POWER AND AUTONOMY IN THE NURSING HOME

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ABSTRACT

As with all organizations, nursing homes have an internal hierarchy that guides decision-making practices and policies. Nursing assistants (NAs) are positioned at the bottom of the hierarchy. They are generally the last nursing home employees to be solicited for input regarding practices and the last to learn about mandated policies created by upper level management. Consequently, they have the most limited amount of power compared to other staff. The one group of people that is impacted by all levels of the hierarchy and generally positioned at the bottom of all power relations in long-term care is nursing home residents. Residents’ daily life is directly influenced by nursing policies and practices, staff shortages, staff’s ability to provide timely care, and staff’s opinions about what type of care residents should receive.

This dissertation is a compilation of three publishable manuscripts that describe the balance of power and hierarchy within the nursing home. Data were collected through observations and interviews with NAs in long-term care settings at one Veterans Affairs Medical Center (VAMC). All data were analyzed using grounded theory.

Nursing homes are slowly shifting from a paternalistic medical model to a biopsychosocial model of care that promotes quality of life and autonomy. Unfortunately, the current conceptualizations of autonomy are not appropriate for long-term care settings. Without a cohesive framework for autonomy in long-term care, nursing home staff are apt to continue their approach to daily care consistent with a paternalistic, medical model of care. Therefore, the aim of the first paper is to present an applied conceptual framework for “everyday autonomy” in the
nursing home. Additionally, a decisional framework is presented to assist NAs in determining what degree of resident autonomy to support.

Within the framework of everyday autonomy, NAs are challenged to explore ways to support resident autonomy. The purpose of the second paper is to describe how NAs can support resident autonomy in long-term care. Through observations and interviews with NAs, ten autonomy-supportive approaches were identified. Suggestions for future research are presented.

Several barriers to successful recruitment emerged during this study. The purposes of the final paper presented in this dissertation are to describe my recruitment process in detail, present challenges to recruitment, and reflect on the strengths and weaknesses of my recruitment strategies. Additionally, I summarize the characteristics of NAs in relation to power and hypothesize links between these characteristics and barriers to recruitment of the NA population. Finally, I propose possible strategies for effective recruitment of NAs for research in long-term care settings.
DEDICATION

To my daughter, Isabelle, and my husband, Joey, for their daily support and encouragement. To Angie, my mother, for her exemplary work ethic that I strive to achieve. To Mary and Frank, my grandparents, for their unconditional love, support, and inspiration. Without them, this body of work would have not been possible.
LIST OF ABBREVIATIONS

NA  Nursing assistant
LPN  Licensed practical nurse
RN  Registered nurse
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INTRODUCTION

My dissertation consists of three manuscripts describing multiple aspects of my qualitative exploratory work with nursing assistants on the topic of resident autonomy. In this introduction to these three manuscripts, I first present my initial plan for the study and describe how the research evolved and changed, leading to the conception and development of the content presented in this dissertation. Second, I present the aims of the three papers and discuss my hopes for future research. Lastly, I provide a description of the data analysis process.

I proposed to conduct a qualitative research study to develop a grounded theory of how nursing assistants (NAs) understand concepts of autonomy and beneficence and how they resolve ethical dilemmas between the two. Early in the research, I realized that NAs experience moral distress as a result of ongoing ethical conflicts between autonomy and beneficence. Conflict was evidenced throughout all of the transcripts. However, NAs did not have an outlet through which to share and explore their concerns and did not have supportive structures in their organization to assist them in making sense of their thoughts, feelings and actions related to these ethical dilemmas. By their accounts, NAs did not receive training on ethical dilemmas associated with autonomy and beneficence; rather, discussions between NAs and supervisors regarding ethical conflicts occurred primarily in the context of mental status change resulting from infection or progressing medical conditions. Consequently and by no fault of their own, NAs’ understanding of autonomy and beneficence was limited, associated with high distress, and often unhelpful (in terms of guiding their actions toward autonomy supportive solutions for the residents and in terms of resolving their own distress).
Constructing a grounded theory of NAs’ limited understanding of autonomy and beneficence may have satisfied the goal of a completed dissertation but would not have resolved the quandary that led to NAs’ moral distress. Furthermore, a theory based on participants’ minimal knowledge of a phenomenon is unproductive and valueless. Therefore, the aims of the research shifted to fill a literature and clinical gap related to autonomy and beneficence dilemmas that NAs experience in long-term care. However, by beginning my work with a semi-structured interview guide that included discussions of broader topics related to but outside of the concept of autonomy (e.g., how did the NAs define their positions, what activities did the NAs engage in most frequently in their positions; see appendix for full structured interview guide), including ethnographic observations of NA work as well as interviews in my research design, and by altering that interview guide in an iterative manner as I proceeded through interview and analysis cycles, I was able to go beyond the limited responses the NAs provided to the specific questions about autonomy and fully take advantage of the unexpected information about autonomy that these other information sources provided.

In the first manuscript of this dissertation, an applied conceptual model of everyday autonomy is presented. The model emerged from qualitative interview and observation data collected with NAs and was constructed using a grounded theory approach. This paper developed because I discovered that NAs were naturally describing a continuum of autonomy as they told me about a variety of resident-NA encounters. Additionally, the paper presents a decision framework that can be used by NAs to guide their daily decision-making process when determining whether or not to support residents’ autonomy. The applied conceptual framework of everyday autonomy (see pg. 34) is based on a continuum that ranges from full to restricted autonomy. The space between the two anchor points on the everyday autonomy continuum
represents a vast array of opportunities for NAs to support resident autonomy. I plan to submit this manuscript as a qualitative research article to the *American Journal of Nursing*, which does not have a word limit restriction. I chose this journal because the journal’s aim is to disseminate clinical information and research on controversial issues to the healthcare community including nurses, managers, and administrators in healthcare settings.

The second paper of this dissertation presents 10 autonomy-supportive approaches that emerged from the strategies the NAs described and I observed. When these approaches are implemented, the opportunities for everyday autonomy represented by the autonomy continuum are theoretically realized. The qualitative data I collected also revealed NA approaches that resulted in restricted autonomy, as well as factors associated with full autonomy (i.e., the two anchors of the everyday autonomy continuum); I am planning future manuscripts beyond the scope of this dissertation that will more fully explore these data. I plan to submit this manuscript as a qualitative study to *The Gerontologist*, which has a 7,000 word limit restriction. I chose this journal because I want this manuscript to reach professionals in a range of clinical and research disciplines, with the hope of inspiring others to explore additional approaches to promoting resident autonomy or develop educational programs to teach staff about the approaches described in this manuscript.

The final paper in this dissertation is a methods paper, exploring the challenges of recruiting NAs for research participation. Literature on recruitment barriers and facilitators for research in the NA population in long-term care is nonexistent. In the final paper, I present my recruitment process and the barriers I encountered; I was diligent, persistent, and creative in my approaches to recruitment. Over a period of months I slowly developed true relationships with many of the NAs, such that they welcomed me into their social groups and conversations.
whereas at the beginning of my work the extent of NA communication with me was stiff politeness and suspicion. This achievement was made possible because I committed hours at time for months in a row to visit each shift and just be with the NAs and residents, not requesting anything but just being a helpful and friendly presence. I was a regular presence in all units, at all times, including 8pm, midnight, 5am, and during the day. And yet, despite my eventual hard-won relationships, I still did not meet my recruitment goals. Reflecting on my experience, I present possible strategies that may aid researchers in developing a recruitment plan that is successful at recruiting NAs for qualitative research in long-term care, as well as attempt to foster more realistic expectations for other researchers regarding the time and resource commitments necessary for successful recruitment. I plan to submit this manuscript as an article for “The Forum” to The Gerontologist, which is restricted to 5,000 words. The Gerontologist targets many researchers in long-term care, and it is hoped that this manuscript will initiate discourse and research on the difficulties of recruiting NAs in nursing homes.

Because I have chosen the dissertation option in which I present three submission-ready manuscripts, and because the length of manuscripts in the peer-reviewed journals most appropriate for these papers is limited, I will supply here additional information regarding my data analysis methods. My data collection efforts resulted in 13 interviews and 91 field notes from approximately 80 hours of ethnographic observations. Analyses followed the grounded theory approach. Data were analyzed in four stages: open coding, focused coding, axial coding, and theoretical coding. These stages of coding are consistent with grounded theory methods of analysis and are described in the first paper of this dissertation. Briefly, the stages of coding were iterative rather than linear. For example, open coding was carried out for several transcripts; when new codes emerged, previously coded transcripts were coded again to search for data
associated with the new codes. The iterative process continued throughout coding. At times, categories and themes that developed in later stages necessitated additional open coding. When this occurred, another cycle of coding was conducted, beginning with open coding and moving through the subsequent stages.

During open coding, interviews and field notes from observations were coded in Microsoft Word using the track changes and comment functions, and codes and associated text were stored in a multi-page Microsoft Excel spreadsheet document (i.e., the codebook). In the codebook, codes were recorded in rows, and columns were used to separate data by participant. The organization of the codebook evolved across the analysis process to allow for comparative analyses (i.e., comparing data, codes and themes within and across data). During focused coding, initial categories were formed, with additional spreadsheet pages being added for each new category. Additionally, hypotheses about the relationships between codes and categories were constructed by expanding the complexity of the codebook to include relevant process codes (i.e., if-then; antecedents and consequences) in columns perpendicular to primary codes in the rows of Excel. Increasing the complexity of the codebook structure allowed me to link data and codes and further examine the differences, similarities, and relationships across data. During axial coding, initial categories were reorganized into larger conceptual themes that emerged from hypothesis testing. Some initial categories were kept and expanded. Other initial categories were re-categorized into existing themes or re-conceptualized and placed into new codebook pages.

The resulting codebook includes approximately 410 codes and 11 Excel pages representing the major categories and themes that emerged from the data. The codebook will be made available for review by the dissertation committee during the dissertation defense and
represents a very strong piece of the audit trail for my work, increasing its credibility and validity.

The manuscripts that compose this dissertation include only a few of the themes that resulted from my qualitative research. I aim to continue scholarly work with this codebook by producing manuscripts on other major themes that emerged. As previously stated, conflict was a pervasive theme throughout the data and represented the moral distress that NAs experience. Unfortunately, the existing literature on moral distress is limited to nurses. I aim to contribute to the literature by describing moral distress in NAs that is related to ethical dilemmas associated with autonomy and beneficence. Other areas of focus in the future include NAs’ language related to autonomy and person-centered care, NAs’ understanding of decision-making capacity associated with resident autonomy, and NAs’ opinions of cultural transformation.
EVERYDAY AUTONOMY: A CONCEPT AND DECISION TOOL TO SUPPORT PERSON-CENTERED CARE IN THE NURSING HOME

The Omnibus Budget Reconciliation Act (OBRA) of 1987 introduced major changes affecting the regulation of nursing homes with the overall goal of improving quality of care and quality of life for nursing home residents (Institute of Medicine, 2001). Consistent with the goals set forth by OBRA 1987, nursing homes are shifting from a paternalistic medical model to a biopsychosocial model of care that is person-centered and collaborative in nature. Autonomy is widely recognized as a basic human right (Christman, 1988) and an essential component of quality of life as well as of person-centered care (Ells, Hunt, & Chambers-Evans, 2011; Kane, 2001). Research has indicated that nursing home residents who perceive a greater sense of control and support for autonomous decision-making and action in their daily life have a lower mortality risk and better psychosocial outcomes including greater social and physical activity, positive mood, decreased level of depression, greater life satisfaction, and greater overall well-being as compared to controls (Kasser & Ryan, 1999; Langer & Rodin, 1976). Thus, any efforts that support facility use of a resident autonomy-supportive model of care that supports resident autonomy will move the industry further toward the vision of quality care introduced in OBRA 1987.

Unfortunately, few resources are available to assist nursing home staff in understanding and applying the concept of resident autonomy. Current conceptualizations of autonomy are heavily theoretical and overly complex, and because most were not developed with the long-term care context in mind they tend to assume full decisional capacity whereas the resident population
of most nursing homes represents a minimum dementia prevalence of 50% (Lithgow, Jackson, & Browne, 2012). The primary purpose of this paper is to introduce an applied conceptual framework for everyday autonomy in the nursing home. Additionally, a decisional framework is presented to assist staff in determining what degree of resident autonomy to support. The frameworks were primarily developed to address the decisional needs of NAs, although it should also prove useful to nurses and the wide variety of other disciplines who work in the nursing home setting. The frameworks were developed for NAs based upon the voices of NAs – they emerged from a grounded theory study that was conducted at a Veterans Affairs Medical Center (VAMC) and focused on NAs’ experiences and perceptions of autonomy and beneficence as is described in the methods section below.

**Background**

**Autonomy**

Autonomy is an abstract and complex construct that many scholars have worked hard to operationally define (Ballou, 1998; Collopy, 1988; Davies, Laker, & Ellis, 1997; Keenan, 1999; Perkins, Ball, Whittington, & Hollingsworth, 2012; Sherwin & Winsby, 2011; Welford, Murphy, Wallace, & Casey, 2010). Often, autonomy refers to independence and free choice, and is characterized by self-rule or self-direction (Beauchamp & Childress, 2001; Collopy, 1988; Davies et al, 1997; Kane et al., 2003; McCormack, 1993; Moody, 1992). The autonomy definition challenge is likely due in part to the distinct differences among autonomy constructs from the moral, political, medical, and rehabilitation literatures (Beauchamp & Childress, 2001; Cardol, De Jong, & Ward, 2002; Christman, 1988; Clapton & Kendall, 2002). For example, non-interference (i.e., not being influenced by external or spurious internal factors) is a major
characteristic of autonomy in the moral and political philosophical literature, but it is not represented (nor viewed as necessary) in the rehabilitation literature.

Unfortunately, most existing conceptual frameworks of autonomy are not applicable to long-term care because they fail to take into account the range of resident characteristics and experiences that are common in nursing home environments. The literature on autonomy in long-term care highlights why typical conceptualizations of autonomy are not appropriate for nursing home residents. Collopy (1988) emphasized the inherent bias toward diminished resident autonomy based on the liberal views of autonomy and described staff’s tendency to underestimate residents’ cognitive and functional abilities. Collopy’s work is the only effort at building a basic structure for everyday autonomy in long-term care. He outlined autonomy polarities that exist in nursing homes (e.g., decisional versus executional autonomy), and offered suggestions on how to shift staff’s approach to care to support resident autonomy. Although Collopy’s work was instrumental in emphasizing the deficits of current autonomy concepts and detailing existing polarities in the nursing home, it lacked a conceptual framework for an autonomy continuum that is inherent in the everyday life of nursing home residents.

A newer concept of autonomy, known as relational autonomy, emerged from feminist theory over the past two decades. Relational autonomy is an umbrella term used to highlight and describe the fluid nature of autonomy; autonomy is fluid because it is directly and continually shaped by social relationships and social context (Mackenzie & Stoljar, 2000). The flexibility and interconnectedness that is emphasized in relational autonomy makes it a moderately appropriate concept for long-term care and other settings where assistance and shared decision-making are important (Epstein & Street, 2011; Hunt & Ells, 2011). As noted by Ells, Hunt, and Chambers-Evans (2011), relational autonomy also closely aligns with the foundational goals of
patient-centered care because of the emphasis on individuals’ values, communication, and collaboration.

Although relational autonomy supports autonomy within caring relationships, it rejects the notion that a personal autonomy can exist that is not based on interconnectedness. As indicated in Baltes’ (1996) model of selective optimization with compensation, individuals with functional and cognitive limitations are often successful at compensating for weaknesses to maintain full autonomy. Accordingly, a conceptual model of autonomy that encompasses a full range, including liberal autonomy (i.e., full autonomy) and relational autonomy, is needed.

**Rational Decision-Making**

As previously mentioned, rational decision-making has been noted as a requisite for autonomy (Agich, 1990; Aveyard, 2000; Ballou, 1998; Christman, 2011; Collopy, 1988; Holm, 2001; Piper, 2010). Rationality is the most complex component of consent capacity in the medical and psychological literature, and it is often the sole decisional component that nursing home staff assess when they informally evaluate capacity for autonomy (ABA & APA, 2008; Collopy, 1988). Nursing assistants provide the majority of daily care to residents and are, thus, in the best position to support residents’ everyday autonomy. However, they do not receive training on capacity assessments. Rather, this type of training is limited to mental health professionals and lawyers, and less so to physicians.

Guidance on how to assess for adequate everyday decision-making capacity and rationality of nursing home residents is lacking. The most applicable assessments are those for capacity for independent living, but even these evaluations are too complex and irrelevant to everyday decision-making in long-term care (American Bar Association and American Psychological Association, 2008; Law, Barnett, Yau, & Gray, 2012). Furthermore, the very
nature of rationality is complex. The average “normal” community-dwelling adult knowingly makes low- and high-impact irrational decisions every day (e.g., choosing to smoke, choosing to eat fast food, choosing to climb onto a rolling chair to quickly get something off a shelf, choosing not to wear a seat belt, choosing to follow too close to the car ahead, choosing to put off advance care planning despite the inevitability of death; Ariely, 2009). Our choices and preferences are often arbitrary and relative to our personal experiences and perceptions of others’ experiences. What one views as rational, another may see as illogical. Therefore, rationality alone is likely not an adequate criterion for everyday autonomy among nursing home residents.

Methods

Participants

This study is part of a larger research project designed to explore the processes and staff perspectives of cultural transformation (i.e., organizational change toward a person-centered care model) in one VA Medical Center that included several different types of community living center neighborhoods (CLCs; formerly known as nursing home units). Nursing assistants from all shifts at the CLCs were eligible to participate in the study. Recruitment occurred during work hours on all shifts, including day (7:30am to 4:00pm), evening (3:30pm to 12:00am), and night (11:30pm to 8:00am). Sampling methods included snowball and purposive sampling. Snowball sampling was carried out by eliciting appropriate referrals from study participants. Purposive sampling, a common method used in grounded theory, included identifying and recruiting NAs who were able to offer a range of experiences and opinions about perceived resident autonomy.

Data Collection

The institutional review boards of the Tuscaloosa Veterans Affairs Medical Center and The University of Alabama granted approval for this study. Data were collected between
September 2012 and September 2013. Employing theoretical sampling, data were collected and analyzed simultaneously in an interdependent iterative process. Data were collected through both observations and participant interviews, allowing for methodological triangulation to strengthen study credibility. The purposes of observations were to develop rapport with staff, establish research presence in the settings, and document the overall culture of the settings with a focus on how staff supported and restricted autonomy. Observations were conducted in public settings. Over 80 hours of observations were conducted. Field notes were written after each observation documenting actions and interactions among residents, NAs, and other staff.

Interviews were conducted to explore NAs’ experiences and perceptions of supporting resident autonomy. Nursing assistants who participated in interviews were provided a copy of the consent form and engaged in an informed consent process prior to consenting to participation. Demographic information was obtained, including age, race, site of NA training, satisfaction of current job rated on a 10-point Likert-type scale, and number of years at current job. Interviews were semi-structured and were 20 to 45 minutes in duration. Participants were also invited to complete a second interview. Ten NAs consented to participate, but only eight NAs completed the first interview. There were several barriers to research recruitment, which are presented elsewhere (Jacobs, 2014). Five NAs participated in two interviews each, and three NAs participated in one interview each, rendering a total of 13 interviews. All interviews were audio-recorded and transcribed verbatim.

**Data Analysis**

Field notes and interview transcripts were analyzed using grounded theory methodology. Four coding techniques specific to grounded theory were employed (Charmaz, 2006; Corbin & Strauss, 2008; Creswell, 1998; Saldaña, 2013). First, open coding was conducted to describe
each discrete piece of data. Specific code types used during the open coding process included in vivo, process, and versus codes (Saldaña, 2013). In vivo codes captured the data content using participants’ language. Process codes identified the indicated actions and interactions that were represented in the data. Versus codes were used to describe conflicts and struggles between concepts, perceptions, and people.

The second phase of coding, focused coding, was more selective and conceptual than open coding. Within this phase, codes were examined for similarities, differences, and connection and initial categories were formed based on conceptual content. Hypothesis testing regarding the relationships between categories began during focused coding, creating a fluid transition to the third phase of analysis known as axial coding. During axial coding, categories and codes were further examined, hypotheses were extended and tested, data were reassembled and reorganized into larger conceptual units (themes), and analytic themes were explored through comparative analysis by examining the differences and similarities and relationships between the themes. Finally, theoretical coding was used to integrate major themes into a conceptual model, constructing a primary theory that was grounded in the data.

Interviewer triangulation was employed as a method to check and improve research credibility. The first author coded all transcripts and field notes, and integrated the data in a codebook using Microsoft Excel. The second author coded five transcripts and reviewed the codebook. Approximately 20 coding meetings between the first and second author were held during the coding process to discuss codes, resolve any inconsistencies between the coders, and discuss major themes and the final theory.

Throughout the process of data collection and analysis, analytic memos were frequently written. One purpose of the memos was to engage in research reflexivity and document the
research process. Memos were also used to reflect on codes and operational definitions during the open coding phase. During the latter phases of analysis, memos were written to document comparisons between the data and describe possible networks between the data, including observed patterns, categories, and theories. Memos were not coded as data; rather, memoing was used a method to make sense of the data.

Results

Participants

The majority of NAs who completed the interviews were African American (75%) and female (75%), which is representative of the NA population in the VAMC setting of the study. Duration of employment ranged from one year to 12 years ($M = 7.13$). Satisfaction with current job ranged from five to 10 on a 10-point Likert-type scale (1 = extremely dissatisfied, 10 = extremely satisfied). Half of the sample received NA training at an educational facility or organization, and the other half were trained “on the job.”

Grounded Theory Frameworks

Analyses resulted in a conceptual framework we call the “continuum of everyday autonomy” and a decision-making framework to guide staff in their everyday decision-making regarding the provision of autonomy support. These two frameworks are presented below.

**Conceptual framework: Continuum of everyday autonomy.** The conceptual framework presented was grounded in the interview and observation data. *Everyday autonomy* emerged as the core construct, referring to the autonomy exercised by residents (and affected by NA actions) in their choices and actions in daily life in the nursing home. Everyday autonomy lies along a continuum, and the identified anchors include full, relational, and restricted autonomy. The level of residents’ everyday autonomy is largely dependent upon staff decisions
about if and how to support resident autonomy in a given situation. In turn, staff decisions are directly influenced by their level of understanding and empathy for residents’ situations, and their interpretations and attitudes regarding their inherent responsibility to minimize residents’ physical risk. Relational power is another factor that affects everyday autonomy. Power is situational and intentional, and it waxes and wanes as everyday autonomy shifts along the continuum (Foucault, 1978). The more power that staff exercise in regards to resident situations, the less power is left for residents to exercise, and vice versa. Everyday autonomy is rarely static; instead, everyday autonomy is ever changing. Figure 1 illustrates a hypothetical numeric range of everyday autonomy to demonstrate the neutral position of the midpoint and the positive and negative positions of the two endpoints, whereby the increasing positive numbers represent greater relational power and autonomy of residents and the increasing negative numbers represent less relational power and autonomy of residents. The three anchors on the everyday autonomy continuum are described below.

**Relational autonomy.** Relational autonomy is the midpoint anchor on the everyday autonomy continuum and characterizes a neutral position that results in balanced relational power between staff and residents. It is conceptualized as a “soft approach” that NAs can use when full autonomy is not feasible or safely possible. Relational autonomy allows NAs to initiate a partnership with residents to find ways to minimize physical risks while also supporting as much autonomy as possible. Examples of staff engaging residents in relational autonomy include: (a) staff providing assistance to a resident during the resident’s self-care activities such as bathing and eating, (b) staff encouraging a resident to use a walker for mobility due to a recent fall, and (c) staff recommending to a resident that he/she bathe sometime “today” due to risk for infection associated with multiple consecutive days of not bathing.
**Full autonomy.** Full autonomy is an endpoint anchor on the everyday autonomy continuum and is defined as independent decision-making or action that occurs without influence or assistance from others. The range of decisions and actions is vast, and includes both very complex decisions with high risk, but also much simpler decisions with low risk. Thus, most nursing home residents, even those with mild to moderate cognitive impairment and/or physical disabilities, have the capacity for full autonomy for at least some decisions and actions.

Examples of residents exercising full autonomy include: (a) deciding not to eat because of lack of appetite, (b) choosing to bathe in the morning rather than the evening, (c) deciding not to participate in an activity, such as bingo or church service, (d) staying up late in the evening to watch a television show, and (e) deciding to take a walk around the nursing home unit for exercise.

**Restricted autonomy.** The other endpoint on the everyday autonomy continuum, opposite of full autonomy, is restricted autonomy. It is characterized by distinct paternalism and disregard for residents’ values and preferences over protection against physical risks without consultation with the resident or resident’s surrogate decision-maker. Two of the most common health-related concerns that motivate staff to restrict autonomy are fractures resulting from falls and aspiration resulting from consumption of foods and liquids that are contraindicated in persons with swallowing difficulties. Capacity evaluations by mental health professionals or medical doctors may be warranted in situations when a resident’s food preferences do not correspond to the medical professional’s advice for pureed foods and thickened liquids. NAs feel helpless in making decisions that go against the dietician’s or doctor’s orders. As one NA stated, “Well, to my understanding, if it’s a doctor order, it’s our job to incorporate what the doctors order.”
Restricted autonomy is appropriate in situations of imminent, life-threatening danger and when assessing residents’ preferences (or, when the resident has severely compromised decisional capacity, the surrogate’s preference) is not feasible. However, these types of situations are often brief, and consideration of residents’ values in conjunction with evaluation of associated physical risk can aid in moving toward relational autonomy.

**Determinants of autonomy.** A seesaw is a helpful metaphor for understanding how a resident’s decision or action comes to move to a particular point on the everyday autonomy continuum. Figure 2 illustrates the everyday autonomy continuum as a seesaw that can be caused to tip towards one autonomy endpoint or the other, depending on how each given situation is acted upon by the NA and the resident. The interview and observation data yielded evidence of three main determinants of where upon the autonomy continuum the residents’ decisions or actions may come to rest (value placed on minimizing physical risk, empathy for resident experience, and relational power), and a fourth determinant was added based upon the autonomy literature and consideration of what was not represented in the data (maximizing physical and psychological well-being). In Figure 2, the first two determinants of autonomy (valued placed on minimizing physical risk and empathy for resident experience) represent the effort that is placed on the seesaw, whereas the third determinant of autonomy (relational power) is the output force. The fulcrum on which the lever rests represents NAs’ balance of maximizing physical and psychological well-being.

**Value placed on minimizing physical risk.** A primary theme that emerged from the data was the high value that NAs placed on minimizing residents’ risk for physical harm. NAs shared many stories about their work with residents in which they had placed higher value in their responsibility for preventing physical risk than they had in their responsibility for honoring
residents’ preferences. The outcome of this decisional process was predictably higher levels of autonomy restriction for residents. The following excerpt characterizes this focus on minimizing risk of physical harm.

It’s hard not to get….when you’re passionate about your care, it’s hard to just sit there and watch ‘em, you know, do what you know….what they know is not the best thing for ‘em. It’s hard, so you get your emotions wrapped up in takin’ care of these guys because we have a vested interest in our veterans, too. So, these guys here, I’ve only been workin’ with most of ‘em since January, February, but I still have a best interest in them. I don’t want to see ‘em doing anything to harm themselves, put themselves into a worse… So, whatever opportunity I see that, “Hey, we need to do this, we need to do that, we’ll do the thing differently,” you know… You always want to see them get better. So, by sittin’ there watchin’ continue to make bad choices, eventually I might step in, you know. (112)

Although NAs emphasized the need to minimize physical risks, they did not place emphasis on promoting autonomy for the sake of minimizing psychological risks. One NA noted the benefit of autonomy, stating, “I think it [choice and independence] gives ‘em a better quality of life because they’re able to… to tell us, you know, what they want to do.” Although this NA acknowledged possible benefit from increased autonomy, she did not indicate an inherent responsibility as a caregiver to promote autonomy to minimize the risk of decreased psychological well-being. In other words, the NA viewed psychological well-being as a product of autonomy rather than a motivation for supporting autonomy. The following excerpt illustrates NAs’ propensity to value minimizing physical risks over minimizing psychological risks.

Oh, I think it’s great. You know, because, it’s something… It takes – I’m sure – that it takes a lot out of… Our guys are older guys. So, once you take someone’s independence
away, you know what I’m saying? It just takes a lot outa them. So, to allow them to have their own choices, independence…it’s um, it’s great, as long as it’s not harming health-wise, you know what I’m saying? (110)

*Empathy for resident experience.* Staff empathy for residents was a precursor to staff support of resident autonomy. When NAs were aware of and able to understand residents’ values, or when they attempted to view situations from the residents’ perspectives, NAs were more likely to be open to honoring residents’ choices. Imagining being in the resident’s position, asking about past behaviors and routines, critically thinking about the current environment, and asking about present values are all strategies that staff can use to empathize with residents.

The following quotations are excerpts from interviews with NAs that highlight how empathy leads to increased honoring of autonomy. In the first example, an NA hypothesized why some residents prefer to stay in their bedrooms rather than sitting in the living room area and interacting with others. When formulating his hypothesis, the NA considered how the residents’ past experiences and current environment might influence their current preferences and behaviors.

LJ: Um, and, do the veterans come out and interact – do things together?

112: We have a couple that do. We have some that just don’t want to. And, I believe they don’t want to because for so long they been in the environment where they been around a lot of noise, dealing with the overcrowded units. So… 25, 35 bed unit. So, now they have their own rooms and TV in their rooms…it’s peace and quiet. [The NA chuckled.]

LJ: They’re set.
112: Yeah. (We laugh.) It’s quiet, you know. And you come out here…it get a little noisy in here sometime with the few staff and few residents out here. So, I mean, I understand why they stay in their room.

Another NA described a resident who preferred to stay in his bedroom most of the day because he enjoyed relaxing in his recliner and did not like interacting with many people. As evidenced from the NA’s interview, she constructed her understanding of the resident’s preferences from observations and interactions with the resident.

You know, like I said the recliners and stuff, we had one resident, well he (is) deceased now, and he liked his recliner that he has at home. So, he said the chairs we had not comfortable, you know. He feel like nothing (is more) comfortable than his recliner. So, they made arrangements for the recliner to get here. And, during the daytime, he don’t like interacting with the other residents, or the other veterans, or whatever. And, he likes to stay in his room. (109)

One NA explained that staff were upset about a resident consistently sleeping in the bed until the afternoon; however, staffs’ perceptions of the resident’s behavior changed when they conducted a root cause analysis and developed an understanding of how the resident’s life influenced his values and preferences.

I only have one guy that wants to lay in bed all day. And, I can’t go in there and be like, “Hey, you need to get up.” You know, he worked night shift for thirty years, so he slept all day for thirty years. That’s not gone change because he came to the hospital. You know…so. Just let ‘em do what they gone do. When he’s up, he’s there, he’s fine, he’s functional, he has no problems. So…. Who am I to go in there and say, “You need to start wakin’ up at 8 o’clock in the morning”? Now, that was the issue we talked about in RCA
[root cause analysis], where he, uh, somebody had a problem with him layin’ in the bed so long. That’s his routine before he came to the hospital. He worked night shift. He was tired – worked long nights – he slept all day. (112)

Relational power. Relational power between NAs and residents is dynamic and always present. A balance of relational power is a product of equal “force” between staff and residents as well as staff’s balance between minimizing physical risks and empathizing with the residents’ experience. The unbalanced force or relational power results in a shift from the neutral position of relational autonomy toward a positive direction of full autonomy or a negative direction of restricted autonomy. The following quotation taken from an interview with a NA illustrates how everyday autonomy results from a balancing act of relational power between staff and residents.

So, uh, I think it’s [autonomy] a good thing, but I think it’s – you know, the old saying is “once an adult, twice a child?” To some extent, they go back to children. And so, after a while when you see that they’re just going to be reluctant – period – to doing what they need to do, then you have to take the initiative step and say, “Well, OK,” – in your mind – “He’s gone back to a child. I’ve got to help him to…” Then, I’ll talk to them and…and help them to make this decision…being their choice. You know, sorta turn it around using reverse psychology – and turn it around and talking to them in a way where the choice is made and they feel like they did it, you know. (107)

Another example, provided below, demonstrates the balance of relational power as a resident’s autonomy moved from restricted to relational.

109: We done had a couple that didn’t like the pureed because, uh, their problems that they’re having, the reason why they’re on pureed. So, when they have problems with it, we let the charge nurse know, and she’ll put in a order that, you know, to let [dietitian] go
over and let [dietitian] talk to ‘em and let ‘em know why they on it. Which, they already know why because it already been discussed with ‘em. So, sometimes they will make choices of whether… Like, we had one that was on pureed. He doesn’t like the pureed. So, they made a choice of, uh… And, then when he eats and he drinks, he aspirates. So, what they did, they made a choice of lettin’ him have mechanical…to see how…

LJ: And that’s the meat ground up?

109: That’s the meat ground up. And they made the choice to let him, try him on that one and see how it works. So, we had to observe him and see how it work. As long as he not drinking a thin liquid while he eating, he is always fine. So, we tell her, “Well, he doin’ fine with the mechanical, but only thing that, you know, that we notice that he might drink some tea and start aspirating, coughing and going on. So, as long as he drinking the nectar thickened liquid while he eating, he do fine.” So, they decided to let him have the mechanical, and he drink, uh, the nectar liquid while he eating. Then, he can have the thin liquids like thirty minutes after he eats.

LJ: OK. And he’s fine with that?

109: He said he’s fine with that.

LJ: OK. Well, good.

109: He just didn’t want the pureed.

Maximizing physical and psychological well-being. As indicated above, the NA interview and observational data indicated a focus on physical well-being (minimizing physical risk). The data were notable for the lack of discussion of psychological well-being (including quality of life). NAs reported difficulty balancing physical and psychological well-being because they viewed the two concepts as distinct dichotomies that cannot exist together. Specifically,
NAs’ understanding of resident autonomy was “they can have whatever they want,” which led to NAs’ conceptualization of dichotomous constructs – autonomy versus physical well-being. One NA stated, “So, I’m like, it’s not that we don’t want ‘em to [have autonomy], but if you… You can decide you want to give ‘em their way, or you provide safe care.”

NAs’ inability to understand how to maximize physical and psychological well-being associated with autonomy was likely a product of several factors. First, NAs indicated a lack of training on how to integrate their responsibilities of promoting autonomy and protecting residents’ physical well-being. NAs spoke of being inundated with various yearly internet-based trainings but could not recall trainings specific to autonomy. Second, NAs did not participate in interdisciplinary treatment team meetings and did not view the team or other clinical providers as sources of support for their perceived conflict between maximizing psychological and physical well-being associated with decisions about what degree of autonomy they should support. Consequently, NAs lacked opportunities to discuss and learn how to maximize physical and psychological well-being.

Ideally, both psychological and physical well-being associated with autonomy should be maximized as much as possible. The key to maximizing both is to consider the strength of residents’ values and preferences, the cost to residents’ psychological well-being if values and preferences are not honored, and the potential cost to residents’ physical well-being if values and preferences are supported (Calkins, 2007; Dunbar, Sink, Bailey, & Starnes, 2011; Hunt & Ells, 2011). We believe that the NAs who participated in the present study experienced difficulty with integrating support for psychological and physical well-being related to resident autonomy because they lacked a decision-making framework that outlines steps to balance psychological and physical risks associated with autonomy support and restriction.
Decisional framework: Decision-making about degree of autonomy support. A decisional framework that staff can use when determining what degree of resident autonomy to support in everyday situations is presented in Figure 3. A list of questions to assist staff in their exploration within the decision-making process is shown in Table 1. Consistent with a person-centered approach, staff should first engage in perspective taking by assessing residents’ preferences and values. Generally speaking, this is best applied as an ongoing process that includes “getting to know” the residents. Learning about residents’ histories, including their hardships and triumphs, opens the door to developing a deeper understanding of what residents value and why. Working with residents over time in this manner, staff can develop a working knowledge of residents’ preferences and values and can move through this stage of decision-making quickly and efficiently.

Second, staff should assess the physical risk of residents’ choices and actions. People in the general population engage in multitudinous unhealthy behaviors or habits every day, so many of the residents’ choices or behaviors will likely have some negative health-related consequences, either in the short-term (e.g., a resident with an unsteady gait attempting to walk without a walker) or long-term (e.g., a resident deciding not to take prescribed medications). However, evaluating potential risks and considering the risks relative to the residents’ care plans are important steps in a person-centered process of decision-making. For example, if a resident chooses to lie in bed all day and not participate in physical therapy, his or her preference is in opposition to an agreed upon care plan that includes physical rehabilitation. In contrast, if physical therapy is not a part of the resident’s care and rehabilitation is not a component of the care plan, the level of physical risk may be viewed as less severe than the former example, especially if the resident agrees to turn in bed often to reduce the risk of pressure ulcers.
Finally, the last stage in the decision-making framework is to decide what degree of autonomy to support. Information gleaned from the first two decision-making steps should be combined to select a degree of autonomy that is optimal for the resident. At times, it may be difficult to balance equally benefits of autonomy and physical risks. The following excerpt is of an NA describing her approach to a common situation about a resident who did not want to bathe. This example illustrates how the NA balanced resident autonomy and responsibility for the resident’s health. The NA’s approach included initially restricting autonomy but including the resident as a collaborator in care by providing appropriate but limited options.

107: And some of ‘em, we have to make the choice for them. I have to stress that because there are some just would rather do without cleaning themselves up, period. And, and, and it’s – you know, we realize that’s an illness. You know. But then, that’s when we have to take the initiative step to say, “Well, you have to have a bath today.”

LJ: Yeah.

107: And uh, “So, well, do you want to wait until before you go to bed, or do you want to just do it now?” And they’ll say, “Well, I’ll just wait.” And so I remind them what they said. “Remember you said you was gonna wait. Well it’s time now.” And sometimes they’ll go on. Sometimes they will say, “No, I will not.” And then we have to say, “Well, yeah, you need to do it.”

**Case example.** To illustrate how to apply the decision-making framework, a hypothetical case example is provided below.

Mrs. Mills, a widowed 89-year-old Caucasian female, was admitted to the nursing home because her only living daughter, whose health was declining, was unable to continue caring for her in the home. Mrs. Mills had a medical history of stroke, type II diabetes, and major vascular
neurocognitive disorder (also known as vascular dementia) of mild to moderate severity. She required assistance with ADLs including bathing and dressing, but she was mobile and used a walker. After living in the nursing home for a couple of weeks, staff found snacks, condiments, plastic-ware, and straws stashed in Mrs. Mills’ dresser drawer. In talking with Mrs. Mills, staff learned that Mrs. Mills took these unused items during mealtimes and put them away so that they wouldn’t “go to waste” and in case she needed them later. The staff initially labeled her behavior as “hoarding” and decided that this habit would not be tolerated, resulting in restricted resident autonomy.

**Decision-making process.** Using the framework for everyday decision-making about degree of autonomy support (Figure 3) and guiding questions (Table 1), staff are likely arrive at a different conclusion. In this case example, Mrs. Mills was a teenager during the Great Depression, and she learned to conserve, especially food-related goods, as a result of being raised in a large, poor family. Throughout her life, she gathered all unused condiments in her purse following any dining occasion and stored them on her kitchen table at home. Thus, Mrs. Mills’ behavior developed when she was a child and continued through adulthood. Her impulse to store unused condiments and plastic-ware was so deeply ingrained in her typical behavior that it would likely impact her negatively if staff forced her to stop. In fact, a paternalistic approach in this case example might even create resistance from Mrs. Mills, resulting in unfavorable interpersonal relationships between Mrs. Mills and the staff. In contrast, supporting her behavior through noninterference would allow Mrs. Mills to maintain some sense of normalcy in her everyday life in the nursing home.

In this example, Mrs. Mills’ behavior had no impact on her physical health, and it was not in opposition to her care plan to maintain physical function. In fact, Mrs. Mills generally
engaged in behaviors that staff find favorable, such as taking her medications, eating food consistent with her DASH/no-salt diet, always using her walker to ambulate, bathing according to her bath schedule, and engaging in group exercise. Given that Mrs. Mills’s behavior was very important to her and was associated with no risk to her physical health, staff should consider fully supporting Mrs. Mills’s autonomy by allowing her to continue storing unused items in her drawer. If Mrs. Mills’s condiment and plastic-ware stash grows to an unmanageable size, staff could assist her in finding a way to organize, such as placing small boxes in the drawers to contain the items or discarding expired items. Therefore, the final decision in this example is to support Mrs. Mills’ autonomy fully, but realizing that a more relational degree of autonomy may be more appropriate in the future if problems arise.

Summary. The case example of Mrs. Mills illustrates how empathizing with residents by gaining an understanding of residents’ histories and current values can positively influence staffs’ perspectives and result in supporting residents’ autonomy. More complicated cases include situations in which residents’ physical health might be critically compromised if autonomy is supported. For example, full autonomy support cannot be offered when a resident who has moderate to severe dementia wants to go for a walk alone outside the nursing home. However, engaging this resident in relational autonomy is possible by escorting the resident outside for a walk, assisting the resident to a secured patio, or redirecting the resident toward a pleasant activity. In any case, the decision-making framework presented in Figure 3 offers a person-centered approach that staff can use to determine the degree of autonomy that can be supported.
Discussion

The existing autonomy constructs are too narrow, conceptual, and complex for applicability by direct care staff in long-term care, which can be detrimental to the movement toward person-centered care. Collopy’s (1988) work was instrumental in providing the foundation for conceptualizing how resident autonomy can be enacted in long-term care and emphasizing how autonomy is often restricted due to staff’s propensity to underestimate residents’ cognitive and physical abilities. If staff do not have a framework to provide guidance on how to support resident autonomy, they are likely to continue a paternalistic approach to care as described by Collopy (1988). The purpose of this study was to develop an applied conceptual model for everyday autonomy that is applicable to long-term care settings and create a decision-making framework that NAs can use to guide their approach to provide person-centered care that maximizes physical and psychological well-being associated with autonomy.

Using data collected from observations and interviews with NAs, a continuum of everyday autonomy emerged. The midpoint anchor on the continuum, relational autonomy, represents the neutral position of autonomy that is appropriate for situations in which full resident autonomy is not feasible or possible due to factors such as residents’ physical limitations or potential risks to residents’ physical well-being. In most situations in the nursing home, resident autonomy is likely to fall near this midpoint anchor due to the inherent culture of “caring.” The relational autonomy anchor is consistent with the literature on autonomy in rehabilitation settings and provides evidence that autonomy can be maintained in caregiving relationships between staff and residents (Hunt & Ells, 2011).

One endpoint on the everyday autonomy continuum represents full autonomy. The existence of full resident autonomy that was reported and observed in the setting of this study
illustrates three important points. First, full autonomous action and decision-making can happen regardless of a person’s ability to rationalize all consequences or demonstrate full decision-making capacity. This finding is in contrast with the conceptualization of autonomy in the moral and political philosophical literature (Ballou, 1998; Christman, 2011; Piper, 2010). Second, full autonomy is possible in a long-term care setting, though it happens significantly less so than other degrees of autonomy due to the inherent nature of staff’s role in protecting residents’ physical health. Finally, the presence of full resident autonomy demonstrates the progressive movement toward person-centered care and emphasis on psychological well-being that many residents, clinicians, researchers, and policy makers have hoped for over the past several decades (Kane, Caplan, Urv-Wong, Freeman, Aroskar, & Finch, 1997; Kane, Freeman, Caplan, Aroskar, & Urv-Wong, 1990).

Several determinants of resident autonomy emerged from the data. Relational power is a major factor that is present in all situations related to resident autonomy. NAs’ tendency to focus on minimizing physical risks caused them to exert more power, which ultimately resulted in resident autonomy that fell near the restricted autonomy anchor on the everyday autonomy continuum. However, when staff empathized with residents’ present experiences, they demonstrated a fuller understanding of residents’ preferences and values which they incorporated in their decision-making process when determining the degree of autonomy that would be supported. Although several NAs demonstrated awareness of possible psychological benefits of autonomy, they discussed difficulties with integrating autonomy support and protection of residents’ physical health, which highlighted the detriment of lacking a decision-making framework. Without a proper framework, NAs tended to focus on maximizing physical well-being with little regard for maximization of psychological well-being.
Developing a model that included determinants of resident autonomy aided in the development of a decision-making framework. The decision-making framework and related guiding questions provide a blueprint that NAs can use when navigating the difficult decisions regarding support for everyday resident autonomy. Consistent with literature on person-centered care (Ells, Hunt, & Chambers-Evans, 2011), the decision-making framework emphasizes the assessment of residents’ values and preferences in conjunction with an evaluation of potential physical risks. Additionally, it highlights the need for consideration of how autonomy support and restriction may impact residents’ psychological and physical well-being.

Limitations

The primary limitation in this study was the small number of NAs who participated in interviews. Several barriers to research recruitment were encountered and fully described elsewhere (Jacobs, 2014). Additional NAs may have provided information that could have altered the emergent common decisional process that is presented in Figure 2. To remedy the small sample of NAs who participated in interviews, over 80 hours of observation was conducted across three strikingly different nursing home units in the study setting. Furthermore, observation data was collected until saturation occurred and no new themes emerged.

This study was conducted in one organization, and the facility began promoting person-centered care several years prior to data collection. Information from NAs at other facilities may have produced different or additional determinants of autonomy. Furthermore, every nursing home has a different culture, which is created by the nursing home administrators, staff, and residents. Aside from the model of care, other characteristics in nursing homes, such as resources or staffing, might influence staff’s decision-making process when determining what degree of autonomy support is possible.
Lastly, the maximization of psychological and physical well-being, which is represented as the fulcrum in the conceptual framework of everyday autonomy and related determinants (Figure 2), was not directly measured. Psychological and physical well-being resulting from varying degrees of everyday autonomy are likely more complex than what is presented in the conceptual framework. However, further exploration of these constructs was beyond the scope of this study.

**Recommendations for Practice, Policy, and Future Research**

Several notable findings from this study have implications for future practice and policy. First, NAs lacked training on how to integrate support for resident autonomy and protection of residents’ physical health. Moreover, NAs believed that these two constructs could not co-occur. Applicable and meaningful training on the concept and application of autonomy support in the nursing home is needed. Such training might include presentation and discussion of hypothetical case examples, role play, and problem-solving sessions and weekly discussions about struggles related to supporting resident autonomy. Ells, Hunt, and Chambers-Evans (2011) suggest that training focused on development of communication and interpersonal skills would help staff engage in person-centered care that supports resident autonomy.

A lack of perceived support from treatment team members and other clinical staff was evidenced in the present study. Additionally, there was an absence of support from an ethics committee. A study by Dunbar et al. (2011) demonstrates the benefit of having clinical providers and an ethics committee involved in difficult decisions regarding the support of resident autonomy. Clearly, the involvement of many team players in difficult cases projects support that NAs need in order to honor residents’ autonomy. In order for person-centered care and resident
autonomy to flourish, support networks with clinical providers, supervisors, and ethics committees need to be established.

The proposed conceptual frameworks may have promising implications in the practice of person-centered care. However, additional research is needed to determine the applicability of the everyday autonomy continuum and the decision-making framework. Specifically, future qualitative research should explore the applicability of these conceptual frameworks across a variety of long-term care settings such as skilled nursing facilities and specialty care units. Further research should also focus on qualifying and quantifying additional anchors along the everyday autonomy continuum to expand the ease of use. To test the usability and effectiveness, a standardized tool is needed to evaluate the reliability and validity of the conceptual frameworks in nursing home practice.

The presented frameworks were developed from interview and observation data obtained from NAs. Given the push toward person-centered care and implications of autonomy in quality of life and overall psychological well-being, the conceptual frameworks should be expanded by gathering data from nursing home staff in other disciplines as well as nursing home residents. Broadening the range of available data would advance the presented conceptual models, which could potentially further the promotion and application of person-centered care in nursing homes.
**Figure 1.** Hypothetical numeric scale of the everyday autonomy continuum.
Figure 2. A conceptual framework for everyday autonomy and related determinants
Figure 3. Everyday decision-making about degree of autonomy support
### Table 1

*Guiding questions for the decision-making process*

<table>
<thead>
<tr>
<th>Assessing Resident Values and Preferences</th>
<th>Assessing Risk of Physical Harm</th>
<th>Determining Degree of Autonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How strong is the preference?</td>
<td>1. How severe and certain is the risk of physical harm?</td>
<td>To what extent can the resident’s preference be honored?</td>
</tr>
<tr>
<td>2. How relevant is the preference to the resident’s values?</td>
<td>2. How relevant is the preference to the resident’s care plan for healthcare or rehabilitation?</td>
<td>A. Fully, without modification or shared decision-making</td>
</tr>
<tr>
<td>3. How will supporting the preference impact the resident emotionally or psychologically?</td>
<td>3. How will supporting the preference impact the resident physically?</td>
<td>B. Partially, with limits/modifications or shared decision-making</td>
</tr>
<tr>
<td>4. How will restricting the preference impact the resident emotionally or psychologically?</td>
<td>4. How will restricting the preference impact the resident physically?</td>
<td>C. Not at all</td>
</tr>
</tbody>
</table>
SUPPORTING EVERYDAY AUTONOMY FOR RESIDENTS IN NURSING HOMES

Autonomy, a highly regarded human right in the Western world, is often diminished in situations when a person is dependent on another in order to accomplish tasks or fulfill wishes (Baltes, 1995; Christman, 1988). The very act of being admitted to a nursing home is an experience of autonomy loss because loved ones rather than personal choice often place individuals there. Moreover, when an individual enters a nursing home, a certain degree of privacy and personal space is also lost. Furthering the decline of autonomy among nursing home residents, nursing assistants (NAs) and other nursing staff are challenged to provide direct care for a large number of residents, which often results in assisting with and delivering personal care that is not consistent with residents’ preferences (Kane & Kane, 2001). Activities of daily living (ADLs) including bathing, grooming, and toileting are often performed on a routine schedule so that NAs can provide efficient care. It is common for residents to be labeled “incontinent” and be made to wear adult diapers because facility systems do not support NAs in providing individualized care such as assisting residents to the restroom in a timely manner (Sacco-Peterson & Borell, 2004). Additionally, residents often do not have control of their schedules, including bedtimes, mealtimes, and bath times.

Research on autonomy in long-term care evidences the benefit of and desire for autonomy among residents in nursing homes. Early studies by Langer and Rodin (1976) and Schulz (1976) highlight the positive effects on well-being associated with choice and control. More recent research has not only indicated subjective benefits of autonomy related to quality of life but also lower mortality among nursing home residents (Duncan-Myers & Huebner, 2000;
Kasser & Ryan, 1999). Moreover, individuals residing in nursing homes report that they value autonomy and believe it to be a necessary component of a satisfactory life (Cooney, Murphy, & O’Shea, 2009; Kane et al., 1997).

Since the Omnibus Budget Reconciliation Act of 1987, quality of life has been a major area of emphasis in long-term care (Institute of Medicine, 2001). Consequently, long-term care is slowly shifting from a medical model to a biopsychosocial model of care that focuses on the person rather than just the illness or disease (White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009). Advocating for personal autonomy is at the heart of this person-centered movement (Calkins, 2007; Flesner, 2009; Welford, Murphy, Wallace, & Casey, 2010). In a previous paper, I presented an applied conceptual framework for everyday autonomy in nursing homes that was constructed using grounded theory (Jacobs, 2014). This framework posits an autonomy continuum that ranges from full autonomy to restricted autonomy. Between the two polarities on the continuum lies relational autonomy and represents opportunities to engage in autonomy-supportive approaches to promote resident autonomy. Where a given interaction falls on the continuum is influenced by relational power between staff and residents. Relational power defines the constant implicit and explicit negotiation of power that is inherent in long-term care settings.

An autonomy-supportive approach includes a positive communication style that is not dominating or forceful but, rather, promotes collaboration. Scholars in the areas of education, parenting, coaching, health care, and psychotherapy have studied antecedents and benefits of autonomy support (Su & Reeves, 2011). Findings from this body of research indicate that an autonomy-restrictive approach develops when the teacher or caregiver focuses on the end goal rather than the process, especially in the context of performance-based outcomes (Deci, Spiegel, Ryan, Koestner, & Kauffman, 1982; Grohnick, Gurland, DeCoursey, & Jacob, 2002). In other
words, when tasked to teach a skill with the overall goal of improving students’ or dependents’ performance, educators and caregivers engage in controlling or paternalistic behaviors such as uttering directives, providing solutions or answers to problems, and making “should” and “ought” statements (Reeve & Jang, 2006). In contrast, an autonomy-supportive approach in this context is characterized by offering encouragement and rationales, being responsive to questions, and being open to dialogue rather than monopolizing discussions.

Autonomy support is a fundamental aspect of person-centered care in nursing homes. However, only one published study has described autonomy-supportive behaviors in long-term care. Whitler (1996) interviewed registered nurses (RNs) in eight nursing homes to explore the techniques they used to support resident autonomy. Interview data reflected five strategies, described broadly by Whitler (1996) as methods to assist residents in making decisions. The strategies included the following: (a) personalizing instructions based on the RN’s values and experiences; (b) shaping instrumental circumstances by advocating for residents’ autonomy and finding creative solutions to support residents’ autonomy; (c) providing information to residents so they could make informed decisions; (d) describing pros and cons of decisions for residents; and (e) persuading residents. Whitler noted that, although not directly stated in the nurses’ interviews, mentioning opportunities and assessing decisional capacity should be included as forms of assisting residents as well. Understanding how RNs support resident autonomy is important. However, NAs provide the majority of care to nursing home residents, and understanding how they support resident autonomy can offer insight on how person-centered care can be implemented in long-term care.
Purpose of Study

There is a lack of research describing autonomy-supportive techniques in long-term care and, more specifically, it appears that there have been no studies to date detailing how NAs support resident autonomy. As the person-centered care movement progresses, NAs will need to find ways to honor residents’ preferences and choices while also providing care that, at times, residents might initially decline. Thus, learning how NAs in a person-centered care facility grapple with such matters can offer insight into effective strategies that allow NAs to do their job and, at the same time, respect residents’ wishes. Using qualitative methodology, the present study aimed to explore autonomy-supportive approaches NAs used at a long-term care setting that was in the process of shifting toward a person-centered model of care.

Methods

Participants and Procedures

Approval for research was granted by the institutional review boards of the Tuscaloosa Veterans Affairs Medical Center and The University of Alabama. The study was conducted for one year at two Community Living Centers (CLCs; formerly known as nursing home units) and one Cottage (a small, stand-alone nursing home consistent with the Green House model) at a Veterans Affairs Medical Center. Two data collection methods were used to increase the validity and breadth of data collected. The first data collection procedure included observations of NAs during all shifts, including day, evening, and nights shifts. Obtaining consent for observations was neither feasible nor necessary because observations were conducted in public areas only, which included living rooms, dining rooms, kitchens (all settings had an on-site kitchen), and hallways. All staff were provided information about the observations before they were conducted. Autonomy support behaviors were noted, and field notes were written following each
observation. Observations were conducted until data saturation occurred and no new information was gleaned. In total, over 80 hours of observations were conducted across the three study settings.

The second data collection procedure included 20- to 45-minute semi-structured interviews with NAs. Nursing assistants from all shifts were invited to participate in interviews. Recruitment for interviews was conducted in the last eight months of the study period. Participants were provided information about the study, procedures, limits of confidentiality, potential risks and benefits of participation, and participant rights. Eight NAs agreed to participate and signed informed consents. All participants were invited to participate in a second interview. Five NAs accepted this invitation, which resulted in 13 interviews total. All interviews were audio recorded and transcribed verbatim.

**Data Analysis**

This project was part of a larger grounded theory study. The approach to data analysis used for this paper was thematic analysis, a product of an early analysis process in the grounded theory approach. The first author coded all field notes and interview transcripts and integrated the data. The second author coded five selected interviews for the purpose of adding credibility. Weekly meetings were held to discuss all codes and themes. By comparative analysis, data were compared within and across interviews, and observations continued until data saturation occurred (i.e., no new themes emerged) and themes were refined.

**Results**

Autonomy-supportive approaches are defined as strategies used to influence residents in some way for the purpose of increasing positive, healthy behaviors or decreasing negative, unhealthy behaviors. The primary characteristic of autonomy-supportive approaches was that
resident choices and preferences were ultimately honored. Additionally, communication tone was a factor related to the effectiveness of each approach. Ten domains of autonomy-supportive approaches emerged from the data. As shown in Table 1, these domains were assisting, monitoring, encouraging, bargaining, informing, providing directions, persuading, asking, providing options, and redirecting. Nursing assistants often employed more than one strategy in each autonomy-supportive interaction with residents.

Assisting

The primary responsibility of NAs is to assist residents with ADLs. Accordingly, NAs reported and were observed assisting residents with daily tasks. Autonomy-supportive approaches to assisting were characterized by providing aid that the resident wanted or openly accepted without hesitation and assisting in a timely manner. Autonomy-supportive assisting was further divided into respectful assisting, helping to fulfill a desire or wish, and stepping in.

Respectful assisting. Respectful assisting is defined as providing help while verbally or nonverbally communicating that the resident is a collaborator in care tasks rather than a dependent individual that lacks capacity for self-care. It was used while assisting residents with an ADL such as bathing or grooming. Respectful assisting was most often used when residents wanted to exercise independence in self-care but needed some support due to physical or cognitive limitations. One NA described:

But, uh, we more or less assist them. And like I said before, I try to make them feel lead, that they’re in charge of what we’re doing. But at the same time, I’m knowing their capabilities. Somewhat to, uh…like, “Well, I can do this,” (personifying resident) and then they’ll help you do a little something, and I’m like, “Well, I think you did that nicely. Let’s just touch it up a little bit here.” (108)
**Helping fulfill a desire or wish.** Although NAs explained that their primary job was to assist residents with ADLs, they also described occasions when they went above and beyond their duties to fulfill residents’ wishes. For example, one NA noted that she and other NAs have cooked meals at home to bring to the residents when they have special requests such as a dessert cobbler. Another NA mentioned that she has bought food, such as fried chicken, for residents when they did not like the prepared dinner from the nursing home kitchen. Similar helping behaviors expanded across activities other than mealtime. For example, one NA described assisting a resident outside the facility so that the resident could smoke a cigarette.

**Stepping in.** Residents were encouraged and, at times, expected to do chores because NAs placed a strong value on supporting functional independence. For example, some residents were expected to wash and dry their laundry and change their bed linens. Nursing assistants recognized that there were times when residents did not want to engage in chores and would “step in” to fulfill residents’ responsibilities. One NA described her approach in this situation:

> I just said, “OK. If you don’t want to do it right now, I’ll come back later. And if you still refuse, OK, I’ll do it this time. But, the next time we’ll have to talk about it a little longer.” You know. “If you don’t want to do it today, you want to think about doin’ it tomorrow?” (111)

**Monitoring**

Monitoring was defined by an in vivo code titled “keeping an eye out.” Nursing assistants were consistently thinking about the safety of residents, and monitoring was a strategy they used to prevent harm or quickly intervene if harm occurred. As an autonomy-supportive approach, NAs were observed monitoring residents while they engaged in potentially risky activities, such
as walking or eating foods outside of the prescribed diet, with the intention of intervening when accidents occurred or were about to occur.

As far as eating, some of them are not able to eat…to feed themself. They can eat. There are certain foods they have to have. They want, uh, food that they can have a regular diet. Some of ‘em really want it, and I want ‘em to have it. But, they have a swallowing problem. They won’t chew it well enough because they’re choke risk, and you have to really monitor them. And then sometimes I do take maybe a fried piece of chicken instead of the pureed, you know the pureed kind, the mechanical, and just cut it up really really fine for them so they can get the taste of the crispiness and the fried, you know, at the same time satisfying their taste, but looking out for them. (107)

**Encouraging**

Encouraging was a strategy NAs used to motivate residents, with the intention of positively shaping their behaviors in the moment or in the future. Positive communication tone was an essential component to effective encouraging. Specific autonomy-supportive encouraging strategies included *boosting confidence* and *praising*.

**Boosting confidence.** Infrequently, NAs would encourage residents to engage in self-care independently or with minimal staff assistance by boosting residents’ confidence in their functional abilities. This strategy was executed by reminding residents’ what they were capable of accomplishing or what they had recently accomplished. For example, one NA wanted a resident to dress himself, but the resident insisted that he was not capable of putting his shirt on. The NA encouraged the resident by saying, “Yeah, you can put your shirt on. I saw you do it the other day. Remember? You got your shirt and put it on.”
**Praising.** Nursing assistants praised residents for engaging in care tasks with the intention of encouraging independent self-care and helping behaviors in the future. Praising occurred by attending to a goal that the resident accomplished and offering emphatic approval or reward. Nursing assistants believed that nearby residents who witnessed the praise would also benefit because it would motivate them to do tasks independently in the future also.

So, when I come in sometimes, they’ll (residents) say, like, uh, “Look. Come here. I need you to see. Look. Come here.” I said, “What?” “I went in there last night and you was not here, and I put my shoes right there [imitating a resident].” I said, “Good for you!” You know, I really clapped. I said, “You really did a wonderful job.” And I said, “Did you hear that?” – if there’s another resident around. I was like, “Did you hear that? He went in there and nobody had to tell him to put his shoes up. He changed his clothes, got his hygienes together, and he put his shoes right there.” And he was like, “Yeah, I did that.” He was really, really proud. You know. So, I think giving ‘em some praise or awarding them for what they do, and then…. (107)

**Bargaining**

Nursing assistants used bargaining as a strategy to get residents to do things, such as bathing or participating in an activity, in return for honoring a specific resident wish. Bargaining is a type of autonomy-supportive approach because the resident ultimately has control over the negotiation – he or she can either participate in the activity the NA negotiates for or not. In the following example, an NA describes how she used bargaining to get a resident to calm down and go back to sleep in the middle of the night.

He will get…he will try to get up out the bed to try to make it to his wheelchair to get up and go, ‘cause he feels somebody outside waiting on him. So, I conversate with him and
let him know that, you know, “Nobody’s outside waiting on you, and I’m gone need you to stay in the bed where you won’t fall and hurt yourself,” or whatever, ‘cause we moved the wheelchair from beside his bed ‘cause we had to put the blue mats down because he will come out the bed. You know, for preventing him from hurting himself or breaking a hip or whatever. And he still will try to get up. So, and I told him, I said, “If I get you up out the bed and take you outside and let you see that nobody’s out here, would you come back…?” – It’s at night now [providing situational context]. “Would you get back in the bed and have a good night?” Or whatever. And he was like, “Well, I will have to see.”

(109)

**Informing**

Nursing assistants are excellent sources of information for residents and treatment team members. They are knowledgeable about the daily schedule in the nursing home and can provide helpful information to residents as they navigate everyday life. Accordingly, one type of autonomy-supportive informing is labeled *informing about an opportunity*. Also, NAs spend more time with residents compared to other staff and are, thus, are in an ideal position to assess and advocate for residents’ preferences. This second strategy is categorized as *informing others’ about residents’ preferences*.

**Informing about an opportunity.** Residents had many opportunities to exercise autonomy in the nursing home; however, they were sometimes not aware of these potentially autonomous moments unless staff inform them. For example, several residents in the CLCs and cottage stayed in their bedrooms most days and only came out to eat meals. When a social event or recreational activity was available, NAs informed all residents of these opportunities, even those residents who preferred to stay in their bedrooms. By informing the residents about the
activities, NAs provided residents the opportunity to accept or decline the invitations to participate, further supporting residents’ autonomy. In the following example, an NA explains that she informs residents what foods will be served at breakfast, which gives the residents a chance to make an informed decision about whether to get up and eat breakfast or sleep late.

And you know, they’ll usually want to know, “Well, what are we havin’?” And you can tell ‘em and, sometimes it depends what you’re havin’ as to if they’ll get up and eat or not. But…it’s the same thing for lunch. We’ve got some that’ll sleep through lunch. (113)

**Informing others about residents’ preferences.** Although NAs do not have the power to override doctors’ orders that conflict with residents’ preferences, they are equipped with valuable knowledge about the resident and can advocate for them. Furthermore, they can educate new staff about what residents prefer. For example, a new staff member was observed telling a resident to sit in his chair at the kitchen bar while he ate his meal. An NA familiar with this resident informed the new staff member that the resident prefers to stand while he eats so that he can interact with the kitchen staff on the other side of the bar. Although NAs were not directly observed informing higher-level staff about residents’ preferences, they reported that they tell treatment team members when residents refuse to eat pureed food.

We’ve had one or two since I’ve been here that just refused to eat that (pureed food). And, of course, when we sent the RN around there, theirs [their meal] would actually be changed to accommodate them. So… We’ve had one or two that just, “I’m not eating pureed.” So, they’ve changed it and worked it up to the mechanical, which is a step up. But, we have to monitor that, you know, for a little while, and see how they’re doing and stuff. (108)
Providing Instructions

Nursing assistants often provided directions to residents. Sometimes the directions were given to prevent harm, but this type of instructing usually resulted in restricted resident autonomy. For example, NAs would often instruct residents to sit down to reduce the risk of falls. In contrast, an autonomy-supportive approach to providing directions was intended to increase functional independence.

Providing instructions in the moment to increase independence. Most observed and reported accounts of providing directions were intended to increase residents’ independence in the moment. This strategy was appropriately used during self-care tasks or chores when residents forget necessary steps. For example, NAs provided instructions about how to dress, fold clothes, and bathe. The following excerpt illustrates an NA’s approach to providing instructions to a resident during bath time.

And there are some that says they can’t, and they look like they’re capable, but they don’t. You know. They won’t wash their hair. They won’t wash under their armpits or whatever. So they’re not…I’m like, “OK, let me help you out just a little bit.” And they’ll think…they’ll do something…“Oh, I know how to bathe. You don’t have to help me. I got this.” You know. I’m just like, “Yeah, well, let’s just get this part right here. Get you rag and put some soap on it. Make sure you hit under here, wash under here and wash there.” Because, I do want them to feel independent, you know. But at the same time, if they’ll lead, it’s their body; they need to feel that way. And, I want them to always feel good about what they’re doing. (107)

Shaping long-term behaviors for independence. Only one NA reported using a behavioral strategy coded as shaping. Shaping is accomplished by presenting an activity one step
at a time and only moving forward when the first action is mastered. For example, if an NA wants a resident to learn how to do laundry, he or she will first instruct the resident to put clothes in the washing machine. When the resident masters this step, the NA will teach the resident to put laundry detergent in the machine and turn it on. Consecutive steps are not introduced until the resident is proficient at loading and washing clothes in the washing machine. The only example provided in the present study is included below.

Um, a resident that wasn’t making his bed. Uh, we decided that, uh, every morning when he gets up, uh, we’ll be in the room with him. First, we started helpin’ him strip his bed, and we started helpin’ him put his linen on his bed. Then we worked him up and said, “Ok. It’s time for you to do it on your own.” So, we…he stripped the bed off and put them in a bag and take it to the laundry room. We put his linen in his room for him, and if he doesn’t make his bed up, he just lays on the mattress. Nobody wants to lay on a bare mattress. [He laughed.] So, he gets up and makes his bed. (112)

Persuading

Nursing assistants often used autonomy-supportive persuading to get residents to engage in healthy behaviors or refrain from partaking in unhealthy behaviors. This approach was used in a variety of situations including ADLs (e.g., bathing and dressing), instrumental activities of daily living (i.e., taking medications), and recreational activities. Persuading was divided into the following categories: persuading by presenting rationale, persuading by ensuring trust, and persuading by providing an opinion.

Persuading by presenting rationale. When residents did not want to participate in an activity, NAs would often present a rationale for why they should. For example, one NA described a situation when a resident did not want to put on pajamas. Instead, the resident
initially insisted on wearing his day clothes and shoes to bed. After providing a simple rationale for why the resident should change clothes (i.e., it would be more comfortable), the resident complied. The following is an excerpt taken from an interview that illustrates how an NA persuaded a resident to refrain from engaging in a potentially risky behavior.

A particular patient was in restorative program. You know…to… And he would raise up and pull his-self up on the rails in the hallway. That’s part of his training…you know, wheelchair ambulation and stuff. Um, and he had fallen the day before. So, the next day after supper, he had, you know, got through eating and pulled away from the table and just pulled up to the wall by himself. And, when he does these exercises, the restorative staff is there in case anything goes wrong. And, he just proceeded to go over there to the wall, and wanted to do his exercises on his own. So, I went over there. I said, “You just fell yesterday, so you probably a little unsteady on your feet.” And, you know, I just, asked him to sit down in the chair. I said, “Now, restorative works with you doing this, so let’s just wait and not do this until restorative gives you the ok to do your exercises. And he gave me the [he made a “thumbs up” motion] thumbs up. (108)

**Persuading by ensuring trust.** At times, providing a rationale was not a sufficient approach to persuade residents. Instead of moving toward an autonomy-restrictive approach, such as forcing residents to comply, NAs used a different persuading tactic. Nursing assistants used the rapport they had with residents to their advantage by using persuasion to ensure that residents could trust them, which often resulted in compliance.

Um, some of ’em say, “I don’t need that. That’s not the color [medicine].” You know, some of the medicines’ color vary. And if it’s not the color that they’re used to, we really have a problem. Now, we have one I can pretty much talk to and say, “That’s the same
medication. You know, its…the color’s changed, but it’s good for you and you need that. You really need that. And so, just take it.” I say, “I promise you, you know. Now, you and I are ok, and we’re friends, and I wouldn’t fool you.” And he was like, “Well, I might this time.” (107)

**Persuading by giving an opinion.** Nursing assistants provided their opinion about matters as a way of persuading residents. This method was observed in a variety of situations. For example, during an observation at lunchtime, a resident did not want to drink his water. An NA near the resident encouraged him to drink the water because it was healthy, and she followed up her response by stating that she liked water. Persuading residents by giving an opinion was most successful when the resident respected the NA who provided the opinion. The following excerpt was taken from an interview with an NA that all of the residents liked.

And, to me, baths are so important because you need to be clean. Everybody wants you to be clean. But there are some that think they’re not dirty; they hadn’t worked, they hadn’t sweated, so they’re not dirty. So, we have a few issues with that. Last night was a good example, ‘cause I mentioned to one of ‘em about takin’ a bath, and he said, “Naw, I had one the night before last.” And I said, “Well, I had one the night before last, and I had one last night, and I had one before I came to work.” And, I said, “I think everybody needs a bath.” Well, about 30 minutes later, he said, “Well, if you think I need to take a bath, I’ll take one.” So, he took a bath last night. ” (113)

**Asking**

Asking is an autonomy-supportive approach NAs used to engage residents in communication about preferences. When NAs asked residents questions over time, they learned their preferences and were more efficient at offering person-centered care. Asking was divided
into three categories: *asking preferences*, *asking as a form of suggesting*, and *asking “why” to understand the root of residents’ preferences*.

**Asking preferences.** Nursing assistants noted that residents’ preferences were assessed when they were admitted to the nursing home. These preferences were documented and stored in a binder that was not accessible to the NAs. Consequently, NAs were tasked to ask residents about their preferences often for the purpose of providing person-centered care. However, at times, residents’ preferences changed, especially when they were avoiding a particular care task. As illustrated below, NAs regularly asked residents when they were ready to bathe, and they frequently asked the same residents multiple times during their shift.

Well, if I, if I go in and ask ‘em do they want to take a shower, and they tell me no….so, I’ll probably leave out and go back later and ask again, because you know that we have veterans that, you know, that dementia or whatever. So, sometimes I go back. And, if you go back, they might say, “I’m ready.” You know. So, I will go back and ask about three or four times before I put down that they didn’t want a bath today, or ask them what day would they want they shower or bath or whatever. (109)

**Asking as a form of suggesting.** Sometimes, NAs used questions as a way to suggest things. This strategy was particularly useful when residents were not required to engage in a specific activity, such as washing laundry, or when residents were generally agreeable. The following example illustrates how an NA applied this strategy to get a resident to make up his bed, even though tidying was not the resident’s responsibility on this nursing home unit.

But, we have a few, a couple, who try to make their beds. And sometimes, you know, we’ll go back and check and make sure everything is ok. But, they’ll pretty much try it, you know, if we ask them. So, yeah. They aren’t going to voluntarily make the bed, but
some of ‘em we’ll ask, “Are you gone make your bed today?” And, you know, they’ll go ahead and do it and try to spread it up and everything.

**Asking “why” to understand the root of residents’ preferences.** When NAs were not able to convince a resident to engage in a certain behavior, such as taking medicine or eating pureed food, they attempted to understand why the resident was resistant. Gaining a better perspective on why residents made certain decisions allowed NAs to empathize with residents and address their concerns. One NA explained that he conducts a “root cause analysis” to better understand how residents’ values influence their preferences. In the excerpt below, an NA lists the questions she asks residents when they choose not to take their medications.

“Let’s just talk about this. What’s goin’ on? Why you don’t want to take your medication?” You know. “What are you thinking right now? Why do you feel like it would hurt you? Why do you feel that we would hurt you? We’re tryin’ to help you. We’re here for you. What do you need? What do you need to talk about? What would make this work? What can we do to have you less angry or less agitated?” (107)

**Providing Options**

Nursing assistants promoted residents’ autonomy by providing options in a variety of ways, such as offering different choices for snacks or movie showings. In almost any situation, options were available. Though, sometimes options were limited due to inherent constraints of nursing home policies, resources, or staff availability. For example, residents had the option of waking early or sleeping late, but their breakfast options depended on their choice of rise time because there was not enough staff to cook for residents whenever requested. Residents who were early risers were afforded the opportunity to eat a hot breakfast, such as eggs and sausage.
However, residents who chose to sleep late were often not offered a hot breakfast; instead, they could choose to eat cereal or some other food item that did not require cooking.

Occasionally, NAs felt that it was necessary to exercise a certain amount of paternalism to get residents to engage in self-care behaviors. These events happened when residents consistently refused to comply with NAs’ requests. One NA stated, “And some of ‘em, we have to make the choice for them. I have to stress that because there are some just would rather do without cleaning themselves up, period.” However, even during these situations when NAs were making commands and restricting autonomy for a greater good, they ultimately loosened their control and supported residents’ autonomy by providing any options that were feasible. An NA explained, “And some just will not (take a bath), and that’s when you step in and say, ‘OK, you have got to have a bath. Do you want to do it now, or do you want to do it later? But we gotta do it today.’”

Redirecting

Nursing assistants used redirecting, which is defined as diverting one’s attention away from one thing and on to another, when residents who had cognitive impairment wanted to engage in an activity that was potentially harmful or not feasible. It is classified as an autonomy-supportive approach because it was used in place of explicitly telling residents they could not partake in their desired activity. In the following excerpt, an NA describes how she applies redirection.

LJ: Tell me about an experience that you’ve had when a resident wanted to do something that you thought was unhealthy or unsafe, and you felt that it was your job to keep them safe or prevent harm.

107: Uh…I had that to happen a couple of times. Uh, what I do is I try to redirect ‘em.
And when I see that I can’t, I’ll, uh, talk to them. I’ll try to talk to them. And then I’ll try to start some other activity, like, “Do you want to play a game? Let’s watch a movie.” They all like *Wheel of Fortune*, you know. And, “Let’s play a game,” or whatever. And, we have this game named Wii, you know, that they do.

**Discussion**

A plethora of research has supported the benefits of autonomy among nursing home residents, which has influenced the shift toward a person-centered approach in long-term care. Although autonomy-supportive behaviors have been studied in disciplines such as education and parenting, strategies specifically employed by NAs in nursing homes have yet to be described. The purpose of this study was to explore approaches NAs used to support resident autonomy in a person-centered long-term care setting. Using the qualitative methods of observations and interviews, ten autonomy-supportive approaches were found.

Nursing assistants used a variety of approaches that were helpful in exerting a positive influence among nursing home residents. Consistent with the everyday autonomy continuum presented by Jacobs (2014), NAs employed autonomy-supportive strategies that fell between the polarities of full and restricted autonomy. Common characteristics among all approaches included communicating with residents in a respectful manner and honoring residents’ preferences to the extent possible. In many cases, NAs used more than one approach in a given interaction with a resident and adjusted their approaches if their initial tactic was not effective.

The results of the study indicate that NAs have a range of autonomy-supportive strategies they can use when shared decision-making is warranted. Such situations might include a resident refusing to bathe for an extended period of time or a resident attempting to walk without support from a walker after a recent fall. Caregivers’ inherent tendency in any potentially harmful
situation is to protect, and often this protection is exerted in a paternalistic manner. However, as indicated in this study, strategies such as persuading and redirecting were effective at inhibiting residents from engaging in risky behaviors. These autonomy-supportive strategies were ideal alternatives to a paternalistic approach that may have resulted in resistance from the resident.

Other autonomy-supportive approaches allowed for a certain degree of resident freedom. Nursing assistants placed a high value on functional freedom and independence, which they supported through strategies such as assisting, monitoring, and encouraging. Other times, NAs advocated for freedom and autonomy by informing residents of available opportunities and providing options.

**Limitations and Conclusions**

Limitations of this study included the sample size and study setting. Despite an eight month period of recruitment, only eight NAs participated in interviews. Efforts were made to offset this limitation by increasing the number observations that were conducted. Second, the study was conducted in three nursing home settings in one VAMC located in the southeast. It is possible that NAs in other long-term care settings may employ other autonomy-supportive approaches. Further research is needed to describe that array of strategies that NAs can use to support resident autonomy in a person-centered approach to care.
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The purpose of this paper is to describe the difficulties encountered while recruiting nursing assistants (NAs) for a qualitative research study in a community living center (CLCs; previously known as nursing home units) and a cottage (a small nursing home structure consistent with Green House Model) at a Veterans Affairs Medical Center (VAMC). Only one other published paper has described recruitment challenges in a nursing home NA population. That paper reported obstacles encountered during recruitment of all levels of nursing staff (including registered nurses and licensed practical nurses; RNs and LPNs) from other medical settings (e.g., hospitals; Shaha, Wenzel, & Hill, 2011).

NAs have distinct characteristics and are different from other nursing staff levels in many ways. NAs are the staff who spend the most time with the resident. They are also among the lowest paid nursing home staff, and they have one of the highest workplace injury rates in the nation. It is thus reasonable to expect that recruitment challenges in the NA population are likely unique and possibly more complex than other staff populations. The first objective of this paper is to highlight the inherent characteristics of the nursing home NA position to provide context to illuminate potential recruitment barriers. Second, strategies we used to recruit NAs are described in detail to highlight the complexity of recruiting NAs for qualitative research in long-term care at a VAMC. Finally, potential solutions to recruitment barriers are discussed.
Nursing Assistant Characteristics

“Power is everywhere… Power is not something that is acquired, seized, or shared.”

(Foucault, 1978, p. 94)

Power

Power is always present and is a consequence of hierarchies and relationships (Foucault, 1978). NAs occupy the lowest clinical provider position in the nursing home and inherently have the least power. This lack of power has major implications for the NAs’ position in the nursing home itself and also in society because of the accompanying socioeconomic status (NAs receiving wages that are often near the levels of minimum wage workers). Subsequently, this lack of power is associated with numerous psychosocial stressors related to lack of sense of self-efficacy (i.e., control over one’s own time management, limited ability to make choices regarding task prioritizations and task implementation, and limited ability to impact the decisions and actions of other clinical providers in the NH environment) as well as stressors related to socioeconomic status. Living a life that is consistently associated with minimum power has negative consequences. Being the “low man on the totem pole” in regard to power relations can result in discrimination, fostering an attitude of suspicion. Limited power also engenders resistance, which may be an adaptive strategy to deal with associated stress (Foucault, 1978). Below, characteristics of NAs and the work environment are described. The effect of power, or lack thereof, is present in many aspects of NAs’ jobs and may affect how they respond to participating in research.

Socioeconomic status. NAs are generally less educated than nursing staff. According to statistics from the National Nursing Home Survey, approximately 75% of NAs between 2004 and 2005 had a high school diploma or less (Centers for Disease Control and Prevention [CDC],
2010). NAs’ low education level may negatively impact their willingness to participate in research. If NAs have not participated in research before, they presumably do not understand the purpose and process of research. Consequently, NAs are likely to perceive research as similar to audits or nursing home inspections. Audits and state nursing home surveys are evaluative and directly impact NAs and the nursing home. Therefore, when given the opportunity to decline participation in research that is misunderstood as evaluative, most NAs are more than likely to choose not to participate.

Related to educational attainment and the inherently low-paying wage of the NA job, over 63% of NAs between 2004 and 2005 had a family income of less than $30,000; furthermore, over 57% of that percentage of NAs had a family income of $20,000 and less (CDC, 2010). Lack of financial resources and stability has significant implications. For example, NAs may lack money that is often needed for reliable transportation or upkeep and repair of vehicles, possibly resulting in tardiness or absenteeism at work. NAs may have dependent children, grandchildren, or older adults that live in the home, and poor financial resources leads to difficulties with paying for childcare or in-home caregivers for older relatives; consequently, NAs may have to miss work due to lack of assistance. Because NAs have a low-paying job, they may be inclined to have two or more jobs to make ends meet.

NAs’ work life is impacted by stressors related to financial burden, participation in research may feel like a burden. They may also decline research participation as a way to exercise a small amount of control in their lives. Even if NAs do agree to participate, they may have difficulty scheduling a time to meet with the researcher due to transportation or childcare issues beyond their control.
**Race.** Another significant demographic difference between NAs and nurses is racial composition of the population. Nationally, almost 40% of NAs identify as being African American, whereas the majority of LPNs and RNs identify as being Caucasian (CDC, 2010). Race is an important characteristic not to be overlooked because NAs are often reminded of the color of their skin and contextual discrimination related to power relations (Ryosho, 2011). Over 87% of nursing home residents are Caucasian, making race a salient attribute as a large percent of African American NAs care for mostly Caucasian residents (Jones, Dwyer, Bercovitz, & Stahon, 2009). In fact, NAs readily express that race and associated discrimination are distinct matters that negatively influences the work environment (Dodson & Zincavage, 2007). NAs have reported that they regularly experience racism by residents, family of residents, and other staff (Ejaz, Rentsch, Noelker, & Castora-Binkley, 2011; Ryosho, 2011). Therefore, the salience of race and associated prejudice often results in NAs feeling victimized by an implicit divide between “us” and “them,” furthering the inequalities in perceived power and subsequent resistance.

Race is a distinct factor related to recruitment barriers in research. Literature on the difficulty of recruiting African Americans for health services and biomedical research is growing, and researchers are increasingly investigating strategies to rectify this issue (Allman et al., 2011; Ejiogu et al., 2011; Nueces, Hacker, DiGirolamo, & Hicks, 2012; UyBico, Pavel, & Gross, 2007). Among the factors influencing research recruitment, mistrust of research appears to be the most distinctive barrier to recruiting African Americans (Brandon, Isaac, & LaVeist, 2005; Corbie-Smith, Thomas, & St. George, 2002; Durant, Legedza, Marcantonio, Freeman, & Landon, 2011). Researchers have speculated that the Tuskegee Syphilis Study precipitated African Americans’ mistrust, especially regarding health services and biomedical research.
However, researchers investigating the impact of this unethical and exploitative research study have concluded that African American’s mistrust of research is not fully explained by knowledge of the Tuskegee Syphilis Study and could be a consequence of personal and global experiences of racism and discrimination (Brandon, Isaac, & LaVeist, 2005; Durant et al., 2011; Katz et al., 2008; Scharff et al., 2010). Furthermore, this mistrust does not necessarily extend to just biomedical research. Diaz, Mainous, McCall, and Geesey (2008) found that African American males in their study were more likely to provide DNA for research purposes rather than divulging personal information about private topics.

**Responsibilities and time.** NAs have a challenging job. They spend the most time providing care to residents compared to other staff and have been described as “the backbone of the facility” (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013; Jones et al., 2009; Parmelee et al., 2012). Not only do they perform strenuous and physically demanding tasks that contribute to a high number of work-related injuries (Khatutsky, Wiener, Anderson, & Porell, 2002), but they are also challenged to be time efficient, providing a great deal of care in the shortest time possible, so that they can meet all of the residents’ needs. Adding to the stress of time constraints is the high turnover rate among direct care staff in nursing homes. A study of the 2004 National Nursing Home Survey data revealed a 74.5% turnover rate for NAs (Donoghue, 2010). High turnover can often result in periods of understaffing and create obstacles to providing quality care as newer staff adjust to the work climate and familiarize themselves with the staff and residents (Bowers, Esmond, & Jacobson, 2000).

NAs often lack control over how their time is managed. They are often “shift workers” and may be scheduled to work a variety of shifts without consenting to when they are scheduled. Thus, an NA may be scheduled to work day shift on Monday and night shift just two days later.
Additionally, the shortage of NAs resulting from turnover causes NAs to get pulled from one unit to the next to fill gaps of coverage. NAs rarely have control over which units they work or which residents they care for. Even if an NA develops strong relationships with select residents, he or she is not guaranteed consistent assignment to these residents.

Because NAs may be essentially powerless in many aspects of their work schedule, they may have difficulty committing to research participation because they have little control over their availability. Even if NAs do schedule a time to participate in research, the appointment is not a guaranteed commitment because there are so many possibilities of issues that may arise that are beyond NAs’ control. Participating in research during nonwork hours may not be an option, especially if the NA has another job, lacks transportation, or has other responsibilities. Lacking control and power over so many factors makes it very difficult for NAs to commit time to research participation.

Recruitment Strategies and Challenges

We conducted a qualitative study in a VAMC long-term care setting to explore NAs’ experiences and perceptions of their responsibilities associated with caring for nursing home residents. Three long-term care settings within one VAMC were included in the study. Nursing home leaders were aware of and supported the study, though leaders did not take part in recruiting staff to participate. NAs from all shifts were eligible to participate. The three work shifts included day (7:30am to 4:00pm), evening (3:30pm to 12:00am), and night (11:30pm to 8:00am). The study methods consisted of participant observations and 20- to 45-minute audio recorded semi-structured interviews. Individual interviews were scheduled according to the NAs’ preferred time and setting. Participants were recruited and data were collected by the first author.
Recruitment Process

Observations began six months prior to initiating recruitment for interviews. Although observations generated research data, building rapport and establishing relationships with staff were major objectives during observations. Observations varied in length depending on the activity in the setting and the individuals who were present. For example, if there was minimal interaction in the environment and staff had little presence, observations were approximately 20 minutes in duration. In contrast, observations lasted as long as one hour if staff were present and interactive with the researcher. Over 80 hours of observation were ultimately conducted.

Building relationships with the staff consumed many of the observation hours.

Building rapport. A primary focus of the initial observations was determining how to develop relationships with the staff and, more specifically, NAs. Several barriers to interacting with NAs emerged. First, NAs were very busy during certain times of the day, which made it almost impossible to interact with them for any significant period of time. The most difficult time to develop rapport with NAs was directly after dinner between 5:00pm and 8:00pm. During this time, NAs were busy assisting residents with bathing and dressing and were only visible for a minute at a time when they escorted residents to and from the living room areas. Social niceties, such as smiling, saying “hello,” and other small conversational exchanges (e.g., “How are you?”, “Good to see you”) were offered anytime a staff member was nearby, including the very brief moments that staff were visible.

Directly before, during, and after mealtimes were not ideal times for developing relationships. All staff were visible during these times, but their attention was focused on
assisting residents to the dinner tables, communicating with kitchen staff who were cooking and/or plating food, assisting residents with eating, and cleaning the tables when residents finished their meals. Staff were generally very conversant with each other during mealtimes and may have been open to communicating with me if I was able to help them by assisting residents with eating. However, being an “observer” rather than an “assistant” limited my ability to interact with staff at mealtimes.

Another barrier to building rapport was infrequency of opportunities for welcomed interaction. During the observations, I discovered that approaching NAs for conversation while they were working alone was undesirable. NAs were never blatantly impolite when approached alone; however, they provided verbal and nonverbal cues that indicated disinterest in the conversation. Such cues included: (a) lack of eye contact; (b) not exchanging verbal niceties; (c) answering questions with short, one-word responses; and (d) stating that they were busy. In contrast, the most appropriate time to approach staff to build rapport was during social encounters that included at least two staff, but these interactions were variable with no consistent pattern. Before staff-researcher relationships were built, staff did not invite me to join their social encounters. This was a clear indication of the divide between “me” and “them.” During these initial social interactions, I inserted myself in social conversations and conveyed interest in developing relationships with them. Once relationships were forming with select staff, other staff members who were initially neutral began responding to me favorably when they witnessed the relationship I had with others. Over the course of the study, relationships with staff grew and staff readily engaged me in conversation and even offered invitations to play domino games and watch television shows with them.
Aside from the friendly social exchanges, there were three major indications that relationships had been formed. First, when staff disclosed information about their personal lives, a message of friendship was conveyed. The first remnants of a developing friendship were evidenced by staff discussing their likes and dislikes about various things including movies, television shows, and foods. These topics were neutral and did not elicit strong emotions or content. However, as staff became more comfortable with me, they shared information about their past and current struggles including family issues, health concerns, and work-related problems. On a few occasions, staff elicited my opinion about their problems, which communicated that our relationships consisted of trust and respect.

Staff began to take interest in my personal life, which was the second indication that bonds were forming. Gradually across the study period, staff progressively asked more personal questions. These questions were always welcomed and allowed trust to develop. Staff conveyed sincere interest and concern in my well-being. For example, after late-night observations, staff expressed worry about me driving home at such late hours and offered coffee to keep me awake. Anytime I disclosed personal information about work-related accomplishments, staff offered sincere congratulations and hugs on occasion.

The third sign that relationships were developing was staff’s comfort with joking around me, with me, and on my behalf. Banter was a part of the NAs’ culture in the nursing home, and it occurred often. Staff regularly joked with each other, which commonly consisted of one staff member poking fun at another in good spirit. On one occasion, a staff member demonstrated great comfort with me by jokingly stating, “I saw you walking down the hallway the other day, looking like a little white girl, like you were too good to even speak to me.” Good-humored
statements that would be absurd or rude if delivered in a neutral tone signified the melding of “us” and “them” so that the degree of separation was not as prominent.

A calculated strategy I used to balance power relations and build trust was helping. Unfortunately, nursing home policies limited some of my opportunities to help. For example, I attended “feeding” training with a speech language pathologist so that I could help staff by assisting residents with eating at mealtimes. After the training, the nursing home policy changed to exclude volunteers from this activity and I was never able to assist with meals. However, I helped in other ways, including opening doors, engaging residents in conversations, relaying resident requests to staff, assisting staff with setting dinner tables, moving furniture, and pouring drinks for residents. Staff occasionally expressed appreciation for the help, and they always commented, “You don’t have to do that.” However, they never reached a level of comfort that permitted them to ask for my help.

**Maintaining rapport by tolerating discomfort.** An unanticipated and uneasy commitment emerged during the process of developing relationships with staff. At times, staff’s jovial sense of humor was uncomfortable to witness or take part in. During one observation, a staff member was using song to highlight people’s shortcomings. The staff member’s song was initially directed toward other staff, poking fun at their personalities. However, when a resident approached this staff member, a song was created to poke fun at the resident. The resident ignored the song, but another staff member nearby laughed and said, “You’re wrong for that.” On another occasion, a staff member was observed trying to persuade a resident to participate in an activity. The staff member engaged me in the humor that was used to influence the resident’s decision. The staff member jokingly used peer pressure by stating that the resident was trying to
“act cool” in front of me. Then the staff member proceeded to pantomime boxing punches near the resident’s face to get him to engage in interaction.

Other situations that elicited discomfort with observing and developing relationships with staff included moments when staff did not provide necessary care or assistance to residents. During an observation, a resident asked a staff member the location of the nearest restroom. The resident’s pants were already unbuttoned and unzipped, and he was standing in the living room area. Three staff were present, and one staff member called out the resident’s name and poked fun at him for having his pants unbuttoned. Instead of assisting the resident to the restroom, a staff member told the resident to sit down, and he was not assisted at any point in the remainder of the observation. Situations such as these were disconcerting to witness; however, to maintain rapport that had been established with staff, I was tasked with engaging in the cultural norm, which was to maintain an unfazed demeanor.

**Recruitment Challenges**

A passive recruitment strategy was employed first. NAs were provided with information about the study in written and verbal form and were told to contact us if they were interested in participating in interviews. Not one NA spontaneously expressed interest in participating. Not surprisingly, this strategy was unsuccessful, so it was followed by a more active (and resource intensive) approach to recruitment – the first author and other members of the research team began directly approaching staff and asking them to participate. As we had laid out in our Institutional Review Board protocol, we were conscientious about the risk of perceived coercion and risk that NAs might worry that declining participation would negatively impact their job. Therefore NAs were only approached when they were not within earshot of nurses or others who might have supervisory responsibilities, and it was frequently emphasized that participation was
voluntary and only the researchers would know who consented to or declined participation. During these recruitment conversations, staff were provided with information about the study purpose, risks and benefits of participation, and participant rights. They were frequently reminded that all data would be kept confidential and supervisors would not have access to their data. In essence, the recruitment conversations with staff paralleled the consent process.

This active recruitment of NAs was a challenging and time-consuming process. First, NAs were frequently difficult to locate. Staff schedules were often made weekly and often varied drastically from week to week, making it difficult to plan which NA to target for recruitment, when, and on what CLC unit. Schedules changed often, and staff were frequently pulled from one shift to another and from one unit to another. Several appointments were made with NAs to further discuss the study and complete a consent form; however, due to their unexpected schedule changes, they were difficult to track; those particular NAs ultimately did not participate in the study.

Other recruitment difficulties were immediately realized after initial recruitment conversations with staff. Many forms of “soft refusals” were experienced. Several NAs noted that they lacked time to participate, despite assurance that interviews could be scheduled at a time convenient for them. Two NAs reasoned that they would not be appropriate participants because they had worked in the study setting for less than a year, although they were assured that length of employment was not a criterion for study inclusion. A few NAs commented, “You don’t want to hear what I have say,” indicating that they would not have positive information to contribute to the study. The importance of gathering information from all viewpoints was explained, but the NAs declined anyway. Several NAs declined participation without providing a reason, and others did not directly decline or accept the invitation for participation.
One potential explanation for these soft refusals was a misunderstanding and suspicion of the written consent form. Throughout recruitment conversations, NAs were informed that they would need to sign a consent form to participate in interviews. It was explained that the purpose of a consent form is to document that participants receive appropriate information about the study. During recruitment conversations, NAs did not directly voice concerns about signing a consent form, but several seemed especially disinterested in participating when this topic arose. Furthermore, several NAs who completed the formal consent procedure to participate in an interview indicated reluctance to put their signature on a form. They questioned the reasoning and noted suspicion about the procedure. In fact, the first participant to formally consent to participation stated that he believed his signature on the consent form would allow his supervisors to trace his interview data back to him, and he feared he would be reprimanded for the information he expected to share in the interview. Not surprisingly, this NA ultimately declined to participate despite repeated assurances of confidentiality.

During the eight months of recruitment, after 80 hours of time spent on the units building rapport and recruiting for the study, only ten NAs consented, and of those only eight completed the study. Two NAs declined participation after providing informed consent because they reportedly lacked time to participate in interviews. Of those participants who completed the study, three completed interviews while off-duty and five participated in interviews while on the clock. NAs who participated during their work shift noted that there were additional staff to cover them, and nursing assistants who decided to participate during their off time did so because they worried there would not be adequate coverage during their absence.
Reflections

Passive support from nursing home leaders was invaluable because it allowed us entrée to the nursing home setting. Additionally, the leaders’ endorsement served as an assurance to staff that their participation would be supported. A closer association with leaders would have situated us too near the center of power, threatening our ability to bond with staff and conduct credible qualitative research.

Consistent researcher presence in the nursing home setting was an important strategy that enhanced the research process and opened access to NAs who may have otherwise disengaged with researchers. Genuine relationships were established, which enhanced the authenticity of the data that were collected through observations and interviews. Every effort was made to establish trusting relationships with staff. As previously explained, there were numerous indications that the researcher-participant barrier had been broken. However, despite the varied and persistent efforts, a certain degree of mistrust prevailed. Frank suspicion was expressed up to the final days of the study. During one the last observations, a staff member announced to nearby staff that they needed to be cautious about the content of their conversations because an observation was being conducted and they could potentially be reported.

In hindsight, the ongoing recruitment conversations with staff that included full discussions about the risks and benefits of participation, procedures to ensure confidentiality, and the necessity of a signed consent form may have inadvertently triggered an unnecessary sense of formality. Legal terms such as confidentiality and participant rights could have accidentally activated an adversarial schema that is associated with legal action. VAMCs are unionized, and many, perhaps the majority, of NAs are union members. VAMCs also enforce strict human resources policies to protect employees and govern how employees can and cannot be evaluated
or disciplined. Perhaps because these union and HR programs are so well-organized and formal, NAs in a VAMC are typically familiar with union actions and human resource complaints, and both are associated with power and can lead to punishment. Consequently, the conversations with NAs that were meant to convey protection were ultimately detrimental to our study. Our persistence in initiating these conversations may have also been unwelcomed and perceived as too forceful. Although it was our duty to provide detailed information to NAs about research participation, the approach we used was ineffective and possibly detrimental to recruitment.

Possible Solutions for Effective Recruitment of Nursing Assistants

Based on our experiences with research recruitment, we propose several approaches that may assist other researchers in successful recruitment of NAs in long-term care settings. Two strategies, passive support from leadership and efforts to build trusting relationships with NAs, were useful in our study. However, certain mistakes were made (i.e., strong focus on the consent process) and that history could not be undone. The initial approach to research recruitment is important because it sets the stage for future interactions and buy-in from staff. Consequently, effective recruitment strategies are needed at the forefront of a study to increase the likelihood of success. Of course, all recruitment strategies must be approved by an IRB before implementation.

1. Engage in prosocial behavior such as helping. Helping can be accomplished in a variety of ways, such as leading activity groups with residents, assisting with various tasks as mealtimes, cleaning after meals, distributing snacks to residents, assisting staff with putting linens on beds, and monitoring residents with staff during outings or outdoor activities.
2. Get approval for verbal consents. In our study, NAs expressed discomfort with signing a consent form for fear of having a paper trail that could link them to the study. Obtaining IRB approval to get verbal consent may decrease some of the mistrust that was apparent in our study. The verbal consent could be clearly documented in a memo directly following the verbal consent procedure.

3. Socialize with staff. Try spending different times in the staff break rooms to determine the most ideal times to interact with NAs in that environment.

4. Take notes or employ a notetaker during interviews so that audiotapes are not needed.
   
   We believe this was a major concern for NAs.

5. Accompany NAs to any mandated trainings or in-services. Being perceived as an equal and engaging in similar activities may help establish rapport.

6. Send personally addressed emails to NAs if they have an email account. The content of the emails might provide a reminder about the study and the important role NAs have in research participation.
REFERENCES


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APPENDIX

Goal 1: To explore CNAs’ perceptions of resident autonomy and CNAs’ beneficent responsibility to residents

Interview Script:
1. First, I want to talk to you about your role as a CNA. What do you see as your main responsibilities as a caregiver?
2. How do you think about resident independence and choice?
3. How do resident independence and resident choice fit in with your caregiver responsibilities, or affect your caregiver responsibilities?
4. Do your supervisors ever discuss resident independence and choice with you, or have you received any training that has touched upon these topics?
5. Tell me about an experience when a resident wanted to do something you thought was unhealthy or unsafe and you felt it was your job to keep them safe or prevent harm?
   a. What happened?
   b. How did this affect how you performed your job?
   c. Thinking back on that experience, how did you feel at the time?
6. Cultural transformation has been happening in the CLCs for a while now. How, specifically, has your work with residents changed as a result of cultural transformation?
   a. Tell me about an experience when a resident wanted to do something and you felt he now should be able to follow through with his choice because of cultural transformation?
7. I can imagine that sometimes a resident might want to do something that you or other employees feel is potentially harmful. Now, because of cultural transformation, do you ever feel unsure about whether or not to allow the resident to follow through with his choice?
   a. What do you think about in this kind of situation?
   b. How does it make you feel?
   c. How does it affect how you perform your job?

Goal 2: To describe which activities of daily living and other activities CNAs deem important and not important for the maintenance of resident autonomy

Interview Script:
I want to learn about your opinion of resident independence. Specifically, I’m interested in your thoughts and values about their independence in specific activities.
1. When you think about how residents spend their day, what kinds of activities do you think of? That is, what are the categories of activities that residents must take part in, need to take part in, and/or have the option to take part in?
   a. ADLs
   b. Leisure/Recreation
   c. Rehabilitation/Restorative
   d. Other?
   e. Or do you think of the categories differently?
2. Thinking about resident control or independence, are there categories of activities, or specific activities for which resident control or independence are important or should be prioritized?

3. Are there categories of activities, or specific activities for which resident control or independence is less important or should not be prioritized?
   a. (If this varies by resident) How/why is it different for different residents?

4. Can you tell me a little bit more about why you think these activities (show list of CNA’s responses) are important for resident independence and these activities (show list of CNA’s responses) are not important for resident independence?

5. Please give me some examples of situations in which you think resident choice or independence should be limited?

**Goal 3: To explore techniques CNAs use to promote or maintain resident autonomy**

*Interview Script:*
I’m interested in learning about the specific ways in which CNAs work with residents to encourage resident independence.

1. Please give me examples of ways in which you give residents choices.
   a. How do you think this helped the resident?
   b. What are the most successful ways you’ve given residents choices?
      i. How are they helpful to your job?
   c. What are the least successful ways you’ve given residents choices?
   d. (If this b and c above vary by resident) How/why is it different for different residents?
   e. Thinking back, is there something you might do to improve how you offer choices?

2. Please give me examples of ways in which you encourage residents to do more independently or with less assistance from you?
   a. How do you think this helped the resident?
   b. What are the most successful ways you’ve encouraged resident independence or reduced residents’ need for assistance?
      i. How are they helpful to your job?
   c. What are the least successful ways you’ve encouraged resident independence or reduced residents’ need for assistance?
   d. (If this b and c above vary by resident) How/why is it different for different residents?
   e. Thinking back, is there something you might do to improve how you encourage resident independence or reduce residents’ need for assistance?
February 13, 2014

Andrea Lynn Snow, Ph.D.
Department of Psychology
College of Arts & Sciences
The University of Alabama

Re: Medical IRB Protocol # 08-009-ME-R5
“TVAMC Community Living Center Culture Change Evaluation”

Dr. Snow:

The University of Alabama IRB has received the revisions requested by the full board on 10/15/13. The board has reviewed the revisions and your renewal application is now approved for a one-year period.

Your application will expire on October 10, 2014. You will receive a notice of the expiration date 90 days in advance. If your research will continue beyond this date, complete the renewal portions of the FORM: IRB Renewal Application. If you need to modify the study, please submit FORM: Modification of An Approved Protocol. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the FORM: Request for Study Closure.

Should you need to submit any further correspondence regarding this application, please include the above application number.

Good luck with your research.

Sincerely,

John C. Higginbotham, Ph.D., MPH
Medical IRB Chair
The University of Alabama
UNIVERSITY OF ALABAMA
INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN SUBJECTS
REQUEST FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS

I. Identifying information

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<tr>
<th>Principal Investigator</th>
<th>Second Investigator</th>
<th>Third Investigator</th>
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<td>Michelle Higgen</td>
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Title of Research Project: TVAMC Community Living Center Culture Change Evaluation

Date Submitted: 9/1/13
Funding Source: Veterans Affairs Health Services Research & Development (HSR&D)

Type of Proposal [ ] New [ ] Revision [ ] Renewal [ ] Completed [ ] Exempt

Please attach a renewal application
Please attach a continuing review of studies form

Please enter the original IRB # at the top of the page

UA faculty or staff member signature: ________________________________

II. NOTIFICATION OF IRB ACTION (to be completed by IRB):

Type of Review: ☑ Full board □ Expedited

IRB Action:

☑ Rejected
☐ Tabled Pending Revisions Date: __________
☐ Approved Pending Revisions Date: __________

☑ Approved-this proposal complies with University and federal regulations for the protection of human subjects.

Approval is effective until the following date: 10-10-14

Items approved:

☐ Research protocol (dated __________)
☐ Informed consent (dated __________)
☐ Recruitment materials (dated __________)
☐ Other (dated __________)

Approval signature __________________________ Date 2/13/14

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