

COMMUNICATION IN THE NURSING HOME:
A GROUNDED THEORY OF NURSE–CNA
COMMUNICATION

by

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ABSTRACT

Quality nursing home care is a national health concern. Projections of increasing residency rates are coupled with growing concern about nursing home staff capacity and ability to provide quality care. The Institute of Medicine Committee of the Future Health Care Workforce for Older Americans suggests that efforts are needed toward improving nursing home workforce skill. Nurses and certified nursing assistants (CNAs) comprise the majority of the nursing home workforce; CNAs provide 80% of resident care. Despite their significant role as direct caregivers, little is known about nurse–CNA interactional processes, including how they communicate.

This relative lack of existing information suggested a need for better understanding of even fundamental communication processes from nurse and CNA perspectives. A grounded theory approach guided this study to gain understanding of nurse–CNA communication processes and factors that influence the processes from the perspective of nurses and CNAs when providing direct care to nursing home residents. Goffman’s dramaturgical concept of front- and back-stages, supported by the premises of symbolic interactionism, provided an analytical framework for exploring nurse–CNA communication processes in the complex context of the nursing home setting.

Data were obtained from observation, shadowing, and interviews of nurses and CNAs on two ~ 40-bed long-term care units in a nursing home. Systematic procedures

for inductive data analysis suggested that nurse–CNA communication processes were guided by four “rules of performance”: (1) maintaining information flow, (2) following procedure, (3) fostering collegiality, and (4) showing respect.

Nurses and CNAs communicated as opportunity arose in the midst of resident care and described their communication processes in relation to efficiency of care that was affected by the presence or absence of cooperation, initiative, and reciprocity. Role ambiguity stemmed from nurse–CNA hierarchical position associated with delegation and supervision; contextual ambiguity resulted from the dual purpose of the nursing home as a health care institution and the resident’s “home.” The interplay of “rules of performance” on the front- and back-stages of direct care should be considered in the development of contextually applicable policy and practice strategies that are relevant to nurses and CNAs providing care to nursing home residents.

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CHAPTER 1

INTRODUCTION AND STATEMENT OF THE PROBLEM

Nurses (registered nurses, licensed practical nurses, licensed vocational nurses) and Certified Nursing Assistants (CNAs) are direct care staff who provide the majority of professional medical and personal care to more than 1.3 million people currently in nursing homes (Institute of Medicine (IOM), 2008; Werner, 2011). Nurses deliver and oversee resident care, and supervise CNAs who provide nearly 80% of individual personal care to residents including activities of daily living (ADL; McGilton, Tourangeau, Kavcic, & Wodchis, 2013). The significant time CNAs spend providing individual care situates them as likely to be first to see changes in resident status, and uniquely positions them as front line caregivers who communicate information about the resident to the nurse (Heliker & Nguyen, 2010; Holmberg et al., 2103).

Communication is often implicated as a factor contributing to nursing home outcomes (Rosemond, Hanson, Ennett, Schenck, & Weiner, 2012; Wagner, Damianakis, Pho, & Tourangeau, 2013). Studies associate ineffective communication in nursing homes with high rates of direct care staff turnover, increased error risk, and subsequent negative impact on quality of resident care (Scandrett et al., 2012; Wagner et al., 2013). Apker (2012) has identified four “best practice” communication skill sets that stress the

influence of context and role expectations on the dynamics of communication processes in health care organizations. Apker categorizes best practice skill sets as: (1) collaboration –working together for the collective good, (2) credibility-showing proficiency and expertise, (3) compassion-displaying empathy to build relationships, (4) coordination-leading or managing work processes. Specific skills within each category such as seeking and providing information, adjusting communication as needed, displaying respect and affiliation, and promoting and valuing feedback are posited as effective communication behaviors contributing to an optimal health care work environment (Apker, 2012).

Communication has been widely studied in acute care settings and effective communication among care providers is recognized as essential for providing safe and quality care. Information about communication among nursing home staff is limited in general, and even more so regarding nurse–CNA communication practices when providing direct care to residents (Castle, Wagner, Sonon, & Ferguson-Rome, 2012; Colon-Emeric et al., 2006). Communication among direct care staff in the nursing home is complicated by the often physically and emotionally taxing work of caring for residents with multiple chronic conditions and multiple care needs. Some experts suggest that direct care staff may not receive sufficient preparation to effectively address the complexities of care in the nursing home environment (Rubin, Balaji, & Barcikowski, 2009). Despite the recent call for better preparation of long-term care staff to improve nursing home outcomes, there are gaps in nursing education regarding care of complex nursing home residents, and effective use of leadership and communication skills when working with unlicensed personnel in nursing home settings. Moreover, CNA education

is task oriented with little education in communication skills (IOM, 2008).

Recent efforts, including provisions in the Affordable Care Act (ACA), aimed at improving nursing home care and resident outcomes have been implemented in some nursing homes identified as demonstration projects. These demonstration nursing homes, although limited in number have resulted in successful quality improvement processes using standardized communication approaches and practice guidelines (Miller, 2012). Experts suggest that one barrier to widespread implementation of successful quality improvement projects is the need for better understanding of how nursing home care processes, including communication practices among all levels of staff, relate to resident quality of life and better care outcomes (Vogelsmeier & Scott-Cawiezell, 2011; Werner, Konetzka, & Kim, 2013).

Background

The quality of nursing home care is a pressing national health concern. Those 85 years of age and older are the second fastest growing segment of the population and account for over half of the nursing home population (Werner, 2011). Furthermore, 8,000 baby boomers will turn age 70 each day beginning in 2016 and will continue to do so for 18 years (Lee & Sumaya, 2013). Nursing home residency rates are projected to increase by 57 % in 2030 (Administration on Aging [AOA], 2013). Concern about adequacy of the nursing home workforce has heightened attention on improving nursing home staff capacity and ability to provide quality care to improve resident outcomes (IOM, 2008; Tyler & Parker, 2011).

Experts suggest that continuing efforts are needed to increase nursing home

quality of life and improve resident care outcomes, and should be aimed at improvement of nursing home care processes (Werner et al., 2013). Communication processes have been identified as contributing to successful nursing home quality improvement efforts; in nursing homes where quality improvement efforts are unsuccessful, staff identifies the need for better communication skills and practices (Rantz et al., 2012). Implementation of techniques and strategies to improve communication in acute care has been shown to decrease occurrence of adverse events, improve patient care outcomes, and increase health care provider job satisfaction (Renz, Boltz, Wagner, Capezuti, & Lawrence, 2013; Vardaman et al., 2012). However, there are fewer studies of nursing home communication processes and most focus on interactions between nurses, physicians, residents, and families (Nazir et al., 2013). Few studies include CNAs; those that do emphasize CNAs' significant task-oriented role in resident care, while revealing a conspicuous absence of information about how they interact with other nursing home staff including nurses (Pfefferle & Weinberg, 2008).

Although there is limited information about communication processes in the nursing home, there are studies that identify its importance in the safety of residents transferring to or from the nursing home (Kirsebom, Wadensten, & Hedstrom, 2012). More than one-third of nursing home residents are hospitalized yearly and recent estimations suggest that 60% of those transfers could have been prevented with appropriate and timely treatment of the resident in the nursing home. The financial cost is considerable; in 2005 Medicare and Medicaid spent 2.6 billion dollars on nursing home resident hospitalizations that were potentially avoidable (Walsh et al., 2012). In addition to the financial burden, hospitalization places individual residents in jeopardy for

decreased quality of life post hospitalization (Ouslander et al., 2010). Multiple chronic conditions and complex care needs increase resident vulnerability to complications when a change in their condition occurs, emphasizing the importance of effective communication about residents in the nursing home before transfer becomes necessary (Lee & Sumaya, 2013; Spector, Limcangco, Williams, Rhodes, & Hurd, 2013).

Study Purpose and Research Questions

The connection between communication and quality of care supports the use of best practices in communication processes to improve health care outcomes. Techniques and organizational strategies to promote communication skill have been successfully used in acute care, but have had limited success in nursing homes. Difficulty in implementation is attributed in part to the complexity of balancing efforts to improve resident clinical outcomes with resident quality of life (Grabowski et al., 2014; Ouslander et al., 2011).

The continuing struggle to improve nursing home resident outcomes and quality of life has prompted renewed interest in person-centered care and nursing home culture change (IOM, 2008). These concerns, often studied at the systems-level, point to the importance of effective care practices, such as communication skills of direct care staff in the nursing home (Rosemond et al., 2012).

The purpose of this grounded theory study was to gain better understanding of nurse–CNA communication processes at the point of resident care in the nursing home. Investigation was conducted from the perspectives of CNAs and nurses at the fundamental level of direct nursing home care to answer the following questions:

- Research question 1: What are the observed processes of nurse–CNA communication that occur during the course of their work in the direct care of long-term care nursing home residents?
- Research question 2: How do nurses and CNAs describe the communication processes that occur during the provision of direct care to nursing home residents?
- Research Question 3: What do nurses and CNAs perceive as positive or negative influences on their communication processes in the nursing home?

Design and Methods

A grounded theory design was used to explore CNA and nurse perspectives about their communication processes, their practices during communication interactions, and their perceptions about what impacts their communication processes. A purposive sample of nurse–CNA direct care staff in a nursing home located in the Mountain West region of the United States was obtained. Grounded theory methods of theoretical sampling and constant comparative analysis were used, and data were collected through observation, shadowing, and interviewing.

Theoretical Framework

There are three primary premises of symbolic interactionism theory: (a) individuals act toward objects based on the meaning that the objects have for them, (b) individuals construct meaning through interaction with others, and (c) meaning is modified through a process of interpretation as individuals interact with objects and

others (Blumer, 1969). Stemming from the premises of symbolic interactionism, Erving Goffman's dramaturgical framework suggests that individuals are essentially actors on a stage who behave in certain ways to fit the requirements of a particular context, and that the context includes both front- and back-stages (1959). Front-stages and back-stages have different rules that the "performer" must understand and interpret in order to give an appropriate "performance." Front-stage behavior is the performance of a role designed to present a particular effect, and can be adapted to meet the expectations of the audience. Back-stage behavior is where there are no expected roles and individuals act authentically in informal performances (Goffman, 1959).

The concept of front- and back-stages as regions where distinctive performance occurs in the nursing home becomes particularly relevant for this study of nurse–CNA communication processes, when linked to the concept of the nursing home as a "total institution." Goffman identifies one type of total institution designed for persons considered incapable and harmless, such as nursing homes in which all spheres of individual life are encompassed and regulated, and where action occurs in the presence of others (Goffman, 1957). Application of the concepts of front- and back-stages as regions where different rules apply provides a framework for distinguishing context within the "total institution" environment of the nursing home. Further, analysis from this framework is supported by a symbolic interactionist paradigm that identifies "performances" as socially constructed actions produced by and understood through the context in which they occur (Crotty, 1998; Goffman 1959).

It was initially conceived that in the total institution environment of the nursing home, front-stage communication processes of CNAs and nurses may encompass

publicly viewable communication practices in the performance of their expected role as direct care staff, such as information exchange at the nurse's desk or change of shift report. Furthermore, expectations of front-stage behavior may be proscribed by regulatory requirements, organizational policy, and public scrutiny. Back-stage communication may occur in areas where authentic expression is not subject to audience expectations, such as break rooms or hallways where interactions may be less formal. It is possible that the space immediate to the resident may shift between front- and back-stage regions depending on who is in the audience and what the expectations are. It is also possible that the nursing home organizational characteristics such as positional hierarchy could cause nurses and CNAs to assume expectations for front- and back-stage behavior that may or may not promote best communication practices. Finally, in keeping with inherent themes of symbolic interactionism, it is assumed that nurses and CNAs will act interact in the communication process on basis of what it means to them. Their cultural beliefs may influence their interpretation of the meaning of their interaction, and affect how they modify their action in relation to the environment.

Assumptions

Foundational assumptions of symbolic interactionism propose that human actions are based on meaning attached to objects, and that meaning is constructed and interpreted through interaction with objects and others (Blumer, 1969). Assumptions underlying this study are:

- 1) Communication is a process for conveying information which involves reciprocal interaction between two or more people.

- 2) Communication processes can be observed and described by one not participating directly in the communication.
- 3) Communication processes are shaped by individual meaning assigned to the interaction by those who are communicating.
- 4) Communication processes are shaped by the context in which they occur; context includes front-stage and back-stage areas.

Significance

The individual and personal nature of care provided by CNAs results in significant time with residents and interaction with them in ways that no other nursing home staff experiences. CNAs work directly with residents and report directly to nurses about the residents, yet few studies explore nurse–CNA communication as a collaborative resident care process. There is little description of actual nurse–CNA communication practices, and none that include description from the perspective of CNAs and nurses who are uniquely positioned as the direct care givers who provide the majority of resident care.

Some studies have included CNAs and nurses in the examination of high rates of turnover in nursing homes, and have identified the need for a supportive work environment that promotes collegiality and teamwork (Rubin et al., 2009). Many of the studies identify effective communication as foundational for a supportive environment but stop short of defining communication, or identifying how effectiveness is perceived by those who are communicating (Zheng & Temkin-Greener, 2010). Investigation from an emic perspective will result in an authentic description of nurse–CNA communication

practices. Viewing nurse–CNA perspectives of the meaning and interpretation of their communication interaction performances from a front- and back-stage framework may help explain the influence of context on their communication processes.

A deeper understanding of actual nurse–CNA communication processes will be a foundational step toward improving the capacity of the nursing home direct care workforce to better care for the increasing nursing home resident population. Results from this study should help nursing home leaders (e.g., administrators, directors of nursing) understand how resident information is shared among direct care staff and identify organizational factors that hinder or support communication processes. This knowledge may enhance quality improvement efforts by identifying where development of specific process improvement strategies and education could be targeted to maximize enhancement of direct care staff communication processes. Better communication processes may positively impact nurse and CNA job satisfaction, which in turn may impact resident care processes. Better understanding of the communication processes of nurses and CNAs at the point of resident care may be a fundamental step toward improving the quality of care to residents in nursing home settings.

Definition of Terms

Certified Nursing Assistant

Certified Nursing Assistants (CNAs) are health care personnel who work under the supervision of a licensed nurse and provide personal care to residents including eating, bathing, dressing, and toileting. In Utah, CNAs must be trained and certified to provide care in nursing homes that participate in Medicare ("Certified Nursing Assistant

Candidate Handbook-State of Utah," 2013). Certification involves a minimum of 75 hours of training and passing a state competency exam (Sengupta, Ejaz, & Harris-Kojetin, 2012).

Direct Care

Direct care encompasses a broad range of care to individual residents that include assisting with meals/eating, medications, mobility, hygiene, dressing, and monitoring resident condition (Khatutsky, Wiener, Anderson, Akhmerova, & Jessup, 2011).

Nurses

Nurse refers to those who are licensed to practice nursing as defined by the state of Utah Division of Occupational and Professional Licensing Act-Title 58, Chapter 31, Section 2(11) and Section 2(12), and includes licensed practical nurses, licensed vocational nurses, and registered nurses. Responsibilities of licensed nurses include delegation to and supervision of unlicensed assistive personnel ("Utah Division of Occupational and Professional Act," 2013).

Nursing Home

A nursing home is a state-licensed health care facility that may or may not be certified to participate in Medicare and/or Medicaid reimbursement programs. Nursing homes provide medical supervision, nursing care, rehabilitation services, room and board, and activities for convalescing residents or those with chronic and/or long-term illnesses. Levels of nursing home care is defined by the State of Utah as intermediate care that

provides 24 hour care to residents who need licensed nursing supervision and supportive care, and skilled care that provides 24 hours licensed nursing services, 8 hours of which are RN coverage ("Levels of Care," 2013).

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CHAPTER 2

LITERATURE REVIEW

The purpose of this study was to gain understanding of nurse and Certified Nursing Assistant (CNA) communication processes during the provision of direct care of nursing home residents. A grounded theory approach guided the study because the relative lack of information about nurse–CNA communication processes suggested a need for fundamental exploration of the experience from CNA and nurse perspectives.

Glaser and other grounded theory experts advise that reviewing the literature prior to beginning a study can be detrimental by creating researcher bias that potentially misdirects, confines the scope, or imposes other’s ideas on the findings (Glaser, 1978; Schreiber & Stern, 2001). However, Strauss notes that literature can help the researcher make conceptual connections to existing theory and that prior knowledge may increase researcher sensitivity to theoretical possibilities in their own data (Strauss, 1987). Other grounded theory experts note that a literature review helps the researcher establish an area of study by identifying what has been studied and what has not (Dunne, 2011).

Charmaz (2006) recommends the use of extant literature, especially for novice researchers, to establish context for the study purpose, explain the study significance, and demonstrate how the study will contribute to existing knowledge. Those recommendations provide rationale for this literature review and an organizational

framework for its content. The first section describes the nursing home setting. The second section reviews aspects of communication in the nursing home. The final section explores what is currently known about nurse–CNA communication processes in the nursing home. The concepts of front-stage where formal and expected behavior occurs, and back-stage where informal behaviors occurs, are applied as a framework for categorizing literature that describes CNA and nurse communication practices.

Nursing Homes

Ownership, Payment, and Size

Information from a national nursing home survey, conducted by The Center for Disease Control and Prevention’s Division of Health Care Statistics provides an overview of nursing homes in the United States (Jones, Dwyer, Bercovitz, & Strahan, 2009). The majority of nursing homes are proprietary (61.5%), 30.8 % are nonprofit, and 7.7% are owned by the government and other entities. Most nursing homes (87.6%) are both Medicare and Medicaid certified. More than half (54.2%) of nursing homes are affiliated with larger organizations that own several facilities; 45.8% are independently owned. In 2004, there were 1.7 million available nursing home beds with an average of 108 beds per nursing home. The average occupancy rate is 87% (Jones, Dwyer, Bercovitz, & Strahan, 2009).

Levels of Care and Services

Long-term care is a range of services and support for both personal and medical care. Nursing homes are one type of long-term care, and may be a freestanding facility or

a unit of three or more beds in a larger facility (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013). Nursing home care includes skilled nursing and 24-hour supervision and primarily provides three types of services; custodial care, rehabilitation services and skilled care. Custodial care is the regular provision of routine assistive personal care and supervision beyond room and board; rehabilitation services are those that are needed for treatment of injury, disability or illness intended to regain usual functional ability; skilled care is that given when treatment, management, observation, and evaluation is needed and may include specific intervention such as intravenous injection or wound care (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013).

Many of the services provided to nursing home residents are contracted through outside providers and may include physical, occupational and recreational therapy, as well as dental, hospice, pharmacy and diagnostic services. Pharmacy (84.1 %) and medical director (83.5) are the services most commonly contracted. Medical services are often provided by private physicians from the community, and less than 20% of physicians are employed by the nursing home (Jones et al., 2009).

Nursing Home Workforce

Administrative Staff

The nursing home administrator directs and administers all activities of the nursing home and is accountable for management decisions that affect how departments or service areas are utilized to provide care and services to resident facilities. The nursing home administrator reports to an advisory board or facility owner. The director of nursing is responsible for the administration of nursing services, which includes planning,

coordinating all nursing services, and often, related services, and evaluation of the services in relation to quality of resident care. An office or business manager is responsible for managing Medicaid, Medicare, other insurance reimbursements, and private pay for services.

Nursing Staff

The national nursing home workforce of 936,000 employees includes registered nurses, licensed practical nurses, licensed vocational nurses, certified nursing assistants and nurse aides. Certified nursing assistants (600,800) comprise the majority of nursing staff employed in nursing homes and are often referred to as front-line staff (Jones et al., 2009). The Centers for Medicare and Medicare Services calculates nursing home staff by the number of hours worked divided by the number of residents over a 2 week period, and reports it as hours per resident per day (HRPD). The national average of nursing staff HRPD is 1 hour and 37 minutes for nurses, and 2 hours and 27 minutes for CNAs (Services, 2004). Problems recruiting and retaining a stable workforce is identified by experts as the most pressing challenge facing nursing homes, and is reflected in the average annual turnover of 71% of CNAs and nearly 50% of nurses (IOM, 2008; Miller, 2012).

CNAs provide individual personal care including activities of daily living, under the direction and supervision of nurses. CNAs observe resident responses to care and report changes and concerns about residents to nurses. Licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) under the direction of medical providers and registered nurses perform many of the same tasks as CNAs, in addition to administering

medication and treatments. LPNs and LVNs may supervise CNAs, document changes in resident conditions, communicate with other health care team members, and help develop resident care plans. Registered nurses (RNs) provide skilled interventions, and supervise, assess, and evaluate the overall nursing care of the resident. RNs may function in the role of charge nurse to coordinate care in a nursing home unit, or as an assessment coordinator to collaborate with others in the development and evaluation of comprehensive resident care plans (Torpey, 2011).

Nursing Home Residents

Nearly 1.3 million residents live in more than 16,000 facilities in the United States, and more than 3 million people utilize nursing home services at some point during the year (Jones et al., 2009; Werner, 2011). More than half of all nursing home residents are either totally dependent or require extensive assistance in activities of daily living, which includes, bathing, dressing, toileting, transferring, and eating (Jones et al., 2009). The largest age group in nursing homes are those 85 years and older, who account for more than half of all residents; the typical nursing home resident is an 85 year-old White female and takes 9 or more medications (Jones et al., 2009). Circulatory disease is the most common primary diagnosis at admission (23.7%) followed by mental disorders (16.4 %) and nervous system diseases (14%; Jones et al., 2009).

Nearly 10% of all residents had a hospitalization or emergency department (ED) visit in the 90 days prior to the survey (Jones et al., 2009). Almost 66% of residents have some advance directive, the most common being a do-not-resuscitate order, followed by a living will, feeding and other treatment restrictions; 3.5% had a do-not-hospitalize order.

More than 10% of residents had a pressure ulcer, and 75 % of those were at stage 2 or higher. Of those with a stage 3 or 4 pressure ulcer, almost 43% had been in an acute care hospital prior to admission to the nursing home. About 23% of nursing home residents reported pain within the last 7 days, and almost 34% had suffered a fall within the last 180 days (Jones et al., 2009). Quality and safety of nursing home care is heavily regulated and is the focus of national efforts to improve resident outcomes, yet many nursing homes continue to have poor performance (Bonner, 2013; Mukamel, 2011).

Sociocultural Characteristics of the Nursing Home

Nursing homes attempt to meet the significant health care need of caring for older adults who are unable for a variety of reasons to care for themselves. In addition to physical care, they provide social and physical structure that becomes the home where many people live out their lives. Nursing homes are complex care facilities that operate under extensive government regulation and evaluation, consumer-driven recommendations for models of care, and largely unfavorable public perception (Rosemond, Hanson, Ennett, Schenck, & Weiner, 2012). Some consider nursing homes to be an ineffective use of limited health care resources with little benefit, to persons who are highly dependent and have limited potential (Grabowski, O'Malley, & Barhydt, 2007; McClosky, 2010; Young, Inamdar, Barhydt, Colello, & Hannen, 2010).

Recent efforts have been aimed at changing public perceptions of nursing homes as providers of institutionalized care that results in loss of resident independence, autonomy, and dignity (Tyler & Parker, 2011). Experts agree that in order to change perception of care, the culture of nursing homes need to change (Zimmerman, Shier, &

Saliba, 2014). Culture change strategies have included emphasizing person-centered care, creating more homelike atmospheres, nurse practitioner-led coordination and collaboration processes, improving processes to decrease fall and pressure ulcer risk, and improving the utility of annual surveys of nursing homes (Bradshaw, Playford, & Riazi, 2012; CMS, 2012; Rosemond et al., 2012). Despite these efforts, public perception about nursing homes remains largely negative; less than 10% of media portrayal of nursing homes is positive (Miller, Tyler, Rozanova, & Mor, 2012).

Communication in the Nursing Home

The importance of communication skills in the provision of safe and quality health care is well known. The 2000 Institute of Medicine report identified failure of communication as one type of error contributing to as many as 98,000 avoidable patient deaths annually in hospitals (Kohn, Corrigan, & Donaldson, 2000). Hospital improvement strategies have focused on enhancing teamwork and collaboration, and effective communication has been the most frequently addressed competency to decrease occurrence of adverse events, improve patient safety and quality outcomes, and increase health care professional's job satisfaction (Renz, Boltz, Wagner, Capezuti, & Lawrence, 2013; Vardaman et al., 2012; Weaver, Dy, & Rosen, 2014). Communication is no less important in nursing home care and reinforced by studies of resident care quality, safety, and workforce stability that nearly always include ineffective communication as a factor (Anderson, Corazzini, & McDaniel, 2004; Cohen-Mansfield, Jensen, Resnick, & Norris, 2012; Decker, Harris-Kojetin, & Bercovitz, 2009; Forbes-Thompson, Gajewski, Scott-Cawiezell, & Dunton, 2006).

Communication about residents in the nursing home is a complex process. Lyhne, Georgiou, Marks, Tariq and Westbrook (2012) suggest that the multiple care needs of residents necessitates multidimensional communication exchanges; unlike acute care where clinical information of patients is the usual focus, communication exchange about nursing home residents should include clinical as well as social, behavioral and activity coordination information. Communication may involve interactions between many people, including direct care staff, administrative staff, care supervisors, providers, auxiliary staff, families of residents, and residents (Georgiou, Marks, Braithwaite, & Westbrook, 2013). Processes of communication may be impacted by staffing issues, work-flow, and a work environment complicated by often physically and emotionally taxing work of caring for residents with multiple and complex care needs (IOM, 2008).

Quality for nursing home residents is defined by Spilsbury, Hewitt, Stirk, and Bowman (2011) as quality of care and quality of life. Quality of care is the delivery of effective and safe physical and clinical care, quality of life refers to resident autonomy and choice in their care (Spilsbur et al., 2011). Nursing homes that focus on both quality of life and quality of care have better resident outcomes than those that do not, however, most nursing homes continue to measure quality with clinical outcomes (Grabowski et al., 2014; Spilsbury et al., 2011).

One outcome that has received recent attention due to provisions in the 2010 Patient Protection and Affordable Care Act (PPACA) is the delivery of treatment to residents in the nursing home before hospitalization becomes necessary (Spector, Limcango, Williams, Rhodes, & Hurd, 2013). More than 25% of people living in nursing homes are hospitalized each year. With timely intervention close to 60% could have

received treatment in the nursing home averting considerable financial and personal cost associated with hospitalization (Grabowski et al., 2007; Polniaszek, Walsh, & Wiener, 2011). In 2005 Medicare and Medicaid spent 2.6 billion dollars on potentially avoidable acute hospitalization of nursing home residents (Walsh et al., 2010). Hospitalization increases the risk of complications likely to result in decreased functional ability of residents posthospitalization (Ouslander et al., 2010). A U.S. Department of Health and Human Services report suggests reduction of avoidable hospitalization could result from quality improvement efforts aimed at improving communication skills and processes among nursing home staff (Polniaszek et al., 2011).

Resident safety outcomes are better in facilities that have effective communication processes that include clear resident safety goals (Arnetz et al., 2011; Kurowski, Gore, Buchholz, & Punnett, 2012). Resident safety is at particular risk is during transition to or from the nursing home, when ineffective communication increases potential for negative outcomes (Doupe et al., 2011; Kirsebom, Wadensten & Hedstrom, 2012; Nelson, Washton, & Jeanmonod, 2013). Information about the resident from nursing homes is often inadequate with gaps in resident history and missing clinical and behavioral information, suggesting the need for improved communication processes prior to the need for transfer (Goins, 2012; McCloskey, 2011; Naylor, Kurtzman, & Pauly, 2009).

Communication Improvement Processes and Tools

Ongoing concerns with safety and quality outcomes in the nursing home drive policy development and consumer advocacy efforts to improve resident care. Improving

communication processes and tools generally tops the list of recommendations for improving nursing home care quality and safety (Rosemond et al., 2012). The organizational capacity needed for nursing homes to improve quality performance and improve safety outcomes is not clearly understood, but communication is identified as one of the necessary components (Vogelsmeier & Scott-Cawiezell, 2011). Experts indicate that the lack of widespread success and implementation of quality improvement processes in the nursing home can be attributed to a poor understanding of work-flow processes, including communication among all levels of staff (Georgiou et al., 2013).

The 2010 PPACA contains provisions that provide impetus for development of quality assurance process improvement programs. Development of new care models and care processes have proven successful in isolated implementation and evaluation (Miller, 2012). The INTERACT (Interventions to Reduce Acute Care Transfers) program is an example of quality improvement designed to improve nursing home staff ability to effectively communicate changes in the status of residents (Handler, Sharkey, Hudak, & Ouslander, 2011). INTERACT incorporates a variety of decision support tools, and includes specific observation and communication guidelines for front-line staff when a change in resident status occurs (Handler et al., 2011). Performance of direct care staff is considered key to overcoming barriers to implementation of the program (Ouslander, Bonner, Herndon, & Shutes, 2014).

Structured communication tools proven to improve communication in acute care have been implemented with limited success in nursing homes. The use of SBAR (Situation, Background, Assessment, and Recommendation/Request) was found by nurses to be a useful technique for communicating with physicians about nursing home

residents, but a lack of time to complete the tool was identified as a barrier to implementation (Renz et al., 2013). Electronic health record systems are frequently suggested as a communication improvement strategy for ensuring documentation of objective and consistent resident information that is easily accessible to all care staff (Munyisia, Yu, & Hailey, 2011a). Verbal communication has been the preferred way for direct-care staff to exchange information but a recent study indicates increased staff receptivity to electronic documentation as an efficient way to update resident status on progress notes, and to receive information about resident care needs (Munyisia et al., 2011a). Electronic health record system adoption rates in U.S. nursing homes is reported to be between 18 and 47%, but inconsistent terminology and definitions of use limit the accuracy of the report (Abramson, McGinnis, Moore, & Kaushal, 2014).

CNA and Nurse Communication

Providing the majority of direct care in the complex nursing home environment can be physical and emotionally taxing and potentially have a negative influence on nurse and CNA communication processes. Communication has implications for job satisfaction and staff turnover, with ineffective communication strongly impacting increased turnover which in turn negatively impacts quality of resident care (Horn et al., 2010; Spilsbury et al., 2011; Thomas, Mor, Tyler, & Hyer, 2013).

Studies about communication between nursing home staff and residents primarily relate to work environment and job satisfaction. CNAs and nurses perceive a satisfactory work environment as including effective communication and collaboration in the care of residents (Sikma, 2006). There is scant information about how CNAs and nurses work

together to care for residents, or what their communication practices are during the course of their shift. What is known is that most of their communication occurs during the performance of other tasks, adding a layer of complexity that increases the risk of distraction (Munyisia, Yu, & Hailey, 2011b). Documentation of resident status and events that have occurred during the shift usually occur at the end of shift with heavy reliance on memory because there has been no time to document it during the shift (Munyisia et al., 2011b). A recent study aimed at improving coordination of the 24-hour care of residents identified that very little is known about how that process currently occurs in the nursing home (Lyhne et al., 2012).

Studies that include nurses are likely to focus on communication in relation to specific resident care tasks such as medication administration, or specific care needs such as when caring for persons with dementia or providing end-of life care (Wheeler & Oyebode, 2010; Zheng & Temkin-Greener, 2010). Studies of CNA communication are few and likely to be about relationships with residents (Heliker & Nguyen, 2010). Specific communication interventions such as shared story-telling and reminiscence are shown to contribute to the quality of residents' lives by giving them an opportunity to participate in activities (Heliker & Nguyen, 2010; Medvene & Lann-Wolcott, 2010). Residents are more satisfied with their care when they are informed and active in decision making about their care (Falk, Wijk, & Persson, 2011; Williams, Ilten, & Bower, 2005). CNAs provide 80% of direct care to residents; it is not surprising that effective CNA communication is linked to resident perceptions of good quality of care, and CNA perceptions of good communication with residents contributes to their job satisfaction (Kostiwa & Meeks, 2009; Medvene & Lann-Wolcott, 2010).

Families of nursing home residents identify inadequate communication with nursing home providers and staff as a source of stress (Givens, Lopez, Mazor, & Mitchell, 2012; Marziali, Shulman, & Damianakis, 2006). When families perceive that communication with staff is open, honest, and promotes their involvement in care, they are more satisfied with their relationships with staff and with the care that the resident receives (O'Shea, Weathers, & McCarthy, 2014). In some instances when residents have particular care needs, such as those associated with Alzheimer's disease, families have specific preferences for how staff communicates with the resident. For example TALKK (Tell them; Ask them; Listen to them; Know their family member, Know dementia, Share knowledge with them) is a recommended pattern for communication interaction with a resident who has dementia (Palmer, 2012).

CNAs and Communication

CNAs occupy the space between the resident and nurse to whom they report. The work CNAs do is important; it is both physical and emotional, as they assist residents with their most fundamental needs. The amount of time they spend and their close daily interaction with residents may place CNAs as first to see changes in a resident's condition (Chaudhuri, Yeatts, & Cready, 2013; Munyisia, et al., 2011b). Although their work is on the front line there is little information about CNAs communication practices on the front-stage. We know little about their perspective of resident care processes or how they communicate concerns about resident quality or safety care issues (Pfefferle & Weinberg, 2008; Temkin-Greener, Cai, Katz, Zhao, & Mukamel, 2009; Tingstrom, et al., 2010).

Inclusion in team work when caring for residents, being listened to when they have concerns about residents, and a desire to be heard regarding care improvement efforts are identified as important to CNAs (Caspar & O'Rourke, 2011; Choi & Johantgen, 2012; Kostiwa & Meeks, 2009). Lack of appreciation, recognition and respect from employers and supervisors, and poor quality of supervision are common reasons for CNAs to leave their jobs (Bishop, Squillace, Meagher, Anderson, & Wiener, 2009). Supportive supervision is perceived by CNAs as inclusion in team work when caring for residents, and having input about residents (Choi & Johantgen, 2012).

CNAs would like more training in communicating with supervisors (Sengupta, Harris-Kojetin, & Ejaz, 2010). However, federal training requirements for CNAs have not changed since they were established in the Nurse Aide Training and Competency Evaluation Program of the Omnibus Reconciliation Act of 1987 (U.S. Department of Health and Human Services, 2002). Common criticisms of CNA training is that there is not enough education on communication and interaction skills and little time to practice clinical application of those skills (Sengupta et al., 2010). Less than 80% of CNAs received training in communicating resident care issues to families, or how to work with supervisors (Sengupta et al., 2010).

CNAs are considered to be nonprofessional caregivers although the work they do is significant in the continuous provision of resident care (Chung, 2013). CNAs are low in the nursing home organizational hierarchy, yet the results of their care, such as the clean and comfortable appearance of residents, is readily apparent to others and often a basis for judgment about quality of care (Chung, 2010). Communication practices of CNA, as yet largely unexplored, may reveal back-stage communication practices that

significantly impact the quality of resident care.

Nurses and Communication

As CNAs may link the resident and the nurse, it is the nurse who may serve as the link between the front-line care of residents to other health care professionals including therapists, social workers, and providers (Apker, Propp, Zabava Ford, & Hofmeister, 2006). Nurses' concerns about their work environment suggest that their communication practices are more likely to occur on the front-stage. For example, nurses identify that participation in strong work relationships that include professional collaboration decrease the likelihood that they will leave their position (McGilton, Tourangeau, Kavcic, & Wodchis, 2013). Nurse dissatisfaction arises from their perceptions of an unsupportive work environment that limits opportunity to participate in planning and decisions on policy, practice, and improvement processes, or limits their capacity to communicate with administration regarding problems (Bellot, 2012; Bowers & Nolet, 2014; Choi, Flynn, & Aiken, 2012).

In addition to coordinating and evaluating care, a large part of the nurse's responsibility is supervising and delegating care to CNAs, contributing in part to a hierarchical relationship among direct care staff, and placing CNAs at the bottom. Perceptions of being unvalued is reinforced by CNA requests for better communication; they want to feel listened to when they have concerns about patients and recognized as part of the team that can contribute to planning of resident care (Bishop et al., 2009; Rubin et al., 2009). Because of their proximity to CNAs in the direct care of residents, nurses may be in the best position to receive and respond to potentially significant CNA

back-stage communication practices and potentially maximize their contributions to the front-stage where formal resident care decisions are made (Castle & Engberg, 2007).

Future Considerations for Improving Communication in the Nursing Home

As population demographics change, there are indications that older adults will be entering nursing homes with smaller social support networks. These networks have in the past provided important verbal discussions in which residents can express concerns and needs for managing their conditions and making decision about their care. Nursing home staff may be called upon to fill that particular communication need (Abbott, Bettger, Hanlon, & Hirschman, 2012).

Hospitals, in response to readmission rate penalties that are associated with the Patient Protection and Affordable Care Act, may find new ways to build care coordination relationships with nursing homes that require new levels of communication (Butcher, 2013). The Center for Medicare and Medicaid Services Quality Assurance and Performance Improvement Initiative is designed to broaden quality improvement activities in nursing homes. Best practices for quality care, identified in demonstration homes, will likely include improved communication processes for which direct care staff will need to be educated (CMS, 2012).

Finally, the 2008 Institute of Medicine call to ensure a better prepared workforce that is adequately trained and sufficient in size to care for the increasing number of older adults may result in an opportunity to more closely examine the demands on the workforce that current nursing home culture and practices generate (IOM, 2008). New

generations of direct care workers may have different expectations for work-life balance, different intrinsic value of satisfactory work environments, and different communication patterns that affect work processes. Development of a strong future workforce may benefit from a fundamental understanding of the base on which it builds.

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CHAPTER 3

RESEARCH DESIGN

A qualitative research approach was used to study nurse and CNA communication processes during the provision of care to nursing home residents. Corbin and Strauss (2008) describe qualitative research as a way “to enter the world of the participants, see the world from their perspective, and make discoveries that will lead to the development of empirical knowledge” (p. 16). A grounded theory design was used to investigate communication practice of CNAs and nurses, from their perspectives, as they provided direct care to nursing home residents.

Theoretical Framework

Symbolic interactionism provided the theoretical framework that supported this grounded theory approach for studying nurse–CNA communication processes as they provided care to residents. A fundamental assumption of symbolic interactionism is that understanding of how meaning and behavior are constructed best occurs through naturalistic study of experience that does not necessarily lend itself to laboratory study or pre-established protocol (Blumer, 1969). The use of grounded theory methods for the collection and analysis of subjective data, such as data obtained from interview and

observation of CNAs and nurses in the nursing home, fit appropriately within the symbolic interactionism tenet that study of human interaction must occur within its natural context. (Sbaraini, Carter, Evans, & Blinkhorn, 2011).

Mead, strongly influenced by the pragmatism of Dewey, established the foundations of symbolic interactionism as social processes of interaction through which meaning of ourselves, “our very personhood” is formed (Crotty, 1998, p. 74). Blumer developed the term “symbolic interactionism” defining it as

a down-to-earth approach to the scientific study of human group life and group conduct. Its empirical world is the natural world of such group life and conduct. It lodges its problems in this natural world, conducts its studies in it, and derives its interpretations from such naturalistic studies. (Blumer, 1969, p.47)

Symbolic interactionism purports that meaning is central to human action, and conceptualizes human interaction as a social process in which individuals actively construct meaning. The premises of symbolic interactionism are that (a) individuals act toward objects based on the meaning that the objects have for them, (b) individuals construct meaning through interaction with others, and (c) meaning is modified through a process of interpretation as individuals interact with objects and others (Blumer, 1969).

Symbolic interactionism guides the study of human behavior through analysis of meaning that humans assign to symbols within a social context (Blumer, 1969). Erving Goffman (1959) incorporates concepts of symbolic interactionism when he suggests that humans are actors whose interactions are essentially role performances shaped by situation and context that includes front- and back-stages. On the front- and back-stage, role performance is constructed through interaction with others and designed to meet audience expectations (Goffman, 1959). Individuals act towards the role performance from the meaning that it has for them, and modify it based on their interpretation within

the context of their environment (Blumer, 1969). Goffman, from a symbolic interactionist perspective, maintains that an individual's action on the "front-stage" is constructed through cultural conventions and norms, and may be altered to meet external expectations of whoever is the audience. "Back-stage" actions are those that occur not in response to what is meaningful to others, but rather what is meaningful to the self (Goffman, 1959). When applied to nurse–CNA communication processes as a role performance in the nursing home, the potential influence of cultural beliefs in relation to the organizational culture is underscored.

Individual's role performance occurs through actions intended to manage others' impressions of them, which essentially shapes their social identity and in turn shapes expectations of their roles (Goffman, 1959). The concept of expected roles in the performance of nurse–CNA communication processes is reinforced when considering the nursing home as a "total institution." According to Goffman, a total institution is characterized as bureaucratically controlling and encompassing all spheres of human life (1957). Goffman identifies nursing homes as an institution for those who are considered harmless but incapable of caring for themselves. There are role expectations associated with an individual's position within the institutional bureaucracy, such as the position of nurses and CNAs as direct care givers to nursing home residents (Goffman, 1957). Performance of these institutional roles is subject to expectations of the front- and back-stage as they exist within the total institution.

In this study, the concepts of the front- and back-stage are applied as a both an organizing and analytical framework. Nurse–CNA communication processes were categorized in relation to official and unofficial expectations associated with the front-

and back-stages, and analyzed in relation to how the expectations influenced nurse–CNA construction of meaning in their communication interaction. The front-stages were initially conceived as those places where performance (nurse–CNA communication interaction) was shaped by regulatory requirements, organizational goals of care, and public scrutiny. The back-stages were conceived of as places where performance was not bound by those expectations and where the “truth” of the performance could occur (Goffman, 1959, pp. 106-140). These concepts of front- and back-stage were intended to serve as a framework for identifying where communication interactions occurred, and analyzing the contextual influence on CNA communication processes.

Methodology

Study Purpose and Research Questions

The connection between communication and quality of care has been established and supports the use of best practices in communication processes to improve health care outcomes. Techniques and organizational strategies to promote communication skill have been successfully used in acute care, but have had limited success in nursing homes. Difficulty in implementation is attributed in part to the complexity of balancing efforts to improve resident clinical outcomes with resident quality of life (Grabowski, Elliot, Leitzell, Cohen & Zimmerman, 2014; Ouslander et al., 2011).

The continuing struggle to improve nursing home resident outcomes and quality of life has prompted renewed interest in person-centered care and nursing home culture change (IOM, 2008). These concerns, often studied at the systems level, point to the importance of effective care practices such as communication skills of direct care staff in

the nursing home (Rosemond, Hanson, Ennett, Schenk, & Weiner, 2012).

The purpose of this grounded theory study was to gain deeper understanding of nurse–CNA communication practices at the center of resident care in the nursing home. Symbolic interactionism themes of meaning, action, and interpretation supported my methodological commitments to interact with CNAs and nurses in the nursing home, explicate meaning from those experiences, and construct a grounded theory of their communication processes (Charmaz, 2006). Investigation from the perspectives of those at the fundamental level of direct care of nursing home residents, CNAs and nurses, was conducted to answer the following research questions:

- Research question 1: What are the observed processes of nurse–CNA communication that occur during the course of their work in the direct care of long-term care nursing home residents?
- Research question 2: How do nurses and CNAs describe the communication processes that occur during the provision of direct care to nursing home residents?
- Research Question 3: What do nurses and CNAs perceive as positive or negative influences on their communication processes in the nursing home?

Setting

Data from *Nursing Home Compare*, a federal government website comparing data of all Medicare and Medicaid-certified nursing homes in the United States, were used to identify potential nursing homes for this study (CMS, 2004). Criteria for facility selection included convenience of location to maximize researcher time in the setting, and facility

size, determined through consultation with a nursing home expert as sufficient to provide researcher access to adequate number of direct care staff (personal communication G. Towsley, April, 2013). A letter of support from the administrator of selected nursing home was obtained after an initial meeting describing the purpose and general procedures of the study (Appendix A). Additional meetings with the Director of Nursing (DON) were conducted to introduce and explain the purpose of the study.

The nursing home where the study took place was in the Mountain West, had 120+ beds and was Medicare and Medicaid certified. It was privately owned by a corporation that owned or leased several skilled nursing facilities in Western states. Comparison of this facility to national nursing home data regarding size, type of ownership, and average ratings of health inspections, staffing, and quality was obtained from the Center for Medicare and Medicaid Services website *Nursing Home Compare*, and is presented in Table 3.1.

Within the facility were two equal-sized long-term care units identified in this study as units one and two. Each unit had a nurse's station located centrally in the unit, and shared other common areas such as the resident dining area, resident and staff outside smoking area, and conference room, and staff break-room. The facility also had an advanced care unit for medically complex patients that offers intensive skilled nursing, ventilator and tracheotomy services and a posthospital rehabilitation unit designed to help patients return home, which differ from the goal of providing long-term medical and social care to those with chronic illness who are unable to care for themselves (facility website). Because the focus of this study was communication in long-term care, the study area was limited to the two long-term care units in this facility.

Participants

Protection of Human Subjects

Approval for the study was obtained through the Institutional Review Board (IRB) at the University of Utah. Participants in this study were CNAs and nurses employed by the nursing home to provide direct care to residents. Inclusion criteria included all direct care nursing staff employed by the facility as either full time or regularly scheduled part-time, over 18 years of age and English speaking; those who spoke English as a second language were not excluded. Participants were included regardless of length of employment past new hire orientation in order to include perspectives from nurses and CNAs with potentially large variability in individual work history and experience.

Informed consent was obtained from individual CNAs and nurses prior to shadowing or interviewing them. Appendix B provides a copy of the consent document. Participants were informed of the purpose of the study, the procedures for protecting confidentiality and data management, potential risks and benefits to participants, the voluntary nature of participation, and intended use of study results. The participants were assured that the study would not affect their job performance, and that this study was not an evaluation of their competency. The participants were informed that as a mandatory reporter, the researcher was obligated to report any observation of resident abuse or suspected abuse.

Participants were informed that no individually identifiable data would be reported from this study, and that their names would not be used in any reports of publications. All data collected were de-identified and stored using an identification

number. Pseudonyms were used during analysis and no names were used in the report of findings. Residents who were in the care of CNAs and nurses who were being observed and shadowed did not need to provide informed consent because no identifiable health information about them was obtained.

Qualitative research experts recommend that the participant sample be large enough to achieve data saturation, but not so large as to inhibit detailed analysis (Stern, 2007). Data saturation for this study was assumed to have occurred when new data did not add new information and when all identified concepts and themes were supported by the data (Guest, Bunce, Johnson, 2006; Hallberg, 2006; Sbaraini et al., 2011). There are more CNAs than nurses employed as direct care staff; 10 CNAs and 7 nurses were asked and consented to participate in this study. Of those CNAs and nurses who were asked to participate, none refused. Participants were observed as they provided care to residents, across all shifts and days of the week in two long-term care units in the nursing home. During the initial period of observation, time was spent in common areas of the nursing home, usually at the nurse's desk, but also hallways and the resident dining room, to get a sense of CNA and nurse communication interaction, and to theoretically sample nurses and CNAs for shadowing and observations. Table 3.2 describes the data collection.

Study Procedure

Grounded theory is a qualitative research methodology originally developed by Glaser and Strauss for generating theory (Glaser & Strauss, 1967). It is used in behavioral sciences, and frequently in nursing, to explore under-studied social processes from the perspective of those with direct experience (Creswell, 2007; Glaser & Strauss, 1967).

Grounded theory methods of theoretical sampling, continuous comparative analysis, specific coding procedures, and analytic memoing were used to meet the study purpose of describing CNA and nurse communication when providing direct care to nursing home residents.

According to Glaser and Strauss (1967) the methods of grounded theory are not linear but “should blend and intertwine continually from the beginning of an investigation to its end” (p.43). Taking a constructivist theoretical position, meaning was co-constructed through a subjective relationship between the researcher and the participants. Data and analysis were constantly compared to participant data, and researcher interpretations of the data were labeled as codes and categories. The resulting theory is an interpretation (Charmaz, 2006; Birks & Mills, 2011). Figure 3.1 depicts the process for this study. Initially, data collection occurred through theoretical sampling. Subsequent open, axial, and selective coding led to the identification of core categories. The final phase was identification of relationships among core categories. Grounded theory methods of analytical memoing and constant comparative analysis occurred iteratively throughout the process.

Data Collection

The data for this study consisted of observations, shadowing, interviews, and limited review of written documents that nurses and CNAs used in their communication processes.

Observation

According to Corbin and Strauss (2008), individual's actions in relation to their surroundings create the dynamic processes that comprise an experience. Nurses and CNAs were observed as they went about their work of caring for residents in an informal way that allowed collection of the data from the "ground up" (Charmaz, 2006, pp. 20-21). Initial observation occurred across shifts in the "front-stage regions" of both long-term care units of the nursing home (the front desk, dining room, and hallways) and created a sense of who participated in communication about residents, where and when it occurred and what it was about. During this observation period, nurses and CNAs became familiar with the researcher and purpose of the study. Additionally, the researcher became familiar with the CNAs and nurses and their communication processes, and was able to note emerging thoughts, ideas, or questions for further exploration. Through the process of theoretical sampling, individuals were identified who appeared able to share their perspectives about their communication processes. These individuals consented to participate, and provided additional data, elaborated on existing data, or clarified emerging concepts through additional observation, shadowing, or interview.

Shadowing

Although shadowing is a data collection strategy usually associated with ethnographic methodology, it was hoped to be useful in this study to add a layer of researcher immersion (Charmaz, 2006). It was anticipated that shadowing would provide greater access to the "back regions" of the nursing home, such as break areas, hallways, and perhaps at times, resident rooms, where informal interactions may occur, and where

communication interactions may be less prescribed by formal standards and audience expectations (Goffman, 1959). However, because most communication occurred in common areas, data obtained from observation and shadowing were analogous: both provided similar opportunities to see nurse–CNA real-time and everyday communication interactions in the context of organizational and environmental conditions. Shadowing and observations became interchangeable methods of data collection, and participants for both were identified through theoretical sampling. Charmaz (2006) describes theoretical sampling as a strategy that emerges as ideas and questions arise from early data analysis, prompting further inquiry, rather than an explicit procedure based on a priori categorization.

Field Notes

Observation and shadowing were recorded as field notes. Field notes were open-ended written narrative that included descriptions of processes, behaviors including non-verbal, and physical environment details associated with nurse–CNA communication. All narrative field notes were hand-written during observation and shadowing of nurse–CNA communication interactions. As soon as possible, and no later than 1 week post-collection, hand-written field notes were transcribed as electronic word documents.

Semistructured Interview

Individual face-to face semistructured interviews were conducted with individual participants selected through theoretical sampling of CNAs and nurses who seemed particularly able to address questions that arose and to elaborate on categories and

concepts that emerged. For participant convenience, interviews were conducted at the facility in areas selected for privacy, most often the conference room behind the nurse's desk. All interviews were conducted by the researcher and audio recorded for later transcription. To avoid work-flow disruption, effort was made to conduct the interviews at mutually convenient times. Most interviews occurred during scheduled breaks, or at a time when it was determined that the employee could be away from the resident care activities. No participants expressed a need to be interviewed in a location outside of the facility; all interviews occurred in the nursing home.

Demographic information was obtained from participants after consent and prior to observation, shadowing, or interviewing. Participants were asked for information regarding age, gender, education, position and length of time in position, and history of previous health care experience.

As recommended by Charmaz (2006), an interview guide with broad introductory questions and probes was developed prior to the interview, to lessen the risk of distraction and prevent pointed questioning that could have inhibited participant reflection (pp. 29-31; Appendix C). Theoretical sampling resulted in re-interview of selected participants. Decision making for subsequent interview direction, probes, and development of follow-up questions were documented in memos as soon as possible after each interview. (Hallberg, 2006). An interview guide that included initial interview questions and additional probes was developed and used following the initial four interviews (Appendix D).

Documents

Charmaz (2006) indicates that documents can provide another perspective of the “front-stage view” (Charmaz, 2006, pp. 37-38). Documents used to provide data for this study were only the physical objects that were used by individual participants as part of their communication process, for example, individual reminder notes written by CNAs or nurses at any time during the course of resident care. The documents were viewed with permission from CNAs and nurses who agreed to be shadowed and or interviewed. Documents were read while at the nursing home, data from them were recorded in field notes. No identifiable resident health information from any of the documents was recorded.

Data Management

A digital audio recorder was used to record all interviews. The recordings were saved as audio files on an encrypted and password protected computer to which only the researcher had access. All audio recordings were transcribed verbatim by the researcher, or a transcription service that had signed a confidentiality agreement. Audio recordings were transcribed into word documents stored on the same encrypted and password protected computer to which only the researcher had access. After transcription was completed, audio recordings were erased from the recorder.

Some memos were hand-written at the nursing home, and then transcribed as word document. Most memos most were documented outside of the nursing home on an encrypted and password protected computer to which only the researcher had access. All memos were saved on that same computer.

Hand written field notes were kept in the researcher's possession at all times when in the nursing home. Original paper copies of field notes were stored in a locked filing cabinet. Field notes were transcribed by the researcher into an electronic word document and stored on an encrypted and password protected computer. Because this is a dissertation, interview transcripts and field notes (hand written and electronic) were periodically reviewed with the dissertation supervisory committee chair and an additional committee member.

Grounded Theory Analysis

Theoretical Sampling

Theoretical sampling is an fundamental strategy of grounded study design that guides the researcher decisions about what data to collect and how and where to collect the data (Glaser & Strauss, 1967). This participant sampling strategy was driven by the emergence of categories, concepts and questions that arose from constant comparative analysis of data and provide impetus to pursue additional data beyond that obtained from initial sampling (Charmaz, 2006). Essentially, additional sampling of participants occurred because they seemed particularly able to elaborate on central concepts of interest (personal communication K. Cloyes, June, 2014).

Constant Comparison

Constant comparative analysis is the cyclical comparison of events, codes, conceptual labels, and conceptual categories throughout all levels of collection and analysis (Birks & Mills, 2011). This process adds depth to conceptualization by

“generating successively more abstract concepts and theories through inductive processes of comparison” (Charmaz, 2006, p. p 187) Data consisted of general observations, such as during change of shift, individualized observations obtained during shadowing of selected participants, and interviews with selected participants. These data were analyzed using constant comparative analysis: comparing data to data and to emerging categories, comparing categories to categories and then comparing categories to concepts (Corbin & Strauss, 2008, pp. 73-74)

Coding Procedures

A code is the symbolic representation of the “content and essence” of the data and is captured by a “word or short phrase” (Saldana, 2009, p. 3). In grounded theory, coding is the method for defining the data, and will be done through cumulative cycles of naming, categorizing and eventually conceptualizing the data. (Charmaz, 2006; Saldana, 2009). Constant comparison occurred as data were concurrently collected, analyzed, coded and recoded using NVivo 10, a computer software coding program. The unit of analysis for this study was the smallest meaningful section of words that could be independently understood; most often a phrase but at times entire paragraphs.

Open Coding

The first phase of coding is referred to as open coding and was the process through which the data was examined in order to make early comparisons and analysis about what they suggested, and what theoretical categories began to surface (Charmaz, 2006). Data were in the form of field notes from nurse–CNA observation, shadowing,

and minimal document review, and verbatim transcripts from audio-recorded individual nurse and CNA interviews. The data were essentially broken apart in order to compare and label segments. Gerunds (a verb ending in -ing, that serves as a noun) were used as codes for the data to convey participant action as they described their perspectives of communication processes, for example, “collaborating” and “synchronizing” (Bernard & Ryan, 2010, pp. 271-276). Data were explored at this level to identify similarities, differences, and nuances from which patterns and categories that “fit” and were relevant to participants experiences were identified (Birks & Mills, 2011; Charmaz, 2006).

Axial Coding

Axial coding followed initial coding and was a more directed method for explaining and comparing larger pieces of the data by identifying the most frequent and significant initial codes from which salient categories were identified (Charmaz, 2006). In this phase of coding data were reconnected through decisions aimed at clustering similarly coded data under more focused codes. Through constant comparison of focused codes, categories and subcategories were linked to emerging concepts. For example, data coded as “synchronizing” were coded under categories of “appropriate” and “partial information flow.” This coding cycle coding explained larger segments of the data, and in essence condensed the data with a concept that provided a “handle” (Charmaz, 2006, pp. 57-60).

Selective Coding

In this final phase of analysis, the relationships between emerging concepts were examined with the purpose of identifying and selecting core concepts that included and explained all levels of data from open codes, subcategories, categories, to concepts. As an example, the core concept of “maintaining information flow” was identified as a core concept that explained data that were initially coded as “synchronizing” and then subcategorized into “appropriate” and “partial information flow.” The core concepts were four central themes that became the midrange theory identified as four “rules of performance” that guide nurse–CNA communication processes during the care of nursing home residents. The final NVivo 10 coding scheme and data frequencies in each category can be seen in Table 3.3

Analytic Memoing

Analytic memoing, a fundamental grounded theory method, occurred throughout data collection and analysis. Memoing was done after each encounter at the nursing home, and provided a record of researcher thoughts about the data, ideas that arose from the data, personal perceptions and assumptions, and decision-making processes for data collection and analysis. Memos essentially documented the analytic processes and provided an audit trail of this study (Charmaz, 2006).

Potential Risks

The risks of this study to participants were minimal. Participants were informed about potentially feeling uncomfortable when they discussed their interactions with work

colleagues to the research, and being uneasy when they shared perceptions of work processes. Concerns about appearing to be contentious, finger-pointing or betraying colleagues were discussed. Potential feelings of vulnerability when talking about work processes in general, or describing interaction with persons perceived to have authority over them, were discussed. Although discussed prior to participating, no participants expressed discomfort about potentially being identified by colleagues as a participant in the study; by being observed, shadowed or interviewed by the researcher during work hours. If the participant had experienced emotional discomfort, the researcher would have referred the participant, with their permission, to the human resources personnel support within the facility. Although it was offered as an option, no participant wished to be interviewed in a location outside of the facility.

To avoid the risk to the facility of interrupted resident care, interviews occurred at mutually convenient times that included after work hours, during scheduled breaks, or when it was determined that the CNA or nurse may be away from the patient care area. Follow-up interviews of 2 nurses were arranged a mutually convenient time. Some interviews were interrupted and then resumed: resident care needs always took precedence over study procedures.

Potential Benefits

There were no direct benefits to the participants or the facility; however, findings from the study will be shared with the nursing home administrator and director of nursing. The information from this study resulted in a better understanding of how nurse–CNA communication processes occur.

Understanding nurse–CNA communication processes may improve the quality of resident care by helping determine how communication impacts or is impacted by work processes. The work environment may be improved by understanding how CNAs and nurses currently communicate, and how they perceive those processes in relation to teamwork, collaboration and support, and overall job satisfaction. A better understanding of how CNAs and nurses construct meaning of the communication processes may help when strategizing how to enhance the role of direct care staff, through specifically targeted policy that supports practice and educational strategies.

Potential Limitations of the Study

The study occurred in only one nursing home and there may be organizational specific-process and facility specific context that make the developed theory un-generalizable to other nursing homes. However, elevating the data to the conceptual level makes the theory more transferrable to other settings and potentially mitigates this limitation. Artificial results may have resulted in response to the research and researcher. The Hawthorne effect may have occurred if nurses and CNAs modified their behavior in communication processes because they were being observed or shadowed

Summary

A grounded theory approach guided this study of nurse–CNA communication processes during the provision of care to nursing home residents. Goffman’s (1959) concepts of front-stage and back-stage incorporated concepts of symbolic interactionism and supported the study purpose of generating a substantive grounded theory of nurse–

CNA communication in the nursing home from nurse–CNA perspectives. Data were obtained from CNAs and nurses who provide direct care to residents. The resulting understanding of nurse–CNA communication processes may be useful for improving communication among those who work in nursing homes, ultimately improving care for residents.

Table 3.1
Nursing Home Characteristics

Characteristics and Ratings	Study Nursing Home	National Nursing Home Statistics
Number of beds	120+	80% of U.S. nursing homes have between 50 and 199 beds
Number of Residents	125	87.5 average number of residents in U.S. nursing homes
Ownership	For profit-Corporation	69% of all U.S. nursing homes are for profit
Medicare and Medicaid Participation	Yes	91.6 % of U.S. nursing homes are dually certified
Staffing (hours per resident per day)		
RN	2 hours	50 minutes
LPN/LVN	31 minutes	50 minutes
CNA	2 hours and 42 minutes	2 hours and 28 minutes

Note: Data is obtained from Medicare.gov Nursing Home Compare and Centers for Medicare and Medicaid Services Nursing Home Compendium, 2013

Table 3.2
Method and Time for Data Collection

Method of Collection	Time
Observation on Unit One	28 hours
Observation on Unit Two	20 hours
Individual Shadowing -2 Nurses	12 hours
Individual Shadowing -3 CNAs	18 hours
Interviews - 6 Nurses	Varying length: 10 to 30 minutes
Interviews – 4 CNAs	Varying length: 8 to 20 minutes

Note. Data collection occurred across all shifts and days of week from 10/27/14 through 1/17/15

Table 3.3
Coding Scheme and Data Frequencies

Themes	Categories Within Themes	Frequency of occurrence in all data (Observation/Shadowing/Interview)
Maintaining Information Flow		230
	Appropriate Information Flow	136
	Partial Information Flow	66
	Constrained Information Flow	28
Following Procedure		141
	Following Policy	38
	Following Noncodified Norms	41
	Violating Policy and Norms	62
Fostering Collegiality		151
	Mentoring	107
	Absence of Mentoring	44
Showing Respect		184
	Showing Respect	120
	Absence of Respect	64

Note: NVivo 10 (computer software coding program) was used. Unit of analysis was the smallest selection of words that had independent meaning (phrases and sometimes entire paragraphs).

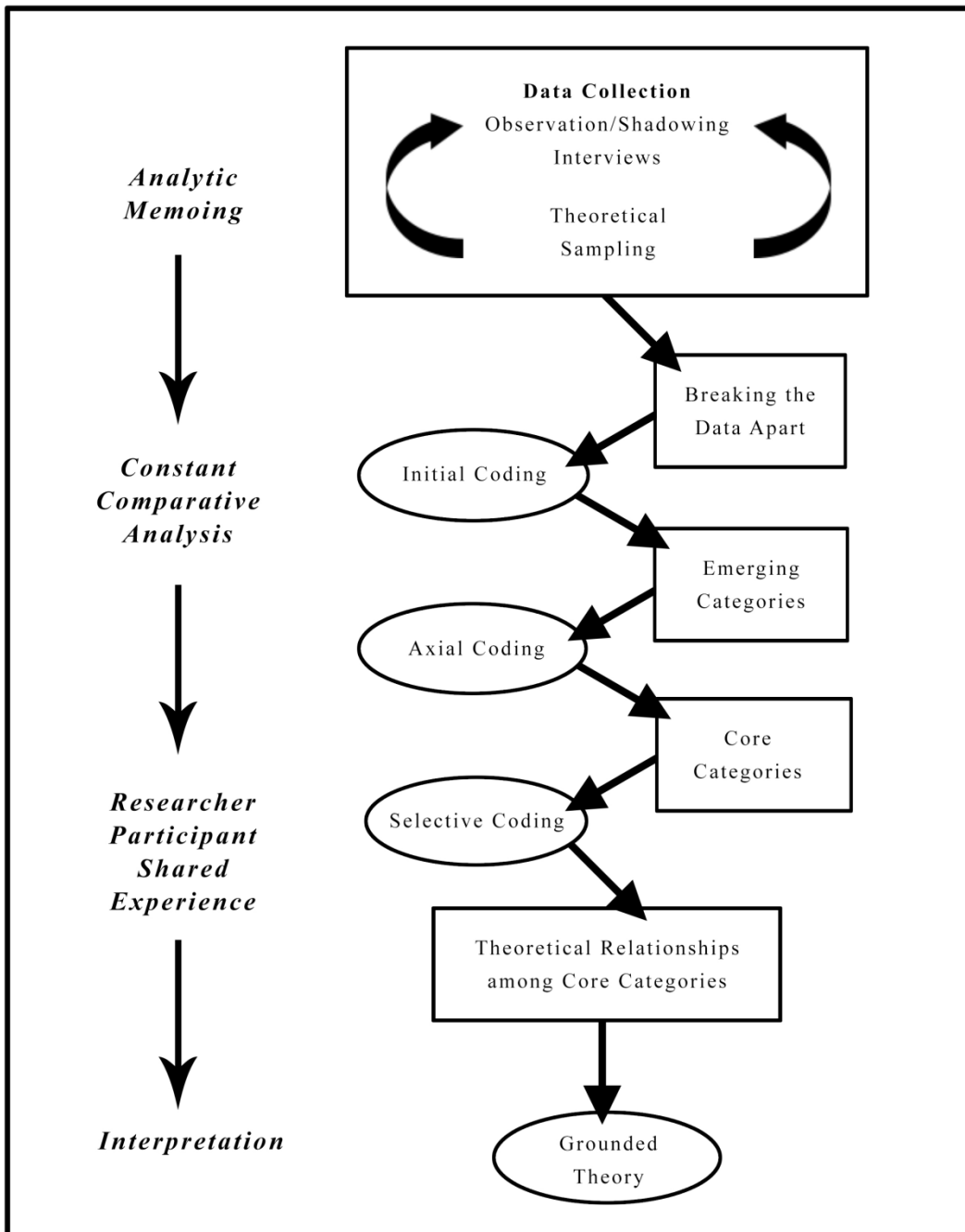


Figure 3.1

Model of Study Process

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CHAPTER 4

A GROUNDED THEORY OF NURSE-CNA COMMUNICATION IN THE NURSING HOME

Abstract

Quality nursing home care is a national health concern. Projections of increasing residency rates are coupled with growing concern about nursing home staff capacity and ability to provide quality care. Efforts are needed toward improving nursing home workforce collaboration and communication skills. Nurses and Certified Nursing Assistants (CNAs) comprise the majority of direct resident care, yet little is known about nurse–CNA direct care processes including their communication processes.

A relative lack of existing information suggested a need for fundamental understanding of communication processes from nurse and CNA perspectives. A grounded theory approach guided this study with the purpose of gaining understanding of nurse–CNA communication processes from the perspective of nurses and CNAs. Application of Goffman’s concept of front- and back-stages created an analytical framework for exploring nurse–CNA communication processes in the complex context of the nursing home setting.

Data were obtained from observation, shadowing, and interviews of nurses and CNAs on two ~ 40-bed long-term care units in a nursing home. Analyses suggested that

nurse–CNA communication processes were guided by four “rules of performance”; (1) maintaining information flow, (2) following procedure, (3) fostering collegiality, and (4) showing respect. The interplay of “rules of performance” on the front- and back-stages of direct care should be considered in the development of contextually applicable policy and practice strategies that are relevant to nurses and CNAs providing care to nursing home residents.

Introduction

Quality nursing home care is a national health concern. Those 85 years of age and older are the second fastest growing age group in the US, and account for over half of the nursing home population (Werner, 2011). Furthermore, 8,000 baby boomers will turn age 70 each day beginning in 2016 and will continue to do so for 18 years (Lee & Sumaya, 2013). Nursing home residency rates are projected to increase by 57 % by 2030 (Administration on Aging, 2013). Concern about adequacy of the nursing home workforce has heightened attention on improving nursing home staff capacity to provide better quality of care (Institute of Medicine [IOM], 2008; Tyler & Parker, 2011).

Gaps in nursing education regarding supervisory skills including communication that promotes optimal leadership and management of CNAs, are recognized as a barrier to efficient care delivery (Siegel, Young, Mitchell, Shannon, 2008). CNA training is task-oriented with little education regarding effective health care organizational communication (Sengupta, Ejaz, Harris-Kojetin, 2012). Experts suggest that efforts to improve nursing home quality and resident care should be aimed toward improving workforce collaboration and communication skills (Werner, Konetzka & Kim, 2013).

Nurses (registered nurses, licensed practical nurses, licensed vocational nurses) and Certified Nursing Assistants (CNAs) provide direct care to more than 1.3 million people currently residing in nursing homes (IOM, 2008; Werner, 2011). The nursing home is a complex setting where residents, many with multiple chronic conditions, live out their lives and receive health care. Nurses, in addition to providing personal care, administer medications, provide wound care, monitor resident conditions, and supervise and delegate resident care to CNAs. CNAs provide nearly 80% of individual personal care to residents, including assistance with hygiene, feeding, toileting, and mobility (McGilton et al 2013).

Problems with communication processes are often implicated as factors contributing to poor resident outcomes, such as decreased resident function, satisfaction with care and ineffective pain management (Rosemond, Hanson, Ennett, Schenck, & Weiner 2012; Wagner, Damianakis, Pho, & Tourangeau, 2013). Understanding of communication among nursing home staff is limited in general, and more so regarding communication processes among CNAs and nurses who are providing care for residents, many with multiple needs (Castle, Wagner, Sonon, & Ferfuson-Rome, 2012; Colon-Emeric et al., 2006). Ineffective communication behaviors among nurses and CNAs, such as not listening or responding to each other, are associated with increased staff turnover and error risk, which negatively impact quality of nursing home care (Scandrett et al., 2012; Wagner et al., 2013). Recent efforts aimed at improving nursing home care and resident outcomes, including provisions in the Affordable Care Act (ACA), have resulted in successful but limited numbers of quality improvement projects using standardized communication approaches and practice guidelines (Miller, 2012). One barrier to

widespread implementation of successful quality improvement projects is the need for better understanding of nursing home care processes, including communication practices among all levels of staff (Vogelsmeier & Scott-Cawiezell, 2011; Werner et al., 2013).

Theoretical Framework

The premises of symbolic interactionism suggest that individuals act toward things based on meaning that they constructed through interaction and modify through an interpretative process (Blumer, 1969). Stemming from these premises, Erving Goffman's dramaturgical framework suggests that individuals are essentially actors on a stage who behaves in certain ways to fit the requirements of a particular context, and that the context includes both front- and back-stages (1959). Front-stage and back-stage concepts describe the relationship between roles that individuals perform during interpersonal interaction, and the audience for whom the role performance is intended. Interaction on the front-stage is public and intended to create a particular impression to meet audience expectations. Back-stage interaction occurs in the absence of a public audience, making creation of a particular impression unnecessary. Front-stage performance can be considered as "official" and subject to audience judgment, whereas back-stage performance is "unofficial" and allows for individual expression that is not subject to public scrutiny (Goffman, 1959).

Communication processes among nurses and CNAs in the nursing home is a motivated social interaction process that occurs on front- and back-stages that are not separated by physical locations, but instead by conceptual position. The boundary between these conceptual spaces is imprecise and dynamic, shifting between institutional

purposes of providing residents with a comfortable, safe home, and meeting physical and medical needs. The concept of the nursing home as a “total institution” is described by Goffman as a type of institution designed for persons considered incapable and harmless. In this total institution all spheres of individual life are encompassed and regulated and action occurs in the presence of others (Goffman, 1957). Application of the concepts of front- and back-stages as regions where different rules apply provided an organizing framework for distinguishing context within the “total institution” environment of the nursing home. Additionally it provided a framework from which to analyze nurse–CNA communication process from a symbolic interactionist paradigm, as socially constructed performances produced by and understood through the context in which they occur (Crotty, 1998; Goffman 1959).

Front-stage communication processes of nurses and CNAs encompasses publicly viewable “official” performance in their expected role as direct care staff, such as information exchange at the nurse’s desk or change of shift report. Front-stage communication processes are intended to meet regulatory requirements, organizational policy, formal job responsibilities including routine care activities, and public scrutiny. Back-stage communication processes are “unofficial” and occur without formal expectations which may result in increased authenticity. Examples of back-stage communication include experienced CNAs or nurses choosing to mentor less experienced coworkers, or when CNAs coordinate individual responsibilities to provide efficient resident care.

Designs and Method

Grounded theory methods were used to explore CNA and nurse perspectives of their communication processes when providing direct care to long-term care residents in nursing homes. Approval to conduct the study in a 120+ bed for-profit nursing home in the Mountain West was granted by the nursing home administrator. Ethics approval was received from the Institutional Review Board at the University of Utah. Three questions guided the study: (1) What are the observed processes of nurse–CNA communication that occur during the course of their work in the direct care of long-term care nursing home residents? (2) How do nurses and CNAs describe the communication processes that occur during the provision of direct care to nursing home residents? (3) What do nurses and CNAs perceive as positive or negative influences on their communication processes in the nursing home?

Participants

Nurses and CNAs were recruited who were employed full or part time as direct care staff on either of two long-term care units in the nursing home, and who had been employed at least long enough to be through new-employee orientation. This criterion was established to ensure that participants had sufficient experience to provide full description of their communication processes. Seven nurses and 10 CNAs consented to participate.

The sample consisted of 7 nurses (5 female and 2 male) and 10 CNAs (9 female and 1 male). Nurses on average were older than CNAs, had been in their current positions longer, and had more years of health care experience. Most nurses had an

associate degree and were registered nurses; 1 nurse had vocational school training and was a licensed practical nurse. Three CNAs had some college credit; 2 were currently enrolled in college. For 1 nurse and 2 CNAs, this was their first health care position; all other participants had previous nursing home experience except for 1 CNA who had previous experience as a home health aide. The demographic characteristics of the participants, shown in Table 4.1 are similar to national demographic descriptions of the long-term care workforce (Health Resources and Service Administration, 2013; Khatutsky, Weiner, Anderson, Akhmerova, & Jessup, 2011).

Setting and Context

Communication processes in the long-term care units occurred most often as face-to-face interactions among nurses, CNAs, and between nurses and CNAs. Other channels of communication were used less frequently. A telephone at the nurse's desk was occasionally used by nurses to page CNAs. Communication processes among nurses and CNAs were highly visible to a broad audience that potentially included administrators, residents, residents' family members, and auxiliary personnel such as therapists and social workers.

A paper report sheet, printed with resident names and room numbers was used by nurses to note pertinent resident information during their shift, and to report to on-coming nurses at change of shift. Report sheets were collected and given to the day-shift nursing supervisor for review in daily administrative facility management meetings. CNAs did not use a change of shift report sheet or keep notes about residents during their shift. CNAs used a resident shower assignment list to coordinate use of the shower room, and

daily resident menu cards to orchestrate mealtime activity.

The electronic health record was used for documenting care and interventions. Most commonly, CNAs documented intake/output, and bed mobility and nurses' documented medication and treatments. Although both nurses and CNAs had access to the electronic health record, it was rarely used by either to review previously documented resident information.

The nurse's station, on both long-term care units, was the hub of activity and where most communication interaction was observed. The two stations were similarly designed and furnished. Both areas were small and crowded with a rack of approximately 44 hard charts, copy machine and filing cabinet. A desk with two computer terminals comfortably accommodated two people. The med carts, one for each side of the unit, were kept in front of the desk.

Nurses, except when giving medication or treatments, sat at the desk. Two nurses, each assigned as charge nurse for a section of the unit, were in frequent and close proximity as they worked at the computers on the desk. CNAs did not have a separate workstation and rarely sat at the desk, but came frequently and briefly nearby to perform many of their tasks. CNAs stored personal items (bags, backpacks, jackets) on a shelf underneath the desk, got keys from nurses to outside supply storage, or asked nurses for supplies from a locked closet behind the desk. They obtained residents snacks, juice, and ice from a rolling metal cooler adjacent to the desk, and brought soiled linen and trash to the utility room directly across from it.

Communication between nurses was about residents and occurred routinely at change of shift when the nursing coming in received report from the nursing finishing the

shift. The type and amount of resident information exchanged between nurses during report varied widely. Some nurses reported information about blood sugar, vital signs, bowel status, scheduled appointments or treatments; other nurses reported little information beyond residents name and a status of “OK.” Resident information exchange between CNAs who were starting their shift with those who were leaving their shift occurred inconsistently. Sometimes CNAs attempted to exchange information at the change of shift through walking rounds on the units, but were often interrupted and did not resume report after stopping to address a resident request.

Both nurses and CNAs communicated opportunistically as need arose. CNAs coordinated timing of tasks and use of equipment, such as use of the unit’s only shower room, or Hoyer lift. Nurses consulted with other nurses if they were unsure about a resident’s condition or needed help with a specific task, such as ordering labs on the computer. CNAs informed nurses when a resident required nurse attention, which most often was a resident’s request for medication. Nurses requested specific time sensitive information from CNAs, such as a resident’s vital signs prior to giving medication. Nurses instructed CNAs when a resident needed care or monitoring beyond usual CNA care.

Data Collection and Analysis

Data consisted of field notes written during observation from the nurse’s desk, hallways, public dining room, and break room of all participants, and individual shadowing of 2 nurses and 3 CNAs, as well as verbatim transcriptions of audio-recorded face-to-face interviews with 6 nurses and 4 CNAs. Selection of participants for

shadowing and interviews was guided by the process of theoretical sampling. As data collection and analysis proceeded, participants who seemed particularly able to provide depth or clarity to themes emerging from the data, were selected to be shadowed or interviewed (Charmaz, 2006).

Constant comparison of data occurred as they were concurrently collected, analyzed, coded and recoded using NVivo 10, a commercial software coding program. Data were sorted, categorized, and resorted coded at progressive levels of abstraction, until four conceptual themes emerged. The process of analytic memoing was used to compare themes and the data contained within each theme, and to develop a midrange explanation of nurse–CNA communication processes when caring for nursing home residents. The process of theoretical sampling continued until saturation was reached; no new conceptual information was identified in the data that required additional codes or expansion of categories (Charmaz, 2006; Janes, Sidani, Cott, & Rappolt, 2008).

Researcher thoughts, emerging ideas, and analytic decision-making were recorded in memos. Data collection was not a linear process; observation, shadowing and interviewing were used as interchangeable strategies for triangulation of findings. Data and iterations of data coding schemes were reviewed periodically by methodological and content experts. As the study progressed, emerging categories and themes were discussed by the researcher with accessible participants (both nurses and CNAs), to clarify understanding and to corroborate the “fit “of the categories with their perspectives (Charmaz, 2006).

Findings

Four themes emerged from the data as a midrange theory explaining nurse–CNA communication processes. “Nurse–CNA Communication in the Nursing Home: Rules of Performance” is composed of four “rules” that guide nurse and CNA as they “perform” in communication interactions when providing direct care to residents: (1) maintaining information flow, (2) following procedure, (3) fostering collegiality, and (4) showing respect. Application of Goffman’s concepts of front- and back-stages, supported by the premises of symbolic interactionism, provided an organizing framework from which to conceptually position the performances, and an analytical framework for understanding the performance from the perspectives of nurses and CNAs in the complex setting of the nursing home.

Maintaining Information Flow

Maintaining information flow was a rule for performance of nurse–CNA communication processes to meet front-stage expectations of providing professional care to residents. Information flow was maintained when communication processes consisted of relevant information given and responded to in a certain time frame. Information flow was not maintained when nurse–CNA communication processes resulted in only partial exchange: not enough information or information given too late. Partial information flow limited nurse and CNA ability to coordinate or manage resident care.

Ideally at the change of shift, outside of resident rooms in public hallways, CNAs exchanged resident information, described as follows by a CNA:

I find out what’s going on with the patients, where they’re at, if they’ve got appointments, how they’re doing physically and their health too, when they’ve

been changed last because we don't want them wet. Things like that, just finding out everything about our patients before they [CNAs from previous the shift] go home.

However, change of shift report between CNA occurred inconsistently, and although CNAs identified the importance of “finding out how they [residents] are doing, and anything that is vital, and needs to be passed from shift to shift,” they frequently described not having enough practical resident information to perform their job efficiently. In addition to not receiving information about residents personal needs (hygiene, clothing and bedding changes), CNAs reported “wasting valuable time” looking for residents when they were not informed during report of a residents scheduled absence from the unit.

CNAs communicated with each other to cooperate in resident care that required more than one person to meet front-stage care standards, for example, a two-person lift, or extra monitoring because of safety concerns. CNAs also communicated to coordinate their expected responsibilities across the unit, as described in the following example from a CNA:

And then, I talk to my coworker... “Okay, I'll do all the vitals,” or I talk to her about getting all our supplies ready...our goal to is get everything prepared and ready and done before dinner, that way we just get them [residents] up, change them, take them to dinner, bring them back and get them ready for bed.

Nurses routinely engaged in the exchange of resident information as an official front-stage expectation at the change of shift. However, nurses identified instances when they did not receive enough information, for example, not receiving information that “this person fell 3 days ago, or they were started on antibiotics.” Most nurses were satisfied with usual report that gave little information beyond resident name, bowel status, blood sugar, and scheduled appointments outside of the facility with therapists or providers, and

some were satisfied with hearing that the residents were “OK.” Report between nurses when a resident is transferred between units was noted as a specific circumstance when information “...can fall through the cracks.” In one example, after a transfer, a resident was left unattended for many hours before nurses on the unit realized he was there.

Maintaining information flow between nurses and CNAs was expected to be a reciprocal performance in which resident information was given and acted upon in a satisfactory timeframe. The process was initiated by either nurses or CNAs, for example, when a CNA reported a resident occurrence to a nurse resulting in prompt follow-up by the nurse, or when a nurse requested an action which the CNA completed in an acceptable time frame. Nurses informed CNAs when a resident required a change in usual care “over and above what they [CNAs] would normally do.” One nurse stated, “If I am looking for something, I’ll let them [CNAs] know exactly what I need and why.” CNAs told nurses “about the condition of the patient and their vitals,” or about “things that go on with the patient, like if they need a pain pill, or need their meds, or whatever the patient’s needs are.”

Maintaining information flow was negatively influenced when communication performances were not reciprocal. As a CNA explained, “Sometimes it’s like I know they [nurses] are busy and they don’t say anything so I don’t know if they’ve heard me or not.” A nurse indicated she was not always sure she was heard by CNAs and advised them to “just open your ears and listen, and kind of get out of your own head for a minute.”

Nurses and CNAs were similarly frustrated when they received information well after they thought it should have been shared as a front-stage expectation of care. One

nurse explained:

...it really irritates me when I find at the end of the shift that someone hasn't urinated all shift or they haven't had a bowel movement in 4 days, or I forgot to tell you this morning I was transferring and he got a skin tear on the side of his elbow. That makes me crazy. If I can, I know about it at the time it happens I can take care of and prevent something.

Timing of nurses' responses was particularly frustrating for CNAs when it interfered with their ability to complete tasks that were expectations of their front-stage job responsibilities. One CNA described being unable to dress a resident during her shift, because a nurse had not responded to her report that the resident's wound needed to be assessed and bandaged.

Communication flow was constrained by challenging workloads and inadequate staffing that made logistics of communication performances difficult, and ultimately interfered with front-stage job responsibilities. Demands on CNA time were described as follows by CNA: "you spend an hour and a half for breakfast and hour and a half for lunch in the dining rooms...then showers that are a half an hour to 45 minutes. When do you have time to do anything else?" CNAs identified that large portions of their time are spent in rooms of residents who are "total care and completely dependent," or have behavior issues requiring extra vigilance.

Nurses suggested that communication between them is constrained by inadequate staffing that was defined by them as either not enough nurses or inconsistent assignment of nurses between units. A nurse explained that "sometimes we'll get extra patients, lots of admits and you don't have staff. That makes it difficult." Another nurse described how nurses are "bounced around" between units:

I work 4 days a week normally, and 3 of those 4 days I'm on a different cart [section on a unit]. I think if you had staff pretty much staying in the same place,

everybody's going to get better care and their communication is going to be better.

Following Procedure

Nurses and CNAs followed procedure in the performance of communication processes that supported nursing home organizational structure and culture. Some procedures were front-stage expectations defined by institutional policies. Other procedures were guided by noncodified norms that arose through a back-stage and unofficial but common understanding of shared values. Norms of cooperation and taking initiative were manifested through “unofficial” performance expectations. The expectation for cooperation was that of working together for efficient resident care; taking initiative was the expectation that care activities would be discreetly assumed and completed.

Policy-based and norm-based communication processes were intricately connected across the front- and back-stages: poor performance in one area negatively influenced performance in the other. However, when policy and norms were performed in concert on both stages, nurses and CNAs described the result in symbolic terms such as a “beautiful routine,” “like dancing,” or “a smooth running machine.”

Some communication processes were performed to meet straightforward front-stage policy expectations, for example, the requirement that all staff speak English in public areas of the nursing home, speak their native language only when it is the language spoken by a resident, and take measures to ensure that communication is conducted in ways that maintain resident confidentiality. In addition, nurses and CNAs described the expectation that an organizational chain of command be followed for reporting

dissatisfaction with a coworker. Effectiveness and safety of the chain-of command is described below by a CNA and a nurse:

So if we have a problem with [another] CNA not doing their job or not taking care of a patient properly then we tell the nurse and then the nurse goes and talks to them. And then if it gets out of control, then it goes up the ladder but usually never goes up that far.

...I have told them [CNAs] if they tell me [nurse] something and I don't do anything about it then take it to the next higher person. And I really like that because they are encouraging people to see what's going on around them and there's no repercussion."

Nurses and CNAs also followed procedure through performance of communication processes based on policy associated with their job descriptions. This policy, as one CNA explained, applied to everyone, "no matter what job you do, you need to perform and follow the rules." Job descriptions defined nurse and CNA roles as front-stage expectations. One CNA stated, "I am not supposed to talk to my coworkers to tell them what to do; the nurses need to do that." Another nurse described the nurse's role by saying "you have to have expectations with your staff and your CNAs...and if you don't communicate with them clearly, things don't get done."

A hierarchical structure associated with job position was acknowledged by both nurses and CNAs and created policy-based expectations of nurse and CNA roles in communication processes. One CNA explained "they [the nurse] can tell us what we need to do and we're supposed to listen to them." A nurse described her role as when a CNA "understands what I assigned them to do, because I am kind of their supervisor and they have to report to me." However, understanding of the role expectation did not necessarily mean that the communication performance itself was good, as illustrated by a nurse who said "When I tell them [CNAs] to do stuff and they do it. That's good

communication.”

The back-stage norm for taking initiative was closely tied to front-stage expectations for job performance, and in some ways contradicted policy-based communication processes based on positional hierarchy. Nurses suggested that CNAs demonstrate “common sense and initiative” when they “do not have to be led by the hand.” One nurse further explained, “I don’t want to have to tell them [CNAs] anything. A good CNA does not need anybody to tell her anything. Your beds are made, your people are showered, and your people are clean. You are fine.” CNAs described initiative in their interaction with nurses as “a good thing, because if I was a nurse it would kind of bother me if I had to tell a CNA exactly everything, what to do.”

The back-stage norm of cooperation was the “unofficial” expectation for communication processes that resulted in efficient work together and was related to policy associated with front-stage job expectations. CNAs interactions “focus on the unit as a whole” as explained below by a CNA:

I talk to her [CNA coworker], like today she went and got all the urinals and I went and got all the oxygen hoses, or I’ll do all the vitals...it’s all about the CNAs working together, communicating together, getting everything done that we’re expected to do.

Nurse’s interactions with other nurses were more likely to be in regard to cooperation to assist with a specific resident in a nurse’s assigned “set of patients,” or to assist with a unit administrative process. A nurse described it as a performance to “help each other”:

Sometimes she [another nurse] has to do, or she doesn’t have time to do a dressing or something, and tell me how to do and I’ll just go do it...the other day and admission comes in. It was her admission, but you know we help each other, and I say I’ll go do this and you do that.

Nurses and CNAs cooperated on the back-stage when a resident need intersected between their individual responsibilities on the front-stage. Examples included when a resident requested pain medication from the nurse before being taken to the shower by a CNA, or when a resident needed to have their briefs changed before the nurse sat them up to give their morning medication. The communication process was not guided by the front-stage need expectation exchange resident information, but by the back-stage norm that cooperation was expected in order to work efficiently.

Norms of cooperation and taking initiative, and work performance expectations were intertwined. One CNA described “It’s like we don’t have to tell each other, we just know, we just know what we have got to get done.” An example was observed at the beginning of a shift, when a CNA without being asked, went from resident room to resident room, including those assigned to another CNA, taking inventory, then gathering and distributing needed supplies (briefs and wipes) and linen.

Nurses and CNAs were not disposed to either cooperate or take initiative when coworkers shirked responsibilities and according to one CNA “don’t do what they are supposed to do.” One nurse explained it as a matter of other nurses needing to “get with it, because I am not going to stay here all night so I can help.” CNAs routinely answered call lights of residents assigned to a CNA who was occupied in another resident’s room, but did not answer call lights for CNAs who were on break too long, or whose lack of preparation (not enough linen or supplies in the room) slowed them down.

Fostering Collegiality

Nurses and CNAs engaged in communication processes that fostered collegiality with coworkers. Communication processes were positively influenced when nurses and CNAs regarded coworkers as willing to do their job, but lacking in training or experience. Collegial communication processes were negatively influenced when a coworker was unwilling or uninterested in improving their performance. Collegiality was fostered most often through staff-to-staff mentoring on-the job and in the midst of resident care, when the need for mentoring was recognized by a coworker. As such, it was an unofficial backstage communication process frequently conducted in public with a potentially front-stage audience.

CNAs voluntarily mentored other CNAs who lacked experience. A CNA explained, that “some people, especially young people who don’t have experience...for a lot of CNAs, this is their first job, that is why they don’t know, they are learning.” Nurses mentored CNAs who “through no fault of their own,” were poorly trained with limited experience, described as follows by a nurse:

Sometimes they [CNAs] don’t understand how to do something or what they should do. I usually step in and give them some more explanation, or sometimes some teaching if they don’t seem to understand what I am asking them to do, or I say OK, come and I will show you what to do.

Experienced nurses were willing to mentor other nurses with less experience regarding resident care and work processes. In one case a nurse described how another nurse assisted her with resident assessment, “If my patient is having a change of condition...and I want somebody’s help if I think I hear something different...something is going on with the patient that I am not sure about.” A different nurse described learning how to complete admission documentation “I work with a nurse who has been a

nurse for longer than me...and so she knows a lot...and so she teaches me.”

In addition to performance that included mentoring, nurses and CNAs also followed the rule for fostering collegiality with coworkers who they recognized were stressed by the challenging front-stage environment and workload, and as a result were struggling to perform their work. CNAs communicated with each other unofficially on the back-stage to offer assistance and support. One CNA described her sympathetic offer of assistance to another CNA who was caring for residents in “one of the harder halls, where there are too many that you have to use the Hoyer that are total care, that are totally dependent...have more wounds, more behaviors.” Another CNA described her back-stage motivation to help a colleague as, “Usually people just...get really tired or they’re sick or something’s going on where it’s like, okay, all right, we’ll try and help you pick up the slack and help you out.”

Mentoring may have been a well-intentioned communication process but sometimes was not well received when it occurred as a front-stage reaction during the course of resident care. For example, when 1 CNA took it upon herself to unofficially mentor another CNA about how to feed and talk respectfully to a resident, she did so to the dismay of the CNA being mentored, in front of other coworkers, residents, and visitors in the public dining room.

Sometimes the intention itself was misunderstood. For example, a CNA when “mentored” by another CNA regarding how to dress a resident with weakness on one side, resented that she was “being told what to do.” The situation was not improved when the CNA whose intention was to mentor explained, “I’m not telling you how to do your job, I’m telling you to stop and think about what you are doing.” Another CNA

described how that misunderstanding might occur when she said “we try to explain the best we can, only some people don’t like to be told what they need to do.”

Misunderstanding of intention occurred when a prospective mentor perceived his or her authority or expertise on the front-stage was being questioned. One nurse described her response when a CNA asked her why she had requested vital signs to be taken:

If I want these vital signs done, I want them done, and you don’t have to know the reason. But if you want to know the reason I will give it to you. But the reason is because I want them done.

Regardless of intention or location of the interaction, mentoring was essentially nonexistent if nurses and CNAs perceived that a coworker was unwilling to make the effort they felt was necessary. For example, in the midst of a busy morning with various people at the nurse’s desk, 1 CNA told another CNA who had questions about the resident shower assignment: “Why are you standing and only watching? You have several residents who depend on you... you can’t pick and choose...you have to do what needs to be done.” In another instance, when a nurse who usually worked on one unit came to the nurse on a different unit and suggested that she, “didn’t have to do anything but just shadow,” the nurse replied, “No honey, you don’t shadow me. I don’t accept anybody to shadow me.” The negative influence on communication processes when a coworker was perceived as unwilling to improve performance was concisely described by a nurse who said, “if you don’t want to help yourself, then maybe I shouldn’t help you.”

Showing Respect

The final “rule,” showing respect, guided nurse–CNA in the performance of communication processes as front-stage interactions that not only acknowledged, but also regarded what coworkers do in relation to expectations associated with their job descriptions. Trust was an unofficial back-stage value that supported respectful communication interactions on the front-stage.

Nurses and CNAs suggested that just receiving a response when they communicated with a coworker was appreciated as a basic indication that they were at least regarded by their coworker. One CNA explained that when a coworker responded to her after she gave information about a resident, “at least I know that I have been heard, when they [coworkers] say “Okay, thanks for letting me know, or I heard you...I got that.” However, in addition to being heard, nurses and CNA appreciated when the information was heeded. Phrases, such as “I’ll take care of it,” “I’ll write that down,” or “OK, I’ll go check it out,” were given by nurses and CNAs as examples of responses from coworkers that indicated that the information they had given mattered to the coworker they had reported it to.

When a communication interaction suggested that an action was a necessary response, the promptness of the action was considered a positive show of regard. Sometimes promptness was perceived to show regard for what a coworker does as an acknowledgment of work responsibilities and time demands. For example, a CNA indicated that she appreciated a nurse’s quick response to her requests for resident attention because “they have so much meds, but they also have all the bandages and everything else...they’re super busy and their charting is ten times longer than mine.”

Nurses gave several examples of CNAs challenging work demands: “you [the CNA] have seven people to get up and they are all heavy,” or “she [CNA] has difficult patients on her hall...too many that you have to use the Hoyer lift for, and are total care.” One nurse said that CNAs “are really busy as you see...they report something to me, there is something that I have to do.” One CNA explained promptness of response as “...respect for your coworkers, you do things in a timely manner and it’ll help everybody.”

Communication processes were negatively influenced when responses were not acknowledged or prompt. Nurses suggested that when CNAs did not respond promptly it indicated a lack of respect for what nurses do. A slow CNA response to a nurse request for resident information or action suggested to 1 nurse that CNAs “forget that they are not responsible for the patient. I’m responsible for the patient. I am responsible for what they [CNAs] do with that patient.” Another nurse describes that when she does not receive information from CNAs in a timely manner it “affects me, it affects my license, my working, because it makes me look like an idiot.”

CNAs suggested that a slow or nonexistent response from a nurse indicated that the nurse had no regard for what they do, as explained below by one CNA:

There are some nurses that it doesn’t matter what you ask them whether it’s something personal, something for the patients, you’re bothering, you’re an inconvenience because they have their own work to do and they have to get it done in a certain amount of time and you inconvenience them.

Respect was shown when nurses and CNAs acknowledged that what a coworker does, matters. Nurses expressed regard for CNAs significant role in resident care saying “they [CNAs] probably know them [residents] better than we do.” Another CNA described why she depended on CNAs for information:

So they’re [CNAs] like the frontline, as far as if somebody’s different or

somebody's got a bruise, because I am working mainly with medicines and treatments, and they're working with the actual person. They see them skin out far more than we do.

CNAs showed regard for nurses' knowledge and ability. One CNA explained that she relies on the nurse to "create a goal or a plan of action" for resident care. Another CNA indicated that "when it is an emergency, they [nurses] are right on top of it."

Trust was the back-stage value that supported nurses and CNAs show of respect during front-stage interactions. One CNA described that trust "is about us personally...because they are not always keeping an eye on us and watching us...and it's kind of cool because it makes us feel like they trust us enough to do our job well." A nurse felt as though "most of my CNAs know me enough...I think the CNAs that I work with trust me...they know they can tell me."

Discussion

The term "communication" is frequently used in nursing home literature without specific definition, yet implicated as a factor for improving the quality nursing home care (Rantz, et al., 2013). The midrange theory that emerged from this study offers an explanation for knowing how nurses and CNAs interact during communication processes in the nursing home. The four "rules of performance" (maintaining information flow, following procedure, fostering collegiality, and showing respect) are presented as guiding nurse–CNA performance in communication process as they provide resident care on the front- and back-stages of the nursing home. These rules do not guide in a linear pattern, but entwine dynamically through front- and back-stage performance expectations in intricate relationships that are influenced by multiple levels of complexity in the nursing

home.

The complexity of care in the nursing home is identified in literature suggesting multidimensional communication is necessary to accommodate nursing home residents multiple care needs (Lyhne, Georgiou, Marks, Tariq, & Westbrook, 2012). Nurse and CNA communication processes in this study were bound by physical space and time associated with challenging workloads that obliged nurses and CNAs to communicate in short bursts when the opportunity arose, regardless of the location and audience.

Consistent with Munyisia, Yu, and Hailey's (2011b) work flow study, nurse–CNA communication usually occurred while they were performing other care activities. As a result, the dimension and boundaries of the front- and back-stages were fluid; official and unofficial expectations were often simultaneously present in a single communication interaction.

Nurses and CNAs most often described their communication interactions in terms of outcomes related to the efficient provision of care. Their perspective may reflect the environment created by current nursing home regulatory requirements and inspection criteria that focuses on resident condition as a result of care activities (Chung, 2013). Further, this perspective is reinforced by the concept of the nursing home as a total institution, where according to Goffman, bureaucratic control of all spheres of activity creates expectations for roles of individuals within the institution (1957). Nurse–CNA communication interactions may be influenced at the organizational level by a prevalence of front-stage expectations associated with the authoritarianism culture of a total institution.

On an individual level, the cultural background of nurses and CNAs add an

additional layer of influence on their communication processes. Among the nurses and CNAs in this study, and reflected in national long-term care workforce statistics, there is a range of cultural variables such as age, gender, race, ethnicity, and socioeconomic status (Khatutsky et al., 2011). From the premises of symbolic interactionism, nurses and CNAs communicate with each other from a position of individual meaning.

Modifications of their communication interactions occur as a process of individual interpretation in order to deal with the environment (Blumer, 1969). Different expectations among nurses and CNAs potentially contribute to the complex relationships between the rules of performance and the fluid nature of the front- and back-stages.

The intricate relationships between the rules of performance and the complex context result in positive and negative performance of nurse–CNA interactions in communication processes. For example, reciprocal communication, identified as a front-stage expectation for interaction necessary to maintain information flow was limited or constrained by time and resources. This finding is reinforced by literature that indicates there has been limited use of structured or standardized communication processes in the nursing home despite successful use in other care settings (Abramson, McGinnis, Moore, & Kaushal, 2014; Munyisia, Yu, & Hailey, 2011a; Renz, Boltz, Wagner, Capezuti, & Lawrence, 2013). Standardized communication processes have been shown to enhance communication in very specific circumstances in the nursing home, such as shift change report (Lyhne et al., 2012; Spanke & Thomas, 2012).

Mentoring is an action that demonstrated how nurses and CNAs fostered collegiality. It occurred as an unofficial back-stage interaction with no formal expectations, but in a publicly viewable location. Fostering collegiality was influenced

by the rule of following procedure. Nurses and CNAs were willing to mentor coworkers who followed norms (noncodified and unofficial back-stage procedure) of cooperation and taking initiative. On the other hand, mentoring did not occur when policy associated with job position was thought to be violated, or intention was misinterpreted. For example, mentoring did not occur when a nurse thought his or her authority was being challenged or a CNA thought they were being “being told what to do.” A lack of mentoring is identified as a barrier to nurse–CNA communication, and there are few examples of nurse–CNA mentoring in long-term care (Rubin, Balaji, & Barcikowski, 2009).

The rule for showing respect was connected to the other rules of performance in various combinations associated with front- and back-stage expectations. Because respect was exemplified by regard that included acknowledgement and appropriate timing of responses, communication processes on the front-stage such as maintaining information flow and following policy were positively affected. However, the rule for showing respect and the rule for following norms had reciprocal effects on front- and back-stage interactions; poor performance of the rule on stage created poor performance on the other. For example, individuals were less likely to cooperate for efficient care if they perceived that they were not shown regard and conversely individuals were less likely to act with respect towards coworkers who they perceived did not cooperate.

The rule for following procedure guided communication actions regarding policy associated with job description and the hierarchical structure imposed by nurse responsibility for delegating and supervising CNA care of residents. However, ambiguity in the performance of those roles was suggested when a nurse explained she was “*kind of*

their (CNAs) supervisor” and a CNA said “we’re *supposed* to listen to them (nurses).” Role ambiguity was reflected in the process reporting resident information. CNAs were expected to inform the nurse when there was a change in resident condition that required nurse intervention, essentially making the CNA responsible for determining the occurrence and significance of resident condition change.

CNA training for assessment of resident is minimal, and beyond their scope of practice (Sengupta, Harris-Kojetin, & Ejaz, 2010). Nurse’s scope of practice includes using clinical judgment to determine if delegation is appropriate based on the condition of the patient and the competence of the person they are delegating care to (National Council of State Boards of Nursing, 2015). There was no front-stage expectation for nurses to assess competency of CNAs, or to assess the condition of the resident prior to the CNA’s provision of care. Nurses may be unfamiliar with that aspect of their practice; literature suggests that nurses lack education in delegation and supervision (Choi, Flynn, & Aiken, 2012). Yet, both nurses and CNAs identified that the nurse was “in charge,” which may reflect nurse–CNA interpretation of bureaucratic expectations of their roles.

Although not as directly connected as is role ambiguity to communication processes for following procedure, there is an ambiguity in the context that may more broadly affect how nurses and CNAs are able to use the rules of performance to guide their communication interactions. The nursing home is a public space where health care is delivered and a private space that the resident calls home (Nakrem, Vinsnes, Harkless, Paulson, & Seim, 2013). Despite widespread language in literature and public discourse that connects the term “resident” to rights, autonomy, and choice in a home-like atmosphere, nurses and CNAs consistently referred to residents as their “patients.”

Nurse–CNA pervasive use of the term “patient” may reflect the complexity and chronicity of the care they provide, or may imply nurse and CNA power and control over frail and vulnerable residents who are unable to live in the “home” without the control that is provided by the nursing home as a total institution.

Implications

Goffman’s (1959) concepts of front- and back-stages provided a framework from which to distinguish the context in which nurse–CNA communication processes occurred; however, the boundaries between the front-stage and back-stage were fluid. Rules of performance guided nurse–CNA communication processes but were entwined on the front- and back-stages with positive and negative effects. The complexity of the environment and the intricately nuanced relationship between the rules of performance and the context are reflected in theoretical, policy and practice implications that are also nuanced and complex.

Other research describes the “hidden complexity “ of long-term care as containing aspects of context that impede the use of best practices and prevent staff from providing high quality of care (Cammer et al, 2013). Applying the theoretical concept of the front-stage as “official” communication and the back-stage as “unofficial” to nurse–CNA direct care practice helped uncover the complexities of nurse–CNA largely opportunistic communication processes. The physical environment of the long-term care units, workload challenges faced by nurses and CNAs, and the context of the nursing homes as a total institution created a preponderance of nurse–CNA communication interactions occurring in the front-stage regardless of the purpose of the interaction.

Back-stage expectations were often demonstrated through front-stage performance, with little opportunity for nurses and CNAs to identify the boundaries between the stages. Further, because communication performance was usually a reaction, nurses and CNAs had no time to use the back-stage to prepare for front-stage performance. Studies in other health care settings identify that use of the back-stage for performance management helps an individual prepare for front-stage interactions (Lewin & Reeves, 2011; Oliver, Porock, & Oliver, 2006). Understanding of how the rules of performance guide nurse–CNA communication in this dynamic context, may make it possible to extricate positive and negative aspects of communication interactions and more clearly identify stage boundaries for more appropriate communication performance. As one example, formalizing mentoring as an “official” front-stage process for fostering collegiality, may help nurses and CNAs understand performance expectations and decrease potential for misunderstood intention.

The rules of performance explain nurse–CNA communication processes at the point of resident care. The term “person-centered care” suggests that those at the center of care, nurses and CNAs, are instrumental for influencing a nursing home culture change to promote resident dignity and autonomy (Bishop, 2014). Nursing home culture change is purported to occur in part through collaborative staff-to-staff relationships and teamwork (Corazzini, et al., 2014). Nurses and CNAs in this study identified that their ability to provide efficient resident care is positively influenced through cooperative communication interactions. Cooperation between nurses and CNAs occur when their largely parallel work intersects at the resident necessitating communication; meeting the resident’s need is a consequence of cooperation rather than a goal of collaboration.

The concept of collaboration is frequently identified in the literature as an important component of teamwork, and team work identified as a necessary component for providing person-centered care (Rubin et al., 2009; Wagner et al., 2013). However, findings from this study indicated that the concept of collaboration may be less relevant in nurse–CNA communication processes than the concept of cooperation. The opportunistic nature of nurse–CNA communication was demonstrated through short interactions with the purpose of efficient completion of tasks for particular residents. Back-stage concepts, such as respect and collegiality were identified by nurses and CNAs to support cooperation. Nursing home leaders (administrators and educators) need to understand how policy and practice strategies will support the positive aspects of the rules of performance that guide nurse and CNA communication processes at the point of care. Better understanding at this level increases the relevance of policy that affects nurses and CNA practice, increasing the potential to effect change in practice toward more person-centered care. Top-down human resource and administrative policies intended to create a more person-centered practice environment may be more effective if they are relevant to practice from the perspectives of those who are practicing.

The practice environment and the goal of efficient resident care are not likely to change until quality is evaluated on something other than outwardly visible resident condition resulting from care activities (Chung, 2013; Rosemond et al., 2012). The current move toward nursing home culture change, focusing on person-centered, rather than process-centered care, is mandated by the U.S. Veterans Health Administration, and included in the Centers for Medicare and Medicaid Services quality improvement projects (Rosemond, et al, 2012). Despite national efforts, culture change in nursing

homes is poorly integrated and inconsistent. A recent survey indicated that less than 2% of the more than 16,000 nursing homes had implemented culture change, which may be due to a lack of empirical data to guide development of effective policies (Grabowski, Elliot, Lietziell, Cohen & Zimmerman, 2014; Zimmerman, Shier, & Saliba, 2014). The rules of performance are intricately related to the context of the nursing home at the level of direct care, potentially giving administrators and policy makers understanding of how nurse–CNA communication affects and is affected by the environment. Insight at this fundamental level may help nursing home administrator and educators identify areas where practice changes or environmental modifications would be most amenable and influential for successful strategic quality improvement processes aimed toward increased job satisfaction of nurses and CNAs, which may improve turnover rates and ultimately resident care.

Limitations and Recommendations for Future Research

The purpose of this study was to identify communication processes from the perspective of nurses and CNAs. Not all nurses and CNAs in this facility were observed, shadowed or interviewed, which is usual for qualitative study that employs a theoretical sampling strategy (Charmaz, 2006). However, nurses and CNAs who participated in the study were identified by the researcher as able to provide additional insight or elaboration. Additional perspective for validating or expanding the findings of this study may be gained by eliciting perspectives from a wider range nurses and CNAs who were not particularly identified by the researcher.

This study focused on nurse–CNA communication processes and offers a mid-

range theory of nurse–CNA communication processes. Nurses and CNAs also engaged in communication about residents with other disciplines, which may influence the model identified in this study. Important perspective may be gained by further study determining if the rules of performance “hold true” for nurse–CNA interactions with other nursing home staff beyond nursing.

The broad purpose of this study to understand nurse–CNA communication processes resulted in a broad understanding that provides a foundation for continued exploration and comparison of potentially variable perspectives based on nurse–CNA position, age, and experience. Additional comparison between the findings from this study and current “best” health care organizational communication practices may be helpful in establishing validity or identifying variables that are unique to the nursing home setting. Future studies should build from this study to further test validity of the “rules of performance” in similar nursing home settings, potential for adaptation in other long-term care settings, and to identify key components of the model that could result in development of a tool for mapping and evaluating long-term care communication processes. A practical evaluation tool would offer administrators and educators a method for identifying education need and subsequent development of relevant practice policy and targeted educational strategies.

Summary

This study offers an initial theoretical understanding of the nurse–CNA communication processes from the perspectives of nurses and CNAs who are providing direct care to residents in nursing homes. The grounded theory approach and application

of Goffman's concepts of front-stage and back-stage provided an understanding of nurse–CNA communication process within the complexities of the nursing home setting. Four themes (maintaining information flow, following procedure, fostering collegiality, and showing respect) describe the “rules of performance” that intertwine across the front- and back-stages in nuanced relationships to guide nurse–CNA communication process.

Understanding how “rules of performance” guide nurse–CNA communication processes, and how they are positively and negatively influenced, suggests that nurse–CNA communication during direct care of nursing home residents could be improved. Nursing home leaders need to develop and implement policy and education that is specifically designed to be relevant and applicable to direct care providers in the nursing home environment.

Table 4.1
Demographic Characteristics of Participants

Participant Characteristics	Nurses (N=7) Range Mean (SD)	CNAS (N=10) Range Mean (SD)
Age (years)	28-63 46.14 (14.25)	19-47 27.9 (9.92)
Years in current position	1.5-25 7.23 (9.29)	.5-9 2.52 (2.91)
Years of previous health care experience	0-25 12.71 (10.06)	0-29 5.4 (9.07)
Education and Experience	Nurses	CNAs
Education (highest level obtained)	Vocational School Program (N=1) Community College-AD (N=6)	CNA Training Programs (N=10) High School Diploma (N=5) GED (N=2) <1 year of College (N=2) >1 year of College (N=1)
Degree/License	LPN (N=1) Associate Degree RN (N=6)	CNA Certification
Types of Precious Health Care Experience (before current position)	CNA-NH (N=4) LPN-NH/ Combat Medic (N=1) LPN-NH/EMT (N=1) None-first job (N=1)	CNA-NH (N=7) CNA-Home Health (N=1) None-first jo(N=2)

Note: NH=Nursing Home; AD=Associate Degree; GED = General Education Development for high School diploma equivalency

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CHAPTER 5

SUMMARY

This study investigated nurse–CNA communication in the nursing home from the perspectives of nurses and CNAs who provide direct care to residents. Three questions guided the study: (1) what are the observed processes of nurse–CNA communication that occur during the provision of direct care to long-term care nursing home residents? (2) How do nurses and CNAs describe the communication processes that occur during the provision of direct to nursing home residents? (3) What do nurses and CNAs perceive as positive or negative influences on their communication processes in the nursing home? Application of Erving Goffman’s concepts of front-stage and back-stage was useful for understanding nurse–CNA perspectives of their communication processes in relation to the complexity of the nursing home environment.

The study was conducted on two long-term care units in a 120+ bed for-profit nursing home in the Mountain West. Seven nurses and 10 CNAs who worked full or part time participated. Observation of nurses and CNAs from common areas, and shadowing of individual nurses and CNAs was conducted across all shifts and days of the week. Six nurses and 4 CNAs were interviewed. The use of grounded theory methods in the naturalistic nursing home setting was supported by the premises of symbolic

interactionism; theoretical sampling continued until data saturation was reached, constant comparison of data continued throughout the study (Glaser & Strauss, 1967). Data were successively coded and categorized at progressive levels of abstraction, until four conceptual themes emerged as a midrange theory of Nurse–CNA communication processes when caring for nursing home residents. Four “rules of performance” were identified as guiding nurse–CNA communication processes: (1) maintaining information flow, (2) following procedure, (3) fostering collegiality, and (4) showing respect.

The first rule, maintaining information flow, describes front-stage communication processes that nurses and CNAs engaged in when providing care to residents.

Information flow was maintained when communication processes consisted of relevant information given and responded to in a certain time frame. Information flow was not maintained when nurse–CNA communication processes resulted in only partial exchange: not enough information or information given too late. Partial information flow limited nurse and CNA ability to efficiently provide resident care. Communication flow was also constrained by challenging workloads and inadequate staffing that made logistics of communication difficult.

The second rule involved procedures that were followed by nurses and CNAs in communication processes that supported the nursing home organizational structure and culture. Some procedures were front-stage expectations defined by institutional policies that included expectations associated with position. Others were noncodified norms that arose through a common understanding of shared values. Norms were manifested through “unofficial” expectations of cooperation (efficiently working together) and taking initiative (assuming and completing care responsibilities). Policy-based and norm-based

communication processes were intricately connected across the front- and back-stages of the nursing home; violation of one process negatively influenced processes of the other.

Fostering collegiality was the third rule that guided nurse–CNA communication processes. Communication processes were positively influenced when nurses and CNAs regarded coworkers as willing to do their job, but lacking in training or experience. Collegial communication processes were negatively influenced, essentially nonexistent, when a coworker shirked responsibilities, or was unwilling or uninterested in improving their performance. Collegiality was fostered most often through staff-to-staff mentoring on-the job and in the midst of resident care, when the need for mentoring was recognized by a coworker. As such, it was an unofficial back-stage communication process frequently conducted in public with a potentially front-stage audience.

The final “rule,” showing respect, guided nurse–CNA communication processes that showed regard for what coworkers do, and regard for the significance of their work. Respect was demonstrated through front-stage processes: acknowledgement of response indicated “being heard,” appropriate action within an appropriate timeframe indicated that the information was heeded and therefore significant. Trust was a back-stage value that supported respectful communication interactions of the front-stage.

Conclusions

“Communication” is a catch-all term in nursing home literature, often implicated as a factor in nursing home safety, quality of care, staff job satisfaction, and job retention. Nurse and CNA communication is described as good, poor, effective, or ineffective; and linked to a wide range of outcomes and processes, such as teamwork, collaboration,

medication error, and high rates of turnover. However, the process of communication itself is rarely studied and there is relatively little information about what nurse–CNA communication processes consist of during the provision of direct care to residents.

This study of nurse–CNA communication indicated that nurses and CNAs perceive their communication processes in relation to outcomes associated with the provision of care, and most often describe it in terms of efficiency. Their perceptions reflect the complex and at times ambiguous nursing home environment, in which nurse–CNA communication processes almost always occurs while they are performing other care rather than as discrete processes, and as a result are affected by multiple dimensions associated with the provision of care. The dimensions include nurse and CNA roles that are at times ambiguous, workload, physical space, and regulatory requirements and the complexity of the nursing home that has the dual context of health care institution and resident home.

In this study nurses and CNAs performed largely different roles in providing care: CNAs provided personal care to residents including eating, bathing, dressing, and toileting. Nurses provided skilled interventions, administered medication, and completed required documentation of care. Nurse supervision, delegation and evaluation of CNA care were largely perfunctory, with sometimes ambiguous responsibility. Nurses and CNAs worked parallel to each other and intersected when a resident’s need required their cooperation. Time constraints associated with a heavy workload, and the physical layout of the unit resulted in communication processes that were opportunistic and episodic, and occurred when cooperation was needed for nurses and CNAs to perform their work responsibilities. Regulatory requirements and inspection criteria focusing on clinical care

outcomes, created an environment of the nursing home as a “total institution” controlling all aspects of activity, which contributed to nurse and CNA communication processes focused on outcomes related to care processes (Goffman, 1957).

Theoretical Implications

Theory is rarely used to help understand the characteristics of communication processes of direct care staff or how their communication processes affect their practice as direct care staff in a nursing home setting (Anderson, Corazzini, & McDaniel, 2004; Cohen-Mansfield, Jensen, Resnick, & Norris, 2012; Decker, Harris-Kojetin, & Bercovitz, 2009; Forbes-Thompson, Gajewski, Scott-Cawiezell, & Dunton, 2006; Lewin & Reeves, 2011; Rosemond, Hanson, Ennett, & Schenck, 2012). For this study, Goffman’s concepts of front-stage and back-stage provided a framework for describing nurse–CNA communication processes within the complex nursing home environment.

Nurse–CNA communication processes were bound by physical space and time constraints associated with challenging workloads. These constraints necessitated occurrence of interactions on the front-stage, although some may have been more suited to a back-stage performance. Front-stage processes were “official” and subject to audience scrutiny, but often motivated and influenced by “unofficial” back-stage expressions. More study is needed to clearly explicate the relationship between front-stage and back-stage processes.

Goffman’s concepts of front-stage and back-stage have been modified and used in other health care settings to study impression management and the “secrets” of the back-stage. These studies suggest performance management on the back-stage helps

participants prepare for front-stage interactions (Lewin & Reeves, 2011; Oliver, Porock, & Oliver, 2006). This study identified that front-stage and back-stage processes in the nursing home essentially occur in the same space and time, either with tension or harmony between their purposes. The blurring of front-stage and back-stage boundaries, which affects communication processes, is reinforced by the concept of the nursing home as a total institution, in which authoritarian control of all spheres of activity. In the sphere of nurse–CNA direct care of residents, the environment of direct resident care is a predominantly front-stage area (Goffman, 1957). More in depth application of a theoretical framework may be a way to distinguish and categorize communication processes in greater detail and illuminate the existence of the relationship between front-stage and back-stage processes. Understanding the relationship may help nurses and CNAs better understand how their communication processes affects their relationship as direct care providers, and ultimately how it affects their provision of care to residents. This level of understanding may provide insight to nursing home administrators and educators for identifying where positive and negative effects could be mitigated or reinforced through strategic intervention.

Practice and Policy Implications

The complexity of the nursing home environment is a key factor preventing best nursing home care practices, and complexity is managed primarily through communication (Cammer, et al, 2014). The implication that improved communication processes may result in better care processes suggests that the ultimate result may be better quality of resident care. However, the complex environment in this study allowed

nurses and CNAs to “see” each other and communicate opportunistically during their mostly parallel provision of resident care. However, it did not allow for separation of front- and back-stage communication processes, which positively and negatively affected their ability to manage the environment. Additionally, the rules of performance that guided nurse–CNA communication processes were not parallel, but were entwined across the front- and back-stages, resulting in implications that are nuanced and variable.

Communication processes were positively influenced when back-stage expectations and front-stage processes reinforced each other. Reciprocal communication (giving information and receiving a response) and promptness of the response, was regarded as a show of respect between coworkers. Reciprocity resulted in appropriate flow of information and efficient resident care. Communication processes were negatively influenced when communication intention and audience expectations were not congruent. For example, policy for maintaining resident privacy and confidentiality was violated when the “opportunity” to communicate about a resident occurred at the nurse’s desk or in a busy hallway where there were unintended audiences.

The complex relationship between the rules of performance and where they occur can facilitate or obstruct nurse–CNA communication processes. For example, the relationship between fostering collegiality and showing respect was demonstrated through peer mentoring that was made more complex by discomfort and defensiveness that arose when nurses and CNAs attempted to mentor coworkers through well-intentioned but unskilled front-stage reactions.

The link between practice and policy is identified in literature that suggests management practices affect care processes and resident outcomes (Anderson, Issel, &

McDaniel, 2003). Policy and strategies for implementation of structured communication processes have been shown to improve communication in other health care settings (Lyhne, Georgiou, Marks, Tariq, & Westbrook, 2012; Renz, Boltz, Wagner, Capezuti, & Lawrence, 2013). Nurses and CNAs identified nursing home leaders, such as administrators and directors of nursing, who implement practice and staff education policies, should be committed to understanding the rules that guide nurse–CNA communication practices, and the relationship between the rules and the environment.

Policy Implications Beyond the Front- and Back-Stages

Culture change is the move toward person-centered care with the goal of better resident quality of life, and is strongly supported by the U.S. Veterans Health Administration and the Centers for Medicare and Medicaid Services. Focus on person-centered care and resident quality outcomes are a fundamental change from the long-standing focus on process-centered care and clinical outcomes. The focus calls for person-centered care processes, including communication processes of direct care staff in the nursing home (Rosemond et al., 2012)

The term “person-centered care” suggests that those at the center of care, nurses and CNAs who support resident’s daily activities of living, may be instrumental for influencing culture change to promote resident dignity and autonomy (Bishop, 2014). However, nurses and CNAs in this study conceptualized communication processes as outcomes related to the provision of care, which is consistent with literature that indicates that although nursing homes are evaluated on performance measures of both quality of life and quality of care, they are rated on their reports of clinical outcomes (Grabowski,

O'Malley, Afendulis, Caudry, Elliot, & Zimmerman, 2014; Spilsbury, Hewitt, Stirk, & Bowman, 2011). Nurse and CNA difficulty in articulating communication processes, and their consistent reference to residents as “patients” may reflect the ambiguous environment created by federal regulatory requirements and state inspections that continue to focus on resident clinical conditions, which is not reconciled with the public movement toward a more homelike atmosphere (Chung, 2013).

The goal of nursing home care, health care institution or a home offering long-term care, has not been codified, and quality of life and quality of care indicators have not been definitively determined to be complementary measurements of quality (Grabowski et al., 2014). As such, culture change remains a “movement” and nursing home care continues to focus predominantly on clinical care outcomes (Chung, 2013; Rosemond, et al., 2012). Until quality of life and quality of care issues are reconciled, nurse–CNA communication processes are likely to remain focused on efficiency of care processes, rather than the effect of care processes. Finding an appropriate balance between the two may be a fundamental step toward realization of culture change.

Limitations

The purpose of this study was to identify communication processes from the perspective of nurses and CNAs. More research is needed to explore potential variability of nurse–CNA perspectives based on position, age, and experience, and evaluate congruency of nurse–CNA perspectives of their communication processes with perspectives of other nursing home staff. Further investigation should be conducted to determine if nurse–CNA communication experiences are reflected in human resource and

administrative policies, and regulatory requirements including mandated education, and to determine where policy change may be most beneficial.

The midrange theory identified in this study offers an explanation of nurse–CNA communication processes in a nursing home in the Mountain West. There may be organizational specific processes and facility specific context that make this theory ungeneralizable to other nursing homes. Further research should be done to test validity of this theory in similar nursing homes and the potential for adaptation in other long-term care settings.

Recommendations for Future Research

This study identified “rules” that guided nurse and CNA communication processes in the nursing home. Future research encompassing more than the domain of direct care in the nursing home, should be done to determine if these rules reflect anything beyond nurse–CNA processes for managing communication in their complex nursing home environment. Nursing homes are socially undervalued health care settings that suffer from low public opinion (Rosemond, et al., 2012). CNAs are among the lowest paid workers in health care and often socially and economically vulnerable (Dill, Morgan, & Marshall, 2013). The rules identified in this study emerged from the perspectives of nurses and CNAs; understanding their reasoning for creating the rules and their motivation for following them may shed light on issues of power, class, and vulnerability, and how those issues affect nursing home care processes.

As direct care providers, nurses and CNAs are in a position to effect change at the level of the resident. Findings from this study suggest that nurse–CNA communication

processes are integral to their provision of care of nursing home residents. Building from the descriptive model identified in this study, the next steps are to conduct research that further defines the key components of the model toward development of a tool for mapping long-term care communication processes. Nursing home leaders, policy-makers, administrators, and educators could use the tool for mapping communication processes to other care processes and nursing home quality indicators. Further development could result in an evaluation tool for identifying gaps and areas of strength where targeted education, process improvement, or policy revision could be most effectively implemented.

An additional next step is to investigate the relationship between nurse–CNA communication processes and the ambiguity that is inherent in their roles as direct care providers in the nursing home. Nurses are expected to delegate care and supervise CNAs, who are expected to report changes in residents' conditions to nurses. However, in this study nurse delegation and supervision of CNAs was perfunctory; neither resident condition nor CNA competence was formally assessed. The expectation that CNAs report resident changes to the nurse essentially placed the CNA in the position of assessing and determine significance of the resident's condition. CNA training for resident assessment is minimal, and beyond their scope of practice (Sengupta, Harris-Kojetin, & Ejaz, 2010). Literature indicates that nurses lack education in delegation and supervision, suggesting that they may not give CNAs adequate guidance (Choi, Flynn, & Aiken, 2012). Policy makers need to not only evaluate requirements for educational preparation of both nurses and CNAs, but increase efforts to develop clear practice guidelines for CNA reporting to nurses, and nurse delegation and supervision to CNAs.

Summary

This study offers an initial theoretical understanding of the nurse–CNA communication processes from the perspectives of nurses and CNAs who are providing direct care to residents in nursing homes. Findings suggest that the four “rules of performance” (maintaining information flow, following procedure, fostering collegiality, and showing respect) guide nurse–CNA communication processes that occur as the opportunity arises during the provision of resident care, and usually as front-stage publically viewable interactions.

The “rules of performance” that guide nurse–CNA communication in the nursing home have practice and policy implications for nursing home leaders. Influences on nurse–CNA communication processes and environmental practicalities should be considered when developing and implementing practice policy. Findings from this study could be used in additional research for development of a nursing home communication process tool for mapping and assessing communication on other long-term care organizations. A better understanding of communication processes in direct care may help create educational and practice strategies to improve communication processes nurses and CNAs at the point of resident care. Improved communication processes may positively impact other resident care processes, and in turn ultimately improve resident care and quality of life.

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APPENDIX A

LETTER OF SUPPORT FROM NURSING HOME ADMINISTRATOR

Ron Kapp
Woodland Park Rehabilitator and Care Center
3855 S. 700 East
Salt Lake City, UT 84106

February, 2014

Dear Ms. Madden,

As the administrator of Woodland Park Care Center, I would like to express support for your proposed research study, *Communication in the Nursing Home: A Grounded Theory of CNA-Nurse Communication*.

I understand that you will be spending time in our facility observing Registered Nurses and Certified Nursing Assistants (CNAs) as they interact when providing care to our residents, and that you will also interview them about their communication interactions and practices. I will facilitate your access to nurses and CNAs on all shifts and in all areas of the facility where they interact during the care of residents.

I am pleased to contribute to your research and know that this study will contribute to our understanding of CNA-nurse communication processes. I look forward to working you.

Sincerely,



Ron Kapp
Administrator

APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL



[IRB_00076128](#)

Connie Madden

Communication in the Nursing Home: A Grounded Theory of CNA-Nurse Communication

This New Study Application qualifies for an **expedited review** by a designated University of Utah IRB member as described in 45 CFR 46.110 and 21 CFR 56.110. The research involves one or more activities in **Category 5,7** (published in 63 FR 60364-60367). The designated IRB member has reviewed and approved your study as a Minimal risk study on 10/1/2014 . The approval is effective as of 10/6/2014. Federal regulations and University of Utah IRB policy require this research protocol to be re-reviewed and re-approved prior to the expiration date, as determined by the designated IRB member.

Your study will expire on 9/30/2016. Any changes to this study must be submitted to the IRB prior to initiation via an amendment form.

APPROVED DOCUMENTS

Informed Consent Document

Revision: Unstamped Copy Template-Informed Consent Document

Literature Cited/References

Reference List: Communication in the Nursing Home: A Grounded Theory of CNA-Nurse Communication

Other Documents

Nursing Home Administrator Letter of Support

Click [IRB_00076128](#) to view the application and access the approved documents. Please take a moment to complete our [customer service survey](#). We appreciate your opinions and feedback.

APPENDIX C

INFORMED CONSENT DOCUMENT

BACKGROUND

You are being asked to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask the researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not to volunteer to take part in the research study.

The research is about how CNAs and Nurses communicate when they are providing care to residents in the nursing home. We know very little about how, where, when and why those communication processes occur and how CNAs and Nurses use those processes in their everyday work together. If we understood more about how CNAs and Nurses understand those processes and how they affect their work, we may be able to think of ways to improve them. This could lead to better care collaboration and better resident outcomes.

You are being asked to take part in the study because your experience in caring for residents in the nursing home gives you perspective that will further our understanding of communication processes. Connie Madden is conducting the study as part of her doctoral education under the supervisor of Dr. Margaret Clayton.

STUDY PROCEDURE

I will be “shadowing” you as an observer during parts of your shifts in the nursing home. I will remain as unobtrusive as possible. I will take notes and observe how, when, where, why, and what you communicate about with colleagues as you are providing care to nursing home residents. I may ask you questions about those processes as I am shadowing you.

I may also interview you at one or more times during the course of the study, to talk with you about your perspective of the communication process and about how you think and feel about those processes, and how you use them to provide care to the residents. I may also ask you about communication interactions that occurred when I shadowed you during your work shift. I may also ask to talk to you again as the study progresses, to ask you how my findings from the study fit with your perspective of communication processes. The interview will be done in a private location within the nursing home, either before or after your shift, or at mutually arranged time and place outside of the nursing home. The total time for the interview will be 30 to 60 minutes.

Interviews will be audio-recorded and transcribed to a word document.

I will also ask to look at any individual paper tools that you use as part of the way you communicate with others when caring for residents. I will read your individual paper tools at the nursing home take notes about them and return them to you. No specific information about you or individual nursing home residents will be documented.

RISKS

The risks of participating in this study are minimal. You might feel slight anxiety at being observed. Your participating in the study cannot be kept private from others who are working during your shift, when I am shadowing you. During the interview, you may feel may feel uncomfortable when discussing interactions with work colleagues and uneasy sharing perceptions of work processes. You may feel concerned about appearing to be contentious, finger-pointing or betraying colleagues when talking about their interactions with them. You may feel vulnerable when talking about work processes in general, or describing interaction your interaction with someone that supervises your work. If you are upset from this experience, you tell the researcher, and she will tell you about resources available to help.

BENEFITS

There are no direct benefits to you in taking part in this study. This study may help CNAs and Nurses who work in nursing homes in the future. The information from this study may help in developing a better understanding of how the processes of Nurse–CNA communication occur which may be useful for improving those process, and have a positive impact on the care of nursing home residents.

CONFIDENTIALITY

I will not report any individual information about you from this study. Your name will not be used in any reports or publications. The name of the nursing home will not be used in reports or publications. All data collected will be de-identified and stored using an identification number. Original paper notes that I write will not contain any individual identifiable information. All electronic data will be stored on an encrypted and pass-word protected computer. Because this is dissertation research, interview transcripts, and field notes (hand written and electronic) will be reviewed with my dissertation supervisory committee chair on a regular basis. Transcripts will be reviewed with other committee members as necessary.

PERSON TO CONTACT

If you have questions, complaints, or concerns about his study, you can contact Connie Madden at 801-440-8333. You can also call if you feel you were harmed by taking part in this study.

Institutional Review Board: Contact the Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also, contact the IRB if you have questions, complaints or concerns which you do not feel you can discuss with the investigator. You can reach the University of Utah IRB by phone at (801) 581-3655 or by email at irb@hsc.utah.edu

Research Participant Advocate: You may also contact the Research Participant Advocate (RPA) by phone at (801) 581-3803 or by email at participant.advocate@hsc.utah.edu

VOLUNTARY PARTICIPATION

This study will include only people who choose to take part. You can tell the investigator if you don't want to be in this study. You can begin participating in the study and then choose to stop later. If you do not wish to take part in the study, or choose to stop, it will not affect your work requirements and benefits.

COSTS AND COMPENSATION TO PARTICIPANTS

There are no costs to you for participating in this study. You will not be compensated for participating in this study. Appreciation to the facility and participants will be acknowledged with an offer to conduct an educational in-service, occasional food, and a modest donation (\$250.00) to the facility for general use.

CONSENT:

I confirm that I have read this consent document and have had the opportunity to ask questions. I will be given a signed copy of the consent and authorization form to keep.

I agree to participate in this research study as you have explained in this document.

Participant's Name

Participant's Signature

Date

Name of Person Obtaining Consent

Signature of Person Obtaining Consent

Date

APPENDIX D

INTERVIEW GUIDE

Semistructured Questions/Probes

1. Tell me about when you communicate with (other) CNAs and (other) nurses during your shift when you are caring for nursing home residents.
2. Where do you communicate with (other) CNAs and (other) nurses during your shift when you are caring for nursing home residents.
3. What do you communicate about?
4. Tell me about the best experience you have had when communicating with other nurses/CNA s?
 - a. What was it that made it a good experience?
5. Tell me about the worst experience you have you have had when communicating with another nurse/CNA?
 - a. What was it that made it a bad experience?
6. What would you like to see happen when you are communicating with other nurses/CNAs?
 - a. Why?

Note: Decision-making for additional probe development will be documented in memos.

APPENDIX E

SECOND INTERVIEW GUIDE WITH ADDITIONAL QUESTIONS/PROBES

Semistructured Questions/Probes

1. Tell me about when you communicate with (other) CNAs and (other) nurses during your shift when you are caring for nursing home residents.
2. Where do you communicate with (other) CNAs and (other) nurses during your shift when you are caring for nursing home residents.
3. What do you communicate about?
4. Tell me about the best experience you have had when communicating with other nurses/CNA s?
 - a. What was it that made it a good experience?
 - b.
5. Tell me about the worst experience you have you have had when communicating with another nurse/CNA?
 - a. What was it that made it a bad experience?
6. What would you like to see happen when you are communicating with other nurses/CNAs?
 - a. Why?
 - b. Do you get different kinds of response from different people?
 - i. Why do you think that is?
7. Is there anything about the environment (working on the long-term care unit) that makes communication between you and (other) CNAs and (other) nurses harder?
 - a. Is there anything about the environment that make is that helps you to communicate with your coworkers?