THE ROLE OF SOCIAL SUPPORT IN DEMENTIA CARE FACILITIES:

STAFF MEMBER PERSPECTIVES

by

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ABSTRACT

The Role of Social Support in Dementia Care Facilities:

Staff Member Perspectives

by

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The intent of this thesis was to investigate the role social support from certified

nursing assistant (CNA) staff plays in long-term care facilities where persons with

dementia reside. In this mixed methods study, survey responses and themes from

interviews were used to observe patterns and investigate extracted meanings that were

relevant to the research questions. Participants were purposively recruited by attending

staff meetings and posting flyers in break rooms and near time clocks in assisted living

and skilled nursing facilities. Both quantitative and qualitative data were collected during

in-person interviews with CNA staff members who work in facilities housing individuals

who have dementia.

The first research question asked to what extent CNA staff members in dementia

care facilities consider offering social support to residents as part of their professional

role. By using both quantitative and qualitative methods, I gained insight as to whether

CNAs place value on this psychosocial aspect of caring for others, specifically those

living with dementia. The other two research questions directly related to the primary

question by clarifying certain factors that may influence CNAs' perspectives. Do staff members who view social support as part of their professional role have more dementia-specific education/training than those who do not? Are there other factors associated with CNAs who feel that social support is part of their professional role? The goal of this investigation was to uncover any possible patterns in social support perspectives among CNA staff members, and further improve dementia care through greater understanding.

Data analysis uncovered an overwhelming uniformity in perspectives of CNAs placing importance on socially supportive tasks in their professional role. Qualitative analysis uncovered several related themes, emphasizing insufficient dementia-specific training, influential personal values of CNAs, and several barriers to effective delivery of social support.

(82 pages)

PUBLIC ABSTRACT

The Role of Social Support in Dementia Care Facilities:

Staff Member Perspectives

Malinda Kay Dokos

In this study, certified nursing assistants (CNAs) who work regularly with long-term care residents with dementia were interviewed to investigate whether they considered providing social and emotional support to people with dementia an important part of their jobs. They were given an online survey, then each participated in an in-person interview that was recorded and later transcribed and analyzed for common themes. Through data analysis, I found that the participating CNAs unanimously considered social support to be an important aspect of caring for someone with dementia, and several personal values were associated with this perspective. They also reported the trainings they had received in preparation for dementia care were largely not sufficient to prepare them for interacting effectively with the residents. Additionally, they cited various other barriers that impede their ability to provide the social support they feel is necessary to provide. Overall, this sample of CNAs did not provide great diversity, and future research should compare these results to more diverse groups.

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I would not have had the courage to begin this journey if it hadn't been for the loving and diligent examples of my parents, Don and Dennie Marley. Life does not always go as planned, but they have taught me to give 100%, no matter what the task, and to not be afraid of a little hard work.

Most importantly, I will be eternally grateful to my best friend, confidante, and husband, Adam. I could not have accomplished this goal without his hard work, support, and willingness to join me on this two-year-long adventure. This has not been the first nor will it be the last challenge we face together, and I'm fortunate to have him by my

side through it all.

Mindy Dokos

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CHAPTER I

INTRODUCTION

According to the most recent Population Reference Bureau report, there will be over 98 million people in America aged 65 or older by the year 2060, more than doubling the current numbers. Additionally, the prevalence of dementia, specifically Alzheimer's disease, is estimated to nearly triple from 5 million in 2013 to 14 million by the year 2050. While life expectancy in the U.S. is increasing, more and more Americans will require long term and dementia-specific care, either at home, or in residential settings such as assisted living facilities and skilled nursing facilities. The Baby Boomer generation has higher divorce rates and fewer children than past generations, thus fewer individuals are projected to receive old age care from family members -- an expected 2.3 million older adults will need to reside in long term care settings by the year 2030 (Mather, Jacobsen, & Pollard, 2015).

Not only will aging individuals require physical assistance with activities of daily living (ADLs), but because the prevalence of dementia is also on the rise, many more residents of long-term care facilities will require further assistance and supervision as they experience onset of dementia symptoms. While there are facilities specifically designed to care for individuals with dementia, a large number of people will continue living either at home with informal caregivers or in long-term care facilities that are not dementia-specific. The direct care staff members of all long-term care facilities, certified nurse assistants (CNAs), need to be prepared to interact effectively with people who have dementia.

Currently, long-term care facilities struggle to maintain resources necessary to

provide quality services for the older adults who need them. One of the most valuable resources nursing homes offer is good CNA staff, which is difficult to maintain due to high turn-over rates (Brodaty, Draper, & Low, 2003). Many CNAs leave their job simply because they do not feel appreciated and fairly compensated for the work they do (Harris-Kojetin, Lipson, Fielding, Kiefer, & Stone, 2004). Because of these high turn-over rates, residents are at risk for poorer care conditions (Mesirow, Klopp, & Olson, 1998; Trinkoff et al., 2013) and long-term care facilities spend excess funds on hiring and training new staff (Mesirow et al., 1998). The financial resources necessary to provide for nursing care may soon be more of a burden than our economy is prepared for (Mather et al., 2015). Looking to the future, not only are more of these facilities and services necessary to accommodate the demand, but also better services to more efficiently provide quality care for residents of these facilities, specifically those living with dementia (McGilton, 2004).

Caring for individuals with dementia is a unique and often challenging task. As dementia progresses, individuals may experience a wide range of difficult new behavioral and psychological symptoms of dementia (BPSD). These symptoms may range from wandering (sometimes called wander walking) and losing sense of time and place, to symptoms of depression, to escalation of emotion in reaction to regular stimuli (Chiu, Chen, Yip, Hua, & Tang, 2006). While symptom severity varies within and among individuals, Camp, Cohen-Mansfield, and Capezuti (2002) have suggested that BPSD occur as the result of the intersection between lifelong personality traits/habits, current mental and physical conditions, and environmental factors. In essence, these difficult symptoms may arise because individuals with dementia have unmet needs and an

inability to communicate those needs. When CNA staff members are unfamiliar with these possible causes for difficult behaviors, it can be detrimental. Not only may individuals with dementia be exhibiting behaviors as a way to communicate some unmet need and likely do not acquire whatever it is that they lack, but staff members become frustrated and experience burn-out quickly (McGilton, 2004). Both CNA staff and individuals with dementia may benefit from more meaningful social connections, allowing them to better understand the needs of residents and prevent severe BPSD.

Social Support

Social support is an important concept in social science research that has been difficult to define historically. For the purposes of this thesis, the definition of social support is the perceived availability and reception of resources, including emotional, instrumental, informational, companionate, or esteem support, from either a formal or informal helping relationship (Gottlieb & Bergen, 2010). This idea of lending social support between individuals is extremely valuable in health care (Cobb, 1976). In his paper, Cobb reported that individuals who feel they are cared for, valued, and part of a network are more physically and mentally healthy. To that end, it should be of utmost importance that medical professionals improve their understanding of how to be socially supportive toward their patients. Indeed, in more recent research, social support has proven to have a positive impact on multiple health-related domains (Krause, 2007; Wills & Fegan, 2000).

Offering social support to someone who is living with dementia can be challenging. Depending on the BPSD that someone may be experiencing,

communication alone can seem next to impossible. How can someone offer support to someone who does not seem to comprehend what is being said, or who no longer understands reality? Research suggests that even individuals with dementia benefit from the clear understanding that someone cares for them and will help them (Kitwood, 1993). Family and friends may generally play a vital role in providing social support, but institutionalization often limits the time residents spend with their loved ones. Nursing care staff in long-term care facilities generally spend 4.1 hours per day with residents (Harrington, Carrillo, Garfield, Musumeci, & Squires, 2018) assisting them with activities of daily life, administering treatments, and performing housekeeping tasks. Although this is a substantial amount of time spent with residents, it is generally spent interacting minimally with patients, simply to complete caregiving tasks (McGilton, 2004). It may be essential that social support also comes from staff members to benefit residents, especially those living with dementia.

Current Study

The intent of this paper is to investigate the extent and role of social support from CNA staff members working in long-term care facilities where persons with dementia reside. The research questions of this thesis are:

1. To what extent do CNA staff members in dementia care facilities consider offering social support for residents as part of their professional role?

2. Do CNA staff members who view social support more as part of their professional role have more dementia-specific education/training than those who do not?

3. Are there other factors associated with CNAs who feel that social support is
   part of their professional role?

First, I examined to what extent CNA staff members in dementia care facilities consider offering social support for residents as part of their professional role. By using both quantitative and qualitative methods, I gained insight as to whether CNAs place value on this psychosocial aspect of caring for others, specifically those living with dementia. The other two research questions directly relate to the first question by clarifying certain factors that may influence CNA workers' perspectives. The goal of this investigation was to uncover any possible patterns in social support perspectives among CNAs, and further improve dementia care through greater understanding.

CHAPTER II

LITERATURE REVIEW

Social Support

Participating in social interactions is a fundamental aspect of the human experience, and is a fairly new topic of study in the social sciences (Antonucci, Ajrouch, & Birditt, 2013). Vygotsky theorized that social processes build individual mental functioning, building the base for higher functioning (Wertsch & Tulviste, 1992). Another theory, the convoy model of social relations, states that people are continuously supported by a network of others, although this network shifts in relationship quality, closeness, and function with characteristics such as age and societal norms (Antonucci et al., 2013). In her theory of socioemotional selectivity, Carstensen postulated that social goals of individuals change as their perception of time changes, but that throughout the lifespan, social goals remain a priority (Lang & Carstensen, 1994).

Social support is a somewhat elusive concept in social science to define and measure. Cobb (1976) described social support as three types of information transferred between persons: that of love and caring, feelings of esteem and value, and being part of a network of communication and reciprocity. Another early theorist described social support as informal helping behaviors broken into four categories: emotionally sustaining behaviors, problem-solving behaviors, indirect personal influence, and environmental action (Gottlieb, 1978). Later, Gottlieb and Bergen (2010) defined social support as the perceived availability and/or receipt of resources via formal or informal social relationships. Another pair of theorists identified six categories of social support from

their review of the literature, including material aid, behavioral assistance, intimate interaction, guidance, feedback, and positive social interactions (Barrera & Ainlay, 1983). Another study by Barrera (1986) divided social support into social embeddedness, perceived social support, and enacted support. Similarly, Krause (2007) broke social support down into categories of enacted and anticipated support in his study. Other studies in the healthcare field differentiate two types of social support as quantity of supportive people, or structural support, and quality of interpersonal relationships, functional support (Wills & Fegan, 2000).

Social Support Definition

Social support is defined in this study as the perceived availability and reception of resources, including emotional, instrumental, informational, companionate, or esteem support, from either a formal or informal helping relationship (Gottlieb & Bergen, 2010). Social support is used as an umbrella term, encompassing these five related behaviors that individuals use to reach out to others. First, emotional support includes such actions as active listening, kind and respectful words, and "being there" for a person (Gottlieb, 1978; Krause, 2007; Wills & Fegan, 2000). Second is the physical, instrumental support, which entails offering services, such as assistance participating in leisure activities or ADLs. Third, informational support includes answering questions or providing needed information or instructions to someone who does not understand something fully (Wills & Fegan, 2000). Fourth is companionate support, making sincere and bidirectional friendship connections with another individual (Gottlieb & Bergen, 2010). Finally, the fifth behavior is esteem support, using communication to encourage another person, likely due to spending time listening to or being around a person and being aware of

some struggle they experience (Cutrona & Suhr, 1994).

Effects of Social Support

In sum, multiple definitions of social support exist, with significant overlap in how this construct is defined. Regardless of the definition used, social support has been investigated numerous times in social and medical research alike, identifying many apparent benefits to higher quality social support. Past research concludes that better social support was generally associated with decreased levels of distress in various diverse samples (Barrera, 1986; Barrera & Ainlay, 1983; Krause, 2007; Wills & Fegan, 2000). Social support has been found to be protective of physical and mental ailments, making them less likely to occur and easier from which to recover, and decreasing need for medication for various symptoms (Camp et al., 2002; Cassel, 1976; Cobb, 1976; Jao, Loken, MacAndrew, Haitsma, & Kolansowski, 2018; Krause, 2007; Wills & Fegan, 2000). Interestingly, social support is generally only measured from the perspective of the recipient of the support (Hupcey, 1998).

Just as perceived social support has been empirically identified as beneficial in a variety of ways, lack of perceived support, or social isolation and loneliness, have also been the topic of many research studies. Social isolation in late life, including factors such as being unmarried, living alone, and have a limited social network, is associated with higher likelihood of onset of dementia in some studies (Chen et al., 2011; Fratiglioni, Wang, Ericsson, Maytan, & Winblad, 2000; Wilson et al., 2007). In addition, loneliness, or the *perception* of social isolation, whether or not there truly is isolation, has been associated with doubled likelihood of dementia development (Holwerda et al., 2012; Wilson et al., 2007). Hughes, Andel, Small, Borenstein, and Motimer (2008) found that

low reported satisfaction with social support was associated with memory decline over 5 years. There are, however, inconsistencies in the literature about the effects social activity and loneliness may have on the onset of dementia (Baumgart et al., 2015; Kuiper et al., 2015). Both social isolation and loneliness are associated with negative health behaviors among older adults, including physical inactivity and smoking (Shankar, McMunn, Banks, & Steptoe, 2011). Social disconnect is highly likely among older adults (Cornwell & Laumann, 2015), even more so among people with dementia (Kitwood, 1998; McGilton, 2004), creating the need to more fully understand its effects and ensure socially supportive environments.

The goals and effects of social interaction change as we age (Charles & Carstensen, 2009; Lang & Carstensen, 1994). Krause (2007) found that older adults who reported more frequent and reliable social support also reported living life fully with clear values and goals. As mentioned previously, socioemotional selectivity theory postulates that the objectives for social activity changes as the perception of future time changes. When time begins to appear limited, such as in older individuals, "emotion regulation" rises to the top of the priority list. Meaningful interactions and experiences with others who are considered to be more intimately connected (family, close friends) are more important than broad experiences with higher numbers of individuals (Lang & Carstensen, 1994). For older individuals in residential care facilities, maintaining these types of emotionally regulating relationships may become very difficult.

Social Support in Long-Term Care

Among older institutionalized adults, simply perceiving oneself as having social support, specifically from peers and staff members, is associated with better well-being

(Carpenter, 2002). Individuals living with dementia have been found to exhibit fewer BPSD when provided with social support and/or contact. Such support and contact are generally provided by in-person interactions, but have also been provided through video or audio recordings of family members for patients to feel their presence simulated (Camp et al., 2002).

Staff members in long-term dementia care facilities can also provide meaningful social interactions (McGilton et al., 2003), although they do not always consider this type of care to be their responsibility (McGilton, 2004). If staff members do not believe social interactions with residents are part of their role, there may be negative implications. In a qualitative study, Paterniti (2000) found that many CNAs in a long-term care facility learned to discount messages conveyed by residents with dementia, including BPSD, verbal communication, and even call lights. Winzelberg, Williams, Preisser, Zimmerman, and Sloane (2005) found that CNAs with more positive attitudes towards people with dementia rated the quality of life of their residents, including their interpersonal relationships, higher than those with more negative attitudes. These findings may suggest that CNAs consider the ability to interact socially to dictate whether residents' lives are worthwhile and influence their own motivation to provide higher quality personal care.

Trends in Dementia Care

Medical Model

Dementia is clinically named major neurocognitive disorder. The most common form of dementia, Alzheimer's disease, is physiologically hallmarked by diminishing

numbers of neurons and accumulations of proteins in the brain, amyloid plaques and neurofibrillary tangles. The protein accumulations inhibit connections and growth of neurons and synapses (Hugo & Ganguli, 2014). Kitwood (1998) outlined five facets of individuals that tend to be influenced by the onset and progression of dementia as personality, biography, physical health, neurological impairment, and social psychology. The basic physiological changes that occur due to dementia spur the more easily observed and potentially detrimental personality, memory, and interpersonal changes.

Traditionally, healthcare professionals have cared for individuals with dementia through the lens of the medical model. One assumption of the medical model is that the mind and body exist as completely separate pieces of the whole, one uninfluenced by the other. Another is the assumption that symptoms of illness are explained completely by measurable, biological abnormalities. A third assumption is that dementia is simply "progressive cognitive impairment associated with corresponding stages of impairment" (Taft, Fazio, Seman, & Stansell, 1997). Medical professionals using this model likely consider BPSD to be symptoms of the disease, needing to be controlled with "treatment", such as pharmacological interventions.

Person-centered Care

Alternative to the medical model is the social model, and in dementia care this social model is most commonly described under the philosophy of person-centered care. This approach aims to improve the biopsychosocial experiences and care of patients (Koren, 2010). In person-centered care, there is a more individualized approach to healthcare. Attention is focused not only to the biological deficiencies and physical needs of patients, but specifically to the details that make a person who they are (Ekman

et al., 2011). According to this model, people seeking medical care should be maintained as individuals, rather than simply referring to their diseased body parts. Patients should also have decision-making power when it comes to their medical care, which is influenced by their history, preferences, and even family members. In a study of Swedish older adults receiving caregiving services both at home and in care facilities, Kajonius and Kazemi (2016) found that procedural caregiving variables, such as patient-staff interactions, respect, and information sharing, were more strongly associated with patient satisfaction with care than structural variables (budgeting, staffing, training) were.

In order to preserve what he terms "personhood," Kitwood (1993) developed a theory of dementia care. His theory states that individuals with dementia, although may often exhibit disordered behaviors due to dementia, continue to experience emotions and may need assistance to understand them and communicate needs. These individuals need their personhood preserved in order to maintain relative well-being as dementia progresses (Kitwood & Bredin, 1992). Nursing staff may need to use specialized communication styles/skills or develop adaptations for communicating with individuals with dementia to have meaningful and positive interactions (Beck, Ortigara, Mercer, & Shue, 1999; Kitwood, 1993). Because of the progressive nature of the disease, communication barriers may change over time. As the social understanding of individuals with dementia changes, Kitwood stated that their "inner stabilizers" are diminished, meaning that positive social interactions become ever more important (1998). When hearing goes unimpaired, these individuals continue to hear and understand the good and bad things people around them say, without having the capacity to know for themselves what is actually true. Self-esteem and ability to discount hurtful suggestions

are diminished.

The physiological and cognitive changes due to dementia are progressive and currently irreversible, but this social facet of change is malleable enough to make positive advancement (Kitwood, 1998). In one study, nursing home residents reported social support networks made up of their peers and staff members as large as or larger than their family networks (Carpenter, 2002).

Barriers to Social Support in Dementia Care

Many CNAs do not understand how to care specifically for someone with dementia. A meta-analysis conducted by Kuske et al. (2007) concluded that training programs to educate CNAs specifically about how to best care for persons with dementia vary in objectives and methods. Each study in their analysis was rated based on several criteria, including if there was a follow-up assessment at least 6 months after the training, whether the participants were all accounted for, and if measures were reliable. Unfortunately, a very small number were rated as good quality. However, various studies have provided findings suggesting that dementia-specific training improves the quality of care provided by CNAs (Beck et al., 1999; Burgio et al., 2001; Chenoweth et al., 2009; McGilton et al., 2003) with mixed effects on CNA satisfaction (McGilton et al., 2003; Squires et al., 2015).

In an extensive literature review, Anderson, Bird, MacPherson, and Blair (2016) found several associations between staff social beliefs and skills and their influence on life experiences of people with dementia. Of the studies included in their review, they found that CNA staff's ability to interact with residents with dementia may be predictive

of resident mood. Other interpersonal factors, such as empathy, focus on person-centered care, and flexibility in care tasks were associated with slowed functional declines and better intake of food among people with dementia.

Another barrier to nursing staff members providing quality social support to their patients is the staffing ratios in long-term care facilities (Koren, 2010). There are clear guidelines from the Centers for Medicare and Medicaid Services (CMS) requiring a registered nurse to be employed 8 hours during day shifts and two licensed nurses to be working 24 hours/day in nursing home facilities. Certified nursing assistants (CNAs), those who perform 90% of the personal care for residents, are required to be "sufficient" to meet residents' needs (Center for Medicare Advocacy, 2014).   This vague guideline allows for inconsistencies in CNA staffing, and can be interpreted differently among CNAs, which leads to a high variability in what is deemed "sufficient." Often, there are simply not enough CNAs present to adequately care for the needs of the growing population of people reaching late adulthood and requiring ADL assistance (Squires et al., 2015).

Improvements in social support provision from CNA staff members to long-term care residents with dementia may influence the staff member as well. Previous studies have found that CNAs working to care for residents with dementia are very likely to experience stress, burnout, and become physically or psychologically abusive towards residents (Beck et al., 1999; Foner, 1994). Chamberlain, Hoben, Squires, and Estabrooks (2016) found in their study of factors influencing CNA job satisfaction that CNAs reported often feeling rushed and emotionally exhausted in their work. Jenkins and Allen (1998) found that staff members who reported lower levels of burnout were more likely

to participate in interactions with residents, and staff who felt they had more decision-making power in their job responsibilities were associated with fewer negative interactions with residents.

Summary

Social support is a universal, fundamental, and valuable aspect of being human, but is often cumbersome to clarify and measure in social science. Regardless of the ambiguity surrounding it, numerous studies document the physical, emotional, and cognitive benefits of receiving social support for diverse populations (Barrera, 1986; Chen et al., 2011; Fratiglioni et al., 2000; Krause, 2007; Willis & Fegan, 2000; Wilson et al., 2007), including those who have been or may be diagnosed with dementia.

CNA staff members who work in dementia care have unique opportunities to provide social support for residents, but do not always do so (McGilton, 2004). Shifting from the traditional medical model to person-centered care, medical professionals of all kinds have begun to place more importance on patients' individual and emotional needs (Ekman et al., 2011). For those serving individuals with dementia, this type of attention to detail is especially important because of their changing cognitive and emotional abilities (Kitwood, 1998). However, previous research has documented several barriers that often prevent sufficient social interaction, including low-quality dementia-specific trainings (Kukse et al., 2006), unfavorable perspectives and interpersonal skills among CNAs (Anderson et al., 2016), unclear staffing ratios (Center for Medicare Advocacy, 2014), and CNA burnout (Jenkins & Allen, 1998).

Current Study

The purpose of the present study was to investigate to what extent dementia care CNA staff members consider social support to be part of their professional duties, how staff members engage in socially supportive relationships with residents, and any barriers that may prevent this relationship from developing. In addition, any demographic factors, training differences, or emerging themes from the quantitative or qualitative data collection were analyzed. The goal of this investigation was to uncover any possible patterns in social support perspectives among CNA staff.

CHAPTER III

METHODS

The current study incorporates a convergent parallel mixed methods approach of quantitative and qualitative data collection, in order to better understand the perspective CNAs have of their professional role in regards to offering social support to residents with dementia. Because of the nature of the research questions, a quantitative survey was used for descriptive purposes to collect demographic information and general opinions about social support in the long-term care sector. Surveys allow for consistent measurement of select concepts among participants. Previous research incorporates this type of quantitative research to investigate social support among various populations involved in long-term care (Ballard et al., 2001; Krause, 2007). In addition, semi-structured one-on-one interviews were used to gain further understanding as to why participants responded the way they did. The use of interviews as a way to collect CNA perspectives and opinions has been used in previous exploratory research (Hunter, Hadjistavropoulos, & Kaasalainen, 2016; Pennington, Scott, & Magilvy, 2003). When used in combination with quantitative methods, these interviews allow for fuller, more informative findings, especially in exploratory research.

Recruitment and Sampling

The sample of CNAs was recruited by solicitation of local skilled nursing and assisted living facilities where residents with dementia reside. With approval from the administration, the two researchers working on this project attended staff meetings and described the study opportunity to the CNAs. Flyers were posted in the break rooms and

near time clocks of the facilities. Participants were compensated $15 for their time in the form of online Amazon gift cards, and given a short survey and interviewed during non-work hours in their place of preference (e.g. a university office or study room in the library). The duration of the interviews was 30-45 minutes. Eligibility requirements for participants included that the CNA staff had to work with residents with moderate to severe dementia, work between the hours of 6 A.M. and 6 P.M., and they had to be fluent in English. Using the recommendations proposed by Creswell (2013) for mixed methods analysis, we conducted 14 total qualitative interviews, including quantitative surveys with each one. The audio quality for the initial three interviews were not amenable to transcription; they were, post hoc, considered trial interviews and the other 11 interviews were included in the qualitative analysis. All 14 surveys were included in the statistical analyses to increase the likelihood that the data could be included in inferential statistical analyses. All interview and survey data were saved using assigned pseudonyms for each CNA participant in order to maintain their confidentiality.

Quantitative Method

For the present study, each interview began with a short 5-10 minute survey (collected via Qualtrics) to gather demographic information, dementia-specific trainings attended, and importance rating on various occupational tasks, including social support domains. All quantitative analyses were conducted using SPSS statistical software. Initially, descriptive statistics and frequencies were done to determine whether parametric analyses were appropriate for the quantitative data. A paired samples t-test was conducted to answer the first research question, comparing the mean importance values

CNAs associated with social and nonsocial tasks related to their work, such as ADL assistance, answering call lights, and being emotionally supportive. Due to the lack of variability in the survey responses, the other two research questions were answered using strictly qualitative analyses.

Qualitative Method

After the Qualtrics surveys were completed, the CNAs participated in semi-structured interviews, each recorded using Zoom audio recording software and saved for transcription from audio to text. The two researchers attended the interviews, one to conduct and the other to make any notes of applicable body language or visual cues related to the participant's responses. Because of scheduling conflicts, only one of the interviewers was present for three of the interviews.

The questions prepared for the interviews and the resulting data were used for this and one other master's thesis project. Thus, not all questions or responses were directly relevant to the research questions of the current study. The complete list of questions is included in Appendix B. Open-ended questions specific to this project include (optional follow-up questions indented):

Why did you choose to work as a CNA as opposed to other jobs?

Tell me about training required for this job.

    Can you describe in more detail the dementia specific trainings you have received?

Do you think these trainings prepared you well for working with people with dementia?

Why or why not?

The definition of social support includes emotional care and respect, encouragement, information and answers to questions, help with problems, and companionship from others. Do you think a person with dementia living at an assisted living facility needs all of these kinds of social support?

If yes, which ones are the most important?

Who should provide this support for them?

If they don't need very much, why not?

What particular characteristics of residents with dementia that make it especially difficult for you to offer them these different kinds of social support?

Think of a staff member who you know has high quality relationships with one or more resident who has dementia. What do they do to build those relationships?

How does this staff member provide social support to residents?

Which positions at this facility are the most responsible for engaging in social support with residents with dementia?

What keeps you from being more socially supportive to persons with dementia in your occupational role?

The interviewer added prompts and additional questions for follow-up for clarity and depth, as needed. Transcription was completed using Otter.ai online software, then interview data was uploaded to Dedoose online qualitative analysis software for coding and theming. Once transcribed accurately and double checked for accuracy, the audio files were destroyed.

The qualitative portion of this study was guided by the hermeneutic

phenomenological approach. According to Creswell, Hanson, Plano Clark, and Morales (2007), this qualitative approach focuses on describing the experiences collected from respondents in order to learn more about a social phenomenon. To do so, using the purposive sample of CNAs who work among people with dementia, the above questions were asked to obtain a sense of their experiences and perspectives. Coding captured the main topics discussed by participants, both expected and unusual. Using the themes that emerged from coded participant responses, this qualitative data became interpretable to add depth and greater understanding to the quantitative findings.

Two coders, both using the data for separate master's theses, independently coded initial transcripts then discussed their reasoning for the codes they assigned. Once the coders reached interpretive convergence in their codes, each proceeded independently to complete coding and theming the data. A third coder with experience in qualitative analyses but no background in gerontology/dementia served as a critical friend and also coded all transcripts (see below). Once completed, the codes and themes were revised to again achieve consistency and validity. This was done by comparing codes, themes, and any written explanation or comment from all three coders, and incorporating the few minor distinctions into the final codes for this thesis.

Credibility, Transferability, and Dependability

While quantitative data in general can be judged by its reliability and validity, qualitative data is judged for trustworthiness using different types of measures (Pitney, 2004). In the present study, both of the primary researchers involved in this study had previous experience working professionally in dementia care, which added to their

understanding of the topics, as well as potential personal biases going into this project.

Credibility and dependability of the codes and themes was established by having the

critical friend independently code material. In an effort to maintain transferability, the

demographic information and general work context for this group of CNAs is included in

the mixed methods approach, and potential limitations to generalizability are described in

the discussion section. Further, the mixed methods approach, combining conclusions

from the qualitative data with quantitative survey results, acts as a form of triangulation,

pairing two different sets of data to draw deeper conclusions and maintain dependability.

CHAPTER IV

RESULTS

All three of the research questions in this project rely on both quantitative and qualitative data to fully understand the experience of the CNA staff members who agreed to participate. For each question, the quantitative findings are presented, followed by qualitative data that are also associated.

Descriptive Results

As displayed in Table 1, the descriptive data for the current sample is quite homogenous. All but one participant was White and all but one was female. Only

Table 1 *Descriptive Data*	Mean (*SD*)	*N* (%)
Age	23.64 (6.81)	
Gender (Female)		13 (92.9%)
Race/Ethnicity		
White		13 (92.9%)
Hispanic		1 (7.1%)
Education Level (Years)	15 (1.36)	
Income Level		
Less than $25,000		12 (85.7%)
$25,000-$44,999		1 (7.1%)
$65,000-$84,999		1 (7.1%)
Months worked as CNA	24.62 (37.92)	
Weekly hours work as CNA	24.31 (6.16)	

Weekly hours – Dementia specific work	19.21 (8.25)
Previous Experience with dementia outside CNA (% Yes)	10 (71.4%)
Dementia specific CNA Training (Hours)	35.07 (49.45)

three participants were over the age of 22, and the majority reported household income levels of less than $25,000 annually. Note the high standard deviations for time spent working as a CNA and amount of dementia training received. These values varied a great deal among participants, ranging from 6-168 months working as a CNA and 3-123 hours of dementia training.

Figure 1. Importance of tasks as rated by CNA participants (sample means).
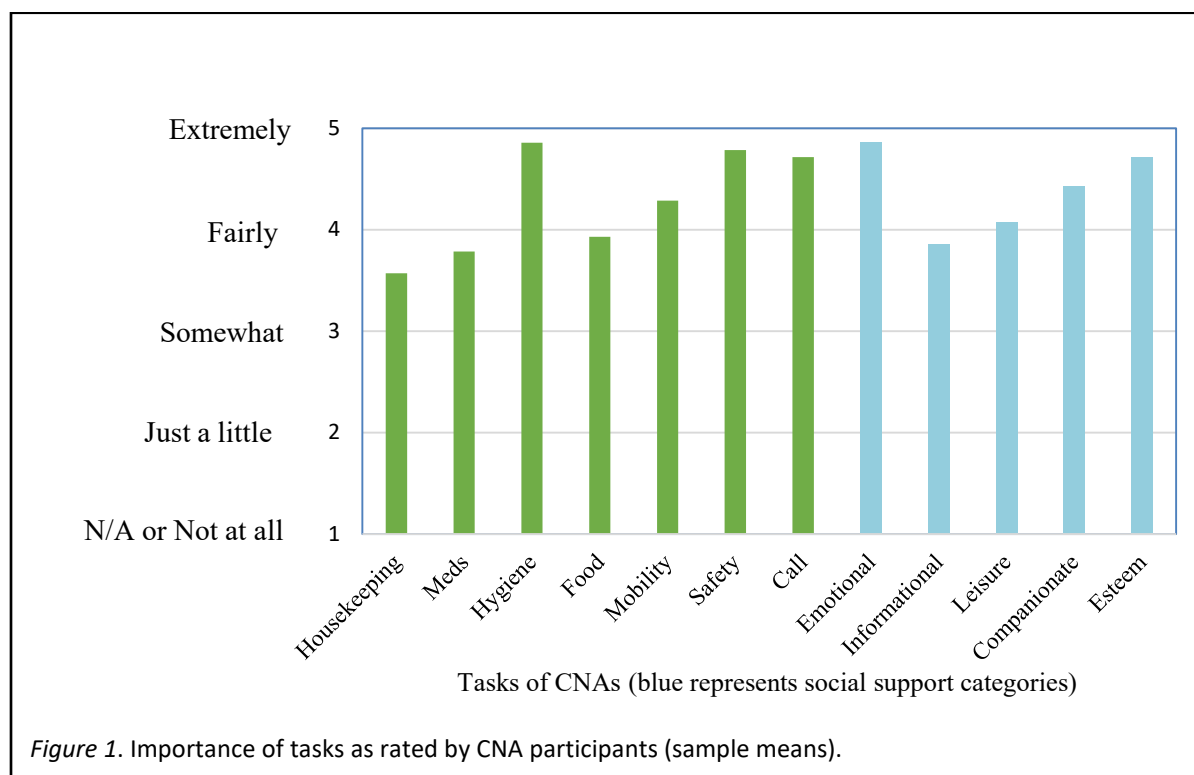
Research Question 1 - Social Support as CNA Responsibility [Quantitative]

The first research question asked to what extent CNA staff members consider various tasks to residents with dementia to be part of their professional role. From the

surveys distributed to study participants, it is clear that social support is considered an important part of the CNA's role in their work, to slightly varying degrees. Of the 12 tasks listed in the survey, 5 of them are considered aspects of social support (i.e., emotional support, assistance with leisure activities, informational support, companionate support, and esteem support). The other seven tasks are more general tasks that are potentially included in the job description of a CNA (i.e., housekeeping, administering medications, assisting with personal hygiene, preparing and/or serving food, assisting in mobility, ensuring safety, and answering residents' calls). In order to assess any overall difference in importance of social versus nonsocial tasks, the mean importance rating for the social tasks and the nonsocial tasks was calculated, and a *t* test was performed. There was not a significant difference found between importance of social ($M = 4.37$, $SD = 0.71$) and nonsocial tasks ($M = 4.28$, $SD = 0.64$), $t(13) = .0498$, $p = 0oc.627$. As noted, the means for both types of tasks were rated just above four, indicating that social and nonsocial tasks were both considered between "Fairly" and "Extremely important" aspects of the CNA's roles. See Table 1 for more complete information about the means of importance ratings calculated from the surveys.

Research Question 1 - Social Support as Responsibility [Qualitative]

The themes related to the first research question are displayed in Table 2.

Table 2

Research Question 1 Themes

CNAs are responsible for social support

Staff as team are responsible for social support

CNAs are responsible for social support. One common theme among all eleven

transcribed interviews was that CNAs are responsible for social support during their daily tasks. Many participants talked about their opportunities to interact closely with residents living with dementia more than any other staff member. One participant named Connie (age 22, CNA for 28 months) stated it this way:

> The biggest person I think [social support] lands on is the CNA. You know, I'm the one that's in their room, you know, 10 to 30 times a day, depending on who it is. And I'm the one answering the question, you know, day after day. Their family isn't in there every day, the nurse isn't in there all the time. The nurse pops in, says hi, give meds, answers questions, whatever, looks at skin or whatever, and leaves. So as a CNA, I'm the one that spends the most time with them. So I think most of these [forms of social support] come from the CNA.

She acknowledged the fact that there are other staff members interacting with residents who have dementia throughout the day, but CNAs have a unique role where their tasks literally take them into each residents' room numerous times every day.

Putting herself in the shoes of someone who gets little to no social interaction on a daily basis, Abby (age 22, CNA for 22 months) commented on how difficult it would be and how important it is that the CNA staff make the effort to engage with residents, even for a few minutes:

> I don't think it really matters who it comes from, honestly, as long as it's coming from somewhere. Because I think about, and it is really so sad, a lot of these people, especially if they live in a facility ...I'm out going about my day and I kind of take it for granted, because I'll see people I know in class, or I'll see my roommates, or I'll talk to my mom on the phone... and like, I'm it for them. And

so I don't know, I just think it'd [be] so hard…I think it just kind of reinforces how

important the CNAs are.

Staff as team are responsible for social support. Most participants agreed that

CNA staff should be the main source of social support for residents, but that it should be

a team effort. Violet (age 21, CNA for 1 year) stated,

Everyone has the responsibility. The CNA is the number one because they're the

ones that are going to be the most involved with all the residents, because they're

the ones that are going to go and give them those cares…the med tech will help.

And then there's people who come in and do activities with them, so that they're

all part of that support. But I feel like the CNA is the main one just because

they're the ones that are like giving most care and doing the one-on-one more than

the others.

Similarly, Ann (age 18, CNA for 15 months) articulated the need to work together

with staff and family members to meet individual needs for support.

I think it needs to be a good balance between the caregivers and the family, and

the nurses. Really just all of the staff needs to be a good support for these

residents because not one person should have to do it all because it's different

shifts, but also each staff or the family can provide a different kind of support.

In sum, these staff members are aware of the need to collaborate with other staff

members in order to fully cater the needs of the residents they serve.

Summary. Both methods of data collection in this study led to the same

conclusion for research question one – the CNAs consider themselves responsible for

offering social support to the residents for whom they care. While some participants also

Figure 2. Importance of nonsocial/social tasks (0=Not at all to 5=Extremely), by CNA.
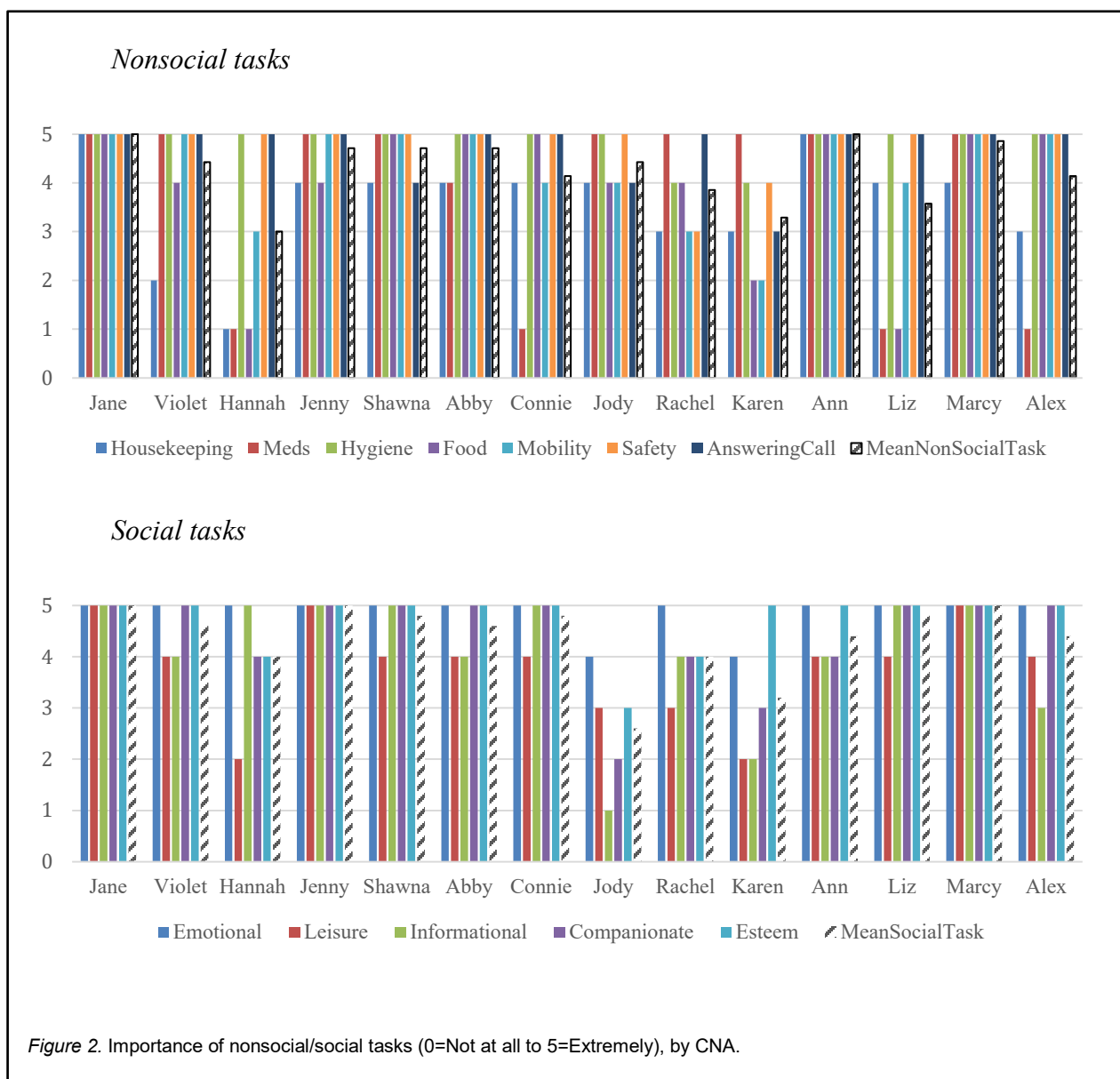
described the importance of working together as a team with other staff members to meet

the social and emotional needs of these individuals, all CNAs described it as their duty.

They have a unique opportunity to facilitate ADL assistance and conversations on a one-

on-one basis regularly with residents who have dementia. Other staff members can assist

in providing support for the residents, but overall, the CNAs in this study considered

support to be primarily their concern. CNAs discussed experiences at length when these

interactions were meaningful and others when they were not favorable, which added to

their daily tasks the undertaking of determining how to facilitate positive interactions with often confused or uninterested residents.

Research Question 2 - Dementia-Specific Training [Quantitative]

The second research question focused on the association between the amount of dementia-specific training CNAs have received, and the amount of importance they place on social support in their occupational role. The amount of dementia-specific training ranged from 3-123 hours. Because of this wide distribution and a natural divide in the data (see Figure 3), amount of training was recoded into two groups: 10 hours or less (*N*=7) and more than 10 hours (*N*=7). Independent samples *t*-test results indicated that the mean scores for socially supportive CNA tasks did not differ significantly between the group who received less than 10 hours of dementia training (*M*=4.5143, *SD*=0.39761)

Figure 3. Reported hours of dementia training by each CNA participant, listed by their assigned pseudonyms.
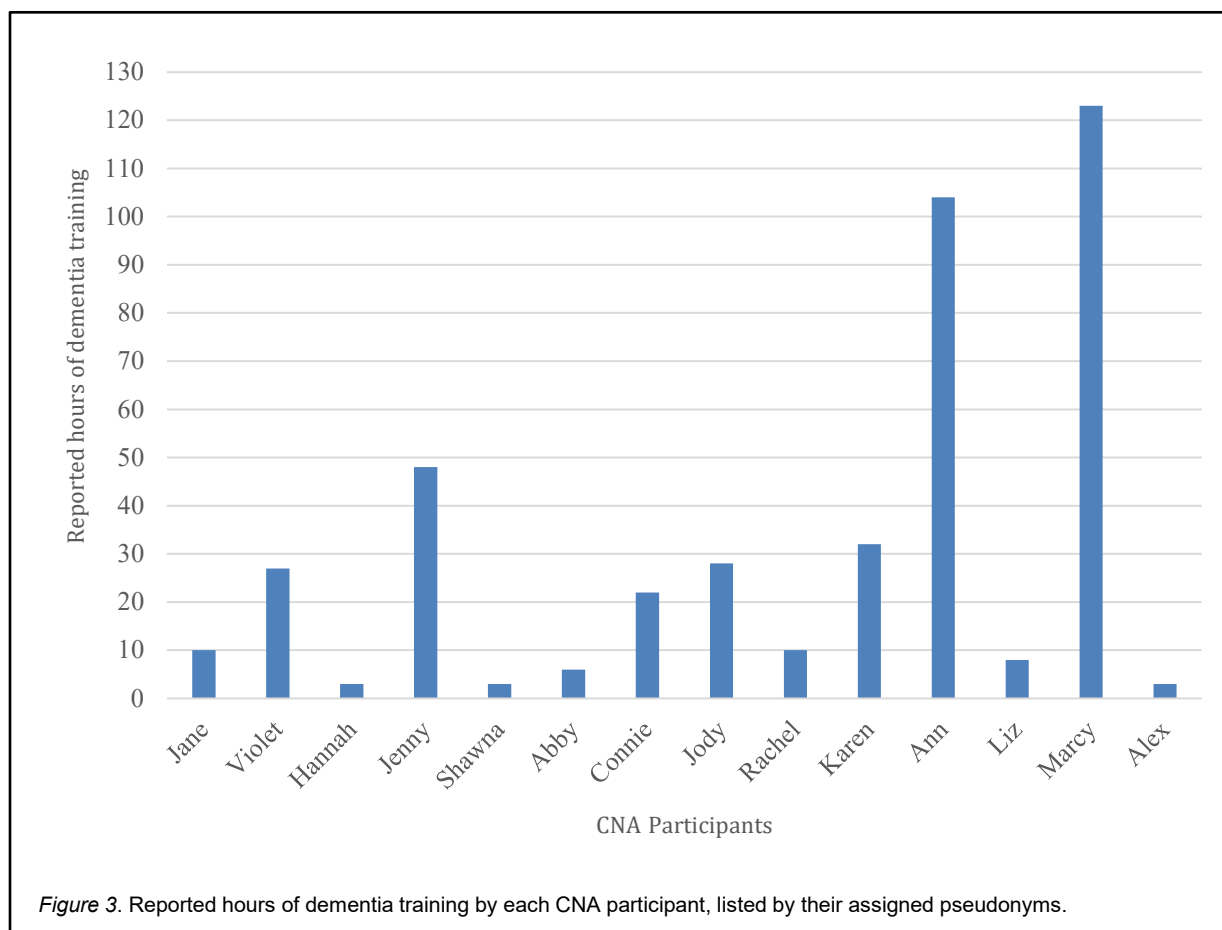
and those who received more than 10 (*M*=4.2286, *SD*=0.94818), $t(8.047)=0.735$,

p=0.483. We note that this may be driven by the fact that we had little variability on the

extent to which CNAs valued the social tasks as part of their role (see Figure 2). All but

one CNA rated the mean of all social tasks as 3 or higher (at least somewhat important).

Perhaps as a demonstration of these quantitative findings, it is interesting to note that the

CNA who reported the highest number of dementia training hours, Marcy (age 41, 168

months working as a CNA), did not articulate much about her training experiences when

asked to elaborate on them in the qualitative interview. She stated that it wasn't until

later in her career that dementia trainings were offered, and while she had attended in-

services, she mostly learned from her own work experiences.

Research Question 2 - Dementia-Specific Training [Qualitative]

During the interviews with participating CNAs, there were five major emerging

themes, which are displayed in Table 3.

Table 3
Research Question 2 Themes

Minimal dementia care training

Beneficial trainings

Dementia care knowledge from coworkers

Dementia care knowledge from trial and error

Unsure how to offer social support

Minimal dementia care training. Perspectives on dementia care training in this

study were overwhelmingly negative. Almost all participants described their experiences

in dementia-specific trainings to be insufficient for their jobs, as well as having to rely

heavily on their coworkers and trial and error experiences in their work. While many

participants described small sections on dementia in their general CNA training, these units were described to be insufficient. Rachel (age 19, CNA for 6 months and received 10 hours of dementia specific training) stated,

> I guess I didn't realize how hard it can be really. When I was training in my CNA class I understood. We watched some videos, we went over lectures on it and stuff. And like what the differences were going to be and ways to help, but I guess I didn't realize what it would be like really in person and how intense it can be.

Abby (age 22, CNA for 22 months and received 6 hours of dementia training) remembered specific situations that she didn't feel prepared for after her training: "…I've had a couple times where I have dementia patients who don't really speak that much, or just like, won't communicate with me. I didn't really know how to deal with that."

One male CNA, Alex (age 35, CNA for 6 months and received 3 hours of dementia training), responded this way when asked about the topics discussed in his training, he said,

> … not a whole lot of time was dedicated to how to interact with them other than, you know, be professional and be courteous and respect their wishes. But there wasn't a whole lot of like, psychological or behavioral training, like how to deal with those kinds of things.

The focus of his training was primarily how to complete ADL tasks, not necessarily on caring for and interacting with people who have dementia.

Many participants explained that if there was a dementia-specific section in their training, it generally focused on dementia as an illness and its progression. Jody (age 20,

CNA for 7 months and received 28 hours of dementia training) stated,

> We talked about the importance of making sure like they're getting fed or things like that, because they forget things really easily. We also just talked about, like different kinds of dementia like Alzheimer's… I think I remember watching a video about the progression of Alzheimer's, like, from very early, early on to stages of death. So that was like, kind of impactful, because it was hard to see, like, their families being like, "I don't even know this person anymore," and stuff like that.

Beneficial trainings. While most of the experiences shared about dementia trainings described them as insufficient, there were a few points that some CNAs learned that were largely beneficial to them in their work. Again, Jody described trainings using scenarios to teach about redirection for individuals with dementia helping in her in interactions:

> We learned about different strategies. Like instead of saying no, that's not correct that you're going to go see your husband who's dead, or things like that, but...walking them around it...that's helped me in some scenarios...being able to be more understanding.

Other examples of trainings that were more helpful were those that focused on specific people and their needs and routines, communicating with and respecting individuals with dementia, and symptoms and the progression of the disease. Violet (age 21, CNA for one year and received 27 hours of dementia training) stated:

> As a CNA you have to have a certain amount of training hours to make sure that you know what you're doing and make sure you know the residents well enough.

Every resident has a specific need and so you have to be able to know how bad

their dementia is so you know how much care they need. It's just part of the

training that you know the specific services they require.

Dementia care knowledge from coworkers. Over half of the participants in this

study talked about receiving their dementia care knowledge on the job from their

coworkers. Alex explained his initial experience this way:

I felt when I…got there working on the Alzheimer's wing, like, pretty unprepared

for how to deal with residents who, they don't want to necessarily, they do"t want

to eat… and yet, you still are required to provide those services for them. And so

it, I felt really awkward, especially showering residents that don't want to take a

shower, because, you know, that's an invasion of their privacy. And so it took me

a while to sort of see how the other CNAs handled things and kind of adapt to it.

The examples and tips from more experienced coworkers is often welcomed.

Similarly, Connie stated the following:

… if I think…this isn't working or some co-workers will say, "I do this with her,

and it really helps her feel calm, and it really helps her be cooperative." So,

talking about it with coworkers helps a lot. Like, 'I've had a hard time with so and

so. What do you do with them?' is helpful conversation."

Sometimes the knowledge gained from other coworkers is based on their mistakes

rather than their achievements, as stated by Abby:

…my first job at [facility name], there were quite a few of the ladies I worked

with…were just impatient and grumpy. There was one resident, she had dementia

and she wasn't pleasant to deal with. But if she would like snap at them, they

would snap right back, and I just saw like...that doesn't work. It just fuels the

animosity and then she's in a bad mood, and they're in a bad mood...and it's like

"Okay, obviously tha"'s not going to work"… I could see what they did and be

like "I'll avoid that...."

Dementia care knowledge from trial and error. Learning through experience

and experimenting with different ways of doing things were common among nearly all of

the CNAs interviewed in this project. One participant, Ann (age 18, CNA for 15 months

and received 8 hours of dementia training), explained her experience as a continual

process of learning, even after some trainings:

> …you're always learning how to talk to them, keywords to say, ways to phrase
>
> things, and it's different for all of the residents. There's not like a one way that
>
> works for all, so it's kind of a lot of like Alzheimer's and dementia is just as you
>
> go, figuring out what happens and what works for that resident.

Similarly, Liz (age 22, CNA for 1 year and received 8 hours of dementia training)

described her experience learning from mistakes and based on getting to know different

people:

> Just have to learn as you go, I guess. That's been the best... I mean, trial and error.
>
> Because…no matter how much training or knowledge I've had before, like, it
>
> always comes as you go and you do it. Like sometimes you don't know how
>
> people are going to react to something because we're individuals and react to
>
> different things…it's not an exact science, either. You just kind of have to learn
>
> what different personalities like and work with it…you just have to make some
>
> mistakes sometimes because you don't know what the outcome will be. And the

next time you're like, Okay, I can't do that again." It changes for each person.

Unsure how to offer social support. Many of these CNA staff members described feeling that they simply did not know how to offer social support to residents with dementia, although they had attended minimal dementia care trainings and felt like it was something they should be doing. Alex expressed his frustration when he has tried to help a resident feel understood and supported during care, but did not know how to help her:

> Sometimes it doesn't do any good, like there's nothing you can say, to get them to cooperate. We have a lady that she is a sweet, sweet lady during the daytime, but if you wake her up at night, she will try to bite and scratch and fight you. And so when she has a soiled brief, you know, we don't want to leave her in her urine or feces, and so we have to change her. But she she's acting as though we're like there to, you know, attack her, or rob her. And so I've tried so many different ways of trying to put her at ease or get her to just cooperate. There's like nothing you can say…So we try to convince her, you know, "We're your friends, we're here to help you." But now, it's kind of gotten to the point where we just, we just do it, because nothing we say really helps.

Liz stated that it can be more perplexing depending on the progression of the disease.

> Well, there are some people who react very strongly or abruptly to anything, if you even just talk to them…maybe they will yell or think that you're coming at them, right? …I would come into a situation, like wanting to sit by some, like, maybe I'll just want to come and keep them company. But because … maybe they don't want me there. They don't know why I'm there. They just…react negatively

to that…I think it's just like the stages of the dementia, like, depending on what stage they're at, it can be more difficult to help them with this social support that they may need.

She also expressed the challenge of supporting multiple residents at once, rather than one at a time.

I think the most difficult thing for me, especially in the memory unit, would be entertaining everyone. Especially when there's not as many aids as there are people or residents there. That has been especially difficult because there's different levels, right. So some people are really, really confused, and other people are like pretty with it still...it's hard to find activities that can help entertain everyone at the same time without other people getting angry or people just sitting there because they can't participate. So I think that's kind of hard, because you see, it's just not as rewarding because you don't know exactly what to do.

Summary. The participants in this study demonstrated in the survey that socially supportive tasks are just as important, if not more important overall, than the included nonsocial tasks. While the range in dementia trainings was quite wide, more trainings did not influence the CNA's perspectives on the importance of social support in their work. The qualitative data expanded upon this finding by shedding light on various ways the CNAs felt their trainings could have been improved. Currently, it appears that CNAs gain the bulk of their knowledge about providing social support for residents with dementia from coworkers and their own trial and error. While this may be beneficial in some ways, there are positive and negative examples of interaction between staff and residents within long-term care facilities, and it may be a challenge for newer CNAs to

accurately discern whose advice to take.

Research Question 3 - Other Associated Factors [Quantitative]

The final research question measures whether any other factors or characteristics of the CNA staff members are associated with greater importance placed on social support in their occupational role. The possible factors included demographic factors, values, hours working in dementia care, time spent working as a CNA, and any personal values coded in the interviews. However, due to the lack of variability in the importance ratings of social tasks, completing such statistical analyses was not possible. Two of the 14 participating CNAs reported a mean importance rating for social tasks near "Just a little important" and "Somewhat important", while all others reported means falling around "Fairly important" to "Extremely important". Without variability to predict, the interpretation of this research question was guided by the qualitative responses.

Research Question 3 - Other Associated Factors [Qualitative]

Themes which emerged from the interviews relating to factors associated with social support importance are displayed in Table 4.

Table 4
Research Question 3 Themes
Values helping others
Bidirectional relationships
"Bond" with resident
Individual needs of staff members
"Depends on what kind of level you choose to take it to"

Values helping others. Many of the participating CNAs mentioned a strong personal desire to help and connect with others as part of their occupation. Liz and

another CNA, Shawna (age 22, CNA for 5 months and received 3 hours of dementia training), expressed this sentiment when asked why they chose to be a CNA as opposed to other work opportunities:

> (Liz) Well, because I love it…It's because we like to help people. And it's like, it just feels like I'm serving all day long, which is really, really nice, even though it's really, really hard sometimes.
>
> (Shawna) I want to do it because it's a job where I can serve others and something that makes me feel good; it is uplifting.

Connie (age 22, CNA for 28 months and received 22 hours of dementia training) stated that even though it is hard some days, the most satisfying moments while working are when she feels she helps someone during a difficult time.

> …nobody wants to live in a nursing home, but at a certain point, that's kind of the option. It gets the point where your family just can't do it, whether you know, time wise or emotionally, or it's hard for them. And so, I know that my job is important, even though it's really hard for me. And some days, it just feels like a checklist. But those are the moments that are rewarding, that remind me why doing it because it's, it's to help somebody feel comfortable…in their last moments of their life. That's what's most rewarding to me. Seeing that something that I did make them feel better about themselves.

While working is a CNA is not an easy task, finding passion in helping others enjoy their lives, particularly when they are in difficult circumstances, helps ease the burden of those more difficult moments for the CNAs.

Bidirectional relationships. CNA staff members who can sincerely enjoy and

gain from a mutual relationship with the residents who have dementia for whom they care are more likely to offer (and receive) social support in their interactions. Shawna shared an example of how staff members can enjoy the interactions they have with people who have dementia by genuinely seeking to know and understand them.

> One of the things we're supposed to do is we're supposed to interact with the residents; we're supposed to entertain them and keep them busy. And so just talking with them and learning about them...that can be fun. And it's really interesting learning about their childhood or the things that they do remember as opposed to the things they don't remember. That's maybe the part of my job that I like most; just learning about people being able to interact with them.

Abby discussed the importance of establishing "mutual respect" with residents, even with something as simple as making eye contact.

> I also think eye contact is very important to both establish trust, and to demonstrate that you are truly listening to a person. I think it just shows respect and people appreciate being respected. And then people are more likely to cooperate with those with whom they have established a relationship of mutual respect.

She acknowledged the influence having this type of connection can have for both parties. A resident with dementia who feels respected will feel more validated as a person, and will be more likely to cooperate with CNA staff members with daily tasks, whether or not they understand the need for the task. This improves the overall experience for both the resident and the CNAs.

> ***"Bond" with resident.*** Another way that some CNAs described creating a

mutually beneficial relationship with residents who have dementia is striving to "bond" with them. Abby shared how she uses appropriate physical touch to make connections with the residents she cares for, which benefits both people involved.

> I feel like especially in facilities, caregivers can get so busy taking care of physical needs that they don't have time to provide for emotional needs as well. So, I think that making effort to take an extra minute to hold someone's hand or touch their arm can go a long way. In my experience, it almost always strengthens the bond between the two of you.

Jody described learning about each other as a way to create those beneficial relationships.

> …the most rewarding is when you can kind of make a connection with someone and, like, be able to smile at them and ask them how their day is going or tell them stories about your life or something. And they think that's cool.

Ann explained that gaining a resident's trust, even if that means doing so multiple times, is a rewarding experience for her as well.

> You're their caregiver, and so you're supposed to help them feel safe and happy. And when you succeed at that, and when they are safe and happy, and they do trust you even though they can't remember your name, or remember that you were there yesterday, when you can, over and over again, just kind of build that connection with them. It's very rewarding.

> ***Individual needs of staff members***. Sometimes certain personality traits, belief systems, or skills of staff members seem to mesh better with residents on an individual basis. There are times that effortful attempts to connect with certain residents simply do not turn out fruitful. Connie explained her experience of passing off a situation of

educating a resident to another staff member based on the impression that they could do what she could not.

> … sometimes it's a lot of information, and I have a hard time condensing it and simplifying it. And, you know, that's on me. And also it's difficult for them to be patient while I'm trying to figure that out…. Sometimes they're just not absorbing that information, they're not absorbing how to do it, you know, so I go, "You know, if you'll just do the simple thing, it'll fix it," and…it can't compute. So little things like that. I think for the most part, we, we figure it out mostly like how to work around it. And sometimes it's just, I need to step out in a different a CNA needs to come in. Like, "You're just going to do better with somebody else." So, it kind of depends on each person.

Similarly, Shawna explained that there are times when some coworkers do not get along based on personality, but those individuals who struggle with other coworkers are able to connect with certain residents with dementia in a meaningful way.

> It's interesting because personality does make a difference. But I know some people who aren't necessarily the best co-workers with other people, interact well with the residents. They're respectful, and kind and really nice.

"Depends on what kind of level you choose to take it to." Creating bidirectional relationships between CNAs and residents who have dementia requires a certain amount of effort on the CNA's part. One subtheme that emerged from the interviews is that the type of relationships they have with residents is based on the effort and time the CNA is willing (and able) to put in. Rachel (age 19, CNA for 6 months) described making such a decision is personal and based on your values.

It takes practice and time. There was a couple of weeks where I slowly worked with dementia people and I didn't work with anyone else on the floor. And like, I don't know, I think I just like got routines down with each one of them. Unless someone tells you what works well, like verbally, it's going to be hard to know what works best for each one of them. There are certain things that…you just have to, like figure it out for yourself, too. And it just depends on what kind of level like you choose to take it to. Because I know there's like certain aides that are there to do their job, and like, get what's [gotta be] done done, but aren't really eager to make a personal connection kind of thing. So like, I think you just have to experience it for yourself and try to work with each resident.

Alex shared a similar sentiment regarding the difference in values and effort put forth by CNAs to create those more meaningful relationships with residents who have dementia. He was asked about how body language helps CNAs be more effective in their tasks.

Well, as far as if we if we use effective in the sense of getting things done, right. I don't know that it really matters. But if effective is making [residents] feel good, then I guess, yeah, just not having a patient countenance or appearance to yourself, using body language that is affirming. As far as like getting things done, yeah, there are CNAs that, they get all the work done very quickly and without necessarily like, you know, taking time to make the residents, like, adding quality to the experience for the residents.

Finally, Ann also described some of the ways she has seen other CNA staff members choose not to focus their energy on creating these mutually beneficial relationships during their work.

They are not as genuine, they're more of like, this is a job, I just want to get it

done. Maybe instead of like trying to, especially with like dementia and

Alzheimer's, you have to realize that they do not know who you are, of course

they're going to be uncomfortable with a stranger doing some of the things that

we have to help them with. So maybe they're not as understanding or seeking to

find understanding for how these people might be feeling. They're not as willing

to work with the resident through an issue, or an emotion that they're feeling.

Summary. Because statistical analyses were not suited to investigate this

research question in the data, the qualitative data serves as the primary source for

answers. While personal values of helping others appeared to play a role in the

importance ratings of social support, striving to form positive bidirectional relationships

with residents also played a role. Almost all mean scores for the importance of socially

supportive tasks were relatively high, except for two participants. While it is difficult to

measure, these two participants did not express their own values for serving others or

acknowledging their individual needs in forming relationships, and only one mentioned

the impact of bonding with residents or making the effort to do so. Future research could

further investigate personal values that impact the quality of bidirectional relationships

between CNAs and residents with dementia, specifically comparing CNAs who do and

do not place value on social support in their occupational role.

CHAPTER V

DISCUSSION

The descriptive quantitative data and the rich qualitative responses collected during this project provide a glimpse into the day-to-day experiences and broader perspectives of CNAs working among long-term care residents with dementia, and how they perceive social support to those residents as part of that role. I expected to find variability in the levels of importance CNAs place on socially supportive tasks in their work. Contrarily, participants rated social support as fairly to extremely important, and the lack of variability in the quantitative findings led to slight shift in the mixed methods approach, whereby the qualitative responses took on more emphasis. That said, this study is still mixed methods in its design and interpretation, and quantitative data were informative. Rather than presenting the results again in linear order from research question one through three, the discussion section will serve to integrate the findings, both across quantitative and qualitative approaches, and across the three questions.

Person-Centered Care

The high sample means on quantitative items related to the importance of socially supportive tasks in their roles suggested that social support for various purposes are understood to be an important part of daily work for CNAs. Among the importance of social support tasks within the CNA role, emotional and esteem support were rated the highest among participating CNAs, followed by companionate, leisure, and informational support. Whether or not these perspectives align with actual behaviors was not determined in this study, however this perspective aligns well with the values associated

with person-centered care (Koren, 2010). Person-centered care highlights the value of recognizing each person for who they are, rather than focusing on their physical or cognitive diseases. Acknowledging "personhood" leads care providers to offer individual focus to each patient or resident receiving care, and to provide them decision-making opportunities regarding all aspects of life possible.

Qualitative analyses allowed me to explore this incorporation of support in the CNA role in more depth. Emerging themes suggest that the participating CNAs felt personally responsible for providing social support for residents with dementia. They also expected and benefitted from other members of their facility staff providing additional support. There was general consensus that there needed to be a team approach to social support of residents, and CNAs were an important member of this team. If each staff member of long-term care facilities, including CNAs, nurses, activities directors, meal servers, and anyone else who has regular contact with residents who have dementia are all contributing to the emotional and social needs of the residents, they will have higher likelihood of having their needs met than if it falls to one staff member group alone.

Many CNAs in this study discussed the difficulty of providing individual social support while balancing their other work responsibilities with their limited time and abilities. One participant, Liz, described the difficulty she felt when she tried to meet the social needs of many residents with dementia simultaneously in a group setting. While this would be the most efficient way to spend her time, she described the difficulty of engaging residents with different interests, personalities, and cognitive abilities at the same time. Other participants shared their ongoing struggle to complete required tasks

for numerous residents without excluding their emotional needs, although they often feel they do not have the time. While there is no obvious resolution to these situations in long-term care, it is clear that many CNAs do place importance on and strive to provide social support, even while doing so may feel unfamiliar, rushed, and not completely efficacious.

Another important aspect of person-centered care that the CNAs cited in this study was the importance of offering as much control as possible to residents, when they interacted with them. Several participants discussed their efforts to communicate options to residents with dementia to allow them freedom to make their own decisions on a regular basis. Such small-scale decisions as choosing clothes to wear, the order for completing personal hygiene tasks, or where to sit in the dining room can be meaningful opportunities to exude independent thinking for residents and improve their self-confidence or feelings of self-worth. These outcomes are similar if not equivalent to those of the social support tasks included in this study.

Dementia Care Theory

In addition to person-centered care, there were several indicators in this study confirming the importance and validity of dementia care theory for this sample (Kitwood, 1993). Not only is it important for someone receiving medical or long-term care to feel respected and valued as an individual, but their individual needs should be met, including specific assistance appropriate for their symptoms of dementia. CNA responses included their need to better understand how to transmit and receive verbal and nonverbal communications with someone who has dementia, the value of emotional bonds created

between residents and CNA staff, and observable improvements in residents due to these principles.

As cited in the literature review, Kitwood (1993), people who have dementia continue to experience emotions, although they do not always understand why or how the emotions may not coincide with reality. Part of the responsibility the CNAs described was knowing how to help alleviate negative emotions without discounting them. For example, Alex explained his struggle to comfort a specific resident with dementia who received routine personal care during the night, but was often confused and clearly was not comfortable with the CNAs doing their job. Additionally, Jody discussed the delicacy of a situation where a resident was asking for her spouse, whom she did not recall had passed away.

Many of the CNAs in this study discussed the value of providing social support and increasing the likelihood of favorable behaviors (Anderson et al., 2016). Connecting on a personal level with residents who have dementia and knowing how to help them feel respected improved behaviors such as eating food at meal times, participating in social activities with other residents or staff members, and completing personal hygiene tasks alone or with assistance. The participating CNAs discussed one specific and often very difficult task and its connection with social support – showering/bathing a resident. Understandably, this task can seem like a complete violation of personal boundaries, particularly for someone who does not understand why they need assistance or feel that cleaning their body is necessary. Getting to know a person, helping them feel comfortable and understand the situation, giving them options and feelings of control,

and communicating clearly were helpful steps in assuring compliance with this necessary task, as well as others.

Barriers in Providing Support

The data from this study uncovered numerous barriers CNA staff members experience when attempting to provide social support for residents with dementia. The applicable barriers for the current report include staffing ratios, the emotional drain felt by CNAs in their work, and lack of sufficient dementia trainings available to them.

First, as illustrated by the discussion regarding person-centered care (Koren, 2010), spending individual time with residents who have dementia is paramount in their feeling a meaningful connection to staff members. According to the participating CNAs, the lower staffing ratios often found in long-term care do not allow for plentiful one-on-one time with residents, aside from providing ADL assistance. Many CNAs expressed their desire to spend additional time with residents listening to them, sharing their own experiences with them, even bringing their children into the facilities to visit them. However, it is unlikely that CNAs could be able to complete the necessary physical tasks for all residents under their care and adequately set aside the amount of time necessary to truly connect with residents on an emotional level. While some explained they are able to make and maintain many connections while attending to ADL tasks, many also discussed the difficulty of carrying on a focused conversation when distracted by the task at hand.

Another barrier CNAs face as they are providing social support for residents with dementia are fluctuations in their own emotional well-being. Because of the frustration

some of the CNAs described due to lack of time/staffing to devote to socially supporting residents, they described feeling emotionally drained themselves. As CNAs rush from room to room, helping each resident as quickly and efficiently as possible to meet the needs of all within appropriate time limits, it is natural that they may feel an emotional drain due to their stress over managing tasks and time. However, when staff members are feeling this way, it can be difficult to provide emotional supports for others, particularly those with dementia.

Finally, another common barrier described by CNAs in this study is the lack of sufficient dementia care training. The range of hours dedicated to dementia-specific training was very large in the sample, yet nearly all the participants verbalized feeling that the dementia care trainings that they received were insufficient for the work that was required of them. Several shared difficult experiences they had encountered which the trainings did not prepare them for, such as interactions with someone with dementia who was nonverbal or who was confused and quite physically or verbally aggressive. According to the responses, the bulk of required trainings that CNAs receive as they are preparing for work involved the physical cares that all patients or residents may need, regardless of cognitive ability. Their responses, particularly the wide variation in reported hours of dementia care trainings, also indicate inconsistencies in requirements for dementia-specific trainings. More in-depth investigation could uncover more about these inconsistencies. The participants listed some aspects of their dementia trainings that were informative, for example teaching different types of dementia, areas of the brain affected by dementia, progression of the disease, and possible symptoms, but this knowledge was not sufficient to prepare them for their interactions with residents with

dementia.

When incorporating social support into their work was included in the CNA training, there were several aspects cited as particularly helpful, including redirection strategies, getting to know needs of specific individuals, role playing scenarios, ways of communicating respectfully, and progression of the disease (which was discussed both as being less and more helpful). Without specific training, CNAs had to pick these skills up through trial and error, or from observations of coworkers that were effective or ineffective with this population. According to these qualitative responses, it is not enough to hone the skills of CNAs to assist with ADL tasks, but to also train them on the social and communicative aspects of working with people with dementia so that ADL needs can be met more effectively, and so that quality of life for residents can be maximized (see also Burgio et al., 2001).

Implications

I learned from the present study that the participating CNAs who have been working among long-term care residents with dementia place a great deal of importance on social and emotional support, not just physical assistance, in their work. However, there are several indications from the qualitative interview data that CNAs are not always able to provide social support as they feel they should. They cited that lack of appropriate training (particularly with low-verbal or behaviorally challenging residents), lack of time, and lack of motivation inhibited engaging socially with residents who have dementia, especially so because social tasks were often viewed as "going above and beyond," rather than basic required tasks in routine CNA work. The participating CNAs

expressed that forming mutually beneficial relationships with residents, and with other members of the care team, improves their abilities to offer social support to residents and enjoy the experience themselves. Understanding these challenges and values at the facility- and society-level may inform the development of improved dementia-care trainings for CNAs and possible updating of required CNA staff-to-resident ratios.

The findings of this mixed methods study may prompt future research in several directions. First, future research should specify improvements for CNA trainings, identifying certain topics or skills that would improve socially supportive behaviors in dementia care settings. Based on the results of this study, trainings for CNAs should include not only skills to meet physical and ADL needs, but interpersonal skills specific for caring for people with dementia. The skills taught in these trainings could include active listening, respectful redirection, how to create mutually beneficial relationships, understanding emotional needs of self and residents, use of meaningful leisure activities in groups and one-on-one, use of socially supportive behaviors during ADL tasks, and when to increase/decrease sensory input for residents with dementia. Including social support concepts in required CNA trainings would promote consistent high quality and holistic dementia care.

Trainings could be further improved with use of specific learning tools, as were described by the CNAs in this study. Communicating and redirecting conversations with residents who have dementia could be more clearly understood by role playing experiences. CNAs would also benefit from discussion based on detailed examples of actual or fictional people with dementia. While current CNA trainings often include information about symptomology and progression of dementia, another improvement in

trainings might incorporate this knowledge with examples of communicating respectfully with people at different levels of disease progression. Discussion regarding such difficult BPSD as physical aggression, diminished verbal ability, and wandering, followed by role-playing to practice respectful communication and/or redirection could greatly improve the experiences of CNA's entering the workforce, as well as the residents for whom they provide care.

Second, further investigation of the efficiency and efficacy of current staff-to-resident ratios in long-term care facilities (particularly memory care units) would be beneficial. The CNAs in this study often discussed lack of time as a barrier to their ability to provide social support, and re-evaluation of current standards may be beneficial. Finally, facilitating research using observational methods to determine how CNA values align with their actual behaviors while working would be useful in understanding the needs for potential training and policy change.

Limitations and Future Directions

The purpose of this mixed methods study was to analyze the value CNAs place on providing social support as part of their occupational duties, and any specific differences in dementia specific trainings or other characteristics that were associated with those differences. As explained previously, the quantitative data for the first research question indicate there is not sufficient variability in reported importance ratings to statistically investigate the latter details. The lack of variability may be due to a generalizable finding – that CNAs as a whole do find social support important, however it is likely these results carry several potential biases due to a small and homogeneous sample, and the sampling

methods used.

For qualitative studies, a sample size of ten to twenty individuals is generally sufficient to reach theme saturation, depending on the research questions (Saunders et al., 2018). I reached saturation of themes within this range, although reaching saturation in our study also may have over-emphasized the homogeneity. This sample was made up primarily of young White women between the ages of 18-22 who had worked as CNA staff for 24 months or less, and the sample was taken from long-term care facilities in a primarily homogenous small city in Utah. One male, one Hispanic participant, and a few participants with extensive CNA experience and/or extensive hours of dementia care training helped add some limited sample variability, but this did not result in quantitative variability on key items. In sum, our responses were informative and consistent, but comparisons with other more heterogeneous samples should be considered.

Another limitation of this study was the potential bias due to the sampling method. As described by multiple participants in this study, there are CNAs with varying levels of personal dedication to providing social support and acknowledging personhood of residents with dementia during their work. It is possible that CNAs who do not experience personal validation in the work they do are less interested in volunteering to participate in research regarding this area, although they are qualified, and their input is valuable. While the lack of variability and consistently high endorsement for the reported importance levels of social tasks in CNA work was a surprise to the research team, it may be due to sampling bias. Future research should consider this bias and utilize randomized sampling methods, in addition to larger and more heterogeneous samples.

The format of the semi-structured interviews poses another possible limitation.

Because of the informality of the interviews, there is the potential for biased responses based on questions being slightly varied. Additionally, responses regarding trainings could have been clearer had the questions specified criteria for trainings (i.e. trainings provided by places of work as opposed to trainings as part of CNA certification). It would be wise to prepare enhanced structure of the interview questions and clarify different forms of trainings in future work.

Conclusion

Social support is an important part of human life, particularly for those who experience significant physical or cognitive changes, such as individuals living in long-term care with dementia. There are many benefits to feeling socially supported, but such life circumstances as the progressive nature of dementia often make meaningful social interaction difficult. In this study, I found that the CNAs in this sample overall value socially supportive behaviors in the work they do with residents who have dementia, regardless of the amount of training they had received. However, several factors, such as insufficient dementia-specific training and education, limited time during work hours, and varying individual interest and emotional capacity, create barriers to their ability to fully provide the support for which they feel responsible. The findings of this thesis provide clear direction for future research, which will improve the experiences of people living in long-term care with dementia and the influential CNA staff members who provide their care.

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APPENDICES

APPENDIX A

QUANTITATIVE SURVEY QUESTIONS

1. How long have you worked as a certified nursing assistant (CNA)?

2. How many hours per week do you work as a CNA (on average)?

3. How many hours per week do you work with individuals with dementia (on average)?

4. Outside of people you care for at work, have you had experience interacting with a family member or friend who has been diagnosed with dementia?

> a. Yes (please specify)
>
> b. No
>
> c. Not sure
>
> d. Prefer not to answer

5. In your opinion, how important are each of the following tasks in your professional role, specifically while working among individuals with dementia? (N/A Not considered my responsibility, 1. Not at all important, 2. Not very important, 3. Somewhat important, 4. Fairly Important, 5. Extremely important):

> a. Housekeeping for residents
>
> b. Administering medications
>
> c. Assisting in personal hygiene
>
> d. Preparing/serving food
>
> e. Taking residents for a walk or assisting in mobility within the facility

f. Ensuring residents are safe

g. Answering call lights

h. Offering emotional support (kind words, active listening)

i. Assistance with leisure activities

j. Offering informational support (giving instructions)

k. Offering companionate support (making sincere friendly

connections)

l. Offering esteem support (encouragement, positive statements)

7. What kind of education or training have you received for your job (indicate all

that apply and amount of hours)?

a. Certification course (CNA course)

b. Clinical hours

c. In-service education/participation

d. Other (please specify)

8. In the above trainings, how many of the hours were devoted specifically to

dementia-care (indicate all that apply and amount of hours)?

a. Certification course (CNA course)

b. Clinical hours

c. In-service education/participation

d. Other (please specify)

9. If you received dementia-specific education/training, why did you attend the

training (indicate all that apply)?

a. Personal interest

      b. Required for job

      c. Extra compensation/incentive

      d. Maintain certification

      e. Other (please specify)

10. How old are you?

11. What is your gender?

      a. Female

      b. Male

      c. Trans male

      d. Trans female

      e. Other (please specify)

      f. Prefer not to answer

12. What is your race/ethnicity?

      a. White

      b. Hispanic, Latino, or Spanish

      c. Black or African American

      d. Asian

      e. American Indian or Alaska Native

      f. Native Hawaiian or Pacific Islander

      g. Other (please specify)

      h. Prefer not to answer

13. What is your household income level?

      a. Less than $25,000

b. $25,000 - $44,999

c. $45,000 - $64,999

d. $65,000 - $84,999

e. $85,000 or more

14. What is your current level of formal education?

a. GED or equivalent

b. High school diploma

c. Some college (specify years)

d. Completed associate's degree

e. Completed bachelor's degree

f. Some graduate training (specify years)

g. Completed a graduate degree (specify degree)

APPENDIX B

QUALITATIVE INTERVIEW QUESTIONS

Career

1. Why did you choose to work as a CNA as opposed to other jobs?

2. How long do you plan to work as a CNA? Do you see this as a long-term career?

    a. Do you plan to continue working in dementia care or in geriatrics? Why or why not?

3. Tell me about training required for this job:

    a. Can you describe in more detail the dementia-specific trainings you have received?

    b. Do you think these trainings prepared you well for working with people with dementia? Why or why not?

Rapport building questions

4. Of all of the duties you have in your job, which do you find particularly rewarding, and why?

5. Which of these duties do you find particularly difficult or dissatisfying, and why?

Interactions

6. How often do you feel you are able to engage in social conversations interactions with residents with dementia?

    a. What makes it easier or more difficult to interact with a person with dementia in social conversation?

7. Think about the times that you think you have had a high quality social interaction with a resident with dementia, or you saw another CNA interacting really well with a resident with dementia. What verbal behaviors, like the ways that you or they were talking to the resident, made this most effective? Prompts:

    a. What kind of volume do you (did they) use? Is there always a "good" volume or are their situations that might require a different level of volume?

    b. What kinds of words/language are used in high quality interactions with residents with dementia? (More prompts: Are these words similar or do they differ from conversations with residents without dementia?)

    c. What is the overall tone of high-quality interactions with someone with dementia, and how might this vary based on the behavior or the mood of the person with dementia?

    d. What specific phrases, if any, do you or other CNAs use in high quality interactions?

8. What verbal behaviors are least effective when working with residents with dementia?

    a. Tell me about ineffective use of language (words/phrases) and overall tone –why are these ineffective?

9. What nonverbal behaviors lead to high quality interactions with residents with dementia?

    a. Tell me about how you approach and use touch/physical contact with residents. Is it similar or different with a resident with dementia?

b. What is the best way to stand/posture yourself when interacting with patients with dementia?

c. What is the best way to use facial expressions such as smiling, eye contact, laughter, etc. when interacting with someone with dementia?

10. What nonverbal behaviors least effective when working with residents with dementia?

a. Prompts: posture, facial expressions, avoiding eye contact, etc.,

11. How did you come to realize the effective or ineffective ways to interact with someone with dementia?

a. Prompts: trial and error? (give an example), observed or asked questions to co-workers, previous trainings (required or not) in learning these behaviors?

12. Possible Follow-up –Summary question:

a. Imagine a co-worker who seems to have the best interactions with residents with dementia. Describe what this person does that makes it go well.

b. Imagine a co-worker who has lower-quality interactions with residents. What would a low-quality interaction look like?

Social Support

13. The definition of social support includes emotional care and respect, encouragement, information and answers to questions, help with problems, and companionship from others. Do you think a person with dementia living at an assisted living facility needs all of these kinds of social support?

      a. If yes, which ones are the most important?

      b. Who should provide this support for them?

      c. If they don't need very much, why not?

14. What particular characteristics of residents with dementia that make it especially difficult for you to offer them these different kinds of social support?

15. Think of a staff member who you know has high quality relationships with one or more resident who has dementia. What do they do to build those relationships?

      a. How does this staff member provide social support to residents?

16. Which positions at this facility are the most responsible for engaging in social support with residents with dementia?

17. What keeps you from being more socially supportive to persons with dementia in your occupational role?