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Taking the Hit: Focusing on Caregiver “Error” Masks Organizational-Level

Risk Factors for Nursing Aide Assaults

Debra G. Morgan^a, Ph.D., R.N.
 Margaret Crossley^b, Ph.D., Reg. D. Psy.
 Norma J. Stewart^c, Ph.D., R.N.
 Carl D’Arcy^d, Ph.D.
 Dorothy A. Forbes^e, Ph.D., R.N.
 Sandy A. Normand, Dip. Recreation & Leisure^f
 Allison Cammer, MSc, BA, RD^g

^aAssociate Professor & Chair, Rural Health Delivery, Canadian Centre for Health and Safety in Agriculture (CCHSA), Wing 3E, Royal University Hospital, University of Saskatchewan, 103 Hospital Drive, Saskatoon, Saskatchewan S7N 0W8, TEL: (306) 966-7905, FAX: (306) 966-8799, debra.morgan@usask.ca (Corresponding Author).

^bAssociate Professor, Department of Psychology, Arts 154, University of Saskatchewan, Saskatoon, SK, S7N 5A5, TEL: (306) 966-5923, FAX (306) 966-6630, margaret.crossley@usask.ca

^cProfessor, Associate Dean Graduate Studies & Research, College of Nursing, 107 Wiggins Rd, University of Saskatchewan, Saskatoon, SK, S7N 5E5, TEL: (306) 966-6254, FAX (306) 966-6703, norma.stewart@usask.ca

^dProfessor and Director, Applied Research/Psychiatry, University of Saskatchewan, Saskatoon, Box 92, Royal University Hospital, Saskatchewan, Canada S7N 0M4, TEL: (306) 966-8769, FAX: (306) 966-8774, carl.darcy@usask.ca

^eAssociate Professor, School of Nursing, Faculty of Health Sciences, University of Western Ontario, London, ON, TEL: (519) 661-2111, FAX: (519) 661-3928, dforbes@uwo.ca

^fProject Coordinator, CCHSA, University of Saskatchewan, Wing 3E, Royal University Hospital, University of Saskatchewan, 103 Hospital Drive, Saskatoon, Saskatchewan S7N 0W8, TEL: (306) 966-2110, FAX: (306) 966-8799, normand@sask.usask.ca

^gResearch Assistant, CCHSA, University of Saskatchewan, Wing 3E, Royal University Hospital, University of Saskatchewan, 103 Hospital Drive, Saskatoon, Saskatchewan S7N 0W8, TEL: (306) 966-6075, FAX: (306) 966-8799, allision.cammer@usask.ca

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Abstract

Beliefs about the causes of events have implications for emotional reactions, distress, expectations for the future, and behavioural responses. This paper reports on two issues: the organizational context that contributes to nursing aide (NA) assault and reporting, and serendipitous findings that arose from investigating unexpected response rates to a survey. Data were collected in 11 rural nursing homes using a structured prospective event-reporting diary to collect detailed information about incidents of physical aggression, followed by focus groups to further explore NAs’ perceptions of these events. Here we report on analysis of 19 focus groups conducted with 138 NAs. Participants described organizational-level factors that constrained their practice, affected their interactions with residents, and created a context that put them at risk for physical assault. These factors also affected their willingness to provide written documentation about aggressive incidents. The key issues were: frustration at being blamed for causing aggression, lack of action to address the problem, and a desire for respect and involvement in decision-making. Organizational changes are needed to modify the contextual factors contributing to assault risk. Researchers must be willing to modify study designs in order to more fully understand the nature of the problem studied.

Key Words: nursing aides, assault, aggression, long-term care, rural

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Taking the Hit: Focussing on Caregiver “Error” Masks Organizational-Level Risk Factors for Nursing Aide Assault

Nursing aides (NAs) provide the majority of direct care in long-term care settings and therefore have a significant impact on the quality of care received by residents. However, providing hands-on care to nursing home residents is often physically and emotionally demanding. Earlier research, conducted primarily in the United States, has pointed to high rates of physical and verbal aggression toward NAs from residents (Gates, Fitzwater, & Meyer, 1999; Shaw, 2004). Individuals with dementia make up a growing proportion of nursing home residents, accounting for 48% to 55% of new admissions (Magaziner et al., 2000). Ryden, Bossenmaier, and McLachlan (1991) found that 86% of nursing home residents with dementia displayed some form of aggression over one week, with 51% being physically aggressive. Other studies have reported prevalence rates for aggressive behaviour of 44% (Kolanowski & Garr, 1999) to 82% (Brodaty et al., 2001) within this population. NAs are more likely to be assaulted than registered nurses (Goodridge, Johnston, & Thomson, 1996; Graydon, Kasta, & Khan, 1994), consistent with the finding that most assaults occur during personal care (Bridges-Parlet, Knopman, & Thompson, 1994; Crocker & Cummings, 1995). As used here “aggression” refers to the resident behaviour and “assault” to the outcome. These terms do not imply intent to harm on the residents’ behalf.

Frequency of assault varies across studies, from over nine physical assaults per aide each month (Goodridge et al., 1996) to daily reported assault (Hagen & Sayers, 1995). It is difficult to obtain accurate estimates because of suspected underreporting by NAs (Crocker & Cummings, 1995; Gates et al., 1999) and measurement differences across studies. Physical aggression has implications for NAs (e.g., physical and emotional health, intent to leave their job) and for residents (e.g., decrease in amount and quality of care, increased potential for staff-to-resident abuse and neglect) (Miller, 1997). Management of behavioural disturbances such as aggression

has focused on environmental modifications such as dementia special care units (SCUs)(Leon, Cheng, Alvarez, & Alvarez, 1997), and on behavioural management training for staff (e.g., Braun, Cheang, & Shigeta, 2005; Landreville, Dicaire, Verreault, & Lévesque, 2005).

Despite higher proportions of older persons in rural communities (Elliott, 2007) and the fact that nursing homes are often the only care setting available to rural seniors with dementia (Congdon & Magilvy, 1998; Rowles, 1996), little is known about these facilities. Rural nursing homes are smaller than urban homes (Coward, Duncan, & Uttaro, 1996; Statistics Canada, 2004) and less likely to have a SCU (Grant, Kane, Connor, Potthoff, & Stark, 1996; Leon et al., 1997), despite a higher proportion of residents with dementia (Phillips, Hawes, & Williams, 2003). Larger size may be a proxy for resources, including specialized dementia care programs and facilities (Leon et al., 1997). Our earlier studies have identified challenges in meeting the needs of residents with dementia in small rural nursing homes (Morgan, Stewart, D’Arcy, & Werezak, 2004; Morgan, Semchuk, Stewart, & D’Arcy, 2003) and higher job strain among NAs than registered nurses in these facilities (Morgan, Semchuk, Stewart, & D’Arcy, 2002).

Background and Conceptual Framework

The findings reported here are from a larger study of rural dementia care aimed at learning about NAs’ perceptions of incidents of physical aggression from nursing home residents, focussing on the attributions that NAs make for these behaviours. A secondary purpose was to explore whether attributions for resident aggression differed for NAs working on dementia SCUs versus those who do not. The impetus for the study came from an earlier study of rural nursing homes in which NAs employed in facilities with a SCU reported significantly less frequent exposure to disruptive behaviours (including physical aggression), less distress from these behaviors, lower psychological job demands, and lower job strain, compared to NAs in non-SCU facilities (Morgan, Stewart, D’Arcy, Forbes, & Lawson, 2005). Within SCU facilities, those who worked more time on the SCU reported higher exposure to aggressive

behaviours, but lower distress, job demands, and job strain. These findings raised questions about how NAs perceive resident behaviors and how this affects their emotional and behavioural reactions to resident aggression. Results of the current study have implications for program and policy development in rural long-term care settings.

Attribution theory (Weiner, 1985) was used as the framework to investigate NAs' attributions for the causes of resident aggression. Weiner proposed that when an event is unexpected, negative, or important, a causal search is undertaken to determine why it occurred. Three dimensions of causality have been described: locus (internal factors within the person vs. external environmental factors), stability (modifiable vs. non-modifiable), and controllability (whether or not the cause is under the volitional control of the person whose behaviour is being explained). These characteristics affect expectations about future events, emotional reactions, level of distress, and behaviour. For example, attribution to nonmodifiable causes can lead to hopelessness and an expectation that the outcome will continue to occur, which in turn influences future behaviour. Jones and Nisbett (1972) proposed that compared to uninvolved observers, those actively involved in an interaction may make attribution errors, because they tend to overlook environmental or situational factors as causes of the other's behaviour, and instead attribute them to stable dispositional or internal qualities of that person. Thus NAs may overlook modifiable factors contributing to resident aggression because the behaviour "engulfs the field" (Jones & Nisbett, 1972, pg. 87). Consequently, interventions to modify environmental or situational factors are unlikely to be implemented, and continued aggressive behaviour will be expected. Because staff training is an important characteristic of SCUs (Leon et al., 1997), NAs employed on SCUs may be more sensitive to environmental triggers, including awareness of their own caregiving approaches. Middleton, Stewart, and Richardson (1999) found that SCU staff were more likely than non-SCU staff to feel responsible for causing aggressive behaviors.

Methods

Data for this study were collected using two methods. NAs used a structured prospective event-reporting log or “diary” to document consecutive incidents of resident aggression, including descriptions of the time, place, type of activity taking place, their views on what caused the incident, and other constructs derived from attribution models (e.g., caregiver emotions and behaviors). This component of the study, which will be reported elsewhere, was followed by focus group interviews to further explore NAs’ perceptions of these events. Due to unexpected events in the first phase, the second phase was modified in order to explore these events. This article reports on findings that emerged from the focus group interviews.

Setting and Sampling

This study was conducted in the mid-western Canadian province of Saskatchewan. The one million people who live in Saskatchewan are dispersed over an area of 652,000 km² resulting in a low population density of 1.7 persons per square kilometer (Elliott, 2006). Healthcare services are provided by 13 regional health authorities. “Rural” facilities were defined as those located in centres with populations of approximately 15,000 people or less, which is slightly more inclusive than the “rural and small town Canada” definition of $\leq 10,000$ population (Pitblado et al., 1999). The study focused on provincial government-funded facilities, which provide the majority of care to people whose needs cannot be met in the community. At the time of the study there were 157 such facilities in the province. Residents pay an income-related charge representing approximately 30% of the actual cost of care. Sampling was based on the objectives of the diary component, where SCU vs. non-SCU comparisons were of interest thus selection began by identifying rural nursing homes with SCUs (n = 13). We then selected those with permanent assignment of staff to the SCU (n = 8), which was more likely in larger facilities. Where possible we tried to match these facilities to a same-size non-SCU rural facility as an additional comparison group. A match was available for only three of the SCU facilities because

most larger homes had a SCU. Operational approval was obtained from the regional health authorities and ethical approval was obtained from the University of Saskatchewan Behavioral Research Ethics Committee. The eight facilities with SCUs ranged in size from 59 to 157 beds ($M, Mdn = 115$). Within these facilities, the SCUs ranged in size from 10 to 33 beds ($M = 22, Mdn = 23$), with 9 to 22 NAs ($M = 13, Mdn = 12$) permanently assigned to the SCU. The populations of the communities in which these SCU facilities were located ranged from 1,919 to 15,107 ($M = 6,229, Mdn = 4,807$). The three non-SCU facilities ranged from 59 to 105 beds and were located in communities with populations similar to those with SCUs ($M = 6,863, Mdn = 4,548$). All NAs were eligible to participate, including casual staff. A signed consent form was obtained from all focus group participants.

Data Collection Procedures

Initial planning took place through a series of telephone discussions with directors of care (DOCs) because of the long travel distances to the facilities, which ranged from 230 kms. (142 mi.) to 825 kms. (512 mi.) per round trip. Our first face-to-face interactions with the DOCs and NAs involved meetings to explain and distribute the diaries. Direct mail or telephone contact with NAs was not possible for confidentiality reasons. Thus posters and individual brochures titled *Understanding Physical Aggression – Let's Take a Look* were sent in advance of our visits. We offered funding for staff relief during meeting times. At these initial meetings we provided an overview of the study, gave an item-by-item explanation of how to document incidents of physical aggression using the prospective diary, and delivered the diary packages to the facility. We explained that follow-up focus groups would be conducted several months later in approximately half of the participating facilities, to allow for an in-depth discussion about caring for aggressive residents.

Because we were unable to communicate directly with NAs we were unable to use multiple-contact survey methods such as those recommended by Dillman (2000). The lack of

direct control over distribution meant that we were unable to obtain the precise denominator needed to calculate exact response rates. However, the DOCs in the 11 facilities reported that a total of 679 diaries were distributed. Based on these numbers, the proportion of diaries returned ranged from 8% to 30% across facilities ($M = 19\%$). These may be underestimates because some NAs attending the focus groups reported that they had not received a study package. Although not unusual for this type of research (Asch, Jedrzewski, & Christakis, 1997), the response rates were unexpected, especially compared to the high return rates in the instrument development phase of the study. NAs in two rural nursing homes had completed two earlier versions of the diary, with 77% to 95% of staff participating. Response rates in our previous survey research with direct care staff in nursing homes have ranged from 63% (Morgan et al., 2002) to 50% and 63% for SCU and non-SCU staff respectively (Morgan et al., 2003). Although we had planned to conduct focus group interviews in five or six facilities, we modified our approach to address the response rate. As described in the following sections, we conducted focus groups in all 11 facilities. In total, 19 focus groups and one individual interview (see **Table 1**) were conducted by the PI (DM) and project coordinator (SN), with meetings ranging from 1 to 1.5 hours.

Focus groups aimed at understanding barriers to study participation. To help us understand what might have lead to the different response rates in the current study, we decided to conduct a focus group in one facility as a first step in a process to understand the situation. After this session we recognized the importance of the information that was emerging and made the decision to continue exploring the factors influencing study participation, conducting as many interviews as needed to understand the issues. Ultimately nine such focus groups were conducted in five facilities. In these groups we learned that the issue of resident aggression and NA assault was a highly sensitive and political issue, and that we needed to provide respondents with a safe environment in which to talk about the problem. For this reason NAs participating in the focus groups were not asked to provide any personal information or written documentation

(other than signing a consent form) and the interviews were not tape-recorded. A total of 74 NAs took part in the nine “barriers” focus groups, with attendance ranging from 2 to 16 participants ($M = 8$, $Mdn = 6$) per meeting. The facilities were selected to ensure representation from each regional health authority involved in the study, and were limited to SCU facilities because SCU vs. non-SCU comparisons were not the focus for this set of meetings. The focus groups were announced with posters, brochures, and inserts for unit communication books that used the same design as earlier communications, with the meeting billed as “*What We’ve Learned So Far...*” Back-to-back focus group interviews were scheduled around shift change to facilitate attendance by NAs working either the day or evening shift. A semi-structured interview guide was used to explore whether there were aspects of the study that discouraged participation, whether the problems were fixable, and what advice they would give us for continuing to study this problem. We requested and received permission from all the groups to take detailed notes. Both the PI and project coordinator recorded and were able to document verbatim most of the discussion. These notes were combined to produce a complete record and entered into a word processing program. A thematic analysis was conducted using grounded theory methods of constant comparative analysis (Glaser, 1978; Glaser & Strauss, 1967). The grounded theory method is aimed at explaining participants’ main concerns and how they are processed, and thus a good fit with the goals of listening to the NAs and allowing them to bring forward issues of concern to them. Data collection and analysis were conducted concurrently, with subsequent interviews guided by the developing analysis. Field notes were also included as data.

Focus groups aimed at exploring physical aggression. In the remaining six facilities (3 SCU, 3 non-SCU) we conducted 10 focus group interviews as originally planned, to explore NAs’ perceptions of caring for physically aggressive residents. The focus groups were attended by a total of 63 NAs, with group size ranging from 2 to 10 participants (M , $Mdn = 6$). An

individual interview was conducted in one facility where staffing levels did not permit a second full group. A semi-structured interview guide was developed to gather complementary qualitative data on questions in the diary. Because of the concerns about who was “behind” the study and its intent we began by addressing these concerns, re-enforcing the information we had provided earlier, that we were independent researchers with no connection to management. Warm-up questions were used to explore how participants had come to work in long-term care and the significance of physical aggression in their work. Subsequent questions were aimed at exploring concepts included in the diary. Because we had originally planned to record these focus groups we audio-taped the first meeting, but NAs were clearly uncomfortable talking about aggression while being recorded. During this meeting only one NA indicated that she had “probably” experienced an incident of aggression recently. In subsequent focus groups we used a flip-chart to document discussion points and took detailed notes, including verbatim quotes, which were later entered into a word processing program. Grounded theory methods again informed data collection and analysis.

Results

Although the two sets of focus group interviews had different initial goals, the analysis converged around a consistent set of themes. Reluctance to participate in the diary component of the study, which was explored in the “barriers” focus groups, was directly linked to the NAs’ experiences in caring for residents exhibiting physically aggressive behaviour. The most significant factors influencing participation were: fear that the study findings would be used “against them,” long-standing anger and frustration at being blamed for causing aggression, and scepticism that the study would result in any change in light of years of documenting aggressive incidents. This exploration of the barriers to taking part in the diary component of the study allowed us to uncover broader underlying systemic and organizational challenges that affected the NAs’ daily worklife and had a direct impact on their experiences in caring for aggressive

residents. The three main themes identified in the analysis were: NAs' perceptions of being blamed for causing aggression when they report resident aggression, the long-standing lack of action at all levels to address aggression toward NAs, and their desire for respect and involvement in decision-making and policy within the organization.

Response to Reports of Physical Aggression – Feeling Blamed

The NAs stated that when they report experiencing aggressive behaviour from a resident, either in a verbal report to their nursing supervisor, or in a formal incident report, they feel that they are being blamed for the incident. NAs consistently described how their reports are responded to by statements that imply that they must have caused the behaviour through an inappropriate caregiving approach. They are constantly told “approach, approach, approach.”

I write up incident reports and the first thing is ‘What was your approach?’ It is always ‘What did you do wrong?’

Always the first question is ‘What did you do to provoke it?’ It is always ‘What was your approach?’

If someone is really physically hurt, like an aide who was badly bitten—always the staff is wrong, ‘you should have done this or that.’

A number of NAs described how being hit by a resident, and then being blamed for it, made them upset and angry. They stated that what they need most is for their experience to be validated, to be comforted and supported, and reassured that they are good caregivers. NAs want the incident to be investigated, but first they want their feelings to be acknowledged. Because other staff do not have the same exposure and first-hand experience of caring for aggressive residents, NAs are very distressed when they believe they are being judged by others.

Start by having management work a few shifts as an aide—they have no idea what we do, what we take. The RNs have no clue. That won't make the aggression better, but at least we aren't getting the double whammy [assaulted and then asked what they did to provoke it].

I would like the focus to be taken off the aides—it is all in how they communicate. You don't say to a woman that was battered, ‘what did you do to provoke it?’ Don't assume

that I did something wrong.

NAs need to be told 'it is okay, you did your best', not 'how did you approach them?' That says you made a mistake. They need to be told they are okay, 'you are not a bad person, you are a good person, we need you here.' Later—you can look at the situation and see what can be done, but right now they need to be validated.

Initially it appeared that NAs were giving conflicting messages about whether or not physical aggression was an expected part of their work. Many NAs indicated that they expected some aggression because of the nature of their work. NAs made statements such as "I don't like it, I don't want it, but it is going to happen," "Who wants to come to work and be afraid? But it's part of our job," and "Nobody wants to be hit...kind of goes with the job but I don't want to get hit." A number of NAs stated that they have been trained to accept it as part of their job.

You are trained that it is part of your job, you deserve it because you work with older people and that is how they are.

This is our line of work and I just have to deal with it—that's what we've been taught to accept. Not much is done about it.

In further exploring NAs' perceptions of whether aggression is "part of the job," NAs indicated that although some aggression is inevitable, what upsets them is their perception that others see it as part of the NAs' job. Participants were angry that there seemed to be an expectation from nurses, supervisors, managers, and families that NAs would be subject to aggression from residents and that they should accept it.

If I work 6 days, the first few day I put up with it, but then you think 'how come we have to put up with this every time we work?' We go to management and we are told it is part of the job, put up with it.

What bothers me is that it is expected that I take it—that is what bothers me most. Families, management—[to them it is] no big deal, really no big deal. It is not acknowledged as an issue—it makes me feel ticked. I don't come to work to get hit—it is not part of my job.

It's part of the job as aides, but not for someone else.

It is [part of the job] really, but it is how it is interpreted that bothers me.

Lack of Acknowledgement and Action

The persistent lack of action in response to their reports of aggressive incidents has further reinforced the NAs' perceptions that others expect them to quietly tolerate aggressive resident behavior. NAs stated that they have been documenting the more severe aggressive behaviors in formal incident reports for years, but they do not know what happens to the reports once they are submitted. In their experience, their reports are not investigated, nobody follows up with them, and they see no evidence that anyone is concerned or interested in what happened. "We have filled boxes of them and nothing is done, not even medications," "We have quit [reporting] because nobody listens—just quit." As one NA stated "Record, record, nothing ever changes." Many NAs noted that they have given up reporting because they just end up feeling blamed for the incident and their formal reports have no effect.

We give them [incident reports] to the RN, it sits on the RN's desk. I think it goes to management—don't know. I think it is supposed to go into a file. Some are supposed to go to the head office.

It gets to management and that is the end. We really don't know where it goes.

It goes to the RN, she takes it to the nurse manager. I think then it goes to the city—not sure. We never get any feedback.

Reporting needs to go on, something should be done right away, people are getting hit, nothing is changing.

The long-standing lack of action in response to their formal and informal reports of aggression has had consequences for relationships between NAs and others in the organization. It reinforces their perception that they are at the bottom of a hierarchy and that their work is not valued. They are frustrated and want the problem to be acknowledged. When they submit a report, they believe it should be investigated. "We want some result of it [report]," "We want management, the doctor, OH & S [Occupational Health and Safety] to meet, to do something with this resident." As the person closest to the situation and most affected, they want to be

consulted about what happened and to have their experience acknowledged. “Management should investigate, come to you, ask you about it.” There is a sense of abandonment that so little has been done to address their concerns.

NAs reported that when they tell the nurses that they are having difficulty caring for an aggressive resident, they are not taken seriously or are told that nothing can be done. Their ideas about why the resident might be aggressive and their suggestions for interventions are brushed off. As the caregivers with the most personal contact with residents, NAs are upset that their observations and input are not sought out and valued.

They never come up with a solution. When we say the resident needs more pain control, they say ‘this is all we can do’.

When we report something to the nurse, she says ‘it’s nothing.’ We are shrugged aside, told ‘it’s not important.’

A frequent comment was that NAs do not have the support of registered nurses and management in situations where residents are aggressive. They want management to be their advocate with nurses and families. A number of NAs reported that some residents’ family members do not accept that their loved one can be aggressive during care and therefore the family may resist implementation of interventions such as medications aimed at reducing aggressive behavior. “As a facility, we need them to stand behind us and say they are getting medicated.” Several participants stated that they have been told by family members that the NAs are paid for their work so they should not complain. NAs believe that the registered nurses should side with them in these situations and make sure that families understand that NAs are not “paid to take abuse.” As one NA stated, “It’s not right that we should be beaten every day.”

We should be backed up. The RN or facility needs to back us up, to say ‘this is what should be taking place.’

We aren’t supported enough—we feel there is no end to it.

[Aggression may be inevitable] but on the other hand it would be nice to have some

support from RNs and other people.

I want management to do something. Inform the family that I am not here to be abused. Not just putting a sticky on the door that abuse isn't tolerated. Families need to hear that staff are not paid to be abused. Families need to be told what is happening when their family member is aggressive.

Desire for Respect and Involvement

A central theme was the NAs' perception of being at the bottom of the organizational hierarchy. Statements such as "we are the grunts," "our word is not counted," and "we don't want to be at the bottom," reflect the NAs' belief that they are not respected and valued for their knowledge and skills. Comments about their place in the organization came up in discussions about the causes of aggression, the situations in which it occurs, and how the problem could be better managed. NAs described many factors that can result in resident aggression, but indicated that they seldom have control over them. They are not invited to be part of a problem-solving process in relation to aggression or other aspects of care planning and decision-making. Many NAs stated that as a group they are systematically trained to be at the bottom of the hierarchy, and that organizational practices and policies that exclude them from participating in decision-making reinforce their perception of their low status.

It is very traditional here—the nurses are up there, and we are down here.

There is a medical hierarchy. It is like the army. It works well to keep us in our place. It [hierarchy] is doctor, nurse, LPN, special care aide [NA]. It is drilled into your head—you report to a certain person. We are trained as underdogs.

We used to be part of the care planning. That got beat out [because it was deemed too intimidating for the family to have a large number of staff at case conferences].

It is hard being the brunt of it. We are not taken seriously by doctors, nurses, management, family.

Because NAs have developed extensive knowledge of individual residents and their needs, it is especially upsetting for NAs to be excluded from decision-making or to have their observations dismissed by others within the organization. As one NA stated, "We work with

them [residents]--you have to do it to know.” Many described unsuccessful attempts to have nurses or managers assist them in providing care in order to experience the problems first-hand. NAs were frustrated about their lack of control over daily routines, administration of medications for pain and behavioral management, and other factors that contribute to aggression or may help to manage it. “We are frustrated, not listened to.” Many NAs expressed hopelessness about the situation and did not know what they could do to change the situation.

For example, pain—if I think Mrs. Smith needs more pain medication. We are told we are not qualified to say she needs pain medication.

I’ve been here 22 years and a new RN comes in to tell me how to do my job. Nothing gets me more than that.

We don’t know where to turn to benefit ourselves.

Perhaps because of their feeling of being unsupported and separate from other staff in the organizational hierarchy, and their need to work together to meet the demands of the job, most NAs supported and helped each other. Their common experience united them, as one NA indicated when she described the NAs as a “sisterhood.” We also heard reports of verbal abuse and bullying of NAs by their peers, but these incidents are not reported to management out of loyalty to their group.

There is kinship among the aides--a division between management and aides. They feel they are the bottom.... nobody tells them that what they are doing for residents is absolutely priceless. It is seen as a ‘lesser-than’ job... we are not taught we are important...there isn’t much praise. Some people see that we do a good job, but we need to hear it from higher up.

Mostly we talk among the aides first, ‘I feel they are in pain—they need more pain medication.’ Then we get on the same bandwagon, call the RN and say ‘I think you better come and see.’ If they hear it from all of us, they might do something.

You need teamwork—do something for me if I am busy. You need to look at the whole [unit], not ‘my side’ or ‘my residents’. You must work together, especially in the [SCU].

Factors Influencing Risk of Exposure to Physical Aggression

As described above, NAs identified organizational factors that influenced NA behavior and put them at risk. Factors such as fear of reporting, lack of action when they did report, and being excluded from decision-making were outside of the immediate NA-resident interaction but had a significant impact on it. In addition to these problems, NAs identified other issues such as workload, lack of flexibility regarding routines, limited access to specialized personnel and programs for behavior management assessment, and inadequate education for NAs, RNs, and physicians. The most frequently cited problem was the lack of time for care, especially for residents with dementia who required more staff time. Because of inadequate staffing levels, NAs had to rush residents through all aspects of care, including bathing, dressing, toileting and feeding. Many described the lack of time for morning care.

We have 40 residents with 4.5 staff. At 7:00 AM we are done report, breakfast is at 8:30, so we have 90 minutes to get 40 residents up.

You are rushed, you have less than 6 minutes in the morning to get them up.

We have to get residents up, washed, pad changed, and to the table in 9 to 11 minutes. The resident doesn't have a clue what is going on—they aren't even awake yet. With Alzheimer's Disease, you need to be slow, gentle. But we don't have time.

There is exactly 4 minutes to dress, lift, wash, shave, get teeth done, and get them into their chair.

“Rushing” care meant that NAs could not involve residents in their own care. It was faster to do it for them, but this approach often made residents upset, agitated, and aggressive. NAs recognized residents' need for a slower pace, more explanation about what staff members were doing, and more time for residents to absorb and respond to directions. They knew the principles of dementia care such as going slow and not rushing care, yet they were usually unable to implement this knowledge because of the workload. “If you talk for a few minutes, the resident can do more for themselves,” “You are pressed for time, so you do it for them, so you

can move on.” NAs described the benefits of taking the time to chat with residents, gain their confidence, and put them at ease before initiating care, but there was seldom time to do this.

Rigid institutional routines that required care to be completed according to a pre-determined schedule contributed to rushing of care and to agitation and aggression in the residents. NAs stated that it is difficult to provide individualized care in a context where they cannot make decisions about how and when care will be provided. “More flexibility with routine [would help], having time to be resident-centred, especially for a later breakfast. It would not be so institutional. We start rattling their chains at 7:00 AM or earlier.” NAs described the need for structure, but also some flexibility with respect to routines.

In everything in life you have to have routine, but what works for one doesn't work for the rest.

Routine is out of our hands. We don't make the rules--we are told they have to be up for breakfast. The odd person you can leave in bed, but it would be chaos if you had too many. We need to finish breakfast on time because they need to lay down, and then we toilet, and then get them up....

Lack of access to specialists, and limited opportunities for basic and continuing education for all levels of staff regarding dementia care and prevention and management of behavioral disturbances contributed to the high levels of resident aggression. Medication management issues were prominent. NAs reported that it was difficult to get aggressive residents assessed. It was also difficult to convince some RNs and licensed practical nurses (LPNs) that medications prescribed for behavioral management should be administered, reportedly because the nurses were concerned about medication cost and side effects such as addiction or drowsiness. “That's the sad part—the meds aren't given.” While some nurses responded immediately to NAs' reports of aggression and the need for medication, “some don't believe in it.” NAs also reported that poor pain control was a factor in resident aggression.

It goes back to getting meds—something we can't control. Some RNs don't agree on giving meds. If the RN does not have a realistic idea, because they don't work hands-on,

they can cut back meds if they think the resident is over-medicated. Sometimes they cut back and don't tell us. We can go for three weeks getting beat on, and then they say 'Oh, we cut back.'

Within facilities with a SCU, few differences were reported with respect to working on or off the unit. This may have been influenced by the inability to selectively sample SCU and non-SCU aides for the focus groups and the limited time for discussion. Issues related to poor physical environments, such as crowding and noise levels were noted, primarily in facilities with no SCU. Lack of quiet space and quiet time caused over-stimulation and aggression. Mixing of residents with dementia with other residents caused conflicts related to invasion of personal space and challenges in creating appropriate environments for groups with different needs. In two facilities, specific comments were made by SCU and non-SCU NAs that indicated better staffing levels on the SCU and more support from nurses in investigating resident aggression.

Interpretation and Discussion

The issue of resident aggression in nursing homes has been reported for many years (e.g., Burgio, Butler, & Bernard, 1988; Ryden et al, 1991) yet it appears that little progress has been made in directly addressing the problem. The NAs who participated in this study reported that they have seen little evidence of action to change the situation. Given the potential for staff injury, lost time from work, job dissatisfaction, and turnover, one has to ask why there has not been more effort to address this serious occupational health and safety issue. Would daily exposure to physical assault be tolerated in other employment settings? Given the growing emphasis on occupational health and safety within organizations, including long-term care, how is it that NA assault has received so little attention?

The conceptual framework guiding the current study was focussed on the attributions of individual NAs. In the prospective diary component of the study, which focused on discrete incidents of aggression, NAs reported primarily resident-related causes such as cognitive impairment, not wanting care, agitation, and pain. In the focus groups, however, NAs described

more distal organizational-level factors that had a major impact on NAs and their interactions with residents. These findings suggest that in order to fully address the issue of NA assault there must be a shift in focus away from the behaviour of individual NAs to the broader system level. Across facilities NAs consistently reported that instead of being supported through these difficult experiences, they felt blamed for causing resident aggression, and little was being done to reduce their exposure. With respect to the three dimensions of causality described in the introduction, NAs in this study attributed resident aggression to external causes (locus) that were not modifiable by NAs (stability), but that could be modified by others higher up the organizational hierarchy. NAs indicated that residents with dementia often do not understand that staff are trying to help them, and they cannot control their behavior (controllability), thus caregivers need to adapt their behaviour. Because of the context in which they worked, NAs seldom had the ability to make these adaptations. The finding that situational, environmental, and organizational factors contributing to aggression are not being addressed, indicates that attribution error is occurring at a broader system level.

Although we started the study with a focus on individual NAs and their attributions, a model that is more consistent with the study findings is the “human error” framework (Cook & Woods, 1994; Reason, 1990; Woods & Cook, 1999). Reason (1990) depicted complex systems, including health care, as having a sharp end and a blunt end. At the sharp end, practitioners interact with the underlying process—in this case NAs providing care at the front line. At the blunt end of a system are regulators and administrators who control the resources and develop the policies that affect the practitioners (NAs) at the sharp end. When “failures” or “accidents” occur, the implicit assumption is often that the person closest to the failure was the cause. The outcome is seen as the result of human error, caused by unreliable or erratic performance of individuals working at the sharp end. The search for causes tends to stop with the individual or group closest to the situation, who could have acted differently. This judgement is made with the

benefit of hindsight about the outcome. Attributing accidents to individual human error is a barrier to the careful examination of system properties external to the individual that influence their activities. The belief that accidents are the result of “isolated blunders of individuals masks the deeper story—a story of multiple contributors that create the conditions that lead to operator errors” (Woods & Cook, 1999, pg. 4). Thus attributing physical aggression to the behaviour of individual NAs masks the underlying systematic factors that put NAs at risk.

Cook, Render, and Woods (2000) describe how simple folk models of health care events that focus on the sharp end can obscure the multiple factors, interacting goals, and conflicting restraints that confronted practitioners, and can lead to “blame and train” (pg. 792) and other ineffective responses directed at the sharp-end. The emphasis on behavioural management training for NAs as the primary strategy to reduce aggression could be considered as evidence of the belief that the problem lies with deficiencies of the NAs. Findings from the current study suggest that NAs have considerable knowledge about how care should be provided, but they are unable to operationalize it because of “blunt end” factors such as inadequate staffing, rigid routines and policies, limited dementia care skills of care providers in positions of authority, limited funding for continuing education programs for all providers, and an organizational culture where physical assault is accepted as part of the NAs’ job. Woods and Cook (1999) argue that human performance is shaped by systematic factors, and that the scientific study of failure is concerned with understanding how these factors shape the cognition, collaboration, and behaviour of workers. Policy decisions have an indirect but powerful constraining downward influence on the behaviour of others in the setting. Pursuing the deeper and complex story behind “human error” often reveals imbalances between the demands that practitioners face and the resources available to meet them. Moray (1994) argues that errors should be seen as signals of the need for a change in practice in the organization. “If, as commonly occurs, they are at all costs concealed, no learning will take place, and they will occur again” (pg. 81).

Implications

A persistent theme in this study was the NAs' perceptions of themselves as being at the bottom of an organizational hierarchy. They saw themselves as having little control over their work and little input into decision-making at all levels, from individual resident care to broader facility-level processes. This situation increased their risk of assault because they were often unable to make decisions about tailoring care to individual residents' needs, placing them in situations that they knew were likely to result in aggression. Lack of involvement in decisions regarding routines and staffing also increased their exposure. The analysis points to the need for multiple changes at the organizational level. Strategies are needed to improve the communication and leadership skills of nurses who provide the majority of daily supervision to NAs. Many RNs and LPNs lack sufficient knowledge, skill, and time to act as an effective team leader and care coordinator in long-term care (Dellefield, 2006; McGilton, McGillis Hall, Pringle, O'Brien-Pallas, & Krejci, 2004). Nurses need skills in responding to NAs' reports by providing support and investigating the incident without suggesting that the NA was at fault. NAs must be acknowledged as full partners in the care team and consulted on care. Empowerment of NAs has been recognized as an essential component of any movement aimed at improving the work environment and job satisfaction of NAs (Gruss, McCann, Edelman, & Farran, 2004).

The emerging field of complexity science points to the critical role of relationships and communication patterns among health care providers in determining quality of care (Colón-Emeric et al., 2006). The free flow of information in relation to clinical problem-solving and input from a wide range of personal and professional backgrounds contributes to better outcomes. Results of a study of relationship patterns and nursing management practices in nursing homes (Anderson et al., 2005; Colón-Emeric et al., 2006) suggest that interventions to improve connection and communication between the interdisciplinary staff would be more likely to improve care than interventions that target individual behaviour change around a specific

medical condition. Results of the current study suggest that improved communication and relationships between NAs and other staff and administration, and strategies that involve NAs in the decision-making and information flow process would go a long way toward addressing the NAs' concerns. Additional implications for practice include the need for standardized protocols to ensure that reports of aggression are consistently investigated. Improved staffing levels would reduce the need to rush care. Although this recommendation may be considered unrealistic by some, increasing the number of caregivers remains a critical goal.

Results of this study highlight the need for improved management of residents with dementia generally, and of those exhibiting aggressive behaviour specifically. The reported lack of action may be related to the inaccurate perception that little can be done. The key role of “blunt end” factors has been recognized in relation to evidence-based practice in long-term care, where uptake of new knowledge has been slow. Studies of factors influencing adoption of innovations such as clinical practice guidelines have identified organizational and environmental level barriers to knowledge transfer in long-term care (Berta et al., 2005). Contextual factors (culture, leadership, evaluation) have been proposed as having a significant impact on the uptake of evidence (McCormack et al., 2002). One strategy for addressing the increasing complexity of care required by nursing home residents has been the development of training programs for front-line staff. A review of the effectiveness of such continuing education programs looked for enabling factors (conditions and resources that allowed the care provider to implement new skills) and reinforcing factors (cues or reminders) (Aylward, Stolee, Keat, & Johncox, 2003). In three quarters of the studies reviewed, new knowledge was provided to staff without any organizational or system support or change. In almost all cases staff showed improvement in knowledge but no change in behaviour. The review showed that successful implementation of educational programs must include organizational and system changes. Follow-up focus group interviews with long-term care staff and management identified management support as the key

to effectiveness of continuing education (Stolee et al., 2005). This is consistent with the current study, where NAs reported that they were often unable to implement their knowledge about best care practices because of the lack of organizational support. Continuing education is an important tool for reducing aggression, but only if it involves all levels of providers, and is part of a systematic review and reorganization of care. NAs may resist participation in educational programs if they perceive that they are being singled out as the source of the problem or if they judge that they will be unable to practice what they are learning.

The reported challenges of accessing specialized services and personnel in these rural facilities are not surprising, given the limited availability of geriatric and behaviour management specialists in rural areas. Because 8 of the 11 facilities had a SCU, which most rural facilities do not, it is likely that they were better resourced than most rural nursing homes. Yet even these homes were limited in the support available. Nurses employed in rural home care and long-term care have identified behaviour management as the major area of interest (Bellaver, Daly, & Buckwalter, 1999). Rural physicians have reported limited access to dementia specialists, and a need for assistance with diagnosis and treatment planning (Teel, 2004).

Conclusion

The NAs who participated in this study were committed to providing the best care possible, even when it meant putting themselves at risk for assault. They felt abandoned to provide care to aggressive residents without support, and powerless to effect any changes in their situation. Management of physically aggressive behaviors has been a long-standing challenge, but the difficulties of finding effective strategies should not prevent organizations from acknowledging and responding more actively to the plight of NAs who are “taking the hit,” both literally and figuratively, for the current situation in long-term care. Creating a climate of safety will require a multi-faceted approach with significant organizational acknowledgement and commitment to change at all levels.

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Table 1. Number of facilities, focus groups, and Nursing Aides by type of group

Focus Group Type	Number of:		
	Facilities	Focus Groups	NAs
Understanding Barriers	5	9	74
Exploring Aggression	6	10*	64
Totals	11	19	138

*Includes individual interview at one facility