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Resident Abuse within the Culture of Long-term Institutions

by

Sandra P. Hirst

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Faculty of Nursing

Edmonton, Alberta

Fall 1999

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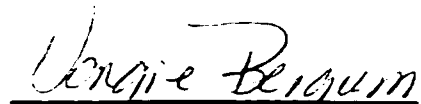

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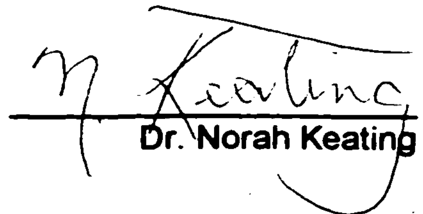

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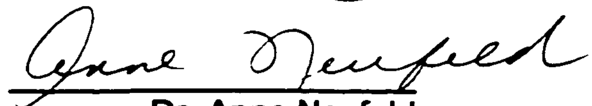

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ABSTRACT

Resident Abuse within the Culture of Long-term Institutions

There is indication in the professional literature, in governmental policies, and in the media of abuse of older adults living in long-term care institutions. Because the term "resident" is often used to describe the inhabitants of such facilities, this phenomenon is considered *resident abuse*. Resident abuse has not come under the same scrutiny as have other aspects of abuse, such as domestic abuse of older adults. This is due, in part, to the difficulty in defining the phenomenon.

The purpose in this study was to assess how resident abuse is perceived by the long-term institutional care culture. Ethnography, ethnoscience and content analysis were used. Participant observation occurred in five urban long-term care institutions. Registered nurses, non-professional staff, older residents and significant others were interviewed individually and participated in focus groups. Patterns of meaning of resident abuse were developed from the data collected from all participants. A taxonomy of resident abuse evolved from the data collected from registered nurses only.

Resident abuse is perceived by participants as behaviour that causes a perception of hurt in older residents. This perception of hurt is voiced by either older residents themselves or by other members of the long-term care institution on their behalf. Participants' views about resident abuse are always framed within the context of institutional life. Two other findings of special interest are noted: (1) within the culture under study, devalued personhood is a common experience of older residents. Devalued personhood often accompanies resident abuse. (2)

Participants often voiced that resident abuse was not present within their facilities; however, they stated that behaviours that they described as resident abuse were common, for example, yelling, and pinching. This apparent inconsistency has implications for long-term institutional policy development.

Findings from the study make a significant contribution to nursing and health care practices. The primary benefit is the contribution to the quality of life of older residents within long-term institutions. In understanding how resident abuse is perceived, administrators and staff working within these institutions will be able to intervene more effectively to reduce its presence within their facilities.

ACKNOWLEDGMENTS

I wish to thank my supervisor Dr. V. Bergum, and Dr. P. A. Field, Dr. N. Keating and Dr. Ross-Kerr. I would also like to express my appreciation to Dr. C. J. Pepler, and Dr. A. Neufeld for their contribution to my final oral examining committee. Their advice and support has been greatly appreciated. I would like to thank three friends, Barbara Metcalf, Jean Miller and B.J. Tucker. They understood, and supported both my laughter and my tears.

I would also like to acknowledge the financial contribution that I received from the Alberta Association of Registered Nurses, the Canadian Gerontological Nursing Association, and the Canadian Nurses Foundation. I was also granted educational leave by the Faculty of Nursing, University of Calgary.

It is with my family that my deepest thoughts and gratitude lies. I have parents and a sister, who love and support me, and two daughters who are a blessing and a joy, and a husband who has never lost faith in me. They gave me the time and love to finish this dissertation. With family and friends, I have been truly blessed.

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CHAPTER 1

Introduction

As a registered nurse, I have cared for older residents living within several long-term care institutions. These institutions as Goffman (1961) pointed out, often assume a culture of their own which develops, in large part, because of the isolation of its residents from experiences of the larger society for a prolonged period of time. The specific culture of long-term care also develops because of the enclosed, formally administered, type of life that the residents live. Currently within long-term care facilities, cultural members place significance upon behaviors and actions that could be called abuse. Staff nurses, working in long-term care institutions, have said,

> *If you ask me about abuse, I think of the family not coming into visit a resident. They say that they will come in, but they never do, or if they do it is to ask their father to sign a cheque* (Hirst, 1994, p. 3)

or,

> *When the aide put Mrs. J. into the tub, she was rougher than I think she had to be. As you get older, the skin gets much more fragile, you have to remember this* (Hirst, 1994, p. 4).

Staff and administrators alike speak of the abuse committed against older residents by professional care providers; however, they also talk of abusive acts being committed against residents by their family members or those important to them (Hirst, 1994). These abusive experiences may be termed *resident abuse*. By developing policies and procedures which they believe address the phenomenon of resident abuse, administrators and staff are responding to the

increasing prominence being placed upon abuse by governmental bodies at all levels of influence, by the health care system, and by the media. Yet there exists within long-term care institutional settings, a tendency to use the term resident abuse without adequately understanding the meanings and descriptors underlying its employment. This tendency is due, in part, to the actions of administrators, researchers and governmental officials, who use externally generated definitions of abuse instead of exploring the meaning and use of the term as it is employed internally by staff and residents within their own facility walls. External definitions of abuse are applied to both long-term care facilities specifically and to health care institutions generally. The risk of using externally generated definitions is that they are perhaps not appropriate to the long-term institutional care culture.

It is timely to address resident abuse and the perceptions held of it by members of the long-term institutional care culture, since over the past several decades institutions have come to occupy a central position in the Canadian health care system. Approximately 8% (200,000 people) of the older adult population in this country, reside in long-term care institutions (Statistics Canada, 1997). Those over 75 years of age consume 60 to 65% of patient days in long-term care facilities in Canada (Crichton, Hsu, & Tsang, 1994). The care provided in long-term care institutions is usually under the direction of registered nurses (Canadian Nurses Association, 1987).

Aging, Older Adults and Long-term Institutional Care

Demographic projections for the year 2016 indicate that individuals aged 65 years and older will constitute slightly over 16% of Canadian society, in comparison to 10.7% in 1986 (Statistics Canada, 1997), and 5% in 1901 (Stone & Fletcher, 1986). Not only are there more older adults in society, these individuals

are living longer. Advancing age often brings with it increasing frailty caused by the presence of chronic disease(s) and associated disabilities. Consequently, to sustain themselves in their later years, some adults turn to long-term care institutions to provide them with a supportive environment, for others the family makes the placement decision. Approximately 7.5% of older adults live in long-term care institutions (Statistics Canada, 1997).

Long-term care facilities are known by a variety of names across Canada, such as nursing homes, special care homes and auxiliary hospitals (Forbes, Jackson, & Kraus, 1987; Statistics Canada, 1997). There is a mixture of profit and non-profit institutions. Provincial inspection and national accreditation processes are used to monitor institutional standards.

Older adults enter long-term care institutions for numerous reasons. The primary one is their inability to provide themselves with the essentials of daily living such as meals or activities of daily care. With the development of increasing numbers of community support services, those who enter long-term care facilities now tend to be older and frailer with a high prevalence of cognitive and physical disabilities. Consequently, they have complex health needs which demand that nurses use this "unparalleled opportunity to demonstrate skilled clinical judgments and the therapeutic value of good nursing care" (Canadian Nurses Association, 1987, p. 11). At the same time, the complexity of care offers numerous challenges to professional staff - registered nurses, physiotherapists, social workers, and to non-professional staff - personal care aides, nursing assistants, and others.

A disturbing way of responding to the challenge of providing care to older residents is by abuse. In the professional literature, the media, and government

publications, the presence of abuse within these long-term care institutions has been identified (Downing, 1986; Meddaugh, 1993; National Advisory Council on Aging, 1991). This has been corroborated through informal observations by staff and administrators. There is evidence that some administrators have begun to address the occurrence of resident abuse with their institutional walls by talking about it, and by developing procedures to respond to reported cases of it (Hirst, 1994; National Advisory Council on Aging). In addition, governmental bodies are also addressing the occurrence of resident abuse through the publication of discussion papers and reference documents on it. However, several factors are impairing the effectiveness of these efforts. First, administrators and government personnel rely upon external definitions of abuse often drawn from a domestic and community based perspective, which may not be appropriate to the long-term care institutional setting. Secondly, informal discussions by the researcher with some long-term institutional care staff before this research began indicated that often they were uncertain as to what constitutes resident abuse. Thirdly, current definitions used in Canadian long-term care institutions appear to be drawn from research done in the United States which may not be applicable to the Canadian context. These three factors contribute to a lack of understanding of resident abuse which, in turn, leads to difficulties in assessment of the phenomenon and subsequent intervention. It is because of these concerns that this research was proposed.

Purpose of the Study

Registered nurses and other long-term institutional care staff are in an excellent position to contribute to detecting, preventing, and effectively intervening in situations of actual or potential abuse of older residents. The quality of their

contributions will influence the culture of the long-term care institutions in which they are employed. It is unreasonable to expect nurses to undertake detecting, preventing and intervening in potential or actual resident abuse experiences without the support of a clear definition and understanding of resident abuse as it applies within the long-term care institutions. Equipped with knowledge of resident abuse, registered nurses will be able to respond more effectively to the needs of older residents.

Research Question

Statistical evidence suggests that resident abuse occurs within long-term care institutions (Downing, 1986; Meddaugh, 1993; National Advisory Council on Aging, 1991). The words *resident abuse* are subject to a variety of interpretations, and perhaps misinterpretations. This means that governmental legislation, health care policies and procedures, and nursing interventions may not accurately reflect how resident abuse is perceived by society generally, or by long-term care institutional staff, residents and family members specifically. The language used by a society is not usually subject to critical inquiry. However, phenomena such as resident abuse can only be initially understood through the use of language. If communication is to be effective, there must be agreement that different people will use the same words for the same things. When the words are used to represent actual things or simple ideas, it is relatively easy to ensure the understanding of this agreement without ambiguity. When the words represent abstract or complex ideas such agreement may be very difficult to achieve.

It was the need for clarity of understanding of resident abuse that led the researcher to propose this study. The purpose of the study was to define and articulate resident abuse as perceived by members of the long-term institutional

care culture. The primary research question is *what is resident abuse as perceived by the long-term institutional care culture?* Secondary questions include: *how do participants perceive resident abuse? how do participants differentiate abuse from neglect and inadequate care?* and *what differences are there among the perceptions of different population sub-groups?* The questions are addressed in a qualitative study using ethnoscientific, enthnological and content analysis approaches.

Relevance of the Study to Nursing

The Canadian Nurses Association (1992) identified violence as a health care concern that falls within the mandate of nursing. Nurses' caregiving role, background in interpersonal communication, ability to maintain close associations with care recipients, and holistic orientation to health, places them in an optimal position to assist older residents for whom abuse is a concern. In order to provide excellent care, nurses practice within their code of ethics and professional mandate.

Registered nurses need to take a dual role to the health care concern of resident abuse. The first is that of advocate, which implies knowledge of the problem, presenting indicators of resident abuse and possible contributors. However, awareness of a problem is inadequate by itself. Knowledge should also make the nurse more sensitive to assessment findings, and to the potential diagnosis of resident abuse. The responsibility is then to respond on behalf and in conjunction with the older resident to provide a safe and comforting environment.

The second response of the registered nurse is to advance knowledge of resident abuse. Nurses have, for the most part, left the study of abuse of older adults for other disciplines to investigate. The little research on abuse, and

specifically resident abuse, that has been done by nurses in this area focuses primarily on detection and assessment issues, decision making processes of those, and instrument development and testing within community settings. The research methods employed are generally quantitative in design, primarily of a survey approach from which statistical data is generated. The dearth of nursing research contributions is particularly significant when the potential to decrease resident abuse is considered as part of the role of the nurse. Resident abuse is an appropriate phenomenon for nursing research as it involves clients, caregivers, environment, health, caring and their interrelationships. Additionally, programs of research by nurses into resident abuse within an institutional long-term care context are needed to enable the profession to contribute to national policy that addresses this health concern.

Organization of the Dissertation

While chapter 1 introduced the study, chapter 2 presents a review of the literature and raises some of the issues emerging from this review. The conceptual framework of the study is discussed in chapter 3. The research design of the study is discussed in chapter 4, as are the site and participant demographics. The findings are presented in chapter 5, and discussed in chapter 6. Chapter 7 concludes by discussing the recommendations from the study's findings for professional nursing practice.

Summary

Older adults enter long-term care institutions because of an inability to meet their own health care needs. Evidence suggests that resident abuse exists within these facilities. The purpose of this study is to understand resident abuse

as it is perceived by those living and working within the long-term care institutional culture.

CHAPTER 2

Literature Review

The care of older residents living in long-term care institutions presents numerous challenges to both staff and administrators alike. Contained in the literature is substantive information on the culture of long-term institutions and on institutional life for older residents. However, the literature that relates to resident abuse is minimal. The review of the literature focused on two primary areas: (1) how aged abuse generally and resident abuse specifically is defined and understood, and (2) stakeholders' perceptions of resident abuse. Stakeholders are defined as participants in the experience of resident abuse within long-term care institutions. From the review of the literature, key issues such as the definition dilemma related to resident abuse are identified and discussed. The chapter concludes with a discussion of the need for qualitative research, as in this study, to answer the question, *what is resident abuse as perceived by the long-term institutional care culture?*

Definitions and Understanding

The review of the literature on aged abuse and resident abuse identified three key findings. First, there were two types of abuse: aged abuse (Block & Sinnott, 1979; Douglass, Hickey & Noel, 1980; Gioglio & Blakemore, 1983; Hudson, 1994; Pillemer & Finkelhor, 1988; Poertner, 1986; Podnieks, 1992a, 1992b, Senstock & Liang, 1982), and resident abuse (Alberta Seniors Advisory Council, 1993; Bianculli, Hoffman & Infante, 1992; Government of Alberta, 1997; National Advisory Council on Aging, 1991; National Clearing House on Family Violence, 1994; Pitsiou-Darrough & Spinellis, 1995). Second, that aged and

resident abuse exist in a variety of forms, including: physiological, psychological, sexual, medication, spiritual, financial, material and/or socioeconomic (Canadian Nurses Association, 1992; Gebotys, Connor, & Mair, 1992; Government of Alberta, 1997; McDonald, Homick, Robertson & Wallace, 1991; Podnieks, 1992a; Robertson & Wallace, 1991).

Third, the lack of a common definition and understanding of aged abuse and resident abuse as demonstrated, in part, by the use of other terms to describe both experiences. Aged abuse has been referred to as *granny bashing* (Renvoize, 1978), *the battered elder syndrome* (Block & Sinnott, 1979), *violence* (Council of Europe, 1992), *maltreatment* (Hall, 1989), and *mistreatment* (Fulmer, & Gurland, 1996; Hudson, 1994; Pitsiou-Darrough & Spinellis, 1995). Similar terms have been used to describe resident abuse, *maltreatment* (Pillemer, 1988), *granny battering* (Baker, 1975), *theft* (Harris & Benson, 1998), and *nursing home crime* (Ullery, 1996). The use of numerous terms to describe aged abuse suggests that it is not a well understood phenomonem.

Aged Abuse

The words that constitute the language of abuse reflect not only obvious facts but also values, beliefs and assumptions (Wilson, 1963) and are often emotionally laden. Public usage of the term, *abuse*, is filled with descriptors: to use wrongly; to misuse; to hurt by treating badly; to use insulting, coarse, or bad language; to injure (The Oxford English Dictionary, 1989). In searching for clarification and understanding of *abuse,* it is easy to lose one's bearings in a maze of complexities. The word, abuse, is composed of two terms, "ab" and "use" (Onions, 1989). The former implies absence as in lacking, for example as to "abstain", which means to do without; it originates from the Latin "off, away, from".

Within medical terminology, "ab" means inappropriate or dysfunctional as in "abnormal". The latter part of the term, "use", is defined as to practice, to put or bring into action or service. It too originates from the Latin referencing a good or helpful end. Joining the two terms, abuse, denotes the inappropriate use of something. Abuse also originates from the Latin, *abusare*, and was used in reference to error, ill used or misdoing (Onions).

The word *abuse* was introduced into the English language during the twelfth and thirteenth centuries (Onions, 1989). In Elizabethan times, in Shakespeare's play, *Taming of the Shrew*, the heroine, Katherina, was subject to physical abuse including deprivation in an attempt to force her to conform to the expectations of her husband, Petruchio. Petruchio spoke of Katherina as his "goods and chattels", and stated that he will be master of what belongs to him (Shakespeare, cited in Clark & Wright, -). Although wife abuse appeared to be tolerated throughout history, there were legal restrictions placed upon it. The expression *rule of thumb* is derived from English common law that permitted a man to beat his wife with a rod provided it was no thicker than his thumb (Dobash & Dobash, 1979). The present day negative connotation of the word *abuse* reflects its historical definition: the noun form of the word can mean "a corrupt practice or custom, the improper or incorrect use, language that condemns or vilifies usually unjustly, intemperately, and angrily, the act of violating sexually and physically harmful treatment" (Onions, 1989, p.59).

While acknowledging its roots, aged abuse is a difficult term to define and as such a definition quandary exists. Some writers and researchers provide no definition of abuse (Floyd, 1984; Gilbert, 1986; Phillips, 1988). Their assumption seems to be that the intrinsic meaning of abuse is understood. However, studies

that are initiated with no articulated definition of aged abuse provide little foundation upon which to evaluate their findings. Their credibility is called into question.

As previously discussed, there are researchers who use aged abuse interchangeably with other terms. Baker (1975) used granny battering as an euphemism for abuse of older adults. Pillemer (1988), Pillemer and Finkelhor (1988) and Pitsiou-Darrough and Spinellis (1995) described abuse as maltreatment, and Valentine and Cash (1986) equated it with mistreatment as did Fulmer (1989), Johnson (1986), and Shah, Veedon and Vasi (1995). Saveman, Hallberg and Norberg (1996) defined both neglect and maltreatment "as not helping the elderly person with his or her needs for food, activation, hygiene, and so on" (p. 223), and differentiate these terms from abuse. Is aged abuse the same as granny battering, mistreatment or maltreatment? The literature does not answer this question. Researchers assume the terms are the same; however, this is an invalid assumption that should be tested through research. The presence of various terms for aged abuse means that there is no consensus as to what it is, which contributes to a lack of understanding of the concept.

There are researchers who offer their own unique definition of aged abuse. Johnson (1986) proposed the following definition, "a state of self- or other-inflicted suffering unnecessary to the maintenance of the quality of life of the older person" (p.180). Her definition is composed of four elements: (1) an intrinsic definition, which conceptualizes the phenomenon, (2) a real definition which identifies constituent elements of the phenomenon, (3) an operational definition which specifies measurable manifestations of the constituent elements, and (4) a separation of the cause of the phenomenon from the outcome. She then

identified constituent elements of this experience such as physical, psychological, sociological, or legal circumstances, measured by intensity (frequency and severity) and density (number of types). Johnson then focused on the primary cause of the experience of aged abuse as active (intentional) or passive (unintentional). Researchers have not tested the credibility of this definition, nor has Johnson articulated the process by which she identified the elements of the experience.

Johnson's (1986) use of a broad statement to define abuse is similar to the definitions used by some other researchers. McCallum, Matiasz, and Graycar (1990) wrote of abuse, as "any pattern of behavior by a person that results in physical or psychological harm" (p. 11). A broad based perspective of aged abuse is so encompassing in scope, that using such a definition is difficult.

There are other researchers who use the word abuse as the heading for a classification system of categories. Some researchers group abusive behaviors into the four categories of physical abuse, psychological abuse, financial abuse and neglect (National Clearing House on Family Violence, 1994). Poertner (1986) differentiated between the categories of physical abuse and severe physical abuse. Shah, Veedon and Vasi (1995) listed six categories, including one that they labeled as self-induced abuse. Podnieks, in 1985(a), identified three categories: physical, psychosocial and exploitation, yet her later work (1992a) listed four: material, chronic verbal aggression, physical violence and neglect. In another work, Podnieks (1992b) used slightly different categories: material abuse, verbal abuse, physical abuse and neglect. However, she failed to define the terms or to identify their relationship to the categories of her previous studies. It is impossible to identify or look for similarities and differences across categories and

research studies, if the terms are not defined. Close examination of abuse categories indicates that the groupings lack uniformity and consistency. Consequently, research into abuse becomes extremely difficult, and of limited benefit, since understanding and generalization of the findings is called into question.

While no agreement for category labels for aged abuse is evident in the literature, there is also no consensus as to which behaviors fall under a label. Categories of abuse contain behaviors identified by the author(s) as being abusive in nature and sharing common traits. Sengstock and Hwalek (1987) included verbal assault and threats not involving a weapon in the category of psychological abuse. Both verbal assaults and threats have a spoken component to them, and neither indicates physical trauma. Saveman, Hallberg and Norberg (1996) included under the same category label of psychological abuse "to humiliate, threaten, ignore and force" (p. 223). Podnieks (1992a) listed insults, swearing and threats under the category of chronic verbal aggression. Lau and Kosberg (1979) listed the "withholding of personal care" under the category label of physical abuse; Wolf, Strugnell and Godkin (1982) identified the same behavior as active neglect, as did Godkin, Wolf and Pillemer (1989). The inclusion of different behaviors under the same category label suggests that researchers themselves have different opinions as to what constitute aged abuse. As long as this pattern of inconsistency continues, comparability and corroboration of research findings will be unreliable. Additionally, the work of researchers is based upon the assumption that their operational definitions of abuse are correct. They have not tested the validity of this assumption.

The use of the term abuse as a heading label for a classification system raises the question of whether dissimilar phenomena have been subsumed under the heading. This is illustrated in the different relationships suggested between abuse and neglect. The most common approach of researchers and others is to include neglect as a sub-category of physical abuse (Phillips, 1983; Podnieks, 1992a, 1992b; Shah, Veedon & Vasi, 1995). Other researchers and writers have singled out neglect as a phenomenon distinct separate from abuse (Godkin, Wolf & Pillemer, 1989; National Clearing House on Family Violence, 1994; Poertner, 1986).

Definitions of neglect as it relates to abuse are inconsistent. Such definitions include qualifying statements related to the type of situation that warrants a determination of neglect or abuse. Phillips and Rempusheski (1985) found that health care providers were more likely to use the term neglect instead of abuse in situations where the caregiver's act was unintentional and the outcomes were less severe. A lack of awareness is implied. This is in contradiction to O'Malley, Everitt, O'Malley and Campion (1983), who suggested neglect exists when the care provider is aware of resources but fails to intervene to provide them.

In the review of the literature it has been shown that the profile of aged abuse has assumed greater significance over the past few decades. However attempts to define it are inadequate and confusing. Researchers agree that attempts to distinguish abuse from other forms of harmful behavior involving older individuals have failed (Hudson, 1991; Johnson, 1989; Podnieks, 1992a). Most of literature on aged abuse relates to domestic settings, and acts committed by

family members. There is growing indication in the literature of abuse of older adults within other settings, for example long-term care institutions.

Resident Abuse

Understanding resident abuse from a long-term institutional care perspective is in its infancy. Published research focuses primarily on incidents drawn from case studies, and on anecdotal cases reported to governmental agencies for investigation. Doty and Sullivan (1983) wrote that "7% of skilled nursing facilities/nursing homes, in the United Sates, had been cited as deficient on the requirement that each adult admitted to the facility is free from mental and physical abuse"(p. 224). Halamandaris (1983) described such criminal practices as theft of resident funds that were entrusted to the nursing home and defrauding relatives by demanding supplemental funds to enhance the care provided to their older family members. More recently, Watson, Cesario, Ziemba and McGovern (1993) investigated the frequency of abuse in long-term care institutions in Orange County, California. They calculated the incidence to be .03 % per bed for skilled nursing facilities and .008 % for residential care facilities. These studies reflect only reported instances of resident abuse.

There is no empirical documentation of resident abuse in Canada. Reports of resident abuse are anecdotal in nature, without research evidence of its occurrence. Podnieks (1983) wrote, "When I first started to research certain well documented examples of elder abuse, neglect and exploitation (by nursing staff), I was deeply shocked" (p. 34). Goldstein and Blank, (1982) without citing statistics, also alluded to the presence of abuse in Canadian long-term care institutions as did McDonald, Hornick, Robertson and Wallace (1991). Hall and Brocksnick (1995) stated resident abuse occurred in nursing homes but provided no clear

evidence of it. Its presence was based upon their definition of resident abuse. The presence of resident abuse is substantiated by federal and provincial/territorial governments, and related agency documents (Alberta Seniors Advisory Council, 1993; Government of Alberta, 1997; National Advisory Council on Aging, 1991; Newfoundland and Labrador Health Care Association, 1996;Task Force on Elder Abuse, 1987), although these reports are without scientific evidence. They are public information documents designed to provide an overview of the resident abuse, and general education and intervention guidelines for a variety of individuals and groups. The Newfoundland and Labrador Health Care Association (1996) and the Interhospital Domestic Violence Committee – Saskatchewan (1995) have produced training manuals that identify intervention guidelines for professionals working in general health care settings, as has the federal government (National Clearing House on Family Violence, 1994).

Relatively little is known about the origins of resident abuse in long-term institutional care settings. Payne and Cikovic (1995) identified whether or not specific behaviours were abusive, and sought the agreement or disagreement of non-professional staff with the abuse categories identified by the researchers. They found that non-professional staff are more likely to commit resident abuse than professional staff; however, since the former represents the largest group of employees in long-term care institutions, this is not a surprising finding. The study's finding suggests that perhaps education or skill level of abusers may be a factor. Payne and Cikovic also suggested that gender is a contributor; males are more likely to be abused than are females.

Stakeholders' Perceptions of Resident Abuse

Within long-term care institutions, there are different groups of individuals; for example, registered nurses, non-professional staff, older residents, family members and other visitors. These individuals are considered to be stakeholders as each may have direct or indirect involvement with resident abuse. In the review of the literature, few studies were located that examined long-term institutional care stakeholders' personal definitions and understanding of resident abuse. There are some studies on aged abuse that are noteworthy since they seek the perspective of stakeholders in other settings. Hudson (1991) conducted a three round Delphi study with a group of sixty-three identified experts in elder mistreatment to inductively develop a taxonomy of resident abuse. Participants were drawn from a range professional and academic backgrounds and included researchers, clinicians, educators and policy makers. Through this process, they came to agreement on the essential components of a five level taxonomy and eleven definitions. No participants appeared to be from long-term care institutional settings; however, some of them had service and administrative activities in unidentified settings. In addition, some of the provided examples of elder mistreatment (i.e. theft, controlling the elder) have potential applicability to resident abuse.

A later study by the same researcher (Hudson, 1994) explored elder abuse from the perspective of adults aged forty to ninety-one, none of whom were experts in abuse. Hudson collected data using the Elder Abuse Vignette Scale and the Elements of Elder Abuse Scale which include questions about aging and abuse experiences, and personal perceptions of elder abuse. Findings from this second study supported aspects of the experts' definitions and taxonomy

identified in her first study. The second study assessed the public's perceptions as to whether specific behaviours were abusive or not, and sought their agreement or disagreement with the abuse categories developed by the experts. These adults were not asked to articulate or formulate their own definitions. In addition, while some comparison was made between answers for middle aged and older adults, it was minimal. The change of terminology by the researcher from "elder mistreatment" to "elder abuse" assumes that participants view these terms as equivalent. Perhaps they are the same phenomena, perhaps not.

Podnieks (1992b) interviewed forty-two older adults residing in the community who had described themselves as being abused when interviewed during a national study on elder abuse and neglect in Canada. Employing a case history paradigm, and telephone interviewing, she categorized their experiences of abuse under the headings that she identified in her initial study (material abuse, verbal abuse, psychological abuse, and neglect). Participants were between sixty-five and ninety-three years of age, which means that the perceptions of older adults were sought; however, the use of pre-determined categories of abuse prevented them from articulating their own definition and understanding of abuse. Griffin (1994) conducted qualitative interviews with ten African-American older adults. Participants were substantiated victims of elder mistreatment (per North Carolina Statute, Chapter 108A-, Chapter 6: Protection of the Abused, Neglected, or Exploited Disabled Adult Act) as identified by adult protective service workers. The type of abuse experienced by participants was classified according to the legislation and Kosberg's (1988) categories of neglect. Griffin reported eight themes that emerged from the interview data that suggests that the understanding

of aged abuse might be different in African-Americans than in the larger white culture.

Phillips and Rempusheski (1985) investigated how registered nurses and social workers made decisions about aged abuse. Each participant was asked to define aged abuse and neglect, and differentiate between them. The researchers concluded that while participants assessed the care-giving relationship between older adults and family members, they overlooked the quality of this relationship when making decisions about the occurrence of abuse. Phillips and Rempusheski noted that stakeholders often got stuck at the stage of trying to make a decision, while making justifications for not being able to decide. Failure to make a decision might have occurred because participants had not clarified their own internal definitions of abuse and neglect, and were experiencing confusion over the terms. Participants may also have felt extraneous circumstances existed; for example setting, safety needs of older adults, which would influence their decision and that they were not asked to voice these circumstances.

Phillips (1983) also examined registered nurses' decision making about aged abuse. In a correlational descriptive study, a selected sample of seventy-four adults aged sixty-two to ninety-one years who were identified as having either a good relationship or an abusive/neglectful one with their family caregivers were interviewed in their own homes by public health nurses. Using an instrument designed by the researcher, thirty nurses were asked to determine the presence or absence of abuse. Phillips based her tool on a definition of abuse and characteristics of abusive situations that she had derived from the pediatric literature. For a number of older adults, the nurses could not identify whether abuse was present or absent. Perhaps difficulty in assigning older adults to either

category occurred because the nurse and the researcher had different definitions and understanding of aged abuse. Conflict between one's internal definition and an externally imposed one may have caused dissonance in the nurse. To resolve the dissonance, the nurse chose to abstain from making a decision. Had any of the unassigned older adults resided in an institution, some nurses reported that they would have had no question confirming abuse had occurred. It appears that setting may influence identification of abuse.

Factors other than setting may influence community stakeholders' decisions as to whether aged abuse occurred. Saveman, Hallberg and Norberg (1993) studied how Swedish district nurses defined and identified abuse of older adults. Twenty-one nurses were interviewed by means of open-ended questions and their responses were analyzed qualitatively. They based their decision upon one criterion - their perceptions that an abusive act overrode the boundaries of an older adult's autonomy.

Limited research has been done with long-term institutional care stakeholders themselves as to their definitions and understanding of resident abuse. Trevitt and Gallagher (1996) reported that Canadian registered nurses working in long-term care institutions were neither knowledgeable about types of abuse nor skilled when dealing with it. The researchers used the five types of aged abuse identified by Quinn (1990) as the definition by which to test the nurses' knowledge and skill. However, perhaps the findings were related to differences in definitions and understanding of resident abuse between the registered nurses and the researchers. To date, potential differences in perceptions of resident abuse between researchers and long-term institutional care stakeholders has not been addressed in the published literature.

Rather than exploring their perceptions of resident abuse, stakeholders have usually been asked to identify its prevalence within their facilities from definitions provided by researchers. For example, Douglass, Hickey and Noel (1980) interviewed twenty-four nurses and nursing aides from twelve long-term care facilities in Michigan about specific types of abusive acts they had seen committed by residents' families or staff within the facilities in which they worked. The number of abusive events was reported as totals in type categories pre-defined by the researchers, and did not identify who performed the act. Interviewees were selected by facilities' administrators, which questions the credibility of the findings, since perhaps only those staff perceived as acceptable respondents were selected. Fisk (1984) gave descriptions of common nursing care situations to thirty nursing aides in two facilities and asked how these situations were usually handled. In a number of cases, the aides reported that noisy, incontinent, or wandering residents might sometimes be verbally or physically abused. Fisk did not ask respondents about abuse that they themselves had committed.

A random survey of nursing home staff by Pillemer and Moore (1989) found high rates of resident abuse according to their definition of the term. Ten percent of nursing assistants reported that they had committed at least one act of physical abuse in the preceding year, and forty percent reported committing at least one act of psychological abuse. As this research studied only two types of abuse, physical and psychological, Pillemer and Moore provided an incomplete assessment of resident abuse since they did not question staff about other forms of resident abuse. In March of 1990, the Office of the Inspector General published the first national study on resident abuse in the United States.

Researchers sought the opinions of two hundred and thirty-two respondents from state and federal organizations who were involved in receiving, investigating and or resolving abuse complaints. Although opinions as to the occurrence of resident abuse from participants revealed a high degree of agreement, no objective data was obtained. Harris and Benson (1998) asked employees at six nursing homes to report through a questionnaire whether they had witnessed or participated in nursing home theft, for example the stealing of a resident's ring or clothing. The researchers identified theft as abuse. Thus, it is not known whether the participants perceived themselves as committing resident abuse.

In 1993, Meddaugh's descriptive study used participant observation to assess interactions between staff members and nursing home residents. While she observed no incidence of overt abuse, she documented its covert presence. One example of covert abuse, by Meddaugh's definition, was the isolation of specific residents from conversations with staff because they behaved in a way that was perceived by staff as unacceptable. In all these studies of prevalence, researchers entered the long-term care institution with a definition that was externally generated and not validated with stakeholders.

Long-term care stakeholders have also been asked to describe their perceptions of the predictors of resident abuse. Pillemer and Brachman-Prehn (1991) used data from a random sample survey of five hundred and seventy-seven nurses and nursing aides employed in long-term care facilities to identify predictors of resident abuse by staff. Using self-reported data on resident abuse, the researchers identified three sets of predictor variables: facility, staff and situational characteristics. They also examined the relationships between these three sets of predictors and specific types of abuse, and found psychological

abuse could be predicted by two types of staff characteristics (negative attitude towards patients and younger age), as well as by two situational ones (staff burnout and aggression by patients toward staff). Physical abuse was best predicted by three situational characteristics: staff burnout, patient aggression, and frequent verbal conflict between the resident and staff member.

In the cited studies of prevalence and prediction, researchers imposed external definitions of resident abuse upon participant stakeholders and did not verify if the definition was consistent with the one they used in their practice. This fault creates bias since stakeholders may have different perceptions of resident abuse than researchers. Differences in perceptions regarding aged abuse has been reported in three recent community focused studies from Finland, the United States and Canada. These studies identified that older adults hold different perceptions of abuse from those of health care professionals, middle aged individuals, and the government (Gebotys, O'Connor & Mair, 1992; Hudson, 1994; Kivela, Kongas-Saviaro, Kesti, Pahkala & Ijas, 1992). Fulmer and Gurland (1996) examined elder-caregiver perceptions of restriction, which they defined as a form of elder mistreatment. Dyad responses for restrictions indicated good agreement as identified on the Conflict Tactics and Fulmer Restriction Scales.

Although not investigating differences in perceptions regarding abuse, other researchers have found variance in views between different stakeholder groups. Oleson, Heading, Shadick and Bistodeau (1994) employed a qualitative approach to compare the perceptions of older residents and nurses regarding quality of life in three long-term care facilities. While they found themes common to both groups, they also note differences in theme frequencies and examples between the two groups. Lavizzo-Mourey, Zinn and Taylor (1992) found older

residents were perceived by their surrogates (usually spouses) to be more satisfied with long-term care than they actually were. Differences in perceptions among health care staff and residents [patients] have been documented in other studies (Freeman & Hefferin, 1984; Hudson & Sexton, 1996; McCauley, Lowery & Jacobson, 1992;Scharf & Caley, 1993; Von essen & Sjoden, 1991).

If differences in perceptions exist between stakeholder groups, then research into resident abuse without input from a number of perspectives has questionable credibility. Few researchers have considered the need for inclusion of emic knowledge, and none have identified if externally imposed definitions are consistent with the one(s) held by stakeholders of long-term institutional care settings. What has not done, to date, is an examination of the definition and understanding of resident abuse from the perspective of stakeholders themselves.

In the review of the literature, a few studies were identified in which the views of stakeholders other than registered nurses were sought regarding resident abuse. Hall and Bocksnick's study (1995) is an example of this type of study. They examined the perceptions of recreational therapists, administrators and residents from six nursing homes in Alberta regarding participation in recreation programs. Through a qualitative interview format, participants' views of participation and degree of resident control in deciding to participate in recreational activities were explored. Results were analyzed within a potential staff conflict-abuse model. While an explanation of the model was not provided, the researchers identified that residents' need for control over participation decisions were unheeded, and this enhanced the potential for "conflict and further abuse" (p. 49). The researchers assumed that lack of control in decision making

was abuse; however, they failed to identify the source of their assumption or if participants agreed with it.

Most noticeable in the few studies of long-term care institutions stakeholders' perceptions is the lack of the voices of older residents themselves. Hall and Bocksnick (1995) work is a noteworthy exception. Older residents often do not or cannot complain even when abused (Speeding, Morrison, Rehr & Rosenberg, 1983). Kimsey, Tarbox and Bragg (1981) speculated that residents do not complain because of fear of retaliation by formal care providers. This reluctance to admit to resident abuse is also a reason that data based solely on health care professionals' reports may be distorted.

All those involved in the experience of resident abuse bring to it their unique views of what constitutes such abuse, formed during socialization within their families, society and cultural groups. It is stakeholders' definitions and understanding of it that labels it as resident abuse. In long-term care institutions, stakeholders are drawn from a variety of ethnic backgrounds (Benjamin, 1997; Bhimani & Acron, 1998). There exists different ethnically based conceptions of what is appropriate behavior towards others (Driedger & Chappell, 1987; Novak, 1997). Differences exist in the standards that are applied to the various ethnic sub-groups in the population, to behavior between parents, children, spouses, and to behaviors between care-givers and those in their care.

One ethnic group may label a behavior as abusive, whereas another group might accept the behaviour as an appropriate way to deal with differences of opinion or responses to feelings. Levinson, Graves and Holcombe (1984) reported upon cross-cultural variation in the definition of abuse between nurses in the United States and the United Kingdom. Attribution of abuse was not

influenced by culture, and differences were reduced when controlling for race. While Levinson, Graves and Holcombe found that white nurses in the United States were more likely to perceive each of the identified acts as being abusive, the difference in their views and those of black nurses were only significant in two of fourteen acts. The findings from this latter study support the need for a variety of perspectives from different stakeholders to gain an accurate understanding of the phenomenon of resident abuse.

In summary, despite growing literature and research on resident abuse, it remains a complex and perplexing phenomenon, in which the views and voices of long-term institutional care stakeholders are not well represented. This is of primary concern as researchers seek to understand such abuse. Stakeholders' ways of defining and understanding resident abuse, if they are made visible, will contribute to increased knowledge concerning how and what to focus on when diagnosing abuse and intervening in practice. In order for stakeholders to judge an action as one of resident abuse, they must have some kind of concept of what to assess.

Issues Arising from the Literature Review

Reviewed research into aged and resident abuse, and into stakeholders' perceptions has been primarily of two types: surveys of prevalence, and interviews with professionals about abuse. From the review, four issues arose: (1) the existence of a definition quandary surrounding the two terms, (2) methodological problems in the research, (3) articulation of core traits of aged abuse/resident abuse, and (4) lack of stakeholders' perspectives regarding resident abuse.

Definition Quandary

The use of definitions of aged abuse and resident abuse in Canada has been strongly influenced by activities in the United States. To date, research on the prevalence of such abuse primarily been done in the United States. While there may be similarities in the experience of resident abuse between Canada and the United States, differences in the health care systems, funding and long-term care institutional practices, ethnic and cultural values, suggest that information generated in the United States should not be assumed to apply to Canada. It is argued that the dependence on research, from a different cultural milieu, has perhaps contributed to a distortion in the understanding of resident abuse in Canada. Resident abuse must be critically researched within the context of Canadian long-term care institutions.

Methodological Problems

Most researchers into aged abuse and resident abuse have not employed comparison control group techniques that would allow for some generalization to the larger population. Instead, small non-representative samples have been used that have yielded particular information, primarily related to occurrence. Because of the differences in sampling and data collection techniques among studies, the different research findings of aged abuse cannot be compared systematically. This lack of comparability adds confusion to the definition, meaning, and understanding of the phenomenon of aged abuse. There have been some noteworthy exceptions to this problem, for example Gioglio and Blakemore (1983), and Pillemer and Finkelhor (1988) who used larger scale random samples that provide for comparison of results and some generalization of findings.

Apart from sampling techniques, other methodological concerns exist. One problem in currently used instruments is the way in which abuse is operationalized by different researchers. For example, Poertner (1986) differentiated abuse into "passive neglect", "active neglect", "severe neglect", "verbal or emotional abuse", "physical abuse", and "severe physical abuse" (p. 17). He then mailed survey questionnaires to one thousand, eight hundred and ninety service providers asking them about their experiences with abuse and neglect of older persons. Podnieks (1992) defined an abusive act as "physical abuse, neglect, psychological abuse, and financial exploitation" (p. 6). Further data employing a different tool was used to measure each type of abuse by means of a telephone survey to approximately two thousand older adults. These differing perspectives contribute to differences in item selection and strategies to measure abuse. This contributes to controversy regarding the presence of abuse, regardless of the setting of the study. A successful measurement strategy for either aged or resident abuse should provide evidence of a relationship between theoretically specified associations and empirically generated relationships. When instruments have been developed and tested, adequate statistical criteria have not been used in their evaluation. The potential exists for measurement error because of unreliable instruments.

Researchers have identified that disclosure of intimate information to a stranger is associated with high levels of risk and embarrassment (Derlega & Chaikin, 1975; Jourard, 1971). This is a source of measurement error since it suggests under reporting of abuse, and therefore, inaccurate findings. Another limitation of abuse studies is the reliance upon the child abuse analogy. Poertner (1986) used an incidence estimation model drawn from the pediatric literature to

estimate the prevalence of abuse and neglect in older adults. However, testing was not been done to identify if the analogy was correct.

Identification of Common Traits

The review of the literature identified a multiplicity of interpretations of both aged and resident abuse. Identification of interpretations of resident abuse is the first step to defining and understanding its essential meaning. The second step is to make these multiple interpretations explicit. Identification of the common attributes is a useful starting point and one on which there appears to be consensus in the professional literature. There are two common attributes related to resident abuse which emerge during the literature review:

- the age of the individual is sixty-five years and over, and
- the experience of resident abuse occurs within a relationship.

The age sixty-five years is consistent with government policy that identifies it as the age one becomes an older adult or senior (Alberta Seniors Advisory Council, 1993; Statistics Canada, 1997). The relationship attribute is drawn from the fact that one commits abuse and one receives it – abuser and abusee. Other attributes mentioned in the literature include the intent of the behavior and the harm done (Fagg, 1994; Foner, 1994; Fulmer & Paveza, 1998; Payne & Cikovic, 1994). However, neither of these attributes distinguishes resident abuse from neglect or other types of inappropriate behavior.

The traits of age and a relationship must be met for behavior to fall within the scope of resident abuse. Given that these common attributes are present, three interpretations of resident abuse can be identified based on the reference standards against which the acts are judged. These are primarily drawn from the general literature on aged abuse, and not resident abuse per se. They are:

- Normative: resident abuse contravenes what society believes to be behavioral norms, despite their transgression being forbidden neither in law nor by institutional regulations.
- Legislative: resident abuse contravenes the statues or prohibitions of federal or provincial laws. Conduct is legislatively defined. Violations can range from minor common law infringements to criminal offenses under the Criminal Code of Canada.
- Institutional: resident abuse is behavior prohibited by an institution through its rules, regulations, policies and procedures. Such restrictions vary among long-term care facilities.

In all three meanings, resident abuse is judged as a violation of acceptable standards concerning the interpersonal treatment of an older resident.

The third step, in trying to understand the essential meaning of resident abuse, and consequently to generate an universal definition, is to tentatively identify from the literature possible attributes of resident abuse that are more commonly identified or implied than others, but are not consistent from study to study. Commission is one such attribute. Resident abuse is an act of commission. It is something done by someone to an older adult. Godkin, Wolf and Pillemer (1989), spoke of "the infliction of physical pain" (p. 211) in describing physical abuse, as did O'Malley and colleagues (1983). It is intentional in essence, and suggests an intention to hurt or cause pain. Intentionality implies self-determination in that the abuser has the power to understand what is happening, to make autonomous decisions, and has the ability to act upon decisions.

However, these same traits of commission and intentionality are not present in all descriptions of resident abuse, especially in the area of neglect. Neglect implies that one individual is failing, or has failed, to carry out certain responsibilities for another. What remains unclear is whether this was a covert act. To illustrate this point, health care professionals may feel that some needs of an older resident are best met by the family and are not their responsibility. The family does not act. Consequently, neither the professional nor family member meets the older resident's need. There is perhaps no legal obligation to do so. The question that can be asked is who is demonstrating neglect towards the older adult?

The identification of core attributes of resident abuse suggests the emergence of a definition that may hold consistent from experience to experience, context to context, and study to study. The final step in trying to understand the essential meaning of resident abuse is through an examination of language and the words used to differentiate between the related concepts; for example, between neglect, inadequate care and resident abuse. The current study will help to resolve the definition dilemma because the findings will yield information that may be used by researchers to test existing interpretations as to their appropriateness and validity. It identified behaviors and attributes that are deemed to be part of the abuse experience, and thus important components of a definition of abuse.

Lack of Stakeholders' Perspective of Resident Abuse

No definitions of resident abuse have emerged from within the long-term care institutional setting where it occurs. Imposed definitions of resident abuse for research purposes are etic in nature. Such externally employed definitions reflect

empirical knowledge, i.e. "knowing that" is a thing, which can be described in precise verbal terms and not emic knowledge of something. The latter is knowledge of the fullness of an experience with conscious awareness and reflection, and can be viewed as a different type of understanding; this type of knowledge is based on inner experiences. The review of the literature indicated that researchers have not sought this type of knowledge. Only external imposed definitions of resident abuse have been applied to the long-term care setting. Differences in definitions and understanding of resident abuse between stakeholders and researchers may exist. If differences do not exist, then this finding needs to be identified. If the perceptions of these two groups are similar, then credibility would be added to the published findings of researchers. From the review of the literature and the discussion of issues that arose from the review, it is obvious that the task of mapping the boundaries of resident abuse has not been completed.

Need for Current Research

The purpose of the research was to describe and identify the meaning of resident abuse in long-term care institutions from stakeholders' perspectives, specifically that of registered nurses, non-professional staff, older residents and significant others. It required a holistic and language focused model of inquiry that was grounded in the experiences of those who live, work and visit within long-term care institutions. A qualitative method was chosen to acquire the in-depth understanding required, without imposing pre-existing expectations or definitions on the setting, and to allow the important dimensions of resident abuse to emerge from the analysis of participants' data. The study is a more emic oriented one than has been evident in previous research.

There are three key arguments in support of the research: (1) the nature of qualitative research, (2) the emic perspective of the study, and (3) the study's role in the development of theory on resident abuse. In support of the first argument, the nature of qualitative research, its use is valuable when the researcher believes that existing knowledge is perhaps biased (Morse & Field, 1995). As evident in the literature review, quantitative researchers entered the long-term care institution with preconceived definitions of resident abuse. These definitions were not validated with the participants of the studies. This lack of validation provides the potential for bias in the studies. The current qualitative study eliminates this source of bias by asking participants to identify and describe their own definition of resident abuse, one which arises from the long-term institutional care setting itself.

Morse and Field (1995) suggested that qualitative research is especially helpful when the research question relates to understanding a phenomenon about which little is known. Quantitative studies conducted so far have been extremely restricted in their scope of investigation. Their questions of investigation primarily related to the identification of the number of reported cases of resident abuse within a facility, or looked for relationships between variables so that causality was established. Quantitative studies did not examine the complex experience of resident abuse, nor did they seek the views of those who experience it. The narrow scope of investigation by quantitative researchers indicates that knowledge of resident abuse is limited. Resident abuse, as an experience, has not been documented in the professional literature. This indicates a need for qualitative research, such as in the current study, since it will provide a description of resident abuse as it is experienced within the setting under study.

The selection of an appropriate research method depends on the nature of the research question. In wanting to understand the experience of resident abuse, a qualitative approach is appropriate. The experience of resident abuse is complex and indivisible into discrete variables. Thus, it requires examination through a research approach that is holistic in nature. As Newman (1979) stated, "A holistic approach is not to be confused with, or construed to mean, a multivariate approach. It is not the summing up of many factors ... to make a whole. It is the identification of patterns which are reflective of the whole" (p.70). Since the basic premise of holism is the foundation of qualitative work, whereas quantitative research methods consider only parts of the whole (Glesne & Peshkin, 1992; Polit & Hungler, 1995), qualitative methods best support the researcher's desire to understand the experience of resident abuse. Articulating knowledge of the whole, the experience of resident abuse itself, as proposed in this study, supports the holistic mandate of nurses and nursing. This mandate is to facilitate development of the individual's potential for health, taking into consideration all aspects of that person (Alberta Association of Registered Nurses, 1991a; 1991b; Canadian Nurses Association, 1987).

The second argument in support of the proposed research lies in its emphasis upon the emic perspective, a characteristic of qualitative research (Glesne & Peshkin, 1992). The emic perspective describes an experience from the participant's point of view (Morse & Field, 1995). It refers to the way that members of the culture themselves envision their world. The etic view, by contrast, is the outsider's interpretation of the experiences of the culture (Morse & Field). To date, most researchers in the area of resident abuse have taken the etic view. The implication of taking an etic approach is that the voices and

perceptions of those who experience resident abuse are not evident in the research. The proposed study will address this deficit through its use of emic research methods. It will articulate the voices and perceptions of those who experience resident abuse within the long-term institutional care setting.

The proposed qualitative approach to the investigation of resident abuse holds promise for truly meeting the needs of older residents and other members of the long-term institutional care setting by identifying what they think or believe is best for them. In quantitative work, there is an assumption that the researcher "knows what is best"; in that the researcher interprets the findings. This may be erroneous. Quantitative researchers seek the factors or causes of phenomena apart from the subjective states of individuals; they assume a static universe, where inquiry could logically be replicated (Glesne & Peshkin, 1992). This supposition of an unchanging word is in direct contrast to the dynamic and ever changing nature of culture (Andrew & Boyle, 1995). A qualitative approach recognizes this dynamic nature, and is an appropriate method for investigating resident abuse within long-term institutions.

While the focus of the proposed study is on resident abuse, it is inappropriate to seek the views of older residents alone. There are others, for example registered nurses, non-professional staff and significant others, who are also integral to the long-term institutions. In order to understand the experience of resident abuse, a research design is necessary that is capable of gaining an adequate understanding from different perspectives. The proposed study will permit the researcher to gain access to multiple perspectives through the participation of registered nurses, older residents, significant others and non-professional staff.

The third argument in support of the proposed research is the value of qualitative study in the development of theory on resident abuse. Registered nurses in their practice need, and government and health care officials require for legislative and policy development, knowledge obtained from both quantitative and qualitative research. Since questions asked by quantitative researchers are different to those asked by qualitative researchers (Morse & Field, 1995), different theoretical knowledge is derived. The proposed study will help provide answers to questions on resident abuse not posed by quantitative researchers. In qualitative research, the collected data is examined for patterns and relationships. The study will provide knowledge of resident abuse that is not currently available to registered nurses, governmental and health care officials and others interested in this health care concern.

The purpose of this study is to define and articulate the understanding of resident abuse as perceived by those who live and work within the long-term institutional care settings. A qualitative approach is the most appropriate means to obtain this understanding.

Statement of the Problem and Research Question

Despite the gradual emergence of literature acknowledging the presence of resident abuse within long-term care institutions, understanding it from a holistic perspective has proven elusive. Study of resident abuse suggests the need to explore this phenomenon beyond the boundaries of occurrences or externally imposed definitions in order to understand how the term is used within the culture in which it is experienced. In other words, a qualitative approach is needed. This research was developed to investigate registered nurses, non-professional staff,

older residents and significant others' perceptions of resident abuse within an institutional long-term care culture.

The primary research question is *what is resident abuse as perceived by the long-term institutional care culture?* Secondary questions include: *how do participants perceive resident abuse? How do participants differentiate abuse from neglect and inadequate care?* and *what differences are there among the perceptions of the four population groups?* The questions are addressed in a qualitative study using ethnological, ethnoscientific and content analysis methods.

Summary

The review of the literature, as documented in Chapter 2, contributed to the identification of issues related to resident abuse. There was, prior to the proposed study, no consistent and articulate definition of resident abuse. This lack of information is addressed in this study. Current definitions were created by those outside the institutional long-term care setting and may not be appropriate for this environment. Core attributes of the concept of resident abuse have not been identified or validated. Additionally, researchers have generally failed to consider the views of those who experience abuse. The issues raised from the review of the literature supported the need to examine resident abuse from the emic perspective of individuals who live and work within long-term care institutions. The research question addressed in this study is *what is resident abuse as perceived by the long-term institutional care culture?*

CHAPTER 3

Conceptual Framework

In this chapter, the conceptual framework of the study is described. Culture and language are the underlying concepts upon which this study was designed and implemented. Both culture and language are discussed, as is the relationship between them. The culture being investigated, in this study, is the long-term care institution.

Overview of Culture

Culture is an important influence on individuals. Human beings do not exist without culture, as it is a universal phenomenon (Andrews & Boyle, 1995). Nevertheless, the culture that evolves in any given society is always distinctive and specific. Most definitions of culture conform to the suggestion that culture is a common system of values, behaviours, beliefs and relationships, which taken together add up to a sense of community among individual participants. Driedger and Chappell (1987) described culture as a group's design for living, a shared set of socially transmitted assumptions about the nature of the physical and social world, the goals of life, and the appropriate means of achieving them.

Culture, as employed in this study, is used to refer to "acquired knowledge that people use to interpret experience and generate social behaviour" (Spradley, 1992, p. 5). Although basic human relationships are universal, Ishawaran (1986) wrote that cultural traits are ways of acting and thinking that are unique to a culture; they involve rules of conduct and tacit laws, often unwritten, that occasionally overlap with the organizational requirements of society. Every culture defines the relationships and roles which people assume as members of society.

Culture, as a shared system of meanings, is learned, defined, and re-visited in the context of people interacting. Any experience, such as resident abuse, must be interpreted against the social setting in which it occurs. The culture provides its members with the meaning of the experience, connects the experience to others and to the values of the society, and makes sense out what would otherwise perhaps seem unreasonable. Leininger (1978) stated that every culture has a perspective of its own world. The long-term care institution, illustrative of this supposition, is in itself a culture, with its own norms, behaviors, value system and roles. Not everyone who enters a long-term care institution shares its culture in exactly the same way. Variations in perceptions may occur among different cultural sub-groups.

The Long-term Care Institution as a Culture

The ability to understand resident abuse is dependent upon knowledge of the culture in which it exists. Goffman (1961) made an important contribution to the study of residential institutions as cultural entities, as he suggested that institutions have an encompassing, total character that is symbolized by barriers to interaction with the external society. The long-term care institution as a cultural entity has several central features. The day's activities are tightly scheduled. Every aspect of life - sleeping, eating, recreation and social activities, is carried out in the same place under policies, procedures, and routines that serve as control mechanisms. Daily living activities occur in the company of others – all of whom are to be treated alike. The limitations imposed within this culture by its rules and routines restrict residents' personal freedom and opportunities for them to control their own lives (Elander, Drechsler & Persson, 1993; Hofland, 1990; Jameton, 1988; Wells & Singer, 1988).

In the long-term care institution, the philosophy that binds together the goals and services of cultural members, specifically staff, is a commitment to caring for its more vulnerable members – its residents. The philosophy of caring is reflected in the policies and procedures of the long-term care institution.

Members of the Long-term Institutional Care Culture

The beliefs, perceptions and practices of the long-term care institutional culture are articulated in the voices of its members. There are distinct groups of cultural members which include: registered nurses, non-professional staff, residents and significant others.

Registered Nurses

Registered nurses rarely select long-term care settings as their first choice for employment (Bushmann, Burns & Jones, 1981). Their job responsibilities are fraught with stresses: conflict with peers, continual contact with death, confused or agitated residents, residents or family dissatisfaction, working with staff from culturally diverse backgrounds, uncertainty regarding treatment options and ageism (Brower, 1985; Coyne, Reichman & Berbig, 1993; Dougherty, Bolger, Preston, Jones, & Payne, 1992); Gilbert, 1984; Hollinger & Buschmann, 1993; Mercer, Heacock, & Beck, 1993; Pillemer & Bachman-Prehn, 1991; Tellis-Nayak & Tellis-Nayak, 1989). To compound job stresses, registered nurses enter a work milieu for which they are unprepared (Huber, Reno & McKenney, 1992; Huckstadt, 1983; Kane & Kane, 1987) because they often lack formal education in gerontological nursing.

A sub-group of the registered nurse population is administrative staff. Nurses, in administrative positions represent a power holding group within the long-term institutional care setting. While they have fewer direct interpersonal

interactions with residents than do primary care staff, their leadership function provides them with opportunities to exert influence on the environment which cultural members live and work (Ryden, 1985). When administrators create a supportive environment that facilitates the delivery of care, one outcome is enhanced resident satisfaction.

Non-professional Staff

Non-professional nursing staff render the majority of physical care to older residents (Banaszak-Holl & Hines, 1996; Burgio & Burgio, 1990; Castle, Brannon & Ringenbach, 1996; Roberto, Wacker, Jewell, & Rickard, 1997). Bowers and Bowers (1992) observed that relatively new nurses aides demonstrated a distinct style of organizing their work that was motivated by individual resident needs rather than by institutional routines. They experienced considerable stress in attempting to meet these needs and either had to quit or conform to established institutional routines. Marks, Smyer and Cohn (1993) reported that competing demands between work and family affected the job performance of nursing home aides. While Castle, Brannon and Ringenbach (1996) described non-professional staff as the most diverse of the current long-term care institutional workforce. Such diversity included age, gender, culture, education and values.

The long-term care literature generally offers a mixed view of non-professional staff. Tellis-Nayak and Tellis-Nayak (1989) noted that nurses' aides were without compassion or commitment. They portrayed a class of cultures, based upon ethnic and racial divisions between long-term care staff and the older residents. Kayser-Jones (1990) characterized nurses' aides in the facility that she studied as infantilizing, depersonalizing, dehumanizing and victimizing residents. However, Foner (1994) identified that most nurses' aides were supportive of and

helpful to older residents. She also stated that "many aides established relationships with patients that they and the patients found gratifying' (p. 245). Diamond (1992) also described non-professional staff as sympathetic.

It has been suggested that occupational position correlates with resident abuse. Three recent studies have documented abuse by non-professional staff (Office of the Inspector General, 1990; Pillemer & Hudson, 1993; Pillemer & Moore, 1989).

Older Residents

Older residents enter long-term care institutions because they are unable to perform activities of daily living require and require assistance to do so (Jackson, 1985; Lagergren, 1996; Reinardy, 1992). It is necessary to differentiate dependency due to inability to meet one's own needs from that imposed upon older residents by the long-term care institution itself. Dawson, Kline, Wiancko and Wells (1986) identified that failure by staff to accurately assess a resident's capabilities led to excessive disability, a condition in which a resident is more functionally disabled than one's physical condition would produce. It has been suggested that long-term care facilities depersonalize people and encourage loss of control (Ambrogi & Leonard, 1988; Avorn & Langer,1982; Jameton, 1988; O'Connor & Vallerand, 1994). Burgio and Burgio (1990) wrote, "the manner in which they [staff] interact with patients can reinforce dependent behavior" (p.298).

Older adults' sense of self-esteem and well being are shaped by the culture in which they live. Most individuals want to maintain an element of control over their being and environment when admitted to institutional facilities (Davidson & O'Connor, 1990; Jang, 1992; Kruzich, Clinton, & Kelber, 1992; Wells & Singer, 1988; Wilde, Starrin, Larsson & Larsson, 1993). Wells and Singer (1988) reported

residents wanted more responsibility and self-direction upon admission than staff gave them. Similar findings were documented by McGinity and Stotsky (1967), Jang (1992), and by English and Morse (1988) in their ethnographic interviews with difficult patients.

When institutionalization forces the individual to relinquish control to a stranger, a sense of powerlessness may be experienced (Avorn & Langer, 1982; Chang, 1978; Jang, 1992; Pohl & Fuller, 1980; Wetle, Levkoff, Cwikel & Rosen, 1988). Powerlessness is associated with learned helplessness in older residents, the acquired belief that one can do nothing about the outcome of an event (Abramson, Seligman & Teasdale, 1987; Seligman, 1975; Slimmer, Lopez, LeSage & Ellor, 1987). Some residents believe external forces control life and self-input is unproductive, resulting in motivational, cognitive and/or emotional deficits. O'Connor and Valler (1994) wrote "the experiences of ... self-determination are relatively more important than objective reality" (p. 536).

Deprivation is defined as a lack or denial, a taking away. For older residents, deprivation may take various forms, one of which is sensory deprivation. Burnside (1988) described this when she wrote, "ennui and boredom are still common complaints" (p.265) within nursing homes. Another form of deprivation is loss of personal belongings. Wapner, Demick and Redondo's (1990) study of one hundred older nursing home residents found that those with possessions were better adapted to their environment. Possessions fulfilled numerous needs including that of historical continuity, comfort and a sense of belonging.

For some older residents, physical factors associated with disease pathology produce conversational deprivation. For other residents, conversational loss may be self-generated. They reject roommates as conversational partners

because of what Goffman (1961) termed the relationship wedge; for example, when one roommate does not communicate with the other, then privacy needs are more easily met. In this circumstance, meeting one type of need (privacy) causes another (the need for human dialogue) to go unmet. The consequences of such loss include social isolation, excess dependency, impaired self- concept and powerlessness (Davignon & Leshowitz, 1986). Lubinski, Morrison and Rigrodsky (1981) investigated the perceptions of older residents regarding spoken communication within long-term care settings. Results revealed that from the residents' perspective, communication was limited, and this limitation restricted their ability to establish relationships with staff and to articulate their needs to them. In a grounded theory study by Wilde, Starrin, Larsson and Larsson (1993), the opportunity to ask questions of staff and to discuss information with them was linked to perceived quality of care. In a similar study, Ryan. Meredith and Shantz (1994) reported that residents did not like what they perceived as the patronizing conversation of staff. Staffs, using such a patronizing tone, were perceived as less respectful and caring than those who used a neutral style of communicating.

Significant Others

Family members and friends are also members of the institutional long-term care culture. They continue to support residents when they are institutionalized (Bowers, 1988; Moss & Kurkland, 1989; Townsend, 1990). Greene and Monahan (1981) demonstrated that residents who were visited more frequently showed significantly lower levels of psychosocial impairment. Kirkconnel and Tindate (1986) identified that residents with close family ties had higher self-esteem and were more likely to feel satisfied about their decision to enter long-term care than those who had fewer family ties.

Bowers (1988) identified that while families attributed responsibility for the performance of most tasks to long-term care staff, they "held themselves responsible for monitoring and evaluating the effectiveness and quality of caring tasks" (p. 363). Dawson and Rosenthal (1996) reported that wives of institutionalized older men reported decreasing satisfaction with the long-term care facility as length of institutionalization increased. Other studies have also reported detrimental outcomes (Rosenthal & Dawson; Rosethal, Sulman & Marshall, 1993; Townsend, 1990). Some researchers have identified positive outcomes of admission for family members, including feelings of relief (Rosenthal & Dawson, 1991) and improved well being (George & Gywther, 1986).

Family members, residents, non-professional staff and registered nurses are all members of the long-term institutional care culture. Culture emerges from and is transmitted and perpetuated through social interaction, through the use of language. Language is the way a culture and the people within it express their perspective. Consequently, language is a powerful way of understanding, describing and explaining the complex phenomenon of resident abuse within the long-term institutional care setting.

Language

Language is the frame of reference used to organize the development and implementation of the study by providing both a theoretical background as to how the phenomenon was going to be studied, as well as a context for the collection and analysis of data. As Emmet (1968) wrote, "On the whole most people take it [language] for granted and do not to any considerable extent subject the language they use and the ways in which they use it to a critical analysis or inquiry" (p. 21).

Lack of critical analysis may be due to the fact that often people, including nurses, ignore what is both commonplace and essential.

Yet language is an essential medium for thought, discovery and knowing. It invokes the verbal articulation of an individual's perceptions and awareness of an experience. This means that the understanding an individual has of an experience is articulated and communicated to others through words. Thus individuals are able to share experiences and their understanding of them. "It is the nature of beings like us with subjectivity to use language to formulate meanings" (Gadow, 1990, p.2). As Gadamer (1993) explained, the emergent ontological shift towards hermeneutics is guided by language. One can know from an emic perspective through language rather than relying on externally generated meanings that may not possess *truth* for the individual. This possibility encouraged the present effort to discover an internally generated definition and description of resident abuse to enhance knowledge of the phenomenon.

Language is an abstraction based on the linguistic behavior of its users (Todd, 1987). Put at its simplest, language is a set of signals by which users communicate. Because of language, human beings can consider the abstract, the non-immediate, and the non-real. Humans invent and construct language, and have the ability to change it. Such changes may occur through the addition of new words or the abandonment of others no longer employed in daily speech, as history demonstrates. For example, "living room" or "family room" has replaced the "Elizabethan sitting room". That language is composed of words is probably its most obvious characteristic. The nature of words, however, is more obscure, for the words reflect not only apparent facts, but also values, beliefs and assumptions (Wilson, 1963), and meaning.

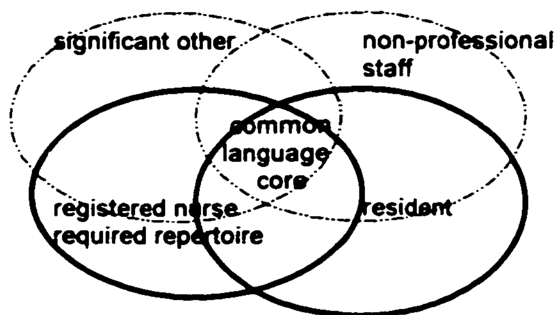
Words have meaning because human beings attach meaning to them. Meaning and language are interconnected. One of the functions of language is to share meaning. It is only when a behavior, an action, or an object is named, drawing up one's thoughts to a conscious level that the meaning (or understanding) becomes visible. At times, two speakers will not have the same meaning in mind when they use the same words. This may be true for resident abuse with the variety of interpretations of the term identified in the literature.

Another function of language is to express experiences within society, and the world. Language crosses geographic boundaries, generation gaps, as well as political and socio-economic divides. Yet even within a language community, a group of people who consider that they speak the same language, there may exist several or even many recognized forms of the language which correlate with the social and/or geographical structure of the community. For example, all members of the long-term care institution share a common language that forms the basis of a general lexicon for these individuals. This does not represent the whole of their language repertoire. Individuals often possess required repertoires, dictated by their roles with in the facility. The registered nurse and resident illustrate this point; the former possesses a required repertoire because of professional education and practice. During one's education to obtain a nursing diploma or degree, one learns the language of health care, including medical terms that describe disease pathologies and presenting symptoms. This language is necessary to enable the registered nurse to work in the long-term care institution. The resident does not possess this repertoire. However, both registered nurses and residents possess a common language which they share with others, including non-professional staff and significant others. This common language

includes the words of daily speech – the words "bed", "toilet", or "meal" illustrate this repertoire. This distinction is demonstrated in figure 3.1, generated by the researcher to express this duality.

Figure 3.1

Common and required repertoire within the registered nurse-resident relationship[1]



The vast majority of words that comprise the common language core are not unique to specific language communities in their references. Reference describes an object, act, experience in the external world that is clearly identified by means of a word or expression (Lyons, 1977). Multiplicity of references is demonstrated in the use of the word *abuse*. The literature review revealed a variety of meanings given to this word by researchers and theorists; maltreatment, mistreatment, granny battering. This implies the interpretation of a word on any given occasion of its utterance is determined jointly by its meaning and by its reference. If the interpretation of the word varies according to the time and place of utterance, there needs to be some means of indexing the object/experience/act in the world and associating these indices with the word.

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[1] the heavier shaded line which encircles the nurse and resident illustrates the cultural members in the cited example. The dotted line illustrates the need to include non-professional staff and significant others in discussions of cultural language.

One means of indexing is through identifying the understanding of the word(s). The assumption is that understanding is discovered by elucidation from within.

The words "resident abuse" carry different interpretations because of the current lack of a specific reference point. The variety of existing definitions as discussed in Chapter 2 suggests a multiplicity of reference points.

The Relationship of Language to Research Method

An in-depth exploration of resident abuse as it was experienced within the culture of long-term care facilities will be undertaken. Three assumptions of the researcher about language guided the research. The first was that language contributes to one's understanding of reality. The second assumption was that individuals possess personal understanding in interpreting the meaning of a word or phrase. The third was that individuals may differ in their definitions of a word or phrase.

If in self-reflection one uses a variety of words, one employs them as one wishes. Words may be modified, changed or even created by the user. However, once one uses words for communication, the scenario is changed. If one uses the term *resident abuse* to denote neglect, then the user may not have succeeded in communicating the meaning of such abuse. Individuals use words to mean various things. There should be agreement that people use the same word for the same meaning. This belief is drawn from the work of symbolic interactionism, which stems from the works of Dewey (1930) and others (Blumer, 1969; Mead, 1934). The symbolic interactionist places importance on the social meanings that individuals attach to the world around them. Blumer wrote that symbolic interactionism rests on three premises. The first is that individuals act towards

things, including other people, on the basis of the meanings these things have for them. The second is that meanings are social products that arise during interactions. The third premise is that individuals obtain meaning through a dynamic process of interpretation.

These premises are consistent with the definition of culture presented earlier, specifically that culture refers to "acquired knowledge that people use to interpret experience and generate social behaviour" (Spradley, 1992, p. 5). The emphasis, in this study, is to inquire about the meaning of the resident abuse experience and related behaviours as perceived by cultural members. Individuals use their culture to interpret an experience. The naming of an experience as resident abuse, or not, arises from the interactions of cultural members. One individual may interpret an experience or a behaviour in a different way from another individual, leading to a different naming of it. This is because while culture serves as a guide for interpreting an experience, it does not dictate a specific interpretation of it (Spradley, 1979). Thus resident abuse is a cultural construct.

When words are used to represent physical things, it is comparatively easy to ensure some consensus of agreement occurs as to meaning, but when the words are used to stand for experiences, such as resident abuse, agreement may be difficult to obtain. Lack of agreement is demonstrated in the definition confusion, described in the literature review (see Chapter 2), that surrounds the uses of the word abuse. When a word lacks clarity, each user ascribes it a meaning through the context of personal experiences. Consequently, effective communication maybe impaired, clarity of words in an empirical sense is thwarted, and the ability of the word to assist in knowledge development and other social

sharing functions of language, is impaired (Emmet, 1968; Gadamer, 1993; Wilson, 1963). As a result of this predicament, the ability of registered nurses, health care policy makers, administrators of long-term care facilities and others to effectively respond to resident abuse is seriously restricted.

Language, its utilization and expression, is the foundation upon which the method of the study was developed. A qualitative approach was chosen because it permitted a specific culture to be studied and categorized in the language of the cultural members, the insider's view. As Aamodt (1991) wrote, "linguistic expressions used by informants during social interactions are the structural blocks of meaning for constructing systems of cultural knowledge" (p. 45). In this study, the culture is the long-term care institution.

Numerous factors influence the selection of words used by members of a culture. Language is modified by cultural members according to the topic of the interaction, the situation, the roles one possesses, and by personal experiences and interpretations ascribed to specific words. For example, since child abuse occurred in the literature prior to resident abuse, it is possible the terminology used to describe child abuse has been an influential factor in describing a similar syndrome in older adults.

Roles also modify language use. If one accepts the distinction between a common language core and a required repertoire as illustrated in figure 3.1, those occupying different roles within a culture may use different words. This suggests that the same word may have different meanings to cultural members in different roles. For example, within the long-term care institutional culture, registered nurses may have a different meaning of resident abuse than do significant others, since these are different roles. If they hold different meanings of the term resident

abuse, they may not be able to talk to each other with clarity and understanding - to say what they mean, or mean what they say though they use the same words.

At times, interactions between cultural roles, for example, registered nurses and residents, represents a clash between the common language core of the latter and the required repertoire of the former. The required repertoire is often technical and scientific, and the common language core is humanistic, embodying the reality of an individual. Emphasis upon the required repertoire may be at the expense of human contact, as it mutes the personal voice of the older resident. Any study of language use must reflect both scientific and humanistic knowledge. In this study, this was captured by incorporating the population groups of older residents, registered nurses, non-professional nursing staff and significant others. Such scope had several benefits, including: recognition of the common core and required repertoire of language and potential difficulties inherent when using words to describe the same experience or phenomenon; inclusion of the humanistic voice of the older resident and members of other cultural sub-groups; a broader perspective on the term resident abuse, and comparison of findings across and within the four groups which contributed to the creditability of findings.

The specific data collection and analysis styles used in this study encouraged the expression of internal meanings through the use of language. Semi-structured interviews and focus groups were used to collect the data. Examination of the conscious linguistic behavior used by participants and thematic categorization of responses was carried out in the analysis. Incidents, descriptors, defining attributes, and typical and atypical incidents of resident abuse were elicited and validated from participants themselves. This research method was

chosen because it encouraged participants to express their own views which represent understanding for them versus employing externally generated definitions which may bear little relevance to their own cultural experiences.

Exploration of internal meaning maybe a blending process, as it creates externally through words a world where older resident, nurse and significant other meet together to share a common reality. This mutual reality provides a method for obtaining the scientific knowledge that nurses need to provide quality care, while listening to the personal voice of residents and those important to them.

Summary

Culture represents a way of perceiving, behaving and evaluating one's world. It defines the relationships and roles that its members assume. Such relationships and roles are based upon the value system of that culture and are governed by established rules of behavior. Cultural values and knowledge are communicated by language. The long-term care institution is no exception to this fact. The long-term care institution is a culture with a sharing of values, perceptions and behaviors among its members.

CHAPTER 4

Research Method

The purpose in the study was to answer the following questions: *what is resident abuse as perceived by the long-term institutional care culture? How do participants perceive resident abuse? How do participants differentiate abuse from neglect and inadequate care?* and *what differences are there among the perceptions of different population sub-groups?* A qualitative method using three research approaches (ethnography, ethnoscience and content analysis) was used. A description of each approach is provided in the overview of the method section. The operational definitions used in the study, and site and sampling descriptions relevant to both ethnography and ethnoscience, are presented as separate segments within this research method section of the study. The discussion of data collection and analysis techniques is divided into three distinct segments to reflect the different research approaches used in this study. The application of standards of rigor, ethical considerations, and limitations of the study are also presented in this section.

Overview of the Method

Three research approaches guided this study: ethnography, ethnoscience and content analysis. The first two approaches will answer the identified research used. The third method is used to enhance the accuracy of the findings from this study. Proponents, often called constructivists or interpretivists (Schwandt, 1994), of these approaches share the "common goal of understanding the complex world of lived experience from the point of view of those who live in it" (p. 118). Each approach is briefly described in this section. Their combined use increased the

breadth and depth of the data obtained. Triangulation of data analysis from these three approaches enhances the accuracy of the findings of the study.

Ethnography

Characterized by inductive, empirical exploration (Leininger, 1985), ethnography is a qualitative approach used to understand the people of a cultural system and to discover meaning as perceived by them. It has been used as a research method in studying both health care systems and nursing practice (Brandriet, 1994; English & Morse, 1988; Sorrell & Redmond, 1995; Townsend, 1992). In employing ethnographic approaches for the study of health care and related concerns, researchers are drawing upon the practice of anthropologists. The duty of anthropologists is to describe specific cultures adequately as it is with ethnographers. The ethnographic researcher gains entrance into a culture and becomes immersed with the people and ways of living in order to understand the meanings that cultural participants attach to behaviours, rites, traditions, knowledge and other experiences. Boyle (1994) described this immersion as the reflexive character of ethnography.

While the roots of ethnography are found in anthropology, it is derived philosophically from symbolic interactionism which stems from the work of Cooley (1902), Dewey (1930), Mead (cited in Blumer, 1969), Spradley (1979) and others. The social interactionist places primary importance on the social meanings people attach to the world around them. Blumer stated that symbolic interactionism rests on three basic premises. The first premise is that people act toward things, including other people, based on the meanings that these things have for them. His second premise is that meanings are social products that arise during interactions. People learn how to see the world from the perspectives of other

people. The third premise, according to Blumer, is that individuals attach meaning to situations, others, things and themselves through a process of interpretation.

Morse and Field (1995) wrote that "ethnography is a means of gaining access to the health beliefs and practices of a culture and allows the observer to view phenomena is the context in which they occur, thus facilitating our understanding of health and illness behaviour" (p. 26). They went on to state that "such information is critical to the provision of care, for the key to a health program is understanding the culture of recipients" (p. 26). In using an ethnographic approach towards investigating resident abuse, understanding is obtained on this health care concern within the setting in which it occurs. The outcome is knowledge of how the context of resident abuse influences the perception of cultural members. This knowledge will enable long-term care administrators, staff and others to develop policies and procedures to more effectively address and reduce resident abuse.

In this study, four population groups: registered nurses, non-professional staff, residents and significant others from five long-term care institutions were used. Data collection consisted of participant observations, semi-structured interviews, focus groups and personal documentation. Ethnographic interviewing with participants is aimed at describing their cultural knowledge, such as the knowledge of resident abuse which staff and others use within the long-term institutional care facilities. Spradley (1979) described such interviews as "friendly conversations into which the researcher slowly introduces new elements to assist informants to respond as informants" (p. 58). Nevertheless, these conversations have a clear and specific research agenda. Spradley also identified three stylistic elements appropriate to ethnographic interviewing: explicit purpose, ethnographic

explanations and ethnographic questioning. These elements are used by the researcher to help participants categorize and organize their perceptions of reality.

A unique characteristic of the ethnographic interview is that three types of questions are introduced in a specific sequence. Descriptive questions were asked first, for example "Tell me about the way older residents are treated that you like best?" Structural questions were then introduced, "Within some long-term care institutions, the concern of resident abuse has been raised. When we talk about resident abuse, how would you define the term?" Contrast questions ended the interview "How would you differentiate resident abuse from neglect or inadequate care?"

Cultural members may hold different perceptions of resident abuse; therefore, throughout data collection, participants' views were compared between and within the four sub-groups. Data analysis, through the identification, description, and validation of patterns of meaning of resident abuse, led to a rich understanding and explanation of it as perceived by participants.

In brief, ethnography is a naturalistic method of inquiry. Its purpose is to study and understand human behaviour in the cultural setting in which it occurs. As such, it employs an emic approach. The outcomes of ethnological research are descriptive and explanatory theories, and understanding of the culture under study, in this case the long-term care institution.

Ethnoscience

Since cultural members use language to convey particular meanings and experiences, it is important to acknowledge how it or specific variants of it are used when studying resident abuse. Coffey and Atkinson (1996) wrote that in the exploration of linguistic symbols or "folk terms" used by cultural members, both

individually and collectively, one has a mechanism for understanding the cultural knowledge of a specific group. One qualitative approach to studying language is ethnoscience. Ethnoscience is the systematic study of the way of life of a designated cultural group in order to obtain an accurate account of their behavior and how they perceive and know their universe (Leininger, 1969; Sturdevant, 1972). It differs from ethnography in that it is a more rigorous, formal and systematized way of documenting, describing and analyzing data through the language of cultural members. Ethnoscience has been used by nursing researchers and those interested in health related research for several decades (Bush, Ullom & Osborne, 1975; Leininger, 1969; Morse & English, 1988; Price & Moos, 1985).

The aim of ethnoscience is to classify information, gained from cultural members, so that it accurately portrays and provides a high degree of scientific integrity about indigenous people's views. There are three underlying assumptions that guided this method. The first is that the researcher must start with the premise that words used within one's own culture, such as the long-term institution, may have different meanings in another culture. The second assumption is that human beings are able to classify and order their knowledge of their world into meaningful relationships which are generally shared within cultural communities (Leininger, 1985). The third assumption is that the hidden or unconscious structuring of experiences is evident in one's language. The task of the researcher is to uncover this structuring.

This uncovering process is done through analysis of answers provided by participants to a series of questions posed by the researcher. Data obtained from participants is constructed into a taxonomy. A taxonomy describes a system of

different contrastive sets about a given phenomenon (Morse & Field, 1995;Spradley, 1979); one such phenomenon is resident abuse. Boyle (1994) described taxonomies as constructed from information provided by a number of participants and to obtain some idea of the range of variation and areas of consistency about how people think about a particular domain of interest. For this study, the domain of interest is resident abuse.

The development of a taxonomy identifies the relationships among the cultural terms; and enable the researcher to establish a visual schemata of how categories and sub-categories (or sets) of cultural knowledge are interrelated. A category is the basic unit of ethnoscience research (Evaneshko & Kay, 1982). Cultural groups arbitrarily organize knowledge based on culturally designated similarities and differences, placing certain items in one category as opposed to another (Watson & Watson, 1969). For example, the culturally designated category of nursing interventions is different from other categories such as medical interventions.

Variation among participants is common as they may use different words to refer to the same phenomenon. There may be both overlap and indeterminacy in categories, as a word or a term can be located in several categories. The complexity of taxonomies is addressed by componential analysis (Boyle, 1994). Componential analysis has two objectives, the first is to specify the conditions under which a participant will call something by a particular term. The second objective is to understand the cognitive process by which a participant decides which of several possible terms should be applied to a specific thing, such as a behaviour.

There are two cautions to this qualitative approach. First, taxonomic analyses are meaningful only if the words (symbols), categories and relationships are those used and identified by the cultural members themselves. Second, the analysis and/or taxonomic structure will never completely reflect the knowledge patterns of the culture under study. Such analysis will only approximate how cultural members actually organize and gain meaning from their cultural knowledge.

In this study, registered nurses were chosen as the single participant group. They are a focal point of resident care and its co-ordination in long-term care institutions, and are considered key informants. They are also the primary group responsible for the development and implementation of policies and procedures within this same setting. While the possibility of including older residents was considered in the development of the taxonomy, the decision was made to eliminate them from this study because of their frail status and often impaired cognitive status. The researcher also felt that she wished to focus in ethnoscience on knowledge developed from registered nurses, since this was her own professional background.

In the analysis of data from this study, ethnoscience provides for a comprehensive investigation of the problem of resident abuse. It will enable the development of a taxonomy by the researcher, which classifies the characteristics, and kinds of resident abuse perceived within the long-term institutional care culture.

Content Analysis

Content analysis was one of the three research methods used in this study. It was used to quantify the narrative, qualitative material on resident abuse.

Bernard (1988) wrote that content analysis is a catch all term which covers a variety of techniques for making inferences from text data. A more precise definition was offered by Downe-Wamboldt (1992); content analysis is a "research method that provides a systematic and objective means to make valid inferences from verbal, visual or written data in order to describe and quantify specific phenomena" (p. 314). As such, content analysis provided a mechanism to yield interesting and theoretically useful generalizations with minimal loss of information from the original collected data.

Wilson (1989) identified three components of content analysis: (1) deciding what the unit of analysis will be, (2) borrowing or developing the set of categories, and (3) developing the rationale and illustrations to direct the coding of the data. These components were expanded upon by Downe-Wamboldt (1992) into a series of seven steps, and were used by the researcher to conduct the content analysis. Spradley's work (1979) supported the steps identified by Downe-Wamboldt, as did Brewer and Hunter (1989), and Morse and Field (1995).

The definition of "unit of analysis" used by this researcher was drawn from what Barclay and Hodges (cited in Kovach, 1991) termed the "idea unit". The idea unit was defined as a constellation of words or statements that relate to the central meaning or chief end of a particular action or situation. The selection of the unit of analysis was guided by the purpose of the study, and in this research the idea unit described the attributes of resident abuse.

The available professional literature, provincial and federal governmental legislation, and policy and procedure documentation on resident abuse was analyzed. The literature was read, and categories of data identified and described. These identified categories were compared to a binary maxtrix (yes or

no) developed by the researcher. The top of the matrix identified the units of study, which in this research are the documentation and literature sources on resident abuse and the categories of data that emerged from them. The left side column of the matrix identified the variables of the study, which were defined as the attributes of resident abuse drawn from the findings of the conducted research. The use of the matrix enabled the researcher to view the units of analysis and variables as two distinct dimensions. Descriptive statistics documented the number of times specific variables, the attributes of resident abuse, as discussed in the literature. No ranking of the materials is done as this is not the purpose of the analysis. Downe-Wamboldt (1992) wrote that content analysis has external validity as its goal. The comparison of findings from the content analysis and the other research methods used provided for a multi-method approach to the study of resident abuse within long-term care institutions.

As a research method, content analysis has its deficits. Approaches such as Downe-Wamboldt's are in jeopardy of surrogating numbers for rich description and contextualization. Mannings and Cullum-Swan (1994) identified that "content analysis has been unable to capture the context within which a written text has meaning" (p. 464). However, Downe-Wamboldt herself addressed this criticism by writing that "content analysis is more than a counting game; it is concerned with meanings, intentions, consequences and context. To describe the occurrences of words, phrases, or sentences without consideration of the contextual environment of the data is inappropriate and inadequate" (p. 314). Triangulation of data helped to address this concern.

Operational Definitions

The following definitions were used in the study:

Long-term care institution: a facility which provides care on a sustained and prolonged basis to meet the physical, social and personal needs of individuals whose functional capacities are chronically impaired or at risk (Ontario Hospital Association, cited in Forbes, Jackson & Kraus, 1987, p. 1).

Non-professional staff: an individual who does not require post secondary education for the position.

Older Resident: an adult who is 65 years or over and who lives within a long-term care institution.

Registered Nurse: a registered nurse employed in a long-term care institution.

Significant Other: the person identified by a resident or nursing staff member as the one who comes most often to visit or who is most important to that resident.

Site Selection

Administrators of long-term care institutions were invited to participate in the study, and five long-term care institutions agreed to open for the study. It was important to draw the sample of participants from several institutions, as facilities vary in their structure and operation; for example, in type of ownership, size and location. Specified in Table 4.1 are the long-term care institutions used in the study.

Table 4.1

Site Description

Site	bed count	setting	ownership	accredited
1	100 – 125	urban	private	yes
2	100 – 125	urban	private	yes
3	125 - 150	urban	private	yes
4	125 - 150	urban	private	no
5	225 - 250	urban	private	yes

The sites ranged from a bed count of 100 – 125 to 225 – 250[1]. The average size was 157.4 beds. All sites were located within one large urban city, and in the same regional health authority in Alberta. While all five were privately owned, they were publicly funded. Four of the five institutions were accredited. All five provided clinical experiences for nursing degree students and other health care workers. The administrator in each facility is a registered nurse. In four of the sites, the administrator had advanced managerial preparation beyond the baccalaureate level. A nurse educator was assigned to each of the five sites, although in three of them this was a part-time position. In three of the five facilities, a social worker was available, on a part-time basis, to work with residents and family members as an advocate on their behalf. In one other facility, a registered nurse fulfilled a similar role.

Sampling

Four population groups from the long-term care institutions were sampled:

[1] bed counts are provided within a range to reduce possibility of identification

registered nurses, non-professional nursing staff, older residents, and significant others of residents. As the purpose of the sampling in this type of research was to include as much information as possible, non-probability, purposeful sampling was utilized in recruiting participants. In this form of sampling, respondents who can best meet the needs of the study are selected (Morse, 1991). Recognition is given to the small sample size of each participant group used in the study. While this is discussed under limitations of the study, it is important to note here that the researcher felt that saturation of data was achieved in the professional and older resident groups. Attempts to recruit more significant other participants were not successful.

Administrators or designates of each facility were contacted by telephone and a meeting held at their site to discuss the proposed research. Each administrator or designate at the initial meeting was provided with an explanation of the study and its objectives, and feedback from the study's findings promised upon completion. The co-operation of the administrator/designate in the formation of a list of potential participants was sought. A potential problem of having the administrator/designate guide the identification of possible participants was that, in their desire to present a favorable image, participants thought too critical or difficult might have been disregarded. Efforts to overcome this problem included clear explanations of the study and assurance that the information obtained would be used in a constructive way. The administrators were guaranteed that neither the facility nor participants would be identified in the study's report.

Using the lists of potential participants, successive respondents were selected in accordance with the need to extend, verify initial analysis and fill in data. In addition, participant observation in the long-term care facilities made it

possible to identify participants not included on the initial listing. The sample was expanded until redundancy with respect to information was achieved.

The information provided to all potential participants included the purpose of the study, the time commitment and a guarantee of anonymity. Participants were also informed that their identities would not be revealed to the administrative staff. Those involved in the study signed informed consents (see Appendices E, F, G, and H).

Registered Nurses[2]

Two strategies were used to recruit registered nurse participants. First, they were recruited through a list of names supplied by the administrator of the facility. An information letter was left on their respective work units (see Appendix A) and a follow up phone call made several days later. Second, administrators/designates gave approval for the researcher to speak to groups of registered nurses to inform them of the study, and to request their participation. Nurses were advised of the information sessions through notices posted on nursing units. Five information meetings were scheduled at times to cover day and evening shifts. Since all five facilities only had one or two registered nurses on the night shift, an information letter was left on the appropriate units for these staff members. At these meetings, an information letter was left with those in attendance requesting them to phone the researcher if they were interested in participating in the study, or would like additional information (see Appendix A).

Registered nurses selected to participate in the study had to:

- be employed in a long-term care facility for a minimum of one year,
- have a minimum of a diploma in nursing, and

[2] The female gender is used for all registered nurses to provide anonymity.

- be registered with the Alberta Association of Registered Nurses.

Ten registered nurses participated. Their biographical profile is provided in Table 4.2. One participant moved to another facility during the course of the research and she agreed to continue her involvement in the study.

Table 4.2

Profile of Registered Nurses (RN) N = 10

job title		
educator/manager	3	(30%)
staff nurse	7	(70%)
educational background (highest level)		
diploma only	7	(70%)
diploma/gerontology certificate	1	(10%)
undergraduate degree	1	(10%)
master's degree	1	(10%)
length of time working in long-term institution		
in long-term care	7 to 24 years	
average	13.62 years	
in this specific facility	.3 to 24 years	
average	7.3 years	
attendance at educational session on resident abuse		
yes	8	(80%)
no	2	(20%)

Non-professional Staff

The same two strategies used to recruit registered nurses were also used with non-professional staff. Letters were left on nursing units and information sessions held for them (see Appendix B). Six information sessions were scheduled throughout the afternoon and in the early evening to ensure that staff

working on different shifts could be informed of the study. Two initial information sessions scheduled after the end of a day shift were canceled since no one attended. In informal discussions with non-professional they identified that they were interested in participating; however, family responsibilities meant that they had to leave the facility as soon as their shifts ended. Administrators had initially requested that information sessions were not held on work time since staff attendance was voluntary, and they did not want staff to feel that attendance was compulsory. With the administrators' permission, subsequent sessions were scheduled during the work period and attendance was in excess of ten staff at each one.

Non-professional staff selected to participate in the study had to:

- be employed in the long-term care facility for a minimum of one year,
- demonstrate ability to communicate in English, and
- be able to attend focus group meetings.

Non-professional staff were drawn from a variety of staff positions: personal care aides (PCA), nursing aides, and nursing assistants. Their demographic profile is presented in Table 4.3.

Table 4.3

Profile of Non-Professional Staff N = 11

first language		
English	7	(63.63%)
other than English	4	(36.36%)
length of time working in long-term institution		
in long-term care institution	1 to 17 years	
average	8.8 years	
in this specific facility	.4 to 17years	
average	4.6 years	

attendance at educational session on resident abuse		
yes	11	(100%)
no	0	(0%)

Older Residents

There were approximately seven hundred older residents living in the long-term care institutions used in this study. The number is approximate because of occupancy counts, respite beds, and temporary acute care admissions. Older residents were recruited initially through a list of names suggested by unit supervisors. They were left an information letter (see Appendix C) at their bedsides, and a follow up visit was made several days to a week later. At that time, further information regarding the study was provided and initial agreement to participate obtained. Some potential participants were obtained through three resident council information sessions and others through informal conversations with them on the nursing units. Older residents met the following criteria:

- demonstrated fluency in English (fluency in English is defined as the ability to complete sentences in English either orally, in writing or with a communication device),

- agreed to participate, and

- were cognitively intact with a score of 5 or more on the Kahn/Goldfarb Mental Status Questionnaire.

The latter criterion was important since a large proportion of the resident population in long-term institutional care settings have varying degrees of cognitive impairment. Since older residents with cognitive impairment may have different perceptions of abuse and may experience it differently than other sub-populations of residents, it was important to potentially include them in the study.

However, it was also recognized that those with more severe impairment of orientation, recall, or judgment might not be able to provide reliable information. Participant observation by the researcher identified that the majority of residents in the institutions under study would be unable to meet the criteria for inclusion in the study. The ten item Kahn/Goldfarb Mental Status Questionnaire (Kahn, Goldfarb & Pollack, 1960) was administered to older residents who agreed to be potential participants to measure their cognitive status. For the purpose of this research, severe cognitive impairment was defined as six or more errors on the test. The Kahn/Goldfarb Mental Status Questionnaire (see Appendix M) has been extensively used with the aged and is appropriate for the institutionalized resident because of its brevity and ease of administration (Berg & Svensson, 1980).

A profile of resident participants is presented in Table 4.4.

Table 4.4

Profile of Older Residents N = 11

age	
range	78 – 89 years
average	80.4 years
length of time in long-term institution	
range	2.3 – 9.1 years
average	6.3 years
Mental Status Questionnaire	
range of errors	1 – 5
average errors	3
previous place of residence	
own home	7
lodge	3
other	1

Residents were drawn from a number of different units within the five long-term care facilities. Nine had experienced the loss of a spouse, one had never married, and one was currently married. One participant died during the course of the study. Of the eleven older residents interviewed for the study, six experienced impairment in their communication skills. These impairments arose from physical detriments such as speech deficits related to cardiovascular accidents or ill-fitting dentures. All participants experienced physical health concerns; for example, severe arthritis and Chronic Obstructive Lung Disease (COPD). These factors influenced both the duration of the interviews and perhaps the quality of the data coming from participants. Difficulties with activities of daily living because of physical health problems were the primary reason for admission to the facilities. Of the eleven residents, five stated their families had influenced their decision to enter long-term institutional care. Three of these five participants voiced unhappiness with this decision.

Significant Others

Potential participants from this population sub-group were identified by a facility's social worker or the registered nurse who fulfilled a similar function. They were contacted initially by letter to request their participation in the study. A subsequent follow-up phone call was used to answer any questions and obtain initial consent to participate (see Appendices D, and H). In addition, resident councils, in three facilities, were approached and informed of the study, at which time a request for participants was made. Some participants were obtained in this manner. Significant others were not matched with older residents. Since the perceptions of a culture and its sub-groups were being examined, it was felt that matching was not necessary. Participants met the following criteria:

- had at least one year experience with institutional long-term care,

- were described by either the older resident or staff as the one who is most important to them or who comes in most to visit,

- demonstrated fluency in English,

- were able to attend focus group meetings, and

- were able to participate in group discussions.

The profile of significant others is presented in Table 4.5.

Table 4.5

Profile of Significant Others N = 5

age		
range	44 to 72 years	
average	64 years	
relationship to older resident		
child	2	(40%)
spouse	1	(20%)
family member (other than spouse or child)	1	(20%)
friend	1	(20%)

Significant others included a variety of family members and friends. In one case, a friend was the legal guardian of a resident. No other participants had legal guardians. None of the significant others were related to older residents who participated in the study. One significant other removed herself from the study for personal health reasons, this dropped the number of participants from six to five.

Data Collection and Analysis

The three research approaches used in this study had their own data collection and analysis strategies. Each approach is described in detail. Personal documentation, in the form of field notes and a diary, was maintained throughout the duration of the study and is relevant to all three approaches.

Ethnography

Three data collection strategies guided the ethnographic approach used in this study: participant observation, semi-structured interviews and focus groups. They were used to answer the research questions: *what is resident abuse as perceived by the long-term institutional care culture? How do participants perceive resident abuse? How do participants differentiate abuse from neglect and inadequate care?* and *what differences are there among the perceptions of different population groups?*

Participant Observation

The researcher spent two to three shifts in most of the facilities as a participant observer for a total of twelve shifts. The time spent in these institutions covered a twenty-four hour period. The researcher's intent was to observe and learn about the every day living experiences of staff members, residents and significant others. During the researcher's professional nursing practice in long-term care facilities, it was obvious that different activities and interactional patterns occurred throughout a twenty-four hour period. For example, family members and other visitors usually visited in the early afternoon or late evening period, and various recreational activities occurred on different days and at various times throughout the day. Other examples included: three facilities had newspaper reading groups scheduled between 0830 and 1000 on different weekdays, a weekly evening bingo game or biweekly bingo in the afternoon. Participant observation also provided the researcher with the opportunity to observe the interactions and behavior of several sub-population groups of residents including those with illnesses that produced dementia and those with chronic illnesses that left cognition intact.

At all sites, the researcher informally talked with registered nurses, other care giving staff, residents and significant others. During the period of participant observation, the researcher positioned herself throughout the facilities to gain a greater understanding of the culture, this included sitting in the dining room during meal times, sitting in on change of shift reports, moving throughout the facilities while resident care was being given, and sitting in the lounges or dining areas during scheduled recreational activities. In addition to the scheduled participant observation shifts, the researcher continued to collect observational data when entering facilities to interview participants and conduct focus groups.

Semi-structured Interviews

Participants from the resident and significant other population groups were interviewed. Both groups were thought to offer different perspectives on resident abuse, since one group lived within the institution and the other brought the larger societal perspective into the specific cultural setting of the long-term care institution. The researcher decided that interviews would not be conducted with non-professional staff because they had no supervisory role over staff members, and probably were not involved in the development of policies and procedures related to resident abuse.

An open atmosphere was maintained, by the researcher, during the interviews to encourage participants to speak in detail about their own perceptions and experiences. All interviews were conducted by the researcher herself, in a location and at a time individually negotiated. Three of the five significant other participants chose to be interviewed at the facility where their older adult was located, and two were interviewed at the researcher's office. For residents, interviews were scheduled to fit in with their daily routines. Early morning, late

evening and meal times were avoided because of the activity on the units at these times. For older residents who shared rooms, an alternative location was found.

Two interviews were conducted with each person in these two population groups. The first one was to obtain data related to the concept of resident abuse. In this process, two types of questions were used to obtain a balanced perspective. One was about the kind of behavior towards older residents within the long-term care institution that the resident/significant other liked best, the other about the kind of behavior liked the least. Using the terms described as "like best" and "like least", avoided emotive terms such as good and bad, satisfactory and unsatisfactory, although it was expected that respondents would describe behaviors which they perceived to be good or bad, satisfactory or unsatisfactory. This study does not show degrees of satisfaction with behavior but in discussing the kind of behavior towards them that were "like best" and "like least", participants indicated what type of care they prefer. This discussion led into the question of what type of behavior was perceived as resident abuse.

A set of guiding questions (see Appendices J and K) created by the researcher helped to focus the interactions. The guidelines were developed in the following manner:

- the actual behavior towards an older resident must have been identified,
- the behavior must have been observed by the participant, and
- the participant had a definite judgment about the criticalness of the behavior (the second part of the question, *"tell me about the way you are treated that you like the best?"* addressed this concern), and

- the participant clearly explained the significance of the behavior towards the older resident.

The second interview provided for follow up and validation of data with the participant. Each interview lasted about forty-five minutes to one hour. All interviews were audio taped. After each interview, the audio-tapes were transcribed and analyzed. At the beginning of the first interview, biographical data on the participant was obtained (see Appendices P and Q); such data included: age, sex, length of stay in institution (where appropriate), and relationship to older resident (where appropriate).

Focus Groups

The views of the four groups (registered nurses, non-professional staff, significant others, residents) were collected through population specific focus groups. Two to three focus sessions per population group were conducted. A minimum of four persons attended each focus group. At the request of one long-term care institution's resident council, a combined focus group of residents and significant others was conducted.

A set of guiding questions (see Appendix L) by the researcher helped focus the interactions. The focus groups were held about two to three weeks apart. A summary of the discussion generated in the first meeting was sent to each participant prior to the second one. These summaries were intended to encourage focus group members to clarify or correct any mistakes in the researcher's part in understanding of the issues discussed. Those attending were phoned twenty-four hours before their scheduled focus group to remind them of the time and location. However, the number of attendants was not consistent from one focus group meeting to the next. Working shifts, changing work

schedules, and last minute family needs, prevented some registered nurses and non-professional staff from attending both their scheduled sessions. One scheduled focus group for non-professional staff was canceled because of work action. A winter storm also reduced the number of people at one combined focus group of residents and significant others. For each focus group, the researcher provided coffee, juice and a snack. Each focus group was audio-taped. For the non-professional group, biographical data was obtained and consent forms signed at the initial focus group (see Appendices F, and O), since the members had not participated in individual interviews. Written notes were made immediately after a group had finished.

The details of the focus groups are provided in Table 4.6.

Table 4.6

Focus Groups

Sub-group	Focus group	No. of participants
registered nurses	1	4
	2	6
non-professional staff[3]	1	5
	2	8
	3	6

[3] Some non-professional staff chose to attend, but did not complete either the biographic data or consent forms.

older residents	1	4
	2	18[4]
significant others	1	18[4]
	2	10[4]

Data collection and analysis occurred concurrently, which enabled the researcher to focus and shape the study as it proceeded. As data analysis began, the researcher created two types of files. The first file type held analytic data. For the analytic data, colored file cards with segments of collected data on them were used. On the cards, the researcher identified, in pencil, preliminary coding categories. This was helpful since the researcher was able to develop and refine her questions for subsequent data collection. The file cards were colored coded to identify which population group the data had come from, and colored dots indicated whether it came from a focus group, interview, or participant observation. A quotation file, also using file cards, was created to contain quotations from the data that might eventually appear in the dissertation. The population group and whether the quote came from an interview or focus group were identified on each card.

Continuous reflection on the data helped the researcher to learn from it. Analysis involved replaying each audio-tape of an interview or focus group, and reading each transcript and set of field notes to identify themes and relationships between them numerous times. Through continuously questioning and reflecting on the collected data, initial coding categories suggested by the researcher

[4] Some residents and significant others chose to attend, but did not complete either the biographic data or consent forms

emerged into patterns and sub-patterns. These patterns and sub-patterns came from the language of the data. Through a progressive process of reflection, sorting, defining and re-defining, the patterns were organized into a conceptual model of resident abuse (see Chapter 5).

Ethnoscience

In reference to the registered nurse participant group, semi-structured interviews were conducted. While it was anticipated that three interviews would be required, it was identified during the study that only two were necessary for most participants. The first step in data collection was to formulate questions to ask that were culturally relevant and meaningful (Spradley, 1979). This was done in the first interview, by listening to participants as they answered the guiding questions (see Appendix I) asked by the researcher to elicit their perceptions of resident abuse. Probing was done to increase understanding of the answers to some of the questions and comments made by participants. In some cases, the researcher asked the participant if a word was similar to another term. For example, "slapping" and "hitting" were seen as similar by participants, as was "yelling" and "shouting". While "talking loudly" was not viewed by participants as similar to "shouting".

In the second interviews, participants were presented with the key terms they had produced during their first interviews. They were asked to sort and stack the file cards on which these terms were printed into the three categories of resident abuse, neglect and inadequate care. Participants were then asked how these categories were similar or different from each other. A frequency count was conducted to establish the most common terms for each category. Participants then sorted each category of terms into sub-categories and then into behavioural

clusters. The researcher probed each category, sub-categories and behavioural clusters with participants until their categorization scheme was fully mapped. The researcher coded the back of each file card with a symbol to indicate how an individual participant had sorted it. These codes were not shared with the participants; they were used to help the researcher in her data analysis, and to provide for comparison of participants' responses. A frequency count was again done after each participant had sorted the file cards into sub-categories and behavioral clusters.

Frequency counts assisted the researcher in shaping the emerging taxonomy of resident abuse. Their use also helped the researcher to validate the categories, sub-categories and behavioural clusters with the participants themselves. Participants were encouraged to verbalize their thinking processes as they sorted; for example, they were asked how one sub-category of terms related to another within the primary category of resident abuse, or why one key term was placed into one category pile and not another. Probing and clarification were used to increase the researcher's understanding of how decisions were made regarding the categorization and sub-categorization processes. When participants experienced difficulty deciding which category or sub-category to put a key term into, they asked to elaborate upon why they were experiencing difficulty. A rough taxonomic ordering based on several organizing principles (inclusion, difference, similarity, cause, intent) emerged from the data collected from the participants. The researcher then refined and articulated the taxonomy from her understanding of the participants' perceptions and structuring processes (see Chapter 5).

All interviews were conducted by the researcher, in a location and at a time individually negotiated. Seven of the participants chose to be interviewed at their facility, and three were interviewed elsewhere. An interview lasted about an hour to an hour and a half. Interviews were audio taped. After each interview, the audio-tapes were transcribed and analyzed. Biographical data on participants was obtained in the initial interview (see Appendix N); such data included: age, sex, educational background, and work experience.

Content Analysis

The third research approach used in this study was a content analysis of the professional literature, Alberta and federal government legislation, and long-term care institutional policy and procedure documentation related to resident abuse (see Chapter 5 for description of data used). The researcher used all the documents that she could obtain. She considered it inappropriate to use either random or quota sampling because of the limited amount of available data on resident abuse. She also considered it important to draw her sampling from a variety of sources.

The reference citation for each document was printed onto a file card, which was coded by colored dots to identify the type of data source (i.e. book, legislation), and whether it was research, theoretical; or anecdotal in content (see table 5.1). While this was a somewhat cumbersome process, it permitted the researcher to have greater ease in viewing larger segments of data. Each of these documents was read and re-read to obtain a sense of the whole. It was then coded as to the definition of resident abuse used by the author(s), types of situations identified as being abusive, and the presence or absence of the categories, sub-categories and behavioral clusters identified through the

ethnological analysis of data from this study. Coding was initially done onto the file cards.

After coding, the data was analyzed by use of a matrix (or grid) developed by the researcher. Identified on one side of the matrix were the citation sources, while on the other side were the coding categories used by the researcher. The use of a matrix enabled the researcher to have a visual schema which assisted her to make meaning of the data, in addition to exposing gaps in the data. The matrix also enabled the researcher to look for patterns, similarities and differences between the literature and the collected data.

Personal Documentation

Data collection was enhanced through personal documentation for all three approaches. Field notes were maintained throughout the study to "identify ideas on relationships within the data, which then provide a beginning cross-check for later analysis" (Field & Morse, 1985, p. 79). These notes related to the following factors: emotional state of the participant, non-verbal behavior, any interruptions to the flow of the interview, an overall impression of the strengths of the interview, and areas of concern or those that require follow up. A diary was kept to record personal insights and perspectives gained during the course of the research, including reflective thoughts that arose from the content analysis of the literature.

Rigor

Qualitative research must adhere to the standards of rigor (Sandelowski, 1986). The rigor, or scientific adequacy, of this study is demonstrated in three domains: (1) method, (2) data, and (3) researcher. While these domains are isolated for purposes of discussion, in reality they are integrated and interrelated.

Method

The qualitative research approaches used in this study (ethnography, ethnoscience) and content analysis are structured by principles that endow them with the systematic and disciplined quality that is requisite to the search for knowledge. Each approach required certain steps, in a certain order, according to certain rules.

In addition to this inherent attention to rigor, other aspects of the study's method demonstrate adherence to it. Using several long-term care institutions provided a sample of participants with a range of perceptions of resident abuse. Four data collection strategies (participant observation, semi-structured interviews, focus groups, and field notes) provided for a range and depth of information to be obtained. Using divergent strategies to examine the research question provided credibility to the findings. Data from the initial focus meeting with each population group was verified with participants by giving each a copy of the transcript and inviting them to discuss it at the next focus group. Verification increased the likelihood of gaining a true perspective on the meaning of resident abuse.

Field notes by the researcher that document the research context, methodological decisions made, analysis process and the researcher's personal response to the study (Rodgers & Cowles, 1993) provided assurance of the reliability and validity of findings (Sandelowski, 1986). As each participant replied to the questions, or conducted the card sorting, differences in facial expression, tone of voice and body posture were noted and recorded later in the field notes. In implementing these aspects of the study's method, rigor was enhanced.

In addition, replication of the research is possible because of the clear identification of the research approaches, including the data collection and analysis procedures used in this study.

Data

All the information gathered came directly from participants, allowing the researcher to avoid superimposing (knowing or unknowingly) her own biases and frames of reference (Bush, Ullom & Osborne, 1975). Stability of participants' responses (Brink, 1991) was enhanced by asking the same questions during the interviews (see Appendices I, J and K) and focus groups (see Appendix L). In collecting the data, the problem of reactivity due to the researcher's presence had the potential to affect validity (Denzin, 1978). This problem was addressed through the use of several interviews and spending time with each participant to develop rapport prior to the start of the interview. The concepts developed using interviews and focus groups are valid since they are derived from the participants (Morse, 1991) rather than being imposed onto the research situation by the researcher.

Researcher

The potential for researcher bias was acknowledged during the design of the study. While the researcher is a registered nurse with previous experience in long-term care institutions, the study was not conducted in a facility to which she was affiliated. There was a need to monitor constantly the impact of her own expectations and biases on the data collection and analysis process. These were documented in the researcher's field notes.

The researcher adhered to consistent and documented data collection and analysis procedures. While the use of a sole investigator enhanced consistency

of the questioning process, analysis of data by the researcher alone supported potential bias. In addition, the possibility of random error exists in single person analysis. Consequently, data analysis was conducted under the direction of two of the researcher's committee members who monitored accuracy and appropriateness of the emerging categories and sub-categories. Triangulation of data from the three research approaches (ethnography, ethnoscience and content analysis) minimized loss of objectivity and provided a more complete understanding of the research questions.

In summary, qualitative research such as this study, into the understanding of resident abuse as perceived by members of the long-term care institutional culture, must adhere to the criterion of rigor to ensure that the research process and outcomes are well grounded, defendable, compelling and relevant.

Ethical Considerations

The procedure for obtaining consents has been previously identified. Ethical clearance for this research was obtained from the Ethics Review Committee, Faculty of Nursing, University of Alberta. Specific steps were taken to ensure confidentiality and to protect the rights of participants (see Appendices A, B, C, D, E, F, G and H). None of the five long-term care institutions required the researcher to obtain ethical approval other than from the Ethics Review Committee. While not requested by any site, the researcher supplied each long-term care facility with a copy of the Ethics certificate, and a summary of the approved proposal for their information, prior to the start of the study.

Confidentiality of all recorded and transcribed material was ensured through the use of codes. No identifying information was provided on any material reviewed by the researcher's supervisor or participants. All material was kept in a

locked file during the course of the study and will be for seven years after its conclusion. A decision will then be made as to whether it will be destroyed.

An unexpected situation arose during the combined focus group of residents and significant others. Prior to starting the discussion for the first group, the researcher reminded the group that they were participating in an approved research study. Information letters were again distributed, in addition to the consent letters and biographical forms for those potential participants who had not been previously interviewed. Participants were given the opportunity to ask questions and to leave the group. No one left. Those present agreed to have the session audio taped. When asked by the researcher if anyone did not want the session taped, no one replied. Despite these strategies to ensure that ethical research standards were met, several participants did not complete any of the forms. For those who did not sign the forms, their presence implied their willingness to participate in the study.

It was of utmost importance to assure participants that strict confidentiality would be maintained with respect to data collection. It had been anticipated, prior to the start of the study, that the need would arise to refer participants to professionals, other than the researcher if concerns emerged during the period of this study. When concerns arose from two registered nurses, they were asked if they wished to follow up through the management structure of the institution in which they were employed. They were advised that perhaps the administrative staff would like to address the voiced concerns, and that interaction with them may have positive outcomes. When both registered nurses declined, it was suggested to them that they contact the Alberta Association of Registered Nurses (A.A.R.N.) and talk to the Nurse Consultant - Practice. They were assured that referral was

voluntary, would not be communicated to anyone in the long-term care institution, and that the researcher herself would not follow up with the A.A.R.N.

Non-professional staff, older residents and significant others were asked if they wished any concerns to be followed up with the administrator of the facility, or the appropriate designate, for example the social worker. One significant other stated that she would assume the responsibility to do so, while another identified that she had already discussed her concerns with the administrator of the facility. Two participants from the resident population group also indicated that they had previously discussed their concerns with the facility's administrative staff. Of those participants who had discussed their concerns, all stated that they had not been addressed to their satisfaction. It was pointed out to residents and significant others that the Alberta Association of Registered Nurses has as part of its mandate the protection of the public, and concerns may be expressed to this association through the Nurse Consultant - Practice. None of the non-professional staff who participated belonged to a professional association although all belonged to a union. Four staff identified to the researcher that they had previously addressed their concerns to their union representative. The participants identified no indication of the outcome of these discussions nor did the researcher ask.

No participant voiced a question about whether a cited example of resident abuse required legal action. In three of the facilities, the social worker was designated as a neutral body and it would have been appropriate for the researcher to suggest to participants that their concerns should be discussed with this individual. In one interview with an older resident, and in another with a registered nurse, the researcher was unsure how to respond to a question; this

was indicated to the participant. In both instances, the researcher returned to talk to these participants about the situations and each one said that they would not be pursuing their concerns. Each one voiced to the researcher that they had needed to express their anger and that she was a "safe" person to hear it.

Limitations

There are limitations to a study of this type. It was difficult obtaining participants in several of the population groups. No non-professional staff attended focus groups that were scheduled after their work shifts. This was true whether the sessions were scheduled at the end of the day shift, or on the evening one. This lack of attendance was similar to the problem experienced at information sessions scheduled for this same population group. Administrative staff were aware of this fact, and permitted the researcher to hold the focus groups over the lunch hour. The researcher purchased pizza for the non-professional staff for each of the three focus groups held. Information sheets posted on the units informed them that the focus groups would be held during the lunch hour. When staff showed up, they were advised that their attendance at the session would identify to others in the facility that they had participated, and if they wished they could take their pizza and eat it in the staff lounge. Some chose to take the pizza and leave, others stayed. This was a successful strategy to obtain non-professional participants. However, it prevented non-professional staff who worked permanent shifts, other than days, from attending. They may have provided different perspectives on resident abuse because the work requirements and the care needs of residents differ among shifts. The length of the focus groups was restricted to less than forty-five minutes because of the duration of staff lunch breaks; this limited the amount of data collected.

It was also difficult obtaining significant others. Potential participants canceled six initial appointments made at a time and location suggested by them. Four of these were re-scheduled, and one of these potential participants canceled again. Two potential participants chose not to participate when the researcher attempted to re-schedule the interviews. Attendance at the second interviews was more consistent and only two were re-scheduled at the request of participants. The primary reasons for canceling were the weather conditions (snow), related transportation difficulties, and personal health needs.

Registered nurses working in long-term care institutions do so at the administrative/managerial level, or as staff nurses who have more direct supervision of non-professional staff and more resident contact. The inclusion of two sub-groups within this population group provided for greater breadth of perceptions of resident abuse. The small number of registered nurses working as staff nurses was a limitation of the study. There may be only one or two of them on a nursing unit. While administrative/management staff appeared eager to participate, it was difficult getting staff nurses to participate. The initial plan to use three facilities was extended to five to gain access to a potentially larger sample pool. The researcher believed that if the registered nurse population group was comprised primarily of managerial staff, this might influence the credibility of the findings.

Interviewing older residents posed threats to internal validity. Some participants, in this population group, sought answers from the interviewer and their expressed views may have been what they felt the researcher expected or wanted to hear. They may have given positive responses due to a lack of readiness to express criticism of the long-term care institution or staff, or perhaps

feared retaliation. While the doors of their rooms were closed during the interviews, staff frequently entered the room without knocking, and this may have threatened residents. Personal characteristics of older residents may have contributed to vague or insufficient interview data. One resident required an analgesic during the interview. Two others required assistance to the bathroom. These needs may have affected their ability to concentrate on the questions asked by the researcher. Four residents required hearing aids, and this may have influenced their capacity to hear adequately and respond to the questions of the researcher. With older adults, rephrasing of the questions by the researcher was common. Validation of understanding of the question was a frequently used communication strategy with this population group.

The researcher also felt some significant other participants were reluctant to talk freely. It was clear that despite assurances that participation would not influence the care received by an older resident, some participants felt threatened or pressured to participate. Two participants voiced this feeling when asked by the researcher. They may have felt pressed to participate in the study. They were given the option of withdrawing from the study but declined. This concern was addressed in both the information letters and consent forms that were distributed to them, and in assurances of confidentiality.

Despite a closed conference room door, on-site focus groups for non-professional staff, older residents and significant others may have influenced the freedom of participants to talk, since they perhaps felt that their comments could be overheard by professional nursing staff and others. This limitation did not apply to the focus groups for registered nurses since both sessions were held off site.

Restructuring of Alberta's health care system was still underway during the initial period of this study. Budgets for all five long-term care facilities were negatively affected. This might have caused some registered nurses distress that was perhaps reflected in their responses. Threats of legal job action from non-professional nursing and other long-term institutional based unions were voiced during the course of this study. Several non-professional staff expressed anger at changes in their job descriptions and work schedules, and in management re-structuring practices. Consistency of interviewing and establishment of rapport addressed this limitation.

Reluctance and/or inability of significant others to attend scheduled focus groups led to the suggestion from one resident's council of a combined focus group of this population group with older residents. All of the participants agreed to participate when this group format was discussed with them. The combined focus groups of older residents and significant others had not been part of the original design of the study, and this may have influenced the findings. One participant population group may have influenced the other, however, this did not seem to be the case, as contributions to the discussion were linked to individual participants and not to groups. A combined group also prevented residents from four of the long-term care institutions from participating since it was not possible to arrange transportation. Significant others from several of the facilities did participate, and thus focus group membership was not limited to one site.

The small sample size of each participant group is a limitation of the study. However, the number of participants in each group continued until data saturation was achieved. For most population groups used in the study, their age, gender,

and ethnic backgrounds were very similar. The greatest ethnic diversity was in the non-professional group.

Partly because of the small size, findings are transferable with caution to other long-term care institutions. All institutions used in the study were from within one Regional Health Authority, and in one urban center. It is unreasonable to assume that these long-term institutions are totally similar in nature to rural ones or even to other urban ones because of such differences as size, staff and resident populations, and ownership. However, there are some similar characteristics across all long-term institutions; for example, registered nurses and non-professional staff are employed within them, many residents are over the age of 65 years, family members visit, and policies and procedures are used to regulate institutional life. This suggests that findings can be transferred with caution to other long-term care facilities, or as Lincoln and Guba (1985) wrote "the degree of transferability is a direct function of the similarity between the two contexts" (p. 124).

Another limitation to the study was the use of the 10 item Kahn/Goldfarb Mental Status Questionnaire (Kahn, Goldfarb & Pollack, 1960) which was administered to potential resident participants. A preliminary interview when this tool was administered eliminated six residents who had appeared able to communicate with the researcher. For all participants, the question consistently answered incorrectly was "who was the Prime Minister of Canada before the current one?" No one replied "Kim Campbell". While this tool does provide information regarding cognitive status, it does not acknowledge the realities of the long-term care institution. Four of the residents ruled out as participants because of their scores were able to correctly answer the name of the staff person who had

helped them during the day, perhaps with their breakfast or getting dressed, and could name their roommate. It is probable that such abilities are a more reliable indicator of effective cognitive functioning than performance on the Mental Status Questionnaire. While it was possible to initiate strategies to minimize the effect of some of the limitations, not all could be addressed.

Summary

A qualitative method was chosen to gain a rich and in-depth understanding of the phenomenon under study. The specific research approaches of ethnography, ethnoscience and content analysis were used to understand how resident abuse is perceived within the long-term institutional care culture. Data was obtained through participant observation, semi-structured interviews and focus groups with registered nurses, non-professional staff, older residents and significant others. The use of different cultural sub-groups of the long-term care institutional setting and multiple research approaches contributed to the rigor of the data.

Chapter 5

Data Analysis: Findings

The purpose in this chapter is to present the results of the data analysis obtained through the method described in Chapter 4. A brief overview of the findings is presented in the first section[1]. To answer the research questions, *what is resident abuse as perceived by the long-term institutional care culture* and *how do participants perceive resident abuse,* a detailed description of the patterns of meaning of resident abuse that emerged from the data is presented in section two. The differences between abuse, neglect and inadequate care as perceived by participants in the study are discussed in this same section. In section three, the importance of personhood is discussed. In the fourth section, registered nurses' perceptions and a taxonomy based upon their verbal descriptions of resident abuse is presented. In the fifth section, the contextual sphere of practice and its relationship to resident abuse is described. This provides further exploration of how participants perceive resident abuse, and how they differentiate it from neglect and inadequate care. In the final section, the results from the comparative analysis of the theoretical, anecdotal, and reviewed research articles are presented.

Participants' Perceptions: Overview of Findings

The analysis of the data on resident abuse within the culture of long-term care institutions was challenging, frustrating and ultimately insightful. While the

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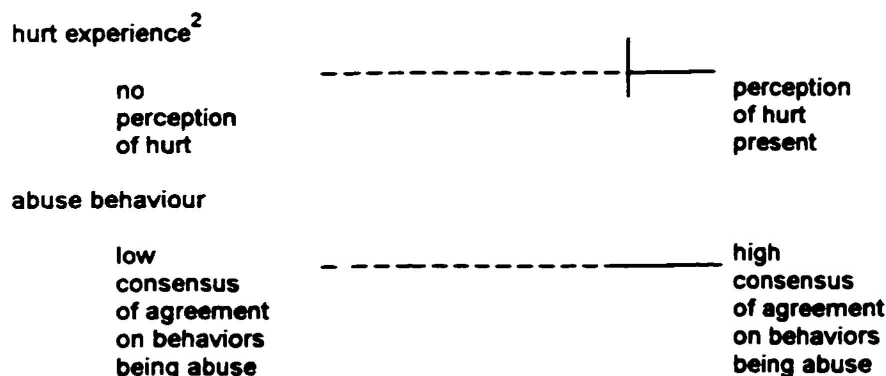
[1] The feminine gender is used regardless of the sex of the participant to preserve anonymity. In cited examples, the sex of the resident, significant other or other cultural member is also feminine for this same reason. Analysis of responses from male and female participants identified no gender differences.

perception of any act of resident abuse is personally and uniquely defined, its meaning has an universality coming from the patterns that are found among descriptions of the experience. Participants perceived resident abuse as an experience comprised of two patterns of understanding: "hurt experience" and "abuse behavior". These patterns are illustrated in figure 5.1.

Figure 5.1[2]

Participants' Perceptions of Resident Abuse



Each pattern is described and selected examples provided for illustration.

The first pattern is "hurt experience". In the collected data, a clear conceptual delineation emerged in the perceptions of participants from all sub-groups between neglect and resident abuse; the delineation indicator (solid vertical line in diagram 5.1) is a perception of hurt. This helped to answer the research question of how participants differentiated abuse from neglect and inadequate care. If hurt was felt by the resident, the behavior was perceived as resident abuse; for example *the nurse reached over and pinched her [resident's]*

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[2] the dotted line suggests the individual perceptions of the participant; the solid line implies consensus of opinion. The vertical indicator that separates the dotted and continuous lines on the abuse behavior axis denotes the clear delineation of participants of the difference between neglect and abuse.

cheek, you could see her [resident] wince (SO)[3]. However, if there was no perception of hurt, the occurrence was described as neglect by participants. Neglect is the failure to meet the needs of the older resident in the absence of hurt; for example *[staff] didn't wash the resident's hands after she's gone to the washroom* (NP). The resident's need for personal hygiene and safety were not met; however there was not a perception of hurt in this experience.

Integral to the "hurt experience" pattern is a relationship between two individuals, often of different sub-groups within the long-term care institutions. Consistent in participants' perceptions of resident abuse is that a transgression of "acceptable" standards governing interpersonal relationships has occurred. An example of acceptable behaviour cited by an older resident illustrates this point, *treat them like you would a fellow Christian* (OR). Another participant said *they treat me like I'm stupid* (OR). In contrast, a resident's significant other described an instance of unacceptable behaviour as *[staff] walking past and not talking to them [residents], that's not right* (SO).

The second pattern identified is "abuse behaviour". Participants identified a variety of behaviours that they perceived as possibly abusive in nature. These descriptions were provided by registered nurses, significant others, non-professional staff and older residents and were similar across population sub-groups. They cited behaviours that were both physical and verbal in nature including the following: *pinching the hand* (SO), *gripping too hard* (NP), *breaking the leg* (NP), *breaking the arm* (RN), *yelling* (RN), *shouting* (SO), *skin tears* (RN), *derogatory language* (RN), *use of restraints* (RN), *shoving* (NP), *leaving them in*

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[3] Quotations are in italics, and are identified as to participant source: RN = registered nurse, SO = significant other; OR = older resident, NP = non-professional staff; RO = researcher observation

pain (NP), *standing at the desk gossiping when you could answer the bell* (SO), *not helping a resident because you don't like them* (RN) and *pushing the step stool away so her feet were just left dangling* (SO). While participants included physical and other behaviors when discussing their individual definitions of resident abuse, they were not consistent in their perceptions. The "low" end of the "abuse behaviour" axis reflects lack of consensus among participants as to whether the cited behaviour was abuse (illustrated by a dotted line); the "high" end corresponds to widespread agreement (illustrated by a solid line).

Participants perceived the occurrence of abuse was influenced by what the researcher termed the "personhood dimension" of a resident. This dimension may also be viewed as an axis. At the "low" end of this axis, there is devaluation of the older resident; a failure to demonstrate respect for the person and to appreciate individual uniqueness. To illustrate, a registered nurse said, *there is no valuing of the older adult, no treating them like a person* (RN). At the "high" end of the axis is valuing of the intrinsic worth of an older resident, and recognition of uniqueness. As one significant other replied, *you need to like older adults to work with them* (SO).

Movement along the axis of this dimension is possible. As participants indicated more consensus in what they perceived as basic human rights and how to treat older residents, they moved towards a "high" level of acknowledgment of personhood. In other words, they showed more commitment to the values of personhood. Participants themselves assumed different positions along this axis, some expressed a "high" level of acknowledgment, *respect should be integral to what we do to older residents* (RN), and *we are talking about people, with needs, and not what they need done to them* (SO). Others occupied lower positions on

the axis, *if they act like babies, then they should be treated as babies* (NP), and *they have to give respect to get respect* (NP). The "low" end of the axis indicates little or no acknowledgment of the personhood of older residents and other participants. There was no difference among the participant sub-groups in the positions they occurred along this dimension. This finding helped to answer the question as to what differences in perceptions might exist among them.

Participants identified that the "personhood dimension" of a resident was influenced by movement along the axis of the two patterns integral to their perceptions of resident abuse. An example is drawn from the "abuse behavior pattern". Greater uncertainly in participants' perceptions as to whether a behaviour was one of resident abuse was indicated by a shift towards the "low" end of the axis. As the uncertainly increased, there was a similar downward shift in the "personhood dimension" axis. There was less acknowledgment of the personhood of older residents. The converse was also true, as consensus grew that a behaviour was an example of resident abuse, greater acknowledgment of the personhood of residents was heard from participants.

Perception of the occurrence of resident abuse is strongly influenced by the context in which it occurs. For example, a participant said; *you have to look at the situation in which the behavior occurs* (RN) and *you have to recognize that many of our residents have behavioral problems* (RN). Another participant stated, *it may look like abuse but you have to know the resident and see how he reacts* (NP). An older resident recognized the difficulties caregivers faced and said: *you can understand why staff lose their tempers at times and shout* (OR). Such responses suggest contextual factors influenced participants' perceptions of resident abuse, *while one person may call it abuse, another may not* (RN), and *it*

depends on the person, they might need to be restrained and it wouldn't be abuse (RN).

Participants suggested the attitudes of administrators or those perceived as being in positions of authority are contextual factors, and as such have the potential to contribute to resident abuse. When tensions between cultural members are high, staff are unlikely to perform at their best, *they [RNs] don't listen to us, when we tell them that the resident is in pain, and that's abuse* (NP). A family member said *they [staff] shudder when I come in* (SO). The structure of long-term care institutions including their administrative organizations, the interrelationships of cultural sub-groups and the physical structure of the facility all influence resident abuse.

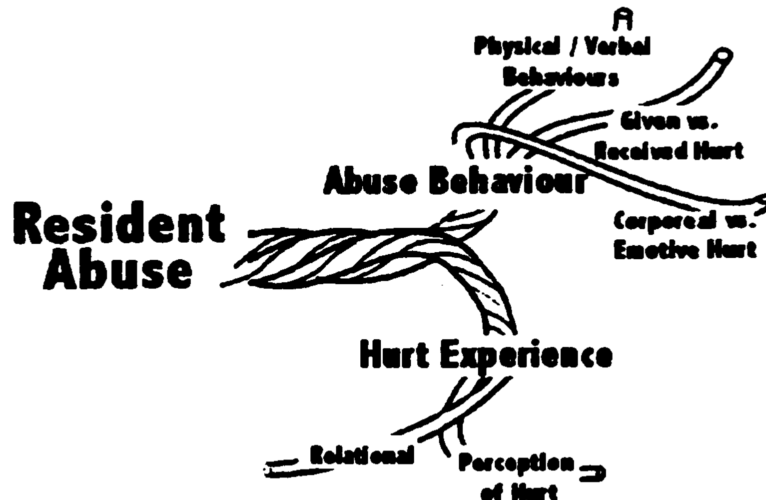
Ethnoscientific analysis of the data resulted in a taxonomy of resident abuse behaviours with the main traits being perception of hurt, commission and omission, context, intentional/deliberate and unintentional, and behavioural clusters. These are described in detail in figure 5.2 and in the taxonomy, figure 5.3.

Participants' Perceptions of Resident Abuse

While the overview of the findings provided a brief commentary on the patterns, this section elaborates upon them. Two patterns emerged from the data during analysis: "hurt experience", and "abuse behaviour". A schematic of the patterns and the threads that resident abuse contains is provided in Figure 5.2.

Figure 5.2

Schematic Representation of Resident Abuse



There is a connectedness of the patterns and threads integral to resident abuse, the personhood dimension of an older resident, and the context of the long-term care institution. Participants from all four sub-groups (registered nurses, non-professional staff, older residents, and significant others) demonstrated a back and forth movement between describing resident abuse and reflecting upon context.

Hurt Experience Pattern

In the data, a clear distinction was made by participants from all sub-groups between resident abuse and neglect, and between care "liked best" and "liked least". This helped to provide an answer to one of the questions in this study, as to how participants differentiated between resident abuse, neglect and inadequate care. Participants' perceptions of resident abuse and neglect were

sometimes contrasted with inadequate care. Expectations of care were held and articulated by members of all the different population sub-groups. These expectations addressed how participants should act towards one another, *kindness, respect, gentleness are all important* (RN), *you should be treated according to the golden rule* (OR), *you can tell when they care about you* (OR), and as one daughter said *they [staff] never talk to me or to my mum except to tell her to do something, and sometimes they just do it and don't tell her - that isn't right* (SO). Expectations also included how care should be given, so that needs of older residents could be met. For example, *you need to make sure they are dry, and not let them go around in wet pants* (RN), and *you don't check a resident's panties in the dining room to see if she's dry, that's just not thinking [about the resident]* (NP).

However, participants also declared that, at times, these expectations are not met, *sometimes it is just a bad day and you say something [to a resident] you know you shouldn't say* (NP), *you just can't give them that second cup of coffee sometimes when you have a floor full of residents* (RN), and *when it's a real difficult resident, it takes longer to answer their call bell* (RN). Such statements reflect the perceptions of caregivers as to what is neglect within long-term care institutional settings. Neglect is the failure to meet the health needs of older adults, including a wide range of physical, psychosocial, and spiritual requirements. These previous statements indicate that staff participants were aware that they had not met some residents' needs.

The following quotes illustrate this failure to meet needs from the residents' perspective, *I liked to be talked to* (OR), *When I need my oxygen tank replaced, you have to tell them [staff], they shouldn't have to be told* (OR), *I'm not a child, I*

don't need to tell them where I'm going, when I'm leaving (OR), and *they [staff] aren't very friendly, I liked it better on the other wing, they were more friendly* (OR). Indicators of neglect from other participants included: *you're just to busy to answer the bell right away* (RN), *they hurry me* (OR), *not wiping the food off the chin* (SO), *they [staff] just left her there crying in her chair, and did nothing* (OR), and *using my mum's sleeve to wipe the bits of oatmeal off ... she was left with a dirty sleeve* (SO). In describing the latter example, the significant other showed obvious distress, as the pitch of her voice and the pace of her words increased. Her posture straightened. She then described what she would have liked the staff to have done, *just given her a gentle little warning that she had some food on her chin. A warm, wet face cloth or even a clean paper towel would have been more appropriate than the sleeve. Mum's dignity would have been maintained. It would only have taken a few extra seconds* (SO).

Neglect is caused by personal actions of various people within the long-term care culture. Staff and residents suggested that they had to accept responsibility for neglect; *they [nonprofessional staff] should know better* (RN), and *they [administration] tell us all the time about needing to communicate with residents* (NP). Another example of perceived cause is *they [nonprofessional staff] do not have the understanding of English that they need* (SO), or as one resident said *[staff] can't even speak the language* (OR). One significant other felt neglect was caused by those staff who saw their role as caregivers and not as nurses, *it's a job for them, they leave right on time* (SO).

In articulating perceptions of neglect, participants differentiated it from inadequate care that occurs because of contextual factors, specifically organizational and/or structural variables, outside of their personal control. This

differentiation was most evident between the two population sub-groups of registered nurses and non-profession staff. It was not as evident in the perceptions of the older resident and significant other sub-groups. One often cited factor was inadequate or unprepared staff, *I often work short staffed* (NP), *outside agency staff come in and they are awful to work with* (NP), and *they are just rushing about all the time* (OR). A second factor is administrative actions, *they are carrying out the orders of other staff* (SO), while another participant said, *you have to do as you're told, or you get a warning and it goes on your file* (RN), and *they [administration] don't like us challenging them or the system* (NP).

When does neglect become abuse? From this study, participants identified that neglect becomes abuse when the older resident perceives hurt. This was how they differentiated between the two experiences - answering one of the research questions posed in this study. Perception of hurt was defined as pain of any type, including corporeal and emotional, felt by a resident. As one participant said, when asked to differentiate between neglect and resident abuse, *their dignity is damaged [in abuse]* (RN). Another participant replied *you could see the pain in her eyes when she was shoved into the chair* (NP). Perception of hurt may be voiced by a resident or by another cultural member on his or her behalf. It arises from the deliberate pain-inflicting actions of another; however, it may also be caused by behaviours of cultural members that were intended to be caring in nature. "Perception of hurt" is one of the two threads observed within this "hurt experience" pattern. The second thread identified in the data is termed "relational". Relational is defined as an association between two individuals. Each thread will be discussed in detail as it relates to the perception of resident

abuse held by participants, and used by them to differentiate such an experience from neglect and inadequate care.

Thread 1: Perception of Hurt

Perception of hurt is a clear indication of resident abuse in the views of all participants, across all sub-groups. If there was no perception of hurt, the experience was described as neglect, a failure to meet the needs of the older resident in the absence of a perception of hurt. Participants stated that they may through their actions deliberately cause resident abuse. It may also be the unintentional result of caring actions. As participants said, *hurt is an outcome of resident abuse* (RN, NP) *it makes you feel bad inside* (OR), and *I saw a PCA [personal care aide] just shove the male resident into the chair, the PCA was quite vicious* (RN). Other participants said *although the staff did not mean to hurt, the resident was in pain and that's abuse* (RN), and *you can cause abuse without meaning to* (NP).

Acknowledgment was voiced by some participants that residents might not be able to perceive or voice hurt because of their cognitive inability or physical decline. As one staff nurse said *they might not know they were hurt, but they were still hurt* (RN). Registered nurses and participants from the other population sub-groups studied defined and articulated the hurt on behalf of the older resident. As one participant said, *you can tell when it hurts* (RN), or *I heard the bone snap when she [resident] fell* (NP), and *I've known my mother all my life, I know when someone or thing has upset her* (SO). Some participants indicated that *sometimes they [residents] will complain that you have hurt them, but most don't* (OR), or *they might grumble or cry out when you move them, and maybe they're in pain, you don't always know. It could just be a reaction* (RN). This interaction,

between action/behaviour and perception of hurt, identifies a relational component to the "hurt experience" pattern.

Thread 2: Relational

A relationship is not something participants have, as if it were a possession, but rather it is the way in which they relate to and interact with others. It implies a sharing between them. All members of the population sub-groups studied enjoy many of the relationships they have with other participants, for often they are perceived as family and friends, *we are like family to them* (RN), *we see them [residents] more often than their families do* (NP), *in her present state they [staff] probably know my mum better than I do* (SO) and *she [staff] took me Christmas shopping on her own time* [staff member off duty] (OR).

Resident abuse is a shared experience, because one party acts or fails to act, and one receives. This finding was consistent among the population sub-groups studied. The hurt of resident abuse contributes to a weakening or disintegration of the relationship between participants. The exchange between members is non-supportive and the perpetrator is not able to facilitate the growth and well-being of the recipient. As one older resident remarked *such staff [who abuse] do not like us* (OR), and another *if I could, I would hit them [staff] back but I'm a gentleman* (OR), while a nurse said *it takes two, one to give and one to get* (RN).

Abuse Behaviour Pattern

The "high" end of the axis (Figure 5.1) indicates participants' consensus as to whether certain behaviors are resident abuse. These include *hitting* (RN, NP, SO), *pinching* (RN, NP), *slapping* (SO, RN, NP) and *causing rope burns [on resident's arm]* (NP). These behaviours were cited across all population sub-

groups. Movement towards the "low" end of the axis indicates less emphasis upon hurt, and more upon the influence of context as to whether a behavior was defined as resident abuse. As one participant said, *you really have to think about why she [resident] is in restraints, she may need it* (RN), and another replied *keep in mind that they [resident] may call out or moan because of other factors, it does not mean that they are abused or are in pain* (RN).

In examining this pattern, three threads emerged:

- physical and verbal behaviours,
- given versus received hurt, and
- corporeal versus emotive hurt.

Each is discussed as they relate to the perceptions of resident abuse held by participants, and as to how they differentiate such abuse from neglect and inadequate care.

Thread 1: Physical and Verbal Behaviours

Resident abuse embodies physical and verbal behaviors. This finding was consistent among the population sub-groups of this study. Cited physical examples of resident abuse included *no dentures inserted prior to meals* (RN), *promoting incontinence with a diaper instead of [adopting] a training program* (RN), *feeding quickly* (RN), *rough transfers of the resident from wheelchair to bed* (NP), *scratching [by staff] with long nails or rings* (NP), and *restricted ambulation not justified by the state of the resident* (RN). Other illustrations were provided: *under medicated* (NP), *over medicated* (RN), *giving my mother something to keep her quiet because they [staff] can't deal with her yelling* (SO), and *changing a resident's attends [incontinence pad] in the lounge [common room]* (RN). Also in this physical domain were: *preventing a resident from leaving [one's] room by*

restraining them in a chair (SO), *prohibiting one from the nursing station with "you don't belong here"* (NP), *depriving a resident of privacy by not pulling the curtains around the bed when you dress them* (NP), and *leaving the bathroom door open [when a resident is on the toilet]* (SO). A non-professional staff member told one of the most dramatic examples,

> *I was working an evening shift. We'll work in teams, or pairs, some work better than others. I walked into a room, and saw her [resident] getting up, she was struggling, she gripped onto the arm of the aide, and swore 'bitch' at her. The aide slugged her in the stomach* (NP).

Verbal behavior comprised the use of specific language by cultural members towards residents. Swearing and threats were cited as examples from all participant sub-groups, and were described as resident abuse whenever they occurred because of the perceived hurt they caused, *she [staff] just told my dad to shut up* (SO), *I heard one of the nurses tell my mum she was going to be put back into her room if she wasn't quiet* (SO), and *she [staff] called him an old fart* (SO). The use of loud and angry tones was also thought to be abusive, *she [staff] just yelled at me* (OR) as was *verbal assault of the resident in an authoritarian, or arrogant voice* (RN, SO). Calling out to the resident, *Hey you! Give me some peace, you're not in a hotel here* (SO), and *you're wet again* (NP) were other provided examples, as was criticizing residents in front of others *you're a messy eater* (SO), and *you're not a baby, hold your fork properly* (NP).

<u>Thread 2: Given versus Received Hurt</u>

A caregiver's intent may be to inflict hurt and pain, *you could see that she meant to do it, she was mad as a hornet* (OR), *she was just being plain mean*

(SO), and *she wanted to punish my mum* (SO). Actions can only be intentional when one is cognizant of one's behaviors; for example, *she was deliberately rough and didn't need to be* (RN). Participants from all sub-groups perceived such behaviours as resident abuse because they were deliberately done, or given. Not all such actions were done by staff, as significant others also contributed abuse: *I walked in as she hit her mum* (NP), *she called her mother 'an old fart'* (NP), and *you could see that she (significant other) was mad at her mum, and called her 'an old bastard'* (NP).

Caregivers provide personal hygienic care to older residents, for example bathing, or toileting. In neither action is there necessarily an intention to hurt. Yet a resident can feel hurt which is in opposition to given hurt. As one participant said, *no matter what you did to her [resident], she moaned, you never knew if you were hurting or not* (NP), and another said *my mum would cry out when they changed her [bladder control pad]* (SO). Participants perceived this as received hurt, in that the older resident felt hurt. Either type of hurt can be present in resident abuse. This finding was consistent among the population sub-groups and helped to answer the research question as to what differences in perceptions of resident might exist among these groups.

Thread 3: Corporeal versus Emotive Hurt

Some behaviors by cultural members produced corporeal hurt in older residents, as manifested by *I've seen bruising* (RN), *rope burns* (NP), *broken arm* (NP), and *clumps of* [resident's] *hair were pulled out* (NP). Clear, objective evidence of resident abuse is evident. There is also emotive hurt, not as easily identified as corporeal, but just as real to participants. *You could see her just shrink back into her chair* (SO), *you would see that she was hurting, and the staff*

didn't even lay a hand on her (SO), and *I don't like to be left alone, I get lonely* (OR). Both types of hurt threaten the personhood of older cultural members.

Participants perceive resident abuse as behaviors that include withdrawal of affection by staff and retreat from the "bedside"; they cause emotional hurt in residents. Provided examples included *not listening* (RN), *using disrespectful forms of address* (RN) *as if to a child*, (RN), and *it's time to go* pee (RN). *Infantilizing*, *using the term diaper and bib instead of protective garments* (RN) and *apron* (NP), manipulating by *depriving of information* (RN) or *falsifying information* (SO), *given [information] so as to prevent the resident making their own decision* (NP), *and deciding on which clothes for the resident to wear, or on what television program or radio station to tune to without consulting the resident* (RN, SO, NP) are other cited examples.

The researcher, on an evening shift, observed one of the most powerful examples of staff retreating behaviour. A personal care aide was playing ball with a group of six ladies, several of whom were in wheelchairs, with the remainder sitting in high backed arm chairs. They were grouped in a corner near a nursing station. The aide threw the ball to each lady in turn, and then started the process over again. This continued for over five minutes, without a word being spoken by the aide. Several of the ladies looked up in obvious surprise when the ball was thrown to them, one cried out when it hit her in the chest. The aide then gave the ball to one of the ladies and left. The older resident started to throw the ball to the other members of the group, calling each of them by name prior to throwing. The recipient picked up her head and caught the ball, the thrower acknowledged the catch by saying *well done, good for you* (OR). The recipient of the ball then threw it to another lady, and again praise was heard coming from the group, *that's it, you*

got it (OR). There were smiles on the faces of several of these ladies that had not been there when the aide was throwing the ball. It is posited that the staff member had caused hurt by her lack of verbal communication with the group of older ladies and her apparent disinterest in their abilities. The older residents by using verbal and non-verbal communication had created a positive atmosphere within the group.

Personhood Dimension

While not integral to participants' perceptions of resident abuse, the personhood of older residents had a strong presence in the study's findings. Participants from all studied population sub-groups identified the importance of personhood. A staff nurse said, *You have to treat them with respect, dignity* (RN). However, the emphasis upon this dimension was much stronger in the registered nurses sub-group than in the other three, and least heard from significant others. Non-professional staff and older residents appeared to place about the same emphasis upon personhood. Staff talked about *wanting to spend more time with residents* (NP), *they have such wonderful stories to listen to* (NP) and *I would have liked to have a few more minutes chatting* (RN). A significant other said, *you have to remember that they are people first* (SO). Residents expressed *I could be your grandmother and how would you like her to be treated, that's what I want* (OR), and *dignity, that's what we want and some of them [staff] give it to us* (OR). Such words demonstrate acknowledgment of personhood within long-term care institutions. Acknowledgment of personhood is recognizing the integral worth of another human being, and demonstrating this in one's behaviors. Personhood itself is that living, dynamic, and historical process in which each individual is involved by virtue of being alive.

The personhood dimension may be viewed as an axis. The "high" end of this axis indicates strong acknowledgment of the personhood of a resident. Documented comments by participants illustrate this point, *all people have a right to make decisions for themselves* (RN), *my mum is special to me, and so are all the other mums here* (SO), *I have feelings* (OR), and *they [residents] have years of experience and knowledge, we can learn a lot from them* (NP). One participant said, *all human beings deserve our respect, deserve to be treated with dignity, perhaps the aged more so than others* (RN).

The "low" end indicates lack of acknowledgment and demonstration of personhood in older residents. Caregivers' actions at this end of the personhood dimension treat the resident's body as a thing, an "it", machine-like in its nature, separate from thoughts and emotions. The resident's body becomes an object that exists for use or misuse by another human being. Participants said *sometimes we forget that we are dealing with people because we get so task focused* (RN), *they [staff] don't know me* (OR), and *I don't like it when they [staff] use my first name without asking* (OR). One significant other stated *mealtimes are awful, it's seeing how many residents one can feed at once ... shovelling it in* (SO). These responses demonstrate that the personhood of an older resident was not always acknowledged.

Older residents perceived themselves to be unique, and being treated as a member of a group rather than as an individual by staff demonstrated to them a lack of valuing of their personhood. As one resident said *they never knock when they [staff] come in* (OR), and *it would be nice if they [staff] told you what they were doing, all of a sudden the water was cold, it just shot down my back* (OR). When staff did not come to know the person as an individual, the older adult was

often treated as an object or simply as a diagnosis, *oh she has Alzheimer's* (RN). This uniqueness of older residents was expressed strongly by this population sub-group and by registered nurses, and to a lesser degree by non-professional staff, and to an even less degree by significant others; this demonstrates a difference in perceptions among the four population sub-groups in this study.

Participants moved back and forth along this axis, *you can't always remember that they [residents] are people, when there is so much going on around here* (RN), *sometimes, I forget that I am working with older people, and that they can't do everything that I can* (RN), and *even a good nurse can lose her cool at times* (RN). These examples illustrate the personhood dimension that emerged from the study's data. Within this dimension, two significant findings were evident. These were "valuing of personhood", and "personhood and abuse". Each will be discussed in turn.

Valuing of Personhood

Through behaviours and words, participants from all four sub-groups studied demonstrated the value that they place upon personhood within the long-term care institution. This demonstrated some consistency of perceptions among them, which helps to answer the question of whether perception differences of resident abuse exist among the sub-groups studied. Residents voiced beliefs about how they wanted to be treated, *like a brother or sister would treat you* (OR), and *basic Christian values, like the Bible said, the way you yourself would want to be treated* (OR). One older resident said *I have lived here [in a long-term care facility] since my family decided I was no longer able to live by myself. I know most of the staff by name and they call me by my first name, it's easier for them. I would prefer my last name … that is how I was taught to treat my elders* (OR).

She went on to say *you can understand why they yell at times ... but it isn't very nice to hear* (OR). Another resident described herself as *being able to do for myself. They don't do anything for me... I don't need them. ... but it would be nice if they stopped in to say 'hello' once in awhile, it gets lonely here by myself* (OR).

During one of the interviews with this resident, a staff member opened the closed bedroom door without knocking, walked into the room and placed clean bed linen on the counter, then left without saying a word. In the middle of another research interview, housekeeping personnel opened the door, left it ajar and departed without doing anything, apparently not seeing the sign on it, in the resident's large handwriting, that read "please close". Again, not a word was spoken to either the researcher or the resident. The resident responded by saying *they don't talk much and usually I can't understand them anyway* (OR). These examples illustrate how some participants value the personhood of older residents, and how some do not. Yet participants from all sub-groups perceived the existence of personhood in older residents.

Findings indicated that some participants valued the personhood of older residents. One staff nurse said, *you have to take the time to listen to them, to listen to their stories* (RN), another participant said *sometimes just closing a door if that's want the resident wants says it all, because it means you asked them* (NP). Another example included, *we want to do a good job, but we just don't have time* (NP) and one more said, *we have to remember that it is their home, and they should make the choices, not us* (RN). Personhood was also valued or not by the way in which care was provided to older residents. Residents described the consideration, kindness and gentleness as important characteristics of a nurse who acknowledges personhood. *They talk to you, not just about towels or*

bathing, but about me (OR). The staff member who valued personhood was usually attentive to the resident, and often used humour in approaching residents, using a joke or humorous comment to foster a feeling of specialness in the older resident. *I always have a joke for her, my kids buy me joke books just for her [older resident], she'll often have one for me, but her's are a bit raunchier than mine* (RN). This made the resident feel special because the caregiver made the effort to acknowledge the resident as a person. This fostered a relationship between the two members of the long-term care institution.

In the ways of treating older residents "liked least" by participants, and behaviours cited as resident abuse, there were strong indications of not valuing personhood. Registered nurses, non-professional staff, residents, and significant others identified the need to give back what should never have been taken away. As one nurse said *give them back their dignity* (RN), *we make the choices for them and that's not always appropriate or fair* (NP), *we take away their worth* (NP) and a family member replied *moving into here [long-term care institution] doesn't mean you lose your adulthood* (SO). The long-term care institution may reflect, for a variety of reasons, lack of valuing the personhood of older residents. These reasons will be discussed in Chapter 6.

<u>Personhood and Abuse</u>

The data revealed that lack of acknowledging and valuing personhood contributed to resident abuse. Participants identified that resident abuse occurred when the personhood of the older resident was orientated towards the "low" end of the axis of the personhood dimension. The care provided by caregivers who did not acknowledge personhood was perceived by some residents as a negative experience, although not always an abusive one. *Treated me like I was an object,*

never even acknowledged I was there, rough with physical care, just a job, here because of the money (OR). Recalling this experience, the older resident showed distress. She slumped back in the chair, her head fell down, and her voice was tearful. She described how she would have liked the staff to have treated her, *a gentle touch on the arm would have been fine, just to let me know that they were there* (OR).

A number of behaviours were observed and participants made comments that indicate the personhood of older residents was not acknowledged. Such a lack was demonstrated in actions towards older residents that did not reflect respect or dignity - actions that denied personhood. Observed behaviours included not closing the door when an older resident was on the toilet, washing a resident's perineal area with the individual exposed to passers-by in the corridor, and opening a door into a resident's room without knocking or announcing oneself (RO). Other behaviours were voiced by participants, *he's just a dirty old man* (NP), *sometimes yelling is the only way that they'll answer you* (NP), and *not covering them up when they are taken to the bathtub, everything is hanging out, it's worse for the men* (NP).

Older residents felt it important to feel that their personhood was acknowledged. The presence of cultural members who valued and acknowledged personhood greatly influenced perceptions regarding resident abuse.

<u>Ethnoscience: Registered Nurses</u>

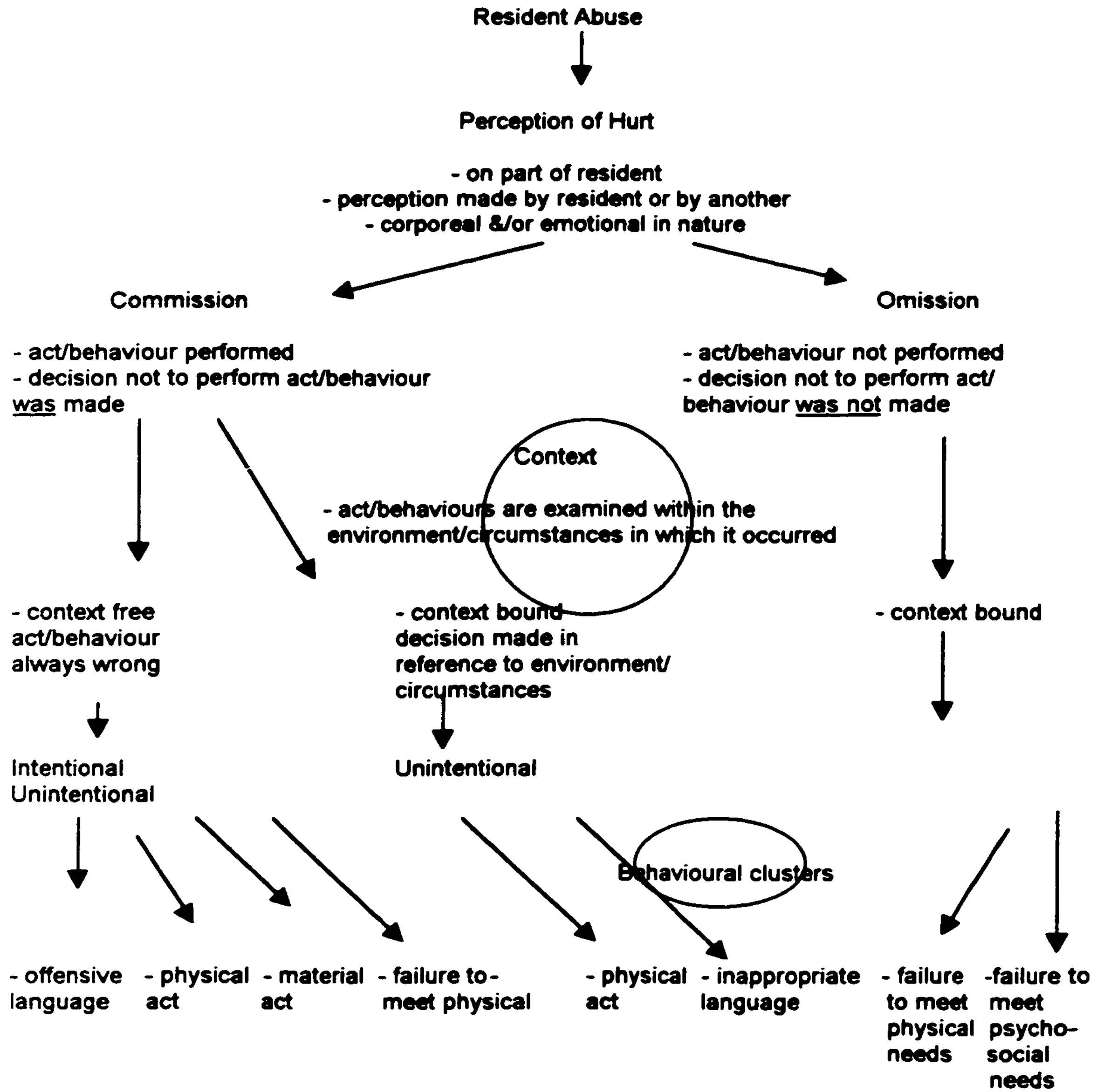
Registered nurses' perceptions of resident abuse were obtained, primarily, by ethnographic interviews. Ten registered nurses participated (see Chapter 4 for a complete description of method and sample). From the data obtained, a taxonomy of resident abuse behaviours was created.

Taxonomy

Part of the research was directed toward developing a qualitatively derived taxonomy of resident abuse based upon similarities and differences as reported by one participant sub-group, registered nurses. How decisions were made regarding the categorization and sub-categorization process is illustrated in Figure 5.3. The arrows on the diagram indicate flow of development, and do not suggest causality.

Figure 5.3

Emergence of Categories, Sub-categories and Behavioural Clusters



The initial labels for the categories, sub-categories and behavioural clusters came from the terms used by the registered nurses during their card sorts. For example, they identified the term *intentional* as the label a category, versus *unintentional.* At times, a word from one participant was verified by the researcher with other participants to identify if it meant the same thing, for example, *intentional* also meant *deliberate, with purpose* and unintentional was used to mean *didn't know they should do it,* and *not meaning to.* The participants also identified all of the behaviours identified with the clusters as examples of actions witnessed by them with the long-term care institution. The majority of cited behaviors were demonstrated in their view by other staff members primarily; however, they were also shown by older residents and significant others. The final selection of category, sub-category and behavioural cluster labels came from the researcher's analysis of the data. The categorization process lead to the development of the taxonomy, as presented in Figure 5.4.

Figure 5.4

Taxonomy of Registered Nurses' Definition of Resident Abuse[4]

Resident Abuse							
Perception of Hurt	Commission	Context Free	Intentional	Offensive Language	Emotional		Swearing
							Yelling/shouting
							Name calling
				Physical Act	Corporeal & Emotional		Twisting arm
							Slapping
							Pinching
							Pulling hair
						Punish-ment	Not taking to toilet
							Not answering call bell
							Inappropriate feeding
				Material Act	Emotional	Taking away control	Removing personal items
							Picking out clothes
							Stealing
				Failure to meet physical needs	Corporeal & Emotional		Not answering call bell
							Not taking to toilet
							Not changing when wet (bed, &/or resident)
							Not providing enough nutrients
				Failure to meet psycho-social needs	Emotional	Inappropriate language	Using "bib"
							Using "granny/grandpa"
							Using "diaper"

[4] as identified on p. 118, the headings for the categories, sub-categories and behavioural clusters came from the registered nurses themselves

Taxonomy of Registered Nurses' Definition of Resident Abuse (con't)

		Context Bound	Unintentional	Physical Act	Corporeal		Moving out of bed or chair
							Positioning/turning
					Corporeal & Emotional	Staff needs	Use of restraints
	Omission			Inappropriate Language	Emotional		Saying the "wrong" thing
							Not using correct words, i.e. "shirt protector"
				Failure to meet physical needs	Corporeal & Emotional		Failure to take to bathroom
							Not providing pain medication
		Context Bound	Unintentional	Failure to meet psycho-social needs	Emotional	Lack of choice	"Forced" social participation
							Not asking if food complements are wanted
							Decisions made without input of resident
							Not talking &/or listening
							Not knocking on bedroom door
							Not closing bathroom door

Results of the analysis yielded five distinct categories of resident abuse characteristics: perception of hurt, omission or commission, context, an intentional or unintentional act, and behavioural clusters, i.e. offensive language. Each category is discussed.

Perception of Hurt

Registered nurses defined a behaviour as resident abuse if it produced an perception of hurt in the older resident. For example, *abuse means that there is hurt* (RN), *the resident feels it physically or emotionally* (RN), and *neglect is different from abuse because ... there is no harmful outcome* (RN). Participants identified that some residents are able to communicate verbally and/or non-verbally their perception of hurt, as one said *she sure told us [it hurt] when we got her up, did she swear at us* (RN), and another said *you could see the elbow pop out when we turned her* (RN). Another participant stated *Mary's*[5] *voice told us she was hurting* (RN). However, for some residents, their physical conditions; for example, a stroke, or Alzheimer's Disease rendered it impossible for them to verbally voice their hurt, and made it difficult for staff to identify which of their actions had caused hurt and which resident behaviours were the symptoms of disease pathology. Participants made the decision that such residents had been hurt and thus abused. As one said,

> *When she is hurting, or when she is upset, her body language tells us. It is so obvious. She gets rigid, even her contractures get more rigid, and you can see that she is resisting us turning her. She is in*

[5] name changed

pain. For many of our residents, we have to make the decisions for them, based upon what we know of them. It isn't always easy to guess what is the problem. With her, I usually know that she is hurting. Is it abuse, sometimes, probably always if we're hurting her (RN).

Other abuse experiences are easier for staff to identify. One participant said, *when you hear staff yell at the resident, then you know right away that is abuse, there is no need for that, even if one is deaf.* (RN). However, the decision that an experience is one of resident abuse still rested with the participants. Participants voiced that at times, other members of the long-term institutional care culture identified that abuse had occurred, *we hear from family members about mother's 'lost' clothes, although she means stolen or that another resident is wearing them* (RN), *we've had complaints from family members that their mother has been mistreated* (RN), and *it's up to the PCA [personal care aide] to tell us if there is abuse on the unit, we don't have the same contact with the residents* (RN).

Commission or Omission

After acknowledging that a perception of hurt had occurred, participants then differentiated resident abuse into the two sub-groups of commission and omission. Commission describes behaviours or actions which were committed by cultural members; *making a deliberate decision not to get something for a resident when she's asked for it* (RN), *or something you do, for example deciding not to get the resident's hearing aid* (RN), and *the family removes personal items from the resident without permission* (RN). Frequently heard from participants were examples related to the use of the call bell, *they'll [staff] will decide not to answer*

the call bell if a resident has been sitting on it [using it a lot] (RN), and *the bell will be removed so the resident can not get it* (RN). Such actions were perceived as punishment for using the bell too often, *it's one way to stop the resident from using it* (RN).

Acts of omission are actions that were not done, *too much to do, so you can't do it all, and so you leave some things undone, even if the resident asks you* (RN), and *sometimes you don't know it should have been done or that the resident wanted it* (RN*)*, but ones that caused perceptions of hurt in an older resident. Another cited example included:

> *it gets so natural that we walk into the resident's room without asking permission, yet we expect our kids to ask permission to enter our bedrooms at home, or we ask permission to enter theirs. We call this the resident's home and do not give them the same courtesies. If we stopped and thought about it, it might make a difference ... for some staff, they have never been taught to knock, ... perhaps it's our cultural expectations ...* (RN).

Often acts of omission were explained as being caused by lack of education. Other illustrations included, the nurse who said, *if we don't train them [PCAs, non-professional staff], then how do they know, they don't* (RN). Another participant stated, *we hire people basically off the street, with little knowledge of how to give care, and expect that them to know how to treat people* (RN).

Within a Context of Care

Registered nurses placed the actions or lack of actions of caregivers and other cultural members, and even their own, within a context of care framework. Registered nurses clearly articulated that perceptions of resident abuse are very

much context driven. Context means the circumstances and environment in which the experience of resident abuse occurs, as one participant said *you have to understand the type of residents we have here, they're usually confused, and some often just yell without reason* (RN). As a nurse said, *you just can't look at the behavior, you have to look at the situation as well* (RN). Another stated, *they [residents] come here because of their problems, families can't deal with them, and we have to ... sometimes yelling is the only way that they hear you* (RN), *you can understand that if you are hit, then you do feel like hitting back* (NP), and *we try very hard not to use restraints, but sometimes it's for the resident's own good* (RN). Other participants articulated the importance of context more clearly as they card sorted, *you have to look at the circumstances* (RN), and *you can't just look at the behaviour of the PCA, you have to look at the behaviour of the resident as well* (RN).

Participants differentiated context into two sub-categories: context bound and context free. The former, context bound, means that the environment always influences the perception of a participant as to whether an experience is one of resident abuse. The use of restraints to restrict the movement of an older resident was the most predominantly cited example of context bound resident abuse. As participants stated, *if a resident is going to fall, we'll use a seat belt for their own safety* (RN), *often we'll use a restraining devise because the family insists on it* (RN), and *you have to put a lap belt on or they'll try and get up out of their wheelchair, and will fall. It's a safety issue* (RN). The use of restraints was influenced by the participants' perception of need for them, and if one was perceived, then their use was not resident abuse.

While participants emphasized the importance of examining a behaviour within the context that it occurred, this did not mean that context was an excuse for resident abuse. Context free means that an act was resident abuse regardless of the circumstance in which it occurred. As one registered nurse stated, *even if a resident yells at you, you can't yell back, it's not right* (RN). Another one said, *there is never any reason or excuse to hit a resident, no matter what she might have done to you* (RN). One nurse responded *some things are always wrong, hitting, pinching, gripping too hard* but this same participant also said *but sometimes you can understand why these things happen, it gets busy, and staff get stressed, they over react* (RN). The behaviours were identified within the context of the long-term care facility.

Intentional or Unintentional Act

Within the context of the long-term care institution, all acts of resident abuse are intentional or unintentional by definition. The criteria used to differentiate between the two is the reason behind the act or the inaction. When the primary goal is to intentionally hurt the older resident, the behavior is resident abuse. As one nurse said, *she [non-professional staff] wanted to hurt the resident, perhaps teach her a lesson, the resident had bit her and she bit the resident back* (RN). One participant identified an incident between herself, the researcher and an older resident. As *you walked in, you saw Annie*[6] *and I exchanging quite harsh words. Annie gave it as good as she got it, and she was grinning from ear to ear. When you [researcher] saw me, I jumped and said, 'she expects it, she says I'm having a bad day, if we don't have our exchange* (OR,

[6] name changed

RO). When asked why she felt the need to explain, the nurse said *you might have misinterpreted, sometimes family members do* (RN). The staff member may not always be smiling and joking but the resident accepts and enjoys behavior that an observer might label as abuse. Mutual consent between the two is a criterion for not defining a behaviour as resident abuse.

Unintentional abuse does not have as its goal the infliction of such hurt. One cited example was, *I was moving her up in bed and she said that I hurt her but I didn't mean to* (RN), and *I saw a resident who had a fractured hip because the PCA [personal care aide) did not want to wait for the lift to be free. I'm sure she didn't mean to do it, but she did* (RN). It may also be caused by lack of knowledge as previous examples have illustrated.

Behavioural Clusters

Participants reflected upon the unintentional and intentional/deliberate actions or lack of actions and grouped them into behavioral clusters. The initial labels for the clusters came from the participants' own words.
Intentional/deliberate has five behavioural clusters: offensive language, physical act, material act, and failure to meet physical needs, and failure to meet psychosocial needs. The cluster of offensive language was subdivided into swearing, yelling/shouting and name calling, *I've used the term bastard myself when I was mad* (RN), *and if swearing works with your kids, then you use it at work with residents, to see if it gets the same results* (RN). Physical acts were those performed to an older resident, *I saw the PCA [non-professional staff] just shove the lady into the chair* (RN), and *sexual, unnecessary fondling would be a physical act* (RN).

Unintentional is divided into the behavioral clusters of inappropriate language, failure to meet physical needs, and failure to meet psychosocial ones. If staff *don't know how to properly lift or transfer, and the resident is hurt, that's abuse because they should know,* (RN), and *when staff don't tell us something that we [registered nurse] should know, and don't recognize that we have expertise, and so the resident doesn't get what he or she needs* (RN). Inappropriate language is a cluster that was strongly expressed by participants, *using the word 'bib' is inappropriate, it's degrading* (RN), *you often hear 'dear', some [residents] like it and others don't* (RN), *we try to teach our aides not to use the word 'diaper' but you often hear it* (RN), and *there are words that should never be used to older residents, 'granny', 'grandma' ...this treats them all the same, and they are not your grandparent* (RN). Some of the cited examples of resident abuse were perceived by the nurses as removing or taking away the control of the older resident, *we make decisions for them, thinking that they can't but even confused residents can make some decisions for themselves, we just don't let them* (RN). Or as another participant said, *sometimes we need to remember that adults can make their own decisions, even if they are the wrong ones or we disagree with them, they have that right because of their age* (RN).

In summary, participants agreed resident abuse is a perception of hurt in an older resident. Consensus was also evident that those acts of abuse may be intentional/deliberate or unintentional depending upon the reason for the behaviour. Yet while the taxonomy suggests a consensus of definition, several contrasts were evident. The supervisor and administrative level of registered nurses stated few examples of resident abuse were evident within their facilities, *I've never seen resident abuse here* (RN), and *it is very rare, and usually verbal*

(RN). On the other hand, registered nurses more directly involved in resident care provided a wealth of examples of resident abuse that they perceived as commonly occurring. One said *administration has no idea what goes on here, you see it a lot* (RN), another replied *I could tell you horror stories* (RN), and *It happens all the time, we just don't recognize it as abuse* (RN).

In summary, the development of a taxonomy of resident abuse serves to identify common elements obtained from the perceptions of registered nurses regarding resident abuse. It also highlighted factors influencing the definition, for example, the cognitive status of the resident and the context of nursing practice in which such abuse occurred.

Participants Perceived Resident Abuse within a Context of Care

The data revealed that sometimes a fine line existed in the perceptions of participants between identifying whether a behaviour was resident abuse or not. It was manifested in such questions as *how much time can you spend with an older resident when you have baths to do?* (NP). *When do you say you can not help a resident go to the bathroom?* (NP). *How long does a resident wait before being taken to the washroom once a request to go is made?* (RN). The answer to these questions lies, in part, in an understanding of context (refer back to Figure 5.1). Data obtained from participants suggests perceptions of resident abuse are very much contextually driven. The physical structure of the facility, composition of staff, work dynamics and resident population of the institutions all shape resident abuse. This helps to answer the research questions under study, *what is resident abuse as perceived by the long-term institutional care culture* and *how do participants perceive resident abuse?*

All five institutions were similar in some contextual factors; for example, in their nature and operational routines. Registered nurses fulfilled leadership roles, including directors of care, nursing unit managers, educators, and team leader positions. All facilities relied heavily on non-professional staff to provide direct hands on resident care. Family members and friends had unlimited access to older residents, although quiet periods were encouraged in all facilities. In all of them, physical care was provided in a hurried manner with minimal verbal communication other than instrumental instructions, *hurry up and move along* (RO), *time for your bath ... clean towels, you're on second breakfast* (NP, RO), and *move on down the corridor, it's time for lunch* (NP, RO).

Residents, staff and significant others all made indirect and direct references to the unavailability of staff because of barriers that they perceived to be institutionally generated, *there just isn't enough staff* (OR), *I have never seen a staff nurse near my mother .... they never come up to me to say hello ... you have to wonder if there is any staff on* (SO). The unavailability of staff reinforced feelings of inadequate care and neglect but not abuse. As one resident said *I don't want to be a nuisance to them, but sometimes you just need a bit of help. I can't wait when I have to go* (OR). These long-term care institutions are rule bound and regulated, by both written and unwritten laws. As one registered nurse commented, *I didn't do what they wanted and got reported, but they were wrong. You can't just make rules and apply them to everybody* (RN).

What was found to be most important in the contextual sphere of nursing practice was the nature of the relationships between different members of the culture. Some residents had difficulty interacting with other sub-groups, specifically non-professional staff. They were reluctant to express their concerns

or ask questions for fears of being a nuisance and taking up the staff's busy time. As one participant said, *they have harder residents to deal with than me, I don't want to take up their time* (OR). Others said, *they [staff] really are overworked* (OR), *they tell us they're too busy* (OR), *they're always busy, but they're not really* (OR), and *you can't understand them [non-professional staff] anyway* (OR). Some residents prided themselves on not needing the assistance of staff, being able to *do it for myself* (OR), *she [another resident] gets the wool for me* (OR), and *being able to help a bit with the other ladies in the room* (OR). Difficulty among cultural sub-groups may contribute to resident abuse.

Another aspect of sub-groups relationships was between older residents and significant others. Data indicated that often older residents move to long-term care institutions because of the wishes of family members, *my daughter felt it would be best* (OR), *my son and daughter found this place for me* (OR), and *my daughter said I would like it here, but I don't* (OR). The data suggested that the more satisfied older residents were with current living arrangements including relationships, the less likely they were to experience relational difficulties with staff. Such difficulties may potentially contribute to perceptions of hurt, and thus to resident abuse.

Impaired status can best be described as a global impairment characterized by the loss of ability to process incoming stimuli in a meaningful way (Burnside, 1988). The ability to reason, follow commands, attend to stimuli and concentrate is altered. While some of the cognitive impairment experienced by older residents may be due to reversible causes, for example dehydration, and hypoxia, for the majority of these older cultural members, cognitive impairment is not reversible. Participants identified how cognitive status influenced the staff

perceptions of older residents; *those who are intact are more likely to know they are being abused* (RN), and *those who are impaired are probably more likely to be abused* (RN). Another participant said *they don't know what's going on, they live in their own worlds* (NP), and *she [resident] complains, no matter what you do, even if it is just to feed her* (NP).

Registered nurses made a distinction between cognitively intact and impaired older residents, whereas other sub-groups did not. Cognitively impaired older residents often had to be restrained *for their own good*, or *to ensure that they are safe* (RN). A cited example was the use of physical and chemical restraints to ensure older residents did *not hurt themselves* (RN). Those older residents who tended to fall or wander out of the facility were perceived as needing to be restrained, a behavior cited as abuse for those older residents who were cognitively intact. These behaviors were described by the nursing staff as deliberate and intentional, however, they perceived the outcome of the action as positive, in that it promoted the well-being of the older resident. In one case, *we have to restrain her at night, she yells all the time and keeps others awake* (RN). Residents who were perceived as disruptive towards others often tended to be abused according to the definition of staff, yet such behaviors were excused because of cognitive functioning. Behavior that was described as manageable appeared to expose the older resident to less risk of abuse. It did not matter if they were cognitively impaired or intact, in that their behavior was less disruptive to other residents and the routines of the institutions.

The data clearly identify that the context of practice influenced participants' perceptions of resident abuse. This was true across all population sub-groups in this study, thus contributing to answering the research question as to whether

differences existed among them. One participant said *you have to remember who we are caring for here* (RN). An example of context influencing perceptions is the use of restraints, in that if registered nurses perceived restraints were necessary to ensure a resident's safety then resident abuse did not occur, and *some [residents] need to be restrained, it's a safety concern* (RN). However, if a resident was restrained because staff were busy, this was resident abuse, *you can't use restraints just because it helps you out* (NP), or *they put my mother in them [restraints] to keep her from leaving the place* (SO). If a resident was restrained because the family *felt that it was for their mother's benefit* (RN) and staff disagreed with this decision, then resident abuse occurred. The influence of context could potentially change the definition of resident abuse within the long-term institutional care setting in the perceptions of all participants.

Comparative Analysis of Resident Abuse Literature

A content analysis of articles in professional journals, relevant papers and publications describing resident abuse in long-term care institution[7] was undertaken. Authorship was not limited to either registered nurses or to those who identified themselves as members of the long-term care institutional setting because of the very limited number of publications by them.

The unit of analysis was the term *resident abuse*, or *institutional abuse*. Because of other terms used in the literature to describe what appears to be the same experience, *elder mistreatment* or *maltreatment*, and *aged abuse* within long-term care settings were equated with the term *resident abuse*. The unit of analysis was examined in reference to the categories determined by the

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[7] Long-term institution includes auxiliary hospitals, special care homes and nursing homes as identified in the literature, and defined in Chapter 5.

researcher: experience of hurt, commission and omission, context, intentionality, and resident abuse behaviour groupings. The categories were designed to be mutually exclusive to provide for external validation of the categories, sub-categories and behavioural clusters identified by the researcher in the findings of her own research.

Reviewed material came from several sources and was of distinct types as presented in Table 5.5.

Table 5.5

Description of Material: By Source and Type

Category	No. of individual works (N = 83)	
books		
complete book	2	(2.40%)
chapter(s)	6	(7.22%)
articles		
research	28	(33.73%)
theoretical	35	(42.16%)
other		
learning manual	4	(4.81%)
discussion paper	2	(2.40%)
unpublished report	2	(2.40%)
presented paper (at conference)	3	(3.61%)
government legislation	1	(1.20%)

Experience of Hurt

In none of the reviewed material was the word hurt used to describe resident abuse. In twelve of the works, specific mention was made of pain or anguish. The dictionary equates these terms with hurt (The Oxford English Dictionary,1989). This mention was made when either the term physical abuse or abuse was specifically defined by the author(s). The Interhospital Domestic

Violence Committee – Saskatchewan (1995) in their training manual on institutional abuse prevention defined physical abuse as "infliction of physical discomfort, pain, or injury" (p. 5). This is similar to the definition used by the Task Force on Elder Abuse (1987) in their report to the Ontario Association of Non-Profit Homes and Services for People. They wrote of abuse as "the infliction of physical pain or injury" (p. 5). Documented in this same report was psychological abuse as "the infliction of mental anguish" (p. 5). Pillemer and Moore (1985) included in their definition of physical abuse "causing physical pain or injury to another person" (p. 315). Pillemer with Bachman-Prehn (1991) used this same definition in a later work. Even in government legislation, reference to hurt was not found. The Alberta Government (1997) included "intentionally causing bodily harm ... emotional harm" (p. 1) in their abuse legislation. The dictionary equates harm with hurt (The Oxford English Dictionary). Hudson (1991) referred to "harmful effects for the older adult" (p. 16). LaRocca (1985) also referred to harm. The implication is that resident abuse does not exist without harmful effects.

If neither physical abuse or abuse was specifically defined, the presence of pain or injury was not articulated in the work. The Task Force on Elder Abuse (1987) was an exception to this finding as was the Interhospital Domestic Violence Committee (1995). It may be that they provided fuller descriptions of the term abuse because they are both training modules for use with staff in long-term care institutions.

Clough (1996) argued that the word abuse should be reserved for "events ... that have a direct effect on the physical and emotional well-being of the resident" (p. 420). The implication is that such events are hurtful, although this is not articulated in this specific work. A perception of hurt was not referred to in any

of the other reviewed works. It was perhaps assumed by the author(s) to be understood as occurring in conjunction with abuse. However, this is an unsubstantiated assumption. This finding is perhaps best explained through the focus of the literature reviewed. The reviewed works addressed the incidences of resident abuse, education, intervention, legal and other associated concerns. The perspective of the individual who experienced abuse was not found in any of the reviewed material except for the works of Meddaugh (1993) and Hall and Bocksnick (1995). However, in neither work was there acknowledged hurt on the part of the resident. It appears that the literature is objective in nature, and the experience is subjective.

Commission and Omission

Six authors clearly differentiated, in conjunction with a provided definition of abuse, between acts of commission and omission. For example, the Interhospital Domestic Violence Committee – Saskatchewan (1995) used these words to describe different types of abuse, as did Knelsen (1991). Hudson (1991) identified that elder mistreatment experts used these same terms to differentiate between abuse and neglect. Sullivan (1996) made reference to "sins of omission" (p. 43). Other authors identified that abuse was a committed act through reported occurrences of it. Pillemer and Moore's (1989) study indicated that 40% of staff admitted to having committed psychological abuse on at least one occasion.

Acts of commission may be more focused in their descriptions. Sengstock, McFarland and Hwalek (1990) described physical abuse as "direct attacks" (p. 33). Pritchard (1996) used the term "inflicted" (p. 6), as did others (Alberta Government, 1997; Task Force on Elder Abuse, 1987). Pritchard also used the phase "to con" (p. 6) an older person. Harshbarger and Morse (1998) stated

"deliberate striking" (p. 36) as physical abuse. Pillemer and Moore (1985) described staff behaviours such as, "pushed, grapped, shoved, pinched ... slapped or hit, kicked" (p. 315). "Inappropriate physical contact" has also been used (LaRocco, 1985). These terms identify commission as a trait of resident abuse since they imply action towards an older adult.

Most authors in reporting abuse incidence did not describe the acts as committed or omitted in nature. The American Medical Association (1992) refers to institutional abuse as mistreatment perpetrated by staff, other patients, or visitors in nursing homes and other care facilities. Foner (1994) suggested since psychological abuse was tolerated by management, it tended to occur. However, was the occurrence one of commission or omission? The same question is raised in reference to the works of Lusky (1988), Tulloch (1987) and others. LaRocco (1985) wrote of "failure to provide" (p. 28) to describe neglect which was different from mistreatment. Bianculli, Hoffman and Infante (1992) used "various patient care deficiencies" (p. 27). In these examples, as in others, it is not clear whether failure was the result of commission or omission. A more subtle term in describing acts of commission is theft. (Clough, 1996; Sengstock, McFarland, & Hwalek, 1990). Harrington (1984) and others have identified it as abuse (Harris, & Benson, 1998; Kimsey, Tarbox, & Bragg, 1981; Ullery, 1996). Sengstock, McFarland and Hwalek (1990) used term "stealing or misusing money" (p. 41), while Clough (1996) used "financial malpractice" (p. 419). These suggest committed acts.

Intentionality

In none of the documents reviewed was differentiation made between intentional and unintentional acts. Several authors did identify intentional acts.

Theft is an intentional act. Pillemer and Moore (1985) defined physical abuse as intentional. This same definition was carried through in the 1991 work of Pillemer and Bachman-Prehn. This later work included defining psychological abuse as intentional in nature. The Alberta government (1997) also used the word intentional. Intentional was not contrasted with unintentional. Neglect can be unintentional (Lusky, 1988). Thoughtless practices was used by one author (Meddaugh, 1993). Hudson (1991) noted that intentionality was not an essential trait of abuse.

Fulton and Bedell (1989) in their legal review of legislation within the United States cite the definition of abuse under Florida statute, " ...or allowed to be deprived" (p. 72). Sengstock, McFarland and Hwalek (1990) used "apparently deliberate" (p. 33) to describe physical abuse. LaRocco (1985) wrote of "inappropriate use ..."(p. 27), and "failure to provide" (p. 28). Sengstock, McFarland and Hwalek (1990) also employed "failing to provide" (p. 33) to describe physical neglect. Sullivan (1996) in reporting on United States' court cases identified one in which a nursing home was in violation of federal regulations for "not making 'reasonable accommodations' for a disruptive resident" (p. 41). Whether the actions were deliberate or not were not identified.

Resident Abuse Behaviour Groupings

While the reviewed literature did not agree on specific categories of abuse, it provided behavioural references to identify that they exist. In the majority of the literature reviewed (88%), the authors directly or indirectly identified that resident abuse was an umbrella heading for a range of behaviors. For example, over 60% of the material reviewed identified physical abuse and listed behaviours under this label. Sengstock, McFarland and Hwalek (1990) included: slaps, punches,

beatings, sexual assaults, and threats in which a weapon was involved. "Pushed, grapped, shoved, pinched ... slapped or hit, kicked" were identified by others (Pillemer, & Moore, 1985, p. 315). Trevitt and Gallagher (1996) used the term "physical signs of abuse, e.g. bruises, fractures, malnutrition." (p. 652).

The inappropriate use of restraints is considered an example of physical abuse (Hwalek & Sengstock, 1986). Others used it as a distinct category. For example, the Office of the Inspector General (1990) identified medical restraints in this way. Other writers included verbal assaults and threats under the general heading of abuse (Sengstock, McFarland, & Hwalek, 1990). Mean language was also used in this way (Mercer, Heacock, & Beck, 1992). Others included mean language and labeling as psychological abuse (Interhospital Domestic Violence Committee – Saskatchewan (1995). The grouping of several behaviours under a heading suggests that abuse behaviours are clustered together.

Pillemer and Moore (1989), Lusky (1988) and Tulloch (1987) identified psychological abuse. This term was used in eighteen of the materials reviewed. Tulloch described behaviors such as placing the call bell out of reach as subtle psychological abuse, a distinction not made by others. This was one of three identified references to call bells. Pritchard (1996) was one of five authors to use the term emotional abuse. Her description is similar to the work of Hall and Bocksnick (1995). They identified that residents' need for control and autonomy were undermined. Removing personal choice was also identified as psychological abuse (Meddaugh, 1993). Trevitt and Gallagher (1996) used Quinn's definitions and identified violation of rights as distinct from emotional abuse.

In the literature, theft is referred to by some (Harrington, 1984;Sengstock, McFarland & Hwalek, 1990; Shield, 1988) and not by others (Diamond, 1992;

Foner, 1994; Mercer, Heacock, & Beck, 1993). Seven of the documents specifically addressed theft of residents' belongings. Sengstock, McFarland and Hwalek (1990) used the term material abuse to describe actions that the participants in this study identified as material acts. These were acts that involved theft or misuse of an older adult's money or property. Harris and Benson (1998) documented theft as did Vinton and Mazza (1994). They grouped such actions as the theft of money, furnishings and clothing into the category of personal possessions. Personal property abuse was used by one author (Office of the Inspector General, 1990).

Comparison of Content Analysis, Ethnographical and Ethnoscientific Findings

A comparison of the findings of the content analysis with those obtained from the other two research methods (ethnography and ethnoscience) is interesting. The traits of commission, omission and intentionality, and the grouping of behavioural clusters are present in both the content analysis and ethnoscientific findings. However, they are not clearly evident in the ethnographical findings. This may be accounted for by the continuum of perceptions of resident abuse that emerged from analysis of the ethnographic data, in contrast to clearly delineated categories that come out of the data of the other two methods.

The perception of hurt that was present in the ethnographical and ethnoscientific findings was not evident in the content analysis. The presence of pain, trauma and injury were identified in the content analysis but not the resident's emotional perception of them, specifically the feeling of being hurt. The objectivity of resident abuse (pain, trauma, injury) was evident in the content analysis versus the subjectivity (resident's perceptions) of it. While not negating

the objectivity, it was the subjectivity of resident abuse that was emphasized in the ethnographical and ethnoscientific data. Content analysis findings did not identify that cultural members could identify perceptions of hurt on behalf of a resident; this was in contrast to the findings from the other two research methods. This is understandable since the findings from the content analysis did not identify a resident's perception of hurt. Also absent in the content analysis findings was the influence of context upon resident abuse; this influence upon participants' perceptions was clearly evident in the ethnographical and ethnoscientific findings. In addition, devalued personhood was a very strong influence upon perceptions of resident abuse in the ethnographical data, its importance was not as evident in the ethnoscientific data, and was absent in the content analysis data.

The number of publications on resident abuse is increasing. However, within the vast majority of the literature reviewed, serious methodological problems limit their ability to shed light on the characteristics of resident abuse (see Chapter 2). Despite the limitations of the literature reviewed, they do indicate that resident abuse is a complex concept.

Summary

Resident abuse exists in long-term care institutions. It involves a process of interaction between a resident and another cultural member that contributes to a perception of hurt. This perception of hurt may be voiced by an older resident or by another on behalf of the resident. Data from participants suggests that the perception of resident abuse was influenced by the context in which it occurred. These findings held consistent for all population sub-groups used in the study: registered nurses, non-professional staff, older residents and significant others. While personhood is viewed as separate from resident abuse, the two are

intertwined in the perceptions of participants. The de(valuing) of personhood accompanies the experience of resident abuse. Some of the findings from the ethnographical and ethnoscientific data, were externally validated by the content analysis of the literature; others were not. This finding reinforces the need to examine resident abuse from within the culture under study, and to replicate this research at a later date.

Chapter 6

Discussion of Findings

The intent in this chapter is to present some inferences regarding resident abuse which have collectively emerged from the findings of the three research methods: ethnography, ethnoscience and content analysis. These inferences are put forward as the starting point for discussion of the findings of the study.

Inferences

Inference 1: Personhood Should be Valued.

Defining personhood is neither simple nor finite. Each individual personally and uniquely defines it; yet it is possible to understand and appreciate the concept. While personhood for each individual, in particular each member of the culture being studied, is a unique formulation, it is common to all individuals. It is that living, dynamic, and historical process in which each individual is involved by virtue of being alive. It is the most multimedia of concepts: simultaneously visible, audible, tangible, and temporal. Continually, one's sense of personhood is explored, extended, and evaluated. It is in terms of personhood that human nature is fashioned, for it is through personhood that one's consciousness is constructed and the raw world interpreted.

Personhood is similar to what Hagerty, Lynch-Sauer, Patusky and Bouwsema (1993) called *relatedness* for both are influenced by the perceptions of others towards the self. However, the latter term addresses a pervasive human concern, that of establishing and maintaining relatedness to others, whereas, personhood encompasses within it relatedness. *Hardiness* is also a concept related to personhood. Maddi and Kahn (1982) defined it as a "constellation of

personality characteristics that function as a resistance resource in the encounter with stressful life events" (p. 168). Both hardiness and relatedness imply one's perceptions versus the essence of self that is what personhood describes. Wade (1998) discussed *personal transformation* as a dynamic, uniquely individualized process of expanding consciousness whereby individuals become critically aware of old and new self-views and choose to integrate these views into a new definition of self. Personal transformation is distinct from personhood in that it implies a restructuring of the self. *Inner strength* is a concept used by some researchers (Moloney, 1995; Rose, 1990) to describe the quality of individuals' lived experiences. However, it describes one trait of the individual and not the holistic picture of self which personhood addresses.

Stein (1995) used the term *self-concept*, which describes an individual's beliefs, feelings and expectations about the self. The self-concept is a stable, complex and multi-faceted knowledge structure. Others have used the term *self* (Forrest, 1993; Kegan, 1982) as a human characteristic, present at birth and evolving within the context of one's surroundings. The self-concept aspect of the person gives the individual a sense of who one is. This need to know who one is gives one the psychic energy necessary to experience a sense of personal unity (Martsolf & Mickley, 1998). The complexity, and enduring nature of self-concept are also traits integral to personhood.

Within a nursing framework, Parse's (1996) theory of human becoming has some similar characteristics to personhood, in that each individual structures a personal meaning which personifies the values and priorities that one has chosen explicitly and tacitly in a mutual process with the universe. While Watson (1985) elaborated upon the concept of soul which also has some similarities to that of

personhood; it "refers to the geist, spirit, or essence of the person" (p. 46). Gadow (1983) suggested that dignity and integrity could be experienced through frailty, and wrote, "it becomes the new form for the life ... the source of still more life" (p. 146). It is the freedom to lavish all of one's intensity upon the creation of a new self-body relation in that "it is the source of intensity and life without which no self is whole" (p. 146). The sense of wholeness which Gadow's definition implies is also manifested in personhood.

The importance of personhood has been articulated in the literature. Benner and Wrubel (1989) wrote that an understanding of how personhood attains moral significance among nurses is critical because the central assumption in the ethic of the nurse-patient relations is that the patient is a person. Boykin and Schoenhofer (1993) wrote that personhood "implies ... living out who we are ... is being authentic, being who I am" (p. 8), and that it is fostered through nurturing relationships with others. Gaut's (1983) definition of caring includes awareness and respect for the personhood of others. Jenkins and Price (1996) wrote that an understanding of the meaning of personhood will assist nurses in understanding the experiences of clients. Other writers have also emphasized the importance of understanding personhood to promote quality of life (McCurdy, 1998; Olsen, 1997; Sabat, 1998).

Personhood is subject to the influence of others. In the long-term institutional care setting, how participants value the personhood of others is apparent in three inter-related ways: behaviours, attitudes underlying these behaviours, and relationships. For example, valuing of personhood is reflected in numerous ways: requesting permission to enter a resident's room, knocking on a bathroom door before opening it, asking if one would like an extra cup of coffee at

breakfast, or greeting one by name. In such ways, cultural members recognize and treat each older resident as a unique and special individual. Such valuing of personhood has been identified as important by other researchers. Tellis-Nayak (1988) found that the staff's attitudes and behaviors associated with recognition of older residents as *special* generated perceptions of excellence of nursing home care. Bowers (1988) stated that family members of nursing home residents emphasized the importance of staff efforts to preserve the *self* of their relatives by viewing them as unique individuals. Similar findings were reported by Duncan and Morgan (1994), and Looman, Noelker, Schur, Whitlatch and Ejaz (1997).

Regrettably, within the culture under study, it was often heard from participants that older residents *need to be treated with respect* (RN), *treat me like you would a sister or a member of your family* (OR), *they [staff] need to remember that my mother is my family, they have a family (SO),* and *we need to give them [older residents] back their dignity and respect* (RN). Could some participants be devaluing the personhood of older resident? Does not this devaluing of an older resident make one feel like an object? It is ironic that acknowledgment is made by participants to give back what should never have been devalued. Having their personhood valued is an integral right of all older residents.

Older residents were not the only ones experiencing devaluation of their personhood. Non-professional staff articulated their own perceptions of devaluation by professional colleagues, *they don't listen to us when we tell them that someone [older resident] is in pain* (NP), or *they just shrug it off when you try and talk to them* (NP), and *they don't respect what we do* (NP*).* Significant others made similar statements, *they [staff] ignore me when I come in,* (SO), *they don't like me* (SO), *you have to keep asking, and asking, and even then, they [staff]*

don't listen (SO), *you can just see it in their faces that they think I'm just complaining again* (SO), and *they just sit out there and ignore us at the desk* (SO).

Perhaps devaluing reflects the ageism evident within the larger society. Available research evidence clearly identifies that negative attitudes have the potential to adversely affect the quality of patient care (Robinson, 1993; Sarvela & Moore, 1989). It is also possible that devaluation expressed by participants reflects normative differences among cultural sub-groups who have different roles within that culture. Such sub-groups have varying rules and norms that deal with interactions among them and with other sub-groups, for example between registered nurses and non-professional staff. Devaluing may also be a way of expressing varying amounts of power allocated to different cultural sub-groups. Sheridan and colleagues (1992) identified that in state nursing homes which failed inspections, the organizational climate was evaluated as showing disdain for lower level care providers. Monahan and McCarthy (1992) reported that nurses' aides "wanted to be valued, they wanted appreciation, praise" (p. 14) ... and comments that devalued them did not promote work gratification. Another explanation for the devaluating of personhood may be the increased emphasis placed by society upon informatics and high technology that might appear to negate the person. Such emphasis upon the learning of and the use of technology displaces the seemingly simpler and yet much richer skills of valuing personhood.

Inference 2: (De)Valued Personhood Underlies "like best" and "like least" Behaviours.

"Like best" and "like least" behaviours toward older residents included a range of instrumental, emotive and relational activities by cultural members. What connected all "like best" behaviours is that they were performed with valuing of

personhood. "Like least" behaviours were often, but not always, aligned to devaluing of personhood, ***she was really rough*** (OR), or ***just pushed her over*** (OR), or ***refused to take her [older resident] to the bathroom when she asked ... told her to wait and never came back*** (SO).

Both within and across cultural sub-groups, participants interpreted behaviours differently. A common example was non-professional staff and older residents. The latter saw themselves as demonstrating satisfactory nursing care, yet residents perceived their actions as devaluing, *if we don't change their pants, then they'll get sores* (NP). While a resident said, *you can see them changing her ... [staff] leave the door open* (OR). Another example was in the perceptions of significant others and all levels of staff; significant others saw their personhood being devalued when they voiced concerns about nursing actions towards older family members and how staff responded to them, yet staff perceived their own actions as appropriate. Such differences of perceptions may be due to the variety of ethnic backgrounds of cultural subgroups. Grau and Wellin (1992) reported that sociocultural heterogeneity between residents and staff resulted in family complaints, which triggered defensive strategies to protect the nursing home facility. Castle, Brannon and Ringenbach (1996) reported that cultural diversity, and related poor language skills and inferior educational opportunities could lead to estrangement of cultural sub-groups. Tellis-Nayack and Tellis-Nayak (1989) indicated that minority staff experienced alienation from the mainstream cultural group of the facility in which they are employed, and Singh, Amidon, Shi and Samuels (1996) reported that there appears to be a relationship between the cultural mix of residents and quality of care in nursing facilities. If sociocultural heterogeneity as a reason for interpretative differences is valid, then an ethnic

reality check is needed to verify if the assumptions about what constitutes "like best" and "like least" care toward older residents are valid. It may well be that cultural sub-groups, because of ethnic differences, approach the care of older residents differently.

It is not valid to assume that valuing of personhood will protect older residents from "like least" behaviours. Some "like least" behaviours reflected handling of the resident's body by staff when performing nursing care, *I cried out when they turned me* (OR), and *sometimes we do cause pain ... when we have to get them [residents] out of bed* (NP). They were described as "like least" because there was an infliction and perception of hurt. However, the attitude and manner of staff demonstrated valuing of personhood, *we know that it hurts, but we have to do it or they'll get [bed] sores* (NP), and *we give her something [pain medication] before we get her [resident] out of bed so it doesn't hurt as much, no body wants to hurt a resident* (RN). The physical condition of the older resident was such that hurt was inevitable. This is a reality of the long-term care institutional culture.

Inference 3: Older Residents experience Devalued Personhood.

In the view of this researcher, personhood is the central and most important concept within the long-term care institutional culture, yet also one of the most elusive concepts to reflect upon. It resonates with the belief systems of the members of this culture; those patterns of thought regarding the origin, cause, purpose and place of humans in the universe. Belief systems give identity and importance to people, and provide frameworks by which people structure their lives. Within these systems typically professional nursing practice settings (such as long-term care institutions), include codes of ethics, which prescribe one's conduct. In addition, staff and older residents have personal belief systems or

may subscribe to a religion that includes a belief system. It is these belief systems which articulate the importance of respect and dignity, as one nurse said *you have to treat them with respect* (RN) ... *dignity* (SO), or as an older resident voiced, *how would you like to be treated.... like a human being* (OR) while another participant said *treat them like a member of your family* (SO).

Manifestation of devaluing is witnessed in the language differences between the different cultural sub-groups. The aspects of the older resident's life which are usually reported at staff changeovers and documented in the chart conformed to the objective, empirical basis of nursing. Out of an initial count of 100 staff-resident interactions done during the first participant observation visit, 98% were instrumental in nature; and of these toileting, meal times and personal hygiene activities were dominant. This type of interaction may also be described as objective in nature in that the intent of them is to facilitate the completion of the instrumental activities of daily living for the resident. However, many older residents lived their lives through subjective narratives. As one participant voiced *I use to teach the exercise program here, then they got in a damn therapist and she said I couldn't do it. She teaches the program that I developed for the city and it was damn good. I used to lead the classes here and they [other residents] liked it. They said it was easy to do. We all had a laugh* (OR). In these narratives, the inner wishes or lives of older residents are heard. The clash of objectivity and subjectivity may devalue personhood, since it means that the voice of the older resident is lost in the formal, objective setting of long-term institution. Tellis-Nyak and Tellis-Nyak (1989) suggested that the *separate worlds* of aides and residents resulted in social tension that may be difficult to bridge. This cultural and social separation was also identified by Grau, Chandler, and Saunders (1995). If cultural

members are talking in different languages, of subjectivity versus objectivity, then they may not be able to communicate with each other.

The devaluing of personhood of older residents is supported in the literature. Bowers (1988) found that family members of nursing home residents emphasized the importance of staff efforts to preserve the *self* of their relatives by viewing them as unique individuals. Grau, Chandler, and Saunders (1995) employed qualitative interviews to assess nursing home residents' perceptions of nursing home experiences. More negative experiences were reported than positive, and the majority of these had as their referent point the interpersonal behaviour of other cultural members. The implication is that some interpersonal behaviours devalued older residents.

It is important to note that there are some exceptions to this finding; for example, Looman, Noelker, Schur, Whitlatch and Ejaz (1997) investigation of family members' positive perceptions of the care provided by nursing home staff to older members. The ability to acknowledge an older resident as a person was perceived as one of the attributes of an engaged nurse. Older adults desired to be acknowledged as the people they were beyond the hospital bed. Acknowledgement included the resident's need for individualized attention from the nurse that made one feel special, treated as an individual, comforted, supported and safe.

Inference 4: Within the Long-term Care Institutional Culture, there are Factors which Promote Personhood, and those which Devalue it.

Factors Promoting Personhood

Personhood promotive traits advance personhood through valuing the uniqueness of each cultural member, in this case the older resident. For example,

when participants were asked about the behaviours toward older residents they "like least" and "like best", there was an underlying assumption validated with participants that some behaviours which value personhood are more caring than others, or that some behaviours demonstrate caring whereas others do not. Caring is defined as the action of the verb *care*, "concern, attention, regard...a view to protect...to look after...provide for" (The Oxford English Dictionary,1989, p. 893). As Gadow (1988) wrote, caring emerges from a commitment to the protection and enhancement of human dignity. It may be argued that caring is part of one's concept of personhood; that a caring person is able to acknowledge and affirm personhood in another. It is integral to the practice of nursing. Watson (1988) wrote that nursing is moving "out of an era in which curing is dominant into an era in which caring must take precedence" (p. 175). Caring is not a mantle one assumes when one walks through the doors of the long-term care institution. It is integral to one's own humanness. Gadow suggested that caring is the commitment to alleviate another's vulnerability. Surely, older residents are among the most vulnerable members of the long-term care culture. How do staff demonstrate caring towards older residents? Data from the participants indicated that active listening to older residents, meeting their needs in a timely fashion, using humour appropriately, and providing a special warmth are caring behaviours. Care was given from a holistic perspective, *recognizing the physical, emotional, social and spiritual needs of older residents* (RN) and the complex, inter-related nature of these same needs.

Through the observations, interviews and focus groups, it was noted some members of the long-term care institutional culture have a sincere and deep commitment to the personhood of all members. As they said *you can't just do*

physical care (RN), *you have to look at the person* (NP), and *we have to worry about the family too at times, because they may need to take a break and not visit so much* (RN). Residents themselves are often actively involved in promoting the personhood of other residents, the example of one older man assisting another with putting on a shirt protector (RO), or of a roommate getting the wool for another illustrates this reality. As one older resident said, *I like to keep busy, they [other residents] need me. It helps the staff* (OR), and another stated *what's the point of ringing the bell, when you can do it for her [roommate]* (OR).

Institutional traits are defined as the physical environment of the facility and its organizational structure. Singh and associates (1996) reported that the amount of time administrators spend in functions related to resident care appeared to have a positive influence on quality of care. They also identified that stability of the administrator of a facility as measured by length of employment had a positive influence. Developed by administrators, and sometimes by unit staff, the policies and procedures of a long-term care institution support the health and well-being of older residents (Interhospital Domestic Violence Committee – Saskatchewan, 1995; National Clearing House on Family Violence, 1994; Newfoundland and Labrador Health Care Association, 1996).

Factors Devaluing Personhood

There are factors within this culture that devalue the personhood of cultural members. For example, staff and older residents may not be able to talk to each other with clarity and common understanding; to say what they mean or mean what they say, though they use the same words. Sandelowski (1991) described this association as asymmetrical in nature with the nurse typically dominant and directive. Conversely, lack of a common language may drown out personhood.

People speaking different languages can not understand each other. Some residents are silenced by an inability to write well or speak coherently due to pathological or aging deterioration which renders them mute. As one participant said, *you have to talk to them as children*, (RN), while an older resident stated, *you can't even talk to them in English. They just ignore you* (OR).

Another factor which devalues personhood is the picture of older residents that staff appear to have; a view of the institutionalized older resident as passive. It is staff themselves who are the active participants of the culture. A staff member reported *we have to do it for them, that's why they're here* (RN), *they can't do it for themselves* (NP), and *most of our residents can not even toilet themselves* (RN). Frequently residents were lined up in the halls without involvement in recreational or other inter-relational activities. An observed example was a newspaper reading session (RO). A nurse's aide read the daily paper to a group of residents gathered for the activity. Her voice never changed as she read a variety of articles from the front page of the paper. No questions were asked of those residents present, nor was any effort made to engage them in a discussion of the events. When one resident asked a question, a brief three-word reply was given. When the researcher talked to several of the residents later, they were aware of the events read from the paper.

Ageism is another reason for devalued personhood. It refers to a social formation or social construction of self in relation to advancing age. It is influenced by the collective norms, values, prejudices and preconceptions "...that have evolved over time and are sustained with minimal consciousness on our part" (Witherell & Noddings, 1991, p.85). Participants develop their concepts of ageism by thinking, feeling, acting and indeed living their lives in terms of and

those of others about the aged. Staff and older residents have been raised within a societal context; a context which appears to influence them towards devalued personhood in old age. Additionally, some cultural members may have inaccurate knowledge or negative stereotypes regarding older residents. As one resident said, *the staff don't really know what I like. They don't ask* (OR). Research cited in Chapter 3 provided evidence of a positive correlation between the attitudes of staff and quality of care given to older residents (Elander, Drechsler & Persson, 1993; Hofland, 1990; Jameton, 1988; Wells & Singer, 1988).

The "sense of home" which residents are encouraged to develop conflicts with the job perceptions of some participants. Non-professional staff have the perception that caring for older residents is a job, *we are not paid enough* (NP), and *it's hard work for the little money* (NP), and *it's a job worked 7 to 3, or 3 to 11 or 11 to 7 and then one goes home* (RN). Job orientation appears to facilitate devalued personhood in older residents, as witnessed during data collection. The activities of the long-term care institution are task orientated and the interactions of resident and staff reflected this reality of practice. This contributes to a sense of job versus acknowledgement of personhood. Nearly all observations and reported definitions of resident abuse can be related to careless or callous interactions between caregivers and older residents. High work motivation and good job performance of these primary care workers are essential to provide a personhood focused culture. Additionally, these staff perform intimate functional tasks that invade personal privacy, possibly increasing residents' sensitivity to the manner in which this care is provided. Non-professional staff may have little extrinsic motivation to provide high quality care. They receive minimal job education, generally *low wages and poor job benefits* (NP) and in the majority of

long-term care institutions have *no opportunity for promotion based on job performance* (NP).

Devalued personhood also emerged because of the power structure that exists within long-term care institutions. The frequent response that values and attitudes are filtered down from administration fails to recognize the power of other members of the long-term institutional culture, *you know who the real leaders are around here, and it's often not the registered nurse* (NP). Also important is the cultural and social distance that separates some cultural sub-groups from others, for example non-professional from professional staff, and staff from residents. As one non-professional staff said *if you're on a good team, it's great, but if it's a bad team, then you each do your own thing* (NP), while another stated *they [administration] have been trying to deal with the problems on the team* (NP). In this study, non-professional staff employed in urban institutions represented economically disadvantaged minority groups, while residents were predominately white and from working or middle classes. The separate worlds of non-professional staff and residents may be difficult to bridge.

Power appears to have a cascade effect within this culture. The power struggles unfolding within the experience of staff and resident could be described as a circle, staff are trying to exercise their power over residents, and at the same time staff experience feelings of powerlessness because they are unable to fulfil their role as a professional practitioner. Devalued personhood gravitates towards the relationship of greatest power differential. It is the powerful against the weak. As one resident said *I'm not a child, I don't want to be treated like one* (OR).

Part of the devalued personhood in older residents is conflicting cultural sub-group values where values compete with one another. Competing values

occur on various levels: personal, professional, interpersonal, and organizational. As individuals, the cultural members hold their own set of personal values that are important in their lives. For the most part, personal values are usually compatible with other cultural values found within long-term care. However, there are times when individual values come into conflict with those of other cultural members. Part of the conflicting values originate in the use of the word *home* to describe a long-term care institution. If *we call such a facility a home, are we not setting up an older resident* (NP), setting expectations, that things will be like they were at home, that one will get choices and make personal decisions?

Another factor devaluing personhood is the clash between values of the various cultural group members and context of the long-term care institution, specifically administrative policies and procedures. Institutional traits and schedules describe the physical setting of the long-term care institution and its organizational practices. Nursing practices in the five institutions were similar. Mornings are fairly busy as staff try to complete the bulk of their work by lunch-time, sometimes with too few on to enable them to carry it out at a more reasonable pace. As some participants said, *we just have too big a workload and they [administration] don't care* (NP), " *there is never enough time, and never enough staff* (NP), and *the expectations [from administration] are too high, most aren't ever on the floor, they don't know what it's like* (NP). On days when students participated in institutional life, the pace increased. The lives of older residents are organized around routines: getting up and dressed for breakfast, meal times, scheduled afternoon activity, snack breaks and then to bed. Such activities tend to transform the older resident to that of object, with little control, power, or ability to participate in decision-making activities. The decision-making

activities are dictated by the strict adherence of most of the staff to accepted routines.

Staff work within a facility with its own regulations, rules and procedures. These often hinder them from entering a personhood relationship with other cultural members, specifically older residents, since their perceived priorities are not resident care but rather meeting institutional demands. Bathing routines, two-hour toileting schedules and regulated mealtimes are the norm. As one participant said, *why can't we leave them in bed for breakfast* (RN), and another stated, *we are better than we once were, but we still have our routines* (NP). A nurse reported, *I got disciplined for putting a resident to bed when he wanted to go because the care plan said his bedtime was 8:30 and it was only 7:30* (RN).

The ringing of call bells in long-term care is constant. The security system itself, double locked gate and coded access panel, are part of the physical environment and are present in all five institutions. As most residents have little or no access to the outside world, other aspects of the long-term care facility appear to take on greater importance. A resident told another resident that he was sitting in *someone else's chair*, and *not to sit there* (OR). This re-enforcement of place was strongly evident in the dining room during meals, and staff and residents alike supported this concern about space. There existed a sense of attachment to one's personal space, that immediate area surrounding one's own bed and chair. A place to retreat to - one that offers some privacy and a place to entertain visitors, is important. At times, residents are able to choose their own rooms, although if a private room is desired, the person may need to wait. One lady, over eighty, who shared a room and did not seem to mind, as she spoke of doing and *looking after the others*, of *taking care of them because it helps the staff out* (OR).

However, this same resident spoke of being moved from one wing of the facility to another without her consent. While she protested the move, it went ahead.

Control through policies or call bells is associated with power, *we have the power not the residents, and we make the decisions* (RN) as a participant said. In control, the care providers have a goal to achieve and the older resident has to conform. Failure to conform with the control agent may draw reprisal from staff, as several residents said *if they don't like it, they let you know*, or *they just don't answer the bell*, and *they punish you* (OR). Often the first thing voiced by older residents when asked about care "liked best" was *oh, they are good here* or *everyone treats you well* (OR), and then contradict themselves within a few moments, *they leave you alone. Well, you know, they get busy, you can't blame them if they lose their temper* (SO), and *I would too if I had to deal with us all the time* (OR).

<u>Inference 5: Resident Abuse is Nameless.</u>

In responding to the question "How would you define resident abuse" some participants suggested it masked crimes, *it's stealing* (RN), *when we "man handle" [a resident]* (NP), and *it's family members taking their [residents'] money* (NP). Others used the word as it if had a precise categorization, *it's financial, material ... sexual exploitation* (RN), and some defined the term as pain, *it's hurting* (NP). When asked what behaviors might demonstrate resident abuse, they included a range of them: *hitting* (RN, NP, OR, SO), *pinching* (RN, NP, OR), *yelling at a resident* (RN, NP, SO, OR), *hurting them* (RN, SO), *not treating them properly*(SO), *slapping them across the face* (NP), *don't give them choices* (RN, NP*), breaking a resident's arm* (RN, SO), *breaking a leg [residents]* (OR),*ignoring needs of residents* (SO), *lack of knowledge of who resident is* (SO), *wheelchair*

belts (SO), *decisions made based on what staff want, making it easy for them [staff]* (SO), *refusing to take them to the bathroom* (RN, OR NP), *feeding too fast* (RN, NP, SO), *inappropriate use of restraints* (RN, NP). When probed, participants perceived these behaviors as abuse if they caused hurt or pain to older residents.

Often participants expressed the view that they have never acknowledged resident abuse. It was an experience, which many voiced, *does not happen in this place* (RN), *well it happens to children* (SO), *I've never thought about it* (RN), *we don't have that sort of thing here, most of them [staff] are nice* (OR), *I suppose it happens in other places, but not here* (RN), *I guess we have it because the government tells us we do* (RN), and *I've never seen it here* (SO). When asked to provide examples of possible abusive behaviours, some participants voiced a connection, *I guess that you would call that abuse* (NP), and *I didn't think about it as abuse, but I suppose it is* (RN). Yet participants from all cultural sub-groups identified that they had seen the provided behavioral examples of resident abuse within their facilities.

One reason for providing behavioural examples of resident abuse, and yet also stating that it did not occur within their facilities, was perhaps to ensure an older family member did not experience retaliation from staff if they heard that complaints were made against them or the facility. This is a documented reason for not reporting institutional abuse (Hall & Brocksnick, 1995; Sengstock, McFarland & Hwalek, 1990). Family members perhaps participated in the study because they felt that the administration expected it, since they had given their permission for the researcher to approach the family. Participation then conformed to the expectations that they felt were placed upon them; however,

stating it did not occur might have been a protective mechanism. Family members perhaps saw themselves as vulnerable members, subject to the wishes of administration.

Another reason may be the increasing emphasis that long-term care institutional administrators and the Alberta provincial government place on resident abuse policies and procedures. Perhaps nursing staff fear the consequences of their actions. For older residents and significant others, who were in the same age cohort, stating that resident abuse did not occur may reflect their generational perspective. Since resident abuse is a term of relatively recent origin, it is not a term that they probably heard when growing up. It may not be within their common language core (see Chapter 3). For registered nurses, it is a term entering their required repertoire, but not one that they were exposed to during their basic nursing educational programs or staff in-services. In the study reported here, this is supported by the fact that eight of the ten registered nurses, and two of the eleven non-professional staff had never attend an education session on resident abuse.

However, the primary reason for observing examples of resident abuse behaviours and yet denying that it occurred within their own facilities was that participants did not categorize the behaviours as falling under the heading label of resident abuse. They perceived examples of resident abuse as discrete and distinct behaviours, not as examples of a concept. Participants did not perceive *resident abuse* as a distinct concept, since it was not a part of their cultural language. This differs from what the cited literature in Chapter 2 suggested that resident abuse is a specific heading under which a variety of behaviours fell. This difference in the study's findings from that identified in the reviewed literature is

significant. The reason for the difference is the research method used to explore the concept of resident abuse. Those outside the long-term care institution, including some researchers, come into the facility and bring with them a category of behaviours that have been subsumed by them to be under the heading label of resident abuse.

As such, it is in the lack of a name that the experience of resident abuse exists, not in its naming. In abuse, one feels the hitting or hears the swearing. In reflecting back one might say *yes, that was abuse*, in that I felt used and powerless, and that the action was intended to hurt, but naming is not part of the experience. The answers to the question, "How would you define resident abuse" by participants suggest that naming is not part of the resident abuse experience. Abuse is a name given through reflection back upon an encounter, or as an answer to a question asked, as one participants said, *I guess it's abuse, but I never thought about it* (RN). The researcher, an outsider of the long-term care institution, asked the question. It was the outsider who named the experience. The naming of *resident abuse* is itself contradictory to the experience. One who experiences it does not call it abuse; the behaviours or the feelings are described, *she yelled at me* (OR), *she ignored my mother* (SO), or *when I asked for a cup of hot tea, she just gripped my arm and pushed me into the chair* (OR), not *I was abused*. Abuse is not the discourse employed in everyday speech by members of this culture. It is a label given by outsiders.

Inference 6: Resident Abuse is a Perception of Hurt.

Perception of hurt is an integral element of resident abuse. Hurt is physical and/or psychological in nature, pain of body and soul. As such, it accompanies resident abuse as a mode of being in the world. It may be temporary and fleeting

in nature or of longer duration. Examples of resident abuse behaviours provided by participants identified that some were intended to hurt, *I've seen them push her into a chair because she was trying to get up, and they didn't like it* (SO), and *she slapped him hard* (NP). This is consistent with the literature reviewed in Chapter 2 in that the abuse carries with it the self-serving misuse of another person. The intention of an abuser was to inflict hurt and pain. The abuser was aware of personal actions and their consequences.

However, intent was not a consistent finding in this study. Sometimes there was no intent to hurt, but there was a perception of it. Resident abuse occurred when the outcome of the behaviour was a perception of hurt to an older resident. An example was staff entering a resident's room without knocking, *they just come in when they want, ... no privacy* (OR), or *staff walking in and leaving clean towels on the bed without saying a word to the resident* (OR). While there was no deliberate intent to hurt, the behaviour was perceived as hurtful and thus potentially abusive by the older resident or by another cultural member.

If hurt is in the perception of a participant (cultural member), it raises the question of who defines resident abuse. Participants saw it as their responsibility to articulate hurt on behalf of older residents, *when we don't close the bathroom door* (NP) and *letting them walk around with wet pants because that's an expression of their rights, when they [resident] doesn't even know they are wet* (RN). A staff member may cause bruising to the arm of the older resident when she transfers him to a wheelchair. Is there an intention to hurt in such an outcome? Is there a perception of hurt? Often older residents are unable to voice their hurt because of cognitive or physical impediments. Other participants voiced it for them. This means that the cultural member perceives and judges an action

on behalf of another; misinterpretation is possible. One example was a loud and seemingly rude interaction between a registered nurse and an older resident. Upon its completion, the staff member turned, saw the researcher and appeared startled. She said *she expects it, she'd be upset if we didn't have our morning spat* (RN). Dialogue later with the same resident confirmed the nurse's statement, *we have a go at each other every morning, she likes it, ... gets my day going right* (OR). If an event occurs between two people and is not perceived by either as hurtful or as resident abuse, is it to be termed abuse because another, an outsider, suggests it? This is the pattern that dominates the vast majority of studies conducted to date on institutional abuse. These outsiders enter the long-term care culture with a preconceived definition of what is resident abuse, and what behaviours one might expect to see.

Inference 7: Resident Abuse is Relational.

Relationships between older residents and other cultural members are not something one has, as they were possessions, but rather are exchanges in which one is relating to and interacting with another, such as between registered nurses and older residents, or non-professional staff and significant others. Such relationships should contribute to the personhood of each, perhaps in affirmation of one's being, or in the giving and receiving of comfort or care. The older resident may affirm the nurse's personhood by saying "thank you" when a second cup of tea is received or another request met. The nurse feels valued and appreciated. In long-term care facilities, the older resident often does not have the option to physically leave a relationship. There is no refuge from an experience that is destructive and detrimental to one's personhood, and perhaps to physical health.

Resident abuse is a relational experience; one party acts and one receives. The older resident receives the hurt inflicted by another cultural member. Thus, by its very nature, abuse is person driven. Its outcome is non-supportive; the perpetrator is not be able to facilitate the growth and well-being of the older resident. This is in sharp distinction with the caring encounters between nursing staff and residents that are expected to occur in long-term care facilities. In theory, the enhanced well-being of the older resident is of paramount importance, and the end to which nursing actions should be drawn.

Resident abuse is experienced as a violation of acceptable standards concerning the interpersonal treatment of others. Thus it contravenes what we, in society, believe to be community norms, despite their transgression being forbidden neither in law nor by institutional regulations. However, there are times when resident abuse contravenes federal or provincial legislation. An example is the new Protection for Persons in Care Act (1997) within the province of Alberta. Whether the breach is one of informally agreed upon acceptable standards or one of legislatively defined conduct, resident abuse is relational in nature.

Inference 8: Resident Abuse is Judged Within a Context of Care

Participants made decisions about resident abuse within two context of care sub-categories: context bound and context free. Context free means that an act was resident abuse regardless of the circumstance in which it occurred. The former, context bound, means that environmental factors were always used by a participant to identify whether an experience was one of resident abuse. One example is an older resident with serious contractures of both legs. Mabel[1] is in bed for most of the day. She had developed a small 2 cm. X 2 cm. decubitus

ulcer on her sacrum. Staff voiced the need to try and keep her off her back to enable the ulcer to heal; however, turning for this particular resident was especially painful. She moaned loudly throughout the procedure. An analgesic administered about an hour prior to turning did not appear to be effective. Staff explained the turning to her, and why they believed that it was necessary. Mabel was unresponsive to their comments, except to continue moaning. Once the turn was made, she immediately stopped moaning and accepted a drink of water from the staff.

According to the definition of resident abuse held by participants, that it is a perception of hurt in the view of the older resident, the argument might be made that the turning of Mabel is an example of such abuse. However in this example, no resident abuse occurred. Care-givers were concerned about Mabel's skin integrity and attempted to inform her of their actions. In addition, they administered an analgesic to Mabel before she was turned, and tried to assess its effectiveness. They judged their actions within the context of care expected by their own professional expectations and those of the long-term care facility in which they were employed. They made the decision that no resident abuse occurred.

Inference 9: Resident Abuse is Preventable.

Behaviors cited as examples of resident abuse show that it is committed by all cultural sub-groups. As to its cause, there appears to be multiple factors that contribute to it, both personal and organizational in nature. Personal factors which might contribute to resident abuse include: when staff are inadequately prepared to provide care to older resident; perhaps language differences, ethnic practices,

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[1] name changed

lack of education specifically of knowledge of normal aging changes or of how to respond to some of the behaviors demonstrated by older residents, and lack of choice in obtaining employment. These traits are changeable; suggesting that resident abuse is preventable.

Long-term care residents place an inordinate amount of stress on nursing staff who have to manage and provide nursing care to individuals who are very dependent in their activities of daily living. Chappell and Novak (1994) reported that the number of residents with gross mental impairment and uncooperative behaviours is related to several measures of physical health stress in nursing assistants. Monahan and McCarthy (1992) also reported that nursing aides found their jobs to be physically and emotionally demanding. Stress has been documented as contributing to resident abuse (Boeije, Nievaard & Casparie 1997; Pillemer, 1988; Sengstock, McFarland & Hwalek, 1990). Addressing some of the demands made upon nursing staff, particularly the nonprofessional staff, could decrease stress in the workplace. The implication is that if these factors were addressed, the incidence of resident abuse would decrease.

The nature of the long-term care institutional culture is a function of its context, for example, physical setting, patterns of dialogue among cultural members and sub-groups, historical forces, and administrative personnel and practices. Members live and work within an open system, which means that they are in mutual interaction with these forces. For example, Al-Assaf, Taylor and Langston (1992) reported that the qualifications of nursing home administrators had a bearing on the quality of care given to clients. Singh, Amidon, Shi and Samuels (1996) found that "administrators with nursing backgrounds, who spend time in patient care management and who had long tenure had strong positive

influences on the quality of care within their facilities" (p. 24). Monahan and McCarthy (1992), and Robertson and Cummings (1996) reported similar findings. It is assumed that the absence of such factors contributes to poor quality of care, and potentially to resident abuse. Administrative changes, hiring policies and educational opportunities being provided to cultural members can address these forces. This also means resident abuse is often preventable.

Inference 10: Inadequate Care is Institutionally Driven.

Differentiation made by participants between the terms resident abuse, neglect and inadequate care identified three distinct phenomena. They defined "inadequate care" as the inability to provide adequate or needed nursing care because of institutional (or organizational) constraints. These constraints were clearly perceived by them as factors outside of their individual control, *you can't deal with 16 residents on evenings, it is just too many, you can't do a good job* (NP), *inadequate staffing* (NP), *they [non professional staff] do not have enough training when they are hired* (RN), *they [administrators/managers] are never on the unit* (NP), *never anybody around on evenings* (SO), and *takes them ages to answer the bell* (OR). Other comments included; *you do the best you can, but they [administration] don't give you the credit, they just push harder* (RN), and *saving money is the bottom line* (NP). These constraints acknowledged the extent of nurse aides' preparation for the position, on the job training or its lack, staffing patterns, administrative styles, institutional routines, and financial resource allocation both to and by the long-term care facility.

Research has been conducted on these constraints within the long-term care institution and their role in influencing the behavior of members of this culture. Crown, Ahlburg and MacAdam (1995) reported that nursing home aides

have less education than those employed in acute care facilities. This suggests they have less knowledge of how to cope both with stress and its causes, and with the sometimes disturbing behaviours of older residents. Monahan and McCarthy (1992) reported that nurses' aides cited lack of time to give older residents quality care, and short staffing as contributors to attrition and poor morale. Hare, Pratt and Andrews (1988), and Bosch and Lange (1987) identified that shift work, rotating shifts and low pay are related to workplace stress. A shortage in nursing personnel in long-term institutional care is supported by the findings of Francese and Mohler (1994). Such a shortage jeopardizes the ability of staff to perform needed nursing care. The cost of nursing care is dealt with by employing the least expensive and prepared staff. The level of resource allocation within nursing homes has been found to relate to quality of resident outcomes (Aaronson, Zinn, & Rosko, 1994; Robertson & Cummings, 1996). Hasselkus, Dickie and Gregory (1997) reported that lack of funding for nursing home equipment was dissatisfying to staff and detrimental to the well-being of older residents.

These constraints are factors which participants believe contribute to inadequate care, but not to resident abuse. Their differentiation was made on the basis of desire. If care-givers wanted to perform needed nursing care but were unable to because of such institutional constraints, then inadequate care occurred but not resident abuse. As some participants stated, *there is only one registered nurse on at night* (RN), and *when you have to feed half a dozen [residents] at one time, then it is just an assembly line* (NP). This inference is of concern. With Alberta's and Canada's aging populations, the need for long-term care institutional beds is increasing. The older residents who occupy these beds often require extensive nursing care related to their consequential losses of physical and/or

cognitive functioning. This means that those who work with them require institutional (organizational) support to provide required care; however, the findings of this study suggest that such support is not always forthcoming.

Inference 11: Resident Abuse occurs Independently of Devalued Personhood.

Devalued personhood and resident abuse both occur within the culture of long-term care institutions. The relationship of devalued personhood and resident abuse is compared to a double helix. While both strands can be separated out for independent study, they are interwoven together within the culture of in long-term care institutions. Attitudes and actions, which demonstrates for example, lack of respect and/or dignity towards older residents, are evidence of devalued personhood which contributes to increased likelihood that resident abuse will occur.

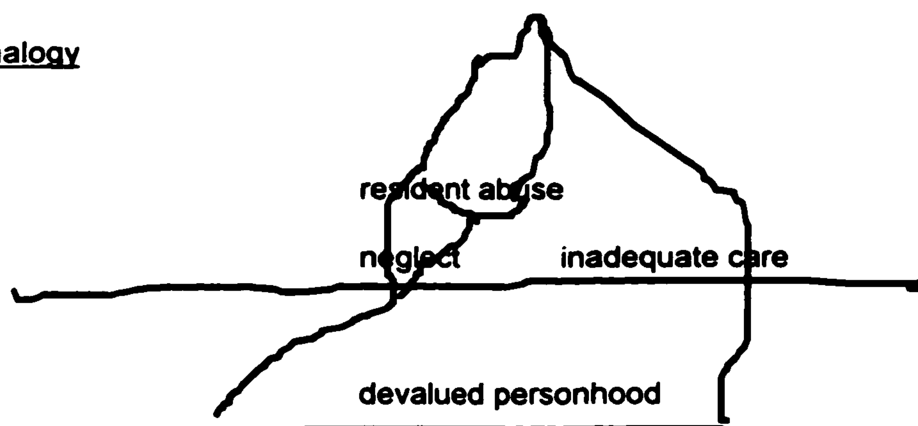
Inference 12: Resident Abuse is Interwoven with Neglect, Inadequate Care and Devalued Personhood.

The pre-identified and independent concepts of resident abuse, neglect and inadequate care studied in this research are woven together, in association with the concept of personhood that emerged from the data. As articulated earlier in this chapter, personhood describes recognizing and valuing the uniqueness of each individual. Study findings underscore the importance of valuing personhood within the culture under study. Participants voiced the desire to be treated in accordance with the attributes of personhood, for example, respect, dignity, being listened to, and valuing. This applied to themselves and to other cultural members. However, they also identified that devalued personhood often occurred within the long-term care institutional culture.

Devalued personhood meant failure to acknowledge personhood. It was not limited to the one cultural sub-group of older residents, but to all studied sub-groups. Devalued personhood is the foundation upon which experiences of neglect, inadequate care and resident abuse lie. The use of an iceberg analogy is appropriate to this discussion to explain this relationship. This is illustrated in figure 6.1.

Figure 6.1

Iceberg Analogy



Devalued personhood underlies resident abuse, neglect and inadequate care. If personhood is acknowledged and supported, then the attitudes and behaviors that constitute resident abuse should not be present. However, because resident abuse is a perception of hurt that may arise even with the most caring of nursing actions, valuing personhood does not remove the risk of resident abuse. It is worth asking if devalued personhood is a self-perception that accompanies resident abuse?

Individuals to the extent that they can use their self-power and with awareness, can freely choose to value or devalue older residents and other cultural members. However, since they are inextricable in mutual interaction with other cultural members and with the long-term care institution itself, both of whom

who are also participating (knowingly or not) in (de)valuing personhood, the feelings that emerge are unpredictable. This means that devalued personhood may result from the most caring actions of staff. While all cultural members are expected to promote personhood, there are some who lack the knowledge, skills and awareness to promote it, and this lack may contribute to devalued personhood. Roberto, Wacker, Jewell and Rickard (1997) identified that non-professional staff were less aware of appropriate responses to meet residents' rights to privacy, choice and respect than were registered nurses.

Neglect is the deliberate action or lack of action towards meeting the needs of older residents by cultural members. Participants spoke of neglect committed by staff and significant others. It rests upon devalued personhood. If cultural members valued another, neglect would not occur since the actions of those individuals would demonstrate attempts to meet identified needs. Older residents are a population vulnerable to neglect because they have decreased ability to voice both their needs and dissatisfaction when they are not met. They also have reduced control over their environment that means they rely on others to meet their needs (Elander, Drechsler & Persson, 1993; Hofland, 1990; Jameton, 1988; Kane, Freeman, Chaplan, Aroskar, & Urv-Wong, 1990; Wells & Singer, 1988).

Inadequate care was perceived by participants as caused by institutional (or organizational) constraints outside their individual control. Since the perception of institutional factors is influenced by the manner in which procedures and policies are implemented, how staffing patterns are constructed, and how cultural members' input into facility concerns are addressed, it too is influenced by (de)valuing of personhood. In long-term care institutions where staff perceive inadequate care levels are high, they also note that administrators have less

respect and concern for them, and decreased interaction with them. Sheridan and his associates (1992) identified poor human resource management as the key underlying factor contributing to poor care in nursing homes. Facilities, in which staff hold the opinion that inadequate care levels are low, possess institutional factors which create and support a culture that values personhood. Thus, inadequate care rests also upon the foundation of devalued personhood.

Summary

Discussed in this chapter are the findings from the study. Valuing the personhood of older residents and other cultural members is the foundation that caring in long-term care institutions rests upon. Devaluing of it contributes to resident abuse, neglect and inadequate care. Resident abuse is defined as a perception of hurt; an older resident may express this or it may be the viewpoint of a cultural member on behalf of the resident. This reflects the inability of many long-term care older residents to speak for themselves. Participants cited numerous behaviours that they identified as examples of resident abuse. However, they also identified that resident abuse is not a term used by them. It is a term imposed by outsiders upon the long-term institutional care culture.

CHAPTER 7

Conclusion and Recommendations

Recognition of the need for quality of care for older adults within long-term care institutions has gained increasing prominence over the past several decades. One of the consequences of this recognition is the awareness that resident abuse occurs within such settings. The long-term care institution is itself a culture with its own rules, behaviours and distinctive society. Those individuals who live, work and visit long-term care facilities may be described as cultural members.

The primary question in this study was *what is resident abuse as perceived by the long-term institutional care culture?* Secondary questions included: *how do participants perceive resident abuse? How do participants differentiate abuse from neglect and inadequate care?* and *what differences are there among the perceptions of different population sub-groups?* Ethnography, ethnoscience and content analysis were used. Participant observation occurred in five urban long-term care institutions. Groups of registered nurses, non-professional staff, older residents and significant others were interviewed individually and participated in focus groups. Non-professional staff participated only in focus groups. Patterns of meaning of resident abuse were developed from the data collected from participants of all sub-groups. A taxonomy of resident abuse evolved from the data collected from registered nurses only.

Resident abuse is perceived by participants from all sub-groups as behaviour that causes a perception of hurt in older residents. There was strong agreement among the participants and sub-groups on this perception. This perception of hurt is voiced by either older residents themselves or by other

members of the long-term care culture on their behalf. Participants' views about resident abuse are always judged within the context of institutional life. Two other findings of special interest are noted: (1) within the culture under study, devalued personhood is a common experience of older residents. Devalued personhood often, but not always accompanies resident abuse. (2) Participants often voiced that resident abuse was not present within their facilities; however, they stated that behaviours that they described as resident abuse were common, for example, yelling, hitting and pinching.

This inconsistency has enormous implications for health care and policy development and implementation related to resident abuse within a variety of health care facilities, not just long-term care institutions. Participants of this study are members of the larger society in which long-term care institutions exist. It maybe then that registered nurses who work in health care settings, other than long-term care institutions, might hold similar views of resident abuse as did participants of this study, as may significant others, and other categories of nursing staff. Thus, the knowledge gained from this study might apply to a range of health care settings. Staff working in such facilities will need to reflect upon the findings of this study, and consider their own perceptions and definitions of resident abuse, and think about their own behaviours towards clients (residents) of all ages, as should all members of society.

In this chapter, the implications of the study's findings are considered in terms of recommendations. Recognition is given throughout to the roles that registered nurses should assume in addressing resident abuse.

Recommendation 1: Researchers, Governments and Long-term Institutional Care Cultures need to Collaboratively Define Resident Abuse.

The phenomenon of resident abuse is not a simple one. It has numerous definitions and descriptors as illustrated in Chapter 2. Currently, there is no universally accepted definition of the term, resident abuse. The existence of a number of different ways in the professional literature of speaking about resident abuse is perhaps an indication that there are a number of different things to be said about it or ways to describe it.

This study used language to describe the perceptions of members of the long-term care institution culture of resident abuse. As Spradley (1979) wrote, "Language is the primary symbol system that encodes cultural meaning in every society. Language can be used to talk about all other encoded symbols." (p. 99). The language that is used by cultural members provides important clues as to how people define experiences and classify their world. This holds true for all cultural settings, including long-term care institutions.

The study of language led to a description of what cultural members thought resident abuse was like and how they defined it. Words are defined according to the perception of the meaning attributed to the experience in relation to other cultural events and experiences. This was how participants defined and perceived resident abuse; an experience judged within the context in which it occurred.

Findings from this study identified that the definitions of resident abuse that have been generated outside the long-term care institution are not consistent with the definition that emerged from within the culture itself. Resident abuse was defined by this study's participants in terms of a resident's emotive response to a

behaviour by a participant, its intent and the context in which the behaviour occurred. External definitions sometimes recognize an emotive response, specifically pain, often acknowledge intent, but never acknowledge context.

Participants in this study made decisions about whether an act was resident abuse within the context in which it occurred, for example, type of behaviour demonstrated by a resident, need to ensure resident safety, or wishes of family members. While some behaviours were always perceived by participants as resident abuse, they still judged them within the context in which they occurred. This means some researchers and participants are not using a common language to discuss resident abuse, and consequently reported incidences of it may be in error.

This is an important point of which politicians and bureaucrats need to be aware, for government legislation such as the Protection for Persons in Care Act enacted by the Government of Alberta (1997) uses an externally imposed definition of resident abuse. The Act states that "abuse means (i) intentionally causing bodily harm, (ii) intentionally causing emotional harm ..." (p. 1). Also included in the Act's definition of abuse are inappropriate use of medications, theft and failure to provide adequate nutrition, adequate medication, medical attention or other necessities of life.

Concluding that resident abuse has occurred may be difficult for long-term care culture members since their definition of resident abuse is different from that identified in the Protection for Persons in Care Act (Government of Alberta, 1997). The validity of the definition of resident abuse within the legislation is problematic for several reasons. The effectiveness of any legislation is directly related to the degree of understanding of resident abuse by those to whom it applies. If a

participant does not perceive resident abuse as occurring then a behaviour will not be reported and an older resident may be left vulnerable to it. Also, if a resident, or other participant, does not perceive an act to be one of resident abuse and an outside visitor to the long-term care facility does and reports it as directed in the Act, there exists the possibility that the participant may be victimized by the legislation.

Compulsory reporting of resident abuse as outlined in the Act enacted by the province of Alberta needs to be amended (Government of Alberta, 1997). The Act makes it compulsory for persons to report cases of abuse against adults in designated facilities; this includes long-term care institutions. Failure to comply is an offense and carries a fine of up to two thousand dollars. The criteria against which a behaviour is identified as being abusive is in accordance with the legislation; however findings from this study identified that participants had different definitions of resident abuse than that used in the Act.

Implementing legislation related to resident abuse is potentially ineffective unless recognition is given to the long-term institutional care culture in which it occurs. Ineffective legislation is wasteful of taxpayers' dollars. The economic costs of resident abuse range from investigation procedures, health care interventions, law enforcement activities, to the lost productivity of those involved in the experience, and these costs fall upon society.

Government and long-term institutions already share the common goal of preventing resident abuse. There are behaviors cited in the government legislation and by institutional personnel which both agree constitute resident abuse; for example, theft, inadequate provision of pain medication, and the intentional failure to provide the necessities of life. However, the Protection for

Persons in Care Act (Government of Alberta, 1997) only addresses intentional acts. Findings from this study identify that unintentional acts may also be perceived as resident abuse, if they cause a perception of hurt in a resident. A common understanding of the term resident abuse needs to exist between long-term institutional care cultures and governments. Mutual collaboration between government politicians and personnel of the long-term care institutional care is necessary to ensure that those who work under the legislation share its language. It is suggested researchers be part of this collaborative process to ensure that they too are working with a similar definition of resident abuse. The value of such revised legislation, done collaboratively, would lie in two areas: (1) more accurate information about resident abuse that would contribute to health care decisions, including resource allocation, and (2) increased quality of life for older residents.

Such collaboration between government and long-term institutions would build a bridge of understanding about resident abuse between the culture itself and the larger society in which it exists. Each culture and cultural group is influenced by the larger society. For example, the social context has shaped long-term care institutional policy and practices over the years. The outcome of collaboration would be a definition of resident abuse that has relevance both for the larger society that legislates actions to address it and for the culture in which it occurs. Working with those who experience resident abuse and using this knowledge to develop legislation is an important aspect of society's development. Such collaboration means that a common definition emerges upon which both the long-term care institution and society can work together to address resident abuse. If bridges are not built between legislative definitions and cultural definitions of resident abuse, then it will continue to occur.

Findings from this study suggest other areas of mutual collaboration. Government and long-term institutions need to have an interdependent commitment to health care education and its funding, and a province wide system for screening job applicants. Lack of knowledge of personhood and attributes which value people as persons, the role that personnel play in (de)valuing of personhood, and the need to promote it when working with older residents were identified in this study. Educational funding is needed to meet these learning needs of institutional personnel. In addition, employment screening processes need to focus on the perceptions of applicants regarding resident abuse, since this study demonstrates that perceptional differences occur. Participants bring with them their own perceptions as to what is resident abuse, a definition that is influenced by their cultural backgrounds and knowledge levels was identified in this study. It is suggested that screening tools should also provide some indication as to how the applicant values or devalues personhood, since it is intertwined with resident abuse. Such collaborative actions should contribute to ending resident abuse. These actions raise privacy and protection of individual rights concerns that will need to be addressed. This should not prevent the implementation of effective and collaboratively designed strategies to prevent resident abuse.

Recommendation 2: Nursing Association Publications related to Resident Abuse need to Reflect Cultural Definitions.

The Canadian Nurses Association in 1992 published clinical guidelines for registered nurses who encounter family violence in their practice. In 1997, the Alberta Association of Registered Nurses published *Professional boundaries: A discussion paper on expectations for nurse-client relationships*. Both documents

address resident abuse. Potentially the documents are resources for personnel working in long-term institutional care.

In neither document are the cultural criteria that define resident abuse within the long-term care institution identified. This is a deficit, as findings from this study identified that differences exist in perceiving resident abuse between those who are institutional personnel, and those who are not. The findings from this study also identified that registered nurses have their own definition of resident abuse and perhaps they do not share the language of their professional associations. It is recommended that professional nursing associations re-examine the documents identified in the opening paragraph (and related ones) to ensure that they reflect institutional definitions of resident abuse.

Professional nursing associations also need to identify the perceptions of resident abuse held by registered nurses in cultural settings, other than long-term care institutions. It may be that each cultural setting has its own definition and understanding of resident abuse. One strategy to achieve this knowledge is the hosting, by nursing associations, of work site focus groups of registered nurses (for example, acute care, community, home care). Nursing associations could also support this investigation through the relationships they have with special interest groups of nurses (for example, gerontological nurses, nurse educators). Such cross-cultural examination will contribute to the development of publications that should forward the work of professional nursing associations to meet the educational needs of its members and to reduce resident abuse.

Since nurse educators often use professional nursing publications in delivery of their courses, there is a benefit to students in the suggested revisions. Nursing students often begin their clinical experience within long-term institutions.

They become members of this culture. They require knowledge of resident abuse, of the language used by other personnel within these institutions to describe resident abuse experiences, and of strategies to recognize and prevent it. Revised publications would help to fulfill these needs.

Findings from this study showed that devaluation of personnel, by different sub-groups, is evident in long-term care institutions. Non-professional staff felt that their voices were not heard by registered nurses, and staff nurses voiced similar feelings about administrative nursing personnel. Joint meetings is one strategy to address this finding since they would provide opportunities to hear each others' voices which will promote personhood.

Recommendation 3: Abuse Free rather than Resident Abuse needs to be a Concern of Long-term Care Institutions.

Current long-term institutional care leadership is responding to media, research and government legislation by the development of policy and related protocols/procedures to address resident abuse. However, while personnel identified that behaviours such as not providing pain medication when needed or food choices, using inappropriate and offensive language, and stealing occur within their facilities; they also stated that resident abuse did not. What is needed in long-term care institutions are policies which promote an abuse free culture. An abuse free perspective is a more personhood orientated approach than resident abuse policy per se, since it focuses on quality of life of residents and not on a specific problem. An abuse free policy statement should acknowledge the valuing of personhood of all people within the institution, and include a definition of resident abuse as it is perceived by them.

There are five points related to the development of an abuse free policy that require discussion. First, valuing the personhood of all people, not just older residents, must be included in the policy. Its inclusion would enable all personnel to understand how their individual contributions, for example promoting personhood through providing choices, or answering call bells, helps to achieve the goal of an abuse free environment. Opportunities should be provided for all persons, including non-professional staff, significant others and residents to contribute to policy development. Often significant others and residents feel threatened and do not report perceptions of hurt or abusive behaviours because they feel care will be compromised, and non-professional staff feel their voices are not heard by registered nurses. These are indications of devaluement of personhood. If the administrative staff of a facility actively seeks the input of all groups within the institution, it would be one way to demonstrate to them that they are valued.

Second, an abuse free environment requires human and material resources to maintain it. Policy provides guidance to long-term institutional care administration in the selection and purchasing of resources necessary for an abuse free environment; for example, educational activities to understand the importance of personhood or in the provision of funds for focus groups of personnel to talk about how residents perceive behaviours. Administration may need to provide support for the (re)-writing of job descriptions, in review of performance measures, and in hiring and employment practices. These documents and practices should include assessment of how individual people promote or negate personhood, and how they contribute to an abuse free facility.

A third point in abuse free policy development is the need for ethical principles to be reflected in them. Findings from the study identified that lack of ethically-orientated care practices, for example failure to knock on a bedroom door before opening it or not closing a bathroom door when a resident is on the toilet demonstrates lack of respect. Ethical principles enhance the operationalization of an abuse free policy and related procedures/protocols, since they promote the valuing of personhood and reduce the possibility of resident abuse.

There is a fourth point; administrative or legal intervention may be required to respond to the actions of some participants within long-term care institutions, for example stealing or physical assault of a resident. An abuse free policy provides assistance to administrators in responding to these actions. However, it is currently difficult to create an abuse free policy because of the definition quandary that prevails regarding resident abuse. Lawyers may be working under a definition of resident abuse that is different to the one used by persons in this study. By employing a culturally created definition versus an external one, policy development, and subsequent assessment and intervention of resident abuse is more likely to be effective within the long-term institutional care culture.

The fifth point relates to the behaviours described by participants as abusive in nature. Such behaviours included shouting, pinching, administering a ropeburn, promoting incontinence with a diaper instead of [adopting] a training program, feeding too quickly, transferring roughly the resident from wheelchair to bed, scratching [by staff] with long nails or rings, and restricting ambulation not justified by the state of the resident. In whatever form it is demonstrated towards an older resident, abuse is wrong. The ethical values that should underlie all human action towards others must be emphasized in long-term care institutions

where often those more vulnerable to ethical insults and injury, such as resident abuse, reside. Personal integrity and responsibility for one's own actions need to be acknowledged.

Resident abuse within long-term care institutions takes its toll on all cultural members. It may well mean the witnessing of abuse increases the likelihood that it will occur again. If the cycle of abuse is to be broken, then recognition of the abuse behaviours must be acknowledged and prevented, and the ethical values which underlie humanity must be emphasized within the facilities. The presence of residents abuse suggests that a segment of the culture accepts, and perhaps endorses it. It is accurate to say that acceptance comes not from agreement that abuse behaviours are acceptable, but rather lack of awareness that these behaviours exemplify resident abuse. It is not enough to establish policies and procedures to assess and intervene in relation to resident abuse. The prevention of abuse requires an examination of the values that underlie long-term care institutions. Policies must promote justice and raise cultural consciousness of this problem.

<u>Recommendation 4: An Advocate needs to be Appointed within Long-term care Institutions.</u>

The need for resident advocacy is obvious. Findings from this study clearly demonstrated that some older residents are abused, and that their personhood is devalued. They are not treated with dignity or respect, and their voices are often unheard. They are also often reluctant to voice their concerns because of possible retaliation. In this study, while three institutions had paid staff assigned to act as an advocate for older residents, in addition to their other job responsibilities, this was not typical. It is difficult for someone who works with

residents to be perceived as impartial if one performs another role (for example, social worker) within the facility. For this reason, an independent individual should be appointed; this may be done through the community service activities of a local university, professional group, or perhaps by cross employment of professionals. An individual could be paid by one facility and work at another as resident advocate. This individual should be given an abuse free policy and related procedures/protocols for dealing with ethical situations, such as lack of pain medication that appears needed, which face institutional residents and staff. If such documentation is not available, then the advocate should be given the responsibility for developing it.

Participants in this study identified that devalued personhood occurs to all sub-groups of people within institutions. Each sub-group needs to have an identified advocate for themselves. The position of resident advocate might be appropriately termed advocate. The individual would assume advocacy responsibilities for promoting an abuse free facility and personhood for all participants. This person should not hold other responsibilities within the long-term care facility. All personnel would have equal access to the advocate, and equality within the setting would support valuing of each individual member.

Recommendation 5: Strategies to Prevent Resident Abuse Using a Critical Thinking Perspective Should be Implemented in Long-term Care Institutions.

Findings from the study identified that all persons within the institution experienced difficulty in defining resident abuse, stating *I've never thought about it [resident abuse]*, or *I suppose that might be called resident abuse*. They did not demonstrate critical thinking about it, perhaps, because they did not believe that it happened within their facilities, and yet they had observed abusive behaviours.

Kurfiss (1988) stated "in critical thinking, all assumptions are open to question, divergent views are aggressively sought and the inquiry is not biased in favor of a particular outcome" (p.2). When operating in this manner, the critical thinking person seeks reasons through evidence upon which to base care decisions, and to ascertain if resident abuse has occurred. It is upon such a foundation that strategies need to be developed and implemented to address resident abuse as it is perceived by participants within long-term care institutions.

For some persons, the primary cause of resident abuse may be lack of knowledge. Findings from this study indicated that some behaviours while unintentional in nature were perceived as hurtful; for example, forced social participation between two residents when the staff member believed that it was in their best interests. Perhaps paternalism or the desire on the part of a staff member to do what is believed in the best interest of the resident, without consulting them, contributes to situations of resident abuse. When this is the case, administrators and educators must identify incorrect beliefs and provide the knowledge required, fomulating accurate understanding of residents' wishes and needs.

Dialogue between staff members must occur. There is a need to encourage critical thinking and interaction around such question as, *what makes this older resident feel valued, how do I communicate with family members so that they perceive their voices are heard,* and *how do I work with colleagues so we all feel respected?* Such interaction among and between different groups has the advantage of helping personnel examine a situation and reach a common decision with others that may have different viewpoints. It promotes critical

thinking and group consensus, so that all work towards common goals based upon mutual understanding of resident abuse.

Recommendation 6: Strategies to Promote Personhood Using an Ethical Care Approach Should be Implemented in Long-term Care Institutions.

Findings clearly indicate that daily, long-term care staff confronted situations where the personhood of older residents, and other personnel is devalued. These situations are often ignored because they are not recognized for what they are. It is impossible to promote personhood without adherence to basic ethical principles. The use of these principles to guide their interactions and behaviours helps staff foster personhood. For older residents, promoting personhood supports their integrity and value, and reduces the possibility of resident abuse.

To promote personhood, staff need to examine their own beliefs and practices. Non-professional staff constitute the primary care provider to older residents. It is these individuals who spend most of their time with older residents, and are often present when potentially devaluing experiences occur. However, professional staff, for example registered nurses, are responsible for other activities related to resident care, and for the leadership support of non-professional staff. They too are involved in potentially devaluing experiences, as the findings in this study demonstrated. Non-professional staff often felt that their opinions regarding resident needs were ignored by registered nurses. All staff need to be able to identify such experiences; this means the ability to recognize the situation as an ethical one, and to have the knowledge as to how to respond appropriately – in a manner that values personhood.

It is recommended that staff employ an ethical decision making approach and related skills to promote the personhood of older residents and indeed all participants. To use such an approach, staff require a theoretical knowledge base in both ethics and resident abuse, as well as opportunities to practice their ethical decision making skills. Yeo (1991) identified three areas of ethical knowledge an individual should possess to function effectively as a caregiver. These are (1) moral beliefs and values, (2) codes, and (3) knowledge of six basic ethical concepts: beneficence, autonomy, truthfulness, confidentiality, justice and integrity. Since the findings of this study demonstrated that participants, specifically registered nurses and non-professional staff, often initiate behaviors that profoundly affect the personhood of older residents, incorporating these principles into their nursing care should promote personhood.

Persons living and working within long-term care institutions encounter situations that require them to make decisions and to act upon them. The decisions are often about the care to be provided or the questions to ask an older resident - acts that may value or devalue personhood. It is not suggested that the best decision is made. In some resident situations, for example the use of physical restraints, there may not be a right or wrong answer. As demonstrated in this study, individuals use the context of a behaviour to help provide answers. They judge acts to be resident abuse or not within the context in which they occurred. Staff need to be knowledgeable about ethical decision making, and need to adopt into their repertoire of skills an ethical decision making model. The use of a model is not meant to be a inflexible process for making decisions about personhood but rather one in which ideas and actions are carefully thought about to determine an appropriate action. The model could also be used to debrief with

personnel after a resident perceives hurt, (resident abuse) to prevent similar occurrences in the future.

In accepting that such knowledge is important, the question arises as to how to provide both the knowledge base and opportunities to practice ethical decision making skills to staff? Dissemination of information about attitudes and behaviors that will potentially enhance personhood is one strategy. However, information by itself will not necessarily produce required behavior changes. Motivation to promote personhood comes, in part, from a personal belief that one has the skills and/or administrative support to do so. This was not the case in this study, both staff (registered) nurses and non-professional staff felt devalued. Within the facilities under study, administrative support must be obtained.

Educational in-service is another strategy to provide staff with ethical content and skills. It is not possible within Alberta to assume that long-term care educators will assume this role, since not all long-term care facilities have educators. In addition, some personnel do not attend in-service sessions because of shift rotations. Also some staff perceive that they do not have the time to attend educational sessions even when scheduled during work time. Therefore attention needs to be paid to the *teachable moment* – that instantaneous interaction which occurs between levels of staff on a unit, or between educator and an individual staff member where one may learn something. Findings from this study identified that there are staff who perform "liked best" care, value personhood and are able to communicate this to others.

Nurse educators need to address this item within their program curricula to prepare future practitioners to recognize and teach in such moments. Staff may find educational sessions painful as they recognize that they contribute to

devalued personhood in others, but they do not have the luxury of ignoring these feelings or thinking that devaluing of older residents will be addressed by long-term care administration. It is recommended that educational sessions be opened up to all personnel, including significant others and residents since abuse is committed by them. The type of educational in-service may have to be modified depending upon the needs of specific cultural sub-groups. Some registered nurses have been exposed to ethical concepts and ethical decision making models during their basic programs. They should assume a primary role in the education of non-professional staff in this area. However, they may need to have their skills refreshed, or to have knowledge of how to use the teachable moment to its advantage. Other registered nurses may not have knowledge and skills in this area and their educational needs must be met. The employment of clinical nurse specialists could address many of the educational needs of staff; however, the salary difference between a specialist and an educator may prevent this possibility within many long-term care institutions.

The use of an ethical decision making approach is helpful in determining behaviours that will promote the personhood of older adults. The combination of ethical knowledge and critical thinking complement each other. Together, they are a potentially effective approach to addressing resident abuse and personhood within long-term care institutions. They both should fall under the mandate of the resident advocate as suggested in recommendation 4.

Recommendation 7: Mentoring Programs Should be Established within Long-term Care Institutions to Reduce Resident Abuse and to Promote Personhood

In this study, participants identified that resident abuse is a perception of hurt on the part of the older resident, and the contributing behaviour is judged

within the context in which it occurs. Personnel model the behaviors that they are familiar with, specifically the roles of spouse, adult-child, and parent. Past behavior is the best predictor of future behaviour. To illustrate this point, if the behaviors demonstrated by an older resident are suggestive of the actions of a child at home, staff draw upon their experiences as parents to find strategies to deal with the behavior. This is especially true for some participants (non-professional staff, significant others). They have no other frame of reference upon which to base their behaviours. Professional nursing staff have more education upon which to understand and base their actions.

Changing the approach of staff to residents means exposing them to new behaviors. This may be done through peer mentoring programs. Staff members who have demonstrated expertise in nursing care "liked best" should be paired with new or current employees to help them acquire personhood promotive skills. Usually new staff are paired with members of the same cultural group, which reduces opportunities of different groups to value each other. Paired work between non-professional staff and registered nurses, and between staff nurses and administrative personnel would provide such opportunities. It would also potentially be of benefit to job switch between different groups for a few days, recognizing the need for resident safety. Each group would gain greater understanding of the other, knowledge that findings from this study indicate do not currently exist in long-term care institutions.

Mentoring programs need to be established for all levels of staff. The findings from this study indicated that administrators themselves did not have formal preparation in developing abuse free environments or in promoting personhood. They need to acquire this knowledge. They will then be able to

support staff who work directly with older residents to achieve these same goals. In addition, for older residents, proper supervision of staff helps protects them from abusive behaviors.

Recommendation 8: Further Research into Resident Abuse and Personhood Should be Conducted.

Although resident abuse exists, there is little reliable data regarding the experience itself within long-term care institutions. This study begins to provide such knowledge; however, it is obvious that further research is needed. The findings from this study need to be validated with individuals of other long-term institutional care settings. The research should be replicated in institutions where the context may be different, for example rural settings and specialized facilities such as veteran institutions. The definition of resident abuse that emerged from this research requires further study to determine which of its identified attributes are critical, and to explore if there are weighting differences among them.

It is recommended that further research into resident abuse and personhood is conducted. The study's findings support two key research needs: (1) the establishment of research programs related to resident abuse and to personhood, and (2) for nurse researchers to assume a lead role in the investigation of these two phenomena within long-term care institutions.

Research Programs

There is a clear need to establish two distinct research programs to focus on, (1) resident abuse and, (2) personhood within long-term care institutions. While there is a relationship between these concepts, they are distinct. Each is worthy of being the core concept investigated in its own research program. The programs would address some of the most pressing questions that emerged from

this study. These questions fall into three areas of investigation: (1) the experiences of personhood within the long-term care institutional care culture, (2) the experience of resident abuse, and (3) resident abuse prevention focused research. Each area will be briefly discussed.

(1) Personhood within the Long-term Institutional Care Culture

The findings from this study indicate that staff in long-term institutions devalued the personhood of older residents. They also identify that functional aspects of care were of priority, and that the ethical component of providing care that promotes personhood was under represented. Acknowledging these findings supports the need to advance research into personhood within the context of the long-term institutional care culture. These findings raised numerous questions: what does personhood mean to older residents and to other personnel? How does it change with the outset of physical decline, a primary reason for older adults' admission into such a culture? How do significant others (de)value the personhood of older residents? Is the personhood of older residents influenced more by the actions of one specific group of personnel? How does care "liked best" and "liked least" influence the personhood of older residents? These are substantive questions that a research program should address.

One component of a research program should be the organizational variables that potentially influence personhood. Most studies of the quality of care in long-term care institutions attempted to relate organizational variables, such as administrative practices, or size of a facility to resident outcomes, for example quality of life. A relatively unexplored resident outcome is personhood. The findings from this study show that devalued personhood is closely linked to resident abuse. While devalued personhood did not always accompany resident

abuse, it is the foundation upon which such experiences usually occur. Residents experience the institution through their day to day interactions with other people in their community, specifically non-professional staff. Perhaps the most important determinant of the personhood experience of older residents is the way that staff treats them. A critical research perspective that is omitted is the quality of staff-resident interaction and its impact upon personhood.

It is important to pursue such a research program in the experience of personhood. It would provide knowledge to support the moral and legal responsibilities of long-term care institutions whose mission is to provide quality of life to those they serve.

(2) The Experience of Resident Abuse

From the onset of this study, the researcher believed that a qualitative perspective was an innovative way to obtain knowledge about resident abuse within the long-term institutional care culture. In this study, resident abuse was always judged within the context in which it occurred, this was not identified in previous studies. The intertwined nature of resident abuse with devalued personhood was also not previously acknowledged. However, there are large gaps in scientific knowledge about the experience of resident abuse. Very little information exists regarding the outcome of being a recipient of resident abuse. Residents articulated that they have been abused; however, they also demonstrated reluctance to talk about their experiences. Anecdotal evidence from this study suggests that the experience does produce negative outcomes. If so, what are they? Are they irreversible or reversible in nature?

No one research approach to resident abuse is sufficient. There is a need to blend qualitatively-derived definitions with quantitative studies. Currently, there

is little reliable data about the prevalence of resident abuse within long-term institutional care settings. The findings from this study identified that previous cited incidences of resident abuse are unreliable because of differences in definitions between researcher(s) and long-term institutional care participants, and lack of stakeholder input. Reliable data concerning the nature and extent of resident abuse is paramount for governmental and health care policy makers. The past several years have seen a marked increase in the number of legislative and health care responses to resident abuse. It is impossible to evaluate the effectiveness of such responses when the incidence of resident abuse is not reliably known.

(3) Prevention Focused Research

An underlying construct of a resident abuse free culture is prevention. This is a high priority area for nursing research. Registered nurses with access, in their work, to all participants have the unique opportunity to conduct research into the prevention of resident abuse. The three levels of prevention: primary, secondary and tertiary offer an effective way of structuring a research program. Primary prevention is prevention in the true sense of the word; it precedes resident abuse experiences. Research of this type advances abuse free environments through education of participants about resident abuse using their own definitions and examples as reference points. Prevention at this level also focuses on how to promote personhood, since this study demonstrated that devalued personhood is the foundation upon which resident abuse often rests. The outcome of primary research is the creation of a cultural climate that supports an abuse free environment through the valuing of personhood.

In secondary prevention, emphasis is upon early diagnosis and prompt intervention to halt resident abuse. The objective is to help the perpetrator realize that abuse is being committed. If decisions regarding resident abuse are made based upon a resident's perception of hurt, context and are influenced by the valuing of personhood, research priority should be given to understanding how these factors relate to each other.

Tertiary prevention is centered on rehabilitation of an individual who has committed abuse or who has been abused. Registered nurses have two clients – the older resident and the perpetrator. Both require assistance. But what type of assistance is needed, and how should it be provided are questions that need to be answered. If resident abuse is a perception of hurt, then what interventions would best address this response?

Nurse Researchers to Take a Leading Role

Very little research into resident abuse has been conducted, and to date nurse researchers have not assumed a primary role in what has been done. Findings from this study suggest that registered nurses, especially those in administrative roles, while acknowledging abusive behaviours towards older residents, also deny that resident abuse occurs within their facilities. It may be that they were not exposed to the possibility that resident abuse occurred during their own basic nursing education. It may also be that they, like their colleagues in the practice of nursing, viewed long-term care with little interest. In other words, they may not be able to begin asking the questions that need to be asked. This is regrettable.

Nurse researchers are in a prime position to develop programs to reduce resident abuse within long-term care institutions, and to test prevention focused

research. They can use research techniques ranging from observation of cultural factors which may contribute to resident abuse to experimental testing of intervention strategies to address perception of hurt, a key criterion of resident abuse. Serious consideration should be given to those research programs that foster partnerships between researchers and registered nurses working in the long-term care culture. This has numerous potential benefits. Registered nurses have a leading role in the supervision of care within these settings, and could contribute greatly to procedure/protocol focused research. The primary benefit is that the researcher and registered nurse would be using an emic perspective for the study of resident abuse.

In conclusion, nurse researchers should assume leading roles into the investigation of both resident abuse and personhood within long-term care facilities. Two distinct programs of research are needed. Acknowledging the need for two programs does not negate the importance of exploring linkages between them. The findings from this reported study have already identified linkages.

Summary

Prevention of resident abuse is a challenge to professional care providers, including registered nurses. While some progress has been made in understanding resident abuse, it is still a relatively new topic for discussion and research. The findings of this study support the statement that resident abuse does exist in long-term care cultures. Emerging from the discussion of the findings were recommendations that need to be addressed to heighten awareness of this experience, and to create an abuse free environment. The outcome will be enhanced personhood for older adults who reside in long-term care institutions.

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Appendix A

Information Letter: Registered Nurses

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing)
phone (403) 289-6134 (home) or (403) 220-6270 (office)

Supervisor: Dr. V. Bergum
University of Alberta

Purpose:

This letter is to tell you about research I am doing in this institution. It will describe how people who are familiar with long term care institutions define "resident abuse."

The information obtained will help health care providers understand how "resident abuse" is defined in long term care institutions. This will help build a better health care system. Your taking part may benefit Albertans.

Participation:

The administrator of this institution has let me ask you to take part in the study. You do not have to take part. There is no expected harm to you if you take part, nor any reward.

I will have three interviews with you, if you take part. You will choose the time and place. Each interview will last between one and three hours. First, I will ask you about the kinds of behavior towards residents that you like best and the kinds of behavior you like least. Second, I will ask you how you define "resident abuse". I will not ask if you have seen abuse. I will tape record the interviews. I may phone you between interviews to ask if the information on the tape is copied correctly.

I will also ask you to take part in two to three group meetings. The group and I will choose the time and place. Each meeting will last about an hour. The approach will be the same as the individual interviews; however, the group setting will let you discuss your definition with others. I will not ask the group if they have seen abuse.

(Please turn over)

I will tape record the meetings. I may phone you to ask if the information from the tape was copied correctly. If you take part in the group meetings, the other group members will know you are taking part in the study.

Phone me at the above number if you would like more information or are interested in taking part. If you phone and decide not to take part, I will not keep a record of the phone call. I will not tell any one of your phone call. If you take part in the study, you will sign a consent form.

Yours respectfully,

Sandra P. Hirst

Appendix B

Information Letter: Non-professional Staff

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing)
phone 289-6134 (home) or 220-6270 (office)

Supervisor: Dr. V. Bergum
University of Alberta

Purpose:

This letter is to tell you about research I am doing in this institution. It will describe how people who are familiar with long term care institutions define "resident abuse."

The information obtained will help health care workers understand how "resident abuse" is defined in long term care institutions. This will help build a better health care system. Your taking part may benefit Albertans.

Participation:

The administrator of this institution has let me ask you to take part in the study. You do not have to take part. There is no expected harm to you if you take part, nor any reward.

I will ask you to attend 2 to 3 group meetings. The group and I will choose the time and place. Each will last about an hour. First, I will ask the group about the kinds of behavior towards residents that they like best and least. Second, I will ask the group how they define "resident abuse." The group will let you discuss your definition with others. I will not ask the group if they have seen abuse. I will tape record the meetings. I may phone you to ask if the tape was copied correctly. If you take part in the meetings, other members will know you are in the study.

Phone me at the above number if you would like more information or are interested in taking part. If you phone and decide not to take part, I will not keep a record of the phone call. I will not tell any one of your phone call. If you take part in the study, you will sign a consent form.

Yours respectfully,

Sandra P. Hirst

Appendix C

Information Letter: Older Residents

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing)
phone 289-6134 (home) or
220-6270 (office)

Supervisor: Dr. V. Bergum
University of Alberta

Purpose:

This letter is to tell you about research I am doing. It will tell how people define "resident abuse." Findings will help health workers understand how "resident abuse" is defined. This will help build a better health care system. Your taking part may benefit Albertans.

Participation:

The administrator of this institution has let me ask you to take part You do not have to take part. There is no expected harm. There is no reward.

(Please turn over)

I will have 2 interviews with you. You will choose the time and place. Each will last about 45 minutes. I will ask you about behaviors towards residents that you like best and least. I will then ask how you define "resident abuse." I will not ask if you have seen abuse. I will tape record the interviews. I may phone you to ask if the tape was copied correctly.

I will also ask you to take part in 2 to 3 group meetings. The group and I will choose the time and place. Each will last an hour. The group will say which behaviors towards residents they like the best and least. Then the group will define "resident abuse". The group will let you discuss your definition with others. I will not ask the group if they have seen abuse. I will tape record the meetings. I may phone you to ask if the tape was copied correctly. If you attend, other members will know you are in the study.

Phone me if you would like more information or would like to take part. If you phone and decide not to take part, I will not keep a record of the phone call. I will not tell any one of your phone call. If you take part, you will sign a consent form.

Yours respectfully,

Sandra P. Hirst

Appendix D

Information Letter: Significant Others

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing)
phone (403) 289-6134 (home) or (403) 220-6270 (office)

Supervisor: Dr. V. Bergum
Faculty of Nursing
University of Alberta

Purpose:

This letter is to tell you about research I am doing. It will describe how people who are familiar with long term care institutions define "resident abuse."

The information obtained will help health care workers understand how "resident abuse" is defined. This will build a better health care system. Your taking part may benefit Albertans.

Participation:

The administrator of this institution has let me ask you to take part in the study. You do not have to take part. There is no expected harm to you if you do. There is no reward.

I will have 2 interviews with you. You will choose the time and place. Each will last about 45 minutes. I will ask you about behaviors toward residents that you like best and least. I will then ask how you define "resident abuse." I will not ask if you have seen abuse. I will tape record the interviews. I may phone you to ask if the tape was copied correctly.

I will also ask you to take part in 2 to 3 group meetings. The group and I will choose the time and place. Each will last about an hour. The questions I ask will be the same as in the interviews. The group will let you discuss your definition with others. I will not ask the group if they have seen abuse. I will tape record the meetings. I may phone you to ask if the information from the tape was copied correctly. If you take part in the meetings, other members will know you are in the study.

(Please turn over)

Phone me if you would like more information or would like to take part. If you phone and decide not to take part, I will not keep a record of the phone call. I will not tell any one of your phone call. If you take part, you will sign a consent form.

Yours respectfully,

Sandra P. Hirst

Appendix E

Consent Form: Registered Nurses

(Code Number____________)

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing)
phone (403) 289-6134 (home) or (403) 220-6270 (office)

Supervisor: Dr. V. Bergum, University of Alberta

Purpose:

I am doing research in this institution. It will describe how people who are familiar with long term care institutions define "resident abuse."

The information obtained will help health care workers understand how "resident abuse" is defined in long term care institutions. This will help build a better health care system. Your taking part may benefit Albertans.

Participation:

The administrator of this institution has let me ask you to take part in the study. You do not have to take part. There is no expected harm to you if you take part, nor any reward.

I will have three interviews with you, if you take part. You will choose the time and place. Each interview will last between one and three hours. First, I will ask you about the kinds of behavior towards residents that you like best and the kinds of behavior you like least. Second, I will ask you how you define "resident abuse". I will not ask if you have seen abuse. I will tape record the interviews. I may phone you between interviews to ask if the information on the tape is copied correctly.

I will also ask you to take part in two to three group meetings. The group and I will choose the time and place. Each meeting will last about an hour. The approach will be the same as the individual interviews; however, the group setting will let you discuss your definition with others. I will not ask the group if they have seen abuse. I will tape record the meetings. I may phone you to ask if the information from the tape is copied correctly. If you take part in the group meetings, the other group members will know you are taking part in the study.

Your name will not be used when the results of this study are discussed or documented. A code number will be on all forms. Your name and any identifying material will be erased from the tapes. All forms will be locked in a cabinet during the

study and for seven years after it is finished. The typed interview notes will also be kept in a locked cabinet. They may be used for other studies if approval is given by an ethical review committee. Findings from this study may be published or presented at professional conferences, but any material that identifies you will not be used.

CONSENT

The researcher has described the research to me. I have had my questions answered. I may phone the researcher, if I have future questions. I know the possible benefits of taking part. I am free to withdraw from the study at any time. I know that if I do not take part or withdraw, my employment in this institution will not be affected in any way. I will be told if information arises during the study that could influence my decision to continue.

I will decide if any behavior is "resident abuse". The researcher will not express an opinion. The researcher will suggest I contact the administrator or the social worker with any concerns. If I do not wish to talk to either one, the researcher will suggest I contact the Alberta Association of Registered Nurses and talk to the Nurse Consultant - Practice. I will decide if I want to follow up on any concerns. My decision will not be communicated to any one. The researcher will tell me if she is unsure of how to respond to my concern. She may talk to her supervisor if I agree to it.

I have a copy of this form to keep.

_________________________ _________________________
(Signature of Participant) (Date)

_________________________ _________________________
(Signature of Researcher) (Date)

Please complete if you want a copy of the study results.

Address: ______________________________

____

Appendix F

Consent Form: Non-professional Staff

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing)
phone (403)289-6134 (home) or (403) 220-6270 (office)

Supervisor: Dr. V. Bergum
University of Alberta

Purpose:

I am doing research in this institution. It will describe how people who are familiar with long term care institutions define "resident abuse."

Findings will help health care workers understand how "resident abuse" is defined. This will build a better health care system. Your taking part may benefit Albertans.

Participation:

The administrator of this institution has let me ask you to take part in the study. You do not have to take part. There is no expected harm, if you take part. There is no reward.

I will ask you to take part in 2 to 3 group meetings. The group and I will choose the time and place. Each will last about an hour. First, I will ask the group about the kinds of behavior towards residents that they like best and least. Second, I will ask the group how they define "resident abuse." The group will let you discuss your definition with others. I will not ask the group if they have seen abuse. I will tape record the meetings. I may phone you to ask if the tape was copied correctly. If you take part in the meetings, other members will know you are taking part in the study.

Your name will not be used when the results of this study are discussed or documented. A code number will be on all forms. Your name and any identifying material will be erased from the tapes. All forms will be locked in a cabinet during the study and for seven years after it is finished. The typed interview notes will also be kept in a locked cabinet. They may be used for other studies if approval is given by an ethical review committee. Findings from this study may be published or presented at

professional conferences, but any material that identifies you will not be used.

CONSENT

The researcher has described the research to me. I have had my questions answered. I may phone the researcher, if I have future questions. I know the benefits of taking part. I am free to drop out of the study at any time. I know if I do not take part or drop out, my job will not be affected. The researcher will tell me anything that could effect my taking part.

I will decide if a behavior is "resident abuse". The researcher will not state an opinion. The researcher will suggest I contact the administrator or the social worker with any concerns. I will choice if I want to contact them. The researcher will tell no one of my choice. The researcher will tell me if she can not respond to my concern. She may talk to her supervisor if I agree.

I have a copy of this form to keep.

____

____________________________ (Date)

(Signature of Participant)

____

____________________________ (Date)

(Signature of Researcher)

Please complete if you want a copy of the study results.

Address:__________________________________

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Appendix G

Consent Form: Older Residents

(Code Number_____________)

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing) phone 289-6134 (home) or 220-6270 (office)

Supervisor: Dr. V. Bergum University of Alberta

I am doing research in this institution. It will tell how people define "resident abuse." Findings will help health workers understand how "resident abuse" is defined. Your taking part may help Albertans.

The administrator has let me ask you to take part. You may say no. There is no expected harm. There is no reward.

I will have 2 interviews with you. You will choose the time and place. Each will last 45 minutes. I will ask you about behaviors towards residents that you like best and least. I will ask how you define "resident abuse." I will not ask if you have seen abuse. I will tape record the interviews. I may phone you to ask if the tape was copied correctly.

I will ask you to attend 2 to 3 group meetings. The group and I will choose the time and place. Each will last an hour. The group will say which behaviors towards residents they like best and least. Then the group will define "resident abuse."

The group will let you discuss your definition with others. I will not ask the group if they have seen abuse. I will tape record the meetings. I may phone you to ask if the tape was copied correctly. If you attend, other members will know you are in the study.

I will not use your name when the study is discussed or reported. All forms will have a code. I will erase identifying material from tapes. I will lock all forms and notes in a cabinet during the study and for 7 years afterwards. They may be used for other studies if an ethics review committee approves.

CONSENT

The researcher has described the research. The researcher has answered my questions. I may phone the researcher if I have future questions. I know the benefits of taking part. I am free to drop out at any time. My care will not be affected if I do not take part or drop out. The researcher will tell me anything that could effect my taking part.

I will decide if a behavior is "resident abuse". The researcher will not state an opinion. The researcher will suggest I contact the administrator or social worker with any concerns. I will choose if I want to contact them. The researcher will tell no one of my choice. The researcher will tell me if she can not respond to my concern. She may talk to her supervisor if I agree.

I have a copy of this form to keep.

____________________________ _________________
(Signature of Participant) (Date)

____________________________ _________________
(Signature of Researcher) (Date)

Please complete if you want a copy of the findings.

Address: ____________________________________

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Appendix H

Consent Form: Significant Others

(Code Number____________)

Project Title: Resident Abuse within the Culture of Long-term Care Institutions

Researcher: Sandra P. Hirst, Ph.D. Student (Nursing)
phone (403)289-6134 (home) or (403) 220-6270 (office)

Supervisor: Dr. V. Bergum
University of Alberta

I am doing research in this institution. It will tell how people define "resident abuse." Findings will help health workers understand how "resident abuse" is defined. Your taking part may help Albertans.

The administrator has let me ask you to take part. You may say no. There is no expected harm. There is no reward.

I will have 2 interviews with you. You will choose the time and place. Each will last 45 minutes. I will ask you about behaviors towards residents that you like best and least. I will ask how you define "resident abuse." I will not ask if you have seen abuse. I will tape record the interviews. I may phone you to ask if the tape was copied correctly.

I will ask you to attend 2 to 3 group meetings. The group and I will choose the time and place. Each will last an hour. The group will say which behaviors towards residents they like best and least. Then the group will define "resident abuse." The group will let you discuss your definition with others. I will not ask the group if they have seen abuse. I will tape record the meetings. I may phone you to ask if the tape was copied correctly. If you attend, other members will know you are in the study.

I will not use your name when the study is discussed or reported. All forms will have a code. I will erase identifying material from tapes. I will lock all forms and notes in a cabinet during the study and for 7 years afterwards. They may be used for other studies if an ethics review committee approves.

CONSENT

The researcher has described the research. The researcher has answered my questions. I may phone the researcher if I have future questions. I know the benefits of taking part. I am free to drop out at any time. My care will not be affected if I do not take part or drop out. The researcher will tell me anything that could effect my taking part.

I will decide if a behavior is "resident abuse". The researcher will not state an opinion. The researcher will suggest I contact the administrator or social worker with any concerns. I will choose if I want to contact them. The researcher will tell no one of my choice. The researcher will tell me if she can not respond to my concern. She may talk to her supervisor if I agree.

I have a copy of this form to keep.

__________________________ ________________
(Signature of Participant) (Date)

__________________________ ________________
(Signature of Researcher) (Date)

Please complete if you want a copy of the findings.

Address: __________________________________

____

Appendix I

Interview Guide: Registered Nurses

Introduction

I am a doctoral student in the Faculty of Nursing, University of Alberta, Edmonton. I would like to know your opinion about resident abuse within long-term care institutions.

Consent

(if subject agrees) If you agree to do this, would you sign this consent form please?

(if subject refuses) Thank you for your time, have a pleasant day.

(if subject agrees) Would you please say 'yes' to indicate your approval to be audiotaped?

First Interview

As part of the study, I need to ask you a few preliminary questions.

Administer Appendix N: Biographic Data: Registered Nurses. Complete form.

Thank you.

Tell me about the way older residents are treated that you like best?

Tell me about the way older residents are treated that you like the least?

Within some long-term care institutions, the concern of resident abuse has been raised. When we talk about resident abuse, how would you define the term?

How would you differentiate resident abuse from neglect or inadequate care?

Appendix J

Interview Guide : Older Residents

Introduction

I am a doctoral student in the Faculty of Nursing, University of Alberta, Edmonton. I would like to know your opinion about resident abuse within long-term care institutions.

Consent

(if subject agrees) If you agree to do this, would you sign this consent form please?

(if subject refuses) Thank you for your time, have a pleasant day.

(if subject agrees) "Would you please say 'yes' to indicate your approval to be audio taped?

Mental Status

As part of the study, I need to ask you a few preliminary questions.

Administer Appendix M: Khan/Goldfarb Mental Status Questionnaire. Complete form.

Thank you.

Administer Appendix P: Biographic Data: Older Residents. Complete form.

Thank you.

First Interview

Tell me about the way older residents like best to be treated?

Tell me about the way older residents like the least to be treated?

Within some long-term care institutions, the concern of resident abuse has been raised. When we talk about resident abuse, how would you define the term?.

How would you differentiate resident abuse from neglect or inadequate care?

Appendix K

Interview Guide: Significant Others

Introduction

I am a doctoral student in the Faculty of Nursing, University of Alberta, Edmonton. I would like to know your opinion about resident abuse within long-term care institutions.

Consent

(if subject agrees) If you agree to do this, would you sign this consent form please?

(if subject refuses) Thank you for your time, have a pleasant day.

(if subject agrees) "Would you please say 'yes' to indicate your approval to be audio taped?

Mental Status

As part of the study, I need to ask you a few preliminary questions.

Administer Appendix: Biographic Data Q: Significant Others. Complete form.

Thank you.

First Interview

Tell me about the way you like best for older residents to be treated?

Tell me about the way you like the least for older residents to be treated?

Within some long-term care institutions, the concern of resident abuse has been raised. When we talk about resident abuse, how would you define the term?

How would you differentiate resident abuse from neglect or inadequate care?

Appendix L

Question Guide: Focus Grous

Introduction

I am a doctoral student in the Faculty of Nursing, University of Alberta, Edmonton. I would like to know your definition of resident abuse within long-term care institutions.

Consent

Thank you for being here to-day. It is my understanding that you have all agreed to be part of this group.

(if group agrees) If you agree to do this, would you sign this consent form please?

(if group refuses) Thank you for your time, have a pleasant day.

(if group agrees) Would you please say 'yes' to indicate your approval to be audio taped?

Focus Group

Tell me about the way older residents are treated that you like best?

Tell me about the way older residents are treated that you like the least?

Within some long-term care institutions, the concern of resident abuse has been raised. When we talk about resident abuse, how would you define the term?

How would you differentiate resident abuse from neglect or inadequate care?

Appendix M

Kahn/Goldfarb Test - Mental Status

(Code Number_____________)

\+ -

1. Where are you now?______________________________
2. What is this place?______________________________
3. What day is this?______________________________
4. What month is it?______________________________
5. What year is it?______________________________
6. How old are you?______________________________
7. When is your birthday?____________________________
8. In what year (or where) were you born?_______________
9. Who is the Prime Minister?____________________________
10. Who was the Prime Minister before him?_______________

total right

0 - 2 errors: no or mild organic impairment
3 - 8 errors: moderate impairment
9 - 10 errors: severe impairment

Appendix N

Biographic Data: Registered Nurses

(Code Number_____________)

position title: _____________

first language: _____________

number of years since graduation from basic nursing program: _____________

highest academic degree/diploma obtained: _____________

length of time working in long term care facilities: _____________

length of time working in this facility: _____________

have you attended any educational sessions related to resident abuse: _____________

please describe:

____

____

____

____

Appendix O

Biographic Data: Non-professional Staff

(Code Number______________)

age: ____________

sex: ____________

position title: ____________

first language: ____________

length of time working in long term care facilities: ____________

length of time working in this facility: ____________

have you attended any educational sessions related to resident abuse: ____________

please describe:

____

____

____

____

Appendix P

Biographic Data: Older Residents

(Code Number____________)

age: ____________

sex: ____________

date of admission to long-term care: ____________

admission diagnosis: ____________

score Kahn/Goldfarb: ____________

Appendix Q

Biographic Data: Significant Others

(Code Number_______________)

age: _______________

sex: _______________

relationship to older resident: _______________

date of admission of Older Resident to long-term care: _______________