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AN EXPLORATORY STUDY OF NURSE AIDES’ COMMUNICATION BEHAVIORS: GIVING “POSITIVE REGARD” AS A STRATEGY

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Aim. The aim of this study was to identify the communication behaviors and strategies used by socially skilled geriatric nurse aides working with residents in long term care facilities.

Background. Communication skills are recognized as tools for establishing relationships and accomplishing care related tasks. A small but growing research literature exists within gerontology around geriatric nurse aide/resident communication. The present study was intended to contribute to this literature.

Design. This study used an exploratory qualitative design involving personal interviews with geriatric nurse aides.

Methods. Interviewers carried out 90-minute interviews with 16 nurse aides who worked at an assisted living facility or a nursing home. Of interest was the extent to which established systems for coding interactions could be used to code nurse aide/resident interactions, or whether new categories would emerge.

Results. The novel finding that all of the aides used a communication strategy that could be characterized as “giving positive regard”, defined as acknowledging the resident, treating the resident with respect.

Relevance to clinical practice. The category of “giving positive regard” included specific behaviors which can be included as content in communication skill training programs.

Keywords: person-centered communication, person-centered caregiving, geriatric nurse aides, long-term care, positive regard and qualitative research.

Introduction

Communication skills and strategies of geriatric nurse aides are important for the well-being and survival of residents of long term care (LTC) facilities, and for nurse aides’ job satisfaction (Kiely, Simon, Jones & Morris, 2000; Parson, Simons, Penn & Furlough, 2003). In the U.S. nurse aides provide 80% of direct care to residents in LTC facilities, and are expected to provide individualized care for all residents (Waxman, Carner & Berkenstock, 1984). Aides’ work with residents can be physically and emotionally wearing, sometimes leading to interactions between aides and residents which are
impersonal, and, occasionally, abusive (Foner, 1994). Good communication skills can be helpful in resolving problems in caregiving situations, as well as in enabling aides to create high quality caregiving relationships which are important sources of life satisfaction for residents (Bowers Fibich & Jacobson, 2001; Sikorska-Simmons, 2001).

Communication skills are widely recognized, within nursing and medicine, as necessary tools for establishing relationships, and there are large literatures on nurse/patient and doctor/patient communication. Current research on doctors’ and nurses’ communication with patients is focused on defining and promoting “patient-centered communication” and caregiving. While variously defined, two core themes are: a) helping patients feel understood through inquiry into patients’ needs, perspectives and expectations, and b) expanding patients’ involvement in understanding their illness and in the decisions that affect their health (Brown, 1999; Epstein, et al, 2005). There is also a small but growing literature on nurse aide/resident communication within LTC facilities which has a similar focus (Carpac-Claiver & Levy-Storms, 2007; Levy-Storms, 2008).

The goal of the present exploratory qualitative study was to identify communication behaviors and strategies used by nurse aides who were skilled at establishing relationships with residents. Of interest was whether new categories would emerge in the present study or whether already developed coding categories would be sufficient to describe the communication behaviors and strategies CNAs said they used. This promised to contribute to the research literature on nurse aides and to identify useful content for teaching communication skills to nurse aide students and staff. The literatures on communications skills served as a starting point. There was an interest in identifying the person-centered aspects of nurse aide/resident interactions. Nurse aide training curricula in the U.S. have been criticized as lacking good materials for teaching communication skills (Abt, 2001).

Literature review

The authors began by reviewing the literatures on interaction between doctors and nurses and their patients, and between nurse aides and residents of LTC facilities. Coding categories from these
literatures provided a starting point for the present study which involved nurse aides’ descriptions of their interactions with residents.

Medicine and nursing

Within medicine the “Roter Interaction Analysis System” (RIAS, Roter, 2002) and closely related systems for coding doctor/patient interaction are being used to teach patient-centered communication skills. The RIAS includes three sections: 1) Socioemotional Exchange, which includes categories such as “Shows Approval”, “Gives Compliments”, “Social Conversation”, “Encourages or Shows Optimism”, and “Self-Disclosure”, 2) Task-Focused Exchange, such as “Asks Permission”, “Gives Orientation”, and “Asks Opinion”, and 3) Global Affect Ratings which rate the emotional context of the dialogue. Intervention-wise Roter reported success in providing medical students with feedback using portions of their coded videotaped interactions with “standardized patients” – i.e. actors trained to play a patient role (Roter et al., 2004). Medical students’ use of open-ended questions and expressions of support for patients increased as a result of such feedback. All of the coding categories from the RIAS were of interest in the present study.

Caris-Verhallen expanded the RIAS by developing a set of categories for coding the non-verbal aspects of interaction between nurses and nursing home residents (Caris-Verhallen, Kerkestra & Bensing, 1999). Behaviors of interest included eye gaze, affirmative head nodding, smiling, forward leaning, affective touch, and instrumental touch. Caris-Verhallen and colleagues found that all of these non-verbal behaviors, with the exception of instrumental touch, were important in establishing a good relationship with the patient. These categories were also of interest in the present study.

Geriatric nurse aide/resident interaction

In an observational study of nurse aide/resident interactions Carpaic-Claver (Carpiac-Claver & Levy-Storms, 2007) distinguished four categories of affective communication: a) “personal conversation”, which included pleasantries and conversation about the resident’s personal life; b) “addressing the resident”, which included using the resident’s name or a term of endearment; c) “checking in”, which involved asking the resident about their comfort or their eating preferences; and d)
“providing emotional support and praise”, which involved complimenting or encouraging the resident. All of these categories were of interest in the present study.

The current literature on nurse aide/resident interaction also includes intervention studies intended to enhance caregiving quality, especially with residents diagnosed with dementia (Levy-Storms, 2008). The goal of these interventions has been to increase “therapeutic communication” between nurse aides working with residents who had cognitive impairments. Therapeutic communication is communication which is intended to help “… overcoming stress, anxiety, fear or other emotional experiences that cause distress” (Levy-Storms, 2008, pg. 9). Several of these studies resulted in an increased amount of personalized social conversation between residents and nurse aides. For example, Burgio (Burgio et al., 2000) demonstrated that it was possible to increase the amount of social conversation and positive statements made by nurse aides using an intervention that involved the development of autobiographical photobook albums. In an intervention designed to improve the quality of nurse aide/resident relationships McGilton (2003) demonstrated that nurse aides’ references to residents’ personal history could be increased. Williams reported on the importance of a category of communication between aides and residents labeled “person-social” (Williams, 2006; Williams, Ilten & Bower, 2005). A distinction within the “person-social” category was “superficial talk” versus “individualized person-social”; the latter category involved acknowledging and addressing the communication partner as a unique individual. Williams was able to reduce elderspeak – a form of communication that involves baby talk, diminutives and collective pronouns – among nurse aides, and this reduction was associated with an increase in individualized person-social communication. Additionally, Sloane (Sloane et al., 2004) demonstrated that when aides gave residents choices around bathing and solicited their active cooperation and feedback, resistiveness to care decreased significantly. Other studies included Van Weert’s in-service training which resulted in more affective touch and utterances (Van Weert et al., 2005). Categories from all of these studies were of interest as well.

Person-centered caregiving by nurse aides
Many of the above empirical studies of resident/nurse aide interactions are related to if not inspired by the idea of person-centered caregiving which has been articulated with reference to caring for older persons. McCormack (2004) articulated four concepts which are essential to person-centered caregiving: a) being in relation, which refers to the importance of promoting the resident’s relationships, especially with caregivers; b) being in a social world, which refers to the importance of recognizing and affirming the resident’s “goals in life” which are often embodied in her/his life history; c) being in place, which refers to the context of caregiving, including organizational aspects; and c) being with self, which refers to the importance of recognizing the resident’s values. Aspects of person-centered caregiving most relevant to the present study were communications which referred to the resident’s personal life, goals, history, and values. Such “person-centered” communication would be intended to promote personal relationships and can be distinguished, at least in principle, from “therapeutic communication”. Communication which is intended to promote social engagement and connection is a broader category than therapeutic communication because such communication transcends specific caregiving tasks.

Additionally, there is a small but growing literature on the importance of close relationships between aides and residents in long-term care. Aides use the term “family” as a metaphor to describe their relationships with residents (Berdes & Eckert, 2007; Sumaya-Smith, 1995). McGilton and Boscart (2007) reported that many care providers saw themselves as being in close relationships with residents and perceived the closeness of these relationships by the degree of reciprocity they experienced with their residents and by their emotional connection with them. Regarding residents, Bowers reported that some residents defined quality of care in terms of relationships with aides which were characterized by friendship and reciprocity (Bowers, Fibich & Jacobson, 2001). McGilton and Boscart reported that residents experienced close relationships with care providers based on the providers’ caring attitudes and behaviors.

In summary, the authors reviewed several literatures as background for the present study: the literatures on doctor/patient and nurse/patient relationships, the literature on nurse aide/resident interactions, including interventions in caring for older persons, and the literature on person-centered
caregiving within gerontology. These literatures provided the starting point for coding the data collected in the present study regarding nurse aides' descriptions of their interactions with residents. Of interest was whether new categories would emerge or whether previously developed categories would be sufficient to code the data from the present study.

Methods

Research design

An exploratory qualitative study design was used to identify communication behaviors and strategies used by socially skilled nurse aides. Sixteen 90-minute, semi-structured personal interviews were carried out with geriatric nurse aides. A purposive sample was selected whereby an administrator from each participating LTC facility identified one or two socially skilled aides within their facility who then participated in a face-to-face interview. Administrators were asked to select aides who were skilled at establishing rapport with residents, families and staff. The rationale for selecting “socially skilled” aides was that such aides likely had good communication skills in relating to residents and constituted credible sources of experiential expertise that might be taught to less skilled aides.

Participating long term care facilities and nurse aides

Nine LTC facilities were selected so as to represent a diversity of care giving arrangements: five were proprietary and four were non-profit. The proprietary facilities were privately owned with profits distributed to shareholders. These for-profits were diverse in size and managerial practice and each was part of a larger chain. One proprietary facility operated on the Green House Model (Weiner & Ronch, 2003) and was a residential home which had been converted to a group home. This facility provided care for six residents diagnosed with Alzheimer’s Disease. The non-profit facilities existed to provide programs and services which might not otherwise be offered by local, state or federal entities, and profits were invested back into the business. Non-profit facilities also varied in size and managerial practice. Several non-profits were associated with religious organizations – i.e. Catholic, Mennonite and Methodist – and all were members of a larger chain. Two of the proprietary facilities had both Assisted Living (AL) and nursing home (NH) components, as did two of the non-profits. The AL components of both the
proprietary and non-profit facilities ranged in size from 35 to 89 licensed beds ($M = 51$), and the NH components, with the exception of the Green House model, ranged from 42 to 90 licensed beds ($M = 79$).

To increase diversity, aides from both ALFs and NHs were included in the study. Sixteen geriatric nurse aides participated in 90-minute personal interviews.² Twelve of the aides worked in AL facilities and four worked in NHs. These nurse aides were identified and recruited separately at each of the nine participating facilities by one administrator at each facility. The criterion for inclusion in the study was the administrator’s judgment that the nurse aide was skilled in establishing rapport with residents, family, and staff. All of these nurse aides were “Certified”. In the U.S. nurse aide caregivers in LTC facilities are required to be Certified through a training process that involves at least 75 hours and which is completed by passage of a state certification exam. The training includes basic content on illness associated with aging and care in LTC settings, as well as a supervised clinical component which involves care of nursing home residents. This training has been required since the passage of the Omnibus Reconciliation Act in 1987 (OBRA).

Fifteen of the CNAs were female and one was male. The CNAs ranged from 22 to 63 years-of-age ($M = 42.2$, $SD = 12.23$). The average number of residents CNAs worked with in a typical week was 32. CNAs typically worked eight hour shifts during one of the three blocks of time: first shift 7 a.m. to 3 p.m., second shift from 3 p.m. to 11 p.m., or third shift 11:00 p.m. to 7 a.m. More than two-thirds (69%) worked first shift, 19% worked second shift, and 13% worked the third shift. The minimum number of years participants worked at the facility was one, the maximum was 20 ($M = 7$, $SD = 6.71$). Participant’s level of education varied, three participants had less than a high school education, nine were high school graduates, and four had more than a high school education.

*Ethical considerations and procedures*

The study was first given to the University’s Institutional Review Board committee for review and was approved. The next step involved an administrator at each facility selecting CNAs at their facility who “had good skills in developing rapport with residents, family members and staff”. Selected nurse aides were then given a letter describing the study and were asked for contact information for the
purpose of scheduling an interview. All of the selected participants agreed to be interviewed. Finally, 90-minute audio recorded personal interviews took place with each participating geriatric nurse aide. The lead author trained two psychology doctoral students in regards to interviewing techniques. These two doctoral students conducted the 16 interviews under the first author’s supervision. All interviews were confidential and participants were given the option of editing portions they did not want included. None of the participants edited their interviews.

Data collection

This exploratory qualitative study focused on CNAs’ answers to a series of questions about the communication strategies they used in caring for residents. The sequence of questions was based on the idea that there is a generic caregiving script which involves a series of activities including requesting entry into a resident’s room, assessing the resident’s status, orienting the resident to the caregiving task, engaging the resident in the task, completing the task, thanking the resident and then exiting the room. The first of these questions was: “When you first walk into a room and initially approach a resident, are there certain things you say?” The next question was: “What kinds of things do you look for?” The third question was, “If the resident is not responsive, what kinds of things might you say or do to engage the resident?” The answer could involve both verbal and non-verbal strategies. The fourth question was, “How can you tell if a resident is having a bad day?” The fifth question was, “If a resident is having a bad day, describe how, if at all, this affects how you relate to them.” The goal of the sixth question was to have the nurse aide imagine working on a task with a resident and the different strategies they might implement. “If you start a task with a resident such as getting dressed and they resist, describe some of the ways in which you might respond. What might you do?” The seventh question was, “Describe the different strategies that you try to use. For example, if repeating what you want them to do doesn’t work then do you try something else?” The eighth question was, “When you are pleased with a resident, tell me about how you might let residents know your feelings?” The ninth question was, “To what extent do you communicate the same way or in different ways for different residents? For example, do you find that some residents like to be touched more than others? Do some respond better than others to praise?”
This question was intended to determine if the nurse aide individualized their care for each resident or if they had a set routine, they carried out for every resident.

These questions about communication strategies were part of a longer interview concerning nurse aide/resident relationships. One question about relationships was of interest here: “Are there some residents who you feel especially close to” (as well as “not especially close to”).

Data analysis and ensuring rigour

Methodologically, this study involved the use of structured content analysis to determine the extent to which previously developed coding categories could be used to code nurse aide/resident interactions or whether new categories would emerge. “Directed content analysis” seemed to be the most appropriate here. Hsieh and Shannon (2005) use this term to describe content analytic techniques where the goal is to validate and extend an already existing set of categories derived from previous research.

The process involved transcribing the interviews, reading them and coding them and, in the process, judging whether the behaviors and strategies described could be captured by prior work: Roter’s categories of socio-emotional and task-focused exchange; Caris-Verhallen categories of non-verbal communication – e.g. affectionate touch (Caris-Verhallen, Kerkestra & Bensing, 1999); Bergio’s categories of social interaction – e.g. positive statements (Bergio, et al. 2000); Carpiac-Claver’s categories of affective communication – e.g. “checking in” assessing resident’s condition and giving choices (Carpiac-Claver & Levy-Storms, 2007; and person-centered communication which involved eliciting residents’ expectations and being responsive to them.

Hsieh and Shannon (2005) suggest creating an audit trail to overcome any bias that might lead researchers to confirm the existing set of categories, rather than discovering new ones. The following audit process was used to establish the trustworthiness of the findings. The first step was to establish a set of coding categories. Both authors and an undergraduate student in psychology used the above categories to code the first two interviews. All three coders found many of the previously developed categories applicable: e.g. “shows approval”, “gives compliments, and “gives choices”. At the same time, all three coders concluded that coding the interviews only by counting these specific behaviors would be too
narrow and would miss the more general strategies and intentions of the nurse aides. Both authors and
the undergraduate coded three additional interviews and, in the process found that several general
strategies and intentions emerged. Most striking was that CNAs were describing behaviors that seemed
to reflect ideas described by Carl Rogers (1961) regarding client-centered counseling. Rogers
emphasized the need to create a secure environment that promoted positive interaction between counselor
and client by communicating “acceptance” and “unconditional positive regard”. The strategy of “giving
positive regard” seemed to capture the spirit and intent of many of the CNAs’ descriptions of their
interactions with residents. Relevant sub-categories included “giving compliments”, “showing approval”,
“spending time with the resident” and “learning resident’s likes and dislikes”. Ultimately, seven macro
categories emerged from the coding process: Giving Positive Regard, Assessing Resident’s Condition,
Coordinating Care, Being Happy/Positive, Giving Choices, Insisting on Control and Self-Disclosing (See
Table 1). The more specific coding categories derived from the literature were used as sub-categories
which were grouped under one of the seven macro categories.

The second stage of the coding process involved unitizing the transcripts. Once these categories
and sub-categories were developed, criteria for unitizing the interviews were created by the second
author. Units included portions of the transcript that fell logically into a single category. Units ranged
from three or four words, to three to four sentences. A new unit was created each time the coding
category changed, or when a second episode of a code-able behavior emerged. A total of 472 units were
coded summing across all 16 interviews.

After all 16 interviews had been unitized the second author and the undergraduate student used
the seven macro categories to code the first five interviews. An initial rate of inter-coder reliability of .80
was achieved. In order to see if this rate of inter-coder reliability could be maintained the second author
and the undergraduate coded all of the units in interviews six through eleven. The two coders succeeded
in maintaining a .8 level of reliability. Given that a high rate of inter-coder reliability had been
established, the authors decided that the second author would code the remaining four interviews
(numbers 12 through 16) and that it would only be necessary for the undergraduate to code half of the
units in each of the last four interviews in order to test reliability. The undergraduate alternated between
coding the first half and the second half of each of the last four interviews. Cohen’s kappa, for
interviews six through 16, based only on coders’ judgments about the macro categories, was kappa = .83
(Cohen, 1960). All disagreements were resolved consensually.

Results

The coding categories and their definitions are presented below in Table 1.

Insert Table 1 About Here

Giving positive regard

“Giving positive regard” was used by all of the nurse aides and was the most frequently coded
macro category in the transcripts of 15 of the 16 aides. By definition this category entailed being
respectful of the resident, acknowledging the resident, showing interest in the resident and showing
approval and/or liking of the resident. This macro category included five verbal sub-categories and three
non-verbal sub-categories. The verbal sub-categories were: greetings, giving compliments, being
friendly, acceptance of feelings and distracting with conversation. The first three were categories used by
Roter (2002). The non-verbal categories were: giving affectionate touch/smile (Caris-Verhallen,
Kerkestra & Bensing, 1999), taking time and doing favors. An example of “Giving Positive Regard” is:

‘If you find out a little bit about their background, I’ve had residents say things
that most people wouldn’t pick up on or didn’t understand, but it’s relating to
something in their past or relating to something that’s very important to them,
and they know what they’re talking about, but if you don’t know something
about them how are you going to know what they are talking about.’

Assessing resident’s condition

This category was also used by all of the aides and involved gathering information about a
resident’s medical, psychological, and emotional condition. The verbal subcategory, “Assessing
condition”, was developed based on work by Roter (1989), and Carpiac-Claver and Levy-Storms (2007)
and involved asking questions about the resident’s condition. Caris-Verhallen described non-verbal communication behaviors and strategies used in nurse-patient interactions (Caris-Verhallen, Kerkestra & Bensing, 1999). Based on this work, one verbal sub-category and four non-verbal subcategories (“assessing comfort/condition”, “assessing medical”, “assessing emotion/voice tone”, “and assessing behavior”) were created. One additional subcategory of “Assessing Resident’s Condition” was included as “other”. This category involved the use of both verbal and non-verbal strategies. An example of “Assessing Condition” is:

‘If it’s someone coming in a wheel chair, for instance, I always check to see that um... they’re sitting up like comfortable in the chair.’

Coordinating care

This category was used by all of the aides and involved statements the nurse aide made that did not involve a specific interaction with the resident. “Coordinating care” has not been present in previous literature and may be most closely related to an organizational aspect of “being in place” (McCormack, 2004). An example of “Coordinating Care” is:

‘Um... I respond as if um... okay, definitely there’s something wrong, the reason why they’re resisting, I would probably go ask the nurse, my charge person, if there was anything I missed in my report about that resident that maybe I missed and then if that wasn’t the case then tell my charge nurse to come in and maybe there’s something wrong and why she’s resisting and she’s agitated.’

Being happy/positive

This category was used by 81% of the aides (13 of 16). Nurse aides consistently described instances of communication with residents that involved creating a positive or upbeat environment for the residents as well as staff. This category was a combination of behaviors and strategies used in creating a positive environment. An example of “Being Happy/Positive” is:

‘...it’s good to meet you, I’m glad to see you today, hey we’re gone a have chicken, I ain’t had chicken in a week, let’s go eat chicken! You just got a, you gotta make it happy, they’re listening, regardless of what you think, they’re listening, you know, and eventually they’ll feel safe enough to come out, but you just got a make it happy otherwise it’s not going to get that way.’

Giving choices
This category was used by 75% of the aides (12 of 16) who indicated that giving residents choices was important to providing care to residents and working with residents. An example of “Giving Choices” is:

‘...say maybe I, you know, got a shirt out, then I would if it was a guy or lady’s blouse maybe ‘do you not like this, is this not one you want to wear, maybe we could go find something else to put on you, do you want to wear a pullover shirt today, or button up the front, to a woman, would you rather have a dress on today or is this blouse okay?’ Cause, there again you have to say ‘I’d like to help you get dressed, is this okay?’

Insisting on control

This category was used by 31% of the aides (5 of 16) and involved the nurse aide being firm with a resident in order to complete a task. This category also included instances where the nurse aide made choices for the resident in order to complete tasks. “Insisting on control” was a new category that was not discussed in previous literature. The following example shows that even among skilled CNAs task-centered, coercive strategies of care giving are sometimes used, especially around bathing:

‘Always take somebody with you cuz those, some that get combative. You always take an extra person with you. Two people is usually better than one cuz then one will go on one side and one will grab his other arm and we’ll say ‘Let’s to, let’s go go to the bathroom’ and sorta talk him into it and it helps if you have two people.’

Self-disclosing

This category was used by 19% of the aides (3 of 16) who discussed telling residents about themselves. These instances involved information about their family, hobbies, or likes and dislikes. Roter described this category as involving “statements that describe the physician’s personal experiences in areas that have medical and/or emotional relevance for the patient”. This category was described by CNAs in the interviews as a strategy for relating with the resident.

Relationships with residents

All 16 CNAs said they developed close personal relationships with some of the residents with whom they worked. All but one of the aides – the one who had most recently completed training – reported that in their CNA training they had been discouraged from developing personal relationships
with residents. Aides said they did not follow this advice because they felt they would not have been able to do their jobs without establishing relationships with residents.

Discussion

The most striking findings of this exploratory study were that all of the skilled CNAs frequently engaged in a communication strategy labeled as “giving positive regard”, and that they perceived themselves to be in relationships with many of the residents with whom they worked that went beyond task-oriented interactions. These findings and their implications are elaborated below.

Emergent categories and established categories

The most frequently coded category involved “giving positive regard”, a macro category that emerged from our attempts to code CNAs’ interactions using more specific, behaviorally-based categories from the literature. The label “giving positive regard” seemed to express a strategy that was implicit in behaviors like: “giving compliments”, “being friendly”, “accepting feelings”, and “giving affectionate touch/smiles”, all categories identified in previous studies of nurse aide/resident interaction.

There were several striking things about the emergence of the idea of “giving positive regard” for the authors. First, this term from Roger’s client-centered counseling seemed to capture the essence of a strategy CNAs’ used to create a safe atmosphere for the residents. This resonates well with the concept of “person-centered care giving” that is being promoted by the culture change movement (Weiner & Ronch, 2003) and helps define it. The communication strategies and behaviors of “learning likes and dislikes of the resident”, “showing acceptance of feelings”, and “taking time” for the resident are concrete illustrations of how CNAs can individualize care and respect the dignity of residents. This level of specificity could be useful in developing materials to teach person-centered care giving skills.

Additionally, it was striking that CNAs developed this strategy in spite of their training, and perhaps as a consequence of their natural talent at helping and being empathic. From a research perspective it would be worthwhile to identify indicators of caregiving and helping talent: i.e. determining whether it is possible to identify CNAs who are especially empathic and likely to give “positive regard” because they
have an intuitive sense that it will be effective. Several efforts are already underway to identify a measure of caregiving talent among geriatric caregivers (Medvene, Grosch & Swink, 2006).

Relationships with residents

The findings here are consistent with earlier research that nurse aides frequently establish personal relationships with residents (Bowers, Fibich & Jacobson, 2001; Monahan & McCarthy, 1992; Sumaya-Smith, 1995). These relationships differ from therapeutic relationships and communications insofar as they go beyond specific caregiving tasks or deficits (e.g. reducing anxiety) and appear more directly related to meeting needs for human connection. Past research has established that aides report having emotionally close relationships with some residents (McGilton & Boscalt, 2007) and sometimes use family metaphors to describe these relationships (Berdes & Eckert, 2007). Such relationships likely exemplify “being in relationship” as articulated by McCormack (2004). Important topics for future research include the conditions under which CNAs develop personal relationships with residents — i.e. the characteristics of LTC facilities which encourage versus discourage relationships —, and the nature of the relationships themselves — e.g. how these relationships are created and maintained in terms of social behaviors and how aides think about them. It will also be important to learn more about the ways in which such relationships facilitate, as well as complicate, the work of nurse aides. Close personal relationships between aides and residents can enhance cooperative and positive experiences. But, experiences of grief and loss can be powerful when close relationships end: either as a result of a resident’s death or an aide leaving. More needs to be learned about the positive and the negative aspects of aides forming personal relationships with residents.

Limitations

The findings in this study must be regarded as preliminary and in need of replication. The findings were based on interviews of CNAs describing their interactions with residents, not on actual observations and coding of interactions. Two of the sub-categories used to code nurse aide/resident interactions may have had less to do with communication strategies and more to do with caregiving behaviors — e.g. “taking time” and “doing favors”. However, when these two coding categories were
excluded from analysis, there were no changes in the percentages of aides who used the behaviors referenced by the seven macro categories used to code the transcripts.

It must also be noted that this study was based on a small and non-representative sample and was picked by administrators rather than residents. It is possible that CNAs were on their best behavior and presented themselves in an idealized way. However, if this was the case it didn’t prevent CNAs from describing themselves as “insisting on control” – a relatively unflattering technique, which 31% reported using. Nonetheless, future studies should include observations of interactions between residents and CNAs, and resident satisfaction data should be used as a criterion for identifying highly skilled CNAs.

Conclusions and implications for practice

Aides’ descriptions of their interactions with residents reflected the spirit of Rogerian techniques for helping relationships – e.g. giving positive regard. These findings indicate the relevance of well-established communication techniques and suggest the importance of teaching general strategies rather than specific behaviors when instructing aides and other staff in person-centered caregiving. On a practical level, the findings here suggest that experienced nurse aides can be used both as a source of information about communication behaviors and skills, and can also serve as models, teaching by example. In the U.S and perhaps elsewhere, nurse aides are already being used in these ways (Little & Clemens, 2005) and the findings here suggest how such content and practices might be expanded. If the quality of care residents receive is to be improved and turnover among aides reduced, it will be important to identify and teach effective communication skills. The findings here suggest some useful content for future training. The findings also speak to recognizing the importance of aides’ personal relationships with residents.

1 Seventeen nurse aides were interviewed, but the answers of one aide were not included in data analysis because they were highly repetitive and judged to be unresponsive to the different interview questions.
REFERENCES


Table 1. Coding Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Giving Positive Regard:</strong></td>
<td>Acknowledging the resident, treating the resident with respect, showing interest, approval and/or liking.</td>
</tr>
<tr>
<td>Verbal Subcategories:</td>
<td></td>
</tr>
<tr>
<td>Greetings:</td>
<td>Initiating contact through friendly statements.</td>
</tr>
<tr>
<td>Giving Compliment:</td>
<td>Expressions of approval, praise, or respect for resident.</td>
</tr>
<tr>
<td>Being Friendly:</td>
<td>Social conversation with residents.</td>
</tr>
<tr>
<td>Acceptance of Feelings:</td>
<td>Nurse aides accepting residents thoughts and feelings.</td>
</tr>
<tr>
<td>Distract w Conversation:</td>
<td>Nurse aide distracting the resident to complete task.</td>
</tr>
<tr>
<td>Non-verbal Subcategories:</td>
<td></td>
</tr>
<tr>
<td>Giving Affectionate</td>
<td>Involves positive forms of non-verbal communication.</td>
</tr>
<tr>
<td>Touch/Smiles:</td>
<td>such as a hug or a smile.</td>
</tr>
<tr>
<td>Taking Time:</td>
<td>Spending time with the resident.</td>
</tr>
<tr>
<td>Doing Favors:</td>
<td>This involves a concrete instrumental action to take care of them (i.e. getting a resident a cup of coffee)</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Learn Likes/Dislikes:</td>
<td>This includes the nurse aide making an effort to learn about the resident, such as the type of food they like.</td>
</tr>
<tr>
<td><strong>2. Assessing Condition:</strong></td>
<td>Gathering information about the resident’s medical, psychological, and emotional condition.</td>
</tr>
<tr>
<td>Verbal Subcategory:</td>
<td></td>
</tr>
<tr>
<td>Assessing Condition:</td>
<td>Asking the resident questions regarding their health.</td>
</tr>
</tbody>
</table>
Nurse Aides’ Communication Behaviors

Non-Verbal Subcategory:

Assessing Comfort/Condition: Looking at body posture to determine comfort or condition.

Assessing Medical: Direct instrumental assessment such as checking the resident’s vitals.

Assessing Emotion/Voice Tone: Listening and assessing their tone of voice to determine how they are feeling.

Assessing Behavior: Observing the resident’s behavior.

Other:

Assessing Condition: This involves assessing the resident’s condition using both verbal and non-verbal assessment strategies.

3. Coordinating Care: Statements the nurse aide makes that do not involve directly interacting with the resident.

4. Giving Choices: Giving residents choices such as the clothing they would like to wear or food they would eat.

5. Being Happy/Positive: Creating a positive, upbeat environment.

6. Insisting on Control: Being firm with the resident to get a task completed.

7. Self-Disclosing: CNA telling resident about self.