respectful care – e.g. workloads, PCH routines, etc. They will be asked to brainstorm ways to overcome organizational barriers. Their suggestions will be incorporated into recommendations to management as an outcome of the training program.

Training methods

Role-play to develop empathy, and skill development

Group discussion for problem solving difficult scenarios

A video presentation of an abusive situation where participants will be encouraged to discuss risk factors that led to the abuse, and how these could have been prevented.

The training program content

1. Competence with compassion: An abuse prevention training program for long term care staff. Modules from this program will be adapted to develop skills in conflict resolution, stress reduction, and abuse recognition. This program was developed in 1991 in Philadelphia by CARIE – the Coalition of Advocates for the Rights and Interests of the Elderly. It was revised in 1999. A study by Pillemer and Hudson, 1993 evaluated the CARIE 1991 program and found that staff reported reductions in resident aggression toward themselves following the training which was seen as possible indicator for staff having learned to avoid or defuse conflicts before a resident became aggressive.
2. The remaining course content will consist of core information taken from an extensive review of the literature on resident dignity.

Evaluation:

The training program will have an evaluation component where participants will complete a pre-test in advance of the training program. This test will measure participant-resident attitudes, participant opinion on resident need for dignity, abuse recognition, self reported empathy, and ability to intervene with residents with dementia in a way that defuses conflict and enhances choice and dignity. A course satisfaction survey will be administered immediately following the training and will incorporate a few questions from the pre-test.

A post test will be administered 3 – 4 weeks following the training. This test will be exactly the same as the pre-test in addition to a few open-ended questions. Pre and post test results will be compared to evaluate the effectiveness of the training in changing attitudes and participant-resident interactions.

A final report will disseminate the findings of the study to the Regional Health Authority to identify the effectiveness of the training and to identify future training needs.

I am looking for student nursing assistants and currently employed nursing assistants, (trained and untrained) to participate in the program. Specific information provided by participants will be kept confidential and the final report will not identify nursing assistants by name. Participation in the program is voluntary; however, participants will have the opportunity to give feedback on the effectiveness of the training and give recommendations for future improvements. For more information on the training program, please call or email at . .

Appendix I

Consent Form

Consent Form

Training Program Facilitator: Jo Ann Egilson,

Faculty Advisor: Dr. Brad McKenzie,

The purpose of this practicum is to develop, implement and evaluate a respectful care training program for nursing assistants who work in personal care homes. It is expected that this program will help improve participants' attitudes towards residents, empathy for residents' situations, conflict resolution skills, abuse recognition and prevention skills and ability to understand and care for residents with dementia. These skills will help participants provide residents with respectful care that enhances their overall sense of dignity and wellbeing. The practicum will be used toward my Master of Social Work degree at the University of Manitoba.

This research has been approved by the Joint-Faculty Research Ethics Board. If participants have complaints about the project they may contact the Human Ethics Secretariat at 474-7122.

Nursing assistants, who are training, recently hired, or working in a personal care home in Assiniboine Regional Health Authority, will be asked to participate in this program, in 3 separate sessions. **The training sessions will be held at East View Lodge personal care home for the first two sessions and the Neepawa Resource Centre for the last session. Both of these facilities are located in Neepawa, MB.** The duration of the training program will be 6 hours, and each session will occur over the course of one day.

Training materials will be delivered by lecture, video, and overheads, but the primary learning method will be participatory with skills development through role plays and group discussions.

There is an evaluation component built into this practicum, so participants will be asked to complete a pre survey prior to the training and a post survey 3 to 4 weeks following the training. A participant evaluation form will be distributed to be completed immediately following the training. Information gathered during the training may also be used by the facilitator for evaluation purposes. Questionnaires will be coded to identify which session participants attended, and to match pre/post tests for comparison purposes. All information gathered will be kept confidential and no personal identifying information will be included in questionnaires or the evaluation report. **During the practicum, completed questionnaires will be kept in a locked filing cabinet under the supervision of the principal investigator and will be destroyed after the practicum is completed.**

Specific information discussed by the group will remain confidential with the exception of disclosure of resident or child abuse/neglect or intention to harm one's-self.

Your participation is voluntary and you have the right to participate or decline participation in any/all components of the training program, and you can withdraw from the program at any time.

By agreeing to participate in the training program, you will also agree to participate in the pre-test prior to the training program, and the follow-up test that will be distributed 3-4 weeks after completion of the training program. If you consent to participate in the program, please fill out the information below:

I _____ consent to participate in the Respectful Care Training Program _____ (date), facilitated by Jo Ann Egilson.

I verify that I am giving my consent voluntarily. This practicum has been explained to me and I have received a copy of this consent form. I understand that I can withdraw from the program at any time.

Signed by Participant: _____ Date: _____

Training program facilitator: _____ Date: _____

If you would like a summary of the final report, please write your name and address below:

Appendix J

PRETEST

Pre Test

ID number: _____

Date: _____

Instructions for completing the survey:

Please answer all questions completely and honestly. Your responses will remain confidential. The surveys are coded so that pre-tests can be matched with post-tests, so a master list will be made that links codes to names. However, no one but the researcher will see this form and tests will be destroyed after data is gathered. No supervisory staff or administrative staff will ever see this form, and your responses will not be linked to your employment record. Everything will be kept strictly confidential.

Most of the questions ask you to select **the best answer** from a list of several answers.

Section I: Please circle the number next to the answer that best fits **your situation**.

1) What is the total length of time you have worked in nursing homes, including the time you have worked at your current job/practicum?

- i) None
- ii) Less than 6 months
- iii) 6-12 months
- iv) between 1 and 3 years
- v) 3-5 years
- vi) more than 5 years

2) What is your current level of education?

- i) Grade 8 or less
- ii) Some high school
- iii) High school certificate or GED
- iv) College diploma/certificate
- v) University degree
- vi) Other. Please specify _____

3) What training do you have specific to nursing assistant work?

- i) No training
- ii) Work experience training
- iii) Health care Aid certificate
- iv) Other. Please specify _____

4) What age are you? Choose from the categories listed below:

- i) 18 -25
- ii) 26-35
- iii) 36-45
- iv) 46-55
- v) 56 or older

II. Please indicate **your ability** to do the tasks described in this section by circling the number below the corresponding column.

How would you describe:	Not much ability	Some ability	Adequate ability	Not required for job
5. Your ability to meet the physical needs of residents?	1	2	3	4
6. Your ability to be considerate of the feelings of residents?	1	2	3	4
7. Your ability to respect the choices of residents, even if it causes more work for staff?	1	2	3	4
8. Your ability to protect the privacy of residents during personal care?	1	2	3	4
9. Your ability to encourage residents' independence?	1	2	3	4

III. Please indicate your organization's support for staff to do the tasks described in this section by circling the number below the corresponding column.

How would you describe:	No support	Very little support	Some support	Adequate support
10. Your organization's support for staff to provide for physical needs of residents?	1	2	3	4
11. Your organization's support for staff to provide for the emotional needs of residents?	1	2	3	4
12. Your organization's support for staff to cope with job stress?	1	2	3	4
13. Your organization's support for staff to access training?	1	2	3	4

IV. Please indicate whether you agree or disagree with each statement as it applies to you by circling the number below the corresponding column.

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
14. I often feel burned out from my work.	1	2	3	4
15. I handle conflict well.	1	2	3	4
16. I am sometimes critical of residents who have behavior problems.	1	2	3	4
17. I display a generally positive attitude toward residents.	1	2	3	4
18. I sometimes treat residents more impersonally than I would like to treat them.	1	2	3	4

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
19. I worry that job stress is making me somewhat less sensitive to residents' needs.	1	2	3	4
20. I understand how frustrated residents must feel when they must wait for their care.	1	2	3	4
21. I take it personally when a resident lashes out at me in anger.	1	2	3	4
22. I am sometimes resentful of residents who need frequent heavy care.	1	2	3	4
23. Sometimes I take the resident's problems home with me.	1	2	3	4
24. Sometimes I don't really care very much what happens to one or another resident.	1	2	3	4

25) In general, do you have enough time to accomplish all the tasks you're assigned to during your shift, or are you short of time?

- i) I have more than enough time
- ii) I have just enough time
- iii) I am somewhat short of time
- iv) I am very short of time

26) In the last month how often did you work shifts that were **short-staffed by one person only?**

- i) Never
- ii) Once
- iii) 2-5 times
- iv) 6-10 times
- v) More than 10 times

27) In the last month, how often did you work shifts that were **short-staffed by two or more people?**

- i) Never
- ii) Once
- iii) 2-5 times
- iv) 6-10 times
- v) More than 10 times

V. Please indicate if you agree or disagree with the following statements by circling the number below the corresponding column.

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
28. "Many nursing home residents are like children: they need discipline from time to time."	1	2	3	4
29. "Personal appearance is important to most residents."	1	2	3	4
30. "Most residents want to live a full life."	1	2	3	4
31. "Most residents don't mind if they are not included in conversations with staff."	1	2	3	4
32. "Most residents would rather do their own personal care than accept help."	1	2	3	4

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
33. "Most residents are just passing the time until they die."	1	2	3	4
34. "Most residents would be embarrassed to wear open-backed clothes, bibs, and incontinent aids."	1	2	3	4
35. "Most residents do not mind if you move/touch their belongings in their room without asking them."	1	2	3	4

VI. Please indicate how frequently **you** generally have had conflicts with residents in **this past month** by circling the number below the corresponding column.

How often have you had conflicts with residents in the past month over:	Never	Once	2-10 times	10 + times
36. Quality of food	0	1	2	3
37. Resident complaining too much	0	1	2	3
38. Resident wanting to go outside the home	0	1	2	3
39. Resident's unwillingness to dress	0	1	2	3
40. Resident's unwillingness to eat	0	1	2	3
41. Resident's personal hygiene	0	1	2	3
42. The toileting of residents	0	1	2	3
43. Conflict over some other issue. Describe:	0	1	2	3

VII. Please indicate how frequently the following incidents have happened to you on the job in the past month by circling the number below the corresponding column.

How many times have residents done these things in the past month to you	Never	Once	2-10 times	10 + times
44. Insulted or sworn at you?	0	1	2	3
45. Pushed, grabbed, shoved or pinched you?	0	1	2	3
46. Threatened to hit or throw something at you?	0	1	2	3
47. Actually hit you or thrown something at you?	0	1	2	3
48. Kicked or bitten you?	0	1	2	3
49. Actually hit you or tried to hit you with an object?	0	1	2	3
50. Are there other incidents when residents were abusive toward you? Please describe below:	0	1	2	3

VIII. Please indicate how frequently you have seen a staff member commit each of the actions listed below in the past month by circling the number below the corresponding column.

How many times have you seen a staff member do each of these things in the past month?	Never	Once	2-10 times	10 + times
51. Confine a resident in his/her room as a disciplinary measure.	0	1	2	3
52. Insult or swear at a resident	0	1	2	3
53. Yell at a resident in anger	0	1	2	3
54. Deny a resident food or privileges as part of punishment	0	1	2	3
55. In your opinion, unnecessarily restrain a resident.	0	1	2	3
56. Push, grab, poke, pinch or hit a resident in anger	0	1	2	3

How many times have you seen a staff member do each of these things in the past month?	Never	Once	2-10 times	10 + times
57. Provide care in a rough manner.	0	1	2	3
58. Talk about a resident's private matters in front of others	0	1	2	3
59. Treat a resident as a child.	0	1	2	3
60. Physically force a resident to accept care.	0	1	2	3

IX. Please indicate how frequently you have committed of the action(s) listed below in the past month by circling the number below the corresponding column.

How many times have you personally done each of these things in the past month?	Never	Once	2-10 times	10 + times
61. Confined a resident in his/her room as a disciplinary measure.	0	1	2	3
62. Insulted or swore at a resident	0	1	2	3
63. Yelled at a resident in anger	0	1	2	3
64. Denied a resident food or privileges as part of punishment	0	1	2	3
65. In your opinion, unnecessarily restrained a resident.	0	1	2	3
66. Knowingly neglected a resident's care needs	0	1	2	3
67. Pushed, grabbed, poked, pinched or hit a resident in anger	0	1	2	3
68. Provided care in a rough manner.	0	1	2	3
69. Talked about a resident's private matters in front of others	0	1	2	3
70. Treated a resident as a child.	0	1	2	3
71. Physically forced a resident to accept care.	0	1	2	3

X. Please read the brief stories below about imaginary residents and indicate how **YOU** as a caregiver would respond to described behaviors. Please place numbers 1-5 in the following boxes in front of suggested interventions with 1 being the most preferred intervention and 5 being the least preferred intervention.

72) Ann gets irritated easily and starts swearing at anyone who makes her do something she doesn't want to do. You are in her room to help her prepare for bed when she starts swearing at you. What would **you** do?

- a) Stare at her straight in the eye and tell her that swearing is "bad."
- b) Swear back at her to show her what it is like.
- c) Tell her to stop swearing and if she doesn't, then leave the room.
- d) Ignore the swearing and ask her what's wrong.
- e) Other. Please specify:

73) You frequently find Frank, who is disoriented, in other resident's rooms rummaging through their belongings. What would **you** do?

- a) Stop Frank from rummaging, and take him to his own room.
- b) Remove Frank and lock the door so he can't go back in.
- c) Approach Frank with a warm smile and ask him to come with you for a walk.
- d) Speak to Frank in a stern voice so that he will understand never to touch other residents belongings again.
- e) Other. Please specify:

74) Betty is sitting in the noisy lobby-reception area, banging her fist on the tray of her Geri-chair. This banging happens most often during visiting hours. Other residents move away, and visitors hurry by if they can. What would **you** do?

- a) Tell her firmly, "No banging, Betty."
- b) Have her sit in a less busy area.
- c) Hold her hands to stop her from banging.
- d) Give her some cookies and tea.
- e) Other. Please specify:

75) Before Arthur, aged 93, entered the nursing home, he had lived alone for a long time. He is not used to having many people around him and prefers to be independent. Arthur often kicks, hits, or pushes away from those staff or residents who come close to him. What would **you** do?

- a) Keep a safe distance and ask his permission before helping him.
- b) Warn Arthur that you will hit him back if he tries to hurt you.
- c) Always have two staff present to provide care, so that one can hold him, while the other provides the care.
- d) Leave him alone as much as possible, except for necessary care.
- e) Other. Please specify:

Thank you for your assistance with this survey!

Appendix K

Post-Test and Participant Evaluation

Test

(To be completed same day as training, at the end of the day).

ID#: _____

Date: _____

I. Please read the statements below, and describe and indicate **your ability** to do the tasks described in this section by circling the number below the corresponding column.

How would you describe:	Not much ability	Some ability	Adequate ability	Not required for job
1. Your ability to meet the physical needs of residents?	1	2	3	4
2. Your ability to be considerate of the feelings of residents?	1	2	3	4
3. Your ability to respect the choices of residents, even if it causes more work for staff?	1	2	3	4
4. Your ability to protect the privacy of residents during personal care?	1	2	3	4
5. Your ability to encourage residents' independence?	1	2	3	4

II. Please indicate if you agree or disagree with the following statements by circling the number below the corresponding column.

Would you generally agree or disagree with the following statements:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
6. "Many nursing home residents are like children: they need discipline from time to time."	1	2	3	4
7. "Personal appearance is important to most residents."	1	2	3	4
8. "Most residents don't mind if they are not included in conversations with staff."	1	2	3	4
9. "Most residents would rather do their own personal care than accept help."	1	2	3	4
10. "Most residents are just passing the time until they die."	1	2	3	4
11. "Most residents would be embarrassed to wear open-backed clothes, bibs, and incontinent aids."	1	2	3	4
12. "Most residents do not mind if you move/touch their belongings in their room without asking them."	1	2	3	4

Thank you for completing this post test! All responses will remain confidential.

Training Program Participant Evaluation

(Complete at end of training day)

Please complete evaluation and place in unmarked envelope; do not write your name on test, as responses will remain anonymous. Circle the number beside the best answer.

- 1) The length of the training program was:
 - i) Too long
 - ii) Too short
 - iii) Just right
 - iv) Other. Please specify:

- 2) The material presented was:
 - i) Easily understandable
 - ii) Understandable
 - iii) Somewhat difficult to understand
 - iv) Very difficult to understand

- 3) Opportunities given to ask questions or make comments was:
 - i) Not enough
 - ii) Too much
 - iii) Just right

- 4) How comfortable did you feel discussing the training topics?
 - i) Very comfortable
 - ii) Somewhat comfortable
 - iii) A little uneasy
 - iv) Very uneasy

- 5) How comfortable were you participating in the role plays?
 - i) Very comfortable
 - ii) Somewhat comfortable
 - iii) A little uneasy
 - iv) Very uneasy

- 6) Please refer to the personal learning goals that you identified at the beginning of the training? Were your learning goals achieved?
 - i) Yes all were achieved
 - ii) Yes, some were achieved
 - iii) No, they were not achieved at all

7) If some of your learning goals were not achieved please list below:

8) Why did you decide to participate in the course?

9) What did you find most helpful about the program?

10) What did you find the least helpful about the program?

11) On a scale of 1 – 10, with 1 meaning very poor and 10 meaning excellent, circle the number that best describes your overall evaluation of the training program?

1 2 3 4 5 6 7 8 9 10

12) On a scale of 1 – 10, with 1 meaning very poor and 10 meaning excellent, circle the number that best describes presentation methods and information delivery by the training program presenter:

1 2 3 4 5 6 7 8 9 10

Thank you for completing this course evaluation! Place your evaluation in unmarked envelope and hand in before you leave.

Appendix L

FOLLOW-UP SURVEY and COVERLETTER

Follow-up Survey

ID number: _____

Date: _____

Instructions for completing the survey:

Please answer all questions completely and honestly. Your responses will remain confidential. The survey is coded so it can be matched with pre-surveys, using a master list that was made linking codes to names. However, no one but the researcher will see this form and tests will be destroyed after data is gathered. No supervisory staff or administrative staff will ever see this form, and your responses will not be linked to your employment record. Everything will be kept strictly confidential.

Most of the questions ask you to select **the best answer** from a list of several answers.

Section I: Please circle the number next to the answer that best fits **your situation**.

1) What is the total length of time you have worked in nursing homes, including the time you have worked at your current job/practicum?

- i) None
- ii) Less than 6 months
- iii) 6-12 months
- iv) between 1 and 3 years
- v) 3-5 years
- vi) more than 5 years

2) What training do you have specific to nursing assistant work?

- i) No training
- ii) Work experience training
- iii) Health care Aid certificate
- iv) Other. Please specify _____

3) If you have worked in a nursing home in the past two months, how many shifts did you work in the month of June, 2003.

- vi) none
- vii) 1-5
- viii) 6-10
- ix) 11-20
- x) more than 20
- xi) record the exact/approximate number of shifts if known: _____

4) If you have worked in a nursing home in the past two months, how many shifts have you worked in the month of July, 2003 up to and including the day you complete this survey.

- i) none
- ii) 1-5
- iii) 6-10
- iv) 11-20
- v) more than 20
- vi) record the exact/approximate number of shifts if known: _____

II. Please indicate **your ability** to do the tasks described in this section by circling the number below the corresponding column.

How would you describe:	Not much ability	Some ability	Adequate ability	Not required for job
5. Your ability to meet the physical needs of residents?	1	2	3	4
6. Your ability to be considerate of the feelings of residents?	1	2	3	4
7. Your ability to respect the choices of residents, even if it causes more work for staff?	1	2	3	4
8. Your ability to protect the privacy of residents during personal care?	1	2	3	4
9. Your ability to encourage residents' independence?	1	2	3	4

III. Please indicate your organization's support for staff to do the tasks described in this section by circling the number below the corresponding column.

How would you describe:	No support	Very little support	Some support	Adequate support
10. Your organization's support for staff to provide for physical needs of residents?	1	2	3	4
11. Your organization's support for staff to provide for the emotional needs of residents?	1	2	3	4
12. Your organization's support for staff to cope with job stress?	1	2	3	4
13. Your organization's support for staff to access training?	1	2	3	4

IV. Please indicate whether you agree or disagree with each statement as it applies to you by circling the number below the corresponding column.

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
14. I often feel burned out from my work.	1	2	3	4
15. I handle conflict well.	1	2	3	4
16. I am sometimes critical of residents who have behavior problems.	1	2	3	4
17. I display a generally positive attitude toward residents.	1	2	3	4
18. I sometimes treat residents more impersonally than I would like to treat them.	1	2	3	4

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
19. I worry that job stress is making me somewhat less sensitive to residents' needs.	1	2	3	4
20. I understand how frustrated residents must feel when they must wait for their care.	1	2	3	4
21. I take it personally when a resident lashes out at me in anger.	1	2	3	4
22. I am sometimes resentful of residents who need frequent heavy care.	1	2	3	4
23. Sometimes I take the resident's problems home with me.	1	2	3	4
24. Sometimes I don't really care very much what happens to one or another resident.	1	2	3	4

25) In general, do you have enough time to accomplish all the tasks you're assigned to during your shift, or are you short of time?

- i) I have more than enough time
- ii) I have just enough time
- iii) I am somewhat short of time
- iv) I am very short of time

26) In the last month how often did you work shifts that were **short-staffed by one person only?**

- i) Never
- ii) Once
- iii) 2-5 times
- iv) 6-10 times
- v) More than 10 times

27) In the last month, how often did you work shifts that were **short-staffed by two or more people?**

- i) Never
- ii) Once
- iii) 2-5 times
- iv) 6-10 times
- v) More than 10 times

V. Please indicate if you agree or disagree with the following statements by circling the number below the corresponding column.

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
28. "Many nursing home residents are like children: they need discipline from time to time."	1	2	3	4
29. "Personal appearance is important to most residents."	1	2	3	4
30. "Most residents want to live a full life."	1	2	3	4
31. "Most residents don't mind if they are not included in conversations with staff."	1	2	3	4
32. "Most residents would rather do their own personal care than accept help."	1	2	3	4

Statement:	Strongly agree	Mildly agree	Mildly disagree	Strongly disagree
33. "Most residents are just passing the time until they die."	1	2	3	4
34. "Most residents would be embarrassed to wear open-backed clothes, bibs, and incontinent aids."	1	2	3	4
35. "Most residents do not mind if you move/touch their belongings in their room without asking them."	1	2	3	4

VI. Please indicate how frequently **you** generally have had conflicts with residents in **this past month**, by circling the number below the corresponding column.

How often have you had conflicts with residents in the past month over:	Never	Once	2-10 times	10 + times
36. Quality of food	0	1	2	3
37. Resident complaining too much	0	1	2	3
38. Resident wanting to go outside the home	0	1	2	3
39. Resident's unwillingness to dress	0	1	2	3
40. Resident's unwillingness to eat	0	1	2	3
41. Resident's personal hygiene	0	1	2	3
42. The toileting of residents	0	1	2	3
43. Conflict over some other issue. Describe:	0	1	2	3

44.

VII. Please indicate how frequently the following incidents **have happened to you** on the job **in the past month** by circling the number below the corresponding column.

How many times have residents done these things in the past month to you	Never	Once	2-10 times	10 + times
44. Insulted or sworn at you?	0	1	2	3
45. Pushed, grabbed, shoved or pinched you?	0	1	2	3
46. Threatened to hit or throw something at you?	0	1	2	3
47. Actually hit you or thrown something at you?	0	1	2	3
48. Kicked or bitten you?	0	1	2	3
49. Actually hit you or tried to hit you with an object?	0	1	2	3
50. Are there other incidents when residents were abusive toward you? Please describe below:	0	1	2	3

VIII. Please indicate how frequently you have seen a **staff member** commit each of the actions listed below **in the past month** by circling the number below the corresponding column.

How many times have you seen a staff member do each of these things in the past month?	Never	Once	2-10 times	10 + times
51. Confine a resident in his/her room as a disciplinary measure.	0	1	2	3
52. Insult or swear at a resident	0	1	2	3
53. Yell at a resident in anger	0	1	2	3
54. Deny a resident food or privileges as part of punishment	0	1	2	3
55. In your opinion, unnecessarily restrain a resident.	0	1	2	3
56. Push, grab, poke, pinch or hit a resident in anger	0	1	2	3

How many times have you seen a **staff member** do each of these things **in the past month?**

	Never	Once	2-10 times	10 + times
57. Provide care in a rough manner.	0	1	2	3
58. Talk about a resident's private matters in front of others	0	1	2	3
59. Treat a resident as a child.	0	1	2	3
60. Physically force a resident to accept care.	0	1	2	3

IX. Please indicate how frequently **you** have committed of the action(s) listed below **in the past month** by circling the number below the corresponding column.

How many times have **you personally** done each of these things **in the past month?**

	Never	Once	2-10 times	10 + times
61. Confined a resident in his/her room as a disciplinary measure.	0	1	2	3
62. Insulted or swore at a resident	0	1	2	3
63. Yelled at a resident in anger	0	1	2	3
64. Denied a resident food or privileges as part of punishment	0	1	2	3
65. In your opinion, unnecessarily restrained a resident.	0	1	2	3
66. Knowingly neglected a resident's care needs	0	1	2	3
67. Pushed, grabbed, poked, pinched or hit a resident in anger	0	1	2	3
68. Provided care in a rough manner.	0	1	2	3
69. Talked about a resident's private matters in front of others	0	1	2	3
70. Treated a resident as a child.	0	1	2	3
71. Physically forced a resident to accept care.	0	1	2	3

X. Please read the brief stories below about imaginary residents and indicate how YOU as a caregiver would respond to described behaviors. Please place numbers 1-5 in the following boxes in front of suggested interventions with 1 being the most preferred intervention and 5 being the least preferred intervention.

72) Ann gets irritated easily and starts swearing at anyone who makes her do something she doesn't want to do. You are in her room to help her prepare for bed when she starts swearing at you. What would **you** do?

- f) Stare at her straight in the eye and tell her that swearing is "bad."
- g) Swear back at her to show her what it is like.
- h) Tell her to stop swearing and if she doesn't, then leave the room.
- i) Ignore the swearing and ask her what's wrong.
- j) Other. Please specify:

73) You frequently find Frank, who is disoriented, in other resident's rooms rummaging through their belongings. What would **you** do?

- f) Stop Frank from rummaging, and take him to his own room.
- g) Remove Frank and lock the door so he can't go back in.
- h) Approach Frank with a warm smile and ask him to come with you for a walk.
- i) Speak to Frank in a stern voice so that he will understand never to touch other residents belongings again.
- j) Other. Please specify:

74) Betty is sitting in the noisy lobby-reception area, banging her fist on the tray of her Geri-chair. This banging happens most often during visiting hours. Other residents move away, and visitors hurry by if they can. What would **you** do?

- f) Tell her firmly, "No banging, Betty."
- g) Have her sit in a less busy area.
- h) Hold her hands to stop her from banging.
- i) Give her some cookies and tea.
- j) Other. Please specify:

75) Before Arthur, aged 93, entered the nursing home, he had lived alone for a long time. He is not used to having many people around him and prefers to be independent. Arthur often kicks, hits, or pushes away from those staff or residents who come close to him. What would **you** do?

- f) Keep a safe distance and ask his permission before helping him.
- g) Warn Arthur that you will hit him back if he tries to hurt you.
- h) Always have two staff present to provide care, so that one can hold him, while the other provides the care.
- i) Leave him alone as much as possible, except for necessary care.
- j) Other. Please specify:

XI: Please circle the number beside the **best answer** from the selections below. If you wish to expand on your answers, do so in the space provided, or on the back page of your surveys.

76. In your opinion, did the Respectful Care training program help increase your sensitivity to the quality of staff-resident interactions?

- i. Yes, very much
- ii. Yes somewhat
- iii. No, not at all

Explain:

77. In your opinion, did the Respectful Care training program help increase your understanding of the meaning behind problem behaviors of residents with dementia?

- i. Yes, very much
- ii. Yes somewhat
- iii. No, not at all

Explain:

78. In your opinion, did the respectful care training program help provide you with useful conflict resolution skills?

- i. Yes, very much
- ii. Yes somewhat
- iii. No, not at all

Explain:

79. In your opinion, did the respectful care training program cause you to interact with more respect toward residents?

- i. Yes, very much
- ii. Yes, somewhat
- iii. No, not at all

If yes, explain how your interactions have changed?

80. In your opinion, did the respectful care training program help provide you with useful stress reduction skills?

- i. Yes, very much
- ii. Yes, somewhat
- iii. No, not at all

If yes, list new skills that you have found useful in reducing stress:

81. In your opinion, did the respectful care training program help you recognize abusive staff-resident interactions?

- i. Yes, very much
- ii. Yes somewhat
- iii. No, not at all

82. Since the training program, have you witnessed staff-resident interactions that you would define as diminishing the dignity (self worth) of residents?

- i. Yes, many times
- ii. Yes, a few times
- iii. No, not at all

83. If yes, what did you do about it **most of the time**?

- i. Report it to the appropriate authority
- ii. Intervene with the staff person yourself
- iii. Nothing
- iv. Other. Please specify:

If you circled # iii. (Nothing), please explain why:

84. On a scale of 1 – 10, with **1 meaning poor success** and **10 excellent success**, please circle the number that best describes the degree to which **you would rate** the Respectful Care program **overall** in meeting the following goals with **most of the participants**:

a. The training succeeded in improving most participants' attitudes towards residents.

1 2 3 4 5 6 7 8 9 10

b. The training succeeded in helping most participants develop empathy for residents' situations.

1 2 3 4 5 6 7 8 9 10

c. The training succeeded in encouraging most participants to provide respectful care for residents.

1 2 3 4 5 6 7 8 9 10

85. What barriers to respectful care do you experience in the workplace?

86. In your opinion, what does the organization need to do to improve respectful care for residents in nursing homes?

87. In your opinion, what can **you** do to improve respectful care for residents where you work?

Thank you for your assistance with this survey