Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

HHS Public Access

Author manuscript

Hosp Top. Author manuscript; available in PMC 2018 April 04.

Published in final edited form as:

Hosp Top. 2013 ; 91(1): 1–8. doi:10.1080/00185868.2013.757953.

Nursing Assistants' Dilemma: Caregiver Versus Caretaker

Michelle D. Holmberg [Program Manager],
Center for Family, Work, and Community at the University of Massachusetts Lowell in Lowell, Massachusetts

Marian Flum [Qualitative Research Director],
Department of Work Environment at the University of Massachusetts Lowell in Lowell, Massachusetts

Cheryl West [Director of Grants],
Development at Mass Bay Community College in Wellesley Hills, Massachusetts

Yuan Zhang [Doctoral Candidate],
Department of Nursing at the University of Massachusetts Lowell in Lowell, Massachusetts

Shpend Qamili [Masters Candidate], and
Department of Psychology at the University of Massachusetts Lowell in Lowell, Massachusetts

Laura Punnett [Professor]
Department of Work Environment at the University of Massachusetts Lowell in Lowell, Massachusetts

Abstract

Focus groups were conducted with over 150 certified nursing assistants (CNAs) in seven nursing homes to obtain their opinions on how the work environment supported or impeded their caregiving to residents. Strong opinions emerged about work environment interference with CNAs' ability to provide quality and comprehensive care. Participants also believed that their supervisors did not respect the value of the care and nurturing that CNAs provided. This contrasted with the respect that CNAs voiced for residents. The findings high-light the need for improved relationships between CNAs and management and suggest some desirable features of work organization in nursing homes.

Keywords

long-term care; nursing assistants; resident care; work organization

---

High turnover and absenteeism in the direct care workforce have been cited as serious problems in the health care industry (Kemper et al. 2008). One study reported that 43% of nurses considered leaving their current jobs within a year (Ma et al. 2009), and another cited 30% of nursing assistants in nursing homes planned to leave their jobs (Parsons et al. 2003). Donoghue (2010) reported 74.5% as a national estimate of turnover for CNAs in nursing homes. Evaluations of nursing home quality measures such as staffing level mix to resident have demonstrated that optimal levels of nurse and certified nursing assistant staffing ratios

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

are predictors of quality of care, after controlling for facility characteristics (Hyer et al. 2011; Alexander 2008).

While caregivers report that providing high-quality care for patients is a deeply satisfying part of their jobs (Utriainen, Kyngäs, and Nikkilä 2009; Chou 2012), many providers also experience job dissatisfaction, mental, emotional, and physical exhaustion, or burnout due to professional demands (Maslach, Schaufeli, and Leiter 2001; Drebing, McCarty, and Lombardo 2002; McCarty and Drebing 2003; Meyer, Raffle, and Ware 2012). Direct care providers experience distress when the work organization interferes with or impedes their ability to care for patients in an ethical and dignified manner (Severinsson and Hummelvoll 2001; Bégat, Ellefsen, and Severinsson 2005). It has been documented, especially in the long-term care sector, that poor communication with supervisors, time pressure, and inflexible organizational policies contribute to mental and physical stress on care-givers (Rafnsdottir, Gunnarsdottir, and Tomasson 2004; Kemper et al. 2008).

It is especially important to examine the perspective of certified nursing assistants (CNAs) because they represent the majority of workers employed in nursing homes and provide the majority of direct services (Donoghue 2010). Currently there is a shortage in the United States of CNAs in nursing homes, which is an issue that has serious consequences for the quality of care provided (Squillace et al. 2009). Studies have demonstrated a relationship between CNA staffing levels and nursing home quality (Hyer et al. 2011). Seven states and the District of Columbia mandate specific maximum levels of numbers of CNAs to resident ratios (Table 1).

We examined the extent to which the work environment in nursing homes, including but not limited to the quality of supervision, supported or impeded the self-assessed ability of CNAs to provide quality, comprehensive care. Three specific research questions that guided this analysis were the following: (*1*) How did CNAs describe the nature of care they provided to residents? (e.g., Did they mainly attend to physical needs, or was their care more comprehensive and concerned with emotional needs, as well?), (*2*) What was the perceived relationship between the work environment and the quality of care that CNAs were able to provide to the residents? and (*3*) What was the work environment's impact on the mental and physical health of CNAs themselves?

Method

Participants and Procedure

We utilized data from focus groups conducted in seven nursing homes in New England. All centers were part of one large corporation. The initial purpose of the focus groups was to elicit CNAs' perceptions of their health needs and the factors in the nursing home work environment that might promote or interfere with their health. All centers had implemented a Safe Resident Handling program designed to reduce low-back injuries in clinical staff approximately two years prior to our investigation. The study was approved by University of Massachusetts Lowell Institutional Review Board.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Twenty-seven focus groups were conducted, each one consisting of CNAs employed by the company. Temporary agency staff was not eligible. Staff members were recruited from all three shifts. Notices were posted and volunteers were then scheduled by each center. Each focus group was guided by a trained facilitator; a second researcher took notes and documented non-verbal responses such as head movement and body language. Each focus group was conducted over two 90-min sessions and on paid time for participants. Focus group questions elicited employee opinions on topics such as workplace health and safety, resident handling and the universal no-lift program, worker participation, health issues at home, health promotion programs, a vision of the ideal nursing home in terms of work and health, and changes that could be made at the workplace to improve worker health and reduce stress. On average there were six participants per focus group. Each participant received a nominal monetary incentive from the researchers for participating in the study. All focus groups were digitally recorded and professionally transcribed.

Data Analysis

Data analysis took part in two phases. The first phase was to read all focus group transcripts and extract relevant sections and quotations pertaining to caregiver stress at work, contributing work organization issues, and CNA relationships with residents. The gathered data extracts were then coded for major themes that emerged; we met to discuss themes and ensure consensus on coding and relevance.

In the second phase, data extracts were read again and coded for emergent subcategories. Memos were written about how the particular data points expressed the main theme, how they were related to other points in the same subcategory, and any noted links to other themes. After this coding we again came to consensus on final themes and subcategories, and the connections among them. No major differences in the responses among the seven centers were noted.

Results

Overview

From the transcripts two distinct themes emerged: the CNA as nurturer of the nursing home resident and, in contrast, the extent to which the CNAs did not themselves feel nurtured by those above them in the occupational hierarchy (Table 2). The CNAs' perception of themselves as nurturers, concerned with the well-being of the individuals under their care, were elicited as an unexpected consequence of the line of questioning that focused on their own well-being. It also emerged that the way the organization is designed and managed seriously hampered participants' ability to provide comprehensive care, because the CNAs felt that their knowledge was not valued and the quality of care that they provide was not respected.

CNA as Nurturer

Identity and practice—Nurturing was described both as an identity and as a practice for participants and represented a comprehensive approach to providing for residents' needs. Identifying as a nurturer was stated both explicitly and implicitly by focus group

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

participants. An example of an explicit statement was, “I'm a caregiver; it's who I am.” Less explicit was when participants described feeling like family to their residents. One participant during a discussion about how the corporation discouraged affectionate gestures such as hugging residents remarked, “some residents don't have family members, so they look at us as their family”.

There was a consensus in all focus groups about the importance of providing comprehensive care. Participants defined this as going beyond the physical tasks of feeding or cleaning to include care of social and emotional needs, which they deemed “quality care.” Many said they would sacrifice their breaks for “time with talk, maybe watch a movie together.” A few mentioned running errands to make life easier on the residents: “I said why are you spending money in the [soda] machine every day? I'll go to the [the grocery store for you]”.

Residents' rights and dignity—Participants in every center were concerned that residents' rights and dignity be upheld at all times. They frequently discussed the need for residents' autonomy in the daily schedule; one participant stated, “It's their right to want to stay in bed in their pajamas, for whatever the reason.” When the state of Rhode Island mandated that chair pads could not be used in case of incontinence, a participant mentioned the potential health hazards (i.e., trying to fully sanitize a cushioned chair) as well as the implications for residents' feelings and rights: “The State says we can't. But it's not a dignity issue [for the State]. It has nothing to do with dignity.”

Even when this belief in residents' rights contradicted caregiver safety, some aides were prepared to side with the residents. One participant described a resident who did not want to use a gait belt:

> She's a stroke patient and where do you draw the line between a patient's rights and your safety and what you're supposed to be doing for transferring them … when they're adamant about not having those gait belts around them or using [the mechanical lift] … Now you tell me, who had the right? Was it us who had the right or the patient who had the right?

Opinions on “ideal” nursing home—It became clear during discussions about the “ideal” nursing home that, as one participant stated, “it would be a place where residents come first.” A universal request was a smaller CNA-to-resident ratio, with participants agreeing that an ideal ratio would be 4–6 residents for every CNA, versus the actual participant-reported ratio of 10–12 residents. Their explicitly stated goal was to increase one-on-one time with residents, and thus to be able to provide care and support beyond physical maintenance.

Echoing the focus on rights and dignity, many participants stated that residents “should be able to live the way they would live at home,” specifically mentioning meals on demand and flexibility to participate or not in activities. Many felt that residents needed more choices and variety in activities offered, including more chances to travel outside of the center. Other participants mentioned that the center needed to be more visually appealing. One participant said, “[the ideal nursing home] would be beautiful. Nicely decorated. The rooms wouldn't be so institutionalized.” The same participant mentioned that some CNAs had already

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

redecorated a few of the bathrooms with resident input, which was cited as an empowering moment for the CNAs because it was done specifically for and with residents.

Organization of the Work Environment

Lack of respect from supervisors and administration—The investigators' questions on work environment issues led to a description in most focus groups of a general lack of respect for CNAs' experiential knowledge. In 13 (50%) of the focus groups it was mentioned that CNA input was neither requested nor welcomed by supervisors or administration. Three focus groups mentioned failed attempts at input, such as suggestion boxes, where aides offered recommendations that were never addressed. Two focus groups described committees that had been formed to deal with worker issues and had then become inactive. When asked if CNAs are invited to provide input, the majority of the participants said they are not, with one participant saying that employees simply have to “do as you're told,” because “we're nobodies.” There was even mention of informal penalties from supervisors and administration if CNAs did speak out, suggesting lack of confidentiality and potential intimidation. In a conversation about the general climate of the center, one participant said, “even if you say it to administration here, it gets out,” and another participant added, “[managers] give you the dirty look.”

Conversely, three focus groups (one at one center, and the other two at another) described situations where their input and concerns were requested and taken into consideration. This discrepancy reflected differences among individual unit supervisors, even within the same center. In contrast to the previous example where participants described being treated as “nobodies,” another worker in a different unit at the same center described how communication is handled in her wing: “Our floor now has meetings on how we feel … whether we can do better for our floor; how we feel dealing with residents … it's working out well.” In this example, support from the unit manager for these meetings improved job satisfaction, so much so that employees on this wing (where their input seemed to be valued) did not want to work with the manager in the other wing. One participant remembered, “I told the patient that I didn't feel comfortable ambulating him all the way over to [the other wing] because I hated to see the chaos that was over there. And that was a big stress for me having to just walk over there and see the chaos.”

Specific policies were also cited that contributed to the general feeling of being disrespected. In particular, many detailed the policy of sending an employee home if an argument or physical altercation occurred between employee and resident, regardless of the role of the employee in the argument. In one situation, a resident had repeatedly referred to an African American employee using a racial epithet, but the administration would not switch assignments because the facility had a “consistent assignment” policy, meaning that CNAs generally cared for the same residents every day. After enduring the abuse for some time, this employee eventually left the resident's room without finishing the work one day, and she was promptly suspended without being asked for an explanation.

The problem of being sent home after resident accusations, without discussion or explanation, was aggravated by a dock in pay: “There's no need for her to be suspended. And then she doesn't get paid for it until they find out it's not her fault, it's the resident's

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

fault. So, she loses three days' pay.” This disrespect for the employee's experience created a sense of distrust for the larger corporation as a cold, uncaring company: “You work for a big company and it's this way or the highway and that's the end of it and that's their focus.”

Participants directly related the consequences of feeling overworked and disrespected to being emotionally and physically exhausted. During a conversation about the climate of the center, one participant said that the CNAs only wanted to feel appreciated by the people they worked with, especially their supervisors:

> [We want to be] appreciated. Yeah. Like I feel like we do so much and to them it's like nothing, because they don't know what we do … Because they're doing a totally different job sitting down writing or sitting down, passing meds, but they don't know what we do for the residents. So, when they talk to us … I feel like a nobody. Like I feel like I'm not a CNA. They treat me like a CNA is nothing.

Since the interpersonal quality of care for the residents did not seem recognized, the job was devalued. With the practice of nurturing and being a caregiver so inextricably bound, the CNA in turn felt devalued as a person.

Lack of teamwork with nurse supervisors—Participants were concerned that nurse supervisors were hindering the practice of providing comprehensive medical care and consequently violating residents' rights. Nurses have the job of documenting medical needs and changes in health status with each resident on their wing; when this does not happen it interferes with both resident and employee safety. When nurses reserve the right to call doctors for help, but do not properly document resident medical issues or incidents, the CNAs believe “it's wrong, because it's a resident who suffers, and we suffer with the resident because we're back and forth and back and forth spending time over the same thing.” One employee noted an instance when there was no documentation of a resident suffering from shingles and wondered what would have occurred had she been pregnant.

Participants were very vocal about nurses ignoring lights and bells on the floor without stopping to see what was wrong. This not only added to the work of a CNA, but was seen as a violation of caregiver's role:

> When there's a light going on and they see you're busy or they're waiting for you to get their patient done so they can do something, and they're standing there waiting, they could help you. At the hospital [the charge nurses] would never do what they've done here.

In describing the RNs walking by the bells, one participant asked, “That's neglect, isn't it?” and an-other responded, “that is neglect.” This speaks to the frustration among participants about the perceived disconnect between nurses and residents. One participant highlighted:

> [There was] the inconsistency of the nurses being on. You'll have one nurse today, but she's not going to be back for the next three days. So when she'll come back and she'll say well, she slept well the other night. I said yes, but you weren't here the whole entire month that we hear her night after night … she is in so much pain.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Again, this issue was also illustrated in contrast by the single group where the nurse supervisors were described as providing technical and moral support, being engaged with residents, and working on the floor with the CNAs. One participant described the effect of open communication on the healthy work environment in this wing: “[The nurse] she's on the floor a lot, so she can see. You know, we tell her, look, this isn't working and it would work better this way and she'll say we'll try it first and then we'll see where it goes.”

Staffing and scheduling—Participants in all seven nursing homes reported staffing and scheduling issues. When other staff members “call out” (i.e., take a sick or personal day), the caregivers on duty feel rushed, have no time for breaks, and are physically exhausted by the end of the day. One CNA stated, “if there's no staffing, we're doing twice the work. And our residents aren't getting the type of care that they should.” Furthermore, many employees are required to find their own replacements when they call out, and the corporate policy of staying home when sick, to avoid resident exposure, is frequently ignored by management. One participant said that the response to calling out sick is, “Why don't you take a couple of Tylenols and call me in a half hour and see how you feel then.”

Some participants were aware of potential solutions to staffing issues through more flexible scheduling. One participant commented about other facilities: “They have totally gone away from the institutional scheduling … the people are self-scheduling and committed to those hours,” and “if you start giving back control I think you'll find a whole lot less issues as far as call-outs and light duty.”

In one discussion on staffing issues, a participant stated succinctly, “we're not giving quality care right now.” Many participants talked about how the lack of time to spend with residents had a negative effect on their performance and especially on their ability to nurture: “I get very upset with that [not being able to respond to residents' needs immediately]. Because it makes me feel like a bad person, like I'm doing a bad job.”

Staff shortages also reduced available time for breaks. One participant described her days as, “sometimes I don't take a break till 8:00 at night and I come in at 2:30, so I'm on my feet all that time.” Another participant made a direct link to short staffing and physical health outcomes for staff when she said, “Well, the calling out … that's a big concern. That puts a lot of stress on people's bodies.”

Residents' families—Working with residents' families was seen as stressful when family members challenged CNA knowledge or treated them as if they were uncaring. A participant described her frustration when family members questioned her care for a resident: “We spend a majority of the time with their family, so we know them better … you might have lived with them before, but they're here so we know them better.” One participant talked about bonding with her residents, and when the family members treated her “badly” she wished she could say: “We're here on the same side as you.”

Perceived discrepancy between respect for residents and disrespect of CNAs—Participants' feelings about how they were treated by those above them in the occupational hierarchy contrasted starkly with their portrayal of how they treated residents. CNAs

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

described their care as simply what is deserved by another human being. However, the same respect was not experienced by the workers from management. The discrepancy is glaring, although implicit: *Why am I, as a CNA, not treated with the same inherent respect and dignity that I treat the residents with? Furthermore, why should I provide comprehensive care, when I am not cared for?* While this disparity was never directly articulated by participants, it was obvious how frustrated and degraded they felt as caregivers. As described previously, they often cited specific policies and procedures that created this perceived contradiction, and they linked it to mental and physical burnout.

Discussion

We report here on 27 focus groups involving a very large number of CNAs in nursing homes discussing the influence of the work environment on their well-being and job satisfaction. The participants described themselves as “nurturers,” providing both physical and emotional care of other human beings. This dual aspect of nursing home work is significant because it addresses the comprehensive health of residents and recognizes the inherent rights and dignity of each individual. This was nowhere more obvious than in participants' discussions on what an ideal nursing home work environment would look like: They cited more time, choice of activities, and autonomy for the residents.

However, the study findings show that CNAs experienced their work environment as interfering with their ability to provide comprehensive care. Short staffing, poor communication, and a generally disrespectful climate all contributed to CNAs feeling rushed, unappreciated, and unable to provide the quality of care that the residents deserve. These consequences caused self-described distress and feelings of failure among the CNAs, who reported experiencing guilt and feeling ineffective. Other studies have found that facilities with lower CNA staffing provide poorer quality of care, which underscores the need for staffing standards (Hyer et al. 2011). It is unfortunate not to have uniform national ratio staffing standards in nursing homes and other long-term care (Zhao and Haley 2011; Park and Stearns 2008; Alexander 2008).

Moreover, there was a glaring discrepancy between how direct care workers felt that they were treated, and how they believed that they treated the residents in their care. The importance of respect arose repeatedly in the focus groups: respect for residents' rights and wishes, CNAs wanting appreciation and acknowledgement from supervisors, and families and administration disrespecting CNA knowledge.

This lack of respect for CNA knowledge has been demonstrated elsewhere in terms of worker pay. Squillace et al. (2009) reported that years of CNA experience do not render higher wages, showing a disregard for the years of practical knowledge and firsthand experience. In our study, many CNAs described frustration with lack of respect for their input, despite spending more direct time with residents than other staff. In their eyes, center administrators believed that CNAs did not contribute anything beyond physical care of residents. This is in stark contrast to what CNAs wish to do and their self-perceptions. CNAs described vividly the ways that they nurtured their residents, going beyond their job description, but not beyond what they saw as their appropriate role.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Study Limitations and Strengths

Generalizability of these findings may be limited because all nursing homes were a part of a single corporation. The study was conducted in the New England area, perhaps making it difficult to generalize to other areas of the country. The participating CNAs were not represented by a union in any of the selected centers, which also could have affected their work experiences. On the other hand, a large number of focus groups were conducted, including CNAs on all three shifts. The focus group transcripts were reviewed in a rigorous manner and there was high concordance among multiple analysts.

Implications for Practice

The needs that these focus groups detailed could be restated as suggesting specific improvements. Staffing difficulties could be reduced with more flexible self-scheduling by employees. This might both increase the quality of care of residents and decrease absenteeism and turnover.

Findings from other studies have shown success in training supervisors on worker mental health promotion, on issues such as listening to employees and providing support for workers returning to work after time away for mental health (Kawakami et al. 2005). Also, job training around stress management and strategies for dealing with the death of patients for incoming CNAs have been recommended (Meyer, Raffle, and Ware 2012). Fostering positive lines of communication between CNAs and their nurse supervisors can help CNAs cope with stressful situations and learn from a more experienced mentor (Bégat, Ellefsen, and Severinsson 2005). Furthermore, participants reported more satisfaction and less frustration with their jobs when they perceived their unit managers or administrators as being open and seeking their input, which echoes results from other studies indicating the positive relationship of supportive supervision and job satisfaction among CNAs in nursing homes (Choi and Johantgen 2012). Improving work relationships, specifically training in respectful communication and teamwork, has been cited as important in direct-care settings (Kemper et al. 2008).

These improvements would not only benefit CNAs' well-being, but also the needs of the employer. A study of nurses showed that participants who perceived a higher quality of patient care within their facility reported a stronger intention to stay in the current job (Ma et al. 2009). These qualitative findings suggested specific organizational policies and procedures that might cause or exacerbate mental and physical burnout and turnover. Future researchers should examine ways to increase positive, collaborative communication between CNAs and supervisors, as a means to promote worker health.

Acknowledgments

The Center for the Promotion of Health in the New England Workplace is supported by grant number 1 U19 OH008857 from the National Institute for Occupational Safety and Health (Centers for Disease Control). This work is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute for Occupational Safety and Health. The authors acknowledge Donna LaBombard for her help as liaison with the centers; Yuan Zhang, Lara Blais, and Shpend Qamili for initial analysis of transcripts; and Suzanne Nobrega for liaising with centers and assistance during particular interviews.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

References

Alexander GL. An analysis of nursing home quality measures and staffing. Quality Management in Health Care. 2008; 17:242–51. [PubMed: 18641507]

Bégat I, Ellefsen B, Severinsson E. Nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of well-being—a Norwegian study. Journal of Nursing Management. 2005; 13:221–30. [PubMed: 15819834]

Choi J, Johantgen M. The importance of supervision in retention of CNAs. Research in Nursing & Health. 2012; 35:187–99. [PubMed: 22262015]

Chou RJ. Resident-centered job satisfaction and turnover intent among direct care workers in assisted living: A mixed-methods study. Research on Aging. 2012; 34:337–64.

Donoghue C. Nursing home staff turnover and retention: An analysis of national level data. Journal of Applied Gerontology. 2010; 29(1):89–106.

Drebing C, McCarty EF, Lombardo NB. Professional caregivers for patients with dementia: Predictors of job and career commitment. American Journal of Alzheimers Disease and Other Dementias. 2002; 17:357–66.

Hyer K, Thomas K, Branch L, Harman J, Johnson C, Weech-Maldonado. The influence of nurse staffing levels on quality of care in nursing homes. The Gerontologist. 2011; 51:610–16. [PubMed: 21602292]

Kawakami N, Kobayashi Y, Takao S, Tsutsumi A. Effects of web-based supervisor training on supervisor support and psychological distress among workers: A randomized controlled trial. Preventive Medicine. 2005; 41:471–8. [PubMed: 15917043]

Kemper P, Heier B, Barry T, Brannon D, Angelelli J, Vasey J, Anderson-Knott M. What do direct care workers say would improve their jobs? Differences across settings. The Gerontologist. 2008; 48(1): 17–25. [PubMed: 18694983]

Ma JC, Lee PH, Yang YC, Chang WY. Predicting factors related to nurses' intention to leave, job satisfaction, and perception of quality of care in acute care hospitals. Nursing Economics. 2009; 27:178–202. [PubMed: 19558078]

Maslach C, Schaufeli WB, Leiter MP. Job burnout. Annual Review of Psychology. 2001; 52(1):397–422.

McCarty EF, Drebing C. Exploring professional caregivers' perceptions: Balancing self-care with care for patients with Alzheimer's disease. Journal of Gerontological Nursing. 2003; 29(9):42–8.

Meyer D, Raffle H, Ware LJ. The first year: Employment patterns and job perceptions of nursing assistants in a rural setting. Journal of Nursing Management. 2012; doi: 10.1111/j.1365-2834.2012.01441.x

Park J, Stearns. Effects of state minimum staffing standards on nursing home staffing and quality of care. Health Services Research. 2008; 44(1):56–78. [PubMed: 18823448]

Parsons SK, Simmons WP, Penn K, Furlough M. Determinants of satisfaction and turnover among nursing assistants. The results of a statewide survey. Journal of Gerontological Nursing. 2003; 29(3):51–8. [PubMed: 12683308]

Rafnsdottir GL, Gunnarsdottir HK, Tomasson K. Work organization, well-being and health in geriatric care. Work. 2004; 22(1):49–55. [PubMed: 14757906]

Severinsson E, Hummelvoll JK. Factors influencing job satisfaction and ethical dilemmas in acute psychiatric care. Nursing & Health Sciences. 2001; 3:81–90. [PubMed: 11882182]

Squillace MR, Remsburg RE, Harris-Kojetin LD, Bercovitz A, Rosenoff E, Han B. The national nursing assistant survey: Improving the evidence base for policy initiatives to strengthen the certified nursing assistant workforce. The Gerontologist. 2009; 49:185–97. [PubMed: 19363014]

Utriainen K, Kyngäs H, Nikkilä J. Well-being at work among ageing hospital nurses in northern Finland: A grounded theory study. International Journal of Circumpolar Health. 2009; 68:145–57. [PubMed: 19517874]

Zhao M, Haley D. Nursing home quality, staffing, and malpractice paid-losses. Journal of Health Care Finance. 2011; 38:1–10.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 1

Certified Nursing Assistants to Residents Ratio, by State

State	Day shift	Evening shift	Night shift
Arkansas	1:6	1:9	1 : 14
District of Columbia	1:6	1 : 10	1 : 15
Delaware	1:7	1 : 10	1 : 15
Maine	1:5	1 : 10	1 : 15
Michigan	1:8	1 : 12	1 : 15
Oklahoma	1:6	1:8	1 : 15
Oregon	1 : 10	1 : 15	1 : 20
South Carolina	1:9	1 : 13	1 : 22

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 2

Summary of Issues

	Description	Example from transcripts
Individual-level themes		
Caregiver as identity	View themselves as “caregivers” inherently (i.e., an intrinsic part of their personality).	“I'm a caregiver, it's who I am.”
Caregiver as practice	Believe holistic care is part of job (i.e., they want to treat the physical and emotional needs of residents).	“It's a matter of spending quality time with your patients.”
Residents' rights and dignity	Frequent concern about residents being treated with respect.	“It's their right to want to stay in bed in their pajamas, for whatever the reason.”
Description of “ideal” nursing home	Responses included that the nursing home would be well decorated, increased autonomy for residents, broader range of activities for residents, etc.	“It would be a place where residents come first.”
Experience stress when they cannot provide holistic care	Frustration and stress are experienced when they feel as if they cannot provide what they consider to be quality care to residents.	“I get very upset with that [not being able to respond to residents' needs immediately]. Because it makes me feel like a bad person, like I'm doing a bad job.”
Organizational-level themes		
General climate	Interactions with administration, supervisors, and coworkers.	“You work for a big company and it's this way or the highway.”
Supervising nurses	Some supervisors are seen as unsupportive and unhelpful.	“When there's a light going on and they see you're busy…and they're standing there waiting, they could help you.”
Staffing and scheduling	Constant short staffing and inflexible scheduling add to physical stress and concerns about the level of care being provided.	“If there's no staffing, we're doing twice the work. And our residents aren't getting the type of care that they should, that they need.”
Working with families	Patients' families may question caregiver's knowledge or commitment to helping their loved ones.	“We're here on the same side as you.”
Perceived lack of respect	A perceived lack of respect for their expertise from supervisors and/or families can contribute to stress and frustrations.	“They treat me like a CNA is nothing.”
Treatment of residents versus CNAs	Perceived discrepancy between CNAs' respect for residents versus disrespect of CNA knowledge/expertise by the organization and/or families.	“[Residents] should be able to live the way they would live at home.” “I feel like we do so much and to [supervisors] it's like nothing.”

Note. CNA = certified nursing assistant.