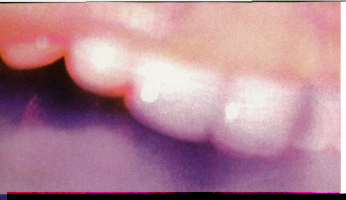

Assault of Long-term Care Personnel

ABSTRACT

The purpose of this study was to explore contributing factors, consequences, and solutions to assault of long-term care personnel. The study sample consisted of three focus groups composed of certified nursing assistants and administrators employed in long-term care facilities within a large Midwestern city. Using content analysis methodology, multiple themes emerged: worker attitude, vulnerability, work culture, job tasks, training, working short-staffed, financial concerns, changes in social values and health care, community crime, substance abuse, accepting assaults, coworker threats, issues of retaliation, professional withdrawal, and inability to share experiences. Preventive measures suggested by the participants are consistent with those recommended by the Occupational Safety and Health Administration. Implications for staff and administrators include both personal and workplace strategies. Recommendations include implementing more comprehensive violence prevention programs that includes conflict management and training tailored to the type of residents.

Violence in health care is increasing, especially in long-term care (LTC) facilities where nursing personnel are the most frequent victims of assault (Bureau of Labor Statistics [BLS], 1998). According to the BLS (1996), in 1994, 38% of nonfatal workplace assaults occurred in health care. Of the more than 20,000 assault-related injuries, 41% occurred to nursing personnel, including certified nursing assistants. Statistics in 1996 show, compared to the assault-related injury and illness rate of 2.2 per 100 full-time workers in private industry, health care industry rates were five times higher (11.6/100), and LTC rates were 15 times higher than private industry (36.3/100) (BLS, 1998).

Current reporting systems for these statistics and others are based on Occupational Safety and Health Administration (OSHA) logs, workers' compensation claims, and incident reports. These reporting systems are well recognized to grossly underestimate the prevalence of violence in health care (Hewitt & Levin, 1997). Compared with physical assault that

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may result in reportable injuries, verbal abuse and threats are less likely to be documented and, therefore, not captured (Lanza & Campbell, 1991). Furthermore, data from existing sources do not provide sufficient detail to:

- Understand the nature of physical assaults and threats of harm.
- Understand the circumstances in which they occur.
- Suggest strategies to prevent the occurrence of workplace violence.

Survey data, however, can capture the full spectrum of workplace violence, regardless of whether the incidents were ever formally documented. Survey findings consistently report that verbal abuse, threats, and physical assaults are common from the perspectives of LTC staff and administrators (Gates, Fitzwater, & Meyer, 1999; Miller, 1997).

LITERATURE REVIEW

The source of workplace violence is varied. Studies show LTC residents who are cognitively impaired or have dementia perpetrate most threats and assaults to staff (Malone, Thompson, & Goodwin, 1993). However, residents who are cognitively intact and, to a lesser extent, families and coworkers also threaten or assault the workers (Gates et al., 1999; Malone et al., 1993).

Relatively little is known about factors that contribute to assault, the nature of resulting injuries, or effects on the workplace, the assaulted staff, and coworkers. In reviews on workplace violence, factors associated with personal-worker, workplace, and environment or situations affect the risk of violence (California Occupational Safety and Health [CALOSHA], 1993; Hewitt & Levin, 1997). In LTC, personal-worker factors were identified as contributing to assault, such as gender and race differences between staff and resident, as well as staff attitudes including acceptance of violence (Gates et al., 1999; Lusk, 1992).

In addition, workplace factors (e.g., job tasks, safety training, case mix, staffing) have been recognized as factors related to assault (Malone et al., 1993; Rudman, Bross, & Mattson, 1994). In research on physically aggressive behavior of LTC residents, assaultive behavior has been associated with providing personal-care activities (e.g., dressing or changing, bathing, toileting) to residents who are cognitively impaired (environmental factor) (Hagen & Sayers, 1995; Malone et al., 1993). Similarly, assaults increase at certain times of the day, primarily during the times of personal-care activities, such as dressing and bathing, which invade the personal space of the resident (Hagen & Sayers, 1995). Research also has shown that in residents who are cognitively impaired, agitation leading to aggressive behavior can increase at mealtimes and nighttime (Cohen-Mansfield, Marx, Werner, & Freedman, 1992). There is also the possibility that LTC staff behavior, which often involves invading the personal space of residents who are confused, may precipitate aggressive, and even violent, behavior toward health care workers (Burgener & Shimer, 1993).

Less is known about the consequences and possible preventive measures for violence against LTC workers. Suggested consequences include job dissatisfaction, attrition, lost work time, or other types of effects on the overall environment of care. Few studies could be found that investigated consequences of violence to LTC workers. Long-term care staff report physical and emotional effects of assault, as well as thoughts of leaving their position (Gates et al., 1999; Miller, 1997). An additional consequence is that health care workers have assaulted patients in retaliation (Farrell, 1997; Levin, Hewitt, & Misner, 1996).

During 1996, the median number of lost workdays in all industries for reported nonfatal assault injuries was five (BLS, 1998). Bureau of Justice Statistics data from 1987 to 1992 indicate that workplace violence resulted in half a million workers missing 1.75 million days of work, with an annual cost of $55 million (Bachman, 1994). Generally, workers' compensation claim data represent severe injuries. In a review of accepted workers' compensation nonfatal assault claims by a nationally based insurer, the total cost for 28,692 claims was more than $84 million during 4 years. Of these claims, health care ranked second for both the highest number of claims and total costs (Hashemi & Webster, 1998).

Preventive measures related to personal-worker and environmental factors have been suggested to decrease assault in LTC. However, it is not clear whether these interventions are effective (Hagen & Sayers, 1995; Rudman et al., 1994). For example, studies have relied primarily on staff training to manage aggressive behavior. Some studies report a short-term decrease in aggressive behavior (Hagen & Sayers, 1995; Wilkinson, 1999). Nonetheless, the LTC personnel-assault–injury rate continues to rise.

CONCEPTUAL FRAMEWORK

This study used an ecological occupational health model to examine multiple factors hypothesized to contribute to verbal and physical assault of LTC workers (Levin, Hewitt, & Misner, 1998). The model (Figure) is broad-based and proposes the workplace, as well as the individual worker and the external environment (com-

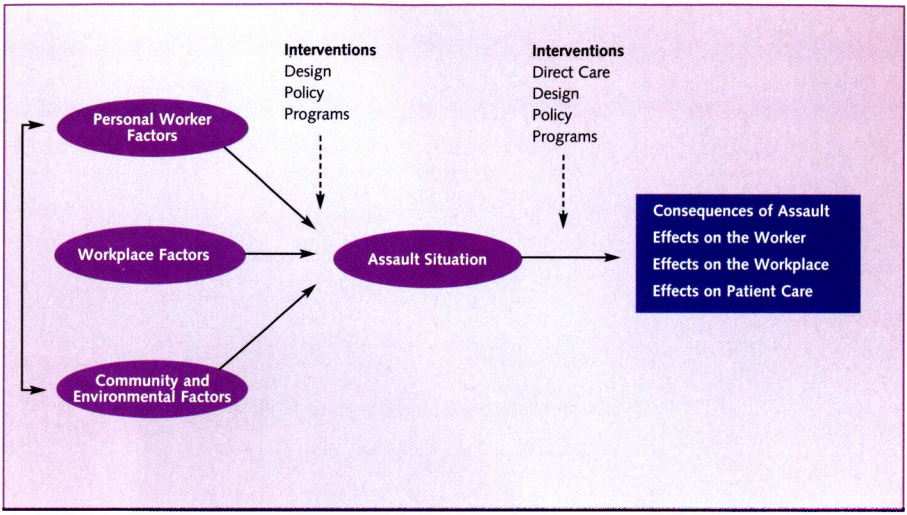

Figure. Ecological occupational health model of workplace assault.

munity), contribute to the likelihood of assault. Worker factors might include the nursing personnel's gender and work experience, attitude, and sense of vulnerability toward assault.

Workplace factors might consist of such determinants as work norms and policies, work context, staffing patterns, job tasks, safety training, physical design of the work area, and presence of security personnel and safety equipment. Community factors reflect the external environment and include the type of resident admitted, geographical location of the facility, and the prevalence of substance abuse, weapons, and violence in the surrounding area.

In the model, worker, workplace, and community factors are interrelated. Because injuries resulting from violent acts can be both physical and emotional, in this ecological model, both verbal and physical assaults are considered. Lack of reporting hinders prevention efforts, as well as efforts to minimize the personal and financial costs of the assaults. The possible consequences of workplace violence encompass both short- and long-term effects on the worker (e.g., physical and mental health) and workplace (e.g., lost work time, medical costs, disability, attrition, changes in job performance, morale).

Assaults adversely affect the quality of resident care directly through reduction in services, and indirectly by affecting the overall environment of care (e.g., absenteeism, attrition, morale). Prevention efforts, or solutions, are directed at the individual, workplace, or community through such interventions as policy enactment, program development, or physical redesign.

STUDY PURPOSE

The purpose of this study was to explore, using the ecological model, the factors contributing assault on LTC workers and the consequences of assault on these workers, as well as on the workplace. There were three objectives for the study:

- Determine the perceptions of LTC workers about worker, workplace, and environmental factors contributing to the incidence of assault and its consequences.
- Determine short- and long-term effects of violence on LTC workers.
- Use workers' experiences to identify possible solutions to violence in LTC facilities.

METHODS

This exploratory study used focus groups to gain knowledge about assaults of LTC workers, as well as prevention and intervention strategies acceptable to both staff and management. The focus groups were conducted in a large metropolitan community in a state where the health department targeted LTC facilities for assault risk reduction efforts.

Three focus-group sessions were held, each lasting 2 hours. Two focus groups were composed of certified nursing assistants (CNAs) and one of administrators. Access to the CNAs was through a mailing list supplied by a union that organizes LTC workers. Access to the administrators was through the state's list of licensed LTC facilities. Letters requesting participa-

TABLE
THEMES FROM THE FOCUS GROUPS

Themes	*Distinct Context*
Person Factors: Issues Related to the Worker	
At risk or sense of risk	Coworker focus versus resident focus
Worker attitude	Concern for resident rights and behavior; respect for the resident, work ethic, and social skills
Workplace Factors: Issues Internal to the Workplace	
Culture or climate	Little support, respect, or communication; poor working relationships; Will get blamed if report
Job tasks	Relocating residents, denying privileges, activities of daily living
Training	Basic training no longer sufficient
Staffing	Focus on always working short-staffed; being pulled from regular assignment; too much overtime
Financial concerns	Low pay, high turnover; lack of supplies
Environmental Factors: Issues External to the Work Setting	
Changes in social values	Responsibility, work ethic
Community crime	Violence in employees' home life
Substance abuse	Focused on employees
Changes in health care	Risks of combining mental health with long-term care and rehabilitation
Assault Experiences: Verbal and Physical Altercations	
Acceptance	More acceptable from residents, but not from coworkers
Type	Emphasis on verbal abuse and threats from coworkers
Effects of Assaults: Short-term and long-term consequences	
Issues of retaliation	Initial reflex response (e.g., automatically hitting back)
Withdrawal	No longer able to go provide extra care or attention
Not able to share experiences	Supervisor blame; fear of retaliation
Solutions: Recommendations for prevention	
Personal	Take time, be calm, call behavior team last; take short breaks to refocus; report coworker abusive behavior
Administrative	Orientation to residents; teamwork and conflict resolution
Training	
Adequate staff	Quality and quantity of staff; terminate low quality staff
Support	Show respect and listen

tion in the study were mailed to a random selection of names from each of these lists. Those who responded and were currently employed in a LTC facility and could attend one of the scheduled focus-group sessions were assigned to a group.

Care was taken so individuals assigned to the same group would not know each other. In addition, administrators were assigned to a separate group. These precautions were taken to assure participants that it was safe to disclose sensitive information. Participants were compensated for travel and time comparable to their hourly wage.

The participants represented eight facilities, most nonprofit with 150 to 200 beds. The CNA participants consisted of six Black women and one Black man; the median age was 31. The CNAs ranged in experience in LTC from 1.7 to 20.5 years (median = 5.7). The median time in their current position was 3 years. The three administrators were White women with a median age of 43. The administrators varied in the number of years worked in LTC (1.5 to 20) and the length of time in their current position (< 1 to 13).

A discussion guide steered the focus-group sessions. A preliminary guide was developed based on the model and previous research (Levin et al., 1998). To provide assurance that the discussion guide was targeted appropriately, members from the union and a LTC administrative consultant reviewed the guide before the first focus-group session. The guide was modified and probes were added as the sessions progressed. Probes were used to clarify and elaborate. Each audiotaped session used a moderator who guided the discussion and an observer who documented key points and nonverbal behavior. Sessions were conducted in a community meeting room away from the workplace to facilitate open discussion.

After each session, the observer and moderator debriefed to identify emerging themes, record any significant nonverbal content, and to propose any procedural changes for subsequent sessions. Data included notes from these debriefing sessions and verbatim transcripts. Data were analyzed using content analysis methods and the software package, Ethnograph v5.0 (Scolari, Sage Publications Software, Thousand Oaks, CA) (Seidel, 1998). Accuracy of coding data was verified as evidenced by an interrater agreement of .80.

RESULTS

Using the ecological occupational health model, themes that emerged are described in relation to:

- Characteristics of the CNAs and administrators (person factors).
- Internal workplace factors.
- Community factors (Table).

Additional themes emerged that were related to the assault experiences themselves, short- and long-term effects of assault, and possible solutions. The themes were consistent across the focus groups.

Person Factors

The CNAs reported they always felt at risk for assault from residents. In addition, both CNAs and administrators felt at risk, as they often feared their coworkers or employees. One CNA said:

> You witness something and you sign your name to it. I'm not supposed to fear my life because I wrote someone up. [But] I'm not protected off the premises.

Another person noted:

> I keep my distance away from my coworkers and keep my eyes open, 'cause you know they can make much more things move on me than a resident.

The administrators expressed fears because of threats from employees they had terminated for inappropriate behavior, such as carrying a weapon to work or abuse of residents. Additionally, CNAs noted that being new and lacking experience in LTC put them at risk.

Worker attitude also contributed to the likelihood of an assault. Lack of respect for residents, being short-staffed or rushed, and disregarding resident preferences (e.g., to delay giving a bath) may hasten a verbal or physical assault. Some coworkers had limited social skills and showed a poor work ethic, which created tension within the work team. Most times, this tension was displayed through verbal abuse and threats, and occasionally, the violence would escalate to physical assault.

Workplace Factors

Workplace factors that contribute to assault dominated much of the discussion in all the sessions. Participants raised several issues related to the workplaces' culture or climate. For example, both CNAs and administrators articulated the need for support and respect. The CNAs expressed the lack of support and respect from supervisors and administrators, who often did not respond to issues that the CNAs brought to their attention. Whereas administrators felt providing support to employees about issues related to work and home life was a significant part of their workday. One CNA said:

> We are here for the residents all the time. Yet, our input is not as important as management's. CNAs are the bottom of the pit.

Generally, poor working relationships were reported. The administrators noted that RNs typically avoided handling staff conflicts. The CNAs reported they did not seek help from staff nurses to handle concerns about coworkers. The CNAs felt that the culture in LTC facilities is such that they would be blamed for reporting conflicts with coworkers or altercations others had with residents. For CNAs, lack of communication about specific resident needs between shifts and when they were assigned to new residents increased the likelihood of an assault.

The CNAs noted there were certain job tasks that carried some risk for them. For example, residents would take out their anger on CNAs when they were delivering "bad news" such as denying smoking privileges or relocating the resident to another room. This is distinct from the violent outbursts or actions associated with providing direct care activities, such as bathing and toileting residents.

Basic education for certification as nursing assistants was supposed to train them to work with older adults. However, they felt this training was insufficient preparation for dealing safely with clients who were confused, demented, or mentally ill, who would increasingly comprise the LTC population. A CNA remarked:

> When I first got certified I was not properly trained on the behaviors...I approached the bed, let down her siderails and she "whomped" [hit] me.

Also, they felt that staff could learn more effective interpersonal skills in dealing with conflict and distressing information.

The CNAs noted that isolated instances of working short-staffed did not increase their risk of assault. However, chronic inadequate staffing, which often results in being pulled to other units or working overtime, did put them at risk for assaultive behavior from residents, as well as from coworkers.

A related theme was financial concerns. The low pay of CNAs was linked to high turnover. In addition, the lack of necessary resident supplies, including clothing items, often upset the residents and family members.

Community Factors

Many expressed concerns associated with changes in social values. Some of these concerns were about a lack of work ethic and responsibility such as "no call, no show," which affected staffing. Coupled with this was the sense that crime in the community influenced the likelihood of an employee being a victim of a violent act while working within the LTC

facility. For example, both CNAs and administrators expressed sadness over the pervasiveness of violence in the community and especially within employees' homes. One said, "We have had boyfriends calling up and threatening that they are coming in to work to get them." However, they felt violence was universal.

Drug or alcohol use among employees and residents plays a role in assaultive behavior. For example, applicants often are not hired because they fail the drug test. However, despite initial drug testing, CNAs reported that substance abuse seemed to be a common problem at work. Substance abuse among the work force reflects the pervasiveness of substance abuse in the community. In addition, residents are now coming to LTC with recent histories of substance abuse, according to the participants. The shift in resident mix is caused by the changes in health care, where young individuals with mental health problems are combined with older adults and individuals with rehabilitation needs. One participant said:

> One of the men [resident] was going through withdrawal. Now we gotta watch the vulnerable women... He's doing sexual things to them.

Assault Experiences

Participants recalled assault incidents that ranged from verbal abuse, racial slurs, and threats to physical altercations including being pushed, grabbed, hit, or scratched. Sexual harassment and fondling were often associated with the assaults. Although the residents were frequently the assailant and less often family members, CNAs and administrators were more concerned with assaults perpetrated by coworkers and staff.

These CNAs felt that assaults from residents were more acceptable than from coworkers, and if they did their job well, assaults from residents were minimal. The CNAs emphasized the verbal abuse and threats they received from coworkers, saying:

> I'm not worried about the resident, but the staff can get really personal... I've been cursed out by a lot of staff members.

Effects of Workplace Assaults

Initially, both CNAs and administrators were unprepared for abuse. The CNAs were more likely to take the abuse personally and reported feeling hurt and angry. At first, they reflexively wanted to retaliate when abused by a resident, but managed to refrain from striking back. Over time, their response was to withdraw by no longer being able "to go the extra mile." For CNAs, this was a loss because personal rewards were gained from close relationships with some residents.

The CNAs were reluctant to recount their assault experiences from residents or coworkers with supervisors for fear of being blamed or retaliated against by coworkers. They did share their assault experiences with their own family members. Administrators told their own family members about threats to protect them rather than to elicit support. All of the participants denied somatization, even with probing.

Preventive Measures or Solutions

Participants described strategies for preventing assaults they could implement themselves, as well as strategies requiring administrative support. One personal strategy was to take time to approach residents with respect and care, while "checking their bad mood at the door." They also noted that a behavioral management team should be used as a last resort because it sometimes resulted in escalation of the violence. Another strategy is to walk away from a volatile situation to either gather one's thoughts or to call in someone else to handle the situation. Although fearful, CNAs thought they should take responsibility for reporting coworkers who abused residents or staff.

Participants identified several administrative solutions including training, adequate staff, and support. The CNAs require training related to the needs and approaches that best suit the types of residents in their facility, as well as the best strategies to deliver care to individual residents. For both CNAs and professional nurses, a more challenging training need is to learn to work effectively in teams. This involves learning social and conflict resolution skills, and for nurses, appropriate delegation and supervision.

Both CNAs and administrators identified the need to have adequate staff to prevent workplace violence, both in terms of quality of staff as well as staffing numbers. High turnover and absenteeism effectively reduce the work force. Participants discussed the importance of screening potential hires. Administrators specifically listed careful review of background checks prior to hiring, as well as other strategies such as obtaining restraining orders against aggressors, installing security systems (e.g., door alarms, restricted access), and calling police when handling difficult terminations. Finally, CNAs and administrators concurred that administrators need to show support to the staff through active listening and displays of respect.

DISCUSSION

Examining the perceptions and opinions of staff and administrators about assault in LTC is critical to understanding the context of violence within this unique setting. Considering these opinions, as well as LTC context, is strategic to developing preventive measures acceptable to staff and management.

Focus-group methods provide researchers the opportunity to gain an in-depth understanding, from those involved, of the context of violence within LTC. However, caution should be taken when interpreting the results of this study. The overall purpose of focus groups is to identify the subjective reality of those involved with the topic. As a result, individuals who participate in focus groups are usually interested in the topic and, therefore,

may express opinions that differ from those who did not attend. Consequently, results of focus groups are not meant to be generalizable. Instead, they aim to be representative of opinions of similar groups (Stewart & Shamdasani, 1990). In addition, perceptions and opinions may differ across settings and samples.

A limitation of this study is the small group size. Although participants received confirmation and reminder notices, many CNAs and administrators did not attend their scheduled session because of inclement weather or unannounced state health inspections for LTC agencies conflicting with the scheduled focus groups. Small group size can be a problem in focus-group research because there is always the chance that important issues or differing opinions will not be expressed. However, in this study, suppression of differing opinions was less likely because participants were assigned to groups to assure anonymity and sessions were held away from worksites.

These approaches, considered standard within focus-group research, are designed to increase the likelihood that sensitive issues are raised or differing opinions expressed (Stewart & Shamdasani, 1990). Furthermore, it seems unlikely that differing opinions were suppressed in this study because the participants expressed views that were sensitive in nature. However, the extent to which differing viewpoints may not have been expressed because of small numbers of participants and resulting lack of variation and breadth of experiences remains unknown.

Although the participants considered all factors (e.g., personal, workplace, community) to be associated with assault, more emphasis was placed on workplace and community factors. Participants experienced a range of violence from verbal abuse and threats to physical assaults by residents, residents' families, and coworkers. However, LTC personnel were primarily concerned about verbal abuse from coworkers. Assaults from residents were considered preventable. Violence was perceived as "part of the job" and was tolerated from residents, especially when the violence is considered related to the diagnosis.

Participants did not accept violence from coworkers. Verbal and physical assaults profoundly influenced their personal and professional lives. Blame is a perceived consequence of violence in LTC settings, even when the worker is the victim.

Being aware of the risk of assault, showing respect for and taking time with the resident, and having appropriate social skills are all important in preventing resident and coworker assault. Nurse managers need to coach staff on ways to allow residents some choices. Similarly, staff may need administrative support and guidance in how to relinquish control. For example, completing tasks based on resident preference versus a specific time schedule. "On-the-spot" or "just-in-time" training may be more successful than general training sessions in meeting these training needs.

Workplace factors that place LTC personnel at risk for assault include lack of training specific to the type of residents, as well as assigning job tasks that result in changes or restrictions for the residents. Schools that train nursing assistants need to prepare their graduates for the current practice setting, which includes caring for individuals with chronic mental illness and dementia. Administrators, who hire their graduates, should urge schools to update the curriculum accordingly.

Additional workplace factors considered important and previously reported in the literature are a disrespectful work climate that fosters poor working relationships, inadequate numbers of qualified staff, and high turnover due, in part, to low wages. Although always a difficult management issue, higher wages help to retain quality staff, reduce the likelihood of assault, and reduce costs associated with turnover. Providing a supportive work environment that encourages reporting of all assaults, without automatic blame, is an important step toward preventing future assaults.

Although the CNAs and administrators identified several community factors previously reported in the health care violence literature, the specific context differed in this study. For example, the prevalence of community crime and substance abuse are frequently mentioned in the literature. However, within LTC the focus was not on the residents, but on substance abusing employees and employees who experience violence in their home life. The participants also considered that changes in social values and in the health care system increased their risk of assault.

Acceptance of violence from residents or patients, as well as tolerance based on diagnosis or intention is consistent with other research conducted on assault in LTC and other health care settings (Gates et al., 1999; Levin et al., 1998). However, coworker or horizontal violence is rarely discussed in the workplace violence literature related to health care (Farrell, 1997; Kivimaki, Elovainio, & Vahtera, 2000). Even more rare, are issues of retaliation (Farrell, 1997; Levin et al., 1996). Issues of retaliation affect resident care. Therefore, all nursing personnel need to be proficient in conflict management. Coupled with this is the need for better integration of leadership and management skills throughout nursing curricula.

Education and support are needed for personnel to embrace their right to a workplace free of violence. As many participants expressed the influence of violence in the community on their worklife, LTC facilities should consider offering programs on domestic and family violence, as well.

Preventive measures suggested by the participants are consistent with those contained in the guidelines aimed to prevent violence in health care released by OSHA (U.S. Department of Labor, 1996). The main components of OSHA's violence prevention program are:

- Management commitment and employee involvement.
- Worksite analysis.
- Hazard prevention and control.
- Training and education of employees, supervisors, and managers.
- Recordkeeping and program evaluation.

The OSHA recommends LTC facilities develop and implement a written violence prevention plan that contains these five components.

SUMMARY

This study extended the work conducted by Miller (1997) and Gates et al. (1999) by using an ecological occupational health framework and different focus-group methodology. The current study is part of a series, which is identifying the unique context of violence across health care settings. Future research will test the linkages and relationships of the ecological occupational health model across care settings, and implement an integrated nursing intervention aimed at altering factors that contribute to assault.

KEYPOINTS

ASSAULT OF LONG-TERM CARE PERSONNEL

Levin, P.F., Hewitt, J.B., Misner, S.T., & Reynolds, S. Assault of Long-term Care Personnel. *Journal of Gerontological Nursing,* **2003, 29(3): 28-35.**

1. Verbal and physical assaults from residents and their family members are accepted as "part of the job" by certified nursing assistants (CNAs) and employers, whereas threats and verbal abuse from coworkers are not.
2. Violence affects the personal and professional lives of long-term care personnel.
3. To develop effective prevention measures that are acceptable to both CNAs and employers, multiple factors need to be considered, including personal, organizational, and societal issues.

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