IT’S JUST PART OF THE JOB, ISN’T IT?

VIOLENCE AND AGGRESSION IN THE NURSING HOME

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This thesis is submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

The University of Newcastle

November, 2007
DECLARATION

I hereby declare that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to this or any other University or institution

................................................

Jean Elizabeth Booth
ACKNOWLEDGEMENTS

I find it difficult to believe that I have arrived at a point where I am able to formally acknowledge those people who have helped and supported me throughout this process. There are numerous times when I felt that I would never reach this point, and if I hadn’t had support from those close to me, I would never be in this position.

I would like to thank my original supervisor Irene Stein, for assisting me when I was embarking on this journey. When Irene was unable to continue as my supervisor, the support and encouragement I received from Margaret McMillan and Isabel Higgins has been incredible. Their positive attitude and amazing patience for one who had so much to learn will never be forgotten, and if it weren’t for them, I would certainly not have reached this point.

The residents and their families who allowed me to observe them during my observation period and the nurses who volunteered for interviews will never be forgotten. Without them, this study could not have taken place. The honesty and forthrightness of the nurses during the interviews has enabled me to highlight the problem that confronts them on a daily basis.

This journey will also be remembered for the family events that have occurred. Two weddings and 5 grandchildren have been memorable events that have occurred during the period of this study.

My family have given me the most incredible support during this time. My ever patient husband who helped with photocopying and computer problems, but most of all, his unending patience and love never goes unappreciated.
Our children and their families have always been amazingly supportive, if not somewhat exasperated that it has taken so long. To Tamara, Bruce, Billy, Naomi and Sam; Natasha, Michael, Matthew, Joshua and Elise; Brendon, Rachael and newly arrived Noah and finally, our older son Simon, my sincere thanks from the bottom of my heart.
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ABSTRACT

There is little evidence to show the critical factors that impact on managing aggression in people with dementia and what model of care ensures integrity for both the resident and the personnel responsible for their care. Aggression in this study is defined as “an overt act, involving the delivery of noxious stimuli to (but not necessarily aimed at) another organism, object or self, which is clearly not accidental” (Patel & Hope 1992, p 212). This study used ethnographic techniques, incorporating the use of critical incidents, to explore and explain the culture and context of care situations where nursing personnel experience aggression and violence when dealing with residents with dementia. A Critical Incident Technique was used to identify behaviours of both staff and residents that contributed to and/or reduced the amount of aggression that occurred. In particular, this study explored the nature of aggression and the responses of staff and the tensions that exist in the maintenance of the rights of both personnel involved in care and the residents for whom they care. Findings revealed the extent to which responses to violence and aggression are related to staff education and understanding of dementia, as well as the illness that the resident is suffering at the time. Staff had employed some creative ways to manage aggression in residents. This indicated that a model of care, based on person centred care (Kitwood, 1997) would be appropriate for the management of these residents. A framework for an alternate model for the care of people with dementia who are violent and aggressive based on the person-centred care approach is proposed and suggestions made for future research.
CHAPTER 1

Background to the study

Introduction

Increasing episodes of violence directed towards health care professionals is causing concern in the health industry (Australian Nursing Federation, 2003). Nurses, who are responsible for delivering the most intimate of care, are exposed to this violence every day (Australian Nursing Federation, 2003). Hospitals and governments are developing strategies to address this problem in the acute care setting. Unfortunately, little is done to address the very same problem that is presenting concern in the aged care industry. The present study focuses on an exploration of the critical factors that impact on carers’ responses to aggression in people experiencing dementia.

Chapter 1 introduces the reader to the aged care industry and those who work in this area. Discussion will also include an exploration of dementia and the problems associated with caring for residents with dementia including issues associated with those who exhibit violent behaviour. Finally, the research questions for this study will be provided.

Ageing and society

Society does not value the aged (Tonuma & Winbolt, 2000). Ageing is seen as a negative aspect of life. There are concerns that policies, structures and systems in society will not be able to support the growing ageing population as the “baby boomers” reach retirement. The aged are not seen as attractive in a society that values youth and good looks (Tonuma & Winbolt, 2000). Television advertisements are aimed at the young. This attitude may change, however as
the “baby boomers” reach retirement and become an influential group in society given the large numbers on this aged group.

Typically, the residents of aged care facilities are women. Once again, this is a societal group that can be discriminated against (Nay, 1992). As a result of these societal views on ageing, funding to aged care facilities and for aged care in the community is minimal and strategies to manage symptoms relating to ageing are under resourced (Nay, 1998).

The Aged Care Industry

Currently in Australia there are 2930 certified residential aged care facilities. These facilities offer a total of 183,395 places (Commonwealth of Australia, 2006). Two thirds of these facilities are owned and managed by the religious and charitable sector. Other providers are the private “for profit” sector and there are some Government owned facilities (McCallum & Mundy, 2002). These facilities are situated in towns and cities throughout the country.

The breakdown of ownership of residential aged care facilities in 2002-2003 according to the Department of Health and Ageing (2003, p 1) was as follows:

<table>
<thead>
<tr>
<th>Religious/Charitable</th>
<th>Private</th>
<th>Government</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>65.5%</td>
<td>25.8%</td>
<td>8.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 1.1 Ownership of Aged Care Facilities in Australia.
According to Hogan (2004, p 8) the number of Residential Aged Care Services (RACS) in each state is as follows:

<table>
<thead>
<tr>
<th>STATE</th>
<th>TOTAL RACS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>23</td>
</tr>
<tr>
<td>New South Wales</td>
<td>935</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>14</td>
</tr>
<tr>
<td>Queensland</td>
<td>503</td>
</tr>
<tr>
<td>South Australia</td>
<td>295</td>
</tr>
<tr>
<td>Tasmania</td>
<td>94</td>
</tr>
<tr>
<td>Victoria</td>
<td>814</td>
</tr>
<tr>
<td>Western Australia</td>
<td>260</td>
</tr>
</tbody>
</table>

Table 1.2 RAC Services by States

From these statistics one can see that the challenge is one that needs to be addressed at national, state and local levels.

_Funding_

Facilities are funded by the Commonwealth of Australia. This funding is based on resident dependency. Dependency is measured by the use of the Resident Classification Scale (RCS). This, in turn is used to calculate the amount of funding a facility will receive for each resident. The Resident Classification Index (RCI) was a tool introduced in July 1988, which was aimed at assessing the dependency of a resident. The tool had 13 categories. The score obtained in assessing these categories determines the level of dependence of the resident; this in turn determined the amount of funding the facility should receive to care for that resident (Commonwealth Department of Human Services & Health (1995).
Auditors from the department responsible for administering the *Aged Care Act* at the time, visited nursing homes on a regular basis, checking documentation against the RCI claim, either ratifying the claim or disagreeing with the claim, thereby marking them accordingly and mostly reducing the funding to the facility.

The RCI was reviewed in 1992 (Commonwealth Department of Human Services and Health, 1994). The most significant change in this tool was the increased focus on behavioural problems. Facilities were able to obtain more income if they had residents with behaviour problems. Verbal and physical aggression and behaviours that required extra staff time and attention were now recognized as a condition of the aged. Funding now licensed the representation of behaviour problems as care scenarios. These were now considered a common affliction of the aged. Such behaviours made admitting these residents to a facility very attractive. The need to deal with behavioural problems meant access to more money. In fact, during this period physical aggression was weighted higher than what might be readily recognised as specialized nursing procedures. Physical aggression scored a 6.07, and specialized nursing scored 3.56 (Commonwealth Department of Human Services and Health, 1995).

A new funding tool, called the Resident Classification Scale (RCS) was introduced in 1997. This tool had 21 questions with six of these related to behaviour. This was twice the number in the RCI. Behaviour problems, including aggression, were becoming more acceptable as components of care scenarios in nursing homes (Commonwealth of Australia, 2005).

There were now eight funding categories. Each of these categories determined how much funding the facility would receive based on the category assigned to
each resident. Residents classified from Category 1 to 4 were classed as high
care (nursing home) residents, whilst residents who were classified from
Category 5 to 8 were classed as low care (hostel) residents.
The emphasis on behaviour problems, including aggression has continued over
the last decade. It is interesting to note that this new tool now weights Technical
and Complex Nursing Procedures (11.16) higher than Physical Aggression
(3.05) (Commonwealth Department of Health and Ageing, 2003). However,
there are now six questions on the RCS, which relate to behaviour problems.
Such problems as wandering and intruding, verbal and noise disruption,
physical aggression, emotional dependence, danger to self and others and other
behaviours that do not fit into the above categories all attract weightings in the
RCS. The total weighting of all these behaviour problems is 20.08. This ensures
that managers and proprietors are rewarded when they admit residents with
these problems. From personal experience the researcher can attest to the
literature which notes that a resident does not display one behaviour problem
in isolation. In particular, residents who are physically aggressive may also be
verbally disruptive, dangerous to themselves and others and wander and
intrude on another’s space.

A specific objective in the design of the new Resident Classification Scale (RCS) was to
better recognize the high cost of caring for people with dementia and to fund providers
appropriately. The funding structure of the RCS was intended to remove the financial
disincentive to providing appropriate care for people with dementia (Gray, 2001, p xxix).

As a result of the validation process carried out by Government officers, owners
and managers of facilities believe that the only way to ensure their claims are
not marked down is to ensure there is adequate documentation to support their
claim. If claims are marked down, providers face a financial penalty. Government officers visit each facility at least annually to validate RCS claims.
The officers examine all documentation relating to the care of the resident, and
then decide whether the person is receiving the correct level of funding to meet
that care (Commonwealth of Australia, 2005).

Quality

To ensure quality of care for the residents of these facilities, including those who exhibit behaviours that challenge their carers, facilities must be accredited with the Aged Care Standards and Accreditation Agency.

The Aged Care Standards and Accreditation Agency is an independent body that was established to ensure that facilities provided a minimum standard of care to residents. This accreditation has a maximum of three years. However, if aged care homes are identified as having areas that require improvement, they may only receive 1 or 2 years accreditation.

The Accreditation Standards cover the following areas, each of which is relevant to this study:

- management systems, staffing and organizational development;
- health and personal care;
- resident lifestyle; and
- physical environment and safe systems (Gray, 2001, p 87).

When assessing a facility against the standards, the agency looks at complaints which may have been made against the facility, the systems and processes the facility has in place, policies, practices, feedback from families and their residents, and other relevant information. Feedback on the management of challenging behaviours is part of this. Support contacts from the Agency also ensure that standards are maintained (Commonwealth of Australia, 2005).

The design of facilities is likely to reflect the needs of both residents and their carers. All facilities are expected to undergo a building certification process. This process is designed to ensure that the building is safe and appropriate for
the care of the residents who live in that facility (Commonwealth of Australia, 2005).

*The Aged Care Act of 1997* has legislated that each nursing home should present a homelike environment for the residents. The question relevant to this research is “What is a homelike environment?” particularly for those who are suffering from dementia.

It is difficult to find a definition of a homelike environment. Norberg (2001, p 157) describes a homelike environment as one that allows the feelings of “being connected to significant others, significant things, significant places, significant activities, oneself and transcendence”. Significant in this definition is the lack of appreciation of the physical and environmental aspects, for example wall to wall carpet and ensuites.

It is important to note at the commencement of this thesis that in the recent two year review of aged care reforms, Gray (2001, p 83) found that there was “a high level of compliance with the requirements, and that most, if not all, providers will meet the standards”.

*Residents’ Rights and Responsibilities*

With the reforms within *The Aged Care Act 1997*, came the charter of residents’ rights and responsibilities. This was an important development in the aged care environment.

Complaints from residents and/or their families however need to be contextualized and not immediately accepted or are taken as correct. Proprietors and managers need to pay attention to the staff’s version of the complaints, and gather a full appraisal of the situation. Because there is so
much emphasis on Residents’ Rights the potential exists for staff and others to believe that this should be interpreted as ‘the residents is always right’. Frequently when such a conflict emerges, the staff member may feel they are always seen as being in the wrong. ‘Resident’s rights’ is the catch cry that is used in these instances. This is often translated to mean, ‘the resident is always right’ There is also a charter of resident responsibilities which needs to be part of the management strategy for dealing with critical issues. (Commonwealth of Australia, 2005) Both staff and proprietors need to focus on the rights of the resident, and the rights of the staff.

One of the greatest challenges facing those who work in Aged Care has been the care of the resident who suffers from dementia. The care of these residents has now been recognised as much a part of aged care as those who have suffered a stroke, or other debilitating condition. As a result, the RCS tool is now designed to ensure those residents who have dementia and the subsequent behaviour problems, which result in many care challenges, score higher than those residents who do not present with these issues. This indicates that behaviour problems that are associated with dementia are beginning to be seen as a common issue in aged care. Thus, the symptoms of dementia and aggression pathology will now be explored as background to this study.

Dementia: Incidence in society

The prevalence of dementia in society is increasing. As our population ages, the number of elderly people with dementia increases.

A document produced by the Commonwealth Department of Health and Ageing (2003) identifies the following trends in our ageing population.
Currently, the proportion of people in Australia over the age of 70 is 8.9% of the population (1.67 million). It is predicted that this will increase to 15% (or 3.67 million) of the population. In 2001, it was estimated that the number of people over the age of 60 who suffered from dementia is about 157,000. This is expected to increase to 251,000 people by the year 2020.

This same document suggests that 28% of residents who are classified as low care have dementia, whilst 60% of high care residents suffer from dementia. Dementia has only been recognised as an illness in more recent times. Prior to this recognition, dementia was considered a normal part of the ageing process. It was frequently described as senility. Garrett & Hamilton-Smith (1995), state that the effect of dementia on society was largely ignored in Australia until the late 1970s.

Affected persons were subject to a wide range of ad hoc arrangements, including home care, various residential establishments (none of which made any special provision for people with a dementing condition) and even psychiatric hospitals (Garrett & Hamilton-Smith, 1995, p 5).

Prior to dementia being recognised as an illness, sufferers were confined to mental asylums. In these institutions they were treated in the same manner as those with a mental health illness. Dementia is considered an incurable illness and, as a result, staff tend to focus on the biological needs of the resident with dementia, rather than paying as much attention to the mental health needs of these people.

What is dementia?

Dementia is a name applied to a number of conditions in which there is “deterioration in intellectual functioning due to pathological changes” (Luckmann & Sorensen, 1987, p 489).
Dementia is a term used to describe a number of symptoms or characteristics caused by diseases which attack, damage and destroy brain tissue (Sherman, 1999, p 10).

People who suffer from the diseases of dementia suffer from problems with memory, the ability to think and to make judgments. Speech, coordination and behaviour are also affected. All these problems cause sufferers difficulties with their day-to-day life (Sherman, 1994).

Symptoms of dementia include difficulty with abstract thinking, short-term memory loss, difficulty with concentration, mood swings, outbursts of anger, disorientation, and changes in personality such as depression, paranoia, hostility, suspicion (Holmes, 1997).

People with dementia also experience problems with recognizing familiar objects or people, performing previously learned activities and difficulty with language and communication skills (Medza, 1996).

In the more advanced stages of the disease, sufferers will display some of the following characteristics;

- Inability to recall recent events and has little or no distant memory
- Confusion about:
  - time and place – often gets lost
  - people – confusion re identity of people
  - naming objects, often misuses objects
- Agitation and restlessness; walks endlessly, wanders, tries to escape, clings to people
- Difficulty initiating activities of living. eg. showering, dressing, and eating
- Difficulty understanding and using words
- Continually repeating the same question over and over. Does not remember that they have just asked the question
- Personality changes
- Hallucinations and delusions
- Suspiciousness e.g., accuses people of stealing their belongings. Hides belongings, and then forgets where they have put them
- Prefers to be alone. May be apathetic, withdrawn and/or depressed
- Displays uninhibited behaviour (e.g., undressing)
- Demanding, noisy and aggressive
- Incontinence
• Difficulty in movement such as standing, sitting and walking (Sherman, 1994, p 9).

Sufferers of dementia can usually manage quite well in the early stages of the disease. This is particularly true if they have a carer who lives with them. As the disease progresses, the ability to manage in normal society diminishes. Behaviour problems are most often the result of the inability of the dementia sufferer to rationalize and make decisions. Lees, Hecht & Hall (1998) identify those behaviours that cause difficulties both for the person who suffers from dementia and the carer.

The most common types of behaviour that cause difficulties are:

• Physical aggression.
• Verbal aggression
• Noisiness, Including screaming and repetitive calls
• “Sundowning”
• Wandering
• Agitation and restlessness.
• Intrusiveness
• Confusion and disorientation
• Sexually inappropriate behaviour
• Anxiety
• Behaviour related to depression.
• Sleep disturbance (Lees, Hecht & Hall, 1998, p 23).

Types of dementia

There are a number of primary dementia diseases. These are Alzheimer’s Disease, Multi-infarct dementia, Lewy body disease, Fronto-temporal lobe dementia, Pick’s disease, Creutzfeldt-Jakob disease and Huntington’s disease. Secondary dementias are those which occur secondary to such diseases as alcoholism, brain injury, brain tumour, Parkinson’s disease, AIDS, vitamin B12 deficiency, thyroid deficiency, calcium excess and syphilis (Sherman, 1999, p12). The characteristics of each disease of dementia depend on the area of the brain affected.
One can see from this short overview of dementia that there are numerous patterns of behaviour that need to be managed by carers in Residential Aged Care Facilities. The development of residential aged care facilities in Australia will now be discussed in order for the reader to fully appreciate societal responses to ageing and the aged in Australian society.

A brief history of Aged Care in Australia

Stevens (1993) tells us that the elderly were not recognised as a social group during the early days of settlement. Instead, they were included in the group not known for their age or the illness they may have had, but by the fact that they could not contribute to the colony. In essence, they were recognised for their poverty. As the demand for care of the aged, infirm and destitute grew, benevolent asylums were established to meet this need. Gradually the role of these asylums changed. They became asylums for those who suffered from chronic illnesses. In essence, these early benevolent asylums became the first public nursing homes in Australia (Stevens, 2003).

Schultz (1991) describes a report by the inspector of charities regarding the state of the Melbourne Asylum in 1881:

There was accommodation for four hundred, but over six hundred people were in residence. Because all the services were over taxed the whole place was dirty and untidy. The bed clothing was dirty and old clothes and rubbish were hidden everywhere. He said the food was good, but the serving of it was ‘repulsive’. He considered the management faulty and wanting, especially in female influence and over sight (Schultz, 1991, p 152).

For the first half of the 20th century, institutions such as hospitals were mainly responsible for accommodating the elderly (Cullen 2003, p 27). Some accommodation was also provided by private establishments. One can readily appreciate that this was inappropriate for both and for the management of care
The Menzies Government of 1954 introduced the “Aged Persons Homes Bill”. This Bill provided for:

*Matching grants for the development of ‘homes for the aged’. In doing so it noted that the whole concept of the bill is government aid to voluntary effort and self-help and for the matching on a pound for pound basis funds actually raised by an eligible organization (Cullen, 2003, p.28).*

These homes became homes that were appropriate for old people to live in, not homes that provided care to the frail aged. It was not until 1966 that the government decided to modify its focus to include nursing accommodation in homes for the aged (Cullen, 2003).

From this time, approaches to aged care in Australia were subject to a number of funding changes. The next significant change after the 1954 Bill was the introduction of the Aged Care Act in 1986. The then Labour Government set out to reform the care of the elderly in Australia.

The basis of these reforms included:

- The abolition of deficit funding
- Funding based on the dependency of the residents.
- Two separate sources of funding (Commonwealth Department of Human Services and Health, 1995).

One source of funds was based on resident dependency. This money allocated had to be spent on nursing staff and if not used for nursing staff, had to be returned to the Government:

*The Care Aggregated Model (CAM) funding arrangement provides for nursing and*
personal care staff in non-government nursing homes (Grant & Lapsley, 1991, p 195).

The other source was for the service aspect of management that is for electricity, catering, laundry and the like.

*The infrastructure costs (food, laundry, and return on investment) of nursing homes have been met by the Standard Aggregate Module (SAM) (Grant & Lapsley, 1991, p195).*

A tool to measure dependency was introduced, the RCI. (Commonwealth Department of Human Services and Health (1995). These changes heralded the tighter regulation of the industry. Nursing homes were now subject to monitoring based on standards of care. Proprietors also had to justify the amount of money spent on nursing staff and auditors visited at least annually to audit RCI claims.

However, in the early 1990s the care of those with dementia became a political issue. Inappropriate practices in some nursing homes had highlighted the inadequate care being delivered to residents who suffered from dementia. Some facilities found that the only way to manage these people was by the use of restraint, both physical and chemical. As a reaction to this, the then Minister for Aged Care, introduced The National Action Plan for Dementia Care (NAPDC) in 1993:

*The aim of the NAPDC is to strengthen the capacity of all aged care programs to respond to the needs of people with dementia and their carers. This approach recognizes that virtually all aged care programs have people with dementia and their carers among their clients and that these clients have a wide variety of needs (Howe, 1994, p 10).*

This funding was used to educate those who were caring for people with dementia. Apart from the requirements of the RCI, there were many issues within the industry. Proprietors resented the funding model, with its focus on money that must be used for nursing staff. They resented the continual
regulation of the industry.

The previous nursing home funding system was criticized as providing no incentive for providers to achieve efficiencies in their operations, and as ensuring expenditure of funds for approved purposes but not necessarily ensuring quality of care. The reconciliation process lagged a financial year behind, giving no early warning of any lack of care (Gray, 2001, p 84).

As well as these issues, there were reports of unscrupulous operators who did not provide adequate care for their residents (Commonwealth of Australia, 2003). The system did not address issues of poor care, nor did it promote quality care of residents. This lack of ability to enforce quality care for residents along with funding sustainability and lack of choice for residents were reasons that led to the newly elected Liberal Government implementing new legislation. The government took on board the concerns of the proprietors about the funding model. Legislation, introduced on July 1st, 1997, brought many changes:

The elements of the Structural Reform Package included unifying nursing homes and hostels under one system, introduction of the Resident Classification Scale (RCS) as a single classification and funding tool to cover the full spectrum of care needs, and the introduction of greater flexibility for respite care. Daily care fees, income-tested fees, and accommodation payments also formed part of the package …//… A standards framework comprised of accreditation and building certification was introduced to underpin quality assurance. These changes were brought about by the introduction of the Aged Care Act, 1997 (Gray, L 2001, p xxi).

There were claims that the former system which quarantined this money for nursing staff did not allow proprietors to be flexible with their staff.

Under the previous CAM funding arrangements, nursing home providers were unable both to pay staff above award wages and claim this as a legitimate cost for funding purposes. Care staff costs funded by the Commonwealth were limited to the relevant award wage. This meant that providers were structurally inhibited from entering into salary packaging arrangements or provide higher wages to attract and retain key staff (The Commonwealth of Australia, 2001, p 21).

Unfortunately, this reform did not necessarily result in improved staff numbers.
in aged care. A report of an Industrial Relations Hearing in Queensland in 2000, a general practitioner claimed that the poor staffing levels compromised the doctor’s ability to care for residents in aged care facilities (Hospital and Healthcare, 2000).

Lefebure (2003) claims that income is inadequate; in fact proprietors are struggling to meet the costs of managing nursing homes, let alone finding extra money to pay staff over award wages. The funding of the aged care system does not allow sufficient money to employ appropriately qualified nurses, let alone attract more skilled nurses to aged care.

Gray (2001) also expressed concern about the effect the legislative changes of 1997 have had on staffing.

It was suggested by staff, consumers, providers, and State and Territory governments that the reforms had seen a decrease in the overall level of residential aged care staff and the hours they devoted to direct care. It was also felt that there had been a negative change in the skills mix, with many staff not having the necessary training or qualifications (Gray, 2001, p 96).

Braithwaite (2001) believes that this model has done little to address the needs and the quality of care delivered to residents.

As a model for improving the quality of care in nursing homes, relying on fees and consumer choice is naïve. Residents are too sick to vote with their feet…… Sensible policy for providing nursing home care requires a larger welfare state, a larger regulatory state, and encouragement of public, non-profit providers. Australia’s recent experience shows that to head in the opposite direction is medically, economically and politically irrational (Braithwaite 2001, p 445).

Accreditation replaced The Commonwealth Nursing Home Outcome Standards, and the Aged Care Standards and Accreditation Agency was
established to monitor care and standards in aged care facilities (Commonwealth of Australia, 2003).

One can see from this brief overview that at the macro level, policy responses to changing demographics in Australian society have led to greater scrutiny of structure and processes within facilities that provide care for the elderly in Australia. The focus of the contextual background to this study now turns to the micro-level of care of the elderly.

Caring for the Person with Dementia

It is important to acknowledge that every aged care facility in Australia would care for residents who suffer from dementia. However, there are often specialist dementia facilities which are those facilities that can provide a safe environment for the person with dementia who is at risk from wandering.

These environments usually have a locked entry (frequently accessed by use of a key pad) and a secure yard that will permit residents to wander at will, whilst ensuring that they cannot wander on to roads.

The design of these facilities varies. They range from a converted wing of a nursing home that has only had a lock placed on the door and a fence surround to ensure residents are safe, to a purpose built facility.

One such facility design is that of the unit for the confused and disturbed elderly (CADE) which were developed in Australia: “The first unit, Pepper Tree Lodge was opened in Queanbeyan, NSW in 1987” (Atkinson, 1995, p 29).
CADE units have been designed with a set of principles in mind. These principles are smallness, domesticity, proximity to local community, reduced extraneous stimuli, highlighting of important stimuli, simple environment with total visual access and provision for planned wandering (Atkinson, 1995).

The number of residents who lived in a CADE unit varied from 8-10. Unfortunately, under the present funding system, CADE units are no longer viable and as a result are closing down. The researcher was involved with the planned relocation of residents who were accommodated in the CADE unit at Queanbeyan. This unit was closed because it was not able to be sustained within the current funding requirements. Residents from these units are being transferred to dementia units which house 20-30 residents and are usually attached to a larger aged care facility.

The design of purpose built facilities for the care of residents who suffer from dementia will vary, however most are designed with the comfort and safety of residents in mind:

> We may not be able to cure dementia but we are now most certainly able to care for people in such a way that they are comfortable and relaxed, feeling safe and secure. The environment is one of the most significant elements of this successful contemporary philosophy of care (Price, 2003. p.31).

Calkins (1988) discusses some specific points that should be remembered when designing facilities for dementia sufferers. These are as follows:

Residents who **wander** become frustrated when confronted with dead-ends. Calkins (1988) suggests that to overcome this problem, the corridors should lead to a room. I.e., a corridor with a room at each end gives residents the feeling of going to and coming from somewhere. The external environment should have paths that do not end. Circular, winding paths or paths that
wander from one exit from the facility to another entrance will give the residents the feeling that they are going somewhere, and will not suffer the frustration of coming up against a dead end. “When corridors become dark passages with no definable destination point they create dealings of uncertainty and anxiety” (Price, 2003, p 31).

**Resident rooms** should include familiar furnishing and memorabilia for the resident who lives in them. A favourite chair, family photos, familiar bed coverings will assist the resident to recognize this room as their own space. As well, a favourite chair in the living room will help the resident to recognize their space in this area. It may be necessary to have the resident’s name on the door so they can recognize their room easily.

**Living areas** are shared areas. These areas are usually most effective if they are similar to the same area in the resident’s home. Furniture that is less institutional and more homelike goes a long way to encouraging residents to feel comfortable and at home. Such furniture also gives residents cues that help them to recognize the type of behaviour that is appropriated for that particular area.

**Dining areas** should include tables and chairs that resemble those in the normal home are most appropriate. Smaller tables, seating 4-6 residents also replicate what the residents are used to. This kind of furnishing will also give residents cues as to the appropriate behaviour for this area. Appropriate table settings and tablecloths or place mats will also help promote this environment.

It is important that the facility be designed with the needs of the residents in mind. Facilities should try to avoid corridors that have dead ends. Some
facilities are designed in such a manner that the main living areas such as dining and lounge rooms can be easily accessed from the bedrooms.

Within the environment there a number of strategies that can be implemented to ensure that the residents have a stress free environment. Such stimulations as loud music, PA systems, televisions, call bells, and noisy machinery can be very distressing to the resident with dementia. The dementia facility should not be a thoroughfare for visitors and staff. This kind of “busyness” with people coming and going can cause extreme agitation for the dementia sufferer:

*Environmental factors such as understimulation and overstimulation can lead to the development of undesirable behaviours. With nothing to do, a patient may become bored or restless and begin to wander or become involved in self-stimulating behaviours such as repeatedly yelling or calling out to caregivers. Multiple, simultaneous, or unnecessary stimuli may be difficult to interpret or be overwhelming (Carlson, Fleming, et al, 1995, p 1108).*

**Staff** should be quietly spoken and remain unflustered if things go wrong. It is important that residents are not rushed, as this will increase their agitation. Staff should also be prepared to be flexible, and able to adapt to the moods and needs of the residents. An ability to be spontaneous is important, as advantage should be taken of nice weather, to perhaps organise a picnic outside for the residents. It is important that the people who are employed in aged care are employed because the want to work in that area of nursing (Price, 2006).

Price (2003) suggests that poor **lighting** may contribute to behavioural problems in those residents who suffer from dementia. Poor lighting results in dementia sufferers becoming “bewildered and even frightened by the negative forces that arise from a poorly lit environment” (Price, 2003 p.31).

Dementia presents in a number of ways and with a variety of behaviours. In order to ensure the optimum care for those who suffer from this disease, it is
important to ensure that the environment is appropriate. Loud noises, dead ends in corridors, shiny floors and poor lighting can all contribute to confusion and restlessness in these residents.

Having discussed issues that are seen as important in maintaining an environment that is stress free for the resident experiencing dementia, it is now important to examine the development within the nursing profession in response to the changing clientele in aged care facilities.

Nurses in Aged Care

A great deal of information is available in the historical development of care for the elderly in Australian society since colonization. In early colonial times, the delivery of care was performed by convict women: The early hospitals employed only the roughest, lowest, outcast women as nurses because they did not pay for better (Crichton, 1990, p 15).

Magistrates often punished those women brought before them by sentencing them to work in the asylums. This indicated how little importance was placed on the care of those who lived in these places (Stevens, 2003). Crichton (1990) likened these women to prostitutes and claimed that these were the only women that would work for the poor wages that were offered. On hearing of the effectiveness of the Nightingale nurses in England, it was decided that a Nightingale School of Nursing should be established in Australia:

*Nightingale established nursing as fit work for respectable women. However, the nurses’ role was defined as an extension of a woman’s natural role. Nurses were defined as doers, unintellectual handmaidens to the doctor (Nay, 1992, p 12).*

The need for trained nurses to work and manage the benevolent institutions
and care for the aged and the infirm was becoming more and more evident. In particular demand were those nurses who had been trained in the Nightingale tradition.

Finally, in 1877 a Commission of Inquiry recommended that nurses be employed to care for those who lived in the asylums (Stevens, 2003):

*The inquiry of 1877 was especially significant for older people and the nursing profession. The inquiry sought a solution to the unsatisfactory care of inmates by bringing Nightingale trained nurses and older people together in a relationship that coalesced into a lasting cultural expectation: the ennursment of old age (Stevens, 2003, p 23).*

The legislation of the colony reflected the change in the culture to recognize and accept that the elderly have complex needs. It is interesting to note that the need for trained nurses to work in aged care was recognized before the same recognition was given to the general public hospital system.

This legislative change did not go unchallenged, however. There were those in the community who believed that untrained staff were sufficient to care for the elderly in our community (Stevens, 2003). However, Stevens (2003, p 24) claims that:

*Once engaged the Nightingale nurses made an immediate and continued improvement to the lives of older people in their care as well as the long-term economy of the state.*

During this period, Aged Care Facilities were designed and built based on a hospital model. There were large rooms that could accommodate anything up to six residents. Bathrooms and toilets were communal, and little thought was given to providing an appropriate environment for these clients. In fact, Aged Care Facilities were nothing more than hospital wards with long-term clients. Care was provided for these people on a medical model. Documentation was poor and reflected the medical model approach by nursing staff as well as the
design of the building:

The day to day clinical practice of (nursing) staff has usually been documented as process lists— that is, tasks to be done for the residents. Where individual care plans existed, they were often checklists that failed to reflect individual assessment of the client, or individual goal setting in response to identified problems; rather, they reflected the routines of the nursing home (Andrews & Friend, 1989, p 10).

The changes to the Aged Care system during the 1980s and the resultant funding tool resulted in nurses becoming very conscious of the importance of accurate documentation. This was particularly important because of the constant auditing of Classification claims, and the likelihood of funding being lost if the documentation was inaccurate.

This relentless auditing resulted in nurses documenting excessively and not always successfully. Often, the auditors would peruse the documentation, with the belief that if the care was not documented, then the claim was not supported.

Documentation became the focus of the nurses, often at the expense of nursing care delivery to residents. In most cases, so much time was spent on documenting what should be done, that little time was left to actually perform the care that was documented.

Stoyles (2003) in reporting a study conducted by Australian Healthcare Associates claims that registered nurses were only spending 30% of their time on hands-on resident care. This study obtained data from 10 residential aged care providers in Victoria and New South Wales. Information was obtained by face to face interviews and staff competing daily time sheets. Stoyles (2003) also argues that this excessive paper work is one of the reasons for nurses being reluctant to work in Aged Care.
Porter and Ryan (1996) conducted a study that examined the gap between theory and practice and concluded that whilst nurses documented religiously and wrote nursing care plans, these were then filed away and were not used as a tool to deliver care to their patients. Porter and Ryan (1996) claim that this quandary facing nurses is a direct result of the capitalist society in which we live.

Whilst it is acknowledged that Porter and Ryan’s (1996) study involved acute care nurses, this same observation can be applied to aged care nursing. In aged care nursing, funding is directly dependent on documentation. Thus the pressure on nurses to document accurately is intense in aged care.

Currently, there is a shortage of nurses worldwide. Nowhere is this more evident than in the aged care industry. This, along with the funding, is the reason for the employment of untrained staff in nursing homes.

There are three tiers of care staff in aged care. The lowest tier is the assistant in nursing or, if they are employed in a hostel, they are called Personal Care Workers. Next, there is the Enrolled Nurse, and then the Registered Nurse.
Table 1.3 elaborates on this.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Education</th>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse (RN)</td>
<td>University Degree or Hospital Apprentice-type system</td>
<td>Overall supervision of all other staff. Responsible for medication administration, ensuring care delivery is appropriate; contacting and negotiating resident treatment with doctors.</td>
</tr>
<tr>
<td>Enrolled Nurse (EN)</td>
<td>1-2 year education in TAFE or in hospitals.</td>
<td>Can attend to minor treatment of residents (e.g. simple dressings) responsible for provision of basic nursing care. Showering, dressing, feeding etc. Now able to administer medications if appropriately qualified.</td>
</tr>
<tr>
<td>Assistant in Nursing (AIN)</td>
<td>1 year part time education in TAFE</td>
<td>Responsible for the provision of basic nursing care to residents. Requires supervision from both Enrolled Nurses and Registered Nurses. Not able to act independently</td>
</tr>
</tbody>
</table>

Table 1.3: Nursing Designations in Aged Care

AINs make up a large proportion of the workforce. In many cases, these people do not have any training at all. Over the last 5-10 years some form of training has been offered for those who wish to enter aged care in this role. Certificates 2, 3 and 4 in Aged Care are now offered by many TAFE colleges. Whilst there are now people available with these qualifications in aged care, the validity of the qualifications is sometimes questioned. In most cases, those with these qualifications are ill-equipped to work in residential aged care. Whilst these people may be able to perform the tasks asked of them, they are not able to understand why they are performing these tasks (Angus & Nay, 2003). In some instances proprietors are still forced to employ untrained and unskilled people if there are no qualified people available. The employment of people with minimal or no education suggests that the people they care for are not as
valuable as people in other areas of health who are cared for by appropriately trained staff (Edwards & Forster, 1998). The lack of education manifests in a number of ways. For example, nurses may make ageist jokes, talk to the residents in a manner, which can be termed as ‘baby talk’ and focus on tasks more so than the individual (Edwards and Forster, 1998).

There are a number of factors, which affect the employment of nurses in nursing homes. Aged care nursing is seen as the lowest end of the nursing scale of esteem. Nurses who work in aged care are regarded by society in much the same way that the people they care for are regarded by society (Nay, 1992).

In universities where nurses are now educated the focus has been predominately on the acute sector. Aged care is not promoted in a positive manner, despite the fact that it can be very rewarding and challenging (Stevens, 1999, Beattie, 1999). Stevens (1999, p 167) claims that the “current education systems socialize our key acute-care workers to marginalize and be intolerant of older people.”

Beattie (1999, p 135) describes the extremes in the education of nurses who work in aged care in Australia:

*In Australia hands-on care is provided by non-nurses at one end of the aged care spectrum. At the other end of the spectrum, we are creating a skilled workforce of nurses capable of rigorous and compassionate care of the elderly whose roles and reimbursement are not expanding commensurate with their education.*

It is important to be aware that all RNs and ENs nurses who are authorized to practise in a state or territory of Australia are expected to practise within the Code of Ethics and the Code of Professional Conduct that has been developed for all Australian nurses (Australian Nursing and Midwifery Council 2005.)
Whilst there is no such code for untrained staff who work in aged care, one would assume that under delegation to registered and enrolled nurses, these guidelines would be pertinent.

**A nurse must:**
1. Practise in a safe and competent manner
2. Practise in accordance with the agreed standards of the profession.
3. Not bring discredit upon the reputation of the nursing profession.
4. Practise in accordance with laws relevant to the nurse’s area of practice.
5. Respect the dignity, culture, values and beliefs of an individual and any significant other person.
6. Support the health, well being and informed decision making of an individual.
7. Promote and preserve the trust that is inherent in the privileged relationship between a nurse and an individual, and respect both the person and property of that individual.
8. Treat personal information obtained in a professional capacity as confidential.
9. Refrain from engaging in exploitation, misinformation and misrepresentation in regard to health care products and nursing services (ANMC, 2005).

*Figure 1.1 Code of Professional Conduct for Nurses in Australia*

**Value statements:**
1. Nurses respect individual’s needs, values, culture and vulnerability in the provision of nursing care.
2. Nurses accept the rights of individuals to make informed choices in relation to their care.
3. Nurses promote and uphold the provision of quality nursing care for all people.
4. Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share this information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded.
5. Nurses fulfil the accountability and responsibility inherent in their roles.
6. Nurses value environmental ethics and a social, economic and ecologically sustainable environment which promotes health and wellbeing (ANMC, 2005).

*Figure 1.2 Code of Ethics for Nurses in Australia*

In examining the type of person who works in Aged Care it would be important to determine if these people are also a disadvantaged group who have low status in society. Most of the people who work in this industry are female and the remuneration is important to them given their background:

*The vast majority of elderly people are women; in nursing homes they outnumber men three to one. Gerontic nursing is a ghetto of low-status, disadvantaged women, victims of a misogynist patriarchal society (Nay, 1992, p.15).*
The unregulated care providers require only a minimal education and, for many, this may be the only employment they have had in their life. They work in an area that is poorly funded and potentially are devalued by members of society.

Resident care is delivered under extreme conditions. Staffing numbers are minimal, which results in a very task-oriented approach to resident care (Angus & Nay, 2003). The Aged Care Act of 1997 has contributed to this by removing the nurse to resident ratios of the previous CAM/SAM funding arrangements (Angus & Nay, 2003).

Nurses who work in aged care are as susceptible to violence as those who work elsewhere. Residents who live in nursing homes are becoming more and more violent. There are a number of reasons for this, which will be identified later. It is common for people with psychiatric problems as well as those who suffer from dementia to present with a number of behaviour problems. The most concerning of these problems is aggression.

The researcher became interested in exploring this topic because of her experiences with a number of serious injuries sustained by nurses who work in aged care: a fractured wrist, fractured sternum and serious shoulder injury have been just three of the injuries I have witnessed during my working life. Whilst these injuries were serious, from the literature one can see that little has been done to address the problem. Restraint in the form of sedation or physical restraint is frowned upon, and the process one must go through if they wish to implement restraint of any kind is so onerous that many do not want to go down this path.
There is also very little warning about the behaviours of a resident before they are admitted to a facility, and once a resident is admitted, the problem becomes that of the carers.

It was factors outlined in this chapter that prompted me to conduct this study using ethnography. There are two major purposes to this study. The first is to highlight the problem. That is, to draw it to the attention of the public, and those who make decisions about where people live at a time in their lives when they need care. Second there is a need to arrive at some means of managing the situation involving greater violence to ensure that nurses who work in aged care are better protected from that violence.

Data collection by non-participant observation as well as interviews of staff that are caring for these residents will inform the study conclusions. These methods were used in order to identify the experiences of those who cared for the aggressive resident in the context of nursing homes.

The study explored the following question:

**In situations where personnel are managing aggression in people with dementia, what are the critical factors that impact on their response to that aggression?**

There are a number of sub-elements of the super-ordinate question:

1. **What is the nature of the caring environment of elderly demented persons?**
2. **How do RAC personnel respond to and manage the demented person’s aggressive behaviour?**
3. What are the tensions that exist in the maintenance of the rights of both personnel involved in care and the residents for whom they care?

4. Are current approaches to managing long term care needs of residents with dementia sustainable in the RAC environment?

5. What type of model of care for the elderly demented person displaying aggression has integrity (effective, efficient and efficacious that is, safe) for both the resident and the personnel responsible for their care?

The following chapters will examine the current literature on this subject, in particular, looking at aggression and how it is managed by nurses in general. The rationale for choosing a critical enquiry approach will be discussed along with explanation of the methodology, the methods and study design. Findings will also be presented and analyzed within the Critical Ethnographic framework context. Chapters four and five will present the findings of this study. Chapter six will present a proposed model of care that could be adopted to manage this situation and conclude with an overall recommendation for future research.
CHAPTER 2

Literature Review

This chapter will present an overview of the literature relating to violence and aggression in health care. The reasons given in the literature for the increase in violence in health services as well as aged care will be examined. Consideration will be given to when this aggression is likely to occur and the actions taken to address this problem will also be discussed.

First, a definition of aggression will be identified, and then a brief review of how violence and aggression is managed in other settings such as psychiatric nursing and school teaching will be presented. This will look at the people who are most likely to be assaulted as well as how nurses react to an episode of assault. The attribution of blame for assault, and the rights and responsibilities of residents and the duty of care is addressed with relation to aged care residents and staff. The social status of nurses who work in aged care, as well as perceived powerlessness will also be examined as a factor which might limit solution oriented responses to aggression. Person centred care (Kitwood 1997), a contemporary concept, will also be discussed as the basis for a model of care that may be applicable to the care of residents with dementia.

Patients who suffer from dementia were more likely to strike reflexively at carers (Petrie, Lawson & Hollender, 1982). Craig (1982) states that aggression is less predictable in patients with dementia. The fact that aggression is identified as being unpredictable, as well as the fact that aggression is likely to be a reflex action, presents some difficulty in attempting to define aggression in the person with dementia. Patel & Hope, (1992) have also identified a difficulty in applying
a definition of aggression to people with a cognitive deficit. Most definitions, such as those proposed by Lanza, (1992, p 163) which defines aggression as occurring “when patients use physical force with their bodies or an object to harm the staff member” rely on the intent of the person to cause harm. Patel and Hope, however, suggest that in people with a cognitive deficit, aggression is more a reaction rather than an intent to cause harm. Thus a definition, which recognises that aggression is a result of intent is not appropriate to be applied to people with dementia. Patel and Hope (1992, p212) propose an alternative definition, which is as follows:

*aggressive behaviour is an overt act, involving the delivery of noxious stimuli to (but not necessarily aimed at) another organism, object or self, which is clearly not accidental.*

Aggression can occur in all areas of health. Paediatrics, psychiatric nursing and accident and emergency are areas that report of care provider aggression aimed at health care workers. This aggression is aimed at all types of health care workers, but nurses are by far the group most at risk of experiencing violence directed at them. This is probably because nurses are responsible for delivering the most intimate of care (Australian Nursing Federation, 2003, Holden, 1985).

Violence is now recognised as a major occupational health and safety concern in health care. The Australian Nursing Federation and the Victorian Department of Human Services have expressed concern about this situation. Claims that nurses are leaving the workforce because of the unsafe working environment have been identified in a report into nurse recruitment conducted by the Policy and Strategic Projects Division of the Victorian Department of Human Services. (Department of Human Services, 2001).
However the contexts of aged care have received very little recognition as areas where nurses are at risk of aggressive and violent outbursts from the residents in their care. In fact, aged care nursing is seen as the easy alternative for those nurses who do not have the skills to work in the acute sector (Collison, 1992). Despite this perception, aged care has been found to have a high incidence of aggression and violence towards nursing staff (Gates, Fitzwater and Meyer 1999; Holden, 1985).

One might ask why the incidence of aggression in aged care increased. The continuing increase in aggression and violence towards nurses in aged care can be attributed to a number of reasons (Petri, et al 1982; Snowdon, Ames, Chiu & Wattis, 1995). The changing profile of ageing with a corresponding increase in the incidence of dementia in society is a critical factor.

The increase in the incidence of dementia in society means that those persons who suffer from this illness are being cared for in nursing homes. Dementia with its many facets can cause behaviours that have never been evident in the sufferer to suddenly appear. Burnside (1988) reminds us that dementia is pathological; it is not part of the ageing process. Burnside describes the challenges nurses face when caring for residents with dementia:

*The care is time-consuming, gruelling and requires the utmost patience. Every aspect of nursing is called into play – medical, surgical, psychiatric, community health – and numerous ethical issues arise* (Burnside, 1988 p 73).

Aggression is considered the main reason for people with dementia being admitted to a nursing home or psychiatric institution (Cohen-Mansfield & Billig, 1986; Petri, et al 1982) and is one of the most difficult behaviours for nurses to manage.
A further reason for the increase in aggression in aged care facilities is the fact that many residents have previously been sufferers of psychiatric illnesses. With the closure of psychiatric institutions in the eighties, the long term care of these people has fallen to the aged care industry.

In some instances, residents admitted to aged care facilities may have an undiagnosed psychiatric illness, or a long standing psychiatric illness that displays similar behaviour to that of a resident with dementia. Unfortunately, these residents have nowhere else to go, so are usually cared for in aged care facilities. This dilemma is a direct result of deinstitutionalization in the psychiatric sector. Snowdon, et al (1995, p 207) in a survey of psychiatric services for elderly people in Australia found that “Most long-stay elderly patients with dementia in Australia (even those with marked behavioural disturbance) are cared for in nursing homes rather than psychiatric hospitals”.

Given that there is nowhere else for these people to go, those with extreme behavioural problems as a result of their dementia, those who would previously have been admitted to a psychiatric facility, or those with a developmental disability and others with a long standing mental illness are all being admitted to nursing homes.

The Commonwealth of Australia in a Guide for Occupational Health and Safety in aged care claims that aggression:

Is unpleasant for the staff member and also impacts on the quality of care, staff morale, staff turnover, and resident satisfaction and perception of safety. It can lead to an increase in workers’ compensation claims. When staff members experience stress-related illness as a result of their work, this is an occupational disease and is compensable under workers’ compensation. (Commonwealth Department of Health and Aged Care, 2001a, p1).
What is the implication of this for nursing home staff? First of all, nursing home staff do not have the training to manage these people. Hudson (1995) and Freyne & Wrigley (1996) suggest that staff with psychiatric training manage aggressive behaviours better than those who do not have this training. Such factors as aggression, lack of reward and recognition and not being valued and appreciated all contribute to job dissatisfaction for nurses working in aged care (Ellis & Pompili, 2002).

Studies of Aggressive Behaviour in Aged Care

The literature reveals that there are numerous studies of aggressive behaviour in the confused elderly residents of nursing homes (Shah, 1992; Bridges-Parlet, Knopman & Thompson, 1994; Cohen-Mansfield, 1986; Cohen-Mansfield & Billig, 1986; Ryden, Bossenmaier & McLachlan, 1991; Cohen-Mansfield, Marx & Rosenthal, 1989; Burgio, Jones, Butler & Engel, 1998). These studies describe the aggressive behaviour and the incidence of that behaviour in nursing homes.

Further studies reveal possible reasons for this aggression. Frustration, loss of control and unresolved life issues have been identified by Cohen-Mansfield (1986) as reasons for aggression occurring in those with dementia. Craig (1982) suggests that increased emotional distress could also contribute to aggressive outbursts. Authoritarian staff/resident interactions can also contribute to aggressive reactions as well as a noisy and excessively stimulating environment (Ryden & Feldt 1992). Distasio (1994) identified practices such as hurrying the resident and poorly educated and inexperienced staff as factors that can provoke an aggressive reaction from the resident.

Levin, Hewitt, Misner & Reynolds (2003) identified that worker attitude can contribute to aggression from residents:
Lack of respect for residents, being short staffed or rushed, and disregarding resident preferences (e.g. to delay giving a bath) may hasten a verbal or physical assault (Levin et al, 2003, p 32).

Respondents in the study conducted by Levin et al (2003) felt that isolated incidents of staff shortage did not present problems, however they believed that continued periods of staff shortages did put them at risk of assault from residents.

It is widely documented that aggressive outbursts are more likely to occur when a resident’s personal space is invaded. Such procedures as showering, dressing, feeding, toileting, turning and transferring of residents are when aggressive outbursts are more likely to occur (Cohen-Mansfield, 1986; Jones, 1985; Bridges-Parlet, et al 1994; Hagen & Sayers, 1995; Cospito & Gift 1982).

Most aggression in nursing homes occurs during times when there is a high level of activity, that is between the times of 0800hrs and 1000hrs and 1500hrs and 2000hrs (Hagen & Sayers, 1995). These are usually the busiest times in nursing homes, when residents are being showered and assisted to get out of bed, or when residents are being prepared for bed and settling at night. As mentioned by Ryden & Feldt (1992), over stimulation can be a reason for aggressive outbursts, then, at these times when the environment is busy and noisy, it is reasonable to expect that aggression would be likely to occur.

Management of Aggressive Behaviour

Numerous studies suggest measures to prevent and/or manage this aggressive behaviour. Feldt & Ryden (1992); Hagen & Sayers (1995); Kuei-Ru Chou, Kaas & Richie (1996); Ryden & Feldt (1992); Fitzwater & Gates (2002) and Mentes & Ferrario (1989) describe educational programs that are aimed at increasing
nurses’ understanding of dementia and aggression as useful in limiting the incidence of aggression. These programs assist staff to identify factors that contribute to aggression, thus enabling them to plan care with a view to reducing the likelihood of outbursts.

Negley and Manley (1990) found that by modifying the environment, the incidence of aggression in an Alzheimer’s and related dementias unit decreased.

Skewes (1998) trialed the use of tender loving care to reduce aggression in residents. Whilst figures from this trial were inconclusive, the author claims that subjective reporting from staff indicated that the trial was successful.

Gormley, Lyons and Howard (2001), in a randomized controlled trial of a management program for behaviour management in the community, found that behavioural strategies such as identifying and avoiding triggers, using calm communication techniques, validation and distraction may be helpful in reducing incidences of aggression. Unfortunately, no definite conclusion can be drawn from his study.

Egan, et al (2007) conducted a trial of identifying the life histories of residents and making this information available to care staff. The information enabled staff caring for these residents to have a better understanding of the resident as a person. Along with a change of staff attitude towards the residents they were caring for, staff also introduced individualized activities (for example, singing) when caring for the residents. The researchers claimed that the incidence of aggression decreased among some, but not all, resident participants. This research does, however suggest that gathering such data on residents and
making the information available to staff is certainly worth trialling in aged care facilities.

The most common tactic used to manage aggressive behaviour is to withdraw from the situation. It may have been that the nurse withdrew from the situation or that the resident was removed from the situation in order to decrease the severity of the aggression (Scarfe & Keating, 1998; Levin et al, 2003). The theory behind this tactic is that the resident may forget why they were angry when the nurse returns a few minutes later. Some nurses try and gauge the mood of the resident before entering the room (Levin et al, 2003).

Koch and Hudson (2000) conducted a Participatory Action Research project in community care aimed at developing a model for best practice in the prevention and management of workplace violence. Elements of this model, particularly those that guide the reporting of such incidents could be usefully implemented in aged care. Procedures guiding this reporting such as what to do, who to contact, what to document, are worth consideration when developing procedures for managing aggression:

In some instances nurses prefer to use restraint to manage aggressive behaviour. A study by Hantikainen & Kappeli (2000, p 1200) found that:

Some staff members justified their decision to restrain the elderly by reference to their right to protect themselves against what they regarded as unfair attacks by residents or against impertinent behaviour. Sometimes residents’ behaviour caused fear in nursing staff who also said they often felt they were badly treated. They did not feel they were under any obligation to accept this treatment, which typically involved physical or verbal aggressiveness on the part of the resident, continuous shouting or refusal to accept treatments. Staff members restrained the behaviour of residents by threats, by issuing orders or by subordination, using techniques that were perceived as increasing their safety and as safeguarding their rights.
Medication, although frowned upon by the authorities, can have a place in the management of behaviour problems associated with dementia.

Antipsychotic medications have been used for some time with mixed success to manage aggressive residents in aged care facilities. The rationale for using these drugs has been to reduce such symptoms as delusional thinking and provide a degree of sedation, thereby reducing the chance of aggression (Pulsford & Duxbury, 2006). Carbamazepine has also been trialled in the management of behaviour problems and anxiety in the elderly:

> The pharmacological approach to aggression management therefore focuses on using medication to minimize the occurrence of unwanted behaviour rather than assisting people with dementia to interact with others, or to get their needs met in positive ways (Pulsford & Duxbury, 2006, p 614).

Older people, and in particular patients with dementia, tend to be more prone to the side effects of antipsychotic medication than younger people. The interaction of antipsychotic medications with the medications the resident is already taking is also a concern. The choice of antipsychotic depends on the resident’s physical health. For example, such medications could not be used for a resident who suffers from Parkinson’s disease (Neil, Curran & Wattis, 2003).

Psychotic conditions may cause residents to be distressed and frightened resulting in aggressive behaviours. Antipsychotics should be considered only when all other avenues of management have been exhausted (Neil, et al, 2003). Tariot, Erb, Podgorski, Cox, Jakimovich & Irvine (1998) found that Carbamazepine can be tolerated and is safe when used to treat agitation in residents who suffer from dementia. There was no functional or cognitive decline with this medication.
Aggression and agitation can also occur as a result of pain (Baptist Community Services, 1998). In particular, such pain may occur when the resident’s personal care is being attended, resulting in an aggressive outburst. Staff moving the resident when attending to this care may cause pain to the resident which can result in an aggressive response. In some instances, it is difficult to determine if a person who has dementia has pain. In this instance it is worthwhile putting the resident on pain medication to identify if this makes any difference to the behaviour. Douzjian, Wilson, Shultz, Berger, Tapnio & Blanton (2000), conducted an informal study of residents in an aged care facility. Those residents who were on psychotropic medication to control difficult behaviour were given regular analgesia. This resulted in a reduction of the amount of psychotropic medication to the residents as well as a lessening of the difficult behaviour experienced by the resident.

Doctors are reluctant to order medication in the management of behavioural problems in the elderly. In fact Holden (1985) found that nurses in all areas of nursing had difficulty in firstly convincing doctors that the patient was aggressive, and then, when they had convinced the doctor that aggression was occurring, doctors were still reluctant to prescribe any medication to manage the behaviour. One of the subjects of Holden’s (1985) study told how doctors did not believe that the patient was aggressive unless the patient had been aggressive towards the doctor.

The fact that medication is not seen as an acceptable means of managing behaviour problems is of concern, as, in some cases this may be the only way to protect both staff and other residents from being harmed by an aggressive resident.
The effect of this aggression on nursing staff

As has already been presented most studies conducted in aged care in relation to violence and aggression, describe the behaviour, identify causes of the behaviour and also suggest means to manage the behaviour. Unfortunately, few of these studies examine the nurses’ feelings regarding their experiences with episodes of aggression. Recommendations are based on care for the resident and understanding the aggression, rather that the effect this aggression may have on the nurse. In fact, it appears that even when a nurse is assaulted, the person considered most important and requiring the most care is the resident who was responsible for the assault. Little consideration is given in the literature to the nurse who has been assaulted. Nurses are also reluctant to defend themselves when attacked by a resident.

In order to identify the effect of this behaviour on nurses, it has been necessary to refer to the literature in the psychiatric nursing area. Cooper & Mendoca (1989) found that patients who suffer from “mental retardation and dementia are approximately twice as likely to be associated with assaultiveness as those who suffer from schizophrenia”. The psychological effects of assault experienced by nurses can be significant. (Wykes & Whittington, 1991) Whilst staff may continue to work as normal, they are exposing themselves to the trauma. In some instances they may work in the same ward, sometimes with the person who had committed the assault. Staff used talking to fellow staff members as a means of coping with the event.

In the psychiatric area, the most common strategy to assist staff who have been assaulted has been to develop a service to provide support to those staff. In all instances staff who have been assisted by these groups have reported positive outcomes (Murray & Snyder, 1991; Dawson, et al 1988; Engel & Marsh 1986).
In a study of the experiences of staff who cared for residents with dementia in nursing homes felt less supported than their colleagues in mental health. As well psychological well being and job satisfaction were lower among nursing home staff (Cole, Scott & Skelton-Robinson, 2000).

Aggression from residents can have a detrimental effect on the morale of nursing home staff. It can also lead to burnout and high staff turnover. Staff can be afraid to return to work, and even more afraid to attend to a resident who has assaulted them. Aggression can also impact on the quality of care staff give to residents (Gates et al, 2003). Such factors as aggression, lack of reward and recognition and not being valued and appreciated all contribute to job dissatisfaction for nurses working in aged care (Ellis & Pompili, 2002).

Staff feel hurt and angry after being assaulted by residents. Some take the abuse personally, even expressing a desire to retaliate by striking back (Levin, et al, 2003). Other studies have found that staff feel powerless and unappreciated as well as physically and emotionally hurt (Gage & Kingdom, 1999). Further studies have found that resident aggression contributes to emotional exhaustion and depersonalization of staff (Evers, Tomic & Brouwers, 2002). Gates,Fitzwater, Telintelo,Succop & Sommers (1999, p 14) found that the effects of aggression on staff can be “increased absenteeism and sick leave, property damage, decreased productivity, security costs, litigation, worker’s compensation, and reduced job satisfaction”.

Nursing home staff were asked to rate 14 vignettes of challenging behaviours according to how easy they were to manage. The only staff variables that were constant in those staff that experienced management difficulty and able to predict management difficulty were staff anxiety, supervisor support, and the
ability to relate to residents. Qualified staff also had greater difficulty with the management of challenging behaviour (Moniz-Cook, et al 2000). The same study found that when staff had support from a psychiatrist, their ability to manage the aggressive residents improved. This was also because the staff were aware that there was an available emergency bed in the hospital if an emergency arose. Further areas that experience violence and aggression are home care workers, nurses who work in accident and emergency, and teachers (Doherty, 2003; Lee, 2001).

**Violence and aggression in other areas.**

A survey conducted by Limpus (2002) of community and residential aged care nurses found that community workers also believed that violence was part of the job, and something they should get used to. Nurses in Accident and Emergency regularly experienced violence and, despite training in aggression management, continued to be ill equipped to manage such an incident when it occurred (Lee, 2001).

Teachers however are not as willing to tolerate violence as nurses seem to be. An article by Doherty in The Sydney Morning Herald (July, 2003) describes the fact that teachers have threatened to take legal action against the Education Department in an attempt to prevent violence in the classroom. Teachers claimed that students throw furniture, spit, and physically and verbally abuse them.

Who is likely to be the victim?

It is helpful to identify the types of people who are likely to be assaulted. Studies have found that recently hired staff are more likely to be assaulted than
staff that had been in the facility for some time (Lanza et al, 1991). Assaults against nursing assistants are common and many nursing assistants are assaulted daily. (Gates, et al 2002). Little (1999) looked at factors that might predispose nursing staff to being assaulted when at work. The study took the form of a random sample of 200 Registered Nurses in New Hampshire. The findings of this study raised the possibility that staff that have experienced some form of physical and/or sexual abuse during childhood may be at risk of being abused by patients in a health care setting.

Further studies have identified that those who were abused were usually less educated than those who were not, younger caregivers were more likely to be abused than older workers and full time staff were more likely to be abused than part time staff (Meddaugh, 1986). Levy & Hartocollis (1976) found that male staff were more likely to trigger an aggressive incident than female staff.

Nurses reactions to assault

Nurses’ reactions to assault were varied. Lanza (1984) found that nurses felt they could not express their feelings because of a sense of professional responsibility. That is, they had a job to do, and must get on with it. Others believed it would be unprofessional to express their feelings. Lanza (1984) concluded that whilst nurses experienced intense reactions following physical assault, they were reluctant to acknowledge these feelings. Reactions can last much longer than the time the nurse is away from work, and that those who have been assaulted frequently deny any reaction to the assault in an attempt to rationalize their reactions.

Nurses reported sleep disturbances, loss of appetite and strained family relationships as responses to assaults experienced by nurses Lanza (1988). Some
nurses denied any reaction, stating that the patient did not know what they were doing and that assault was part of the job. Other reactions were:

*Initial shock and disbelief; anger at the patient, other staff and self; upset, scared, fearful; increases startle response; depressed, crying, less trusting, more cautious; compulsive behaviour; returning to work too soon; difficulty concentrating; difficulty returning to work; (Lanza, 1988, p251).*

Reporting the Assault

Unfortunately, nurses tend not to report every incident of assault. They only report where an injury has occurred (Lanza & Campbell, 1991; Beck, Robinson and Baldwin, 1992; Lyon, Snyder & Merrill, 1981). Lanza & Campbell (1991) suggest that nurses do not report assault for a number of reasons. Some staff believe that only severe assaults would be reported, and then only if the patient meant harm. Assaults may be so common, that nurses don’t see them as out of the ordinary believing that assault is part of the job. Excessive paper work, fear of blame and peer pressure may also deter a nurse from reporting assault. Lion, et al , (1981) suggest that this reluctance may be the result of nurses denying that a problem exists. The Australian Nursing Federation claims:

*There is a code of silence that goes with the underreporting of violence against nurses. For a long time few nurses who would stand up often felt they were invalidated. Nurses like to think that they can take care of any situation that comes up. They tend to see themselves as advocates for patients and often feel compromised if they experience violence. A nurse would say nothing rather than complain about someone they have been trying to protect (Australian Nursing Federation, 2002, p 2).*

This could relate to a sense of powerlessness felt by nurses. Nurses have been a group that has trained and worked in a male dominated field. They have been seen as the doctors’ handmaidens. That is, “the perception of nurses by society has long been influenced by men” (Hunt, 1998, p.3). Prior to the introduction of university education for nurses, doctor’s also taught nurses. Practices such as
holding doors open for doctors to enter a room have contributed to the feeling of powerlessness experienced by nurses. The movement of nurse education to the universities has contributed to a move away from this culture. Unfortunately, change has not been as rapid as hoped. This is because new graduates are being socialized into a hospital system that facilitates the belief that doctors continue to hold all the power (Nay, 1998).

Koch and Hudson (2000, p23) found that incidents were not reported because of the trivialization of an incident by peers and supervisors. All incidents that are reported should be taken seriously, and addressed in the same manner. It is important that if the person making the report states that a violent incident has happened, then it is taken that the incident has occurred. If staff have asked for and not received support after earlier incidents, they may feel that there is little use in requesting support after further aggressive incidents (Conlin Shaw 2004).

As women age, their powerlessness increases. Unfortunately, this is not addressed by trends in either feminism or nursing. It is worth noting then, that nurses who are caring for the aged are continuing to be devalued by society. Hunt (1998) reminds us that technology is where most of the health dollar is spent with very little going to addressing the management of chronic illness because of its lack of appeal to the public.

Support for staff who have been assaulted

Astrom et al (2004) found that staff were able to gain support from fellow staff. Supervisory staff were less likely to provide support than the staff who worked beside the person who had been assaulted. Ryan and Poster (1991) discuss the importance of support services for nurses who are assaulted when performing their duty. Ryan and Poster (1991) suggest that counselling by a person from
another discipline should be offered to the victims. Other support services could involve self-help group support, or support could be offered by professionals who are not employed by the hospital. Support and acknowledgment from management are also important in assisting the assaulted nurse to cope with the experience. This approach is further supported by Murray and Snyder (1991) who describe the introduction of a consultation service to support nurses who experienced assault. Members of the consultation team are on every shift, thus providing immediate support for the assaulted nurse. This service was believed to be most helpful by those who utilized the service.

In another facility, an Assault Support Team (AST) was established to support nurses who had been assaulted. Those who utilized this service found it to be most useful, and felt that their feelings were dealt with constructively (Dawson, et al 1988).

Engel and Marsh (1986) have also found that a task force established to support staff that have been assaulted was most successful and beneficial in helping staff deal with the emotional trauma of the assault.

Who is to blame for the assault?

A further study by Lanza (1987) which involved presenting nurses with vignettes in which the seriousness of the assault was examined the area of blame placement for the assault. This study found that female victims were more likely to be blamed for the assault than male victims. Nurses who were mildly assaulted were more likely to be blamed for the assault than those nurses who were seriously assaulted. Also the older the person, the more likely they were to blame the victim. Nurses who had been assaulted themselves were
less likely to blame other assault victims. Lanza (1984) in examining the practice of blaming the victim from the point of view of attribution theory claims that blaming the victim comes from a need to control the environment. Lanza & Carifo (1991) suggest that because people like to think that hospitals are not violent places, blaming the victim actually helps to place the assault in some kind of order:

*Blaming may assist in managing the observers’ feelings of anxiety by attributing causation to staff error or poor judgment, but it distorts the event and adversely affects the victim (Murray & Snyder 1991, p 25).*

In other cases, victims blame themselves and review the incident to identify where they went wrong (Lanza, 1983).

Duty of care

Whilst the nurses have a duty of care to the residents irrespective of whether they are aggressive or not, most residents suffer because of their aggression. Care is rushed, and nurses spend as little time as possible with the resident in an attempt to avoid being assaulted.

Aged care nurses describe management of the aggressive resident as one of the greatest problems they face in their daily work (Glasspoole & Arman, 1990). Winger, Shirm & Stewart, (1987, p 28) claim that “Even one or two patients with serious behaviour problems present potential burden and increased responsibility for management by nursing staff”.

Staff have described the nursing home environment as a combat zone where they always have to be on their guard (Gage and Kingdom, 1995). Further
studies have found that assaults against nursing assistants were common, occurring on a daily basis (Gates, et al, 2002).

Burgio (1988) suggests that there may be a relationship between staff turnover, resident abuse and behaviour problems in the elderly demented resident. This physical abuse, and the nature of the clients nursing home staff are dealing with, can also have a detrimental effect on staff moral in nursing homes:

_The stress of experiencing both verbal and physical abuse by residents is amplified by the demoralizing effect of working with persons who show progressive decline rather than improvement, despite the care provided (Ryden, et al, 1991, p 94)._ 

Aggression influences how staff react to and care for the resident with dementia. An observational study of nurse-patient interactions on a geriatric ward revealed that nurses spent less time with those residents who were confused, than with those residents who were not confused. As well, these residents who were aggressive were not included in social activities. (Meddaugh, 1991). Winger,et al (1987) and Gates, et al, (1999) found that nursing home staff tended to withdraw from aggressive resident. The result of this is that aggressive residents have less contact with people and are generally isolated from activities in the nursing home.

Models of Care

There are two models of care that are mostly used in aged care. These are the Eden Alternative and Person Centred Care.

The Eden Alternative was developed in response to an observation by its founder, Bill Thomas, who identified that residents of nursing homes were
subjected to conditions of loneliness, helplessness and boredom. Such conditions resulted in poor quality of life for these residents. Thomas (1996) coined a term for these conditions, calling them the three plagues. The Eden alternative model is based on recognition of these conditions, developing a human habitat that includes animals, pets plants and children, encouraging companionship, developing daily activities, encouraging spontaneity, deemphasizing programmed activities and drugs, empowering caregivers with decision making ability and having leaders committed to the development of this model. Bergmann-Evans (2004) in a study aimed at identifying the effectiveness of the Eden alternative in reducing loneliness, helplessness and boredom, found that the model did reduce the conditions of helplessness and boredom, however it had little effect on loneliness.

Person Centred Care is an alternative model of care that encourages nurses to focus on the remaining skills and cognitive ability of the person with dementia, rather than on the illness (Kitwood, 1997). This model of care advocates treating residents with unconditional positive regard and non-judgmental respect. The resident is the focus of care. This opposes the task oriented approach where care delivery is focused on getting the work done and expecting residents to fit in with the needs of the facility, rather than the facility fitting in with the residents’ needs (Tonuma & Winbolt 2000). Martin & Younger (2001, p.443) remind us that “people with dementia may only be present as an absence, their own lived experience largely forgotten or ignored.”

Kitwood, (1997) who proposed the use of person centred care in the care of residents with dementia presented the following five needs of persons with dementia. These are comfort (the need for tenderness and the security which comes from being close to another person), attachment (the need to be connected to others), inclusion (the need to be included as part of a group),
occupation (a need for meaningful and appropriate activity), and identity (the need to know who one is).

The principles of Person Centred Care as proposed by Kitwood (1997) recognise that each person is a unique individual and a complex human being, that each person should be recognised for their abilities, not their disabilities, that personhood should be recognised as well as the value of others (such as staff).

Personhood is a term used by Kitwood (1997) to describe how we recognise who we are and where we fit in the world around us. Personhood is an intrinsic part of PCC and places an emphasis on the positive effects of daily interaction with other people.

Nolan et al (2004) take this concept a little further by including relationships as an important facet of person centred care. This concept is:

underpinned by the belief that all parties involved in caring (the older person, family carers, and paid or voluntary carers) should experience relationships that promote a sense of:

- security - to feel safe within relationships;
- belonging – to feel “part” of things;
- continuity – to experience links and consistency;
- purpose – to have personally valuable goal or goals;
- achievement – to make progress towards a desired goal or goals;

Nolan et al (2004) refer to a series of workshops where the participants were presented with the above senses in an effort to identify the relevance of these senses. Comments from staff were positive and indicated that they helped provide a sense of direction.
Nolan et al (2004) also believe that the recognition of the senses framework by nursing staff is a means of developing therapeutic relationships between staff, the resident and their family. This relationship is based on trust as well as the staff member developing an understanding of the life of the person in their care.

In order to do this, the person centred care model encourages a greater understanding of the resident which, in turn may enable a better understand the behaviours and actions of the resident. Stokes (2005) points out that this is not just about understanding the normal habits and routines of the resident, but also about understanding the fears, insecurities, superstitions and those things that comfort a person.

Ericson, Hellstrom, Lundh & Nolan (2001) found that if carers had access to a detailed history of the resident before they developed dementia, they were able to build an effective relationship with the resident and, in turn provide better care to that resident. This biographical approach to resident care has also been supported by Clarke, Hanson and Ross (2003, p 701) who found that "hearing the resident’s life story helped staff to see the person in the context of their whole life".

Egan, et al (2007), suggest that a greater understanding of a resident’s life may help to minimize aggression from residents. They also found that the quality of the relationship between the nurse and the resident improved because the nurses felt they were able to identify the residents as real people. In addition, staff were able to individualise care activities such as dancing with residents.

Clarke, et al (2003) remind us that not all residents and/or their families may wish to tell their life story. If this is the case, then their wishes must be respected. In other cases, it may take some time for staff to develop a
relationship with a resident where they will feel comfortable recounting their life story. Again, recognition needs to be given to this fact.

Therapeutic relationships are extremely important to the concept of person centred care. A therapeutic relationship is one where the “nurse and the patient relate to one another (bringing with it) additional tangible benefits” (Price, 2006, p 53). A therapeutic relationship allows the resident to express fears and anxieties in an environment of trust and safety for both parties.

Trust is central to a therapeutic relationship. Hupcey and Miller (2006) claim that whilst trust is based on the nurse’s competence and expertise, the interpersonal skills of the nurses in this relationship are also vital. It is, however, worth noting that once trust is lost, it is very difficult to rebuild.

In order to develop a trusting relationship, it is important that residents are cared for by the same staff. Constant rotation of staff can be detrimental to the relationship between the staff member and the resident. (Ericson et al, 2001).

Price (2006) claims that to truly enable therapeutic care to be practised, there is a need to ensure staff members have the required skills. They need to have good psychosocial and interpersonal skills as well as those required to deliver good physical care. Price (2006) further expands on the types of interpersonal skills required to ensure residents are supported as they relay their life story. These skills include a sincere professional interest in the experience and the concerns of the resident, active listening and the ability to ask questions in a sensitive manner.

Person Centred Care also means that the resident controls their daily activities. That is, they are not forced to fit in with facility routines. This can present some
difficulty in the aged care facilities of the present time because of the minimal staffing numbers that force staff into a task oriented approach to care (Tuckett, 2005). For Person Centred Care to be successful, a change of culture in aged care facilities must occur. Everyone working in the facilities must be committed to this approach if Person Centred Care is to be successful.

Status of the aged and those who work with them

Nurses who work in aged care are working with a group of people who are devalued by society (Elliott, 1989). While this impression of the aged persists, so will the perception of nurses who work in aged care can be perceived as negative by fellow nurses and society.

It is significant that little has been written about the incidence of violence in aged care. Care of the aged is considered the poor relation in the health care field. Nurses who work in aged care are looked down upon by their peers. Elliott (1989) describes how nursing colleagues in other fields have asked when she last did ‘real nursing’.

Carr and Kazanowski (1994) believe that ageism in society results in poor living conditions for the elderly, whilst at the same time contributing to poor working conditions for those who work in aged care. These working conditions can be exacerbated even further if nurses are on the receiving end of violent and aggressive acts from the residents for whom they care. Perhaps this is the reason that there have been so few studies that examine the experiences of nurses who are on the receiving end of violence and aggression from their elderly residents.

Students cited in a study by Gattuso and Bevan (2000, p 892) spoke about how:
The general public think nursing the elderly is degrading work. Residents can be rude and ungrateful and treat you like slaves. There is never enough time to do things properly.../... You can’t acknowledge your feelings when you are having a bad day and you can’t provide quality of care. You feel isolated and unable to vocalize opposition to certain policies”.

Legislative changes implemented as a result of The Aged Care Act, (1997) have further exacerbated the degrading of the position of nurses working in aged care. One of the effects of this act has been to increase the number of unskilled workers caring for the residents resulting in a lowering of standards of care:

The degrading of the skills of nursing staff inherent in such concepts as multiskilling and the strain on the professional nurses who witness the lowering of standards of care contribute to the emotional cost of caring, with the result that many senior Gerontic nurses are leaving the profession at a time when the need for skilled nursing care is more critical than ever, given the ageing of the Australian population (Gattuso & Bevan, 2000 p 892).

The importance of psychosocial and interpersonal skills in caring for the aged needs to be recognised. Price describes interpersonal skills as:

i. A sincere interest in the experience and concerns of the resident.
ii. Active listening.

Women bear most of the brunt of ageism (Nay Brock 1988). When this is coupled with aged care, then the stigma of working in this field is intensified. In most cases these nurses do not choose to work in aged care, they work in this field for convenience (that is, the hours suit them) or because they couldn’t get any other work. Nolan et al (2003) believe that the only people who should be providing care to the aged should be those who genuinely want to do this. That is, people who are only working in aged care because they don’t have any other work options should not be employed.
Therefore one ends up with women caring for the aged in an environment in which they are trapped. These women endure violence from their residents in much the same way that a battered wife endures violence from her husband, because they believe they are trapped and feel there is no way out of the situation they are in. Violence aimed at these people is often seen by them as part of the job. Something they must accept. Many feel that their management doesn’t support them. Many feel they are to blame for the assault.

Aggression in nursing homes is underrated and under reported. Many nurses believe that it is part of the job, and something they must learn to put up with. Gates, et al (1990, p 20) identify the fact that:

There appears to be a lack of awareness (among carers and administrators) that such daily violence may result in consequences to employees’ attitude, mental health and eventually resident care. For example, there were little efforts to provide support to the caregivers such as counseling, recognition of feelings, support groups or incident problem solving.

Aggression in nursing homes is increasing. The ramifications of this are extremely serious. Proprietors have a duty of care to provide a safe environment for their staff, whilst at the same time being expected to admit people who are very difficult to care for because of their aggression. Should we take into account the fact that residents have a responsibility to not harm or abuse staff, and that the proprietor of the nursing home has a duty of care to provide a safe environment for their staff, then the admission of these residents to nursing homes should be reconsidered.
Residents’ Rights and Responsibilities

In discussing residents’ rights, it is pertinent to look at the definition of rights. The Dictionary.com describes rights as being “in accordance with what is good, proper, or just”. This dictionary also states that rights are “that which is due to anyone by just claim, legal guarantees, moral principles, etc.”

In keeping with this definition, resident rights can be described as the rights that are due to a resident in keeping with what is good proper or just. These rights have been further articulated by the Department of Health and Ageing in a list of 20 points. Along with these 20 points are a further 4 points of resident responsibilities (Commonwealth of Australia, 2005).

### The Charter of Residents’ Rights and Responsibilities

**A. Each resident of a residential care service has the right:**
- to full and effective use of his or her personal, civil, legal and consumer rights;
- to quality care which is appropriate to his or her needs;
- to full information about his or her own state of health and about available treatments;
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect;
- to live without discrimination or victimization, and without being obliged to feel grateful to those providing his or her care and accommodation;
- to personal privacy;
- to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;
- to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;
- to continue his or her cultural and religious practices and to retain the language of his or her choice without discrimination;
- to select and maintain social and personal relationships with any other person without fear, criticism or restriction;
- to freedom of speech;
- to maintain his or her personal independence, which includes as recognition of personal responsibility for his or her actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict these actions.
- to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions;
- to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service;
- to have access to services and activities which are available generally in the community;
- to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service;
- to have access to information about his or her rights, care, accommodation, and any other information which relates to him or her;
- to complain and to take action to resolve disputes;
- to have access to advocates and other avenues of redress; and
- to be free from reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.

**B. Each resident of a residential care service has the responsibility:**
• to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;
• to respect the rights of staff and the proprietor to work in an environment which is free from harassment;
• to care for his or her own health and wellbeing, as far as he or she is capable; and
• to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.

Figure 2.1 Charter of Residents’ Rights and Responsibilities.

This charter of Residents’ Rights and Responsibilities is expected to be followed in every aged care facility in Australia. All too often, ‘Residents’ Rights’ becomes the catch cry. This is often interpreted as ‘the resident is always right’. Little consideration is given to the fact that this charter also includes residents’ responsibilities. One of the very few responsibilities residents have under this charter is to respect the right of staff and the proprietor to work in an environment which is free from harassment. Unfortunately, little consideration is given to the responsibilities of the resident, even to the extent that staff are reluctant to defend themselves when being assaulted by a resident because they are afraid of harming the resident.

The Commonwealth Department of Health and Aged Care (2001) produced a booklet titled ‘Code of ethics and guide to ethical conduct for residential aged care.’ This booklet recognises the rights of both residents and staff. Those rights are:

- the right of individuals to be treated with respect;
- the rights of individuals to life, liberty and security;
- the rights of individuals to have their religious and cultural identity respected;
- the right of competent individuals to self-determination
- the right to an appropriate standard of care to meet individual needs;
- the recognition that human beings are social beings with social needs.

(Commonwealth Department of Health and Aged Care, 2001, p. 1)

The implementation of this booklet has gone largely unnoticed and, as a result very few staff and residents are aware of its existence.
The system

Proprietors are often not told that a resident is aggressive prior to admission. The question then asked is: ‘would the resident have been admitted, had the proprietor been aware of their aggression?’ Hook (2002) cites a case of the Hume Shire in NSW, Australia who is suing the Southern Area Health Service for referring a 60 year old man to one of their aged care facilities, claiming they had not been advised of his behaviour prior to admission. Unfortunately when the facility realized that they were unable to care for this man, there was little they could do about it as they were obliged under the Aged Care Act, 1997 to keep this man in their facility until alternative accommodation could be arranged. This was despite the fact that the man had sexually assaulted another resident of the facility. Another facility that was having extreme problems managing an aggressive resident, did not receive assistance until this resident had pushed another resident over, resulting in the death of the resident who was pushed. (Kelly, 2004).

The above example highlights the inadequacies of the system. The ACAT assessment tool does not accurately reflect behaviour problems. This tool is used to assess a person’s suitability for nursing home care. It is applied by the Aged Care Assessment Team, who are then decide the likelihood of the person requiring either high or low care. These are not readily identified during the assessment. This results in facilities admitting residents unaware of their behaviour problems, and /or the level of care that is required for the new resident.

A further concern highlighted by Kelly, (2004) was that the fact that even when the resident had assaulted another resident, and was identified as being completely inappropriate for the care able to be delivered by the facility, it was
some months before alternative accommodation was found for the resident. This is a common problem associated with aged care at the present time. Finding alternate accommodation for an inappropriate placement is extremely difficult. It would appear that aged care has become the dumping ground for those residents who are difficult to place.

The Department of Health and Ageing (2003, p 9) reminds proprietors that they “may ask a care recipient to leave if the care recipient has intentionally caused .......... serious injury to an employee of the approved provider, or to another care recipient”.

Unfortunately, a condition of the resident being asked to leave the facility is that the proprietor must find “suitable alternative accommodation........that meets the resident’s assessed long-term needs and is affordable by the resident” (Department of Health and Ageing, 2003, p 9).

Whilst the Department of Health and Ageing claims to support facilities in the management of difficult residents, the rights of the resident continue to over ride the rights of staff and fellow residents.

This literature review has attempted to set the scene for the research project and inform the choice of methodology. The literature has addressed a number of issues relating to violence and aggression in health and more specifically, aged care. Reasons for the increase in aggression in aged care as well as situations that are known to precipitate a violent outburst in the resident with dementia and current methods for managing such outbursts have been identified. Reviewing the literature in a range of areas has enabled a development of an understanding of the effects of this violence and aggression on those who care for patients. The experience of teachers and nurses who work in Accident and Emergency has also been discussed. The position of women in society and the
undervaluing of those who care for the aged have also been presented. These emergent issues have confirmed the choice of ethnography as a suitable approach to answering the research questions.

The next chapter will further examine the rationale for the methodology, and the appropriateness of this methodology for this research project.
CHAPTER 3

Methodology

Introduction

Chapter 1 provided an overview of the aged care system in Australia. This included a brief historical description as well as an explanation of the funding and legislative processes affecting the industry. Chapter 2 reviewed the literature relating to aggression and violence in aged care. This chapter also examined the effects this aggression has on nurses, and issues surrounding the type of aggression that occurs as well as when this aggression is likely to occur.

This chapter elaborates on the reasons for choosing to conduct this study using a qualitative approach and in particular why it was decided to use a critical ethnographic methodology. Discussion will centre on the detail of the development of the ethnographic approach, and how it applies to this study. To begin there is some preliminary discussion on qualitative approaches to research and the suitability of the approach over the quantitative paradigm.

Qualitative and Quantitative Research

Quantitative research is more structured than qualitative research, and is based on extracting data about a controlled environment and the use of set procedures governing how the research should be conducted (Morse, 1991). An example of a quantitative research project might be the determination of the number of aggressive incidents in a certain aged care facility within in a defined period of time. The present study deals with an acknowledged high incidence of aggression as reported in the literature reporting on previous studies on
aggression and violence in aged care facilities. However it was felt that more needs to be understood about these situations reflecting the management or mismanagement of violence experienced by the carers of older Australians in aged care facilities. Qualitative research procedures were seen as more valuable in generating explanations for these phenomena. They are not as prescriptive in terms of the determination of variables and rely more on such processes as inference, insight, logic and even luck in terms of the explanations for certain outcomes:

"The laboratory of the qualitative researcher is everyday life and cannot be contained in a test tube, started, stopped, manipulated, or washed down the sink. Variables are not controlled, and until qualitative researchers get close to the end of a study, they may not even be able to determine what these variables are. Therefore, theory development, description and operationalization are often the outcomes (Morse 1991, p1)."

Qualitative research is “an attempt to gain an in-depth understanding of meanings and definitions of a situation presented by the informants” (Wainright, 1997, p 1) Qualitative research helps us to understand what it is like to live in that person’s situation. It also helps us to understand how the person or people being studied make sense of the situation they are in. Qualitative research also helps us to understand why people act in particular ways.

Ethnography is one methodological approach that is used to conduct a qualitative research project. Ethnography is an approach that attempts to gain a better understanding of context and experiences and in particular to describe the experiences of those who belong to a particular culture (Thomas, 1993). This is achieved by the researcher conducting intensive observations in the field as well as in-depth interviews with those who live and experience the culture. Ethnography enables knowledge of a culture to be gained from the experiences of individuals and their interpretation of these experiences.
An ethnographic approach is appropriate in this instance because I want to determine the nature of the experiences of those nurses who care for elderly people whose behaviours include aggression. Further to this, I want to gain an understanding of how the phenomena around violence have developed and how political, economic, historical and social factors have been influential in this apparently harsh development with a helping profession attempting to deal with a vulnerable group that is, residents of aged care facilities. For this reason, I have chosen to undertake an ethnography underpinned by critical incidents which enables the analysis of the findings emerging from situations of violence in episodes of care, according to the factors which may have been impacted on by the culture being studied. Thomas (1993, p4) describes critical ethnography as beginning “from the premise that the structure and content of culture makes life unnecessarily more nasty, brutish, and short for some people”.

Thomas (1993, p 4) described the critical aspects of ethnography as follows:

Conventional ethnography refers to the tradition of cultural description and analysis that displays meanings by interpreting meanings. Critical ethnography refers to the reflective process of choosing between conceptual alternatives and making value-laden judgements of meaning and method to challenge research, policy and other forms of human activity.

Developments in Ethnography

Ethnography originally developed from anthropology, which examined other civilizations. Ethnographers lived and worked in these settings in an attempt to develop an understanding of their cultures. Eventually, the locations for ethnographic studies changed from settings overseas to settings in their own countries such as schools and hospitals (Savage, 2000).

According to Fontana (2004), whilst critical theory can be traced back to ancient times, the formation of modern critical theory was based on the teachings of
Karl Marx. The aim of this approach was to make society aware of the harmful effects of modernism and capitalism. The Institute for Social Research which was founded in Germany in 1924 (more commonly known as the Frankfurt School) provided a forum for the discussion of Marxist ideas by members, who, whilst having vastly divergent views on Marxism, were always united in their critical approach to society (Fontana, 2004). Habermas, who joined the school in the 1950s, believed that critically focused research was necessary to “expose concealed domination and oppression” (Fontana, 2004, p2).

The theorists of the Frankfurt School such as Habermas and Friere have been responsible for influencing the development of western critical theory (Fontana, 2004).

There were two reasons for the attraction ethnography held for the followers of the Marxist tradition. The first attraction was that it allowed for the exploration of the social relations and practices of capitalism within schools, hospitals and other such institutions in everyday society. It also provided the ability for researchers to identify and delve deeply into areas of oppression and exploitation. This enabled the researcher to gain first hand experience of the forms this oppression and exploitation might take, and also be able to identify practices that could enable those in this situation to be free of this oppression and exploitation (Jordan and Yeomans, 1995).

The Frankfurt School also provided another alternative to the positivist paradigm. The positivist school of thought proposed that all studies of society should have a scientific basis in much the same way as the physical sciences. This conceptualization of research did not include consideration of the impact on humans arising from their experiences, or the extent to which beliefs and
emotions could impact on the research project (Porter, 1998). One of the major concerns with the positivist paradigm and developments in ethnography was the fact that ethnographers, in an effort to make their study more ‘scientific’, attempted to objectify their research. This attempt to conduct such a ‘clinical’ approach to studies did not take into account the impact on the human experience of the people being studied and, indeed the researcher themselves had on the study. Jordan and Yeomans (1995, p 393) describe the work of ethnographers who have adopted this leaning towards the positivist paradigm.

While their work gives often detailed and attractive ethnographic accounts of their stay(s) in the field, the ethnographers institutional or material standpoint within the everyday world is rarely connected or made problematic in relation to his or her ‘subjects’ lived actualities.

Foley and Valenzuela (2005). on the other hand believed that once a researcher abandoned the positivist paradigm of objectivity there was no reason for them to ignore their intuitive or subjective ways of knowing. That is, their own life experiences and biases would become considerations within the study. This is most commonly addressed, and managed in a way that does not impair the research, by using the technique of self reflection during the research processes therefore I chose to adopt a strategy (see audit trail Appendix G), the application of a Critical Incident Technique (CIT) to assist in assuring a greater level of critical appraisal of the data sets and manage any personal bias that might impede objective interpretation of the study findings.

Analysis using Critical Incidents Technique

A higher level of analysis of incidents as observed by me or as relayed by participants was conducted with the use of a CIT. This tool is recognised as helpful in examining issues in episodes of care such as those in this study. Polit and Hungler (1991, p280) noted that:
The critical incidents technique is a method of gathering specific information about people’s behaviours by examining specific incidents relating to the behaviours under investigation. The data for a critical incident study are typically collected in a semi structured interview.

This tool is frequently used in qualitative approaches such as action research (Bellchambers, 2005), however, I found it to be useful in the analysis of incidents that I observed during the observation period or that were relayed to me through the interview process.

It was particularly helpful in identifying behaviours of participants and residents. The identification of these behaviours also had the potential to assist in the development of recommendations for a model of care that would be useful in the care of dementia residents in the future.

Analysis was conducted using the Situation: Action: Outcome process. This process enabled me to identify behaviours that were influential in contributing to the situation be it positive (no episode of aggression) or negative (episode of aggression) as outlined below:

This technique…//…focuses on a factual incident which may be defined as an observable and integral episode of human behaviour. The word ‘critical means that the incident must have a discernable impact on some outcome; it must make either a positive or negative contribution to the accomplishment of some activity of interest. (Polit & Hungler, 1991, p280).

It was important to capture the “critical” elements of the phenomenon under study. In doing this, I considered Fay’s points elaborated below.

Fay (1975) identified the main features of critical social science (my italics). Rejection of the positivist model of science was the first of these features. Understanding how people perceive their world, their intentions and desires and the rules and meanings of their social order is important in developing a critical appreciation of a situation.
Another feature identified by Fay(1975) was enlightenment. Enlightenment is the recognition that many of the behaviours of people are not the result of conscious knowledge and choice, but the result of social situations over which they have no control. Critical social science attempts to identify:

...those systems of social relationships which determine the actions of individuals and the unanticipated consequences of these actions” (Fay, 1975 p 94).

In order to change their social arrangements and become emancipated, people must arrive at a new self-understanding of their situations and experiences. This change must be made on the basis of rational discourse. “This process of rational discourse includes an acceptance of the place of historical accounts in an understanding of social situations and social conflict” (Street, 1992). Fay (1975) reminds us that such changes never occur simply by reading some theoretical work, but by critical reflection on behaviours.

It is important to remember that critical theory is not only aimed at generating knowledge that will explain a phenomenon, but also attempts to address the injustice of a particular society. That is, critical theory must be the catalyst that will inspire action. Critical theory also attempts to make the world a fairer and more equal place for all who live in it. This theory can only be verified when the anticipated change has been realised (Parker, 2007).

In order for critical theory to be effective, consideration must be given to the issues of ideology, false consciousness and hegemony. Goodman (1998) identified the role ideology plays in the critical aspects of ethnography, and the issues raised by this. Before discussing this, however, Goodman (1998) reminds us that ideology is not an issue in positivist social research as its findings do not
consider the values of the researcher. This belief, however, is misguided as one cannot be separated from our own ideologies, no matter how ‘scientific’ we may think we are. As a contrast, ideology is central to critical research.

*Ideology is taken to represent the concepts, beliefs and values that characterise a social group and develop and sustain shared meanings through the practices of communication, decision making, production and reproduction. (Street, 1992).*

The ethnographer not only needs to be aware of their own ideologies, but must also learn and understand the ideologies of their subjects. In doing so, the researcher must identify the purpose of the study. From a positivist perspective, the purpose is to discover knowledge that can be determined as truth (Goodman, 1998). In the current study details of statistics from the literature are provided. However in a critical approach, the purpose is to develop an understanding of a social reality and the conventions and power relations that surround and have developed that reality.

Goodman (1998) also reminds us that situating oneself as a researcher attempting to conduct emancipatory research can present dangers. The notion of “false consciousness” as coined by Marx is one such danger. False consciousness is when a person has been so thoroughly socialized by a dominant ideology that they will not be able to identify the fact that they are oppressed. Hegemony enables the oppressor to maintain their privileged position by a constant process of struggle between unequal social forces. This process is invisible and subordination is achieved through participation in social practices and processes. Street, (1992, p 79) describes hegemony as a;

*totalizing concept that saturates social understandings to the extent that political, social and social constructions of reality become invisible to most people. This invisibility enables hegemonic relationships to be continually recreated and reconstituted through power and knowledge relationships, which legitimate the dominant group.*
Identifying the ideologies through which one develops and understands life is not as simple as it sounds. Goodman points out those ideologies can be constantly in flux, changing as different situations confront us as we progress through life.

Nevertheless in order for me to develop the level of understanding I sought, I have to be open about where I am coming from (my particular experiences and perspectives) and disclose my own ideologies in the process.

The Problematic of Critical Enquiry.

Simon and Dippo (1986, p 197) describe the term problematic as “a particular structure of concepts that make it possible to pose some kinds of questions while simultaneously suppressing the possibility of posing others”.

By identifying the basis on which relations and events are deemed to be important or unimportant, the problematic enables us to define what is the field of the visible and the boundary of the invisible (Simon & Dippo, 1986). This identification begins by focusing on the sets of social practices of a particular group of people situated in a particular time and setting that are part of the normal pattern of their everyday life. In the instance of this study, the hierarchical structure that exists in hospitals as the result of the Nightingale influence is still evident in nursing homes today (Tonuma & Winbolt, 2000). Such a focus on social practices is vital to the critical problematic because it enables a link to be identified between experience and subjectivity and the relations of power that mark the landscape of our social world. Therefore the researcher has delved into the past, historicising the practices and forms, because the approach to a study such as the current one, helps us to understand
the limits with which we live. The character and basis of these practices is identified in order to understand the ways that historically structured social forms are enacted to organize, regulate and legitimate specific ways of being, communicating and acting (Simon & Dippo, 1986)

What can Ethnography do?

The aim of this study was not to identify the right or wrong of the nurse participants’ actions and stories, but to develop an understanding of their world in the Nursing homes where they work. It was important, when looking at these issues around aggression and violence, that I was aware of the culture in which they worked as well as the history and political influences, which impacted on them in their everyday work. Wainwright identifies essential elements, which are important to critical methodologies. One such element is the application of dialectic logic. This infers that society is constantly changing:

*Essentially this dialectic approach addresses the relationship between objects and events in the material world and their subjective representation in human consciousness* (Wainwright, 1997, p5).

Dialectic logic enables an understanding of how subjects have used prevailing phenomena in order to transform them and ensure that their needs are met. In order to do this the researcher must identify the historical issues that have been responsible for the phenomena developing.

The second element identified by Wainwright(1997) is the deconstruction of categories or phenomenal forms. A detailed description of the phenomena is not sufficient to address this; in fact these findings should be examined in order to define how they depend on a series of relationships with other phenomena and social and economic events over a period of time (Wainwright, 1997).
The deconstruction and resulting critique of categories have the effect of explaining the social relations that underpin the phenomena. That is, rather than there being a description of the phenomena, there is also an explanation for the occurrence of these phenomena. Deconstruction also can reveal political cultural and personal factors that may not be evident in the initial description of the category.

Critical social research enhances the face validity of the research because "it entails the synthesizing of the subjective testimony of informants with a broader historical and structural analysis" (Wainwright, 1997, p.7).

Issues which emerge as part of data from participant observation, can be placed in an historical and structural context; thus giving an explanation to the other descriptive data that are discovered through interviews. Information found in the literature therefore is also used to influence the direction of the discussion of outcomes of the study. Wainwright (1997) claims that this then gives rise to a constant interweaving of deductive and inductive logic. The researcher forms a researcher agenda from the information gained from an additional review of the literature and the information gained in and recorded about the participant observational phase of the study. This enables the researcher to focus on a particular area of concern or interest.

Ethnography has a number of means to collect data for study. In this study, both non-participant observation and in-depth interviewing were used because of the nature of the phenomena being observed. The interview questions were more ‘directed’ in order to understand the nurses’ experience of aggression.

As already noted the final analysis was not derived from the data alone, but from a study of the data in relation to the broader social perspectives identified.
in the literature review. This is in keeping with the qualitative research process which, Wainwright (1997) suggests, is not necessarily well ordered, as the researcher must conduct an ongoing literature review throughout the project. As an interesting or provocative piece of information is discovered, the researcher may refer to the literature for more information, or pursue the discovery with more directed questions.

Thomas (1993) believed that a critical approach to ethnography can be used to identify areas in which a culture or group of people are disadvantaged, and can also give those disadvantaged people the opportunity to do something to improve their circumstances. A critical enquiry can be used to bring about social change.

Social reality can be partly understood as a mixture of interconnected conversations, underlying this is a set of conventions that give it a sense of identity. Goodman, (1998,) identifies these conventions as:

Social location, attributes of the participants, (age, class, race, gender occupation, life experience) style of communication (verbal, written, visual, behavioural) and the communication topics).

All these factors impact on the nurses participating in this study. The age, education, gender, communication style and topics therefore will be identified throughout the study.

A critical approach is also based on the assumption that we live in a world of inequality, that the distribution of wealth and knowledge is unequal. The methodology recognizes the importance of power in influencing the experiences of people. The oppression that characterises contemporary societies is most forcefully reproduced when subordinates accept the social
status as natural, necessary or inevitable (Foley & Valenzuela 2007). That is, the subordinates believe that their lot in life is what it must be and there is nothing they can do to change it. A large percentage of those who work in aged care are called Personal Care Assistants (PCAs) or Assistants in Nursing (AINs). These people have little or no formal education, and have the potential to be vulnerable to the influence exerted by those with more authority.

The outcomes of the present study have the potential to highlight this anomaly and subsequent research reports and publications could bring such issues to the attention of these carers. Critical enquiry is now becoming the method of choice for those researchers who are aiming to make a difference with their studies. By informing participants and providing them with the required knowledge to choose to change their circumstances if they wish.

In this context, Critical enquiry as the preferred approach is considered to be most appropriate when a group of people appear to be suffering oppression. Critical enquiry has a political intent and demonstrates a desire to change the conditions of the oppressed to a more equitable situation. Researchers using this approach feel an obligation to emancipate those within a certain culture who are marginalized. An important way in which this emancipation is effected is to arm those marginalized with the knowledge to understand why they are in such circumstances. Soyina Madison, (2005) explains how this knowledge then gives them the power to work on gaining a more equitable existence:

> Knowledge is power relative to social justice, because knowledge guides and equips us to identify, name, question, and act against the unjust. (Madison, 2005, p.6)

When the researcher is conducting the study they move from what is actually happening to what they believe could happen, given that the subjects are armed
with the knowledge to address the inequality identified. From the readings to date it would be fair to say that critical enquiry can be a very exciting framework in which to analyze ethnographic data. As well, critical ethnography can also be a catalyst through which to bring about social change (Manias & Street 2001).

Whilst the data collection process is the same as that which is used for an ethnographic approach, the difference is that the researcher usually has an understanding of the political and historical context in which the phenomenon is occurring, and may have some idea about what questions they may wish to ask. The researcher will fluctuate between data collection and further literature review, as they also may pursue a particular line of interviewing should interesting data be identified.

In conventional ethnography, the researcher attempted to maintain distance from the subjects of the study. That is, the claim was that the study was truly objective because the researcher claimed to have no impact on the subjects being studied. Critical researchers (Manias & Street, 2001) dispute this, saying that it is impossible for the researcher to have no impact on the beliefs and experiences of those they are observing. In critical enquiry, the reaction of the people to the researcher is said to also become a source of data. That data set is seen as being relative to the subjects’ positions rather than constituting evidence of disturbance created by the researcher (Bruni, 1995).

From the discussion above the researcher confirmed her contention at the outset of the study, that given the research questions and study aim, the examination of the experiences of nurses who work with residents with dementia who display aggression, a critical approach is the methodology of choice. However given the context of the study, the vulnerability of those for whom care is provided in the aged care context and the reports from the literature on the
experiences of carers in this context (Nay, 1988) it is essential when relying on a critical approach to examine the concept of power in this study.

The importance of power

Whilst critical social theory has an egalitarian view of power, providing a safe environment for individuals to freely discuss their experiences, it is also important to remember that the hidden power relations in a situation need to be identified (Manias & Street, 2001).

As already noted an expression of false consciousness is almost inevitable when a person has been so thoroughly socialized by a dominant ideology that they will not be able to identify the fact that they are oppressed. This is potentially the case with both the carers and those for whom the care is provided in the present study. As noted earlier in this chapter, hegemony enables the oppressor to maintain their privileged position by a constant process of struggle between unequal social forces. This process is often invisible and subordination is achieved through participation in social practices and processes.

One issue that became obvious to me at the commencement of the study and from the preliminary literature review was the potential for feelings of powerlessness among the participants. Power is that which keeps people in disadvantaged situations:

*Power does not just operate on people but through them. Power relations are those that structure how everyday life will be lived; that structure how forms are produced and reproduced to limit and constrain, as well as contest and define what one is able to be (Gramsci (1971), in Simon & Dippo 1986 p 197).*

For the purpose of this study, I have chosen to apply the dimensions of understanding power as articulated by Heaney (1996).
Heaney (1996) has identified three dimensions to the understanding of power. The first dimension identified is the open and explicit conflict in decision-making, where power is established by the outcome. This power is characterized by force over the opposition. This may be physical or mental force. In this situation, this type of power can be identified in the continual presence of the need to acknowledge ‘residents’ rights’, which has the potential to be misinterpreted as ‘the resident is always right’. Further evidence of this type of power is when a senior person has control of a roster and has the power to make roster decisions that might compromise a person’s family life with little potential for negotiation over the decisions made.

The second dimension of power occurs when potential competitors are excluded from the decision making process, thereby weakening the opposition by withholding critical knowledge. This is critical to understanding oppression and the relationship between knowledge and oppression. The person with the knowledge holds the power and as a result is able to influence and construct knowledge. For instance, nursing homes may be asked to admit a resident, but the aggressive nature of this resident is not evident until the resident is admitted. This presents the facility managers with a dilemma, as they are unable to discharge a resident after they have been admitted.

In some cases, non-decisions are used to keep issues from being raised. Heaney, (1996) claims that this is a profound, if largely invisible, form of power. Heaney, (1996, p 4) goes on to explain how non-knowledge and limited access to critical questions are a prior condition of non-decisions:

*The control and manipulation of knowledge, as well as the resulting mobilization of bias, represents a more economical and far-reaching exercise of power than reliance on overt force or the direct imposition of will.*
The third dimension has the capacity to eliminate opposition by making people feel secure. In this instance, it could be the security of income that the participants receive from employment in this area. It could even be as simple as the management agreeing with the staff member and acknowledging that there is a problem with the staff member, but never actually doing anything to address the problem, or the fact that the staff believe that the situation they are in is the best possible position, and cannot change it, nor do they want it changed. Heaney, (1996, p 5) also says that:

…the oppressed are not only powerless, but they are reconciled to their powerlessness, perceiving it fatalistically, as a consequence of personal inadequacy or failure…

The largest group of people who work in Aged Care are untrained or minimally trained and have little chance of finding employment elsewhere. This is particularly so in the communities where the facilities in this study were located. It is fair to say that these people are not only looked down upon by nurses who work in the acute sector, but they come from a lower socio-economic group of society. Many see aggression and violence from residents as part of the job, and something that must be put up with. That is, they are powerless to change the situation they are currently experiencing. Highlighting these phenomena will contribute towards the awareness of the situations faced by these nurses on a daily basis, and hopefully, enable them to develop skills to manage the situation they find themselves in.

Why use a critical approach in this study?

On conducting the literature review, I became aware of a number of quantitative studies that looked at aggression in care situations involving the elderly. (Shah, 1992; Bridges-Parlet, et al, 1994; Cohen-Mansfield, 1986; Cohen-
Mansfield & Billig, 1986; Ryden et al., 1991). Qualitative studies, of which there were very few, (Negley & Manley, 1990; Skewes, 1998) only served to describe the situation. There were no studies that examined the phenomena by looking at how these phenomena had been shaped and influenced by social, political, economic and historical factors.

In this study I considered the Nursing Home as a cultural entity, and governed by rules, practices and beliefs in the same way that rules, practices and beliefs govern any other cultural setting. Thus the Nursing Home context was consistent with and appropriate in an ethnographic approach.

A Critical approach is also deemed appropriate for this study because the researcher wanted to fully appreciate how nurses themselves understand their experiences, and how this understanding has been influenced by social, political, historical and economic factors. This is particularly pertinent when one considers the social and economic status of those who work in aged care. Typically, aged care nurses are seen as the poor cousins of nursing. They are looked down upon by nurses who work in other sectors of nursing such as acute care (Tonuma & Winbolt, 2000). The extent to which these views impact on the care delivered warrants consideration.

Criticisms of Critical Enquiry

As noted above, critics of qualitative approaches to research, in this instance, the an ethnographic approach, believe that objectivity is compromised because of the subjectivity of the researcher. Some believe that there is an ‘anything goes’ mentality in those who conduct this type of research (Smith, 1998). In the process of critical enquiry, this issue is acknowledged by identifying the subjectivity of the researcher. In fact the researcher reflects on the relationship
they have with the participants and the impact this relationship may have on the findings of the research.

Questions also surround the concept of validity in critical enquiry. Robertson, (2005, p 90) addresses this in the following statement.

*Validity is achieved if respondents further self understanding and, ideally, self determination through their participation in the research (Robertson, 2005, p 90).*

A further criticism is that the research addresses the needs of only one group of people. Clark (2007, p 3) suggests that the aim of a critical approach to ethnography “is not to explain the ‘typical’ person, but to analyze that person’s possibilities and limits within a culture”. Whilst this project does only address the experiences of one group of people, it can be easily replicated to identify the experiences of other similar groups of people.

Manias and Street (2001) identified that whilst enabling the facilitation of dialogue between participants, this methodology can be limited by the researcher’s own desire to find the ‘hidden’ truth which can be manipulated by the researcher. In this instance the use of memos for personal reflection and the CIT attempts to address any inappropriate manipulation of the data set or an overlay of a limited, biased interpretation of the emerging data sets.

Conclusion

The elderly are a marginalized section of the community as are the nurses who care for them. Carr and Kazanowski (1994) believe that ageism in society results in poor living conditions for the elderly, whilst at the same time contributing to poor working conditions for those who work in aged care. Nay Brock (1988) believes that women bear most of the brunt of ageism. She believes that when this is coupled with aged care, then the stigma of working in this
field is intensified.

Given that nursing is traditionally a female workforce, and, as with other caring roles of our society, nurses are not accorded the recognition that is deserved, Street (1992) claims that nurses exhibit characteristics of other oppressed groups. She also claims that the hospital has been an area that has contributed to the oppression of nurses, largely because of the male domination in these settings. Nursing the aged is the poor cousin of the nursing profession, even frowned upon by other nurses. That is, not even nurses from other nursing specialties recognize the value of the work performed by these nurses. Roles such as caring for the elderly are devalued by a society who is only interested in complex medical and technological interventions. In fact Street, (1992, p 59) claims that “Nurses in low status caring roles are faced with the dilemma of doing good while feeling bad”.

In the context of this study, nurses who are already devalued by society are even more marginalized by the very nature of the work they perform in caring for aggressive residents who suffer from dementia.

Critical enquiry is considered important for this research as it offers the opportunity to understand the reality of the situation, by providing insight into the political, historical, social and economic aspects of the context. This in turn enables an understanding of oppressive situations previously seen as unable to be changed and contributing to the hopelessness of the situations in which the participants find themselves (Fontana, 2004).

By using a critical approach, the researcher will be able to develop an understanding of their situation, and, with this new insight and knowledge,
participants may have the power to work towards changes in their context of practice.

The following chapter deals with the method used in conducting this study. Techniques for the collection of data will be described as well as the methods of analysis.
CHAPTER 4

Method

Introduction

Chapter 3 dealt with the methodology. This chapter describes the procedures undertaken to conduct the study. As mentioned earlier, the study utilised methods appropriate to an ethnographic approach to collect and analyse data. Participant observation was undertaken over a period of two weeks to collect data relating to the environment in which the nurses worked, and to observe how they interacted with the residents when they were caring for them. Interviews were also conducted with nurses to gain an understanding of their experiences in caring for aggressive residents. Consistent with ethnography, the chapter will commence with a brief overview of my experience and understandings that I brought to the study and a description of the context in which the study was undertaken and the processes of ethics clearance and gaining access to these facilities.

The Researcher

I have been working in residential aged care facilities since September 1974. During this time I have worked in a variety of positions. These have been as an ‘Assistant in Nursing’, an ‘Enrolled Nurse’ and a Registered Nurse. Since gaining my qualification as a Registered Nurse, I have worked in various roles, these being Associate Charge Nurse, Charge Nurse, Director of Nursing/Chief Executive Officer (CEO), and Regional Director of Nursing. As mentioned previously, all this experience has been in the Aged Care sector.

I had completed 2.5 years of a 3 year General Nurse Training in the 1960s.
This enabled me to qualify as an Enrolled Nurse. After some 15 years in this position, I chose to attend University and completed an Undergraduate Diploma of Health Science (Nursing) which enabled me to practise as a Registered Nurse. It was during my time at university that I decided that my speciality would be Aged Care. My reason for this was that I found I could apply much of what I was learning most effectively in aged care. This choice of practice context was frowned upon by my colleagues who made such statements as “You will be wasting four years of study” and “You don’t need knowledge to work in aged care” or “Why don’t you want to be a ‘real nurse’?”

Despite this negativity, I persevered and obtained employment in an Aged Care Facility. From then, I worked in various positions as described above.

My experience in aged care has been extensive and, I believe adequate to ensure I have an understanding of all facets of aged care nursing. I feel that it is particularly helpful in this study as I understand what it is like to be an AIN, EN and a RN. I believe that this has helped me to relate to the study participants, and to understand a little more about their perceptions of their experiences.

I chose to study nurses’ experiences with aggression because in my management roles I became acutely aware of a trend that showed an increase in aggression occurring in the facilities in which I was working. I also believed that there was a need to assist nurses who were experiencing situations involving aggression. I was also experiencing my own frustration with managing these residents and trying to arrive at an outcome that met the needs of the resident as well as the nurses who were caring for them.
The Location of the Study

The study took place in two aged care facilities in rural NSW. One facility was in a country town with a population of approximately 2,250. The other facility was situated in a large regional city with a population of 57,000.

The design of the facilities was very different. One provided single rooms with ensuites and a specific dementia unit, whilst the other facility had shared rooms as well as shared bathroom/toilet facilities. The participant observation was conducted in the facility that had single rooms and ensuites.

Interviewees chose where they would like to be interviewed. Most chose to be interviewed in the facility in which they worked; however two chose to be interviewed in their own home.

Gaining Entry to the Field

Formal ethics clearance had been granted by the University. In order to gain entry to the field, I met with the manager of one facility. The manager then passed my request onto the Board of Management who invited me to attend a board meeting to discuss my study with them. Following this meeting the board allowed me to conduct the study in their facility.

The other facility was one of a number owned by a large not for profit organisation. To gain entry to this facility, I applied to the Ethics Committee of this organisation, and permission to conduct my study in the facility requested, was granted.

Recruiting study participants

Having been granted access to the facilities I then met with staff in each facility and told them of the study and asked them to participate in the study.
Handouts explaining the study (Appendix D) were left with staff, along with a stamped self-addressed envelope. Staff were asked to return a tear-off strip to me, and I would contact them about organising a time and place to meet with them. The only criterion for nursing staff to participate in this study was that they must be working with aged care residents in either one of the facilities nominated for the study.

Prior to the interview, consent was obtained (Appendix E). Staff participants were assured of confidentiality and the right to withdraw at any time. Consistent with the ethical requirements for the conduct of the study they were also informed of avenues to complain about any of the study processes or procedures if they felt this was necessary.

Obtaining consent to observe residents

I had a prepared letter for residents (Appendix F) and/or their families which was sent to all families and/or residents asking if they would participate in the study. These letters were posted to the families by the facility staff members. This ensured free choice and the maintenance of privacy. A stamped, self addressed envelope was included with the letters to enable a tear off strip to be returned to me with contact information should they wish to discuss the study and my request with me.

I had a very good response from the families in the facility in which I finally conducted non-participant observation. Unfortunately, there was no response from the families in the other facility, which is why no observation was conducted in that facility.
The families who wanted more information were contacted, and I met with them individually to discuss the study and ask their permission to observe their family member during my time at the facility. Families were also informed that if they chose not to allow their family member to participate in the study, or wished to withdraw them from the study at any time, then they were free to do so. Consistent with the approach taken with staff participants, I met with the family members in an environment of their own choosing. The only requirement of residents was that they would allow observation of them during the non-participant observation period. Families were happy for their relative to participate in the study. Family representatives signed a consent form, (Appendix C) and were given a copy for their records. Families were also given an information sheet about the study which also provided details about who to contact if they had any concerns about the manner in which this study was being conducted.

Data Collection

*Interviews*

In-depth interviews were conducted with nurses from both facilities. These interviews were tape recorded, after receiving consent from the participant. One participant did not want her interview taped, but she did consent to me taking notes throughout the interview.

Taped interviews allow for a greater degree of accuracy when compared to note taking. Taping interviews also allows the interviewer to maintain eye contact during the interview (Rice & Ezzy, 1999). This enables the interview to be conducted in a more relaxed and comfortable environment.
In the facility where observations were also conducted, interviews were conducted with nurses during the period of observation. These interviews were conducted before and after the periods of observation. I visited the other facility and conducted interviews on site. In this instance, staff chose to be interviewed at their place of work. These interviews were conducted over a weekend as this was convenient for the participants.

*The Interview Process*

Each interview tape was identified by a code that related to a staff member. The only way to identify the staff member after the code was assigned was to match the code with the code given to the participant on their consent form. I was the only person who had access to the consent forms. Consent forms (Appendix E) were stored in a locked filing cabinet at my home and on the completion of the research will be stored at the University for the required period of five years.

At the commencement of the interview, nurses were asked to talk for five minutes about their experiences in working with residents who suffer from dementia and who display aggression. They were asked a question phrased as follows “What is it like for you to be caring for residents who have dementia and who display aggression?”

The in-depth interview also contained both closed and open-ended questions. (Appendix A). Closed questions were used to obtain such data as experience in aged care, experience in caring for people with dementia, age, education and gender. Open-ended questions required nurses to describe experiences with aggressive residents, how they coped after the event, what they did immediately after the aggressive attack, what type of support they received from their colleagues, immediate supervisor and management, how they felt
about the support they received and what if anything they felt could be done to prevent such incidents from happening again. All staff members were asked to describe an attack they may have witnessed on a fellow worker. The questions above were also asked of staff in relation to the attack they had witnessed.

When preparing these questions I was conscious of the need to learn how staff made sense of the situation in which they found themselves, hence the open-ended nature of the interview process. Closed questions would have elicited only limited information, and very little, if anything about staff experiences. Open-ended questions that encouraged the participant to talk about their feelings and the strategies they used to manage the situation were more suited to the research questions and the methodology.

Whilst ethnographers believe that the in-depth interview should not have pre-conceived questions, a critical approach requires a more structured approach in order to address specific issues which may have arisen as a result of the observation period and literature review (Wainwright, 1997).

As a result of the literature review, the above questions were prepared in advance. Furthermore it became evident during the observation period that staff made a distinction between incidents of aggression that occurred in the facility and incidents of aggression that may have occurred in a public place from a person who was not diagnosed with dementia. This is why I added the question asking how they would respond if they were assaulted by a stranger when they were out shopping. This question was asked at the conclusion of the interview.

The length of time of the interviews varied, most lasted from 45 minutes to an hour. Some did go over this time, largely because the participant had a lot to
talk about in relation to this subject. In-depth interviews can last anytime from 30 to 90 minutes (Rice and Ezzy, 1999).

The Director of Nursing (DON) from one of the facilities was also interviewed in order to obtain an understanding of their experiences with aggressive residents. The DON was also asked to talk for five minutes about personal experiences with aggressive residents and/or aggressive incidents. Other questions asked of the DON focused on the following: how they dealt with a nurse who had been assaulted; who they believed was to blame for the assault; strategies they have implemented to manage the situation; whether they believed that a problem existed, and if so, why was there a problem, and finally what support do they offer to the nurses who have been assaulted?

All tapes were transcribed by the researcher. This further guaranteed confidentiality to the participants.

Non-participant Observation

During the non-participant observation stage I observed the facility and the interaction of the members of this facility. I also interviewed and interacted with members of the facility. I took field notes during the non-participant observation phase of this study. The intent of the non-participant observation stage was to observe how nurses interacted with residents and with each other. I was also looking to see if there were any episodes of aggression, and how the nurses managed these. I was included in discussions with nurses during their tea and meal breaks.

I tried to be as unobtrusive as possible during this period of the study. I tried to sit in an area that was away from any residents. The residents enjoyed having an extra person around, and many would come and sit next to me and chat.
Observation occurred over a consecutive period of fourteen days, where I spent 8-9 hours on site each day. I varied the times and hours that I was on site. This was intentional to ensure I had a good picture of the facility practices throughout the day. I did not conduct any observation during the night knowing from professional experience that most incidents of aggression occurred during the day and in the evening. I also believed that I had achieved saturation with the data set.

As well as taking notes during this period, after each observation period, I also made journal notes of my experiences. These notes usually included any conclusions I had arrived at as a result of the observation, and also a summary of the activities over the day as I had seen them. I also took this opportunity to document any conversations I had had with staff throughout the day.

Description of Sample.

Nurses in both facilities were asked to volunteer for the study. It was interesting to note the enthusiasm of the nurses to participate, and many wanted to tell me their stories before appropriate consent had been obtained. This indicated to me that the topic was relevant to these staff, and that they had a desire to talk about their experiences. In all, 24 nurses were interviewed. Simple descriptive statistics were applied to the quantitative data set.
Gender

Of the 24 interview subjects, 21 were female and 3 were male.

![Gender of subjects](image)

**Figure 4.1 Gender of subjects**

**Designation**

Designation ranged from Director of Nursing, Registered and Enrolled Nurses to Assistants in Nursing with and without qualifications.

![Designations of subjects](image)

**Figure 4.2 Designations of subjects**
Age of subjects

Subject ages ranged from 21 to 64 years with a median age of 48.5 years and a mean age of 45.8 years

![Figure 4.3 Age of subjects](image)

Length of time in nursing

Length of time in nursing ranged from 1 to 49 years with a median of 8.25 years and a mean of 15.8 years

![Figure 4.4 Length of time in nursing](image)
Length of time working in aged care

Length of time working in aged care ranged from 1 to 49 years with a median of 7.25 years and a mean of 15.8 years

Figure 4.5 Length of time working in aged care

Length of time working with people with dementia

Length of time working with people with dementia ranged from 1 to 49 years with a median of 6.5 years and a mean of 9.6 years

Figure 4.6 Length of time working with people with dementia
Employment status

Two subjects were employed on a full time basis with 17 subjects being permanent part time and 5 subjects employed as casual.

Figure 4.7 Employment status of subjects

Qualifications of nursing staff

Two of the RNs had some form of tertiary education. As well, the RN who was working as an AIN had just completed a graduate certificate in Aged Care Management.

A few staff had undertaken extra post graduate study. This took the form of education in Gerontology, a Graduate Diploma in Health Science, training in Palliative Care, training as an Activities Officer, in dementia management, as a work place assessor, manual handling and as a fire officer. Others attended in-services when they were offered. These sessions covered such subjects as dementia management, depression in the elderly, delirium, suicide in the elderly, palliative care, loss and grief, back care, fire and evacuation training,
documentation. There was a small number of staff (3) that said they undertook no extra education, including in-services.

Qualitative Data Analysis

Collection of data in qualitative research should be flexible. That is because collection of data and analysis occur at the same time; the researcher must be prepared to change sampling strategies and collection methods (Crabtree & Miller, 1992).

Audio tapes were transcribed verbatim by the researcher. Qualitative data were analysed in the following manner:

- Each interview transcript was read and re-read in order to get a sense of the whole data set and for meaning.
- A line by line approach was taken to highlight significant statements to answer the research questions. In particular significant statements that indicated tensions were noted for further analysis.
- Cross-references were made to field notes and additional notes in order to contextualize highlighted statements.
- Significant statements were analysed, categorised and organised into themes.
- Analysis was conducted using a critical approach in particular considering the historical, economic, social and political factors that have impacted on the understanding of the participants of their situation.
- Significant/critical events were further highlighted as potential critical incidents.
- Critical incidents were then selected to identify behaviours from both nurses and residents.
Limitations of the research design.

There were times when I was not able to meet all the original plans of this study. This was because gaining access to residents and/or their relatives to obtain consent to conduct non-participant observation in one of the two facilities to be observed was very difficult. This was probably because I was known to the management of the one facility where observation was able to take place. In the other facility, there was reluctance on the part of families and residents to agree to this observation. In the case of this study, it was decided to not go ahead with the observation in the other facility.

**Limited scope of the study.**

The data were gathered from 2 Nursing Homes in country NSW, Australia. Each Nursing Home was managed differently. One Nursing Home was a community owned facility managed by a Board of Management, which consisted of local community members. The second nursing home was managed by a larger organization, which has a number of aged care facilities throughout NSW.

The critical ethnographic approach examined the political, social and economic factors which impact on these homes and the staff and residents who work and live in these homes. A weakness of this study is that the research addresses the needs of only one group of people (Nurses in 2 facilities in country NSW).

**Researcher’s association with the facility**

Morse (1991) argues that the researcher should enter the field of study as a
stranger. Whilst I was known to the management of the facility in which I conducted observation, I was not known to the staff and residents, nor had I been in the area of the facility where the residents lived. Thus I met the staff and residents as a stranger.

**In-depth Interviews**

These interviews enabled me to obtain a full appreciation of the way people understood their experiences. Protocols were adhered to: Interviews, which were conducted in private, enabled participants to give responses that were not influenced by their peers, as might have been the case in focus groups. I believe I avoided inappropriately prompting or providing cues to the interviewees. I allowed the interviews to proceed in a natural manner. The length of the interviews is indicative of the willingness of the participants to discuss their experiences.

**Ethical Considerations**

The following ethical principles were maintained throughout the data collection processes:

**Interview process and obtaining consent**

Consent to tape record the interviews was obtained. Some participants may have found this taping of their responses disconcerting, and may have had difficulty relaxing when being taped. In fact, one participant chose to not be taped, so I made notes as the interview was conducted. Notes were only taken after the participant agreed to this, and the consent form was signed.
In order to develop and maintain a rapport with the participants prior to the interview commencing, I spent some time chatting to them and helping them to feel relaxed and comfortable before actually commencing the interview.

**Interview Transcriptions**

The maintenance of privacy was ensured as interview transcripts were transcribed by me. Once the audio tape of the interview was transcribed, I compared it with the tape recording on two occasions. When I was satisfied that the transcript was an accurate report of the taped interview, the tapes were destroyed.

**Privacy and confidentiality**

In order to recognize participants if I needed to contact them for further information, I assigned each participant a number. This number corresponded to a number on their consent form. The consent forms were stored in a locked filing cabinet drawer, and I was the only person who had access to this drawer.

**Independence of project.**

It was important that participants were aware that this was a truly independent project. Participants were assured that the information they provided to me would only be used for this study, and that I was not working for ‘the government’ or for the facility owners.
Fear of Recrimination

Subjects were assured that they would suffer no recrimination because of their particular responses to questions or if they chose to withdraw from the study.

Researcher dilemma

If a nurse was assaulted in my presence as a researcher, I could be faced with a dilemma, that is, whether to refrain from intervening or acting to intervene for the protection of the nurse. I would need to make this decision at the time of the incident. I behaved throughout the period of participant observation, as an observer, who was not employed by the facility, and was not therefore, covered under the vicarious liability of nursing Acts. I did consider that I might, however, foreseeably become a person rendering assistance in an emergency (for example, in the case of an incident of aggression). This position is provided for in the NSW Nursing Act. Other than in the situation described, I believed I was not involved in the care of the resident. In hindsight I now recognize that whilst I did not provide any physical care to the resident, I was never the less influencing the behaviour of the resident by my presence in the facility. This was not participation, but the residents would often come and chat to me, no matter how unobtrusive I tried to be. I think that having another person around did influence the behaviour of the residents. That is, they could come and talk to me, and they had someone to listen to them potentially enhanced their experience of care on that day, but did not violate the study intent

Consent

In order to gain the confidence of the subjects, I ensured that they fully understood that confidentiality would be guaranteed before they gave consent. Subjects were offered the option of having the interview in their place of work
or an alternative setting if they felt more comfortable with that. This enabled subjects to feel they had a measure of control over the process, and to ensure they would feel at ease when being interviewed and to withdraw consent for participation in the project or use of their data at any time. Ample time was allowed for the interview as well as a period of time prior to the interview commencing for the researcher to build up a rapport with the subject and again to give them an opportunity to withdraw consent.

Consent to observe must be obtained from all who were in the area when non-participant observation is conducted. Data were not collected of participants who chose to not participate in the study. As many of the families of the residents were elderly themselves, I was careful to reassure them that no harm would come to their family member, nor would they be disadvantaged in any way should they decide not to participate in this study.

It was important that when I was obtaining consent that the study was fully explained to the participant, and that they received enough information to give informed consent.

**Vulnerability of elderly participants**

I recognised that the participants, who were observed during the non-participant observational period, and their family members who were asked to give consent can be a vulnerable group of people. The possibility always exists for these people to be exploited. With this in mind, I was very careful to ensure that these people were not exploited in any way.

**Researcher bias**
I have worked in the aged care industry for 20 years. I originally thought I should not bring any pre-conceived ideas to the study. I now believed that this was not possible, and the way to manage this would be to disclose my beliefs about the area of study.

Storage of data

The participants were assured that all data would be stored securely and that participants would not be identifiable in any way. Only the researcher had access to raw data. Data were stored electronically and secured with a password for the mandated period.

Protocol for obtaining consent

1. The purpose of the research was explained to the prospective participant.
2. The method of data collection and matters relating to confidentiality were explained.
3. The prospective subject was informed that they were under no obligation to participate in the study and could withdraw from the study at any time.
4. Prospective participants were given an information sheet, which explained the purpose of the study and the contact number of the researcher, and the Human Research Ethics Officer at the Research Branch of the University of Newcastle.
5. After this, time was given to the prospective subject to read the information sheet and to ask any questions before being asked to sign the consent form.
Validity and reliability

The questions chosen by me were developed following extensive reading in the area of aged care. This ensured content validity. This was followed by discussion with people who were currently working in that area who were those that I considered to be experts in the area and would be able to determine a level of confirmability, credibility and face validity of the proposed approach. Finally, my extensive experience in aged care assisted in the development of questions that could be considered as appropriate for this project and advice was sought on the authenticity, content and construct validity of the questions and the approach to the more general aspects of data collection (Morse, 1991).

Preliminary findings from the study were discussed with my colleagues. I also presented a summary of the findings to nursing management at the hospital where I worked. These discussions revealed that findings were consistent with informal observations of those who worked in the area, thus again ensuring a level of confirmability and face validity.

My own experience in this area also provided the opportunity to identify, that which was believable or credible and thus meaningful. The use of informal discussion with others working in the area, along with my own experience in the area provides a “basis for convergence on truth” (Polit & Hungler 1991, p 383).

Selection of participants needed to be purposeful. However whilst the experiences of these participants may not be generalizable to the population as a whole, the study does present the experiences of this particular population of nurses, and the study processes can be replicated in other settings.
Despite such measures in critical enquiry the aim is to achieve a greater understanding of their situation, and to prompt actions to address the inequities of particular situations (Robertson 2005).

Conclusion

This chapter has focused on the study methods, the observations, the interview processes and the use of memos. Aspects of the validity and reliability and the application of ethical principles and protocols were covered. The demographic data have also been presented.

I described how when in the non-participant observation stage I observed the facility and the interaction of the members of this facility. I also noted that I interacted with members of the facility, partly to gain their confidence but also to immerse myself in the field. I took field notes during the non-participant observation phase of this study. The intent of the non-participant observation stage was to observe how nurses interacted with residents and with each other. I was also looking to see if there were any episodes of aggression, and how the nurses managed these. My initial perceptions of the nature of interactions in residential aged care were tested. The following chapter commences the more in depth analysis of the observations, interviews and include personal reflections from my field notes.
CHAPTER 5

Findings

This chapter will discuss the findings from the investigation by first, using direct excerpts from formal documentation, the researcher’s field notes of observation sessions and feedback from interviews as well as references from relevant literature. Observation and interview data will then be analysed with the use of a Critical Incident Technique (CIT) referred to in the methodology chapter. This is a second level of analysis that will provide insight into elements of practice that enhance or inhibit episodes of aggressive behaviour. Further to this references from the contemporary literature will provide additional commentary on the discussion of the findings.

An initial discussion will centre on the environment (context), which is reliant on data from observations, document analysis and the literature and addresses

Question 1 What is the nature of the caring environment of elderly demented persons?

The data from observation of the context of care will be followed by a discussion of the experiences of nurses who work in this area as reported in their interviews. This data set provides insight into answers to the following:

Question 2 How do RAC personnel respond to and manage the demented person’s aggressive behaviour?

Question 3 What are the tensions that exist in the maintenance of the rights of both personnel involved in care and the residents for whom they care?
These questions will, in part, be answered through the use of the CIT as the analytical tool applied to observation and interview data. This will assist in identifying nurse and resident behaviours that have contributed to or assisted in the delivery of safe and therapeutic care and the management of aggressive incidents. This in turn will assist the researcher in confirming the consistency in patterns of nurse and resident behaviours with safe and therapeutic practice and optimal resident outcomes with the development of a conceptual framework arising from the findings of this study and lead on to answers to Questions 4 and 5:

**Question 4 Are the current approaches to managing long term care needs of residents with dementia sustainable in the RAC environment?**

**Question 5 What type of model of care for the elderly demented person displaying aggression has integrity (effective, efficient and efficacious, ie safe) for both the resident and the personnel responsible for their care?**

Responses to Questions 3, 4 and 5 will be explored in the following chapters.

The following discussion centres on answers to Question 1 from my observations of the nature of the environment, behaviours indicative of the nature of care and the workforce skill mix.

**The nature of the environment**

In discussing the caring environment, critical appraisal of the following areas will be performed for impact on care processes and the management of aggression: The physical environment, the culture within that environment and the relationships of people within the environment from notes made during the
observation sessions. It is important to note that greater depth of insight into the facilities operations was achieved in only one nursing home.

*The physical and social environment*

The facility that was involved in the observation was one that was designed to accommodate residents in three separate houses. Each house was as “homelike” as possible.

![The facility from the road: Houses look like many homes in the community.](image)

Residents spent much of their time in the kitchen. This would be something that was familiar for the people housed in this facility. In the country, many families focused their activities around the kitchen. The kitchen was the hub of the home. In housing people in such a facility, it should contribute to appropriate management of the residents who suffer from dementia.
The kitchen table played an important part in the daily routine, and in fact some residents sat at the table all day. This would be in keeping with most homes of people in the area which are rural communities in which the kitchen table is the focal point of the family home. In fact, in the time when the residents of this facility would have been much younger, the kitchen would have been the main room of the house. This was the room where most family members would congregate. There would have been two reasons for this. One would have been because most houses had wood stoves and as a result, the kitchens would have been warm and inviting.

The second reason would have been that kitchens in these areas would have been large enough to accommodate the whole family. There was no TV. TV seemed to change the focus of families once it was introduced. In today’s environment families are likely to congregate in a lounge room or family room, and the kitchen does not seem to be the focus of the family.

The design of this facility, particularly the kitchen/living area promoted a calm and comfortable environment for the resident. Price, (2003) describes how important it is to design and build facilities with the comfort and safety of the residents in mind. Price (2003) also believes that the environment contributes to the current beliefs in how to care for residents who suffer from dementia.
The house did not have a great deal of stimulation such as adverse or excessive noise, and a lot of people going in and out. Occasionally, a resident would tap her foot on the floor repeatedly. This did not seem to cause the other residents to become more agitated than usual. However, on one occasion, the observer noticed that a visitor spoke very loudly and was very busy when visiting her mother. It was noticeable that the residents were rather agitated during her visit, but settled quickly when the visitor left and the noise returned to a more normal level. Carlson, Fleming et al (1995), recognize the importance of a stress free environment for those who suffer from dementia. Loud talking is one such stressor that can cause residents to become agitated.

Nurses used a very old fashioned diversionary tactic when trying to settle residents who were becoming agitated. They would ask the resident to sit at the table and offer them a cup of tea. This was a strategy that was frequently used.
with effect. As well as having the effect of settling an agitated resident, it may have had the effect of improving the amount of fluids consumed by the elderly residents, thus reducing the likelihood of both urinary infections and dehydration.

Practices in the house were similar to those found in the homes of the residents who lived in the facility. Often residents would help with such chores as feeding the cat, washing and drying dishes, sweeping and vacuuming. Again, this could have contributed to residents feeling comfortable in their environment.

Nurses were involved in serving meals. As such they were able to discuss with the residents what was on the menu and to ask them their likes and dislikes. Again, this could be said to be familiar with what the residents had experienced in their own homes.

Staff and residents interacted in a very positive manner. It was evident that staff had a good relationship with the residents and their families. There was a genuine sense of camaraderie and family among staff, residents and the residents’ families.

Residents were able to experience privacy because they lived in single rooms with ensuites. Privacy would have helped residents to feel more secure when being showered, dressed and changed.

This unit was a specialised dementia facility. The design of this facility mirrored as much as possible, the resident’s own home. Government legislation (The Aged Care Act, 1997) supports such a concept. Atkinson (1995), in describing the CADE units established in the late 1980s, recognizes that the concept of an
environment that is as close to a home as possible is the best environment for people with dementia.

![Lounge area with fireplace](image)

**Figure 5.3 Lounge area: The fireplace in the corner would have been a feature in most homes in the area.**

This facility also addressed the recommendations made by Calkins (1995). Residents’ rooms included familiar furnishings and most rooms were decorated with photos of those people who were important to the resident. Living areas were also based as much as possible on the home environment. The kitchen was the centre of activity of the facility.

Lighting was very good with a great deal of natural lighting from large windows. If there were to be a criticism of this facility it would be the fact that there was one corridor that ended in a dead end. The other corridor allowed residents to walk into the garden and walk around paths in the garden area. Price (2003) reminds us that corridors that end abruptly caused frustration and agitation for the person who suffers from dementia.
Having provided an overview of the physical environment, attention now turns to observation of activities that occur on an everyday basis. There needs to be some reiteration of the point that the presence of the researcher will inevitably influence the study participants. Nevertheless the observations did yield data on a range of behaviours.

Behaviors indicative of the nature of care

The following discussion will include analysis of situations reported by participants or observed by the researcher using the Critical Incident Technique. Analysis of the data sets will identify behaviours of nurses that either contributed to or prevented an incident of aggression. Behaviours which could have or did result in an aggressive incident will also be discussed in relation to the Boundaries of Professional Nursing Practice.
Relationships

This section will commence with an account of activities that were demonstrative of the nature of relationships between nurses and residents that occurred during the period of observations. Judgments about outcomes for residents will be guided by contemporary Codes of Professional Conduct and the NSW Nurses Registration Board Guidelines on Professional Boundaries (1999).

Calkins (1998) identified that the correct selection of staff was vital to the wellbeing of the resident. It is important to notice that staff are part of the environment, and as such should be softly spoken. One important quality that staff should possess is the ability to remain unflustered and to not rush the resident. The atmosphere during my observations was always relaxed and friendly. It was very obvious very early in the period of observation that staff never seemed to be rushed, nor did they rush the residents.
The following illustrates the behaviours of nurses that have demonstrated their interactions which may have prevented incidents of aggression occurring.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded observation</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff were polite &amp; respectful to residents</td>
<td><strong>Staff demonstrate respect consistent with Codes of Professional Conduct</strong></td>
<td></td>
</tr>
</tbody>
</table>
| "Do you want to have your shower, now (name)?" "Would you like to go to the toilet?" "Would you like a cup of tea?" Staff always spoke to the residents as they entered and left a room. | **Respectful behaviour**  
**Meets need for privacy.** |
| Outcome | Lack of incidents which provoked aggression | **Demonstration of sensitivity, concern consistent with Guidelines for professional Boundaries (NSW NRB 1999)** |
| There was also a sense of "family" in this facility, a sense of belonging & sharing in care | **Staff demonstrate respect and listening** |
| All staff (including the Director of Nursing, the Chief Executive Officer and the laundry staff) knew the residents well and took time to chat to them as they visited the house. | **All staff noticing the resident** |
| Outcome | Staff created a sense of belonging | **Sense of homeliness for resident**  
**Person-centred care Consistent with Codes and Guidelines** |

Table 5.1 CI Analysis 1
### Table 5.2 CI Analysis 2

If a resident asked for something, staff attended to it immediately. If this could not happen, the staff would tell the resident why it could not happen and also keep telling the resident they had not forgotten them, thus minimising potential for agitation and maintaining a therapeutic (helpful) relationship.

If a resident looked as though they might become restless and agitated, staff were very quick to introduce a diversionary tactic. In this case, it was most likely that the resident would be asked if they would like a cup of tea. This was very successful. Other diversionary tactics that appeared simplistic but were timely and representative of the general strategies were such things as asking a resident who was very restless to feed the cat, asking another to help with the vacuuming.
The following quote is an example of two residents who were engaging in a conversation with each other. Whilst this may have been confusing to an observer, it can be said that the two residents were validating each other. Residents were displaying behaviours of mutual respect, listening and trust. It demonstrates that the two residents have a relationship with each other that is complementary. In order for this to occur, the nurses would need to be aware of which residents had similar interests and were able to get on. Once this is identified, the nurses would be responsible for bringing the two residents together thus enhancing their comfort zone.

L: “Mary and I have been missing one another”
G: “Oh dear”
L: “I was in a solicitor’s office when I was young”
G: “Oh dear, dear………dear, do you know my mother, Mrs Boyd? I’m waiting for her and she doesn’t know where I am. She was over in that little hall in the corner”
L: “I’d better get to those letters”
G: “If you see my mother on your trips, tell her to come and see me. Tell her it’s not very nice being lonely”.

If nurses were not aware of the common interests of the two residents, and placed different residents together, the potential for violence would be greater.

Nurses showered residents in an appropriate manner. Privacy was well maintained with the facility being designed to allow for each resident to have his or her own ensuites. It was noticeable throughout the time the residents were being showered that the nurses were extremely calm and gentle when performing this procedure. It was worth noting that whilst a particular shower was being observed, there was no sign of aggression from the resident, however, staff said that this was most unusual as this resident was usually very aggressive when being attended to. Another resident was observed having his shower that same day and whilst staff were just as calm and gentle with this resident, he was extremely difficult to shower because he was so rigid (and
possibly experiencing pain), and resisted staff attempts to shower him throughout his shower. This form of resistance is also recognised as a type of aggression, but it is important to acknowledge that it could have been pain related. Lifting machines were used to transfer residents when appropriate. Nurses usually asked for help when transferring residents with lifting machines this enabled discomfort to be minimized.

If residents wished to remain in bed they were free to do so thus minimizing coercion and possible reactionary aggression. A lounge room was attached to the kitchen. Residents could watch TV if they wished, although most of the time there was music playing in the background which the residents tended to prefer to listen to rather than watch the TV.

The impact of various activities has the potential to influence the climate of care and hence the potential for aggression to emerge. Residents had regular outings and the activities coordinator spent time in each house with the residents. She helped them get ready for outings, and if there were no outings planned she organised activities for the residents. These activities might be cooking or reading the paper to the residents. On one occasion the activities coordinator made pancakes with the residents. The activities coordinator involved all residents in this activity. Some were just talking about when they used to make pancakes, whilst others were actively engaged in the process. On this particular day, the activities coordinator had also brought a bear she had made to show the residents. This bear was shared around the residents with each resident giving the bear a cuddle, before passing it on to the next one. A hairdresser also visited regularly and residents were taken to their room for their hair to be attended to.
At lunchtime it was interesting to note that residents were offered a choice of meals as it was being served. In particular they were asked if they wanted roast or mashed vegetables. Residents answered in a manner consistent with their preferences and were happy with their selection. Nurses cut up meals for those residents who needed this. They also assisted those residents who were unable to eat their own meal independently whilst at the same time prompting those who needed to be reminded to eat. A husband of one of the residents visited at meal times to assist his wife to eat. Residents were given their sweets as they finished their main meal. It is worthy of note that every resident had his or her own spot at the table. This is consistent with the acknowledgement of personal preferences. They did not sit in any other place, even if they were just sitting at the table talking to someone.
When residents asked such questions as “When’s Mum coming?” staff would answer by saying, “She’ll be here tomorrow”. Residents seemed content with such answers and accepted them readily. On some occasions residents had claimed to lose belongings. Nurses always took time to help them locate their lost items. The following excerpt demonstrates a staff action that comforted and reassured a resident. Without this action, the resident may have become agitated and upset.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded observation</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions observed</td>
<td>L. “I can’t find my lipstick”</td>
<td>Resident experiences memory loss.</td>
</tr>
<tr>
<td>Nurse: “It might be in your bathroom, I’ll take you there when I come back”</td>
<td>Nurse demonstrates behaviour of listening and showing concern.</td>
<td></td>
</tr>
<tr>
<td>Nurse returns in about 10 minutes: “Come, L, we’ll go to the toilet, comb your hair, do your face”</td>
<td>Awareness of resident’s individual needs.</td>
<td></td>
</tr>
</tbody>
</table>

Table 5.3 CI Analysis 3

The nurse demonstrated behaviours of listening and concern and reassured the resident, which is an example of person-centred care. The nurse was aware of where the resident kept her lipstick, and was able to help her find it.

The facility had two cats, which were pampered by the residents. One resident in particular believed they were her own cats and would encourage them to sit on her knee as often as she could. Contact with animals minimizes stress.

Whilst the observation was being undertaken there were no instances of aggression. However, on one occasion when a nurse was trying to get a resident to sit at the table for lunch, there was a short display of aggression from a resident.
The following excerpt demonstrates actions taken by the nurse which prevented an aggressive episode.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded observation</th>
<th>Interpretation from application of CIT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse: “come on E, look what Tom brought for you”</td>
<td>Nurse encouraging resident to sit and eat her lunch.</td>
<td></td>
</tr>
<tr>
<td>E: “No”. (This was expressed in a very aggressive manner, and she physically pulled away from the nurse)</td>
<td>Nurse firmly took resident to table.</td>
<td></td>
</tr>
<tr>
<td>Actions observed</td>
<td>The nurse then took E firmly but not aggressively by the arm and led her to a chair, helped her sit in the chair and put her lunch in front of her</td>
<td>Indicative of individual assessment of resident needs and maintenance of her nutrition.</td>
</tr>
<tr>
<td>Outcome</td>
<td>E immediately began to eat</td>
<td></td>
</tr>
</tbody>
</table>

Table 5.4 CI Analysis 4

The nurse in this instance demonstrated that she had individually assessed the resident and intervened in a manner that appeared directive but ensured that the resident would not lose the opportunity to eat. As a result of this firm but direct approach, a potential aggressive incident was avoided. This again, is an example of person-centered care. The nurse knew the resident well enough to know when she could be firm with the resident and achieve the desired outcome for the resident.

The approach of the nurses caring for the resident with dementia was often similar to their approach to children. Many said, ‘they (the resident with dementia) are just like children”. Evidence of their lack of education and understanding was displayed by their attitude to residents who were aggressive.
Whilst staff appeared to be very caring of their residents, they spoke to them in a manner that one would use when speaking to a toddler.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded observation</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse speaking to resident in a childish manner as she leads her to the toilet</td>
<td>Nurses attempting to gain compliance from resident when meeting moving towards the toilet.</td>
<td></td>
</tr>
<tr>
<td>Actions observed</td>
<td>The use of expressions such as ‘what are you up to Nellie Noo? “Nellie, Nellie, Noo, what are we going to do wit’ you”</td>
<td>Evidence of patronizing behaviour</td>
</tr>
<tr>
<td>Outcome</td>
<td>Whilst this manner of speaking was potentially effective in gaining compliance it appears demeaning.</td>
<td>Evidence of violation of resident’s right to be treated with dignity. This is potentially a “Boundary transgression” (NSWNRB 1999)</td>
</tr>
</tbody>
</table>

Table 5.5 CI Analysis 5

The behaviours demonstrated by the nurse in this instance were **patronizing**, and demonstrated a lack of respect and dignity for the resident. The nurse was also coercing client compliance which is in fact a level of “over-involvement” and thus might not be seen as “therapeutic” and could also be a catalyst for aggression.

**Workforce skill mix**

The work environment seemed to represent a view that was based on tasks and getting ‘finished”. The very nature of the people employed in these facilities can set the tone for the work environment.
In particular Assistants in Nursing provided most of the resident care. These are the people with the least education and skills. They often worked in a very task oriented approach and did little to recognise the individual needs of the resident. Participants commented at interview that this may contribute to the number of aggressive incidents, and the reaction of these staff to such incidents. One participant acknowledged that the minimal education of AINs could contribute to episodes of aggression. That is, that staff that had little training reacted worse to an assault than those who had been trained.

_They were upset, wondering why they would be here. A lot of the carers that take it more difficult like they can’t, are not trained, and I find that that’s a problem, when the non-trained staff that haven’t been in the caring of aged, they react sometimes worse. Or take it worse, instead of just letting it flow over them (EN)._ 

_The Aged Care Act (1997) introduced changes that removed the requirement to have 24 hour Registered Nurse coverage in aged care facilities. This was despite the fact that a Senate Inquiry into these changes recommended that ‘the highest quality of care should be available to residents by qualified and trained staff’” (Angus and Nay, 2003, p 2). This change has resulted in fewer staff being employed and, those that have been employed having little or no training._

Nurses in this study also spoke about working longer than their rostered hours to ensure their work was completed. This extra work was unpaid. Staffing was as follows: 1 nurse worked from 0700hrs to 1500hrs;

1 nurse worked from 0900hrs to 1700hrs;

1 nurse worked from 1500hrs to 2200hrs.

A Registered Nurse covered the entire facility and would visit to administer medications and address any concerns staff may have about the residents.
Night cover was by nurses in other homes in the facility, with the residents in the dementia unit being monitored by a sensor system.

This situation, along with the poor pay and the increased workload is responsible for the difficulty in employing Registered Nurses in aged care (Angus & Nay, 2003). Further to this, participants at interview reported that the lack of a wide range of work available in the small community, and the fact that staff only worked in aged care because this was the only work available and not a first preference, was a factor that may contribute to low levels of commitment to residents and an increase in the incidence of aggression in these facilities:

*Particularly in small country (towns) where employment is low so people take jobs because it is available and they really shouldn’t have the job and sometimes they can actually contribute to the person that shows aggression (EN).*

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded observation</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of a need to have well trained staff caring for the elderly.</td>
<td>Difficulty employing suitably committed &amp; qualified staff.</td>
<td></td>
</tr>
<tr>
<td>Actions observed</td>
<td>In small country towns where unemployment is high, many potentially take positions in aged care because there is nowhere else to work</td>
<td>Untrained persons who cannot find other work are employed.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Reports of people working in aged care who were unsuited to the position.</td>
<td>Potential for compromised resident care unless education is available for staff.</td>
</tr>
</tbody>
</table>

Table 5.6 CI Analysis 6

Registered Nurses who are employed in aged care bear the responsibility for the minimalist approach to care received by the residents even when they are not directly providing that care (Angus & Nay, 2003).
Summary of Observation Sessions

At the conclusion of the observation sessions of the one facility, I believe that there was clear evidence of a positive suite of relationships among staff and residents and their families. Clearly, my field notes show the presence of a sensitive resident oriented individualised approach to care. In almost every instance, there was a clear recognition of the residents’ rights, and almost without exception, the communication from staff to residents was effective and showed concern for the delivery of therapeutic care.

Concerns I did note, however were related to the fact that nursing staff performed a number of domestic activities such as cleaning, vacuuming, serving meals and washing dishes. Further to this staff worked more than their rostered hours to ensure all their work was completed.

It is also worth noting that the facility had a sensor system which monitored residents at night. The dementia unit was unmanned at night, with staff in other areas of the facility observing residents via the sensor system and responding accordingly. The facility was also investigating the possibility of introducing an electronic documentation system.

Occurrence of Aggression.

The staff claimed that they were “under pressure to get the job done”. The demands of documentation, attending to domestic chores as well as attending to resident care can place pressure on staff to ensure all tasks are complete. The residents’ experiences of their immediate environment can be very confusing to them Residents with dementia do not like to be rushed and as staff have indicated, this can result in aggressive outbursts.
The following excerpt illustrates how aggression can occur when the focus is on getting the work done.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded interviews.</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, pretty much the same experience as that which I had in that we’d come into the room to reposition this particular person, and barely got within arm’s throw of the resident and she starts abusing this particular person</td>
<td>When preparing to reposition a resident staff needed to get close to the resident. Presence of roughness and bullying</td>
<td></td>
</tr>
<tr>
<td>She sort of wasn’t sure how to cope with it, but she kept walking forward, and she copped a whack and the spitting and that sort of thing and this lass unfortunately fired back with some verbal, sit down! behave yourself! Aggression, in a tone that just fired this person up and she just kept on and on and on and I said, “Oh look, I think it’s time we’ll have to leave because she’s not going to be accepting of anything to be done with her right now” This other lass wasn’t terribly happy, she wanted the job done, and that sort of thing.</td>
<td>Lack of individualised assessment of care, taking time, showing concern.</td>
<td></td>
</tr>
<tr>
<td>But we ended up going out of the room, and I said, well we’ll go and do another task and then we’ll come back and we were able to do it that way. We got away with it that time, but on occasions that particular resident could have caught us out on even the second and third attempt, and so we weren’t able to do anything with her that morning or something because of that situation (AIN).</td>
<td>Absence of sensitivity, individuality, taking time. Violation of resident’s right to choice, respect and dignity (NSW NRB 1999).</td>
<td></td>
</tr>
</tbody>
</table>

Table 5.7 CI Analysis 7

This incident demonstrates what can happen when the nurse does not adopt appropriate behaviours. Behaviours present were roughness and bullying, whilst behaviours of individualised assessment of care, individuality, violation of resident’s right to choice, respect and dignity, taking time and showing concern were absent. This resulted in the resident being aggressive and unable to receive care at that particular time. The nurse did not attempt to plan care around the therapeutic needs of the residents, care has been planned
around the needs of the nurse to get the job done; the bullying approach of the nurse is an attempt to coerce client compliance and leads to crossing of boundaries in what is regarded as therapeutic in a nurse resident relationship.

Similar frustrations were presented by those residents who displayed aggression, particularly when personal care was being delivered. Once again these people have the potential to disrupt the smooth running of the facility. The concept of leaving the person and returning at a later time to deliver care can be ignored by those staff members who wish to get ‘finished’. This then presents an immediate battle zone as the nurses try and deliver care to the aggressive resident. This is related to a mentality where resident needs are secondary to the rituals and routines of care delivery which are designed to meet the needs of the staff and the facility. That is, the resident has to ‘fit in’ with the system, rather than the system meeting the needs of the resident (Tonuma & Winbolt 2000).

The other part of the environment is constructed by the concept of ‘Residents Rights’. It would seem that this is all too often interpreted as ‘the resident is always right’, and can be a significant reason for staff ‘putting up with’ resident aggression. There is a need to consider both staff and nurses’ rights. It is almost as if the moment staff enter the facility, they must always give in to resident’s rights.

Residential Aged Care personnel response to and management of the demented person’s behaviour.

In answering Question 2, participant reports on the nature of the aggression, when aggression is likely to occur, suggestions on how staff members manage the aggression and their response to aggression will be presented. Studies from the literature are used to support evidence from the study.
The nature of the aggression

It is important that when discussing aggression in aged care to look at the type of aggression that is experienced by these personnel. Participants described being hit, spat on, bitten, kicked, pinched, having their hand/arm twisted, grabbed on the breast, pushed, and scratched as the types of assault they faced every day. Participants spoke of having their nose broken, shoulder injuries and scratches to their eye. Some even spoke about being attacked with a weapon, being either a wet face washer or a lump of wood. These findings are supported by Levin, et al (2003) who identified being grabbed, pushed, hit or scratched by residents and Astrom, et al, (2004) describe types of violence directed at staff as pinching, hitting, kicking, spitting, grabbing and pinching. The following excerpt demonstrates how quickly a seemingly calm situation can turn to an incident of aggression.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded interviews.</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>We’d sponged her, and I was just tucking her in.</td>
<td><strong>Settling resident.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Actions observed</strong></td>
<td>And she said to me ‘see this’ and I thought right has she got a nail broken or something and she went for my nose. I screamed,</td>
<td><strong>Staff member attempts to meet resident’s needs</strong></td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Staff member had broken nose. Staff member stunned because assault was not expected (EN).</td>
<td><strong>Staff member experiences assault despite apparent therapeutic behaviour</strong></td>
</tr>
</tbody>
</table>

Table 5.8 CI Analysis 8
This incident demonstrates the fact that there are times when aggression will occur no matter what the nurse does to avoid it. But participants in this study also spoke about residents using weapons to attack staff. One staff member told how “a lady broke a glass and chased one of the girls up the hall with it. A number of staff recounted the same story of how “an RN was hit by a man with a chock of wood”. It seems difficult to predict when an intervention is not interpreted as helpful or well intended by the resident.

**Timing and management of aggression.**

Nurses also talked about the triggers they believed resulted in an aggressive incident. In all cases the most significant trigger was the delivery of personal care to the resident. This invasion of the resident’s personal space was the greatest trigger. Scarfe and Keating (1998) have indicated that agitation most often occurs when nurses are attending to the residents’ ADLs. Staff may have been dressing, showering, toileting, transferring, and feeding residents. Studies by Cohen-Mansfield, (1986); Jones, (1985); Bridges-Parlet, et al (1994); Hagen & Sayers (1995) and Cospito & Gift (1982) all support this finding. That is, any activity that invaded the resident’s personal space was likely to elicit an aggressive incident.

Aggression at this time is most likely a result of the resident being unable to “remember, reason and solve problems” (Carlson et al, 1995, p1108). Often residents may believe that staff members are assaulting them when they attempt to shower, dress and attend to the activities of daily living of the residents. This inability to reason then leads to the resident hitting or kicking in order to (they may believe) protect themselves. Further to this, participants identified that violence also occurred when they were transferring and feeding residents.
Astrom, Karlsson et al (2004) also found that violence can occur when administering medication.

Nurses tried a variety of ways to manage this. One was to get the procedure done as quickly as possible to ensure that the resident had only a little time to attack the nurse. There is a risk that this might not be seen as therapeutic care. However, how nurses approached the resident could make a difference to a care situation. Participants felt that if they were to approach the resident in a calm manner the incidence of aggression would be reduced. Speaking calmly to the resident and taking more time with them was considered useful. Actions such as rushing the resident and approaching the resident in an aggressive manner only seemed to exacerbate the situation. Participants told of some staff pulling back the bedclothes without telling the resident they were going to get them out of bed. Such actions can demonstrate a lack of respect for residents, and therefore result in an aggressive response. Levin, Hewitt et al (2003) have also identified that such an attitude can contribute to aggression directed at the nurse.

Participants spoke of some residents who acted in an unpredictable manner. That is the resident could be nice and happy, when, for no apparent reason, their mood would change resulting in them lashing out at the nurse. The following two excerpts describes how aggression can occur when least expected.
### Table 5.9 CI Analysis 9

This situation demonstrates how the nurse **individually assessed the resident** and noticed the resident would not be receptive to care at that particular time. By withdrawing from the resident and returning at a later time, the nurse behaved in a thoughtful way, respected the rights of the resident and avoided an incident of aggression.
Table 5.10 CI Analysis 10

In this situation, even though the nurse was attending to the resident and showing the resident courtesy and respect, the resident kicked the nurse under the chin.

Another interview example involved a nurse bending down and doing up a resident’s shoelace. Both were with both happily chatting away, when the resident put her hands down and attempted to choke the nurse. Such unpredictable incidents make the care of these residents very difficult. This could be the reason for nurses rushing through procedures in order to avoid such an incident occurring again. It is important to note that this rushing when attending to a resident could actually perpetuate the problem and cause further aggression.

Participants told of how aggressive incidents could make them ‘jumpy’. By this they meant that they were afraid the incident could occur again at any time. Many participants considered that they could not harm the resident in any way.
When you’re actually dealing with her, she’s (the resident) fired up again, and your initial response is OK, protect yourself, make sure you don’t drop them if you can help it (EN).

**Managing the Aggression**

Nurses manage the aggression in a number of ways; some believe that aggression is minimized if you are careful how you approach a resident. That is, you talk to the resident, tell them what you are going to do, and do not do anything that may startle them. Participants spoke about assessing the resident, even from the door before entering the room. Such a strategy has been identified by Levin et al (2003) as a means of managing the aggressive behaviour. If the resident appeared to be anxious and irritable, staff would return at a later time to attend to the resident when they were calmer.

Whilst this is a strategy that some participants believe is successful, this could also contribute to the isolation and in extreme cases, neglect of the resident. Meddaugh (1991) identified that nurses spend less time with residents who were confused than those who didn’t experience confusion. Another study by Winger, Schirm & Stewart, (1987) found that nurses tended to withdraw from aggressive patients. The nurses in this study used the strategy of withdrawing from the resident if the resident was aggressive and returning at a later time when the resident might be in a more cooperative mood. In some cases they would ask another nurse to take over for them, as a fresh face may not elicit the same behaviour from the resident.

If this is the case, then it is likely that nurses did not spend as much time with the residents who were aggressive as they did with the other residents who did not display aggression. Other studies (Scarfe & Keating 1998) have found that when aggression occurs, nurses only attend to the most basic needs of the resident such as toileting and ensuring they are safe.
Some participants believed that the aggression was a sign that they had somehow done something wrong. They felt that aggression was a warning to the staff that they had been too rushed or that the resident may have been in pain, or that the resident was just using aggression because they were frustrated with their lot. Carson et al (1995) have suggested that every behaviour has meaning, and is usually the only means the resident has to communicate. Unfortunately, it is not possible to interpret and identify the message in all behaviours.

Participants also told of their attempt to identify the triggers that might have preceded the aggressive incident.

Participants also had developed strategies that were individualised to the resident. Some residents responded and remained calm if the carer recited the Lord’s Prayer with them. Others responded to singing and/or discussion about their family or other interests.

Participants also felt that you must not let the resident see you are frightened, whilst some felt that if you soldiered on and ignored the behaviour, this would let you manage the resident without the corresponding aggression. Strategies such as ‘ducking and weaving’ and maintaining eye contact were also suggested.

*Have eye to eye contact with them, talking, talk directly into their eyes. Don’t look away because they think they have got you frightened. ........ Because if they think they’ve got you frightened, they’ve won, and you may as well walk away from the situation (EN).*
**Blaming**

In order to make sense of the aggression, nurses chose to identify a reason for the aggression.

Participants believed that aggression happened because the resident did not like their personal space being invaded. In some instances staff believed that the residents did not know what they were doing, and as a result were not responsible for their actions. One excused the behaviour by saying “I accept it as part of the disease rather than the person” (AIN):

> It used to really, really upset me initially, but as you become familiar with what dementia does to people and that sort of thing, you learn to just accept it I guess after a while and brush it off (AIN).

Some staff blamed themselves for the incident when they were assaulted. This supports Lanza (1983) who found that many victims blame themselves and review the situation to see where they went wrong. Others wanted to blame the staff members that were assaulted. In most cases the persons who were blamed were those who had minimal qualifications, or were relatively new to the facility.

It is interesting that nurses chose to blame the victim in some circumstances. Lanza (1984) believes that blaming the victim comes from a need to control the environment. This may be because nurses like to think that hospitals/nursing homes are not violent places, and by blaming the victim, they are able to make some sort of sense out of the assault. (Lanza & Carifo, 1991). Others accept that aggression as part of the job, and because they work in aged care, they need to accept the aggression.

> I suppose a part of me accepts it as part of the job and I don’t tend to get upset by it (AIN).
The nurses’ response to aggression

Participants told of their frustration and anger at the situation they were working in. They spoke about having to put up with the situation and being treated as if they were nothing but a “piece of dirt”. Unfortunately they believed that it was part of the job and they had to ‘put up with it’:

*Some days you get really frustrated with them and you know they can’t understand why they’re doing it but you’ve just still gotta be there for them sometimes you feel as though you’re a piece of dirt (AIN)*.

Astrom, Karlsson et al (2004) found that staff experienced astonishment and antipathy against the resident as well as feelings of powerlessness, insufficiency and fear. In fact, staff could find that initiative and power in this situation is transferred to the resident.

One participant believed that the violence and aggression experienced in an aged care facility was no different to that you would experience when hit by a member of your family. It really did not mean anything.

*The same as hitting your family members it’s different, and I suppose we do look at them as part of family and do you pick up why people stay with abusive husbands or wives? Because you know them and make excuses for them (AIN)*.

The preceding quote demonstrates how a participant has made sense of the situation. The literature has identified that there is the possibility that staff that have experienced some form of physical and/or sexual abuse during childhood may be at risk of being abused by patients in the health care setting (Little, 1999).

Participants also told of looking at what they (nurse) may have done to cause the aggressive episode. That is, had they considered the dignity and feelings of
the resident when they approached the resident to deliver care? Nurses told each other of strategies they used in dealing with aggressive residents:

There’s a level of acceptance. I think that’s what it is. And it goes back to the dementia – they’re not aware of what they’re doing so we accept it (AIN).

One male participant believed that he experienced fewer episodes of aggression because he was more patient and did not rush the residents as much as the female carers.

Participants also spoke about the tension they would feel if they were told that a resident had assaulted another carer. This made them more cautious and a little apprehensive when approaching the resident.

Reporting the Assault

Of the nurses interviewed, very few indicated that they had completed an incident report. Reasons for not completing the report were lack of time; that the behaviour was normal for the resident; that there was no point unless there was visible evidence of the assault. Time spent in completing incident reports would be time spent away from residents’ care. Some staff indicated that if they completed an incident report for every assault they experience, that they would be spending all their time completing these reports:

I don’t think we worry about that, because it happens all the time and we’d be writing incident reports all the time. And it’s just part and parcel of the job (EN). 

This is in keeping with studies by Lanza & Campbell (1991) Beck, et al (1992), Lion, et al (1981), who also found that assaults were not reported unless there was an injury.
The Australian Nursing Federation (2002) claims that this is because nurses believe they can handle any situation that arises. They also believe that they are advocates of their patients, and feel compromised if exposed to aggression. Nurses are faced with a dilemma when they are expected to complain about someone they are supposed to be protecting:

“There’s been an incident where I’ve actually had a lady bite me and another couple of incidents where I have had scratch marks and I think they’ve been the only times I’ve ever actually put in an incident report and that was only because there was broken skin in case of any further follow up (AIN).

Staff expressed their frustration at reporting a number of assaults from a resident and the lack of action that resulted.

“Well I had written several incident reports and we did discuss it at report time because it wasn’t only me it was all the other staff and I know we’ve got to write incident reports but I said we would have piles and piles and piles of them because it could be a report on half a dozen times per for each attendance of personal care (RN).

Lanza & Campbell (1991) also believed that nurses do not report assaults because they are so common that they are not seen as out of the ordinary.

“From memory I think I spoke to the RN who was on that shift and I think she sort of said that the resident had a tendency to do that but that was just something we had to prepare ourselves for each shift as you didn’t know when she was going to do it (EN).

Lion, Snyder & Merrill (1981) also suggest that the reluctance to report the assault may be a result of nurses denying that a problem exists.

Further to this, a participant suggested that nurses may not report the assault because they may feel they will be seen as stupid for letting the assault occur, or that they may have been responsible for the assault:

Some nurses don’t report it because they look stupid that they cannot do things well. They are rude to the patient, the patient hit them. So I think it is much more than that (RN).
Support following an assault

Nurses believed that fellow workers were supportive and would empathise with them when assaulted. Fellow nurses allowed them to talk about the assault as well as recounting stories of their own. Nurses also warned staff that were coming on after them if a resident had been particularly aggressive.

Yes, they (fellow staff) are very understanding, and at least you can talk it over amongst yourselves there. But that’s sort of private as well, when you do have those sorts of discussions. Because we’re all in the same boat, we all deal with it (in) different ways, though. No we don’t go running to the top each time this happens. We’d never get our work done (EN).

However, one staff member who had been on work cover because of an injury resulting from aggression found that staff members were not supportive. Staff described support from their supervisor (RN in Charge of the shift) as minimal. The supervisor in this case was the Registered Nurse in charge of the shift. This support varied from concern to such comments as “well, that’s something you have to get used to”. In some instances, nurses were told to not complete an incident report as the resident was “always like that”.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Nurse asked RN what she should write about an aggressive incident.</th>
<th>Nurse seeking advice about formal documentation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions observed</td>
<td>RN not very interested.</td>
<td>RN blasé about incident: shows under-involvement in care processes</td>
</tr>
<tr>
<td>Outcome</td>
<td>RN said ‘That’s just him’, meaning that documentation wasn’t necessary.</td>
<td>Inappropriate advice given to nurse: not consistent with safe &amp; therapeutic practice</td>
</tr>
</tbody>
</table>
Table 5.11 CI Analysis 11

This behaviour from the RN demonstrates minimal care and neglect for both the resident and peers. This type of behaviour is very concerning, because if our most senior staff cannot recognise the need for such incidents to be documented, there is little hope of this documentation happening at all. This apparent lack of interest by the RN indicates that the nurse is withholding care from the resident. A boundary crossing (transgression of safe and therapeutic practice) is reflective of a lack awareness of fiduciary responsibility to the residents. (New South Wales Nurses’ Registration Board, 1999).

(The RN) was rather blasé about it because it was a normal behaviour pattern with him. If it had been someone else who wasn’t known for their aggression, probably the reaction would have been different. They would have said what have you done to trigger it? But because he was a person who was known for that type of behaviour they said, that’s just him (EN).

Staff felt that the support they received from management was almost negligible. In fact, they did not believe that management knew that the aggression had even occurred. Participants also expressed concern that when they had requested counselling after an incident; this counselling did not occur until 3 weeks after the event. This finding is supported by Conlin Shaw (2004) who found that staff received little support from management who expected them to deal with the situation as aggression was part of the job.

A similar outcome has also been found in previous studies (Whittington & Wykes, 1992). Astrom, Karlsson et al (2004) found that staff tended to support each other. Registered Nurses however tended to offer only minimal support. Reasons for this could be that staff members do not have a frame of reference for examining the extent to which care situations are consistent with the principles of a therapeutic relationship. They are also so busy performing their
daily tasks that they may not have time to talk to the supervisor, and the supervisor may be in a similar position. Participants did tell of occasional quick chats with the RN in the corridor as they passed. The RN would ask if they were OK, but there was no further follow up. If staff have asked for and not received support after earlier incidents, they may feel that there is little use in requesting support after further aggressive incidents (Conlin Shaw 2004).

In examining the responses of the participants to and management of the demented person’s behaviour, areas including the nature of the aggression, the nurse’s response to the aggression, when aggression is most likely to occur, how nurses manage the aggression, who they believe should be blamed for the aggression occurring, reporting the assault and the type of support nurses receive following the assault, have been examined.

In all instances of assault, behaviours of either the staff or the resident have contributed to the assault in some way. Typical behaviours have been identified in an analysis of the incidents using CIT. As well, behaviours which promote resident and staff well being and respect boundaries of safe practice (NSWNRB 1999) have also been identified.

Registered and Enrolled Nurses should be made aware of the Principles of Safe Practice as published in the document “Guidelines for Registered and Enrolled Nurses Regarding the Boundaries of Professional Practice” (NSW NRB 1999). These guidelines were developed in response to a recognized “need to identify those areas of nursing practice in which the boundaries of professional and personal relationships may overlap”.

The potential for behaviours evident in relationships between nurses and residents to contradict the principles outlined in guidelines are particularly
relevant when dealing with residents with dementia. The vulnerability of these residents and the relationships that can develop with staff that are caring for them on a daily basis for a number of years, makes the principles of safe practice particularly relevant in aged care.

The aged care environment is complex. Much of the caring is delivered to residents by staff that are not registered or enrolled with a regulatory body of any kind. That is, the Assistants in Nursing that have, at the best, a very minimal qualification or no qualification at all are not directly exposed to such principles. In order to address this, it would be desirable that guidelines be adopted by aged care facilities and they become an integral part of staff orientation programs and performance appraisals for all levels of carer.

I populated the frameworks used in the guidelines with key emergent descriptors of behaviours that that I was seeing in the participant responses. The following discussion is based on a set of principles that I turned to in order to explain the phenomenon of therapeutic care. I have modified from those developed for the NSWNRB in 1999. These can assist in informing decisions about boundaries of safe practice for nurses working in aged care. In order to illustrate the emergent data, a diagram was developed by the researcher (based on a diagram previously endorsed by the NSW Nurses Registration Board (1999) to illustrate professional boundaries of safe practice). The diagram (See Figure 4.5) provides a framework of indicators of behaviours that act as catalysts for aggression. The behaviours of the nurse and resident are represented on opposite sides of the diagram.
Figure 5.5 Framework of indicators of behaviours that act as catalysts for aggression.
In order to ensure the best possible care to residents with dementia, nurses should be appraised of the Principles of Safe Practice as published in the document “Guidelines for Registered and Enrolled Nurses Regarding the Boundaries of Professional Practice”. These guidelines can assist nurses (both qualified and those who are unregulated but working under the supervision of Registered Nurses) by providing a sense of direction about safe and therapeutic practice and factors that can diminish or enhance positive outcomes for residents (NSW Nurses Registration Board, 1999).

<table>
<thead>
<tr>
<th>Principles of Safe Practice in Therapeutic Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The priority of nurses is to plan care around meeting the therapeutic needs of the resident.</td>
</tr>
<tr>
<td>2. Nurses need to be aware of their own needs, values and attitudes in a professional relationship.</td>
</tr>
<tr>
<td>3. Nurses must have an awareness of and an ability to describe the therapeutic purpose of nursing actions that are interpreted against resident responses.</td>
</tr>
<tr>
<td>4. Nurses are responsible for ensuring that nursing care is not withheld from a resident as a punishment. Any intent to cause pain/suffering as punishment based on punitive judgement is unacceptable.</td>
</tr>
<tr>
<td>5. Coercing resident compliance may be an abuse of the power imbalance and lead to aggression.</td>
</tr>
<tr>
<td>6. Nurses need to be aware of the comfort zones for both resident and nurse regarding the therapeutic touch.</td>
</tr>
<tr>
<td>7. Care is optimized when nurses and residents do not engage in relationships that are based on victimization or aggression.</td>
</tr>
<tr>
<td>8. Where dual relationships are unavoidable there is a potential for prejudicial practice to occur.</td>
</tr>
<tr>
<td>9. Self-disclosure should be limited to revealing information that has therapeutic value to the resident.</td>
</tr>
<tr>
<td>10. Self-disclosure should only occur within an established therapeutic relationship.</td>
</tr>
<tr>
<td>11. Nurses need to carefully consider their motives for disclosing personal information.</td>
</tr>
<tr>
<td>12. Nurses should apply statement 7 of the ANCI Code of Professional Conduct for Nurses in Australia as the standard for confidentiality. ‘Treat as confidential personal information obtained in a professional capacity’.</td>
</tr>
<tr>
<td>13. Nurses should not use confidential information or their position of power to advantage themselves in any way.</td>
</tr>
<tr>
<td>14. Nurses have professional responsibility to inform residents &amp;/or significant others about the nursing care which residents are receiving. Nurses should assess and negotiate individual residents’ needs for information relating to their care.</td>
</tr>
<tr>
<td>15. Nurses should recognize that the giving and receiving of gifts and involvement in financial transactions within the nurse-resident relationship has the potential to compromise the professional relationship.</td>
</tr>
<tr>
<td>16. The giving of a gift to a nurse by a resident may have an impact on the resident’s significant others.</td>
</tr>
</tbody>
</table>

(Amended from The Boundaries of Nursing Practice, Nurses Registration Board, NSW, 1999)

Figure 5.6 Principles of safe practice
The following table presents indicators of behaviours evident in the study data set from the observations and interviews that in the researcher’s opinion (after applying the CIT) may result in boundary crossing. These are particularly pertinent given that the residents that are the focus of the present study are experiencing symptoms of dementia.

<table>
<thead>
<tr>
<th>Presence of:</th>
<th>Absence of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Favouritism/minimal care neglect.</td>
<td>• Sensitivity</td>
</tr>
<tr>
<td>• Judgemental attitudes</td>
<td>• Individualised assessment of care</td>
</tr>
<tr>
<td>• Burn out: Cynicism</td>
<td>• Listening/talking time</td>
</tr>
<tr>
<td>• Co-dependence</td>
<td>• Presence (being there).</td>
</tr>
<tr>
<td>• Possessive/secret behaviours</td>
<td>• Concern</td>
</tr>
<tr>
<td>• Rudeness/patronising attitude</td>
<td>• Noticing</td>
</tr>
<tr>
<td>• Roughness/bullying</td>
<td>• Accountability</td>
</tr>
<tr>
<td>• Assault</td>
<td>• Understanding</td>
</tr>
<tr>
<td>(Nurses Registration Board, NSW, 1999)</td>
<td>• Putting self into others’ shoes</td>
</tr>
<tr>
<td></td>
<td>• Aware of clients’ rights</td>
</tr>
<tr>
<td></td>
<td>• Effective communication.</td>
</tr>
</tbody>
</table>

Table 5.12 Indicators of Boundary Crossing/Violation for therapeutic relationships

The potential for relationships between nurses and residents to violate the positive and therapeutic outcomes were particularly relevant and were evident during observation when nurses were dealing with residents with dementia. The vulnerability of these residents and the relationships that can develop with staff that are caring for them on a daily basis for a number of years makes the determination of principles of safe practice particularly relevant in aged care.
The top half of Figure 5.5 represents the presence of behaviours that have the potential to act as catalysts for aggressive behaviour. Such behaviours perceived as directive and or abusive by staff towards residents can result in a similar response from residents. This can also be reciprocated. That is, such behaviour from residents may result in abuse from the staff member. For example, a task oriented approach to resident care can result in a response from the resident where they resist care provided by the staff member. Alternatively, care consistent with residents rights, can elicit a response from residents which is favourable to optimal care. Such consistent care can result in therapeutic care delivery to residents and nursing interventions which ensure the safety and efficacy of care delivery to residents who have dementia.

The second half of Figure 5.5 shows that more “person-centred care” (Kitwood, 1997) as being conducive to residents being amenable to care. Reduced environmental stimuli can contribute to residents experiencing calmness and reduce the number of aggressive episodes. The bottom part of the figure represents an absence of behaviours that in turn are catalysts for aggressive behaviour.

Conclusion

The use of the Critical Incident Technique and various Codes of Conduct and guidelines for Safe and Therapeutic Practice throughout this chapter has assisted with the identification of the types of behaviours present in both staff and residents and the outcomes of that behaviour with respect to the incidence of aggression.

The principles of safe practice derived from the NSW NRB (1999) document act as a guide for nurses to assist in their decision making and reflective practice regarding the nurse patient relationship: “Overlapping or blurring of the boundary
between personal and professional behaviours can occur within a nurse-client relationship” (NSW NRB, 1999, p 9). This implies the potential for a less than optimal approach to care and may increase the likelihood of aggressive responses from residents. The expectation of ongoing positive resident/patient relationships can be particularly pertinent in aged care where nurses and residents build up those relationships over a period of years.

The discussions included examples of nurse interactions and behaviours with residents that may/may not have been successful in promoting an aggression free environment.

In conclusion, this chapter has examined the data set collected from observation relating to the physical environment. This data was also used to assess the relationships between staff, residents and their families. Data collected by interview has been analysed and a discussion of the participants’ response to and management of the demented person’s behaviour has followed. A diagram has been developed which promotes an understanding of the consequences of resident and staff behaviour. Explanation of this diagram included an expression of the belief that in order to manage the conflict (relating to boundaries) that staff may experience when dealing with the residents, Principles of Safe practice can provide guidelines to staff about the management of situations that may compromise staff and positive and safe patient care. An appreciation of these principles can assist staff in managing aggressive outbursts from residents in their care.

The presence or absence of indicators of therapeutic practices (See Table 5.12). have led me to speculate that in situations of violence and aggression, nurses react in a number of ways that reflect the following critical elements of behaviour related to levels and nature of education and training, levels of
understanding of residents with dementia, an inability to obtain assistance with the management of these residents, a culture of low self esteem among aged care nurses, a lack of resources and the lack of appropriate accommodation for elderly people who display aggression.

The following chapter will discuss responses to Question 3. What are the tensions that exist in the maintenance of the rights of both personnel involved in care and the residents for whom they care? This discussion will cover findings from the use of the CIT tool. Question 4. Are the current approaches to managing long term care needs of residents with dementia sustainable in the RAC environment? will also be addressed.
CHAPTER 6

Findings: Tensions within approaches to care

Chapter 4 addressed Questions 1 & 2 of the study, providing an overview of the context of practice (RACS) the environment and its relationship to responses from clients that reflect aggression and the impact of the nurses’ experiences on the nature of care provided.

This chapter will be presented in 2 sections. The first will address Question 3. What are the tensions that exist in the maintenance of the rights of both personnel involved in care and the residents for whom they care? These tensions, observed by the researcher and reported on by the interviewees, and the impact of social and historical factors on them, will also be discussed. Excerpts from the interview transcripts and the CIT will again be used to highlight issues. In conclusion, the tensions will be examined by discussing Heaney’s (1996) concept of power, and the consequences that expressions of power have on the experiences of participants in this study.

The second section will address Question 4: Are the current approaches to managing long term care needs of residents with dementia sustainable in the RAC environment?

The response to Question 5: What type of model of care for the elderly demented person displaying aggression has integrity (effective, efficient and efficacious, that is safe) for both the resident and the personnel responsible for their care? will be discussed in the following chapter.
Resident rights versus staff rights

_We are like prostitutes, you know, every one does everything to us and we just shut up and we’re not supposed to talk (RN)._ 

The statement is particularly pertinent in light of the fact that the very first nurses in the colony of NSW were no better than prostitutes because they were the only women that would work for the poor wages that were being offered (Crichton, 1990). Whilst many would be able to demonstrate improvement in social circumstances, relatively speaking, the context of aged care and the undervaluing of the care provide appears to be ongoing.

Whilst the above response from a study participant is quite provocative, nurses working in aged care do experience a number of tensions surrounding maintaining the balance between their own rights and the rights of the residents in their pursuit of sustaining safe and therapeutic care for their clientele. Frequently, nurses felt torn over which rights should take precedence. In addressing this issue, areas such as residents’ rights, resident protection, documentation, admission, discharge, staff qualifications, and the image of aged care nursing will be discussed.

From reports from some study participants there emerges a view that residents’ rights always seem to over-ride the rights of those nurses who care for them. This interpretation of the concept of the pre-eminence of ‘residents’ rights’ has become prevalent in nursing homes. So much emphasis has been placed on this term that staff members are extremely conscious of “residents’ rights”. A charter of residents’ rights is on the wall in every nursing home in the country. Residents have a number of rights that revolve around choices, their care needs and their living environment.
In the first instance, complaints from residents and/or their families regarding these rights are reported to be taken as correct, with proprietors and managers paying little time and attention to the staff’s version of the complaints. Frequently when such a conflict emerges, the staff member is always seen as being in the wrong. “Resident’s Rights”, the catch cry that is used in these instances is often translated to mean, “The resident is always right”.

I recorded in my field notes that during informal discussions with staff at meal and tea breaks, the topic of residents’ rights was raised by staff a number of times. It was very obvious that participants were unaware that they had any rights at all. In fact some participants were particularly afraid of breaching residents’ rights:

“Well, it’s that residents’ rights thing. We must always remember residents’ rights when we are caring for them. Residents can complain to the Department (Department of Health and Ageing) and we would be in real trouble then (RN).

The attitude of management towards staff when they are assaulted can further perpetuate the belief that residents are always right. Participants told of how they were told (by management) “that it’s behavioural and .../... we have to accept it when they do that”.

As a result of this attitude, staff members are requested to identify what triggered the aggressive outburst when they complete an incident report. The form design impels the nurse to think whether they triggered the aggression.

Participants also raised the fact that other nurses’ approach to residents may have been responsible for the aggression.
Residents are able to raise problems with the Complaints Resolution Scheme of the Department of Health and Ageing. Visits from this Department are feared by proprietors and managers of aged care facilities. These visits are always unannounced, and the proprietor is often left trying to address a complaint from an anonymous complainant. In order to avoid the resident complaining to the Complaints Resolution Scheme, proprietors need to moderate care situations and appease the resident, no matter who is really in the right. This is the main reason for the enduring belief that Residents’ Rights take precedence over all those of other people.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded interviews</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff entered room to attend to resident.</td>
<td>Attending to personal care.</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Resident yelled at staff and told them to go away.</td>
<td>Resident threatening towards staff</td>
</tr>
<tr>
<td>Outcome</td>
<td>Nurse response was ‘Sit down! Behave yourself. Resident’s anger and aggression increased (AIN).</td>
<td>Staff rude and bullying resident thus violating CDHAC Code (2001).</td>
</tr>
</tbody>
</table>

Table 6.1 CI Analysis 12

This incident illustrates the nurse is not listening to the resident. Instead the nurse responds in a way that is provocative and not focussed on any number of potential issues, for example related to privacy and access to personal space. A participant also made excuses for the resident, acknowledging they had dementia and were not responsible for their actions:

*I don’t think you can lay blame because their mind is not normal where they can caution themselves and use the strategies that a normal human being could use (AIN).*
Another expressed their belief that when a resident hit them it was not considered assault because the resident suffered from dementia and the residents are not responsible for their actions:

*Not necessarily assault, just, you know hit on the arm or leg ....!/... spitting in the face and scratching (EN).*

One participant did not believe that it was assault because the incident occurred in a nursing home, “*but if somebody up the street did it, well it’s an assault (RN).*

Another suggested that it was a good thing to be smacked by the resident because “*you really deserve a bit of a slap to bring you back to reality*” (AIN). It appears from these reports that in aged care facilities, staff members believe they have no rights. Participants also mentioned the fact that following an aggressive incident, residents are supported and counselled. However, this support and counselling is not readily available to staff. What is frequently neglected and not pointed out to the residents or their families is the fact that this charter also includes the resident’s responsibilities. One of these is that residents must not harm or injure staff members. Unfortunately, too little emphasis may be placed on this point. Staff members deserve to be protected whilst they are at work. Residents and their families must be made aware of their responsibilities when the resident is admitted to the facility.

The Commonwealth Department of Health and Aged Care (2001b) produced a booklet titled ‘Code of ethics and guide to ethical conduct for residential aged care’. This booklet recognises the rights of both residents and staff. Those rights are the:

- right of individuals to be treated with respect;
- rights of individuals to life, liberty and security;
- rights of individuals to have their religious and cultural identity respected;
• **right of competent individuals to self-determination**  
• **right to an appropriate standard of care to meet individual needs;**  
• **recognition that human beings are social beings with social needs (Commonwealth Department of Health and Aged Care, 2001, p. 1).**

This booklet makes the rights of staff much clearer when it states:

> Residents and their families/representatives should treat other residents, **staff** (my emphasis) and the providers with respect, dignity and courtesy (Commonwealth of Australia, 2001, p 12).

The intent of this booklet was to raise the awareness of the rights of ALL people who live and work in an aged care facility. Unfortunately, these rights do not appear to have been brought to the attention of either staff or residents in this study. Not one of the participants interviewed indicated that they believed they had any rights. In fact, they continued to believe that residents’ rights were uppermost. The statement used at the beginning of the chapter, highlighted the carers sense of powerlessness and graphically illustrates the situation she felt nurses were in.

There were tensions evident within care processes that involve the need to deal with aggressive behaviors from both staff and residents. The charter of resident’s rights, and the belief of staff and proprietors that residents have unlimited rights has the effect of assigning a great deal of power to the residents and their families. This belief that residents have all the power has the potential to exacerbate the already low morale and self esteem of those who care for them, and as long as this feeling of powerlessness continues, nurses will not be able to improve their situation. Dealing with aggressive residents further erodes this morale and can contribute to burnout and high staff turnover.
Gates, Fitzwater et al (1999) note that managers and proprietors seem to be unaware of the implications of violence and the impact it can have on the health of employees and, ultimately, on resident care.

It was also evident throughout this study that little appropriate support was given to staff that experienced an aggressive incident. Participants reported that on the one occasion counselling was offered, it took place three weeks after the event. Such factors as aggression, lack of reward and recognition and not being valued and appreciated all contribute to job dissatisfaction for nurses working in aged care (Ellis & Pompili, 2002).

Protection of the resident versus self protection

Participants believed that the resident must not be hurt in any way. They spoke of incidents where they were trying to free a fellow staff member who had been grabbed by a resident. Their greatest concern was trying to free the staff member without harming the resident. In one situation, participants told of how a staff member was attacked by a resident brandishing a piece of wood. There was a number of staff present when this happened, but none intervened for fear of harming the resident. The following two CIs illustrate the tensions faced by nurses when being attacked by a resident.

From the critical incident provided in Table 6.3 one can see that whilst staff members were being hit by a resident, they were afraid to let go because of the consequences to the resident.
<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded interviews</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>resident attacking Registered Nurse with a piece of wood.</td>
<td>Nurse being attacked</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>And I think it was suggested that if it was somewhere else (not in a nursing home) they would’ve overpowered him</td>
<td>No action by on lookers.</td>
</tr>
<tr>
<td>Outcome</td>
<td>...because we’ve got this old duty of care to residents we’re not hurting, etc they didn’t overpower him and it came back onto the staff member (RN).</td>
<td>Limited appraisal of situation: tensions arise from poor interpretation of ‘duty of care’.</td>
</tr>
</tbody>
</table>

Table 6.2 CI Analysis 13

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded interviews</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>resident was pinching a staff member</td>
<td>Act of aggression by resident.</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>... (we felt) terrible, ‘cause it’s difficult too because you’re trying to release someone.</td>
<td>Feelings of staff powerlessness.</td>
</tr>
<tr>
<td>Outcome</td>
<td>At the same time you’ve got to be careful because you could hurt the resident as well (EN).</td>
<td>Tensions between preserving staff and resident safety.</td>
</tr>
</tbody>
</table>

Table 6.3 CI Analysis 14
Excerpts from recorded interviews

Interpretation from application of CIT

<table>
<thead>
<tr>
<th>Situation</th>
<th>Sometimes if we let go .../..., she’d fall on the floor</th>
<th>Staff managing a physically aggressive resident’s transfer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>...so you virtually had to just bear with it and take the blows, it was very hard (EN).</td>
<td>Staff continue to transfer whilst resident hits staff</td>
</tr>
<tr>
<td>Outcome</td>
<td>Resident transferred. Staff bruised</td>
<td>Resident needs accommodated, but staff safety compromised.</td>
</tr>
</tbody>
</table>

Table 6.4 CI Analysis 14

In these instances, staff members were very conscious of the fact that they must not harm the resident, even though the threat to staff safety by the resident was extremely serious. One participant summed this up by saying “the residents here are in my care. I have a duty of care to these residents to protect them” (RN).

In some instances in the present study, participants told of their first instinct which was to hit back at the resident, however they managed to check themselves in time.

Miller (1997) also identified the fact that staff felt they must protect the resident at all costs. Miller found that fear of retribution from management was the major reason for this desire to protect residents at all cost. This even extended to the fact that staff were prepared to put up with being harmed by a resident rather than protect themselves. This is a significant finding, because it explains a great deal of action by nurses who have been assaulted. This is despite the fact that nurses are now being reminded that they have a right to work in a safe
environment. Even though this message is delivered clearly in the area of aged care, nurses continue to believe that the resident must not be harmed in any way (Hudson, 1995).

Despite the prominence of the belief in always protecting the resident, some staff did indicate a desire to retaliate when assaulted. However, they reported being able to contain themselves, because they believed that they must not harm the resident. Levin, et al (2003) also identified the fact that staff “wanted to retaliate when abused by a resident, but managed to refrain from striking back” (p 33).

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded interviews</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>(They) become very aggressive and nasty and spit and scratch sometimes,</td>
<td>Report of assault to nurse.</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>...if you are taken unawares, particularly, your initial reaction is to almost retaliate you know to hit or scratch or spit back but obviously you don’t do that,</td>
<td>First reaction to want to retaliate</td>
</tr>
<tr>
<td>Outcome</td>
<td>…and that makes you feel terrible because you think I shouldn’t be reacting like that but I guess it’s just reactive (AIN).</td>
<td>Guilt for wanting to retaliate.</td>
</tr>
</tbody>
</table>

Table 6.5 CI Analysis 15

This CI and the excerpts below demonstrate that staff are very aware of the residents’ rights, and the need to not exacerbate the situation:

_A couple of them sometimes you’ve, phew, you’ve got to remember to put your reflexes back down in your pocket (AIN)._ 

_I could grab them, but you know you can’t and you’re in a situation that you’re not allowed to touch a resident (AIN)._
Care of aggressive resident versus care of other residents

Nursing staff are not the only people affected by this aggression, other residents are also affected. During this study staff spoke of the fact that many residents were afraid of a fellow resident who was aggressive. A participant told how she was injured whilst trying to prevent a resident from assaulting a female resident he had dragged from her bed.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Excerpts from recorded interviews</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident pulled a female resident from her bed and began kicking her</td>
<td></td>
<td>Aggression shown towards fellow resident</td>
</tr>
<tr>
<td>Nurse intervened, and resident threw (Nurse) her against a window.</td>
<td>Resident responds aggressively to nursing intervention.</td>
<td></td>
</tr>
<tr>
<td>Nurse managed to coax aggressive resident to return to his room (EN).</td>
<td>Coaxing from nurse resolves aggression.</td>
<td></td>
</tr>
</tbody>
</table>

Table 6.6 CI Analysis 16

This is an extreme example of what can happen when residents are located in facilities that are not equipped to manage them. The nurse put her own safety aside to protect the resident.

Hook (2002) recognised the danger aggressive residents present in a report of an incident of sexual assault of an elderly lady by a fellow resident of the nursing home in which she lived. Associated with the threat of injury to residents by aggressive residents is also the fact that all resident care is
compromised whilst staff members are trying to manage the aggressive resident. The time and staff resources utilized in caring for a resident with aggression, means that care to other residents is potentially more rushed and little time is available for anything more than the most basic care.

Person-centered care versus task oriented care

Nurses in aged care are usually working under pressure to care for a number of residents on each shift. Along with this resident care, staff members are also expected to attend to domestic cleaning activities as well as plating and serving resident meals. This routine allows little time for staff to practise person-centred care. In fact, during the observation period I did not notice staff interacting with residents in a social manner. The only interactions that occurred revolved around the delivery of resident care. Residents were expected to fit in with the routine of the facility rather than the facility fit in with the resident’s needs. Participants in the study told of the need to get through the work, and the fact that aggressive residents made this difficult, as they took longer to care for because of their behaviour. Participants described this frustration in the following excerpt:

There’s a sense of fear there and frustration, because you can’t get on with your work and it’s all tied in. You seem to be under pressure to get the job done (AIN).

Tuckett, (2005) confirms these patterns when referring to the task oriented care approach as ‘production line’ care. That is, all that happens in a nursing home is that the residents are washed, fed, got out of bed and returned to bed. The extent to which this has the potential to aggravate residents needs to be questioned.
Documentation versus resident care

A further tension faced by the nurses who were delivering care, was the need to document to ensure adequate funding. Documentation of incidents of aggression, were mostly made in the progress notes, depending on the advice of the Registered Nurse in Charge at the time. Unfortunately, some participants told of being advised by the RN in charge that there was no need to document, as the resident was ‘always like that’. This strategy might not lead to analysis of situations and behaviours that lead to aggression and violence.

The completion of incident reports was not considered necessary unless the staff member was visibly injured in some way. They felt that completing an incident report was futile as nothing was ever done to improve the situation. Further reasons for not reporting assaults is that the assaults are still so common in 2007. Lanza & Campbell in 1991 noted that they were not seen as anything out of the ordinary; staff believe assault is part of the job, they may be influenced by peer pressure or fear of being blamed for the incident. Nurses still may not report the assault because as Lion, et al said in 1981, they are denying that a problem exists.

Participants also believed that completing such forms was another documentation task they had to perform, and that they would prefer to use the time to care for residents rather than documenting:

*I don’t think we worry about that, because it happens all the time and we’d be writing incident reports all the time (EN).*

*We would have piles and piles of ‘em because it could be on half a dozen times per attending personal care (RN).*
However, funding is based on accurate documentation of residents’ identified care requirements. In order to ensure maximum funding, documentation must accurately reflect residents’ needs, and demonstrate that care has been given. Nurses are torn between the need to deliver what they perceive is the best care to residents and the need to ensure maximum income by ensuring documentation is completed and accurate. These tensions warrant careful analysis to determine ‘cause and effect’ and resolution of the complex situations.

Proprietors emphasise the need for accurate documentation. Unfortunately, many argue that documentation is not accurate and able to sustain RCS claims unless there are copious amounts of documentation for each resident.

In order to produce the required amount of documentation, nurses feel they must compromise the attention they place on resident care. In fact, from my observations I noticed that if one was to examine nursing care plans, and calculate how much time was needed to perform the interventions documented in the care plans, the finding would most likely indicate that it is impossible to perform all these interventions in one day as the care plan suggests.

Again, from my observations, one would have to say that whilst many care plans are very well written and accurately reflect the care needs and interventions necessary to deliver this care to residents, very few of these care plans are followed. In fact many care plans are filed away waiting for the RCS auditors to visit. Care plans are not really used as the effective tools for care delivery that they were intended to be. Throughout my observation period I did not see one nurse refer to a resident’s care plan during the time they were on duty. It is also significant that the nurses did not refer to the care plans during the interviews. This indicates to me that care plans are still not being used as
tools for the delivery of resident care. A study conducted by Porter and Ryan (1996) supports this finding as they found that whilst nurses documented religiously and wrote nursing care plans, these were then filed away and were not used as a tool to deliver care to their patients.

Another factor that reflects on care delivery is the time nurses and carers spend in documentation. The process of documentation is the winner. Managers and Registered Nurses know that inaccurate and insufficient documentation will mean further income reductions with a resulting reduction in staffing numbers. They are aware that for the residents to receive the most basic care, staffing numbers must not decrease, thus documentation takes precedence over nursing care.

Admissions versus discharge of inappropriate placements

There is pressure on aged care facilities for financial viability to maintain as close to 100 per cent bed occupancy as possible. In some instances this can mean that a resident is admitted on the same day another resident dies and proprietors are keen to admit those residents they believe will attract the greatest income. Unfortunately, this need to attract income, coupled with the reluctance of some families/carers to admit that the resident is aggressive has caused a great deal of problems subsequently for nursing staff.

Because of the lack of comprehensive assessment prior to admission, some admissions are inappropriate. In some instances residents are sent to nursing homes because there is nowhere else for them to go. These people may be those who would normally be cared for by the mental health system, but with the reduction in long term mental health facilities, there is nowhere else for them to go and, as a result, these residents continue to be ‘dumped’ (participant’s choice of word) on the nursing home as Zimmer, Watson & Treat, 1984; Snowdon, et al.
(1995) reported. When this is discovered by the nursing home, the challenge of moving that person to more suitable accommodation then arises. This adds to the tension around the desire to care for an individual and the challenges inherent in achieving this with limited assessment data.

One participant told of the difficulty in convincing doctors and geriatricians that the resident is unsuitable for nursing home accommodation:

*It's extremely difficult, and it's difficult to convince the doctors and the geriatricians as well because they realise there's nowhere else for them to go. They have to go somewhere and part of their job is to find them a place to reside and help us to manage any problems that arise, but sometimes these problems can be far more than you can deal with (RN).*

The Commonwealth Department of Health and Ageing (2002) has now reminded proprietors that they may ask a resident to leave the facility if they assault, or threaten to assault staff and/or residents (Department of Health and Ageing, 2002). Unfortunately, this is not as easy, nor as simple as it seems. A condition of the resident being asked to leave is that the proprietor must find suitable accommodation for the resident they are asking to leave. The simple fact is that there is no alternative accommodation for these people. The number of psychiatric beds is very limited and one could not ask another nursing home to take these residents, as they would be placing the nursing home in the same situation that they find themselves in. Also, the potential is there for the referring facility to be sued if they do not give all information about the resident to the receiving facility (Hook, 2002).

The nursing home is then faced with an extremely difficult task. This is particularly difficult when the resident may have been what one study participant referred to as “dumped” on the nursing home because those responsible for the resident prior to their admission were unable to find alternative accommodation for them. Thus nursing homes are often stuck with
residents whose behaviour is inappropriate because they are unable to find appropriate accommodation for them.

Registered/enrolled nurses versus unregistered staff

Tension for many qualified staff is the practice of employing unregistered staff in aged care. This can create many problems and exacerbate situations from which aggression might arise.

The registered nurses are responsible for ensuring that those who are caring for the residents are performing appropriately. Unfortunately, as demonstrated in this study the one Registered Nurse who is on a shift may be caring for up to 70 residents (Stein, Pretty & McMillan, 2001). This does not give the RN time to appropriately supervise the manner in which ‘care’ staff are actually caring for the residents.

The industry wide practice of employing untrained staff could be one of the reasons the industry is finding it difficult to attract trained staff. Trained staff may not want to be responsible for those practices of untrained staff which lead to minimal or poor outcomes.

It is worth noting that in 1877, legislation was passed to ensure that only Florence Nightingale trained nurses were to care for the elderly because the colony considered that the elderly “have special needs which require complex and specialized care” (Stevens 2003). Even at this early stage, there were those who believed that untrained staff members were sufficient to care for the elderly despite the fact that resident care improved substantially under the care of the more qualified nurses (Stevens, 2003). Unfortunately, societal changes, demographics and reforms to aged care since 1988 have gradually eroded this
requirement until the current staffing levels of today where most staff members employed are untrained.

Beattie (1999, p 135) described the extremes in the education of nurses who at that time worked in aged care in Australia:

*In Australia hands-on care is provided by non-nurses at one end of the aged care spectrum. At the other end of the spectrum, we are creating a skilled workforce of nurses capable of rigorous and compassionate care of the elderly whose roles and reimbursement are not expanding commensurate with their education.*

The context of care for the frail elderly thus remains fraught with tensions and competing demands on the nursing profession. Traditional images of care are challenged.

The Image of Aged Care Nursing versus the Image of Acute Care Nursing

One of the reasons nursing homes cannot attract registered nurses is reportedly related to image. Aged care is seen as the “poor relation” of nursing and the area that those who could not manage in the acute sector or those who are close to retirement work. Unfortunately, aged care nursing is not recognised for the specialist skills it entails. Current media and television programs paint acute care nursing as glamorous and exciting. Aged care, on the other hand, is seen as drab and uninteresting. Stevens in 1999 reported that nurses who do not work in aged care believe that there are few, if any rewards from looking after people who will never get better and go home.

Unfortunately, the belief held by acute care nurses of their greater value for money, is also reflected throughout society, and influences the way aged care nurses regard themselves. It also influences the choices new graduates make when planning their career. Nay’s (1998) report on the prevailing belief remains, that is that nurses working in age care and the people they care for are
of a lower status than other areas of nursing. Further to this, the decrease in staffing numbers (Chandler, 2003) and the minimal education requirements have perpetuated the view that aged care nursing is not as important as nursing in the acute sector, nor are the people being cared for as important as those cared for by acute care nurses.

Tensions and power

These tensions outlined above demonstrate the sense of powerlessness expressed by the participants. In the present study residents’ rights are quite appropriately a constant reminder to staff that they are to be aware of residents and their rights at all times. Heaney (1996, p 3) saw this type of power as that which has “become so much part of the background that it is observed and internalized”, thus becoming very effective in maintaining the sense of powerlessness of staff who work in aged care facilities. As noted previously, the charter of residents’ Rights and Responsibilities can be found on the wall of every nursing home in the country. Displaying this charter in this manner is a requirement of the accreditation standards. Residents therefore, may be even unobtrusively, exerting power over those who care for them, by the mere presence of the charter of Residents’ Rights and Responsibilities. The fact that staff members reported that they were afraid of the possibility of violating residents’ rights translates to an inability to protect themselves when being assaulted by a resident. They do not believe that being attacked by a resident is actually assault, which in turn demonstrates the level of influence that their interpretation of residents’ rights has over them.

Their action in not reporting an incident indicates that possibly, because of previous inaction, staff now believe that nothing will be done if the incident is reported, or more concerning, that they may be blamed for the assault. This
again demonstrates the sense of powerlessness of staff and the inexperience of appropriate action in these situations. The fact that nothing happens when a report is submitted however, does discourage staff from reporting an incident. Heaney (1996) claims that this in fact enforces non-decisions by keeping an issue from ever being raised. This, he says is a profound and largely invisible form of power.

A further way in which power can be enforced is to withhold knowledge from those over whom one is exercising power. The fact that study participants were unaware of their rights is an example of this type of power. Participants believe that being assaulted by a resident is ‘part of the job’ and this is further reinforced by the senior staff who tell the participants such things as ‘he’s always like that’ or ‘you have to get used to it’. The fact that, in some instances, participants were not aware of the potential for a resident to be aggressive is also another example of how withholding knowledge can become a powerful tool to maintain power over an oppressed group. Those perpetuating a situation of limited information or misinformation include the resident’s relatives as well as medical and nursing personnel. No participant in this study indicated an awareness of their own rights. Another factor that Heaney (1996) believes is essential to knowledge is experience. Experience enables a person to make sense of the knowledge they have, and the importance they place on the knowledge they have. For example, nurses may be aware that assault is illegal, but by totally excusing the assault as part of the dementia, they are able to justify the assault by claiming that the resident did not know what they were doing.

Heaney (1996, p3) talks about a third dimension of power, that which eliminates opposition by the imposition of ‘false consciousnesses’. In this
instance this consciousness is the product of constant conditioning. The participants’ limited understanding of residents’ rights is one such example of this, as well as the status of the staff and that of the residents they care for in society, further enforces the concept of powerlessness. Comparison with the acute nursing sector reinforces the negative attitude of the community towards aged care nurses as does the attitude of other nurses to aged care nurses and the poor remuneration for the work they perform. These factors all contribute to the sense of powerlessness experienced and articulated by the study participants.

The Department of Health and Ageing also exerts a high level of influence and formal authority over both proprietors and staff who work in aged care. The sanctions that can be imposed for any breach of the standards are that the facility cannot admit any new residents for a period of time (usually 6 months), that money can be taken back if RCS claims are unsupported, that unannounced visits from the Aged Care Standards and Accreditation Agency can occur at any time and that complaints are investigated vigorously by the Complaints Branch. All these actions by the Department support the assumption that the Department is to be feared, thereby increasing the power the department exerts over those who work in aged care.

The Department of Health and Ageing is responsible for funding aged care facilities in Australia. Mansour (2006) suggests that funding to aged care facilities is inadequate. The most a facility receives as government subsidy for the most dependent resident is a maximum of $122.77 per day (Commonwealth Department of Health and Ageing, 2006). This funding increases annually by very minimal amounts. For example, in 2006, funding increased by 1.2 per cent. This increase is calculated by the Department using a formula that is known to those who make this decision, but not widely publicised. It is sufficient to say,
that with increases like this, the employment of qualified staff becomes increasingly more difficult. This essentially ensures that most of the staff members employed are unskilled or minimally skilled.

In conclusion it is evident from this section which focussed on the many tensions facing staff and owners of aged care facilities, that nurses working in aged care face dilemmas around maintaining a balance between preservation of their own rights and the rights of the residents in their pursuit of maintaining safe and therapeutic care for their clientele. Frequently, nurses are torn between which rights should take precedence. In addressing this issue, areas such as residents’ rights, resident protection, documentation, admission, discharge, staff qualifications, and the image of aged care nursing has been discussed. In most cases staff members are balancing the tensions outlined above on a daily basis. As they deal with the consequences arising from these tensions, many staff with solutions will fall by the wayside and aged care will be the loser. Whilst this study is based on research in only two facilities, other studies have shown that the experiences of these nurses regarding the tensions they faced are also faced by nurses working in other aged care facilities. Providers are finding it more and more difficult to find Registered Nurses to work in these facilities. The world wide shortage of Registered Nurses, the lack of recognition for the role they perform in aged care and the lack of remuneration commensurate with their qualifications is perpetuating this difficulty. Until these issues are addressed, the problems will continue.

The second section of this chapter will address:
The sustainability of current approaches to managing long term care needs of residents with dementia in the RAC environment.

To address the question of sustainability in a RAC context a brief discussion re the homelike environment will be presented followed by an account of the current situation and its sustainability. Further on, issues surrounding staffing (including qualifications, accountability, commitment and attitude), admission and discharge of residents, and staff and residents rights will be discussed. Current policy legislation and excerpts from the literature will be examined. The Aged Care Act of 1997 has legislated that each nursing home should present a homelike environment for the residents. The question is “What is a homelike environment from the perspective of the resident?”

It is difficult to find a definition of a homelike environment. Norberg, (2001, p 157) describes a homelike environment as one that allows the feelings of “being connected to significant others, significant things, significant places, significant activities, oneself and transcendence”. Significant in this definition is the fact that the concepts such as wall to wall carpets and ensuites do not fit into this definition.

The homelike environment is what the resident believes it is. The greatest contributor to the sense of a homelike environment is a sense of wellbeing. In particular, communication from staff and fellow residents is vital to the feeling of well being of residents (Norberg, 2001, p 157). This communication must demonstrate respect for the resident and should not be based on clinical interventions alone. Ideally, staff in aged care facilities should have the opportunity to communicate with residents in a social environment and not only when they are delivering care to residents.
Bearing in mind this discussion of a homelike environment, areas of concern about the incidence and nature of the violence in the RAC facilities that have been highlighted by this study, suggest that the current management of the care of residents with dementia cannot continue. In order to demonstrate this, the areas of greatest concern as demonstrated by the critical incidents will be reviewed.

Staffing

Discussion with participants and information in the current literature raise the following concerns:

Staff qualifications

Most of the care delivered in aged care facilities is delivered by staff with either no training or a very minimal approach through completion of a Certificate 3 in Aged Care. Throughout the study, participants raised this as an issue. Angus and Nay (2003) have also expressed concerns about this issue. Concerns related to their management of residents with aggression, which can be extended to their limited observation skills and their lack of knowledge of dementia. It has been identified that study participants believed that these staff did not manage aggression well. The impact of staff members who were heard to communicate with residents using ‘baby talk’ during the observation period is of concern. Some staff even advocated approaches such as ‘looking the resident in the eye’ or ‘never letting them see that you are afraid’ as a means of managing these resident’s episodes of aggressive behaviour. Such communication with residents, as well as the method of managing aggressive residents, demonstrates a lack of understanding of dementia and the management of aggression. This limited type of communication also demonstrates the existence of behaviours that are patronising and lack sensitivity. These are indicators of limited interpersonal
relationships or boundary crossing in the therapeutic relationships (Nurses Registration Board NSW 1999; NSWNMB website, 2007).

Managing aggression

In the situations highlighted as critical incidents drawn from the data, inappropriate behaviour management strategies were evident. Aggression should be managed by staff trying to identify triggers and then introducing interventions to avoid the triggers (Cohen Mansfield, 1986). Some aggressive outbursts have reportedly been managed by staff leaving residents for a short time and returning to them at a later time when they have calmed down. Some participants also told how they have identified means of distracting the resident. Measures such as singing to the resident, talking about the resident’s family or even praying with the resident have reportedly proved successful. It is significant to note that such measures are only identified after the staff members have taken time to get to know the resident and their interests. Despite this, there were reports of some residents who were unable to be managed by the staff in aged care facilities. These people require specialist care from those best equipped to manage such behaviour. Freyne and Wrigley (1996) believed that the best people to manage aggressive behaviour are those who have psychiatric training. The latter are not employed in RAC facilities.

Staff unable to change the situation

Participants in this study have told of how they feel they are unable to change the situation that it is part of the job and hence they must accept it. Participants have told how they believe the resident is not responsible for the aggression, because they have dementia and don’t know what they are doing. The suggestion has been that aggression from residents towards staff is no different
from the type of aggression one experiences from family members. That is, this
type of aggression is insignificant and therefore acceptable. This is a
demonstration of the perceptions of the power that the resident holds over the
staff, further promoting the staff’s feelings of powerlessness.

Accountability

Whilst registered and enrolled nurses are registered with their state Nurses’
Registration Board, less educated, untrained staff who deliver the majority of
care to the residents (Tuckett, 2005) are not registered with any body. This
essentially means they are not directly accountable for their actions. The
Registered Nurse in Charge is held accountable for the actions of these
untrained staff. This becomes increasingly difficult when the Registered Nurse
is also responsible for up to 70 residents at a time. With this many residents,
supervision of staff cannot possibly be effective. This, in effect means that
nurses are blamed for substandard care even though they are not providing the

Commitment to aged care

In the small country town involved in the study many people seek work in
aged care because there is no other work available. This leads to the
employment of staff members that are not really committed to care of the aged.
This situation only exacerbates the problem already presented by the lack of
education of staff that are providing the day to day care of the residents. Staff
members were also employed in the aged care facility because this was the only
work they were able to obtain even though they were not suited for it.
Staff safety

Whilst participants believed that aggression was part of the job and not that bad because the residents do not know what they are doing, the potential is there for a staff member to sustain a serious injury.

**Researcher Note: Staff members that I have worked with over the years have experienced serious injuries such as a fractured wrist, hairline fracture of the sternum and a career ending shoulder injury.**

Such injuries could affect staff confidence when handling these residents particularly when Workers’ Compensation costs are recorded.

Staff remuneration

Registered and Enrolled Nurses who work in aged care are paid less than their colleagues who work in the acute care sector (Angus and Nay, 2003). This is but one of the factors that makes working in Aged Care an unattractive option for newly graduated students. It is certain that Registered Nurses who work in Aged Care are not adequately remunerated for their study and experience. It is also worth noting that the average age of participants in this study was 48.5 years. If younger graduates are not employed in aged care, there will be a significant challenge in finding qualified staff available to deliver this care in another 15 years (Stevens, 1999, 2003).

Staff attitude towards aggression

The fact that staff believe it is part of the job and something they have to put up with, leads to a demoralising work environment. More importantly, they do not believe they are in a position to change this situation. Participants believe that
you’ve just got to cope with it (1B). The fact that staff members do not actively seek counselling and support because they do not believe they need it also highlights the attitude of staff to their situation. The attitude of participants towards aggression could lead to low staff morale and enthusiasm.

Staffing Numbers

Staff numbers are decreasing as the government subsidy decreases from year to year (Hogan, 2004). Staff having to rush through their work can be one trigger that can cause and aggressive incident. Staff numbers are not allowing staff to take a person-centred approach to aged care. Instead, their approach is very task oriented (Tuckett, 2005). The only way to address this is to increase staff numbers.

Staff Fear

Participants in this study reported that they are afraid when they have to care for aggressive residents. You feel sometimes fear, depending on how strong the resident is, there’s a sense of fear (AIN).

Resident Rights

The concept of residents’ rights also causes concern. Participants believed that residents’ rights meant the ‘resident was always right’. Staff members have been so indoctrinated with this that they believe that they must never cause a resident any harm, even if that resident was harming them or fellow staff. This has been demonstrated as nonsense when staff members were afraid to interfere when a resident was attacking a staff member with a piece of wood.
Staff members also blame themselves when an incident of aggression occurs. *It was probably my fault because I was aware of the fact that she will do that, and I let my guard down (EN).*

Resident Safety

Residents are also affected by violence from other residents. Participants told of residents dragging other residents from their beds and kicking them. Residents have died as a result of this aggression. Participants also told of residents expressing fear when a fellow resident was throwing furniture around.

Resident Admission

Whilst proprietors are currently prepared to admit residents who display aggression, as the cost of such admissions increases, (these costs will be related to the worker’s compensation claim) proprietors will become reluctant to admit residents with a history of, or a potential for aggression.

Relocation of Resident

Despite the fact that the Department of Health and Ageing have told proprietors they can discharge residents who are aggressive towards staff and other residents, this is a very difficult task. This task is particularly difficult because the proprietor is responsible for finding alternative accommodation for the resident.
Medication

Medication is considered inappropriate for managing aggression; therefore, a relatively simple solution to the problem is frowned upon both by the authorities and staff. Participants in this study have indicated that they feel medication is bad, and must not be used for residents who suffer from dementia (*We don’t want to make them into zombie (AIN)*). Unfortunately, this attitude might actually discriminate against the resident who is aggressive. If a resident is given medication, either an anti-psychotic or pain medication, the management of these residents can be improved considerably, as well this could also enable nurses to deliver appropriate care to the residents without rushing through the interventions because they are afraid of being hurt by the aggressive resident.

The care of the elderly in Australia has presented a challenge to successive governments since the very early days of the colony. A significant decision in the care of elderly was the decision to legislate that Nightingale trained nurses should be employed to care for the elderly (Stevens, 1999).

Since these early days the funding of these services has progressed through a number of funding models until we have arrived at the model within the *Aged Care Act* that was legislated in 1997. Whilst this model has helped in the improvement of environment and care delivery for the residents, it has also increased the workload on Registered Nurses. Registered Nurses are burdened with excessive documentation requirements that draw them away from the direct care of the residents.
This formal model has also been responsible for the increase in the number of untrained or minimally trained staff employed in nursing homes. There are no minimal education requirements for staff to work in aged care. This means that a person can effectively walk in off the street and obtain work in a nursing home (Angus & Nay, 2003). Proprietors are finding it more and more difficult to meet the cost of employing adequately trained staff.

Unfortunately, even if there were adequate funds to employ appropriately trained staff in these facilities, nursing the aged is considered an unglamorous area of nursing (Angus & Nay, 2003). New graduates do not see aged care nursing as a career choice. This, coupled with the disparity in salaries of nurses who work in aged care compared with those who work in acute care makes aged care nursing most unattractive.

Hogan, (2004, p 24) sums up the staffing problems facing the industry:

*The aged care sector, and in particular the residential care sector, continues to face significant workforce issues that need to be addressed in the near future if the quality of residential care services is to be maintained. The general shortage of trained nursing staff in residential care, the ageing of the workforce, particularly in aged care and the lack of wage parity with other health sectors are paramount. The labour shortage is a consequence of the growing shortage of nurses in all sectors of the health system and of specific problems of recruitment and retention of nursing staff in the aged care sector. The lack of wage parity with the acute sector, poor working conditions, lack of educational opportunities and a clear career path, the poor public image of aged care compared to acute care nursing, and other workplace issues make recruitment and retention of skilled nursing staff in residential care services even more problematic than for mainstream health services.*

The current situation in aged care cannot be sustained (Hogan, 2004.) The increasing number of residents who suffer from aggression present management problems and concerns for the safety of both staff and other residents in these facilities. There are media reports of significant negative
outcomes for residents including one resident death which can be directly attributed to aggression from a fellow resident (The Australian, 2003), and a report of a resident being sexually assaulted by a fellow resident (Hook, 2002). If the current situation is allowed to continue, the media will be only too happy to report on any occurrences of aggression towards residents of nursing homes. As long as the aged care industry does not recognise the qualifications and experience of Registered Nurses, with appropriate remuneration, and continues to employ staff with only minimal qualifications the difficulties attracting Registered Nurses will continue (Angus & Nay, 2003). The Registered Nurse workload will also contribute to the difficulties in attracting registered nurses to work in aged care.

This is further exacerbated by the fact that graduate nursing students are reluctant to seek employment in aged care because they see aged care as an unattractive area in which to work, and universities have only recently responded to change this belief (Commonwealth of Australia, 2006).

Governments are beginning to address the problem in the difficulty in attracting Registered Nurses to aged care, but unfortunately in a misguided manner. To address this issue, State Governments are now changing the legislation to allow Enrolled Nurses to administer medications in aged care facilities. In fact, in Victoria, many Enrolled Nurses do not have to undergo any extra training to undertake this task.

With the requirement for only Registered Nurses to administer medications in high care facilities being lifted, this will mean that some proprietors will not have Registered Nurse coverage in their institution for twenty four hours; instead they will employ Registered Nurses to be on call, and only attending the facility when a situation arises that requires their expertise. This limited use
of Registered Nurses is further compounded by the fact that the *Aged Care Act of 1997* effectively removed the requirement for care to be delivered by Registered Nurses 24 hours day (Angus & Nay, 2003).

Government attempts to educate staff in the management of dementia, have not helped with the management of residents with aggression. This initiative was implemented when issues around medication administration to control resident behaviour were raised by a National Action Plan for Dementia (Howe, 1994). The potential of this education might be that staff and doctors are reluctant to consider medications for management of residents, compromising both resident care and staff safety.

The belief held by staff and management surrounding residents’ rights is also contributing to the situation. Staff members are afraid to take action to protect themselves from residents for fear of harming the resident. This has been demonstrated throughout this study with such comments as ‘*We couldn’t let the resident go, as she would have fallen on the floor, so just had to put up with the blows*’ (EN). It is obvious that the focus on residents’ rights is compromising staff safety.

This attitude towards residents’ rights has also meant that staff members believe they cannot change the situation they are in. That aggression is ‘part of the job’ and they must put up with it. This has also been responsible for the belief held by participants that aggression from residents is not assault, and being hit by a resident is just the same as being hit by a family member, therefore it is insignificant.

Participants spoke about being frightened and frustrated, feeling dirty when spat on by residents, wondering what they are doing working in this area,
feeling as if they are just a piece of dirt, feeling used and unappreciated, having difficulty coping with aggression when tired and exhausted, feeling angry, blaming themselves, feeling as if their bodies have been violated and assaulted, shocked and unprepared for the aggression. However, none of the participants believed they could do anything about it because it was part of the job.

Conclusion

Staff members who work in aged care are viewed by the community and fellow nurses as not ‘real’ nurses because they are not working in the acute area with the latest technology (Angus & Nay, 2003). Staff members who work in aged care also believe that they are not as important and skilled as those who work in the acute sector. As long as this view continues, the work done by these staff will continue to be devalued and unrecognised.

Resident care is delivered under extreme conditions. Staffing numbers are minimal, and aligned to a very task-oriented approach to resident care. The Aged Care Act of 1997 has contributed to this by removing the nurse to resident ratios of the previous CAM/SAM funding arrangements (Angus & Nay, 2003). These minimal staff requirements compromise the accreditation standards and the prevailing belief that care should be individualised for each resident. As long as funding remains at the current level, and resident to staff ratios are not a requirement the introduction of models of care based on the person-centred approach will be impossible.

As the incidents of aggression increase and as proprietors begin to grapple with the problem of moving these residents to alternative accommodation and the increased costs associated with the management of these residents, proprietors will be reluctant to admit residents with a history of, or potential for aggression.
This will have the potential to influence the management of beds in the acute sector.

The situation in aged care in Australia and in particular, the care of residents with aggression, is critical and must be addressed immediately. Proprietors cannot continue to rely on the goodwill of staff to work extra unpaid and unrecognised time to ensure residents get the best possible care. (field notes) One needs to question whether nurses will continue to tolerate that aggression as part of the job. Nurses will not work in aged care unless they are better paid eventually moving to the acute sector when remuneration is better.

Staff members who work in aged care deserve to be valued and their efforts recognized. Appropriate support should be offered to assist those who have been assaulted by residents, without trying to apportion blame to the staff. Proprietors need to act to introduce strategies to educate their care providers and thus change staff attitudes and let them know that assault from any person, no matter if they have dementia or not, is totally unacceptable.

Care of the aggressive resident as well as the maintenance of safety of other residents and staff cannot be maintained in an industry that is profit focussed, minimally resourced and reliant on unqualified and minimally educated staff to provide day to day care to elderly residents. The following chapter will propose a model of care that would be appropriate for caring for all residents in aged care facilities. A set of recommendations to address the concerns raised in this chapter will also be proposed.
CHAPTER 7

The Development of a Model of Care and Recommendations

This study asked the question “In situations where personnel are managing aggression in people with dementia, what are the critical factors that impact on their response to that aggression?” This study has identified that in situations of violence and aggression, nurses in aged care react in ways that reflect a number of critical factors. These factors are related to levels and nature of education and training, levels of understanding of residents with dementia, an inability to obtain assistance with the management of residents with dementia, a culture of low self esteem among aged care nurses, a lack of resources and the lack of appropriate accommodation for elderly people with dementia who display aggression.

Data presented in the previous chapter demonstrated that care for elderly residents is delivered under extreme conditions. The potential for levels of aggression in residents to be managed in a way that leads to violence that has negative outcomes for residents and staff is very real. Whilst the facility that was observed was designed in a manner that is similar to that recommended for the care of the elderly resident with dementia, the profile of staffing and numbers along with the range of activities being undertaken by staff suggest that aggression would be difficult to control.

In general, staffing numbers in RAC are constrained, if not minimal, which results in a very task-oriented approach to resident care. The requirements of the Aged Care Act of 1997 have contributed to this by removing the nurse to resident ratios of the previous funding arrangements (Angus & Nay, 2003). These minimal staff requirements compromise the accreditation standards and
the prevailing expectation and belief that care should be individualised for each resident. As long as funding remains at the current level, and particular prescribed resident to staff ratios are not a requirement, the introduction of models of care based on the person-centred approach will be extremely difficult to achieve.

In this chapter, in an attempt to promote appropriate care of residents with dementia and the safety of staff that care for them, guidelines for the development of a model of care are presented. These guidelines are based on the person centred care philosophy, the rights and responsibilities of both residents and staff, nurses’ codes of professional conduct and ethics, residents and staff guide to ethical conduct in residential aged care, the principles outlined within the NSWNMB Boundaries of Professional Practice, the Aged Care Act 1997 and the Aged Care Accreditation standards.

Following articulation of the philosophy of care, fifteen recommendations will be discussed. The final recommendation incorporates the actions that need to be taken when an incident of aggression occurs and the steps to take when reporting the incident.

A Philosophy of Care

Person Centred Care (Kitwood, 1997) is a model of care that encourages nurses to focus on the remaining skills and cognitive ability of the person with dementia, rather than on the illness. This model of care advocates treating residents with unconditional positive regard and non-judgmental respect. The resident is the focus of care. This opposes the approach mentioned by study participants where care delivery is focused on getting the work done and expecting residents to fit in with the needs of the facility, rather than the facility fitting in with the residents’ needs.
The principles on which this care is based embody the concepts of **uniqueness**, (each person is unique), **complexity**, (each person is a complex human being) **enabling** (focusing on the strengths and abilities of the person with dementia), **personhood** (recognition of self and where we fit in the world) and **acknowledging** the value of others (Kitwood 1997). These concepts can be incorporated in care processes as demonstrated by the following study excerpt.

In order to promote calmness in some residents and lessen the likelihood of further aggression, some participants told of the strategies they adopted to manage the aggression. They told of how some residents responded favourably if the staff member prayed ‘The Lord’s Prayer’ with them. Others told of singing with some residents or talking about the resident’s family whilst they were attending to the resident. This indicates that staff had not only taken time to get to know the resident, and their past life interests, but had been able to use this knowledge to care for the residents.

Martin & Younger (2001, p.443) remind us that “people with dementia may only be present as an absence, their own lived experience largely forgotten or ignored”. Understanding the life history of a resident is central to a person-centred approach. This understanding enables staff to develop a plan of care based on the past history of the resident. Staff would be able to talk to the resident about their past interests as well as incorporating some activities into their everyday care delivery. These activities might be dancing with the resident or, as mentioned earlier, praying and/or singing with the resident. Such activities may contribute to a lessening in the incidents of aggression that occur when the residents’ personal care is being attended. The context in which care is provided by staff members is crucial.
Kitwood (1997) also suggests that the same principles should be applied to staff members who work in aged care. That is that the same unconditional regard should also be given to them. If staff are valued and supported then they will be better able to value and support the people they are caring for.

This is particularly pertinent for nurses in aged care who are caring for residents with dementia. The Commonwealth of Australia in a Guide for Occupational Health and Safety in aged care (2001) claims that aggression, whilst being unpleasant for staff is also responsible for the level of staff turnover and reduced staff morale. Aggression can contribute to emotional exhaustion and depersonalization.


Under-pinned by the belief that all parties involved in caring (the older person, family carers, and paid or voluntary carers) should experience relationships that promote a sense of:

• security - to feel safe within relationships;
• belonging – to feel “part” of things;
• continuity – to experience links and consistency;
• purpose – to have personally valuable goal or goals;
• achievement – to make progress towards a desired goal or goals;
• significance – to feel that ‘you’ matter (Nolan et al, 2004, p 49).

In order to effectively introduce a person-centred care approach to the care of residents with dementia, and minimise events of violence and aggression education in this model should occur and be reinforced on a regular basis. Staff members who are employed should be skilled, knowledgeable and enthusiastic. Most importantly, though, staff should want to work with the aged and in particular those who are diagnosed with dementia. (Nolan et al, 2004). Opportunities should be available for staff to reflect on their own values and
beliefs and identify any concerns they may have because ‘delivering person-centred care is inherently demanding’ (Price, 2006, p 54). The environment should be one of mutual respect and trust.

In saying this, it is also important that the philosophy of care encompasses the Codes of ethics and guide to ethical conduct in residential aged care. These codes of conduct were produced by the Commonwealth Department of Health and Aged Care and circulated to all aged care facilities staff and residents in 2001 and are presented in Figure 7.1. This is a significant document because the code is aimed at all who work and live in aged care facilities. That is the same rights apply to staff as well as residents.

The Code of Ethics for Residential Care protects the following rights of individuals.

1. the right of individuals to be treated with respect;
2. the rights of individuals to life, liberty and security;
3. the rights of individuals to have their religious and cultural identity respected.
4. the right of competent individuals to self-determination
5. the right to an appropriate standard of care to meet individual needs;
6. the recognition that human beings are social beings with social needs.

(Commonwealth Department of Health and Aged Care, 2001)

Figure 7.1 Code of Ethics for Residential Care

This framework informing care also refers to the need for nurses to practise within the boundaries of safe practice and in accordance with the nurses’ Codes of Ethics and Professional Conduct (Australian Nursing and Midwifery Council, 2005a).
The proposed philosophical underpinnings of the model will also be cognizant of the requirements of the *Aged Care Act, 1997* and Accreditation Standards and will encompass elements of what is accepted as best practice as depicted in figure 7.2.

**Figure 7.2 Components of the Philosophy of Care**

The above diagram demonstrates the integrated components of the recommended model of care. These components include person centred care, residents’ rights, code of ethics and ethical conduct for residential aged care, the *Aged Care Act, 1997*, Aged Care Standards, Nurses Codes of Professional Conduct and Ethics and the nurses’ principles of safe practice currently under review by the ANMC.
In order for this Philosophy of Care to be successful, the following recommendations will need to be met in order to create an environment that is conducive to the components of the Philosophy of Care.

Recommendation 1

**Establish a staffing profile that is appropriately skilled to care for residents with dementia.**

Irrespective of the philosophy of care, an important factor in the management of residents with dementia is the staffing profile. The staffing profile should consist of competent, enthusiastic and knowledgeable staff.

Every aged care facility has a duty of care to the residents. In order to meet this duty of care, specialist staff members are needed in a number of areas. There should be one staff member who is a specialist dementia nurse. This person would be the resource person for dementia care and will be involved in working with staff in writing care plans, evaluating resident care, and assisting in the management of behavioural problems that may exist.

Further nurse specialties should include wound care, continence, mobility, resident activities, hydration and nutrition, pastoral/spiritual care.

As well as the nurse specialists, there should be a number of qualified staff who deliver the day to day care of the residents. These people should receive more extensive training than they currently receive. Throughout this study it has become evident that the one issue that may have contributed to the occurrence of aggressive incidents was the lack of training of some staff. This thinking is supported by Meddaugh (1987) who found that those who were recipients of abuse were less educated than those not abused.
It has also been mentioned in the literature that residents should be cared for by the same staff as often as possible. That is, the constant rotating of staff through various groups of residents can be detrimental to the care of the resident. Such rotations do not allow the staff members to develop a trusting relationship with the resident (Ericson et al, 2001).

Throughout this study, staff commented on the time taken to care for residents with dementia. This became even more of an issue when the resident was aggressive when being attended. In order to fully implement a Person-Centred Model of care, staff require extra time. It is important therefore that to implement such models staff resident ratios be revised in order to enable delivery of the best possible care to the resident.

Recommendation 2

**Develop an efficient admission and assessment process.**

In order to adopt a person centred approach, assessment of the resident on admission is imperative. This assessment should identify the resident’s abilities and, just as importantly the resident’s life history. On admission, or prior to admission, if possible, every specialist nurse should conduct an assessment of the resident. From these assessments accurate care plans should be compiled. This will ensure that the resident receives appropriate care from the very beginning.

Staff members also need to be aware of the resident’s normal routine as far as personal care activities are concerned. If the resident’s routine in the aged care facility can be as close as possible to that they experienced prior to admission, then the likelihood of episodes of aggression can be reduced. Figure 7.3 provides an overview of the critical elements of the assessment process. The most important aspect of this admission is the life history of the resident. This
life history will enable staff to know who the resident really is. It will enable staff to develop an understanding of the resident, and in most instances, enable staff to understand the reason for the behaviours. Understanding the resident’s life story will give staff the opportunity to see the resident in the context of their whole life. This will take the focus of care away from the illness and their physical needs and on to the person. It is worth noting that obtaining a life history may not occur immediately, as staff will need to develop a relationship based on trust before some residents may be willing to provide the desired information (Clarke et al, 2003).

It is important that all staff are informed of the life history of the resident. This information can be placed in a scrap book of the resident’s life (if the family and the resident agree). Studies have found that staff are able to develop a more effective relationship with residents if they have knowledge of who the resident was prior to the resident developing dementia (Clarke, Hanson & Ross, 2003).

Figure 7.3 Admission and Assessment Process
Recommendation 3

**Develop an efficient and practical aggressive incident assessment process.**

It is important that when an aggressive incident does occur, that an accurate and thorough investigation of the incident is undertaken. This assessment should include the following:

*The resident’s history:* This will include a history of previous episodes of aggression and investigations to identify if there are any medical factors that may have contributed to the incident such as a urinary tract infection or pain. As well, the resident’s life history will need to be referred to identify if there is anything that may have occurred that reflected on a past history or event, causing the resident to respond aggressively. An example of this may be, taking a Jewish resident to the shower. This resident may have lived through the concentration camps of the Second World War, where being taken to the showers may have meant certain death.

*The physical environment:* Assess the environment for noise, busyness, overcrowding and the effect of intense stimulation on the aggressive resident.

*Work practices and routine:* One of the most important aspects of managing residents with dementia is the ability to recognise when routine and practices are not appropriate for a particular resident. Once again, this depends on the recognition of what the resident might be used to. Such questions as preferred time of day for a shower and whether the resident has a bath or a shower must be asked.
**Work load:** Managers need to question the extent to which excessive workload impacts on the provision of appropriate care to the aggressive resident.

**Staff skills:** Further to the above managers need to ensure person-centred care in their facility and that staff receive appropriate education and qualifications and their suitability to the management of caring for residents with dementia.

**Staff team work:** Managers and staff need to self assess on the extent to which they collaborate as a team.

**Facility policy and procedures:** An analysis should be undertaken to determine whether policy and procedures being followed and if they are sufficiently flexible for person-centred care.

**Management:** Managers should account for all aggressive incidents and provide support and counselling to all staff.

Recommendation 4

**Ensure care plans are recognised as important tools in the delivery of resident care, and regularly reviewed.**

Care plans can be important tools in the delivery of care to residents. Unfortunately, these tools are not used to their fullest potential. Too frequently, they are written and stored in the resident’s history, only to be brought out for the RCS review at a later date. That is, they are not used to ensure effective care delivery to residents.

Staff should all be educated in the use of care plans and the need to use them as a tool for the delivery of resident care. Care plans are effectively used if they are stored in a separate folder and staff members are encouraged to read the care plans at the beginning of their shift and take them with them when they attend to the resident. This use of care plans will ensure that staff members are aware of the resident’s needs and the best way to approach the resident to minimize the risk of aggression.
The following diagram presented in figure 7.4 outlines the processes in developing and reviewing care plans. This diagram also refers to the use of experts when difficulties in implementing the care arise, or when plans of care are not successful. It also illustrates the need to constantly review the care plans and nursing interventions.

Figure 7.4 Steps in the Development and Review of Care Plans
Recommendation 5

**Develop a suite of assessment tools that will enhance the delivery of person-centred care.**

The tools used for assessment must be designed to give the most accurate assessment of the residents’ status and needs as possible. In order to achieve this it will be necessary to develop a number of forms/assessment tools and conduct trials using these tools. It is important that the tools are user friendly. Staff who are conducting the assessments need to be well trained and understand why they are performing the assessment. Another vital feature will be that the information gathered by the assessment tools is used to deliver optimal quality care to the resident.

Recommendation 6

**Establish purpose built facilities**

The facilities of the future must be purpose built. In designing these facilities it will be important to ensure they are as close as possible to the environment from which the residents have come. Facilities should promote a vibrant living environment for residents, and enable staff to use information technology to assist and enhance care delivery to residents.

The facility should resemble, as near as possible, a normal home. This enables residents to feel those things that are familiar in the environment as well as contributing to their orientation to their space. Space should be available to accommodate identified resident needs. In keeping with a person centred model of care, this space will allow the establishment of such things as nurseries, beds and washing up facilities. A level of flexibility should always be present to enable the establishment of other areas for residents to focus on such
as a car or gardening equipment. This will enhance care of residents in a manner consistent with a person-centred focus.

External security to the residential area is paramount. Residents require space to move about freely. It is important that this building have no dead ends. This will enable residents to move continuously throughout the building whilst at the same time feeling that they are going somewhere.

Rooms in this area will be able to be locked when residents are not in them. This will assist in preventing residents from entering other residents’ rooms and removing items from these rooms. Preventing residents from entering other residents’ rooms can assist in reducing the incidence of aggression in the facility. On some occasions aggression can occur between residents when a resident enters another resident’s room.

The dementia secure area would be at ground level to enable access to an external garden area to prevent them from feeling closed in. This area should be secured with a keypad which will enable free access to those who are able, but restrict those who are in need of protection from leaving the building. Grounds should be enclosed with swimming pool type fences (or another type of fence that cannot be climbed over) and appropriate locks on access gates.

External environment

An external environment that blends in with the internal environment would be ideal. A sense that the residents are living among the plants and flowers of the external environment creates a calming effect. Water features, fish ponds and paths that have no end are all essential to the wellbeing of the residents. Raised
garden beds will aid those residents who enjoy gardening to participate in this activity in their new home.

A computer program that aids the documentation and delivery of care to residents is essential. A call bell, phone and security system that is all inclusive is a critical feature of a safe environment. The program might include staff working with a palm pilot to capture and enter resident information, that will also act as the telephone, call bell and security alert. This palm pilot can also assist to reduce the amount of time spent in documentation by the staff. The security system will also include motion sensors in all residents’ rooms to enable effective supervision. These sensors should be able to be turned on and off as desired.

Recommendation 7

Employ and retain suitably qualified and motivated staff.

An overriding concern that has surfaced as a result of this study is the fact that many staff are minimally trained, or, in some cases, have no training at all. This issue has been raised by a number of participants during this study. It is imperative that staff that care for our elderly are adequately trained. In order to ensure this happens a number of attitudinal aspects need to be accommodated.

1. The current attitude to aged care nursing and the stigma attached to this area of nursing needs to be challenged. This could be enhanced by ensuring more attention is given to aged care during the undergraduate education of registered nurses.

2. Aged care should not be identified as an area where prospective nurses can only develop basic nursing skills, rather as an area that is a specialist area of nursing such as intensive care and paediatrics.
3. The importance of psychosocial and interpersonal skills in caring for the aged needs to be recognised (Price, 2006). Price describes interpersonal skills as:

   a. A sincere interest in the experience and concerns of the resident.
   b. Active listening.
   c. Asking questions in a sensitive way.

A further issue that has been raised during this study is the fact that some staff are only working in aged care because there is nowhere else for them to work. Nolan et al (2003) believe that the only people who should be providing care to the aged should be those who genuinely want to do this. That is, people who clearly acknowledge they are only working in aged care because they do not have any other work options should not be the preferred employees.

Recommendation 8

**Provide access to experts 24 hours a day.**

As mentioned in the staffing profile, each facility should have a Dementia Specialist Nurse who can act as a resource person for staff. This person would assist in assessment of the resident, as well as managing the oversight of care plans and providing advice for staff when behavioural problems occur.

Along with the specialist nurse, facilities should be able to have 24 hour access to a Geriatric Psychiatry Assessment Team. This team would be called in on occasions when the behaviour becomes unmanageable, and presents concerns for either staff or other residents or both.

The opportunity should be available for residents to be transferred to a facility for assessment and medication adjustment to assist in the ongoing management of the resident. On some occasions, behaviour may be a result of medication, and the only way to identify this is to cease all medications. This is not possible
in the residential care facility because of low staff numbers and the need to protect other residents. In a facility specifically designed to assess such residents, such actions can be undertaken.

Recommendation 9

| Recognition that some residents are not appropriately placed and streamline alternative accommodation |

It became evident when conducting this study that when staff and management of a facility had arrived at the realization that it would be in the best interests of staff, other residents and the resident concerned if that person was moved to a more appropriate facility, they were presented with a very difficult situation incorporating a complex problem. Other aged care facilities would not take the resident, as this was just moving the problem to another location where the staffing levels and skills were the same. Convincing doctors and other health professionals that the resident was inappropriately located was extremely difficult. This is despite the fact that some residents of aged care facilities have died as the result of being pushed by a resident that staff had had difficulty managing.

The Department of Health and Ageing does inform facilities that they may move residents on if they are unable to manage their behaviour. Unfortunately, it is the responsibility of the facility to find alternative accommodation for these residents. In order to address this, facilities need to make sure they assess residents comprehensively before they are admitted to the facility. The facility can say no to an admission, but is unable to evict a resident without finding suitable alternative accommodation.
Recommendation 10

**Establish regional accommodation centres to assist with assessment of residents with behaviour problems. These centres should also have the ability to provide long term accommodation for those who are unable to be cared for in residential care facilities.**

There is no doubt that some residents with behaviour problems cannot be cared for in residential aged care facilities. Attempts to care for such residents have placed both staff and other residents in danger. Before the closure of mental institutions, these people would have been cared for in these facilities. Without these institutions, more and more of these people are being cared for in an aged care environment. Staff education and staff numbers in aged care facilities are inadequate to provide appropriate care to such residents. Alternative accommodation which offers more staff as well as staff with psychiatric qualifications is necessary to ensure optimum care. Such accommodation centres could also be used to conduct assessments and develop strategies to assist in the management of residents who are able to be cared for in the residential aged care facility.

Recommendation 11

**Alter staff attitudes towards aggression.**

Nurses need to learn that aggression in any form is totally unacceptable if not managed well. Making excuses for the behaviours is no longer appropriate. Staff members need to feel supported in this instance; as well they need to learn that being the recipient of extreme aggression is NOT part of the job. That is
that no one should expect to be assaulted when they go to work. It is also important that staff are made aware that assault is illegal no matter in what situation it occurs. In order to encourage staff to report the incidents, it is important that this report is accepted in an environment that does not condemn the person reporting or try and apportion blame to that person.

In order to change staff attitude to aggression it will be important to raise their self esteem. This can be achieved by raising the profile of aged care nursing among other nurses, tertiary learning institutions and in the community. Kitwood (1997) suggests that staff should be treated with the same unconditional regard as the resident. That is, the principles of person-centred care should be directed towards the staff as well.
Recommendation 12

Nominate a staff member to be the person of contact for all aggressive incidents

This person would adhere to the processes outlined in figure 7.5 and:

• Be the person for staff to contact when such an incident has occurred.
• Identify any needs the staff member may have and organize the appropriate follow up to support the staff member.
• Investigate circumstances surrounding the assault.
• Ensure all appropriate documentation is completed.
• Review the resident and care plan to identify any steps that can be taken to reduce/prevent the incident occurring again.
• If necessary negotiate with the resident’s doctor about calling for assistance from the geriatric psychiatry team.
• Ensure all staff are aware that the particular resident has been aggressive and develop strategies to assist staff with the management of this resident.
• Follow up to ensure all appropriate action has been taken and that nursing interventions are effective.
• Provide regular education to staff re aggression and how to manage it.
Figure 7.5 Process for Action by Contact Person

Recommendation 13

Ensure staff are always aware of those residents who have the potential to be aggressive

During and prior to admission, the question should be asked as to whether the person has any potential for violence. This could be identified by the inclusion of a request for commentary on a history of violent and aggressive incidents. Violence and aggression can be the catalyst for the person being admitted to the
aged care facility. Family members are often reluctant to admit that this is the reason for the admission, or that the person has been aggressive at all. Or, if they do tell this is a reason, they will confirm the experience that it was only towards the spouse and no other person. It is important not to make an inference that staff will not be on the receiving end of this aggression.

From the moment a resident is admitted to an aged care facility, staff should be made aware of the potential this resident has for aggression. This should be clearly identified on the resident’s care plan.

Recommendation 14

| Maintain staff safety |

It is important that nurses feel safe at work. In order to facilitate this each staff member should wear or carry a personal duress alarm. This alarm would be able to be activated if they found themselves in a situation of danger.

When attending to residents that have a history of aggression, two staff should be in attendance at all times. Despite the fact that some participants believed that residents found the presence of two staff intimidating, it would seem that this is an important strategy.

A further measure that needs to be addressed under the heading of staff safety is the fact that staff need to be taught some simple measures to defend themselves. I am not advocating that they perform some martial art type activity, but learn some simple measures to get themselves out of the grips of residents. For example if someone is pinching them, be aware of a pressure point on the resident’s arm that if this is pressed, the resident will spontaneously let go and stop pinching.
Recommendation 15

Develop guidelines for the management and reporting of aggressive incidents.

Another fact that became evident throughout this study was that staff did not have any guidelines to follow when an incident, or a potential for an incident of aggression occurred. The proposed model suggests steps that staff must take to reduce the amount of aggressive incidents as well as how to manage during a violent incident.

1. Reporting the incident

It is important that staff have a clearly defined process to follow around reporting the aggressive incident. Koch & Hudson (2000, p23) found that incidents were not reported because of the trivialization of an incident by peers and supervisors. All incidents that are reported should be taken seriously, and addressed in the same manner. It is important that if the person making the report states that a violent incident has happened, then it is taken that the incident has occurred.

Koch & Hudson (2000) suggest the following should be considered when developing a procedure for reporting and managing an aggressive incident.

- What to do after an event
- Who to contact after an event
- Choices available (defusing, debriefing, counselling). Staff who have been affected by the violent incident are offered the following choices:
i. Defusing: Defusing contains the incident and helps staff to recognise that the incident is over. Such a session should be held as soon as possible after the event.

ii. Debriefing: If the defusing process is not helpful, a formal debriefing session may help staff to process the event.

iii. Counselling: Counselling is offered if reactions increase rather than decrease.
   - Formal written documentation reporting the event
   - Entry into nursing progress notes.

These procedures are outlined in Figure 7.6.
2. **What to do if Aggression Occurs**

   Staff should be giving distinct guidelines to activate if aggression occurs. These should include:
• Try a diversion: Talking, singing, praying with resident, whichever is appropriate for the particular resident.
• Sound duress alarm
• Leave resident and return a little later.
• Assess the resident to ensure there is no infection/pain/discomfort that may be responsible for the aggression.

3. The Medication Alternative

The use of medication in aged care to manage behaviour problems is not viewed favourably. Participants reported reluctance to consider medication as a means of managing aggression because they believed the residents would become ‘Zombies’. This is generally the attitude throughout the aged care sector. Unfortunately this attitude compromises both care to the resident as well as staff safety. Aggression prevents staff from attending to quality personal care of the resident. In efforts to work around the aggression, staff members attend to the residents most basic needs as quickly as possible. Studies (Meddaugh, 1991; Winger, et al, 1999) have found that nurses spend less time with residents who are aggressive, than with residents who do not display this behaviour. Medication should be considered in such instances.

It is also important to note that the medication used is not necessarily a medication that will address the behaviour directly. It should always be considered that the resident may be in pain, and this may be the cause of the aggression. Participants raised this probability in the study. In some instances, the only way to determine if the resident has pain is to commence them on pain medication and monitor the outcome. If the behaviour improves then the
strategy has been successful. If there is no improvement, then the need for alternative medication should be considered.

This chapter has proposed guidelines for the development of a model of care that is based on the principles underpinning the philosophy of person-centred care. Management of aggressive residents in nursing homes will always present a problem as the ageing population increases. The current strategy of management of these people in residential aged care facilities cannot be sustained under the present system. In order to assist with the management of these residents a number of recommendations have been made. These recommendations have attempted to address concerns raised by participants throughout the study. The next step in this process will be to trial the recommendations to determine their effectiveness in caring for and managing resident with dementia who display aggression.
EPILOGUE

I chose to study aggression in aged care because I thought it was something that was becoming an issue and little was known or done about it. This interest was prompted by an injury to one of my staff which was sustained when a resident tried to strangle her. It was this incident that caused me to wonder about the extent and the severity of the problem.

I also began to wonder about my position as a manager in relation to this issue and my lack of ability to always provide a safe working environment for my staff. I had managed to prevent staff sustaining back injuries from lifting and believed that I had achieved a safe work environment. Unfortunately, reducing the incidence of injury from resident aggression was not as easy.

I believed that the incidence of aggression was increasing in aged care, and I felt that it was not commonly known among the community or the health professions. I thought that, if nothing else, this study would bring the issue of aggression to the notice of the public.

I had a very simplistic approach to fixing the problem. That approach was for aged care facilities to refuse to admit any person who displayed aggression. I felt that if these people were cared for in the public hospital system, then governments would be forced to find suitable accommodation for them.

I also felt that nurses who worked in aged care were ill-equipped to deal with the problem, and that there was a need for these people to be cared for by nurses who had psychiatric training or experience. I felt that the nursing home was not an appropriate environment for these people.
It was these assumptions that guided my initial thoughts as I set out on this journey. I arrived at a study question which asked: “In situations where personnel are managing aggression in people with dementia, what are the critical factors that impact on their response to that aggression?”

This question was broad enough to allow me the flexibility needed to conduct a study using a critical ethnographic approach, as I felt it was not only important to establish the nature of the environment, (context) but to also identify the experiences of nurses responding to outbursts of violence by residents in aged care facilities.

I was surprised by some of the outcomes. I found that violence was more prevalent than I had originally thought. Every person I interviewed had experienced violence and aggression from residents in one form or other. The fact that nurses in aged care accepted this aggression as part of the job was concerning, as was the fact that nurses believed that residents had all the rights and they had none. This belief was so ingrained that nurses were afraid to restrain a resident who was attacking a nurse with a piece of wood for fear of injuring the resident.

The likening of violence and aggression in the nursing home to violence and aggression in the home, thus making it acceptable, was yet another factor that I was unprepared for. The lack of support for those who were assaulted, and the tendency to believe that it was alright because the resident didn’t know what they were doing was also concerning.

Minimal education of staff, the need to get “the job done”, and the obvious lack of resources were also factors which contributed to this aggression.
This study has also highlighted the fact that the number of Registered Nurses in aged care is decreasing. In fact, legislative changes have perpetuated this, by removing the requirement for Registered Nurses in aged care. The implication is that our elderly don’t require as much skilled care as the young in our society. In this environment where the aged resident is becoming more and more frail, the opposite is in fact true. The need for Registered Nurses has never been as great as it is at this moment.

This study has only scratched the surface. The model suggested as a means of managing the behaviour and the suggested building designs need to be tested. Improved staff education is also important as well as the need to encourage a more positive view of aged care nursing to other nurses and university students.
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Interview Schedule for Nurses
INTERVIEW SCHEDULE FOR NURSES

Gender M/F Age:___________
Designation_________________
Fulltime/Part-time
How long have you been practicing as a nurse? ______
How long have you been working in aged care? ______
How long have you worked with residents with dementia? __________
What are your qualifications?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
Have you completed any extra study in relation to aged care? Yes/No.
If the answer is yes, what study have you completed?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Interview Questions

1. For the first five minutes I’d like you to talk about caring for people with dementia who display aggressive tendencies. That is, what is it like for you?
2. Describe your experiences with aggressive residents.
3. Has a resident ever hit/assaulted you in any way? Yes/No. (If answer is no, go to question 11, if answer is yes, go to question 4)
4. Would you please describe the assault? What were you doing at the time? What happened? How did you feel?
5. What did you do immediately after the event?
6. Describe the support you received from the following people:
   • Your immediate supervisor.
   • Management.
   • Your fellow workers.
7. Describe the reaction of your colleagues.
8. How do you feel about the support you received?
9. What measures should be taken to prevent such incidents from happening again.
10. Who or what was to blame for the incident?
11. Have you ever witnessed an assault on a fellow staff member by a resident? Yes/No. (If answer is no, go to Q 20, if yes, go to Q 12.)
12. Would you please describe the assault?
13. Describe the event as you saw it.
14. What did you do?
15. Describe your feelings following this event.
16. Describe the support you received from:
   - Your immediate supervisor.
   - Management
   - Your fellow workers.
17. Describe the reaction from your colleagues.
18. Who or what do you believe was to blame for this assault?
19. What measures could be taken to prevent such an assault from happening again?
20. Have you heard of, or been told of any other assaults on fellow staff members?
21. Describe the assault as you are aware of it?
22. How did you feel when you heard about this event?
23. Describe how your colleagues reacted?
24. Who or what do you believe was to blame for this assault?
25. What measures could be taken to prevent such an assault from happening again?
26. Do you and/or your colleagues have a formal opportunity for debriefing following the assault of a worker by a resident with dementia? Yes/No.
27. Describe this debriefing.
28. Did you find it to be beneficial?
29. If you were walking in the street and a person (not a person with dementia) came up to you and hit you, what would you do?
INTERVIEW SCHEDULE FOR DIRECTORS OF NURSING

Gender M/F

Age: _____________

Fulltime/Part-time________________________

How long have you been practicing as a nurse? ______

How long have you been working in aged care? ______

How long have you worked with residents with dementia? __________

What are your qualifications? _________________________________________
____________________________________________________________________

Have you completed any extra study in relation to aged care? Yes/No.
If the answer is yes, what study have you completed?

____________________________________________________________________
____________________________________________________________________

1. I would like you to talk for five minutes about your role as a Director of Nursing in relation to care of residents with dementia that experience episodes of aggression. You can talk about anything. I would like to know how it is for you.

2. Has an employee of yours ever been assaulted by a resident with dementia?

3. If so, can you describe the assault?

4. How did you feel about the assault?

5. What immediate action did you take?

6. What procedures were implemented to ensure that such an incident did not occur again?

7. Who or what do you believe was to blame for this assault? Please explain why you believe this.

8. What action do you take to ensure safety of staff in relation to assault from residents with dementia?

9. How do you assist staff who have been assaulted?

10. How do you assist other staff in your organisation following the assault on a fellow staff member?

11. Do you have procedures in place to ensure staff receive appropriate follow up? Please describe these procedures.

12. Why do you think residents assault nursing and other staff in nursing homes?
A STUDY TO DESCRIBE AND ANALYSE THE CONTEXT OF PRACTICE AND EXPERIENCES OF NURSES WHO WORK IN A NURSING HOME SETTING AND CARE FOR RESIDENTS WHO SUFFER FROM DEMENTIA AND DISPLAY AGGRESSION.

This study is being conducted by Jean Booth, RN., BHSc, MHSc, PhD Student of the Faculty of Nursing at The University of Newcastle. It is a critical ethnographic study. The supervisors for this research project are Professor Irene Stein and Professor Margaret McMillan, Professors of Nursing at the University of Newcastle.

The purpose of the study is to describe and analyse the context of practice and experiences of nurses who care for residents who suffer from dementia and display aggression in the Nursing Home setting. It is important to supplement participant observation data with other data to complete the description of the culture and the context in which aggression occurs and is managed.

In order to fully understand this, the researcher will undertake a period of non-participant observation for a period of two weeks. The researcher will observe and record the activities that occur in the unit in which the nurses are working. This observation includes the residents who live in the unit. It does not mean that every resident who is observed during this time will be aggressive.

All information obtained will be confidential, and the residents will be assigned a number to enable the researcher to identify them. There will be no identifiable information in the completed research report.

If you feel that you do not want your family member to participate in this research, then neither you nor your family member will suffer any recriminations. Also, if you choose to withdraw your family member from this study during the course of the study, you are free to do so, and neither you nor your family member will suffer any recriminations. You are also at liberty to withdraw any data that relates to your family member.

If you have any further questions regarding this study, you may contact Mrs Booth on 0358813944: 0358814012 or 0412766320.

The University of Newcastle requires that all participants are informed that if they have any complaint concerning the manner in which a research project is conducted it may be given to the researcher, or, if an independent person is preferred, to the University's Human Research Ethics Officer, Research Branch, The University of Newcastle, Callaghan NSW, 2308. Telephone: 0249216333.
APPENDIX C

Consent Form Resident/Family
STUDY TO DESCRIBE AND ANALYSE THE CONTEXT OF PRACTICE AND EXPERIENCE OF NURSES WHO WORK IN A NURSING HOME AND CARE FOR RESIDENTS WHO SUFFER FROM DEMENTIA AND DISPLAY AGGRESSION.

I ______________________________, agree to my ________________________________ participating in a study to determine and describe the experiences of nurses who care for residents with dementia who display aggression in the nursing home setting.

I am aware that my ________________________________ will not be harmed in any way during this study. I am aware that the study will involve observation of my ________________________________ over a period of fourteen days.

I am aware that all information relating to my ________________________________ is confidential and he/she will not be recognizable when the research is published.

I am aware that all data relating to this study will be stored at The University of Newcastle and that ________________________________ will not be identifiable in this material.

I have been given a copy of this agreement for review, and I understand that if I choose to withdraw my ________________________________ from this study, my ________________________________ will not suffer in any way.

If I have any further questions, I may contact Mrs. Booth on 03 5881 4012; 03 5881 3944; or 0412 766 320.

_________________________________       _____________________
Signature Participant/Representative                      Date

_________________________________       ______________________
Signature Researcher                                        Date
APPENDIX D

Information Sheet Nurses
A STUDY TO DESCRIBE AND ANALYSE THE CONTEXT OF PRACTICE AND EXPERIENCES OF NURSES WHO WORK IN A NURSING HOME SETTING AND CARE FOR RESIDENTS WHO SUFFER FROM DEMENTIA AND DISPLAY AGGRESSION.

This study is being conducted by Jean Booth, RN, BHS, MHSc, PhD student of the Faculty of Nursing at the University of Newcastle. The supervisors for this research project are Professor Irene Stein and Professor Margaret McMillan, Professors of Nursing at the University of Newcastle.

The purpose of the study is to describe and analyse the experiences of nurses who care for nursing home resident with dementia who display aggressive outbursts.

The participant will be asked to meet with Mrs Booth for one thirty-minute interview. This interview will be recorded on an audio cassette.

The record of this interview will be stored with The University of Newcastle on completion of this study. All reference to a subject that may be a means of identifying the subject will be removed as soon as the interview is transcribed. Participants may review, edit or erase the tape recording of their interview if they so wish. Once transcribed, and following the checking of the transcription with the tape, the original tape will be destroyed.

All information or personal details gathered in the course of this research about participants is confidential and neither the participant's name or any other identifying information will be used or published without the written permission of the participants.
Participants in this study will be free to withdraw from the study at any time and in doing so will not be subjected to any penalty or discriminatory treatment. You are also at liberty to withdraw any data that relates to your family member.

If the participant has any further questions about the study, they may contact Mrs Booth on 0358814012; 0358813944; or 0412766320.

The University of Newcastle requires that all participants are informed that if they have any complaint concerning the manner in which a research project is conducted, it may be given to the researcher, or, if an independent person is preferred, the University’s Human Research Ethics Officer, Research Branch, The Chancellery, University of Newcastle, Callaghan NSW 2308. Telephone: 0249216333.
APPENDIX E

Consent Form Nurses
A STUDY TO DESCRIBE AND ANALYSE THE CONTEXT OF PRACTICE AND EXPERIENCES OF NURSES WHO WORK IN A NURSING HOME SETTING AND CARE FOR RESIDENTS WHO SUFFER FROM DEMENTIA AND DISPLAY AGGRESSION.

I, ____________________________, aggress to participate in a study to determine and describe the experiences of nurses who care for residents with dementia who display aggression in the nursing home setting.

I am aware that my participation in this study is voluntary and that I may withdraw at anytime without jeopardy to myself.

Jean Booth RN, BHSc, MHSc, PhD Student of the Faculty of Nursing at the University of Newcastle, has discussed the nature of the study with me, informing me there are no known risks in participating. I am also aware that there are no known benefits and that I will receive no financial compensation for participating.

My participation will involve meeting with Mrs. Booth for one interview of approximately thirty minutes in duration. As well, Mrs. Booth will observe my unit over a period of fourteen days.

My name will not appear in the final report of the study, and all information I share with Mrs Booth will remain confidential.

I have been given a copy of his agreement for review. If I have any further questions I may contact Mrs. Booth on 03 5881 3944; 03 5881 0412; 0412 766 320.

I am also aware of the avenues I may use should I wish to complain about any aspect of this study or the way it has been conducted.

_______________________________________         _________________________
Participant’s Signature                                                  Date

_______________________________________           ________________________
Researcher’s Signature                                                     Date.
Letter to Families
Dear Family/Carer

My name is Jean Booth and I am a PhD student of the Faculty of Nursing at the University of Newcastle.

As well as the studies I am undertaking with the University of Newcastle, I am also a Director of Nursing of an aged care facility.

The purpose of this letter is to explain to you the study I am undertaking which is aimed at describing the practice and experience of nurses who care for residents who suffer from dementia and display aggression in the nursing home setting.

In order to understand this I would like to undertake a period of observation in your nursing home for a period of two weeks. I would like to observe and record the activities that occur in the unit in which the nurses are working. This observation includes the residents who live in the unit. It does not mean that every resident who is observed during this time will be aggressive.

All information obtained will be confidential, and the residents will be assigned a number to enable me to identify them. There will be no identifiable information in the completed research project.

If you feel you do not want your family member to participate in this project, then neither you, nor your family member will suffer any recriminations. Also, if you choose to withdraw your family member from the study, during the course of the study, you are free to do so, and neither you nor your family member will suffer any recriminations. You are also at liberty to withdraw any data that relates to your family member.

I have obtained ethics clearance from the appropriate bodies. I have also received permission from your organisation to conduct this study in the facility. This permission is given on the understanding that correct procedures are followed in relation to confidentiality, and that I obtain permission from those who will be involved in the study.

I also have a current police clearance. I am happy to show you the relevant documents at any time.

My supervisors are Professor Irene Stein and Professor Margaret McMillan, professors at the University of Newcastle.
The University of Newcastle requires that all participants are informed that if they have any complaint concerning the manner in which a research project it may be made directly to the researcher, or if an independent person is preferred, to the University’s Human Research Ethics Officer, Research Branch, The University of Newcastle, Callaghan, NSW, 2308. Telephone: 02 4921 633.

If you are happy for your relative to participate in this study, or would like to find out more about this study, please indicate on the form provided and place in the stamped addressed envelope and post to me. Following receipt of this form, I will contact you to explain the study further, and to obtain your formal consent. Likewise, if you are unsure about this study and would like further information, please indicate on the form.

If you would like to talk to me about this study, please phone me on 0412 766 320.

Yours sincerely,

Jean Booth

Please tear off below and return to me in the enclosed stamped addressed envelope.

___________________________________________________________________________________________________________________________________

I would be interested in talking to Mrs. Booth to find out more about this study.

Name: ____________________________
Phone number: _______________________

Please Note: This is NOT consent for your relative to participate in the study.
APPENDIX G

Audit Trail
Research question 2 deals with management, communication, support, nurses’ responses to aggression.

Codes used for Q2

- context (con)
- timing (tim)
- nurse’s response/experience (nre)

Excerpt 1C Enrolled nurse

*It doesn’t really worry me a great deal (Q2 nre)* I won’t turn… If…there’s an aggressive resident with dementia standing there and who is sort of attending, or addressing their aggression towards me *I don’t run, turn around and run I will stand and I will try and talk the person around, um with a calming affect, find, try and find out what the point of their aggression is, what’s causing their aggression…try and approach them, Not directly on you come sideways, cause if you come directly on your affronting them, con confronting them and they that’s makes them more aggressive you go up, you could, um… and also you’re invading their personal space, which they don’t like if you go and I also put your hand on their forearm that way, if they go to hit, I’ve got control of that hand, which, you know, which is a good thing. I don’t get hit very often (Q2 nre), I can usually tell, you can tell, oh, nine times out of ten, you can tell when the hit’s coming (Q2 tim) and you can take evasive action, but if they’re standing up and they’re…..um…..towards…… if you held onto their hand well you’ve got control of it. *I also like to have the eye to eye contact with them, talking, talk directly into their eyes. Don’t look away because they think that they’ve got you frightened (Q2 nre)*, I think you’ve got to present them with a confident attitude and let them know that, even though they’re being aggressive to you, they’re not frightening you *Because if they think they’ve got you frightened they’ve won, and you may as well walk away from the situation. (Q2 con)* But you, but you don’t become aggressive back you just have like a confident, *calming approach to them (Q2 nre)*. And I’ve found, over many years that that sort of a approach has worked. Um *try not to talk in a condescending manner, um remember that they are adults, and talk, you know, to them as you would as, you know, an adult, and as I said try and find out what’s upsetting them if they’re, and also if they’re being upset in a room with other people, just try and take ‘em away from the situation so you’re not making their situation feel (Q2 re)*, they feel um more uncomfortable when displaying their aggressive actions in front of other people cause then that can demean them as well. *Sort of take them away and have a quiet chat to them on the side if you can, but that is not always possible, and, always try and walk*
beside them that way, you’re not, you’re not overpowering them. Or they don’t feel like you are. I think you’re sort of working with a steel fist in a velvet glove (Q2 nre)

From field notes:
The choice of the critical incident provided greater depth of representation of behaviours that were conducive to minimisation or exacerbation of instances of aggressive behaviour

<table>
<thead>
<tr>
<th>Example of situation demonstrating recurring theme</th>
<th>Excerpts from field notes - recorded observation</th>
<th>Interpretation from application of CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff were <strong>polite &amp; respectful</strong> to residents</td>
<td>Staff demonstrate respect consistent with Codes of Professional Conduct</td>
<td></td>
</tr>
<tr>
<td>Actions observed</td>
<td>“Do you want to have your shower, now (name)?” “Would you like to go to the toilet?” “Would you like a cup of tea?” Staff always spoke to the residents as they entered and left a room Q2 nre. Site 1 EN conversation</td>
<td>Respectful behaviour Meets need for privacy.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Lack of incidents which provoked aggression</td>
<td>Demonstration of sensitivity, concern consistent with Guidelines for professional Boundaries (NSW NRB 1999)</td>
</tr>
<tr>
<td>Example of situation demonstrating recurring theme</td>
<td>There was also a <strong>sense of “family”</strong> in this facility, a sense of belonging &amp; sharing in care</td>
<td>Staff demonstrate respect and listening</td>
</tr>
<tr>
<td>Actions observed</td>
<td>All staff (including the Director of Nursing, the Chief Executive Officer and the laundry staff)</td>
<td>All staff noticing the resident</td>
</tr>
</tbody>
</table>
knew the residents well and took time to chat to them as they visited the house Q2 nre Site 1 observation.

| Outcome   | Staff created a sense of belonging | Sense of homeliness for resident | Person-centred care Consistent with Codes and Guidelines |

1. Key emergent descriptors of behaviours were identified from the participant responses
2. Emergent descriptors were clustered
3. Clusters were themed into areas indicative of the presence or absence of behaviours that act as catalysts for aggression (see figures 5.5, 5.6 and table 5.12)