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Understanding How the Social and Cultural Capital of Certified Nursing Assistants Interacts within the Nursing Home Culture

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Understanding How the Social and Cultural Capital of Certified Nursing Assistants Interacts within the Nursing Home Culture

Abstract
Certified nursing assistants (CNAs) are the primary caregivers with the most frequent, intimate contact with residents, influencing the resident’s quality of life. The current nursing literature does not explore how CNAs’ cultural and social capital interacts with the institutional culture of the skilled nursing home. The purpose of this focused ethnographic study was to understand the cultural and social capital of the CNA, and how a CNA interacts within the skilled nursing home institutional culture. A purposive sampling of CNAs from a skilled nursing home in Upstate New York was invited to be part of the study; 21 CNAs chose to participate. Data were collected through semi-structured interviews with the CNAs and cognitively intact residents, focus groups of the nursing staff and environmental service aides, participant observation and field work journaling. Data were analyzed using Atlas ti™, with repeated reviews to develop domain analysis, a cultural inventory and the cultural themes. Themes identified were We are like family with a subtheme of Protecting family from outsiders and We work together (Teamwork), Communication skills which build relationships, Learning caring from Home, Lessons about being a worker and We influence each other becoming family . Findings of this study revealed that within the study setting the CNA participants identified the importance of developing connections and interacting with the residents and coworkers as family. A contribution of this study to the literature was the recognition of the need to focus on the nonpermanently assigned (per diem/float) CNAs and their role in the institutional culture.

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Understanding How the Social and Cultural Capital of
Certified Nursing Assistants
Interacts within the Nursing Home Culture

By
Linda M. Baier

Submitted in partial fulfillment
of the requirements for the degree
Ed.D. in Executive Leadership

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Dedication

This work is dedicated to Dr. Demetrius George Moutsos who encouraged and supported me and my efforts throughout this learning process.
Biographical Sketch

Linda M. Baier is retired from St. John’s Home, where she was the Staff Development Manager for 23 years. Ms. Baier attended The State University College of Technology at Utica/Rome from January 1976 to December 1976 and graduated with a Bachelor of Sciences in Nursing degree in 1976. She attended The State University of New York at Buffalo from 1978 to 1980 and graduated with a Master of Sciences in Nursing degree in 1980. She came to St. John Fisher College in the summer of 2008 and began doctoral studies in the Ed.D. Program in Executive Leadership. Ms. Baier pursued her research in Understanding How the Social and Cultural Capital of Certified Nursing Assistants Interacts within the Nursing Home Culture under the direction of Dr. Mary S. Collins and received the Ed.D. degree in 2012.
Abstract

Certified nursing assistants (CNAs) are the primary caregivers with the most frequent, intimate contact with residents, influencing the resident’s quality of life. The current nursing literature does not explore how CNAs’ cultural and social capital interacts with the institutional culture of the skilled nursing home. The purpose of this focused ethnographic study was to understand the cultural and social capital of the CNA, and how a CNA interacts within the skilled nursing home institutional culture.

A purposive sampling of CNAs from a skilled nursing home in Upstate New York was invited to be part of the study; 21 CNAs chose to participate. Data were collected through semi-structured interviews with the CNAs and cognitively intact residents, focus groups of the nursing staff and environmental service aides, participant observation and field work journaling. Data were analyzed using Atlas ti™, with repeated reviews to develop domain analysis, a cultural inventory and the cultural themes. Themes identified were We are like family with a subtheme of Protecting family from outsiders and We work together (Teamwork), Communication skills which build relationships, Learning caring from Home, Lessons about being a worker and We influence each other becoming family.

Findings of this study revealed that within the study setting the CNA participants identified the importance of developing connections and interacting with the residents and coworkers as family. A contribution of this study to the literature was the
recognition of the need to focus on the nonpermanently assigned (per diem/float) CNAs and their role in the institutional culture.
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Chapter 1: Introduction

Introduction and Purpose

In the United States, individuals who were in need of ongoing long term physical care related to age or disability may reside in a skilled nursing home (SNH). There were 16,100 SNHs with 1.7 million beds in the U.S., including 638 SNHs in New York State. Within these New York State nursing homes there were 108,779 individuals (Statehealthfacts.org. 11-16-09) who were permanent residents. A SNH’s admission policy identifies services provided and age group(s) within the home, reflecting a portion of the culture of the SNH. A skilled nursing home employs nurses and certified nursing assistants (CNAs) who were available to care for residents 24 hours a day. CNAs assist residents with activities of daily living including eating, dressing, toileting, transferring, and bathing, and were expected to develop a therapeutic relationship with each resident. Nurses, registered and licensed practical, assess or collect data on the residents’ physical, psychosocial, mental, and emotional needs, give medications, physical treatments, oversee the care provided by the CNAs, and provide or assist with residents’ physical care when needed.

Each staff member brings to the job a personal perception of the elderly and the SNH environment. Interactions within the SNH setting were a product of, or were influenced by, the institutional culture of the SNH and the cultural and social capital of the residents and each employee. Cultural capital was defined as the rules and values an individual learns in childhood from their family of origin. Cultural capital provides the
skills and attributes that inform the individual as to how to respond to rules and regulations in a setting (Bourdieu, 1986). Social capital was the ability of an individual to develop a relationship with another person. Social capital reflects the individual’s ability to make social connections and maintain social relationships throughout life (Bourdieu, 1999). These concepts will be defined in greater depth below. The staff member’s perception of the skilled nursing home’s institutional culture and the elderly was shaped by the staff member’s cultural and social capital. Because certified nursing assistants comprise the largest part of the workforce in a skilled nursing home and have the most frequent, intimate contact with residents, it was important to know how the CNAs’ cultural and social capital interact with the skilled nursing home culture.

*Cultural and Social Capital*

Bourdieu (1986) identified cultural capital in three forms: embodied, objectified, and institutionalized. Embodied cultural capital was defined as the form of long lasting dispositions of the mind and body, or the culture of the individual, which was transmitted over time through the family of origin. Embodied culture included the rules and values learned within the family. Objectified cultural capital focused on the material objects such as instruments, or paintings, which were considered by the individual to be of value. Institutionalized cultural capital was defined as academic achievement, the need for the specific type of academic achievement within an institutional setting. In this study, embodied cultural capital was the focus as defined by Bourdieu.

Webb, Schirato and Danaher (2002) stated that cultural capital provided structure for an individual to respond in an institutional setting, such as school or work. Cultural capital was further defined as carrying importance or worth in the form of pride or
prestige related to the individual’s knowledge or skills. However, the importance or worth of cultural capital varied from person to person and setting to setting. For example, a resident in a skilled nursing home setting may have held a position as president of a company, which carried a great deal of cultural capital in the community, but as a resident in a skilled nursing home, this past position may not carry the same level of cultural capital. For a CNA, the individual may be the decision maker within her own family, providing her with a greater sense of cultural capital than at work where she was unable to make decisions related to job duties, work schedule, or how to provide care to a resident.

Social capital was defined as the connections between people (Bourdieu, 1999). People develop relationships throughout their lives, friends from school, memberships in church, community organizations or clubs, reflecting social capital. Each CNA relied on his/her cultural and social capital to determine how to function in the institutional culture and how to respond and develop a relationship with a resident. Each SNH has a specific institutional culture that reflected how the skilled nursing home functioned, including the expected behavior of employees and residents.

Institutional Culture

In the literature, the terms institutional and organizational culture were used interchangeably. For the purposes of this study the term institutional culture was used to refer to both institutional and organizational culture. Bolman and Deal (2008) described institutional culture as “revealed and communicated through its symbols” (p.254). Each institution’s symbols reflected its vision, mission and values, past influential formal and informal leaders, and philosophy. The philosophy or model of care the skilled nursing
home used to provide services to the residents was also part of the institutional culture. For example, the admission policy of the SNH was a symbol of the types of services the SNH was able to provide to residents. Clarke (2006) defined organizational culture as the way things were done in a specific organization. This may include spoken and unspoken rules, the values, and expected behaviors or approaches in the institution.

Each SNH identified the types of services available to residents. State and federal regulations also provide oversight for resident services. For example, the federal Resident Rights Bill, passed in 1987 as part of OBRA, provided the resident with guidelines for resident behavior within the SNH (Institute of Medicine, 1986). Residents have the rights of a citizen of the United States within a SNH except a resident are not able to “bear arms” or have a weapon in the SNH (www.cms.gov, 5-8-10).

The institutional culture also identified for staff what the expectations of staff behavior were within the facility. Each employee received this information through orientation to the skilled nursing home, in the SNHs’ mission statement and values, and the employee handbook. While the concept of an SNH was well established in U.S. society as a care setting for the elderly who need ongoing physical care, many people believe that nurses were the staff providing the majority of care to residents. However, it was the certified nursing assistant who spends the most time interacting with the residents throughout the 24-hour period. Because the CNAs were most closely associated to resident care, the CNAs were the focus of this study. Within the institutional culture, the SNH chose the model to follow to provide care. Many SNHs used the medical model of care to provide services to residents.
The medical model of care primarily focused on treating disease processes and the physical health of the resident. In nursing homes using the medical model of care, the physician oversees residents’ care needs, in a hierarchical organization. Each resident unit was managed by a registered nurse manager, with the CNA as the last in the line of the hierarchy. The CNA most frequently provided physical care for the residents. For some SNHs, the medical model was perceived as too heavily focused on treating disease processes and the physical health needs of the resident, with minimal attention given to the resident’s social needs while living in the skilled nursing setting. These skilled nursing homes were moving to a social model of care known as person-centered care.

The social model of person-centered care returns decision making about daily life routines back to the resident, in partnership with the CNA (Flesner, 2009; Pioneer Network, 2009). In the person-centered care model, the resident and CNA worked together to meet the residents’ expectations for daily living within the person-centered culture. One form of person-centered care was the Eden philosophy. This social model focused on mutual decision making between the resident and the CNA (Thomas, 1992). Decisions included what and when routine activities occurred during the day, such as what time to get up, what to have for each meal, bath time, bed time, and activities for the day. A focus of the Eden philosophy was to build a relationship between the resident and the certified nursing assistant. Within the Eden philosophy a relationship was defined as opportunities to understand and be understood and give and receive from another (www.edenal.org/embracing-elderhood, 11-27-09.) Meeting the residents’ health needs was also a part of the social model, but disease process and physical health needs were not the primary focus of the resident’s care as in the medical model. Regardless of the
type of care, medical or social model, it’s the institutional culture that identified expected employee and resident behavior in the skilled nursing home. The role of the certified nursing assistant was interwoven within the SNH culture and the residents’ care.

Certified Nursing Assistants

Certified nursing assistants were typically high school graduates or were individuals with a general education development certificate (GED), who had taken the federal and state required 100 hours of certified nursing assistant training (New York State Department of Health, 2006) and passed the written and clinical tests. Instructional topics required in the CNA training include Basic Nursing Skills, Personal Care Skills, Mental Health and Social Service Needs, Care of Cognitively Impaired Residents, Basic Restorative Services, and Residents’ Rights (Appendix A). Threaded throughout the CNA training program was the focus on dignity and respect or worth of each resident as an individual. Two other key threads during the training were an understanding of the range of diversity of individuals, and lastly, a demonstration of therapeutic relationships between the caregiver and the resident. As an integral portion of the training it was expected that a person completing the CNA program would strive to implement these four threads into the care provided to residents. The importance of these threaded concepts may become devalued by the CNA as s/he strives to learn about the medical model within the institutional culture, and was trained in the role of the nursing assistant.

The 100 hours of nursing assistant training program followed the medical model of care, reflecting the same medical model of care used in traditional skilled nursing homes. The medical model focused on the more common disease processes in the elderly, such as cognitive impairment, as well as the physical care of the resident. Upon
completion of the 100 hours of the federally mandated nursing assistant training program and successfully passing the required tests, the individual was certified by the state of residence. The 100 hours of training and certificate are required of the CNA prior to hiring by SNH. For a SNH to hire an individual as a CNA, the individual must have a current certificate within the state the individual was seeking employment and the SNH must verify through the state nurse aide registry the individual’s certificate was current and valid. As the new CNA began employment in the skilled nursing home setting, the four key threads, dignity, respect, diversity and therapeutic relationships, from the CNA training program were reviewed and discussed in orientation.

A job description was given to each new CNA employee identifying the specific duties required of the position (Appendix B). Hierarchy of care for the resident was identified for the new CNA during orientation; the physician determined the medical care needs of the resident, the registered nurse manager oversaw the functioning of the unit, the registered and licensed practical nurse oversaw the care of the resident, and the CNA provided the resident with physical care. During the CNA training program, individuals were taught that the registered nurse manager on the unit oversaw the functioning of the unit and any concerns about residents during the CNA’s shift needed to be reported to the registered nurse or licensed practical nurse in charge. As the CNA moved to employment in a SNH, the model of care within the SNH may be different from the medical model within which the CNA trained.

_CNA orientation._ When a CNA joins the staff of a SNH, attendance was required for the general orientation. All CNA’s attend the same orientation regardless of part time, full time or nonpermanently assigned (per diem/float) status. During the orientation
the CNA was introduced to the SNH mission, vision, values, and Eden philosophy. The mission, vision, and values identified for the CNA the expectation of the SNH related to the CNA’s working with the residents. All CNAs, part time, full time, nonpermanently assigned (per diem/float), were expected to develop a therapeutic relationship with the resident(s). During the general orientation, the CNA was also introduced to the residents’ rights, which reinforce respect, dignity, therapeutic relationships, and diversity. Beyond the general orientation, the CNA was instructed on the specific skills required from the CNA Skills Inventory, which was a standardized form for all CNAs employed at SNH in the study setting. Nursing orientation focused on physical skills that the CNA was expected to use while caring for a resident as well as the importance of and how to effectively develop relationships with residents.

These specific CNA classes often focused on communication, body language, tone of voice, resident rights, and disease process, which may influence effective communication, and/or resident interaction. For example, Berdes and Eckert (2001) reported that the CNA’s view of racial remarks from residents varied based on the resident’s cognitive status. The CNA’s ability to demonstrate respect or develop a therapeutic relationship with that resident may be influenced by the resident’s mental status. The CNA may feel less threatened by racial remarks from a cognitively impaired resident and consider the remark related to the resident’s dementia. But the CNA may feel very threatened by racial remarks from a resident who was cognitively intact. Regardless of the resident’s cultural or social capital, the expectation of the SNH was for the CNA to demonstrate the aforementioned threads of respect, dignity, diversity, and therapeutic relationships with the residents. Developing therapeutic relationships,
showing dignity, respect, and diversity to residents may be overwhelming for the CNA who had not had those concepts as part of their family rules or values, or for those CNAs who were unfamiliar with the expectations of the institutional culture on the CNA’s behavior. The CNA may, however, be focused on other aspects of his/her new role - the medical model skills such as bathing, turning, etc. It was important to uncover what the CNAs perceptions were regarding the institutional culture and the CNA’s responses to situations caused by residents and others involved in the workplace culture.

During the orientation process, the CNA was precepted by another experienced CNA from the unit. The preceptor has the opportunity to observe the CNA’s interactions with residents. Any difficulties identified with the CNA’s interaction with residents were brought to the registered nurse manager and to the staff educator. Any issues the CNA demonstrated during the orientation period were addressed by discussion with the CNA and reeducation was scheduled if needed.

A requirement of the CNA certification from the federal government was ongoing education focusing on geriatrics. As an employee, attendance at six hours of geriatric education was required of the CNA every six months. This education was provided in a variety of methods, reading materials, classes, video tapes, and discussions. In these classes respect, dignity, diversity, and therapeutic relationships were frequently reviewed. Building on these four threads, the CNAs were expected to use this information when caring for and interacting with the residents.

Despite these efforts, evidence continued to show that in some SNHs, some CNAs do not apply the four threads during interactions with residents (Tellis-Nayak & Tellis-Nayak, 1989, Berdes & Ekert, 2001, Allensworth-Davies, et al., 2007). According to
these studies, registered nurse managers find that some CNAs do not follow through with these expected behaviors of interaction with the residents on the unit. These CNAs may not smile at residents, or not respond to a resident’s request or may have a harsh tone of voice when speaking to a resident. This lack of therapeutic relationship can stifle relationship building between the CNA and the resident, which was inconsistent with the institutional culture.

The Residents

Skilled nursing homes vary in size, location, and capacity for residents. The SNH that was the setting for this study was located in an urban setting and has the capacity for 475 residents. Within this SNH the majority, (363 of 475 residents) were female and Caucasian. The admission philosophy of this SNH, hereafter referred to as “The Home” was nondenominational, focusing on meeting the individual’s health and psychosocial needs. Review of prospective resident’s health and psychosocial needs occurred prior to admission, examining specific care needs and The Home’s ability to meet those needs. The Home did not provide care for residents who were below the age of 50 or who needed ventilator care, as that particular nursing skill was not available. Residents come from urban, suburban, and rural settings. These settings affect the resident’s social and cultural capital.

The cultural and social capital of the SNH residents may vary greatly compared to the CNA (Tellis-Nayak & Tellis-Nayak. 1989). These differences may have contributed to difficulty developing therapeutic relationships with the residents for some CNAs. The behavior of the resident may contribute to the lack of respect and dignity demonstrated by
the CNA. The literature revealed potential barriers to CNA/resident relationships which can be formed from either the resident or the CNA source.

The Setting

Skilled nursing homes provided care for individuals who have significant deficits in activities of daily living. The age group, and types of services provided within the SNH also vary depending on the SNHs philosophy and mission. Some SNHs were part of a larger health care organization, or have religious affiliation or may be independently owned. The SNH this was located in urban upstate New York.

Established in 1898, The Home has been on its current site since the early 1920s. In 2002, The Home adopted the Eden philosophy (a person-centered model) as its culture, training staff for the past seven years on the principles, concepts, and meaning of the Eden philosophy. However, the medical model of care continued to be used as well within The Home. The mission and vision of The Home was reflective of Eden philosophy: to “nurture life with vibrant, caring and life affirming relationships” and the vision “to be the premier Long Term Care community that nurtures and strengthens the gifts and relationships of all, by working together and living our values.” The Home enumerated five values which reflect both the mission, and vision statement. The five values focused on kindness, appreciation, respect, integrity, and thriving spirit. The mission, vision, and values were identified and discussed with new employees during general orientation and reviewed with established staff throughout the year.

Resident units varied in size from 19 to 42 beds. Each unit at The Home was managed by the registered nurse (RN) manager who was responsible for managing resident care during the 24-hour period. Licensed practical nurses (LPN) administer
medication and treatments to the residents. Certified nursing assistants provided most of the personal care and were to follow the assignments given, follow the residents’ plan of care, along with policies and procedures related to the plan of care and were restricted from making decisions regarding care.

The number of staff on each unit varied depending on the shift and the number of residents on the unit. A unit of 42 residents would have a registered nurse manager, possibly an assistant registered nurse manager, 3 licensed practical nurses and 5 to 6 CNAs. Each CNA’s nursing assignment varied per shift from seven to nine residents, depending on resident needs. Throughout the 8 hour shift, resident care consisted of providing help with physical care needs, such as bathing, dressing, toileting, transferring, and feeding, transporting residents to appointments, activities, and interacting with residents during all these activities. Interacting positively with family members and visitors of the residents was also expected because establishing relationships with residents was such an integral expectation of the CNA role and reflected the institutional culture including the Eden philosophy. For this reason, it was important to study the factors that facilitate or hinder the development of these relationships. Exploring the cultural and social capital of CNAs and residents provided insight to this issue.

*Institutional Culture of “The Home.”* The institutional culture of The Home was comprised of a variety of components including residents, CNAs, nursing and non-nursing staff, the medical model, and the Eden philosophy of person-centered care. Other components that influence The Home’s culture included the state and federal regulations that guide the functioning of The Home. The registered nurse manager coordinated the activities of the unit, attempting to balance CNA assignments in order to meet the needs
of the residents and maintain the cohesion of the staff on the unit. Experience as a registered nurse manager and a leader varied. Some registered nurse managers had been in the position for over 25 years, while others had been in the position for less than a year. The educational background of the registered nurse managers varied: some have an associate degree, others a bachelor’s in nursing, and one was master’s prepared as a nurse practitioner. The educational preparation of the registered nurse manager influenced their leadership skills. An associate degree registered nurse had technical training as a registered nurse, a bachelor’s degree registered nurse was professionally prepared, and a master’s degree registered nurse had advanced preparation in nursing (www.nursingworld.org, 5-11-10). The leadership skills and the personal and educational background of the registered nurse manager influenced how CNAs were managed on the unit. Within the culture of The Home, CNAs were involved with nursing and other health disciplines as part of resident care.

Many other health disciplines were involved with resident needs and care on the unit throughout the day and were part of the culture of the nursing home. A resident received services from a social worker, a therapeutic recreation specialist, dietician, physical, occupational and speech therapists, physician, and nurse practitioner. Non-professional staff, such as environmental service, maintenance staff, and dining service staff also interacted with the resident throughout the day. CNAs had ongoing interaction with these staff members as well as other registered and licensed practical nurses and CNAs throughout the facility. CNAs also interacted with family, visitors, and volunteers, mostly between the hours of 8 a.m. to 7 p.m. However, there was the possibility of visits at any time during the 24-hour period as there were no set visiting
hours. The Home operated 24 hours a day, 7 days a week with nursing staff working to provide resident care during the 24-hour period. The amount and depth of interaction with a resident and a CNA were directly affected by the shift the CNA works. The medical model of care within the SNH included following specific timeframes for routine activities of life, such as meal times, times for medications, and specific employee roles. As a result of the recent implementation of the Eden philosophy, the culture was shifting to a person-centered culture, which aimed to have CNAs involve the residents with making more daily life choices such as what time to get up, what activities to be involved in, when the resident would like to eat, etc. To prepare for data collection, the researcher wrote down personal views of the skilled nursing setting and the institutional culture to provide insight to potential bias from the researcher.

Problem Statement

Cultural and social capital have been used to study student success in schools (Lareau & McNamara Horvart, 1999; Sullivan, 2002; Georg 2004), and the influence on interpersonal interactions in homeless shelters, obtaining career and financial support from family and friends, and between nurses on patient care units (Emirbayer & Williams, 2005; Parks-Yancy, DiTomaso, & Post, 2006; Lauzon-Clabo, 2007). However, the cultural and social capital of certified nursing assistants in skilled nursing homes had not been studied. The purpose of this focused ethnographic study was to understand the cultural and social capital of the CNA, and how a CNA interacted with the skilled nursing home institutional culture.

The focus of this study was how the CNAs’ cultural and social capital interacted with the institutional culture and how CNAs perceived the skilled nursing home
institutional culture. Could this be linked to the CNA’s particular social capital skills? Positive relationship skills may be demonstrated through the body language of the CNA such as smiling at a resident, or looking at the resident when speaking.

Theoretical Rationale

Bourdieu’s (1977) Theory of Practice provided the theoretical rationale for this study. His Theory of Practice attempted to describe and explain the relationships between people, why they do what they do, and the relationships between people and social structures such as skilled nursing homes. This theory further explored how an individual’s culture, traditions, and environmental background influenced the individual’s behavior in society. Within a group, it was not the collective behavior of each individual in that group, but the effect of influences from each individual’s background in the group that influenced individual behavior in society. A complex theory, Bourdieu’s framework includes three concepts: habitus, field, and capital. The concepts of habitus, field, and capital were representative of the social world according to Bourdieu (Bourdieu; Webb et al., 2002; Rhynas, 2004).

Capital was broadly defined by Bourdieu (1986), and included social, cultural, economic, and symbolic forms. Within this study the two forms of capital explored were cultural and social. Cultural capital was defined as the rules and values an individual learns as a child in the family of origin. These rules included how to address an adult or older person, when it was appropriate to smile at a stranger, the type of clothing to wear when going to work as opposed to going to church, for a few examples. Social capital, defined as the ability to make connections with others (Bourdieu, 1999), was an expected capital of the certified nursing assistant in the skilled nursing home and was used in
establishing relationships with their assigned residents. Each individual developed social capital within their life which was influenced by a variety of factors: childhood community, parents’ friends, parents’ educational level, parents’ view of educational attainment, and what the parents consider an appropriate profession for their child, were but a few of the factors (Bourdieu, 1986). Use of cultural and social capital was influenced by the setting. This focused ethnographic study explored how the CNAs’ cultural and social capital interacted within the institutional culture.

The method used in this study was focused ethnography. Focused ethnography explored a specific problem studied within a single milieu with a limited number of individuals (Speziale & Carpenter, 2007, Richards & Morse, 2007, Morse & Fields, 1995). Focused ethnography provided the researcher with the opportunity to observe the culture of the CNA, explore the CNA culture through individual interviews and focus group participation, and explore the CNA culture with the registered nurse manager, registered nurses, licensed practical nurses, environmental service aides and cognitively intact residents from the units of the CNA participants.

Significance of the Study

As the aging population grows and more people enter nursing homes, it was desirable for the resident, the CNA and the SNH, to establish a positive connection with their caregivers. Effective relationships between CNAs, residents, and other personnel of the nursing home culture were a critical and necessary element for quality care and effectiveness in any skilled nursing home. Within the social model (person-centered care), an effective relationship between the CNA and resident influenced the CNA’s ability to follow the resident’s daily life choices. The literature revealed that frequently
the majority of individuals who choose a service job as a career (as opposed to a temporary job on the way to a health profession positions), such as a CNA, tend to be economically challenged, from diverse racial backgrounds, and have minimal educational preparation, defined as a high school education or GED (Cready, et al., 2008). Their cultural and social capital may or may not have prepared them for the relational expectations of both the residents and institutional personnel of the skilled nursing home.

Purpose of the Study

The purpose of this focused ethnographic study was to understand the cultural and social capital of the CNA, and how this may provide insight to what may influence how a CNA interacted with the skilled nursing home institutional culture.

Research Questions

This focused ethnographic study concentrated on two key questions:

1. How do CNAs describe their cultural and social capital?
2. How do these CNAs interact within the institutional culture of the skilled nursing home?

Definition of Terms

For the purposes of this study the following terms were defined. Cultural capital was defined as the rules and values an individual learns as a child in the family of origin (Bourdieu, 1986). It provided the person with the information to respond to a variety of situations. This underlying information influenced the person’s responses in all areas of life.

Social capital was developed throughout a person’s lifetime. Social capital was defined as the connections in and between social networks of a person (Bourdieu, 1999).
Some social capital endures throughout a person’s life, such as friends from school, membership in church, community organizations, or clubs. The ability of an individual to develop relationships with other people affects the individual’s social capital.

Institutional culture was defined as the way things are done in an organization, including the rules and regulations and employee behaviors (Clarke, 2006). The culture may be overt, established through written rules and regulations such as an employee handbook or covert, such as which employees go to lunch first. Orientation to the institutional culture may occur formally through a facility designed orientation or informally by working with another employee.

Summary

In the United States, there were over a million skilled nursing home beds. With the aging population of the U.S. growing, more people who need skilled nursing care will be entering SNHs. Certified nursing assistants provided the most frequent and intimate contact with residents in the SNH regardless of the model of care. Cultural and social capital, possessed by all individuals, influenced interactions within the SNH institutional culture. Greater insight to the certified nursing assistants’ cultural and social capital may provide the SNH guidance to provide needed information by the certified nursing assistant to interact more effectively in the institutional culture of the SNH.

Chapter 2 reviews the literature related to certified nursing assistants, institutional culture and social and culture capital. Chapter three focuses on the methodology of the study, including research context, participants, procedure for data collection and analysis. Chapter four discusses how the findings answered the research questions, data analysis and findings. Finally, chapter five discusses implication of the
findings, limitations and recommendations.
Chapter 2: Review of the Literature

Introduction and Purpose

The purpose of this literature review was to explore current literature related to cultural and social capital of the certified nursing assistant (CNA) and how they interact with the institutional culture; what is known and what is not known. This was achieved through a focused literature review with key words of “certified nursing assistant, cultural capital, social capital, and institutional culture.” Due to the lack of cultural and social capital research in skilled nursing homes, the literature review was expanded to include cultural and social capital in education, sociology, and acute care. The main cultural and social capital topics included education, gender, and class groups, the homeless and acute care. The main certified nursing assistant topics include culture, diversity, job satisfaction, and turnover issues. Bourdieu’s (1977) Theory of Practice provided an expert framework to situate the research. The research questions that were the focus for this review were:

1. How do CNAs describe their cultural and social capital?

2. How do these CNAs interact within the institutional culture of the skilled nursing home?

Topic Analysis

Cultural capital. Cultural capital was defined as the rules and values an individual learns as a child in the family of origin (Bourdieu, 1985). The parents’ cultural capitals
were passed to the child and became the basis of the child’s cultural capital. Georg (2004) conducted a 19-year longitudinal quantitative study with the purpose of exploring cultural capital’s influence on students’ school success. Initially, 2,897 students from the sixth grade (age 12) were surveyed, and participants were surveyed each successive year until age 16, with a total of 1,790 students completing all four measurements. Students, parents, and teachers were surveyed at different periods over a four-year timeframe. In 2002, 19 years after the beginning of the study, 81.8% (N = 1,527) of participants studied were contacted and 22.2% responded to a follow-up questionnaire. For students, questions regarding cultural capital focused on reading books, attending theater with friends, or practicing a musical instrument. For adults, the questions focused on the types of materials read, attendance at cultural activities, such as the theater or galleries, and musical choices.

Three hypotheses were explored: the concept of indirect transmission of cultural capital from the parents, which affects the child’s educational attainment; cultural capital influencing educational achievement and occupational choices of the individual; and that cultural capital does not change over a person’s lifetime (Georg, 2004). The results demonstrated those parents’ reading behavior and disposition toward reading influence cultural capital transmission to the child. Educational achievement was not influenced by cultural capital and there was no effect from cultural capital on occupational choice. While Georg’s study did not find a connection between cultural capital and occupational choice it was identified that parental focus on a specific task influenced the child’s view of that task, such as the practice of a musical instrument. This study demonstrated that cultural capital tended to be stable over a long period of time.
Georg (2004) informed this current research by providing insight into how the parents’ cultural capital of the certified nursing assistant influenced the CNA’s ability to relate to the institutional culture of the skilled nursing home. Identifying the socioeconomic and cultural capital of the CNA may provide helpful insight to the CNA’s perception of the skilled nursing home’s institutional culture, including the residents, and the people who work in the setting. If the skilled nursing home’s institutional culture was very different from what the CNA was familiar with, the CNA might not know how to comfortably interact within the institutional culture. Using the focused ethnographic method of research provided the CNAs the opportunity to describe their familial background which may provide insight into his/her social and cultural capital. This method also provided this researcher with the opportunity to observe the CNAs’ interactions within the institutional cultural setting.

Cultural capital may tell a person how to correctly apply the rules and regulations of an institution or school and in what setting to use that knowledge most effectively. Lareau and McNamara Hovart (1999) conducted a case study of third grade children, parents, and teachers. The purpose of this study was “to show how race acts to mediate the importance of class and has an independent theoretical significance in shaping family school relationships” (Lareau & McNamara Hovart, p. 38.) Interviews focused on parental involvement with the school. The study group was equally divided between white and black students, with the white students being predominantly from the middle class and the black students predominantly from the working or poor class. The town in which this study was done had a history of racial discrimination, which may have overshadowed the perception for some of the black parents.
Through observation and interviews the researchers identified the influence of race and cultural capital affecting the level of parental involvement with the school. The teachers interviewed thought they were being very welcoming to have parents participate in the school, but did not always receive a positive response from the parents. The parents’ perception was some teachers were not always willing to talk about a student who was difficult or to the parent if the parent was difficult. Parents who were able to positively interact with the teacher verbalized a greater sense of equality from the school than those parents who were not able to have this type of communication. Those black parents who had difficulty communicating with the teachers felt their children were treated differently than the white students and this influenced the parents’ ability to address issues with the school. This perception of different treatment from the teachers may have been related to socioeconomic class, past racial discrimination, and cultural capital. The findings of this study identify the importance of knowing both the overt and covert rules of interactions in a given setting (Lareau & McNamara Hovart, 1999). The researchers concluded that the ability of the individual to verbalize or use cultural capital during the interaction varies and was influenced by that individual’s past experience of sharing cultural capital and perception of the rules within that given setting. An individual’s ability to share cultural capital can be effective in any given situation regardless of race or social class.

The Lareau and McNamara Hovart (1999) study provided insight to the current study that identified that even though socioeconomic background and racial diversity may influence the cultural capital of an individual, skillfully using one’s cultural capital may overcome the disparity between individuals. Further, Lareau informed this current
research that knowing the rules and regulations of the institutional culture and how to effectively and appropriately apply one’s cultural capital may influence the ability of the CNA to effectively work within the skilled nursing home’s institutional culture. Determining the CNA’s knowledge of the institutional culture of the skilled nursing home informed this study of the CNA’s ability to verbalize his or her understanding of the skilled nursing home’s institutional culture and the CNA’s perception of areas that were difficult for the CNA to understand or work within the setting. Observing the CNA in the work setting provided insight to the CNA’s interaction with the SNH’s institutional culture, which provided the information to determine the CNA’s knowledge of the SNH’s institutional culture.

*Social capital.* Social capital was defined as the connections in and between social networks of a person (Bourdieu, 1999). CNAs who established relationships with anyone in the skilled nursing home used social capital. Many theorists from social science disciplines have used social capital as an explanation for a wide variety of social problems, from eroding national democracy to crime and safety in neighborhoods (Osterling, 2007).

Emirbayer and Williams (2005) wrote a two-part essay discussing both the cultural and social capital as it applied to homeless shelter clients. Knowing the shelter’s director and culture provided the homeless client with information that could help that client get into the shelter for the night. The ability to make connections with the caseworker(s), or the director of the shelter can provide the homeless client with privileges that other homeless clients cannot access related to the other clients’ lack of social capital. For example, a homeless client might develop a friendship with the
shelter’s director and as a result be allowed to stay in the shelter longer while other homeless clients were made to leave (Emirbayer & Williams). Social capital influences the number and type of relationships a person makes in life. It was not unusual for one person to be able to connect well with a certain person, while a different person might have difficulty connecting with that same person. This was also true for the CNA: the ability to use social capital to connect with residents influenced the willingness of the resident to allow the CNA to care for them or not. Exploring with the CNA, their comfort in connecting with new people, provided information to the skilled nursing home to guide the CNA in effective relationship development within the institutional culture.

Parks-Yancy, et al. (2006), conducted a phenomenological study of working and middle/upper class men and women from three states, with the purpose of exploring how use of an individual’s social capital may affect one’s career. Middle/upper class was identified by the person having a bachelor’s degree and working class if the person did not. The age range of respondents was 25 to 55, with relatively equal sampling between men and women. Semi-structured interviews covered past family, educational and employment history, and how the respondent reached his or her current socioeconomic circumstances. Social capital resources, amount of social capital resources, strong, and weak ties, and career outcomes were the four main issues identified from the data.

Four key factors were identified as social capital resources: information, influence, opportunity, and access to financial resources for the individual (Parks-Yancy et al., 2006). This information provided the individual with the needed factors to identify a possible job, whom to contact, if a job was available, and financial funding, such as free child care, to support the individual in accessing the job. Working class individuals
tended to use social capital resources for a job more than middle/upper middle class individuals. The authors defined acquiring 90% of jobs through social capital resources was considered as high amounts of social capital resources, while acquiring 50% of the jobs through social capital was considered low social capital. Social capital resources that provide financial support varied between men, women, and working class and middle/upper middle class respondents.

Secondly, Parks-Yancy et al. (2006) identified family members, friends, and immediate coworkers who were considered strong ties for social capital. Weak social capital ties would be acquaintances, friends of friends, or relatives of friends. Both working class and middle/upper middle class respondents used strong ties to access potential job settings. Career outcomes were demonstrated to be influenced by social capital resources. The findings of this study identified that “early (dis)advantages generally contribute to later (dis)advantages” when dealing with an individual’s social capital resources (p.111).

CNAs may use their connections (social capital) with family and friends to learn about possible job openings in the skilled nursing home setting. As many CNAs are from the working or poor socioeconomic class it would be considered normal for a CNA to rely on family or friends to find a job, applying the Parks-Yancy et al. (2006) framework. It’s also interesting that the majority of CNAs were women, and frequently single parents, who rely on family to survive. Knowing the CNA’s social capital resources, marital status, number, and ages of children may provide information to the skilled nursing home regarding the CNA’s need for basic education on managing their home and responsibilities. This study informed the current research by identifying the CNA’s
social capital resources and provided insight to the CNA’s choice of job and family support for career of choice.

Lauzon-Clabo (2007) used Bourdieu’s (1977) theory as a framework for a qualitative focused ethnographic study on “pain assessment and the role of social context on two postoperative units” (p. 531). This focused ethnographic study explored how nurses on two different post operative units in the same hospital assessed pain in the post operative patients. The purpose of the study was to determine what differences exist between the two nursing units in pain assessment practices and “what is the influence of nursing unit social context on pain assessment practice” (p. 533).

The study was done over nine months in three phases with different sampling strategies for each phase. Phase one focused on observing the nursing unit’s routine interactions, phase two shifted to observation of the day shift nurses’ pain assessment, and phase three occurred with a focus group being held on each unit. The majority of sampling was done from the day shift of registered nurses on two similar surgical units. Each unit had a registered nurse manager and assistant registered nurse manager, unit A had a total of 12 day shift nurses, and unit B had a total of 13 day shift nurses. “After a presentation of the study on each unit, 83% (N=10) participants from unit A and 77% (N=10) from unit B joined the study, agreeing to be observed doing pain assessment and being interviewed regarding each pain assessment” (Lauzon-Calbo, 2007, p. 533).

While both units demonstrated effective pain assessment, the findings established unique differences between the units in how the nurses interpreted the pain assessment information from the client. Unit A’s nurses focused on the patient’s type of surgical procedure, experiences of pain from past patients who had undergone the same type of
surgery, and the nurse’s judgment of how the patient appeared when being assessed for pain. Unit B’s nurses gathered all the data for the pain assessment of a patient but relied heavily on what the patient reported as his or her level of pain when deciding to medicate or not. Concerns expressed by unit A nurses were that some patients did not appear to be in as great pain as the patient verbalized and the nurse was concerned the patient may be employing drug seeking behavior. On Unit B the nurses felt it was important to take the patients “at their word” (Lauzon-Clabo, 2007, p. 535). Unit culture influenced the nurses’ assessment of pain behavior. In the focus group, Unit B’s nurses stated that if a nurse did not medicate a patient for fear the patient was not truly at the level of pain reported, the oncoming nurse would find the patient in more pain with a greater need to be medicated. As a result the nurses on the unit would confront the nurse who was not effectively medicating patients. Nurses, who did not agree with this belief, would leave the unit. Each individual nurse demonstrated her/his background and beliefs related to pain assessment and how to effectively determine who received medication for pain. The researcher identified the differences in pain assessment routine that emerged between units in the study. Social context was demonstrated on the units with identification of the nurses conforming to the unit’s routine regarding medicating for pain. It is possible for a nurse to make changes on a unit, but the potential of one nurse changing the beliefs and routines of the other nurses is limited and over time the change would be forgotten (Lauzon-Clabo).

Lauzon-Clabo (2007) informed the current study that the culture of the institution influenced the ability of the CNA to conform to unit practices including the type and depth of relationship to establish. Exploring the CNA’s perception of the institutional
culture may provide insight to the degree of comfort a CNA may experience in developing relationships within the skilled nursing home. The degree of comfort the CNA experienced was reflected in the types of relationships developed in the skilled nursing home.

*Institutional culture.* Tellis-Nayak and Tellis-Nayak (1989) conducted an ethnographic study to explore how the social background of the CNA and the institutional culture of the SNH influenced the quality of care provided to the resident. Culled ethnographic data were used from two field studies focusing on the following nursing aides’ (certified nursing assistants – CNAs) factors:

- standard of living from metropolitan areas,
- nursing quality,
- the relationship to the social background of the staff, and
- the institutional culture of the nursing home.

Structured and non-structured interviews were done with 185 CNAs from 20 different skilled nursing homes in an urban setting. Data were also collected from non-structured interviews with 31 management staff in 11 skilled nursing homes and multiple discussions held with skilled nursing home residents, family members, and non-nursing staff members. Findings revealed that frequent turnover of CNA staff and use of temporary staff influence the level of commitment from new CNAs to the skilled nursing home. The researchers identified that residents suffer when staff left due to new staff not knowing the “residents habits, idiosyncrasies and medical needs” (p.311). Temporary or new staff may not demonstrate the same level of caring to the residents, influencing the resident’s sense of well being.
The researchers found that the institutional culture of the nursing home consisted of four factors: “the impersonal old-age business, routine indignities, little comfort or gratitude and personalizing the institutional problem” (Tellis-Nayak & Tellis-Nayak, 1989, p. 311). Depersonalized care provided to residents was seen as the impersonal old-age business. Some CNAs have overwhelming personal issues in their life that may cause the CNA not to focus on the resident, which in turn may cause the resident to feel he or she was being treated as an object. Many skilled nursing homes, unable to find permanent CNAs, may use temporary agencies to provide staffing and these staff may not develop relationships with the resident because they are temporary. Staffing levels in some skilled nursing homes were not ideal, so the CNA has a large assignment of 10 or more residents who need a great deal of physical care. This was hard to do and as a result relationships between the CNA and residents may change. The skilled nursing home may be more concerned about the appearance of the facility and not concerned about providing the necessary supplies or equipment to make the CNA’s job more effective. CNAs may maintain distance with residents to shield themselves from the burden of emotionally caring for the resident (Tellis-Nayak & Tellis-Nayak).

Tellis-Nayak and Tellis-Nayak. (1989) found that poor perception of CNAs from supervisors and coworkers was identified as part of routine indignities. Rigid institutional policies and procedures that require conformity, such as inflexible shift times or repetitious educational programs, were also considered as routine indignities by CNAs. Other factors considered as indignities were careful monitoring of beginning and ending of shift times, amount of time taken for breaks and meals, not responding to CNA suggestions for improvement or changes to enhance resident well being. Management’s
attitudes toward staff as well as the perception that management grouped all CNAs into
the same category of inept workers and inconsistent or poor management and chronic
changing of management were also perceived as routine indignities.

Not offering to help CNAs with resident care needs, formation of cliques along
racial and ethnic lines, and seeing the nursing home as just a place to work, were
identified by the CNAs in this study as the perception of (little comfort or gratitude) from
nurses and coworkers. In-fighting among staff members may have staff members
forming alliance groups leading to bickering between the groups or one side seeking
support from management against the other side. There is little respect from coworkers,
residents, or management.

According to the findings of Tellis-Nayak and Tellis-Nayak (1989), receiving
racial and ethnic slurs and comments from staff and residents was not uncommon in the
skilled nursing home setting. Caring for residents who were demented and unable to
cooperate or were verbally abusive was part of the CNA role expectations. The authors
identify personalizing the institutional problem as a factor in the institutional culture. In
our society, a person who is old and unable to care for himself is considered a non-
functioning person, no longer a productive member of society, but one who needs to be
cared for and the skilled nursing home becomes the place to provide care.

Neither the resident of the skilled nursing home nor the CNA giving the care may
see the institution as “caring” or “home.” However, blame for issues in the skilled
nursing home typically was directed at the person giving the care, the CNA. The CNA
may not feel safe complaining within the institution about the conditions of the skilled
nursing home. Venting of frustration toward residents related to institutional inequities or
perceived unfairness was identified in this study as coping techniques by the CNAs. The CNAs’ ability to cope with their understanding of institutional culture influenced their ability to commit to their job. Negative institutional culture creates staff dissatisfaction, which can lead to poor quality care for residents, leading staff to complain about the institution, complaints from residents to others, and thus a vicious cycle begins (Tellis-Nayak & Tellis-Nayak, 1989).

This study informed the current research by showing that there were problems within the institutional culture of the skilled nursing home, but it did not identify why some CNAs find their role and relationships in the skilled nursing home as rewarding and enjoyable. While Tellis-Nayak et al. identified temporary or agency staff may have difficulty developing relationships with residents, the study does not provide insight to why nonpermanently assigned (per diem/float) CNAs within a SNH may not develop relationships with residents. Exploring the institutional culture may provide insight to positive and negative factors affecting a CNA’s ability to use cultural and social capital to establish relationships. The CNA’s awareness of the institutional culture provided the CNA with knowledge of how to more effectively use cultural and social background connecting to residents and interacting in the institutional culture.

Weiner, Squillace, Anderson, and Khatutsky (2009) carried out a quantitative study using a two-stage probability design with the purpose of exploring wages, benefits, training, and organizational culture as policy interventions that may increase supply and job tenure of CNAs. Nursing home data obtained from the National Nursing Home Survey included 1,500 nursing homes, and information from the National Nursing
Assistant Survey provided CNA characteristics, their compensation, benefits, views of the work environment, reasons for leaving their position, and job satisfaction.

The sample was done in two stages: in the first stage 76% (N=582) of nursing homes were randomly selected from the 1,500 nursing homes. In the second stage, 70.6% (N= 3,017) of the CNAs from the selected nursing homes completed interviews. The hypothesis of this study was that “tenure of the CNA was motivated by the extrinsic rewards of their job, training and mentoring, reasons for being a CNA, institutional culture, personal characteristics, facility characteristics, and the market characteristics of the area in which the facility is located” (Weiner et al. 2009, p. 201). Ordinary least squares regression analysis of the data identified extrinsic rewards such as paid time off, pension plans, and higher wages as having a positive effect on CNA job tenure. Training and mentoring during the first job but not succeeding jobs were also shown to have a positive influence on CNA tenure. A positive correlation between CNA tenure and facilities that had higher numbers of Medicaid residents was demonstrated. CNAs had longer tenure by two months in skilled nursing homes that had higher occupancy by Medicaid residents and specialized care units such as dementia or hospice care. Organizational cultural variables that included respect, effective team work, and independent decision making regarding care did not show longer tenure of the CNA. Even within organizational cultures that identified working in a facility that valued CNAs very much or somewhat did not have a more positive response. The overall sample response demonstrated that within the skilled nursing homes that valued the CNAs, the CNAs left their position two months earlier (Weiner et al.).
Weiner et al. (2009) demonstrated that organizational culture was a factor that influenced the CNA’s ability to effectively interact within the institutional culture, as was the type of resident within the SNH. This study informed the current research that the CNA’s cultural capital may not provide sufficient information to successfully navigate the institutional culture. Lack of cultural capital hampered the CNA’s ability to use social capital to connect within the institutional culture.

Anderson, Coranzzini, and McDaniel, (2004) completed a quantitative study with the purpose of focusing on climate and communication and the impact on nursing staff turnover in randomly selected nursing homes in Texas. The researchers proposed “that climate is a set of management practices that are part of the organizational processes that interact to create a whole” (Anderson et al., p. 379). A random sample of 380 skilled nursing homes staff returned 43% (N=164) of the surveys. The sample included administration, directors of nursing, registered nurses, licensed vocational nurses, and CNAs. Three hypotheses were tested:

1. lower turnover was demonstrated in skilled nursing homes that have a reward culture versus a laissez-faire culture,
2. lower turnover rates relate to perceived levels of greater communication openness, accuracy, and timeliness, and
3. lower turnover would be explained by the interactions between institutional culture and communication patterns.

One area of difficulty encountered during the study was in the identification of a skilled nursing home climate as reward or laissez-faire; the scoring was inconclusive for laissez-faire and the authors redefined the climate as ambiguous.
Reward cultures in this study were seen by CNAs as controlling and paternalistic, thus CNA turnover rate was higher in skilled nursing homes where staff perceived a reward climate as opposed to homes where an ambiguous climate was perceived. The authors identified this interpretation of the reward climate as being paternalistic, maybe related to cultural differences between the administrative group and the CNA group. The majority of the administrative group was predominately white and the CNA group was predominantly non-white. Therefore, hypothesis 1 was not supported.

“Accurate and open communication in the reward climate is interpreted as apparent concern for employee welfare and clear performance expectations” (Anderson et al., p. 385). The study findings were that greater levels of communication openness, accuracy, and timeliness did not influence staff turnover, therefore, hypothesis 2 was unsupported.

Hypothesis 3 was supported; findings demonstrated lower CNA turnover related to the interaction between climate type (attitudinal culture) and communication patterns. The greater the amount, clarity, and type of communication shared among CNAs, the greater the opportunity to enhance connections between CNAs, other staff, and residents. This openness of communication also allowed for greater diversity of thought and action among staff. While communication influenced CNAs’ perceptions of relationships, the manager’s role influenced multiple aspects of the nursing home climate.

Anderson et al. (2004) identified specific factors that influence institutional culture and the CNA’s perception of the skilled nursing home. Knowledge of the institutional culture may influence how a CNA used cultural and social capital to effectively work in the skilled nursing home. Communication styles within the SNH may
also influence how the CNA was able to use capital to effectively communicate with the nursing staff. This study did not address the racial disparity between administration and CNAs, which may influence how the CNA interpreted the institutional culture. Exploring the racial and ethnic background of the CNA may provide insight into how the CNA perceived the institutional culture.

Kane-Urrabazo (2006) reviewed the concept of the manager’s role influencing the understanding of the organizational culture for CNAs. The theory of organizational culture was defined as using a framework of power, role, task, and person. The factor of power identified the need to have trust and communication between the leader and the employee to have consistent understanding and interpretation of role responsibilities. Each employee knowing and working in their role within the institution was part of the framework; this allowed the organizational culture to be consistent. Within the organizational culture, each employee knows his/her job or task and may be part of a greater group or committee completing a task, such as policy writing. The organization managed smoothly when tasks were being completed effectively and in a timely manner, and met the needs of the organization. The person part of the organizational framework looks at both the individual and the total of all employees of the organization. Each person in the organization contributed to the overall success of the organization and the culture. “The organizational culture relied on its managers to present a positive environment for employees” (p.194). Factors that were identified as helping to maintain and continue to develop positive organizational culture included trustworthiness, trust, empowerment, delegation, consistency, and mentorship. These factors were seen as influencing the employee’s satisfaction in the organizational culture. The manager’s
ability to integrate, demonstrate, and role model each of these aspects influenced the employee’s ability to assimilate the organizational culture as his or her own. For example, the manager demonstrating ethical behavior should influence the employee to in turn demonstrate ethical behavior.

There was value to the manager role modeling the positive attributes to reinforce organizational culture. The importance of knowing the organizational culture and having the culture identified by the CNA’s manager may help the CNA use cultural and social capital to develop effective interaction within the skilled nursing home. If the CNA was able to identify the values of trustworthiness, trust, empowerment, delegation, consistency, and mentorship in the manager, the CNA may in turn model those values in extending cultural and social capital to others in the institutional culture.

Parsons, et al. (2003) conducted a state-wide quantitative study of certified nursing assistants. The study focused on “overall job satisfaction, work issues related to job satisfaction and dissatisfaction and analyzed associations between employees’ characteristics, work issues, turnover, and work satisfaction” (p.52). A questionnaire was used to explore work related issues and personal characteristics. Random sampling yielded a 33.1% (N=550) response rate from 70 nursing homes. The majority of respondents were black, unmarried women who were high school graduates. Many had had a positive experience taking care of an elderly family member.

According to the CNAs in this study, the greatest satisfactions with the job involved close relationships with residents (44.7%) and having a relationship with coworkers (20%). Residents were the reason CNAs stayed at their job (35.2%). The greatest dissatisfactions were with institutional and supervisory issues, pay, and benefits.
Bivariate analysis of the data focused on the CNA and work characteristics related to turnover. Work characteristics related to CNA turnover included age of the CNA, years on the job, improving educational status, length of time as a CNA, and hourly wage. Research findings included the less overall satisfaction the CNA experienced, the greater the turnover. Management and organizational issues, such as ability to move ahead in the job, perceived fairness in the job, and work schedules were the factors most strongly related to turnover. These findings provide insight into the factors that contribute to the CNA feeling valued in the job (Parsons et al. 2003). While having a relationship with the residents was a positive factor for CNAs, poor managers, low pay, and difficulty with the institutional culture was shown within this study to lead CNAs to leave their job.

Managers may not have the ability to improve pay or benefits for the CNA but can be effective in establishing a relationship with the CNA. Knowing the CNA’s cultural and social capital may provide the manager with background to build the basis of a relationship with the new CNA employee and potentially help the established CNA grow in the job. Knowing it is the resident connection that provided the greatest satisfaction for the CNA, the manager may be able to improve CNA and resident relationships by helping the CNA effectively use cultural and social capital. Knowledge of the CNA’s cultural and social capital may provide insight as how to improve the CNA’s use of cultural and social capital to more effectively develop and maintain relationships within the skilled nursing home. This knowledge may also help guide the CNA to be more effective in interactions with the institutional culture.
Castle et al. (2007) conducted a quantitative study in 5 states randomly sampling 72 nursing homes and exploring CNA retention with a focus on job satisfaction. From the sample, 1,779 participants were single minority women in their early thirties who had a high school education, who worked full and part-time. Five hypotheses were tested:

1. dissatisfied CNAs were more likely to think about leaving, think about searching for a new job, and search for a new job;
2. CNAs who were dissatisfied with their job were more likely to leave within one year;
3. a CNA’s job dissatisfaction would lead to progressive thinking of leaving to search for a job;
4a. CNAs who had low satisfaction with the reward subscale were more likely to leave;
4b. reward subscale had no direct effect on intent to leave and
5. CNAs who were dissatisfied with the quality of care subscale were more likely to leave.

Independent variables included overall job satisfaction, personal characteristics, role characteristics, facility characteristics, and turnover opportunities. Age, race, marital status, and living distance from the nursing home were the key factors of the personal variables. “Role-related characteristics included number of years at the current nursing home, number of years at a previous nursing home, number of CNA jobs and other jobs held, shift worked, and if the CNA was part-time” (p. 197). Job satisfaction subscales included coworkers, work place support, content, schedule, training, pay, opportunity for advancement, and quality of care.
CNAs satisfied with their job were less likely to leave or be thinking of leaving. The study analysis demonstrated low job satisfaction, pay, and poor opportunity for job advancement were associated with higher intention to leave. CNAs were less likely to consider leaving their job if they felt a greater relationship to residents. Further analysis examining factors of job satisfaction including work schedule, pay, opportunity for advancement, and training were scored highly as factors influencing the CNA’s decision to stay in the skilled nursing home. Castle et al. (2007) demonstrated the importance of the institutional culture and the interaction of the CNA within the institutional culture. Quality of care scored higher as well with CNAs who demonstrated job satisfaction. Higher pay and advancement opportunities also demonstrated that CNAs had greater satisfaction with their job and less intent to leave. This study demonstrated that job satisfaction was influenced by a number of work-related conditions that may not be under the total control of the organization, such as reimbursement rates from the state and federal government. The authors identified that turnover of CNAs was negatively associated with quality of care, and stated identifying strategies to reduce CNA turnover will address this issue.

This study supported the importance of relationships between residents and CNAs and the influence of institutional culture. CNAs with greater skill in using their cultural and social capital have greater satisfaction in their jobs because of the relationships developed with the residents. Helping the CNA who may not be as skilled in using cultural and social capital may improve the CNA’s ability to establish relationships with the residents and improve the CNA’s overall job satisfaction. Identifying the CNA’s
perception of the relationship connection abilities and verifying that information with the resident may show the CNA how to improve use of cultural and social capital.

Bowers, Esmond and Jacobson, (2003) conducted a qualitative phenomenologic study with the purpose of exploring the intrinsic factors contributing to CNA turnover. This study was part of a larger research project involving several SNHs in the U.S. “The SNHs ranged in size from 137 to 166 beds, with two SNHs being urban and one rural and two SNH being for profit and one being non-profit” (p. 38). Currently employed and past employed female CNAs in their thirties with a high school education (80%) from one of the three nursing homes were interviewed. Unstructured, open interviews were the initial interviews; follow-up interviews opened with general open questions with more focused questions in the later interviews. The method used was “grounded dimensional analysis, which is a blend of grounded theory and dimensional analysis allowing the researcher to uncover the connections between the participants’ understanding of a phenomenon and their reaction to that phenomenon” (p. 385).

Findings of the study revealed that job dissatisfaction was with the organizational culture as identified by the CNAs. The dissatisfaction stemmed from inconsistencies between organizational policies and procedures, grouping all CNAs together as having the same skills, abilities, and characteristics, and being devalued as a member of the team. “The CNAs interpretation of underlying messages presented by the organizational rhetoric and the dichotomy between what the organization was saying and the organizational policies was identified by the CNAs as their reason for leaving and not the organizational policies themselves” (Bowers et al., 2003, p. 39). The findings of this study identify that CNAs want respect as team members including having their work
valued and fairness from the nursing home demonstrated as consistency in nursing homes policies and interpersonal interactions.

Bowers et al. (2003) identify the importance of consistency in the institutional culture and the interaction of the CNA within the institutional culture. If the institutional culture was ambiguous, the CNA may be unclear as to the institution’s mission and be ineffective in using cultural and social capital to relate to the resident or the institution. The CNA may not feel secure in seeking clarification of the institution’s underlying meaning and choose to do the job with the least amount of involvement as possible, therefore, withholding cultural and social capital from the resident and the institution. Determining the CNA’s perception of involvement with residents and the institution may provide insight to the extent of use of the CNA’s cultural and social capital.

Bishop et al. (2008) conducted an ethnographic study with the purpose of exploring the influence of the manager on the CNA’s job commitment and how that commitment influenced relationships with residents. Eighteen skilled nursing homes were studied, nine of which identified their culture as shifting to the person-centered culture from the medical model. Interview and focus groups were held with the day and evening CNAs to determine the management philosophy of leadership, management practices, and work concerns of the CNAs. Leadership styles varied within the skilled nursing homes; however, three aspects of leadership were identified as good basic leadership: positive feedback, support for problem solving, and respect from the nurses to the CNAs.

Findings from this study identified the CNA data supported that the CNA’s intent to stay was demonstrated positively if the CNA was satisfied with wages, benefits, and
advancement possibilities. CNAs had greater job commitment when the CNA felt the manager demonstrated respect for the CNA’s work, knowledge, skills, and gave the CNA autonomy to make decisions.

Data collected from the residents demonstrated that resident satisfaction increased if CNAs intended to stay in their current job. Bishop et al. (2008) identified that this concept may be reciprocal for the CNA in that if the resident was satisfied with the CNA relationship, the CNA was most likely satisfied with the resident relationship. Each relationship supports the other, driving the CNA to want to continue working on that particular unit with those specific residents. While many factors influence the CNA’s commitment to the job, all factors, satisfaction with wages, learning opportunities, good supervision, need to be addressed to retain and sustain that commitment. Organizational culture change from the medical model to the person-centered model will not be enough to sustain the CNA’s commitment if the other factors, such as good supervision, learning opportunities and satisfaction with wages are not present.

Bishop et al. (2008) provided insight to the importance of the institutional culture of the skilled nursing home. Knowledge of the CNA’s cultural and social capital may help prepare the CNA to be successful in the institutional culture. This knowledge may also help the CNA more readily connect with residents in the skilled nursing home.

Institutional culture focusing on Eden culture. Prior to 1990, skilled nursing homes focused on using the medical model of care to improve the quality of life for residents (Flesner, 2009). Skilled nursing homes have continued to struggle to meet the needs of residents related to a variety of problems from underfunding to lack of qualified staff. The public, not seeing a great improvement in the social quality of life in the
current form of institutional culture, moved to person-centered care, which began as a trend in the late 1990s.

The concept of person-centered care was to change the view of care for elders in the skilled nursing home setting from medically oriented care to more personalized, individual care. Eden philosophy culture change began 14 years ago by Dr. Bill Thomas (Keane, 2004). The concept of the Eden philosophy culture change was to move skilled nursing homes from the medical model of care, which was a highly structured, hierarchical system of rules and regulations identifying how care was delivered, to a social model of care, a system that places the resident in charge of daily decisions affecting his or her life and routines (Yeatts & Seward, 2000).

Eden philosophy does not require changing the physical structure of the nursing home but does require changing employee thought process related to residents and job task orientation (Holzer, 2007). For example, Eden philosophy requires employees to change the language used in referring to a resident’s functioning or needs, such as identifying a person by name and not a disease process, identifying a need for a person not the person as a need, such as Mrs. Smith needs to be fed, versus Mrs. Smith is a feeder. The challenge of the Eden philosophy was involving all levels of the skilled nursing home staff, from the administrator to the housekeeper, not just nursing staff. Changing how an organization perceives the function of the residents and employees takes a long period of time to accomplish and was an ongoing process as new employees and residents enter the skilled nursing home.

Deutschman (2005) completed a focused ethnographic study with the purpose of exploring the realities of culture change in three SNHs. Selected staff interviews and
observations of day and occasional evening shift staff were done. The goal of the study was to identify from the staff their perceptions of organizational culture, including positive and negative staff experiences. Deutschman defines “culture as a set of values, beliefs, norms, customs, rules and codes that lead people to define themselves as a distinct group with a sense of community” (p. 274).

Data analysis and interpretation identified four areas for improvement in order to change the organizational culture:

1. the need to increase awareness of the individual residents needs regardless of the institutional schedule;
2. employ CNAs who have had effective training and education related to the skilled nursing home resident, specifically focusing on the attitude, knowledge, and skills;
3. role modeling by leaders including training and mentoring to reinforce the mission, vision, and values of the nursing home; and
4. implementing effective relationship development within the nursing home and throughout the community.

The researcher concluded that organizational changes continue within the nursing home industry, and these four factors will need to be addressed if organizational change was to succeed. Job satisfaction may be the most important aspect when making changes. Resident satisfaction was a reflection of employee satisfaction. Support from the community and peer organizations may also be necessary to influence the required organizational change.
Deutschman’s (2005) focused ethnographic study informed this study by providing insight to the importance of the CNA knowing how to effectively interact with the institutional culture. Knowledge of the CNA’s cultural and social capital may provide the skilled nursing home with information to conduct specific focused trainings for CNAs to make the shift in their cultural capital to apply the new learning to the current job and adapt to the changing institutional culture. This information may also help the CNA bring the resident along with the institutional culture change and shift the resident’s social capital to be once again more self-directive with making choices for daily living.

The Deutschman (2005) study further informed this study of the importance of all staff, residents, and families being involved with the cultural change. Without all participants being involved the success of the cultural change will be challenged. Knowing the interactions of other SNH staff with the CNA may also influence the CNA’s views and acceptance of the institutional culture. Being able to identify and address the CNA’s cultural and social capital may influence the effectiveness of helping the CNA accept the SNH cultural change.

Eaton (2000) conducted a phenomenological qualitative study using interviews, case studies, and observations in 28 nursing homes, with the purpose of exploring “how organization of front line service work affects quality outcomes for residents and what the most important mediating and environmental factors were” (p. 595). Direct observation of employees, personal interviews, and case studies were done.

Three different types of skilled nursing home cultures were observed: traditional, medical rehab, and regenerative communities. Work patterns within each of the different
nursing homes were described and compared. The traditional nursing home managers did not share information with the CNAs about the residents, the managers did not trust the CNAs, and the CNAs identified the only reason they stayed was the relationships they have with the residents. The medical rehabilitative type of institutional culture was described as more open, resident information was appropriately provided to the CNAs for care, and many CNAs established effective relationships with the residents. The regenerative communities were defined in this study as communities that did not demonstrate the standard beliefs about aging and disease, disability, and deterioration as did the other two skilled nursing homes. Residents living in skilled nursing homes believed that regenerative communities’ were given greater choice of activities, CNA’s jobs were more varied and required greater use of judgment and skills, and relationships with residents was a priority.

Eaton’s (2000) study informed this research of the importance of the CNA’s relationship with the resident as the institutional culture shifts to more social model care. Knowledge of the institutional culture may help the CNA use cultural and social capital more effectively in establishing relationships in the institutional culture. CNAs will need to successfully use their cultural and social capital to connect with the residents, as the residents will be more involved with daily decision making and having a positive relationship with the resident will be supportive of the CNA’s work.

Certified nursing assistant culture. Certified nursing assistants in urban skilled nursing homes tend to have greater cultural and racial diversity than do the management, administrative staff, or residents. Berdes and Eckert (2001) completed a focused ethnographic study with the purpose of exploring the effects of racial and ethnic
differences between residents and CNAs in three skilled nursing homes. “Racial and ethnic differences were examined from three perspectives:

1. skilled nursing home residents were asked how they felt about being cared for by a person of a different race,

2. CNAs were queried about experiences with racism and how they handled it if encountered and

3. the effect of ethnic diversity among the CNAs was explored” (p. 112).

Three skilled nursing homes, with known racial conflict in the home, agreed to participate in the study. Interviews were conducted with an equal number of residents (N=30) and CNAs (N=30) within each of the skilled nursing homes. Results showed that residents identified race as not as much an issue as the personality of the CNA, quality of care, and the personal care they received. When residents were asked specifically if race was an issue with the CNA providing their care, some residents (N=11/30) identified it was. Some residents used language that was from a different era, but appropriate to that resident’s lifetime, such as colored. The researchers labeled this as “anachronistic racism” (Berdes et al., 2001, p. 114). Other residents used racial slurs to describe some of their CNAs, and the authors labeled this as “malignant racism” (p. 115). Many CNAs had experienced racism from residents, family members, and staff either overtly or covertly in language used.

Study findings revealed that for the CNA, 73% had experienced racism from either a resident (56%), from family members of a resident (23%), or from coworkers (40%). Some CNAs who encountered racism distanced themselves from that particular resident - other CNAs viewed the resident as not being fully aware of what he or she was
saying. African American CNAs reported more incidents of racism than their counterparts, who in this study were black immigrant CNAs. The black immigrant CNAs did not perceive the racial comments as personal attacks.

Racism continues to be a problem in nursing homes. The CNA’s response to racist encounters varied depending on the CNA’s understanding of dementia issues for a resident and whether the remark was anachronistic or malignant racism. CNAs that distance themselves from residents who make racist remarks jeopardize the quality of care given to those residents. The authors identify that race relations between staff members needs to be discussed to improve the ability for team work. If these topics are not discussed and racism was left unheeded in a facility, teamwork will mostly likely not occur.

The Berdes et al. (2001) study informed this research that CNAs may have experienced racism in their past, influencing their cultural and social capital and their ability to establish relationships with residents or effectively interact in the skilled nursing home setting. Addressing racial issues in the institutional culture may be difficult for the CNA, and may not be addressed by the CNA if his or her cultural and social capital is not oriented to that particular issue. The skilled nursing home’s institutional culture needs to be sensitive to the issues of racial discrimination and diversity from both the residents and from staff. Having knowledge of the CNA’s cultural and social capital regarding racial issues and openly discussing how they have addressed these issues in the past may help to alleviate some of the difficulties encountered when establishing a relationship with a resident. The issue of racial discrimination was addressed in the current study in the focus group and individual interview questions with all participants.
Allensworth-Davies et al. (2007) conducted a quantitative study exploring how racio-ethnicity, culture, and language influence interactions that can lead to communication problems, negatively affecting resident care, and CNA’s job satisfaction in four SNHs. The CNAs (N=135) studied were predominantly foreign born, non-white women of diverse ages from 10 nursing homes. Participants completed a survey exploring perceptions of organizational cultural competence and ratings of job satisfaction.

Findings of the study revealed foreign born CNAs identified greater autonomy ($p < .01$) and satisfaction from doing a good job with residents than U.S. born CNAs. Another finding was that non-white CNAs viewed their facilities as less culturally competent ($p = .05$), and more negatively racial than white coworkers reported ($p < .01$). The greatest predictors of job satisfaction for CNAs were job autonomy ($p = .001$) and cultural competency of the organization ($p = .005$). Cross cultural communication and staff responding effectively if a coworker or resident was being treated inappropriately related to race or culture were identified as the strongest positive correlates (Allensworth-Davies et al., 2007). The most negative correlates were staff thinking skilled nursing home problems are related to different cultures and races and thinking coworkers did not want coworkers of different cultural, racial groups to succeed. The researchers identified that managerial training focusing on effective responses to racial disparities, improving cross cultural communications, involving all staff in culture-change activities, and encouraging and supporting staff in professional development and providing consistent performance feedback may improve skilled nursing home cultural competency.
The CNA’s perception of the institutional culture influenced how the CNA will apply cultural and social capital when interacting with the institutional culture and with residents. CNAs who perceive the skilled nursing home as culturally biased may become self protective, less willing to share cultural or social capital, and less likely to establish a relationship within the institutional culture or with residents. Lack of sharing of cultural and social capital by the CNA with the resident may create issues providing effective care to the resident.

Tellis-Nayak and Tellis-Nayak (1989) did an ethnographic study exploring the burden of two cultures, the culture of the CNA and that of the skilled nursing home, and how the two cultures influenced resident satisfaction. The ethnographic data were used from two field studies obtained from interviews done within metropolitan skilled nursing homes in the mid-west focusing on quality of care. Primary data sources were varied with structured CNA interviews (N=132) from 8 skilled nursing homes, non-structured interviews with CNAs (N=53) from 12 skilled nursing homes, non-structured interviews with management staff (N=31) from 11 skilled nursing homes, and multiple conferences with skilled nursing home residents, family members, surveyors, and others familiar with the skilled nursing home setting. Field observations of skilled nursing home life were also conducted in eight skilled nursing homes. A high level of diversity was noted in the CNA population. Four specific CNAs from the sample described their personal life, identifying factors, and issues that impinge on their functioning in life.

Personal profiles of four different CNAs were discussed, identifying how their home and family relationships influenced their attitudes and interactions working in the skilled nursing home. Tellis-Nayak & Tellis-Nayak (1989) identify from the profiles two
categories of CNAs, that of an endurer or a striver. The authors define CNAs who tolerate whatever situation they are in are considered to be endurers, and CNAs who seek to improve whatever situations they are in are strivers. CNAs who function as endurers are also described as CNAs who plod through work with little attachment or emotional response to the residents. An endurer is a CNA who stays in the job regardless of apathy or loss of feeling about one’s work. CNAs who function as strivers, however, are CNAs who want to do better in life and in their job. Often they will leave the nursing home job because their idealism to improve situations for the resident is not fulfilled.

The study further identified that while there were “no ready statistics to document these two patterns prevail in skilled nursing home CNAs, the data supports the common impression that skilled nursing homes hire CNAs who are strivers far more than the CNAs who are endurers, perhaps by a margin of 2 to 1” (Tellis-Nayak & Tellis-Nayak 1989, p. 310). Unfortunately, strivers tend to have the highest turnover rate from the nursing homes, leaving the endurers who may not have a passion for resident care.

Tellis-Nayak and Tellis-Nayak’s (1989) study informed this current study by providing insight into the socioeconomic background that many CNAs experience and how personal background may influence the CNA’s interaction within the institutional culture. Insight to how the CNA’s cultural and social capital may be an issue coming into the skilled nursing home was also provided. The CNA may be unfamiliar with appropriate social capital interactions within the institutional culture. This CNA may also feel less capable in doing the CNA job related to perceived imbalance between the institutional culture and that of the resident and CNA cultural and social capital.
Previous knowledge of the CNA’s cultural and social capital may help the institutional culture prepare the CNA for the job.

Anderson, Ammarell, Bailey, Jr., and Colon-Emeric (2005) conducted a case study with the purpose of identifying how CNAs use life experience and personal decision making skills when providing care to residents. The SNH used in this case study was part of a larger study. Observations and interviews of CNAs (N=11) were used to identify beliefs about residents, their explanation of resident care situations and how the CNAs’ mental models guided their actions. “Within the study group of CNAs, eight of the participants were African American, two were Caucasian, and one identified as race unknown. Interviews and field notes were also collected from other staff focusing on CNA mental models, as “sense-making,” or social relationship patterns” (p. 1009).

Findings of the study demonstrated that certified nursing assistants use their own culture and experience to identify how to establish relationships with residents. The two major themes identified in the study were the “Golden Rule” and “Mother Wit.” CNAs using the Golden Rule expressed treating residents as they, the CNAs, would like to be treated. CNAs that use “Mother Wit” are drawing from personal experience and information passed from mother to daughter. “Sense-making,” a term identified in the study, was the cognitive process that people employ to construct mental models through which they interpret and assign meaning to behaviors or events.

The researchers discuss “the fundamental problem for residents in this study was not the CNAs’ mental models; it was that CNAs acted on those mental models without the benefit of professional interpretations of care situations” (Anderson et al., 2005, p. 1019). This demonstrated that some CNAs were not reporting potential problems to the
nurses, leaving the resident untreated or under treated for pain or depression. Results of the study powerfully demonstrate that nurses were not influencing the CNAs’ behavior related to lack of effective relationship interactions between the nurses and CNAs.

Anderson et al. (2005) informed this study by providing insight to the thought process of the CNA in how the CNA decided how to respond to residents. This study explored how the CNA uses cultural and social capital to develop relationships within the skilled nursing home institutional culture. Establishing positive relationships may improve outcomes for residents and provide the CNA with a greater sense of contributing to a positive skilled nursing home institutional culture.

**Summary**

Establishing effective relationships between CNAs, residents, and the nursing home culture was a critical and necessary element for quality care and effectiveness in any skilled nursing home. The CNAs’ interactions with residents were overwhelmingly intertwined with the residents’ physical and psychosocial wellbeing. While different studies have identified factors that influence a CNA’s interactions, there was lack of research focusing on how the CNA’s cultural and social capital influenced the CNA’s attitudes, values, beliefs, interactions, and ability to establish relationships within the institutional culture.

Exploring how the CNA’s cultural and social capital interacts with the institutional culture may provide institutions with knowledge to inform changes to the CNA’s orientation, and the method of educational programs to improve relationship building. The results contribute to improved CNA job satisfaction and interactions in the skilled nursing home setting. Ethnographic studies (Tellis-Nayak & Tellis-Nayak 1989;
Berdes & Eckert 2001) have focused on specific factors within the CNA’s culture. This current study explored the specific factors of cultural and social capital of the CNA within the institutional culture of the skilled nursing home. The next chapter describes the focused ethnographic methodology used to gather and analyze data to answer the research questions.
Chapter 3: Research Design Methodology

Introduction

Certified nursing assistants are the primary care givers to residents in skilled nursing homes. The purpose of this focused ethnographic study was to understand the cultural and social capital of the CNA, and how this provided insight to CNA interactions with the skilled nursing home institutional culture. The research questions for this focused ethnographic study were:

1. How do CNAs describe their cultural and social capital?
2. How do these CNAs interact within the institutional culture of the skilled nursing home?

The qualitative research method, focused ethnography, was chosen to study the research questions.

Methodology

“Qualitative research is committed to revealing the participant’s point of view focusing on a specific phenomenon” (Speziale & Carpenter, 2007, p. 22). The researcher chooses the method or approach to answer the research question. Focused ethnography, an intensive study of a participant’s culture, uses observation within the participant’s setting, interviewing, and collection of information about the participants from other sources related to the topic of interest (Speziale & Carpenter, 2007; Richards & Morse, 2007; Flick, 2007; Creswell, 2007). Focused ethnography, however, was “used primarily to evaluate or elicit information on a special topic or shared experience” (Richards &
Speziale and Carpenter identified focused ethnography “as having as the focal point a distinct problem that is studied within a single context with a limited number of individuals” (p. 204). For example, Lauzon-Clabo’s (2007) focused ethnography study explored how registered nurses on two postoperative units did pain assessment and how their unit culture influenced the RNs’ views of pain. This study concentrated on learning about the CNA’s cultural and social capital and how this capital interacted within the institutional culture within the specific setting of the skilled nursing home. The result was a better understanding of how the CNA cultural & social capital shapes interactions within the nursing home setting. The participants for this study included CNAs who responded to an invitation letter distributed to all nursing units at The Home. Invitations to participate in the study were distributed to all CNAs who met the criteria of having worked in the home for at least 1 year during the day or evening shifts. CNAs that met the criteria for the study but did not respond to the letter of invitation were personally invited to participate.

Data collection for CNAs in the study occurred in several ways. In order to understand the institutional culture and its interaction with the CNA, data was gathered from selected personnel who are part of the research context. These personnel were recruited after the CNA sample had been established, and included unit registered nurse managers, registered nurses, licensed practical nurses, environmental service aides and cognitively intact residents of the units where the CNA participants worked. The timeframe for this study was four months.

CNAs who volunteered to participate in the study were observed during their work hours interacting with the institutional culture on their resident unit. The CNAs
were also asked to participate in an individual interview at the initial time of data gathering and a focus group at the end of data analysis to respond to the initial culture themes and inventory. Other staff from the CNA participants’ units who were asked to participate in focus groups included the registered nurse manager, registered nurses, licensed practical nurses, environmental service (ES) aides, and cognitively intact residents from the specific units of the CNA participants. The research context includes the setting, demographics, and other descriptors.

Research Context

In 1987, the passage of the Federal Omnibus Budgetary Reconciliation Act required nursing homes to choose between providing all skilled nursing care services or all health related care services (Institute of Medicine, 1986). The Home chose to be a skilled nursing care provider. The Home currently provides long term skilled nursing care, which includes rehabilitation care, comfort care, dementia, and gero-psychiatric care services. The average age of the residents is 85. Within the culture of The Home, a shift was occurring from the medical model of care to the Eden philosophy of person-centered. The Eden philosophy of person-centered care shifts the hierarchy of resident care to the resident making choices about routine daily life with the CNA. The rehabilitation unit uses the term patient as the person who is not planning on residing in the facility after completing the rehabilitation stay. Many of the patients on the rehabilitation unit are younger than 85. Invitations to participate were sent to CNAs on all units.

The Home, had 455 residents, of which 351 were female, with 331 white, 19 black and 1 black/Hispanic and 104 were male, with 95 white, 3 white/Hispanic and 5
black (C.Kabb, personal communication, May 2010). Residents come from a wide variety of areas within the county, as well as surrounding counties and occasionally from out of the state. Payment for skilled nursing home services come from a variety of sources. Some residents pay for all services and care needs directly; this is known as “private pay.” Other residents have exhausted their personal finances and receive health insurance coverage through the Medicaid program. Medicare, a health insurance available for purchase at the age of 65, may be used to pay for nursing home care required after a hospitalization. Some people have purchased long term health care insurance or have private health insurance that pays for skilled nursing home care services. Within The Home, 39% were private pay, 51% Medicaid, 5% Medicaid who chose to use Hospice coverage, and 5% who were Medicare or private insurance (J.Barnette, personal communication, May 2010). Specific demographics and other descriptors about the potential CNA participant sample are described next.

Demographics and other descriptors. In this specific skilled nursing home there were 281 CNAs, 195 full time, 34 part-time and 52 Per Diem. Of the total CNA group 259 (92%) were female and 22 (8%) male; 173 (62%) African American, 66 (23%) Caucasian, 27 (10%) Hispanic, 7 (2%) Asian/Pacific Islander and 8 (3%) categorized as other (B.Daly-John, personal communication, May 2010). A CNA may be assigned to a specific resident unit, and have a group of residents to whom they provide care on a permanent basis. The size of each resident unit varied from 19 to 42 residents, with a total of 14 units. Of the 14 units, 6 have 19 to 25 residents and were identified by The Home as the program units. Program units offer specific care such as rehabilitation, comfort care services, dementia care, and geropsychiatric care. CNAs who have been employed
at The Home for a year or more and who provide care on the day or evening shifts were invited to join the study.

All resident units have an environmental service (ES) aide(s) as support staff. The 40 to 42-bed units have two environmental service aides, while the 19 to 25-bed units have one ES aide (R. Imburgia, personal communication, May 2010). As support staff on the unit, the ES aide(s) were involved with cleaning the resident’s room and the rest of the entire unit. ES aides become close to the residents on the unit typically through taking time to listen to the resident while the aide was cleaning the room. The ES aides were also accepted by the nursing staff as part of the unit team. In this role, the ES aide had the opportunity to watch and hear interactions with residents and CNAs. ES aides from the units of the participant CNAs were invited to join the study. The ES aide(s) was also invited to contribute to the data collection through focus group discussion. Participant observation and field work journaling added to the description of the culture of the institutional culture, discussed next.

*Field work journaling and participant observation.* It is important to identify the researcher’s position within the participant group. The researcher may be an outsider (etic) of the group or an insider (emic) of the group to be studied (Angrosino, 2007; Speziale & Carpenter, 2007). Within this study, the position of the researcher was that of an outsider to the CNA group, while also being an insider as an employee of the organization. Within this view, *reflexivity*, or remaining open to influence on the individual or situation being studied, determining what the researcher’s influence was, and using that awareness to enhance the research realizing the subjectivity was part of the research (Speziale & Carpenter). In keeping with the attributes of credibility of the study,
the researcher’s personal experiences with the culture under study were described through personal journaling prior to and throughout data collection.

Personal journaling or setting aside personal thoughts and feelings, keeps the researcher aware of her beliefs and allows the researcher to separate her beliefs from the data collected (Richards & Morse, 2007; Speziale & Carpenter, 2007). The field work journal included records of events observed, impressions and perceptions from participant observations, and the individual interviews and focus groups. Journaling provided another source of data reflection and added to the contextual source of the study.

This researcher’s role in The Home was that of Staff Development Manager. Within this role, the researcher was involved with teaching clinical material or information to the nursing staff, including CNAs. This researcher had a non-supervisory or evaluative role with the CNAs. Participant observation provided the researcher with information about the institutional culture of the skilled nursing home.

Becoming a part of the resident unit was necessary for participant observation. Participant observation required the observer to increase awareness of the environment and pay attention to all interactions that occurred (Spradley, 1980). Based on CNA response to the study invitation, units were selected for participant observation. Observation of interactions occurred in public areas on the units. The researcher continued with activities she would normally be involved with on the units while doing the participant observation. Sample participants and data collection, are discussed in the next section.
Sample Participants

To provide the data sought in this study, a purposive sampling of full time day and evening shift CNAs from all units who had been employees at The Home for at least one year were invited. CNAs who responded to the invitation letter were invited to be in the study and asked to sign a consent form. Other CNAs who met the criteria for the study were also approached by the researcher to participate in the study. Full time day and evening CNAs with one year of experience in The Home had greater potential to develop relationships within the institutional culture and with residents. This sampling method sought CNA participants who were likely to have the relevant information on the concepts being studied (Patten, 2007). Interviews or focus groups and participant observation continued with more CNAs added until saturation of the data occurred. All participating CNAs were asked to participate in a member check of data focus group.

Locating an effective participant as identified by Spradley (1979) involved identifying a participant that was currently involved in the SNH culture. This provided the researcher the opportunity to explore with the participant the specifics about his/her culture and in this current research, the SNH culture. Registered nurse managers, registered nurses, licensed practical nurse, and environmental service aides who responded to the participation letter (Appendix E) were invited to be in the study and asked to sign a consent form (Appendix F).

Letters of invitation to participate in this study identified the purpose of the study, use of the information, digital recording of the discussions, maintenance of confidentiality of the participant, and the request to contact or see the researcher to participate in the study (Appendix C & E). The letters were distributed to all potential
CNA participants via the mailboxes on each of the resident units. Subsequent to identification, other members of the institutional culture were asked to participate. Letters were sent to the environmental service aides’ mailboxes, and registered nurse managers and registered and licensed practical nurses mailboxes on each resident unit. Interested CNAs were asked to respond to the letter by contacting this researcher by phone or in person. Registered nurse managers, registered nurses, licensed practical nurses, and environmental service aides were also asked to respond to the letter by contacting the researcher by phone or in person.

Finally, potential resident participants were identified by the registered nurse manager as cognitively intact, as a large portion of the residents in The Home have dementia. The researcher met with individual residents, explained the research, and provided a letter of participation (Appendix E). Residents who agreed to participate were asked to sign a consent form (Appendix F).

The consent form described the purpose of the study, information to be collected, and use of the information obtained, risks and benefits of the study for participants, and confidentiality of participants (Appendix F). The sample size for the CNAs, registered nurse managers, registered nurses, licensed practical nurses, environmental service aides, and residents who work with the CNAs who participated in the study varied depending on response and when data saturation occurred. Demographic data was collected from all CNA participants to describe the sample (Appendix G).

Data Collection

Demographic data were collected at the beginning of each individual CNA interview (Appendix G). The demographic data focused on the specific information
identified from the review of the literature. The information obtained from the review of the literature informed the researcher of the background data of the CNAs in the institutional culture that provided insight to the participants’ cultural and social capital. Specific data sought provided insight to the CNA participants’ cultural capital, defined as the rules and values an individual learns as a child in the family of origin (Bourdieu, 1986). Social capital was defined as the connections in and between social networks of a person (Bourdieu, 1999).

**Literature guiding demographic data.** Tellis-Nayak et al. (1989) identified the importance of knowing the background of the CNA including the age, marital status, and ages of children as these factors influence the CNA’s outlook or perception of responsibilities in life and need to work. Parks-Yancy et al. (2006), in their study of social capital and career opportunities, identified the influence of social capital ties, or the connections to one’s family, on family support available to women. Identifying the CNAs’ number and ages of children and parents’ occupations provided insight to the CNAs’ social capital ties. Lareau and McNamara Hovart (1999) discussed in their study the influence of the parents’ education level in informing their children’s cultural and social capital.

Bowers et al. (2003) and Castle et al. (2007) identified that the greater tenure of the CNA with the skilled nursing home the greater the job satisfaction, which may be reflection of the CNA’s cultural and social capital. Therefore, data were collected via the demographic data sheet for descriptive purposes (Appendix G). In the Allenworth-Davies et al. (2007) and Berdes and Eckert (2001) studies, ethnic background was found to influence interaction within the institutional culture. Identifying the ethnic background
of the study participant provided insight to any differences the CNA experienced in the institutional culture.

Based on the literature review, demographic data collected included: age, educational level, ethnic background, marital status, number and ages of children, mother and father’s educational level, mother and father’s occupation, and number of years’ experience as a CNA (Appendix G). All data collection occurred in The Home.

Data were collected in the following ways;

1. A demographic information sheet (Appendix G)
2. Individual interviews with CNA participants using an interview guide, and informal discussion(s) (Appendix D)
3. Observations of CNA participants on their units
4. Focus groups with registered nurse manager, registered nurses, licensed practical nurses, and environmental service aides (Appendix H)
5. Individual interviews with cognitively intact residents who work with the CNAs who participated in the study (Appendix I)
6. A fieldwork journal
7. A follow-up focus group with the CNAs for member checks of the data

CNA participants were asked to do individual interviews or be part of a focus group. All CNA participants chose to be individually interviewed. An interview guide based on the principles from The Ethnographic Interview (Spradely, 1979) provided direction for the participant interviews (Appendix C & E). The interview guide (Appendix D) provided the researcher with broad questions enhanced, for example, by “What was that experience like for you?” and “Can you tell me more about that?”
Questions focused on the cultural and social capital of the CNA, the CNA’s perception of the institutional culture and how the CNA uses cultural and social capital to develop a relationship within the institutional culture (Appendix D).

Authors vary on the number of participants to have in a focus group (Morse & Fields, 1995; Barbour, 2007; Richards & Morse, 2007; Speziale & Carpenter, 2007). Flick (2007) identified a “focus group’s composition and number of participants varies as determined by the research question and intended comparisons” (p.85). Smaller focus group size, no more than eight participants, provided the opportunity for all participants to be interactive with the discussion. The focus group composition for the registered nurse managers, registered nurses, licensed practical nurses and environmental service aides was a maximum of four staff. No focus groups with CNA participants were held as CNA participants chose to be individually interviewed. When data analysis was completed the CNA participants were asked to participate in a focus group for member check of the material.

Once the CNAs were identified through their response to the study invitation, staff members and residents from the CNA participant unit were identified and asked to participate in the study. Focus groups were held with each of the different staff groups who worked with the CNA participants using a specific focus group guide with questions pertaining to CNA participant interactions with residents and the institutional culture (Appendix H). These groups included the registered nurse managers, registered nurses, licensed practical nurses and environmental service aides. Each specific staff group met with their own focus group, in order to provide greater confidentiality for each of the groups to speak freely.
One or two focus groups were conducted with these participants. This provided the opportunity to compare data between groups and provided trustworthiness to the study as the information was not the viewpoints from just one group (Barbour, 2007). To promote question clarity and usefulness, questions for the focus group (Appendix H) for both the CNAs and the other staff members were reviewed by a CNA, registered nurse manager, registered nurse, licensed practical nurse, and environmental service aide who were not participants in the study.

Cognitively intact residents were identified by the registered nurse manager on the units of the CNA participants. The residents were individually invited by the researcher to be interviewed. The procedures used for the study are identified next.

Procedures used. The study was reviewed by St. John Fisher College and The Home’s Institutional Review Boards (IRBs). Confidentiality of the CNAs, registered nurse managers, registered nurses, licensed practical nurses, environmental service staff, and cognitively intact resident participants was maintained for each participant by using a pseudonym during the focus groups, interviews, and participant observations. No other identifying information, such as unit assigned, was discussed in the focus groups. Data from the audio recordings were numerically labeled to maintain confidentiality. The audio recording was down-loaded to the computer and sent to a transcription service. This occurred after each individual interview or focus group was completed. All data and audio recordings will be destroyed seven years after the completion of the dissertation. No specific data, interview, or focus group process was discussed, reviewed, or shared with any member of The Home who was not involved with the current study. This
information was included in the consent form (Appendix F) and letter to participants (Appendix C and E).

The researcher began to spend time on the resident units of the CNA participants observing CNA interactions prior to individual interviews with participants to allow CNA participant comfort with the researcher being in their environment. Data collected from the participant observation was cross-compared with data from the interviews and focus groups. Cross comparison of data provided for validation of data collected (Speziale & Carpenter, 2007).

A room for the individual interviews and focus group discussions was large enough to comfortably seat the participants and researcher. The room had adequate lighting, and one entrance to prevent accidental entry by other staff during the process. Audio recorders were used to collect data during the interviews and focus groups. Throughout the interviews and focus groups the researcher facilitated the discussion and follow up with key comments or ideas expressed by the participant. At the end of the focus groups and interviews, the participants were thanked for their participation. The timeline for the study is discussed next.

Timeline

IRB approval was sought from St. John Fisher College in August 2010 and The Home in September 2010. With receipt of IRB approval from the college and The Home, the CNA participants, full time, day and evening CNAs with a year of experience or more, were recruited. Interview questions were reviewed the last week of September 2010 by CNAs (Appendix D), registered nurse managers, registered nurses, licensed practical nurses, environmental service aides, and cognitively intact residents (Appendix
H) who were not participants in the study. Participant observation began the last week of September 2010 and continued until data saturation occurred in mid-November 2010.

The researcher met with the prospective CNA participants the first week of October and began interviews, which continued until data saturation was reached. Following the completion of the interviews or focus groups, the audio recordings were downloaded to the computer and sent to the transcription service. Field work journaling was completed at the end of each interview and data were reviewed.

The registered nurse managers, registered nurses, licensed practical nurses, environmental service aides, and the cognitively intact residents were recruited the third week of October 2010. Focus groups with registered nurse managers, registered nurses, licensed practical nurses, environmental service aides, and cognitively intact residents occurred during October and November 2010. Following the completion of the focus groups, the audio recordings were downloaded to the computer and sent to the transcription service. This occurred after each interaction with the registered nurse managers, registered nurses, licensed practical nurses, environmental service aide’s focus groups, and cognitively intact resident individual interviews.

Data analysis began immediately after the interviews/focus groups with documentation of researcher impressions from the meeting(s) and continued with receipt of the transcribed information. Immersion within the data continued throughout November and December of 2010. Defense of the dissertation occurred in August 2012. Details of data analysis continue in the next section.
**Data Analysis**

Two essential aspects of data analysis within focused ethnography were identifying cultural themes and completing a cultural inventory (Speziale & Carpenter, 2007). Reflections and impressions of individual interviews, and focus groups were analyzed for themes. Field notes and participant observation notes were reviewed for themes and domains (Spradley, 1980). Transcriptions were read several times with descriptive and theme notations made in the margins to highlight significant statements, sentences, or quotes that provided an understanding of how the participant experiences the culture (Creswell, 2007). “The Atlas Ti computer software program was used to organize the text, recordings, coding, and memos into a project (Creswell, p. 166).” Data analysis was brought back to the participants for verification member check through a final focus group.

Cultural themes require immersion into the data to identify patterns not previously identified and to explore recurrent patterns for reliability (Speziale, et al., 2007). Specific themes to organize the data were established. Overview summaries of the themes were written to identify themes revealed.

Speziale et al. (2007) defined a “cultural inventory as the writing of the ethnographic data into specific domains providing the opportunity to organize collected data” (p. 220). The cultural inventory required the researcher to organize the data into specified and organized domains, listed themes, list of examples, identified miscellaneous data, and identified themes for future study. Interpretation of the data provided a description of the social and cultural capital and the CNAs use of this information when interacting within the institutional culture.
An advantage of focused ethnographic research was that it provided the researcher with emergence in the culture of the key informants and participants in the study. An advantage and disadvantage of the focused ethnography was the limited time for conducting the study. The disadvantage of the short time frame was not having extended observations of the CNA participants. Becoming immersed in the culture of unit or that of the CNAs may also be a disadvantage of focused ethnography. Speziale & Carpenter (2007) identified immersion into the culture as a problem of ethnography that may lead to loss of focus of the research. Another potential advantage and disadvantage of this method was interpretation of the data. The advantage was that the researcher interpreted the data according to his or her information and comparison to the literature. A disadvantage was that another researcher’s interpretation might differ or conflict. This potential conflict however, identified the importance of sharing what was learned and attempting to make sense out of the cultural patterns presented.

Summary of Methodology

The focus of the current nursing literature included CNA job satisfaction, resident satisfaction, and moving from the medical model to the social model in skilled nursing homes. The cultural and social capital of the CNAs and use of the cultural and social capital while interacting within the institutional culture has not been explored.

The study was conducted in an urban skilled nursing home, with CNAs who work full time on the day or evening shift. Demographic data collected identified the age, educational level, ethnic background, marital status, number and ages of children, mother and father’s educational level, mother and father’s occupation, and number of years’ experience as a CNA. The researcher conducted individual interviews with CNA
participants who comprise the purposive sample. Participant observation notes were included in the data analysis. Focus groups were also held with registered nurse managers, registered nurses, licensed practical nurses, and environmental service aides who worked with the CNAs who participated in the study. Individual interviews were held with cognitively intact residents. Analysis of data included review of the researcher’s focus group transcripts and individual interviews for themes and cultural domains. The transcribed data from the interviews, informal discussions, focus groups, and participant observations were member checked to provide trustworthiness with the data, within a final focus group of CNA participants. This analysis is discussed in detail in the next chapter.
Chapter 4: Results

Introduction

This chapter reports the results uncovered during this focused ethnographic study which asked the following two research questions: 1) How do certified nursing assistants (CNAs) describe their cultural and social capital? and 2) How do these CNAs interact within the institutional culture of the skilled nursing home?

Ethnography, an intensive study of a participant’s culture, uses observation within the participant’s setting, interviews with participants, and information collected about the participants from other sources related to the topic of interest (Speziale & Carpenter, 2007; Richards & Morse, 2007; Flick, 2007; Creswell, 2007). Focused ethnography is “used primarily to evaluate or elicit information on a special topic or shared experience” (Richards & Morse, p. 58). Speziale & Carpenter identified focused ethnography “as having as the focal point a distinct problem studied within a single context with a limited number of individuals” (p. 204). The focus of this study was the shared experiences of CNAs as they utilize their social and cultural capital to interact with the institutional culture. This chapter presents information gathered through observation of the CNA participants at mealtimes and from individual interviews with CNA participants. Information about the CNAs from other sources was gathered from interviews with cognitively intact residents, and focus groups held with coworkers of the CNAs including the registered nurse managers, registered nurses, licensed practical nurses, and environmental service aides.
This chapter describes the CNA participants, demographics of the CNA participants, description of the setting, and the participant observation, followed by the themes developed from the data collected through CNA participant interviews and the focus groups from the different members of the institutional culture. An in-depth description of the setting provides the basis to understand the environment in which the CNA worked prior to discussion of the participant observation. Data analyses from the CNA participant interviews, focus groups of the registered nurse managers, registered and licensed practical nurses and environmental service aides, and individual interviews of the cognitively intact residents are then presented. Analysis of the data for patterns identified domains or areas to focus on and cultural themes. Then a cultural inventory was developed and presented (Appendix K). Speziale and Carpenter (2007) defined a “cultural inventory as the writing of the ethnographic data into specific domains providing the opportunity to organize collected data” (p. 220). The cultural inventory required the researcher to organize the data into specified and organized domains, list themes, list examples, and identify miscellaneous data, and identify themes for future study. Interpretation of the data provided a description of how the CNA participants viewed their social and cultural capital and how these CNA participants used this information when interacting within the institutional culture. Member check of the data analyses was reflected in the themes identified.

CNA Participants

Potential participants who met the study criteria (worked in the skilled nursing facility as a CNA for at least one year on the day or evening shift) were selected from the complete list of CNAs who worked at The Home. These CNAs received a letter of
invitation (Appendix C) in their unit mailbox to participate in the study. The letter of participation was sent at the end of September 2010 requesting interested CNAs to contact the researcher. From that letter, three CNAs contacted the researcher to participate within the time frame. One CNA responding to the letter was from a 25-bed unit and two CNAs responded from two different 42-bed units. These CNA participants were the first to be interviewed for the study. The researcher chose to pursue additional individuals by personally inviting CNAs to participate in the study from the three 40-bed resident units as well as recruiting additional CNAs from the five 42-bed resident units. These units were selected because they offered the greatest number of potential CNA participants who would meet study criteria. CNAs were individually contacted in person by the researcher throughout October and November 2010. Of the possible 140 CNAs invited to participate in the study, 22 (16%) agreed to be involved. One CNA who agreed to participate in the study was not interviewed due to repeated scheduling conflicts. A total of 21 (15%) CNAs who met the study criteria were interviewed.

**CNA interviews.** CNA participants were individually interviewed in a conference room with one entrance or in a private office to prevent accidental interruption during the process. Interviews varied in time from 30 min to an hour and were audio recorded. At the beginning of each interview the researcher explained the purpose of the study, and participants were then asked to sign a consent form (Appendix F), which included consent to be audio recorded. Participants received a copy of the consent form to keep. The purpose of audio-recording the interview was explained as were the concepts that would be focused on during the interview. Pre-identified concepts are utilized within focused ethnography a specific strategy to explore specific concepts within a specific
group (Speizale & Carpenter 2007). Prior to beginning the interview, each participant was asked to complete a demographic form (Appendix G). Each interview was done using a structured interview guide (Appendix D), and clarification of comments was sought throughout the interview process. At the end of the interview the CNA was asked if there was anything further he or she wished to share. All participants were thanked for their contributions to the study and invited to a group meeting held at a later date to review initial findings in order to verify the accuracy of the analyses. Participants were encouraged to attend the follow-up group meeting to provide additional feedback on the development of the themes from the data. Specifics regarding the CNA participant’s demographics are described next.

Demographics. Demographics were completed as part of the individual interview process (Appendix G). Of the 21 certified nursing assistants who participated in the individual interviews, 2 (10%) were men and 19 (90%) were women. Ages of the CNA participants ranged from 22-70: 10 (48%) of the CNA participants were between the ages of 22 and 40, 4 (19%) were between 41-50, 6 (28 %) were between the ages of 51-60, and one (5%) CNA was between 61-70. Within the CNA participant group 10 (48%) were single, 5 (24%) were married, 4 (19%) were widowed and 2 (9%) were divorced. CNA participants had children with ages ranging from 1 to 41.

To better understand the social capital of the CNA participants, the level of education of the CNA participants’ parents was included in the demographic background. CNA participants identified the educational background of their mothers as 7 (33%) did not complete high school, 8 (38%) did complete high school, 5 (24%) completed some college, only 1 (5%) completed college. None identified their mother completing post
college education. Identifying their father’s educational level, 6 (29%) did not complete high school, 8 (38%) did complete high school, 4 (19%) completed some college, 1 (5%) completed college. None of the fathers had completed post college programs and 2 (10%) participants did not know their parents educational level.

Within the group of CNA participants, the duration of service may be related to the interaction the CNA has with the institutional culture. The length of time a person had worked as a certified nursing assistant ranged from 2 years (38%) to 31 years (5%), while the length of time the CNA participants had worked at The Home ranged from 1 year 2 months to 31 years. Thirteen (62%) of the CNA participants had worked at the home 1 to 6 years and 4 months, while 8 (38%) had worked more than 7 years. The average length of time a CNA participant had worked at The Home was 6 years and 9 months (38%).

Finally, race/ethnicity was equally divided between eighteen (86%) of the participants with nine (43%) each identifying as white or African American, and three (14%) CNA participants identifying as “other.” Focus groups were conducted with the registered nurse managers, registered and licensed practical nurses and the environmental service aides which provided the study with a view of the CNAs from the institutional culture.

Focus Groups

Focus groups were held with the registered nurse managers, registered and licensed practical nurses, and environmental service aides from the three 40-bed resident units and the five 42-bed residents units on which the CNA participants worked. A focus
group was not held on the 25-bed unit in order to protect the identity of the CNA participant from that unit.

**Institutional context.** During the time of the study, the registered nurse managers provided the overall administration on the resident units and were involved as the CNA participants’ supervisor. The registered nurses were responsible for assessing resident needs and, as with the licensed practical nurses, were also responsible for medication administration, treatments for residents and resident care. The environmental service aides were responsible for cleaning the residents’ rooms and the entire unit.

Nursing staff and environmental service aides were sent a participation letter via the staff member’s mail box explaining the study and requesting the individual to participate in the focus group (Appendix E). The focus groups were held in a room with one entrance to avoid accidental entry by others during the interview process. The focus groups were specific to the role in which the individual worked, allowing each individual to freely discuss their viewpoints from their individual role with the CNA. Five (63%) of the eight registered nurse managers from the eight study units participated in their focus group. Three (33%) registered nurses of the 9 possible registered nurses, 4 (13%) licensed practical nurses from the 30 possible licensed practical nurses, and 7 (58%) environmental services aides of the 12 possible environmental service aides participated in their individual focus groups.

The focus groups lasted about 60 minutes per group. At the beginning of each focus group members were informed that the meeting would be audio recorded. The guidelines (Appendix H) for the focus group were reviewed with participants. The purpose of the focus group was discussed, the consent form (Appendix F) was then
reviewed and given to each participant who was asked to sign and return the form at that time. Participants received a copy of the consent form to keep. Demographic data were not collected from focus group participants. At the end of the focus group, members were thanked for their contributions. Focus group members were invited to join a future meeting to hear the results of the study. Individual interviews were done with cognitively intact residents to provide another view of the CNA participants from the institutional culture.

_Cognitively Intact Resident Interviews_

Registered nurse managers were asked to identify cognitively intact residents on their unit. The researcher then spoke to each cognitively intact resident on the unit to share the purpose of the study. The resident was then informed of the purpose of the interview, the possible amount of time the interview would require, and that the interview would be audio recorded. If the resident was interested in participating, he or she was asked what day and time would be best to be interviewed. Individual resident interviews were done to protect potential disclosure of information by other residents in a focus group. When the resident was interviewed, the researcher re-explained the study purpose and obtained consent (Appendix F) from the cognitively intact resident. If a resident was unable to sign the consent form due to visual or physical restriction, the researcher would audio record the resident’s consent. A copy of the consent form (Appendix F) was then given to the resident.

Of the 14 cognitively intact residents identified by the registered nurse managers, nine residents (64%) agreed to participate in the study. Individual resident interviews took place in the resident’s room or an area that was unoccupied by other residents or
staff. The resident interviews usually took 45 minutes to 1 hour. Demographic data were not collected from the cognitively intact residents. All resident interviews were audio recorded; at the end of the interview the residents were thanked for their participation. Residents were invited to join a presentation of the study findings at a later date.

**Description of the Setting**

For the purposes of this focused ethnographic study, the description of the institutional setting provides background information about the institutional culture of The Home. The Home is the only registered Eden Alternative long-term care community in the Upstate area that offers innovative skilled nursing home options to match the unique needs of each individual. The Home embraces the Eden Alternative philosophy of person-centered care in caring for elders. For the purposes of this study, person-centered care was defined as the resident and CNA working together to meet the resident’s expectations and needs for daily living. The philosophy of the Eden Alternative focused on building a relationship between the resident and the certified nursing assistant (Thomas, 1992.) Central to senior living at The Home was the Eden Alternative mission as defined by The Home which is to nurture life with vibrant caring life-affirming relationships and to create a resident-centered community. The Home strives to have all employees develop a relationship with residents, through activities or care interaction.

Changing the culture of The Home from the medical model, defined as being medically oriented and following pre-established schedules, to the Eden Alternative philosophy of person-centered care was an ongoing process. At the time of the study the medical model of care was still in place within The Home. The medical model included
following specific time frames for routine activities of life, such as meal times, times for medications, and specific employee roles. The medical model of the skilled nursing home also has a standard physical layout for the resident units that was based on efficiency and providing medical care to a resident. While each of the buildings has a different physical layout, there were commonalities such as a nurse’s station, living room/lounge, private and semi-private resident rooms and dining rooms. The Home was a large skilled nursing facility with three buildings dedicated to resident care. For this study all the larger resident units were used for participant observation.

The 42-bed units were laid out in a square figure eight, with two long hallways, a short hallway at each end and short hallway in the middle. Main access to the unit was by elevator located in the center hallway, which opens to the nurse’s station. The living room for the unit was located to the north side of the unit, almost directly opposite the nurse’s station and the elevators. A multipurpose room, located in the center of the unit behind the elevators, was set up with a large conference table in the middle, comfortable chairs or love seats along the walls, a stove and refrigerator, a television and a stereo sound system, depending on the unit. Some of the residents chose to eat their meals in the multipurpose room. The dining room was located at the east end of the building.

The dining room had doubled half-glass doors opening into a large spacious room with a bank of windows located on the west side of the building. On the east side of the dining room there was a kitchenette with a stove, refrigerator, and sink and next to the kitchenette was an enclosed room with a large conference table. This conference room functions as a multi-purpose room for meetings or a small party, and some residents routinely eat their meals in this room. In the main section of the dining room, tables were
placed throughout the space to provide greatest access for residents in wheelchairs. Residents typically have a specific table and place at the table for each meal.

The 40-bed resident building had a different physical layout. The elevator opened to the center of the unit, which was circular, with three hallways leading to resident’s rooms. The secretary’s desk was within the circular area with the nurse’s station, the entrance to the dining room and a multi-purpose room opening off this area. The dining room had three entrances: the main entrance was from the center of the unit, with two side entrances one from each of the two long hallways. The north side of the dining room had a full wall of windows. On both the west and east walls were pictures, with one unit having a flat screen television on the west wall as requested by the residents. The south wall had a small kitchenette with refrigerator and stove, the main entrance was in the middle of this wall and on the other side of the doorway was a window between the nurse’s station and the dining room. The table arrangement in each dining room accommodates the needs of residents in wheelchairs and as in the 42-bed unit residents sat at a specific table and place for their meals.

Data Analysis

This data analysis section will review the methods used to develop the cultural themes and inventory reflective of the CNA participant’s cultural and social capital and the interaction of the CNAs cultural and social capital within the institutional culture. Data were collected from six groups within the institution: CNAs and cognitively intact residents participated in individual interviews; registered nurse managers, registered nurses, licensed practical nurses, and environmental service aides participated in focus groups. Participant observation and field notes were started before the participant
interviews were conducted. Participant observation and the field notes provided another level of insight of the CNAs’ cultural and social capitals interacting within the institutional culture. Data analysis was completed using Atlas ti™ and repeated review of data transcriptions for key words and phrases to determine themes. The first step of data analysis done during the participant observation was domain analysis, exploring the patterns of relationships and interactions between the CNAs, the nursing staff, and residents (Speziale & Carpenter 2007). From the domain analysis, the larger categories in which the domains belong were sorted to develop the cultural inventory. The cultural inventory provided the organization of the material presented in the results. Member check was done with a small group of the CNA participants to review the cultural themes identified. CNA participants agreed with and were supportive of the themes identified.

**Participant Observation**

Participant observations were done on three of the 40-bed resident units and five of the 42-bed resident units, in such settings as the resident dining rooms, unit corridors, living room, and multipurpose room. Only one CNA participant was from a smaller unit of 25-beds. This CNA participant was included in the study and participant observation was done only once on the smaller unit. Participant observation was focused on the larger units during the mealtime, watching meals in the dining room, multipurpose room, or CNAs delivering trays to the individual resident’s room. The 40 and 42-bed units were used for participant observations related to the potential of observing a greater number of nursing staff, CNAs, and registered and licensed practical nurses interacting during the meal times.
In this study, participant observation occurred at mealtimes in order to capture a snapshot of the interaction of the CNAs' cultural and social capital within the institutional culture. Resident meal times were established for each unit. Typically, residents were brought to the dining room for the meal by the CNAs. The breakfast meal was typically the most rushed meal for the nursing staff related to the residents being bathed, dressed, toileted, and transferred to the dining room. Getting residents dressed before breakfast was reflective of the medical model of care, not the Eden philosophy of care.

All nursing staff was expected to help with the mealtime. While the registered nurse manager may not be in the dining room during the mealtime, the registered nurse manager relied on the CNAs to work with other CNAs and nurses to assure all residents received their meals and were helped as needed. Helping each other to get residents into the dining room, serve trays, and feed or help residents with their meal demonstrated how well the nursing staff worked with each other to achieve the goal of all residents receiving their meals.

During one breakfast, a CNA was observed setting up trays, while other staff delivered trays. As the CNAs were setting up and delivering trays, one of the male residents by the room divider yelled out “hey, what about me?” This resident did not have his tray at that time. The CNA setting up the trays called back “I’m coming, I’m almost ready.” A staff member said something to this CNA and the CNA responded, “I know he doesn’t have his tray, I’m saving it for last so I can feed him.” This CNA then took the tray over to the male resident, placed the tray in front of the resident, pulled up a chair and said to the resident, “I saved the best for last.” As the CNA was opening items on the tray she asked the resident if he would like to start with a drink of juice or coffee.
The resident responded and throughout the whole meal the CNA talked with the resident about the food or other topics of interest to the resident. The CNA watched the resident for clues that indicated the resident was ready for another bite or drink. This CNA also positioned her chair close to the resident to comfortably feed the resident and lean into toward him when speaking or responding. When the meal was over, the CNA asked the resident if he was finished and when the resident said he was, the CNA removed the resident’s napkin, and then removed the tray from the table.

This participant observation demonstrated the institutional culture of the meal service and CNA’s expression of her social capital, or how the CNA made connections with others. In the observation above, the CNA connected with the resident through eye contact, body language, listening to the resident’s conversation, and responding to the verbal and nonverbal cues throughout the meal time. The CNA also demonstrated understanding of her cultural capital in her manner of interaction with the resident, specifically treating the resident like a family member, being respectful of the resident’s wants and needs, asking what the resident would like throughout the meal, taking the resident’s preferences into account throughout the meal, and attentively listening to the resident’s conversation and responding. From the resident’s responses and interaction with the CNA, it was clear the resident had a relationship with this CNA. While this observation was a snapshot of an interaction of a CNA and resident, it provided a clear view of how this CNA used her cultural and social capitals to interact within the institutional culture of The Home. This CNA demonstrated her application of The Home’s Eden mission to nurture life with vibrant, caring, life-affirming relationships.
The next section identifies the themes developed from the data collected through CNA participant interviews and the focus groups from the different members of the institutional culture. The major guiding research concepts explored in this study are institutional culture, cultural capital, and social capital. The themes identified for each of these guiding research concepts from the data are in bold italic with the subthemes in italics.

Themes for the Guiding Research Concepts

Themes that emerged from the data that the researcher connects to the guiding research concepts of institutional culture were *We are like family,* and *We work together (Teamwork).* Within the theme of *We are like family* was the subtheme of *Protecting the family from outsiders.* Social capital interacts with the institutional culture through the theme of *Communication skills which build relationships.* The cultural capital of the CNAs was evidenced in the themes of *Learning caring from Home* and *Lessons about being a Worker.* The theme of *We influence each other becoming family* reflects how the cultural and social capitals of the CNAs interact within the institutional culture. Each of the themes will be individually explained, beginning with the themes from institutional culture, followed by social capital, then cultural capital, and then how the CNA participant’s cultural and social capital interacts within the institutional culture. The guiding research concept of institutional culture will be discussed first to provide an understanding of the whole culture of the skilled nursing home before exploring how the individual CNA participant’s cultural and social capitals are expressed. A summary of the chapter will review how the themes answer the research questions.
Institutional Culture

For the purpose of the study, institutional culture was defined as the way things are done in an organization, including the rules and regulations and employee behaviors (Clarke, 2006). The institutional culture of The Home was made public through its mission statement and philosophy. The actual institutional culture was reflected in the daily interactions on the units and in meeting rooms. Institutional culture was reflected in how the registered nurse managers, registered nurses (RN), and licensed practical nurses (LPN), environmental service aides, and cognitively intact residents view their interaction with the CNAs. The first theme discussed is *We are like family*, followed by the subtheme *Protecting the family from outsiders.*

**We are like family.** As the foundation of the institutional culture, *We are like family* was expressed consistently by the CNA participants, residents, nurses, and environmental service aides. CNA participants commented “it’s like family here (The Home), it’s a family oriented environment here (The Home) and the residents share their lives with you and you become like family.” CNA participant 1 stated “the elders, you get attached to them, you become like their family.” CNA participant 18 holds a similar feeling stating; “I like helping people when like their (residents) family can’t help them because we become their family when they don’t come as often as they should.” Cognitively intact resident 1 shared her view of the CNAs becoming part of the resident’s family stating; “first of all they (CNAs) become like my family.” CNA participant 1 stated, “you’ve got to treat them like they’re (residents) your own parents.” This sentiment was repeatedly voiced by the CNAs in numerous ways including “treat (others) like you would like to be treated,” or “treat like you would like your family members to
be treated if they were in the facility,” or “if you treat people the way you want to be treated, then you won’t have any problems.” CNA participant 4 shared her view of respecting the residents stating, “If they’re (resident) asking me for something I will do everything that they want.”

CNA participant 14 shared her view of why she had the relationships with her residents that she did stating; “It’s like your home away from home, you spend so much time there, (it becomes) like your own family.” The importance of the CNA following the resident’s instructions was reflected in CNA participant 15’s statement:

The main thing that they (residents) want is for you to do what they want you to do. I mean as long as you can follow instructions and do what they want done it’s pretty good, they pretty much like you.

Many of the cognitively intact residents interviewed shared their views of how they want to be respected by the CNA caring for them. Residents expressed the desire that the CNA respect how the resident wanted things done during the resident’s care. Cognitively intact resident 6 talked about his view of the importance of the CNA respecting him stating:

Just listen to me the way I tell them (CNAs) my grooming (needs) to be or whatsoever, or things that, like in my room, don’t move this or that because that there I like to stay that same way I got it or whatsoever, and we get along fine.

These views reflect that the Eden mission of The Home, to nurture life with vibrant caring life-affirming relationships, and the Eden philosophy of building relationships between staff and residents has become the institutional culture. The concept of “family”
includes the residents and all coworkers on the resident unit, not just CNAs. Registered nurse manager 2 stated,

(The CNA’s are) wonderful to the elders, to the families. I think of one particular aide (CNA) who’s worked for “The Home” a number of years, and she’s a fabulous aide. She loves, actually loves every one of her folks on her assignment and they love her too.

Establishing a “family” feeling between the residents, CNAs, and staff provides beneficial effects for the residents, the coworkers and the unit. Treating the residents like “family” was also observed by the nurses on the units. LPN 4 stated,

I see them(CNAs) treat these residents and I’ve said it time and again, you treat them like they are your family members because that’s how you want your family to be treated, and I see that that’s what they do. They’re affectionate, they’re caring, they’re gentle, they have respect for their elders.

CNA participants who cared for the same residents over a period of months or years had an opportunity to learn the intimate aspects of the resident’s likes and dislikes, moods, and behavior that reflect the resident’s feelings as observed by the nurses. This was seen by LPN 2 who stated, “if you have the same girls (CNAs) taking care of the same people it gives them (residents) that personal connection with that person and they end up loving them.”

Other staff members on the resident unit felt a sense of “family” from the coworkers and residents. Environmental service aide 6 stated, “I think we should be like one big family, everybody knows their positions, everybody knows what to do.” This view was supported by environmental service aide 1 who stated, “every month we have
(a) meeting together so (we) get together, we get together like family.” Relationships were consistently observed in the setting by all of the employees as well as the CNAs. CNA participants expressed a sense of having a relationship within The Home. CNA participant 6 succinctly described the institutional culture stating, “It’s like family, it’s like family here. I mean everybody know(s) you, I told my husband the other day the security guard knows my name.” Recognition by a staff member from a different department gave this employee the sense of family, of being known within The Home.

Protecting the family from outsiders. On each of the study units, CNAs were permanently assigned to specific residents. The CNA participants discussed the pride they have about their assigned unit and the care they provide for their residents. However, some of the CNA participants voiced concerns about how some other CNAs (other CNAs from outside of the unit or nonpermanently assigned [per diem/float] CNA) treat residents roughly, or are not respectful to residents, or did not follow the resident’s instructions for care. CNA participant 2 talked about an experience she had with a nonpermanently assigned (per diem/float) CNA who had come to her unit stating:

(CNA participant 2 dislikes other CNAs) being sharp with the residents, not cleaning them properly, neglecting them as far as what needs to be done with that resident, you watch all that go on and it’s very frustrating because the permanent aide is not there that day.

These types of behaviors were identified as witnessed by the CNA participants from both permanent CNAs on their assigned unit, as well as from nonpermanently assigned (per diem/float) CNAs. Undesirable behavior from coworkers influenced how some of the CNA participants view some of their counterpart CNAs. CNA participant 3 stated: “My
difficulty is when there’s other staff members who aren’t nice to these people (residents).”

When a CNA participant observes poor behaviors or treatment of residents by staff, these concerns are reported to the nurses or registered nurse manager. Registered nurse manager 3 said, “I have problems with floats a lot of times. They (float CNAs) don’t have a relationship up on the floor.” The lack of relationship with the residents or unit staff by the CNA float creates concerns for the permanent unit CNAs. Registered nurse 1 stated, “They’re (regular CNAs are) concerned when there’s going to be somebody (float CNA) that doesn’t know the resident, taking care of them.” This left the permanent CNA participants feeling helpless in protecting the residents and hoping the behavior would be observed directly by the registered nurse manager and then addressed. CNA participant 3 discussed her frustrations with CNAs who didn’t care for the residents well stating, “I used to go to a nurse manager or the nurse first and then the nurse manager and nothing was done so I just, I figured well let them (CNAs) get caught on their own.” Cognitively intact resident 3 expressed his view of how his opinion was received by some of the CNAs stating:

I can talk and sometimes they (CNAs) don’t like it (when I tell them how I want something done). (The CNA will say) “I know, I know how to do that”, okay good, then let’s do it the right way then. Sometimes they make a few mistakes and I try (to correct them), they don’t like to be corrected too much.

Not having a relationship on the unit with the staff or residents sets the nonpermanently assigned (per diem/float) staff member apart from the others on the unit. However, some CNA floats have established relationships with some of the residents and
staff throughout The Home. CNAs who have developed a deep relationship with the residents also lead some CNAs to be protective of the residents as stated by LPN 3:

“I think most of the CNA’s (have a connection with their residents that they view their residents) like it’s my children you might say and that’s how the CNA’s feel about most of their residents, especially if they’ve had them (residents) for a long time. So they (CNAs) get territorial about their (residents) stuff.”

The CNA’s protective attitude toward residents reflects his or her understanding of the institutional culture’s mission to nurture life with vibrant, caring life-affirming relationships in The Home. As identified by the registered nurse manager, licensed practical nurses, the CNA participants, and the cognitively intact residents, The Home feels like and is a family for those who see and work with each other day in and day out.

*We work Together (Teamwork).* Working together to meet the needs of the residents and the unit is a vital aspect of providing effective care. The CNA participants and other members of the institutional culture offered their view of the importance of working with each other to achieve the best day for the resident.

CNAs are well known throughout The Home as the CNA transports residents to different departments or areas of activities or appointments such as the beauty shop, physical therapy, the medical department, or to the cafeteria for a meal or coffee. The CNA is introduced by a coworker when first orienting to the job and each staff member has a name tag with large print to allow residents and others the opportunity to read the person’s first name easily. Addressing a person by name helps foster interaction between coworkers, which may lead to teamwork. Working together caring for the residents and meeting unit needs through consistent give and take interactions between the CNAs and
nurses demonstrated the CNAs’ understanding of the institutional culture and expectations within The Home. Each registered nurse manager has expectations of the nursing staff on the unit, as do the registered nurses, licensed practical nurses, and CNAs. Registered nurse manager 1 discussed her view of the nursing staff working together or doing teamwork saying, “the teamwork, the respect for each other, respect for all staff---they (nursing staff) know that that’s the expectation.” The ability of unit staff to work together with each other influenced the effectiveness of the nursing staff to provide comprehensive care for residents.

Both the registered and licensed practical nurses reflected on the importance of working with the CNAs. Registered nurse 1 identified how the unit staff works together stating, “they (CNAs) have a safe environment to talk even though we do sometimes talk about things that are not pleasant to talk about, you can still come back and work as part of the team.” Registered nurse manager 4 echoed this sentiment stating, “We (registered nurse managers) all have some heavy duty things going on, but I think as long as people (nursing staff) know that the teamwork is there they feel better.” Licensed practical nurse 2 reinforced this thought through personal experience stating, “I found out it helps if you actually work along with them (CNAs).” Helping nursing staff, nurses and CNAs, on the unit integrate into the team was viewed as vital to developing cohesion with the staff, demonstrating the institutional cultural belief of being there for the residents. Registered nurse manager 3 discussed how on her unit the nursing staff helped a new nursing staff member integrate into the group:

All new people are paired up with a CNA on every single cluster, regardless of the shifts they go to (work) during that time on days, because they need to know
about everybody (residents). That also gives me the opportunity when I speak (to
the new person), how are things going to get a truer picture of how that person is
interacting with the staff, becoming part of the team.

Working together with new nursing staff helped both the new nurses and the CNAs
become familiar with each other’s skills and knowledge and increased the potential for
both the CNA and the nurses to become comfortable working together. The importance
of all staff on the unit being able to get help or assistance from another staff member was
a high priority. While it was important to have the nursing staff help each other, the non-
nursing staff was also part of the team as described by the environmental service aides.

The environmental service aides’ job involved cleaning the unit and resident’s
room. If a resident’s call light was on and the environmental service aide was in close
proximity to the resident’s room but there was not any nursing staff in the area, the
environmental service aide would respond to the residents’ call light and, if able to help
the resident, would. But if the environmental service aide was not able to meet the
resident’s needs because it required hands-on care of the resident, the CNA or nurse was
sought. Environmental service aide 2 described her view of how this worked on her unit,
“I help them (CNA) like team work, and I ask them and they come and help me, very
good teamwork on my floor.” As a group, the staff on the unit viewed working together
with the CNAs as being included, contributing to a sense of cohesion for all staff. The
view of the residents was similar to the staff when exploring how the CNAs work with
others. Three of the cognitively intact residents shared their views of how the CNAs
helped each other on the unit. Resident 1 talked about her view of how the CNAs worked
together stating:
Some of them (CNAs) they go together, some of them go by themselves. It
depends, I just need one aide because I go on the ready stand, but when you get
them (resident) on that Hoyer lift there has to be two (CNAs).

For this resident, knowing the CNAs were there to help each other while caring for other
residents provided a sense of security. If the resident needed more help in the future, he
or she could expect the staff to help each other. Resident 9 stated, “I think the
willingness (of the CNAs) to help one another has been a biggie (important to meeting
the needs of the residents).” This resident identified what most residents were concerned
about. This resident knows that the CNAs practice working together and this gave the
resident greater assurance that her needs would also be met. Working together
effectively involved having relationships with others to accomplish the needed care.

These themes and subthemes of the institutional culture provided a picture of how
The Home was viewed by the CNAs, registered nurse managers, registered and licensed
practical nurses, environmental service aides, and cognitively intact residents. This
information also described how the CNAs were viewed by the members of the
institutional culture, the registered nurse managers, registered and licensed practical
nurses, environmental service aides, and cognitively intact residents.

Social Capital

Using the concept of social capital, the researcher explored how the CNA
develops connection with others. Social capital was defined as connections in and
between social networks of a person (Bourdieu, 1999). Effective use of social capital
allows a person to establish and maintain relationships. Relationships between staff,
residents, and CNAs were influenced by a number of factors, as well as by the staff
member’s role on the unit. The amount of time spent interacting with a person, the
purpose of the interaction, and the connection between two people such as boss and employee, influence the development as well as depth of the connection. Social capital intersects within the institutional culture through the theme of *Communication skills which build relationships*, which focused on how connections were developed between people.

*Communication skills which build relationships.* A variety of communication skills were required to develop a relationship with another person. Three of the communication skills most frequently identified by the CNA participants were observation, listening, and humor. These skills, used individually or in combination with each other, provided the CNA participants the opportunity to develop a relationship with the others.

CNAs used observation routinely in their care of residents to look for changes in the resident’s physical condition. The resident’s body language may help identify subtle changes in mood and behavior which may help to detect health changes. Some CNA participants identified their use of observation before they shared more information with a resident. CNA participant 16 talked about her experience using observation while making a connection with a resident; “I usually observe first before I really open up to that person.” Observing a person first can help to determine the best approach to use. Observation and listening are closely related for many CNAs when connecting with residents or staff members.

CNA participant 10 stated, “I’m just more the person that sits back and observes (when talking with a staff member).” But when talking with a resident this same CNA stated, “Well with the elders it’s a lot different. I mean with them (residents) I can sit
back and they can tell me tons of stories about the past and stuff that they went through, I
connect like that.” The CNA may not be aware of observing the resident while listening
to the resident’s stories, but watches the resident’s facial expression and body language
responding appropriately. While observation helped to connect with a resident, listening
to what the resident said provided more depth to the information from the observation.

CNA participant 5 discussed her beliefs about listening to the residents:

I talk to them (residents) sometimes they just need that ear to listen to or if they
want to go over and talk I don’t mind that either but I listen to them, if I can
respond back I’ll give it, you know, I’ll respond back, and if I don’t have an
answer I’ll be like well I’m going to come back as soon as I get done with the
next visit, I’ll come back and I’ll have an answer for you hopefully, if not that day
maybe the next day.

Listening provided this CNA with information that might go beyond what the resident
was actually saying. Patience and understanding were the reaction of this CNA to what
she heard the resident share. Connecting with another person varied from intense sharing
of feelings to giving directions to sharing a laugh. Use of humor when interacting with
others may provide another avenue to establish a connection.

Expressing humor when interacting with another person can lighten the mood of
conversations. CNA participant 15 described her experience using humor with others
stating, “I tend to use a lot of humor when I first meet somebody, if they laugh at my
jokes, then they’ll like me.” Humor can be very effective in helping a person relax and
share a sense of commonality with the other. A sense of connection with the other person
may provide a sense of security and comfort with that person. CNA participant 20 said
while getting to know a resident if there was something he didn’t know or couldn’t relate to as he was speaking with a resident, he would use his humor. This CNA said:

if they (resident) tell me something that I can relate with we’ll talk about that, or even if it’s something that is just kind of make light of it and joke about it and stuff. Have little inside jokes with them so they know that you’re not just there because you have to be.

An “inside” joke shared only between this CNA and resident secured a relationship between the two. Use of these communication skills helps the CNAs develop relationships with residents, and coworkers. While social capital helps a person develop relationships with others, the person’s cultural capital provides guidelines for behavior in different situations throughout a person’s life. The next aspect of this focused ethnography explores the cultural capital of the CNAs.

*Cultural Capital*

Cultural capital was defined as the rules and values an individual learns as a child in the family of origin (Bourdieu, 1986). The themes identified are *Learning caring from Home* and *Lessons about being a worker*.

*Learning caring from Home.* This theme focused on family members who role modeled caring by either being a healthcare worker, showing the importance of respecting older individuals and/or being involved in providing care for family members. These rules and values became life’s lessons from home that provided guidance to an individual as the person grew into adulthood and throughout life. These were the lessons a person shared with their own children and these were the lessons a person recognized in another person who has learned similar rules and values in their family.
Stories of a family member who was a nurse or CNA or the idea that caring for other people was a valued job from the view of the parents were frequently shared by the CNA participants and identified as good role modeling. Positive interactions with a family member who worked in healthcare may have been the stimulus to explore such a job possibility, and this reflected the family’s cultural capital. CNA participant 4 described her motivation:

My aunt she’s been a nurse and when I was a little girl I used to just look at her uniform, she’d talk about (her work) and (how she) enjoyed her work. So that made me go that direction.

A person’s cultural capital helped inform and may influence another individual’s life choices, as do family views and exposure to interactions with older people.

The parent’s respect for older people was frequently shared by many CNA participants. CNA participant 2 stated, “She (Mother) just told me to make sure I had respect for them (elders).” Two CNA participants, from other countries, described their cultural view of respecting older persons because within their countries an older person was addressed more formally. Both these CNAs said they felt older people were shown greater respect in their country of origin than the CNAs were experiencing in their current work setting. While the concept of how to specifically address an older person was identified by these two CNA participants, other CNA participants talked about being taught the value of respect by their parents or grandparents. CNA participant 5 stated, “My grandmother, she taught us how to respect and to listen to your elders.” The lesson of respecting and listening to one’s elders was shared by many of the CNA participants and one with which the residents in The Home were also familiar. Respect for elders was
a consistent expectation of all staff in the institutional culture. The expectation of respect within the institutional culture was also voiced by the CNA participants related to giving and receiving respect from coworkers and residents.

Many of the CNA participants discussed their family involvement in caring for family members and/or witnessing parents caring for older relatives as children or young adults. Caring for an elder in the family was an expression of the family’s cultural capital and demonstrated how the family viewed the older family members. Some of the CNA participants described how their parents involved them in the process of caring for an older relative. CNA participant 3 shared such an experience saying, “when I was younger my grandfather was in a nursing home and my father would pick me up every night and I would go with him and we would take care of my grandfather.” This CNA also discussed taking care of her grandmother at home stating:

Our family was very close and I think that has a lot to do with it. We were all very close, both sides, and even my kids used to come with me when I used to take care of my grandmother and they just see that, and in fact they all get along with elderly people.

This CNA not only carried her cultural capital value of caring for our own family forward but also taught her children this family value.

Other CNA participants witnessed their parents bringing the grandparents into the family home when they required physical care. For some of these CNA participants the lesson learned was to care for their own and they carried the lesson forward when they had aging relatives who needed physical care. CNA participant 5 discussed how her mother cared for the CNAs participant’s grandmother stating; “we kept them
(grandparents) at home, I kept my mother-in-law at home, my mom kept her mom at home and we just took good care of them, whatever made them comfortable as possible.” This lesson of caring for their own instilled in these CNA participants a sense of duty but also pride. The second theme to be discussed was Lessons about being a worker which identified the concepts shared by the family regarding being a worker and having a job.

Lessons about being a worker. CNA participants discussed the lessons about being a worker that their family shared with them, focusing on work ethic including being punctual, listening to the boss, and being reliable on the job. CNA participant 7 discussed the work ethic he learned from his father stating:

I learned a good work ethic. My dad went to work whether he was sick or (had a high) temperature, throwing up, whatever; he was a manager so he was at work every day regardless of whatever and anything less was not looked well upon.

This work ethic may be considered an extreme example of being responsible and accountable in the job, and may not the best model for working in healthcare. But this CNA participant used this information to guide how he navigated in his work setting. Punctuality for the job was an aspect of cultural capital that was stressed by a parent for some CNA participants as important to keeping a job. CNA participant 10 shared what she learned from her family regarding being punctual for work: “My mom always gets on me, you need to be on time for your job, she basically stresses attendance and being punctual is the main thing that my mom stresses.” CNA participant 10 further said that her mother stressed being on time and having good attendance in the job because the mother felt a job offered opportunities not otherwise available to a person. Work ethics learned from the family provided guidance to these CNAs to value their job, a value
learned from the family of origin, a part of the CNA’s cultural capital that motivated the CNA to do the best job possible.

Other lessons about being a worker learned and shared by the CNA participants included the importance of getting along with coworkers, that a job provided independence and the ability to support yourself and have a good living. CNA participant 12 stated, “I learned that you really need to be self sufficient, you can’t depend on others to take care of you.” CNA participant 16 learned from her father the importance of listening to the boss stating, “Daddy told us when you become an adult and you go out in the world you may not like people telling you what to do, but you have to listen to your boss.” CNA participant 17 said she learned from her parents “when you grow up you have to take care of yourself.” Finally, CNA participant 18 talked about what she learned from her parents stating, “That you have a job you can get what you (want), you don’t really have to depend on nobody. You can be the boss of your own destiny.”

Many of the CNA participants learned more than one lesson about being a worker. These lessons for some CNA participants were repeatedly stated by parents or grandparents, while other lessons were incorporated into the CNA participant’s life as chores, parental expectations, or observations. CNA participant 14 shared what she learned from her parents regarding having a job stating, “it’s (job is) important to support yourself and eventually a family and work hard and they’ve (parents) always worked hard. So I started working when I was 14 and it was always nice to take care of myself.” CNA participant 11 talked about her view of what she learned from her mother about
having a job stating, “she (mother) always raised us to work, we were always hard workers, even in the house.”

The attributes of the CNAs cultural capital in their individual development influenced how the individual worked and interacted with others and the expectations the person has of self in the work setting. Cultural capital also contributed to the CNA participants developing connections with others using their social capital effectively. The CNA participants’ cultural and social capital was portrayed in the institutional culture consistently.

CNA and the Institutional Culture

Data analyses exploring the second research question of the interaction of the CNAs cultural and social capitals within the institutional culture identified one theme; **We influence each other becoming family.** The interaction of the CNAs cultural and social capital within the institutional culture reflected how the CNA participants recognized the similarities between themselves, and the residents they cared for developing deep, long lasting emotional relationships. Having developed emotional relationships with the residents reflected and supported The Home’s mission of “nurturing life with vibrant, caring life-affirming relationships”.

Over half the CNA participants described being emotionally attached to the residents they were assigned. CNA participant 3 described her view of emotional attachment with her residents: “They’re like friends, they’re not just residents, you know, and I think I’m their friend.” All of the CNA participants shared stories of memorable residents, both living and dead, with whom they had developed an emotional attachment. Involving residents in the CNAs family events, checking on the resident when the CNA
was off duty, or bringing in food the CNA knew the resident enjoyed were a few of the stories shared by the CNA participants. As within a family, sharing occurs between family members as CNA participant 1 talked about:

I had a resident she loved cream puffs, so I brought one in for her and laid it on her overbed table, I went in at breakfast time and half of it was gone and I go “what happened to the cream puff”, she said “well who brought it in”, I said “well I did”, “oh that was great she says.”

As simple as the above example seems, it shows the depth of emotional attachment this CNA participant had with this resident. Speaking with this CNA regarding this example, the CNA shared how she was “happy” to bring in the food for the resident: it made the CNA participant feel good as well as the resident.

Registered nurse manager 3 talked about her view of the CNAs emotional attachment with their residents stating:

I think of one particular aid (CNA) who’s worked for The Home a number of years, and she’s a fabulous aide. She loves, actually loves every one of her folks (residents) on her assignment and they love her too. And there again, the families have come to me and said thank goodness for this particular person and they do appreciate the care that their father is receiving from her.

This registered nurse further stated; “I think it’s important that the aides build that relationship with the resident because they know them better than I do, they (CNAs) know the little ins and outs.”  Registered nurse 2 shared a similar view of the CNAs development of emotional attachment with their residents stating, “they (CNAs) become very bonded and attached to their elders.”  Another registered nurse manager talked about
family members who praised the CNA who cared for their mother for being able to get her to eat when the resident wouldn’t eat for them, her own daughters. The licensed practical nurses echoed this sentiment with licensed practical nurse 2 stating, “(The CNAs treat their residents) Like they’re (residents) their family members.” Cognitively intact resident 1 shared how she considered two of the CNAs who consistently care for her as her “daughters.” For some CNAs, having recognized the similarity between the CNA and resident, the CNA identified her willingness to do things for the resident that the CNA would consider doing for their own family member.

CNA participant 11 stated, “I treat them (residents) all as if they were my mother and father.” The give and take of personal information between the resident and the CNA included sharing pictures of each other’s family, sharing plans and dreams, residents talking about what their children or grandchildren were doing or when the resident’s family was coming. These activities and discussions demonstrated how the depth of emotional connection developed. CNA participant 18 talked about a resident with whom the CNA had such an attachment stating, “She (resident) used to call and check on me and she would call and check on my daughter and my cat.” Stories of stepping outside the CNA job description to provide interactions for a resident beyond the setting of The Home were shared by the CNA participants, registered nurse managers, and cognitively intact residents. Cognitively intact resident 1 shared an experience she had with a CNA stating;

I wanted to go to Wal-Mart cause I hadn’t been in a store since 2005. (The CNA said) Friday is my day off, if you want to get on the Lift Line I’ll meet you there and then I’ll be with you, and I said sure, that would be fine and thank you for
giving up your day, she says I’m not giving it up because she says I do my
grocery shopping in Wal-Mart.

Registered nurse manager 2 also talked about this CNA participant meeting a resident at a
local department store and shopped with her on the CNA’s day off. The willingness to
do more for the resident without thought of compensation or because the CNA knew the
resident would enjoy the activity demonstrated the CNA’s application of their cultural
capital and social capital. CNA participant 3 discussed a number of memorable residents
she had included in family activities, demonstrating her depth of caring for her residents.

In one situation this CNA was caring for a younger resident whom she viewed as being
very close stating:

He was like a son to me, and my other son was getting married and the wedding
was at a close park. We invited J B (the resident), and his sister to come to the
wedding and he came in his electric wheelchair, he was decked out in this black
suit, purple shirt, he was so happy. He just couldn’t believe it that I invited him.

The CNA participant’s use of her cultural and social capitals and her established
relationship with her residents led to repeated situations in which the CNA participant
would do special things without being asked by the resident. Doing things for the
residents on the CNA’s own time without expectation of compensation was part of this
CNA’s belief that if a resident needed something and the CNA could provide whatever
was needed the CNA was willing to do it. These examples demonstrated how the CNA’s
cultural and social capitals were used to effectively interact in the institutional culture of
The Home.
The concept of *We influence each other becoming family* goes beyond the individual interactions between a CNA and a resident. The sentiment of influencing each other becoming family was shared by The Home with its Eden-based mission to nurture life with vibrant caring life-affirming relationships. This mission was expressed for all who work, live and interact within The Home in a variety of ways to help the employee be successful in the work setting. Many CNAs shared with friends and family that they feel supported by The Home to make a difference in the lives of the residents. CNA participants discussed how they shared their experiences and feelings about their job and The Home with friends who are also CNAs and encouraged their friends to come work at The Home. This demonstrated just how important it was for the cultural and social capitals of the CNAs to interact within the institutional culture. The CNAs became the representative of “The Home” and potentially bring in new employees who have cultural and social capitals similar to current employees. Having similar cultural and social capitals as current employees sustains the institutional culture that maintains the views of *We are like family* and *We work Together*.

**Member Check**

The researcher held a focus group meeting for interested CNA participants in March 2011. Of the 21 CNA participants, 6 participated in the member check. The member check was held in a conference room with one door to prevent unexpected interruption. The focus group was informed of the purpose of the meeting, to review themes identified from the data and that the meeting would be audio-recorded. The researcher then identified the themes for each of the specific concepts being explored: institutional culture, social capital, and culture capital and general themes. Each concept,
such as institutional culture, was identified and then the themes were presented. Participants were asked their impression of the themes within the concept and their view of how the theme reflected what the participant had shared during their interview. Participants unanimously agreed the themes identified were reflective of their views shared in the interviews. Because the member check was held early in the evolution of the themes, the researcher continued to explore the data analysis to determine if there were any subtle themes not previously identified. As a result, the themes were refined to reflect the nuances of the CNA participant’s cultural and social capitals and how these were reflected in the institutional culture.

**Summary of Results**

This study captured a significant amount of rich data from certified nursing assistants employed in a skilled nursing home about how and why they interact as they do in the institutional culture of the skilled nursing home. Within this focused ethnography, analyses of the data were guided by the two research questions studied 1) How do the CNA describes their cultural and social capital? and 2) How do these CNAs interact within the institutional culture of the skilled nursing home? Institutional culture themes identified were *We are like family*, and *We work together (Teamwork).* Within the theme of *We are like family* was the subtheme of *Protecting the family from outsiders.* Social capital intersected within the institutional culture through the theme of *Communication skills which build relationships.* The cultural capital of the CNAs was evidenced in the themes of *Learning caring at Home,* and *Lessons about being a Worker.* Exploring the second research question of How do these CNAs interact within the institutional culture of the skilled nursing home, the theme of *We influence each
other becoming family was identified. The data analysis explored each of the themes and subthemes and provided insight to the qualities of the CNA participants.

The CNA participants’ cultural capital provided insight and understanding about why a person may be motivated to work as a CNA, influences of a family role model as a health care provider; the CNA witness or being involved in caring for an elder family member, and learning from the family the importance of respecting elders as well as coworkers. Cultural capital also provided the CNA participants with information regarding important behaviors needed to keep a job. The CNA participant’s cultural capital molds who she or he was on the job and supports the development of the CNA participant’s social capital.

CNA participants stated their social capital involved the importance of relationships, as well as what communication skills were used to develop relationships. These social capital skills were learned from the family of origin as a reflection of what the CNA may have been told by the family or witnessed during interactions and connections with family members and people in the community. The CNA participants use their social capital skills to learn specifics about the unit family: the residents, registered nurse manager, registered and licensed practical nurses, and environmental service aides. Insight into the family members of the unit (residents and coworkers) and use of communication skills to build relationships pave the way for the CNA participants to effectively interact within the institutional culture.

The institutional culture reflects the cultural and social capital of the registered nurse managers of The Home and influenced how the CNA participants interacted and connected with coworkers and residents in various situations that demonstrated the
interplay of the CNAs’ cultural and social capital. Many of the CNAs related to residents as family members as shown by sharing their home phone numbers, family pictures, bringing in food, or doing something the CNA knew the resident enjoyed. These interactions were reciprocal from the residents to the CNAs as some residents viewed the CNA as a family member and held the CNA in high esteem. Observation of CNAs during mealtimes demonstrated the CNAs’ special connection with the residents they were helping.

The themes identified the influence, depth and importance of the CNAs cultural and social capital and revealed how they affected their interactions within the institutional culture of the skilled nursing home. In the next chapter, the implications of findings, limitations of the study, recommendations, and conclusions will be discussed.
Chapter 5: Discussion

Introduction

This chapter focuses on the implications of the findings, the limitations of the study, recommendations, summary, and conclusions. The purpose of this chapter is to make connections with the findings of this study and the literature, specifically studies in institutional culture, social and cultural capital. The literature is rich in organizational culture and research on certified nursing assistants focusing on CNA diversity, job satisfaction, and turnover issues in a variety of skilled nursing homes. Cultural and social capitals have been studied in other populations, but not in the certified nursing assistants. The purpose of this focused ethnographic study is to understand the cultural and social capital of the certified nursing assistant (CNA), and how these attributes may provide insight to what may influence how a CNA interacts within the skilled nursing home institutional culture. The methodology in this study, focused ethnography, centers attention on a single topic or concept within a specific setting using a limited number of individuals. This study concentrated on two questions: 1) How do CNAs describe their cultural and social capital? and 2) How do these CNAs interact within the institutional culture of the skilled nursing home?

CNA participants provided information during individual interviews about their cultural and social capitals. Focus groups with the registered nurse managers, registered nurses, licensed practical nurses, environmental service aides and individual interviews with cognitively intact residents provided insight into the institutional culture along with
information from the CNA participants and participant observation. These coworkers, cognitively intact residents, and CNA participants also contributed information related to how the CNA participants interacted within the institutional culture of the skilled nursing home. In the next section, the findings from these research questions are connected to previous studies and current literature related to understanding the cultural and social capital of the certified nursing assistant (CNAs) and how the CNAs cultural and social capital interacts within the institutional culture of the skilled nursing home.

Implications of Findings

The findings of this study reveal that within The Home, the CNA participants identified the importance of developing connections and interacting with the residents and coworkers as family. This study also shines a light on the nonpermanently assigned (per diem/float) CNAs lack of connection to the “family” on the units composed of the residents and coworkers. This study adds to the literature by identifying how the CNA participants describe their cultural and social capital and how these CNAs’ view their cultural and social capital interacting within the institutional culture of the skilled nursing home.

The themes of this focused ethnographic study are as follows. The themes identified in the institutional culture are *We are like family*, with a subtheme of *Protecting the family* and *We work together (Teamwork)*. One social capital theme was identified, which is *Communication skills which build relationships*. Within cultural capital the themes identified are *Learning caring from home* and *Lessons about being a worker*. The theme for the second research question exploring the interaction of the
CNAs social and cultural capitals interacting within the institutional culture is *We influence each other becoming family*.

The implications of these themes:

*We are like family* - This theme provides insight into the level of commitment these CNA participants have to their residents and the pride and sense of importance of their job.

*Protecting the family from outsiders* – This theme identifies the detachment as perceived by the permanently assigned unit CNAs of the nonpermanently assigned (per diem/float) CNAs to the culture of the nursing unit, the residents, the CNAs and other coworkers on the unit.

*We work together (Teamwork)* - This theme demonstrates the importance that CNAs place on cooperation from coworkers and the need for help from coworkers to meet the requirements of the residents and unit.

*Communication skills which build relationships* - This theme is relevant to the CNA participants developing and maintaining connections with residents and coworkers.

*Learning about caring from home* - This theme demonstrates the influence of the family’s care giving behavior for a family member or the influence role modeling care giving has on the CNA who chooses to be a CNA or to work with the elderly.

*Lessons about being a worker* - This theme identifies how the parents’ cultural capital and beliefs about having a job and the rules around employment are ingrained in the CNA participants.
We influence each other becoming family - This theme identifies how the CNA participants use their cultural and social capital to traverse the institutional culture and develop lasting relationships with coworkers and residents.

The next section reviews the themes and the support from the literature. Institutional culture is discussed first to provide the reader with an overall institutional view of the CNAs from the registered nurse managers, registered nurses, licensed practical nurses, environmental service aides, cognitively intact residents and the CNA participants. The CNA participants then describe their view of their social capital and their cultural capital. The final theme presented is We influence each other becoming family which represents the interaction of the CNAs within the institutional culture, and answers the second research question.

Institutional culture

Institutional culture is defined as the way things are done in an organization, including the rules and regulations and employee behaviors (Clarke, 2006). Two themes are identified; We are like family and We work Together (Teamwork). Within the theme of We are like family is the subtheme of Protecting family members from outsiders.

The theme of We are like family identifies the CNAs’ understanding of the institutional culture. The CNAs discussed their views of interactions with residents, the registered nurse manager, registered nurses, licensed practical nurses, and environmental service aides, as positive, supportive, and sharing as a person would be in their own family. Viewing coworkers and residents as family demonstrated the CNAs application of their understanding of the institutional cultural mission: to nurture life with vibrant caring life-affirming relationships. Positive relationships within the skilled nursing home
setting support the CNA’s desire to maintain employment within the skilled nursing home setting and on the unit on which the CNA works.

In Eaton’s (2000), study three different types of skilled nursing home cultures were observed: traditional, medical rehab, and regenerative communities. The regenerative communities were defined in the study as communities that did not demonstrate the standard beliefs about aging and disease, disability, and deterioration as did the other two skilled nursing homes. Regenerative communities’ residents were given greater choice of activities, CNA’s jobs were more varied and required greater use of CNA judgment and skills, and relationships with residents was a priority. This type of community approach supports the effect of the Eden philosophy transition as observed in this study. This reflected the importance of CNAs’ relationships with residents as identified in the institutional culture of the Eden philosophy and The Home’s mission. This current study supports Eaton’s concept of the regenerative community and demonstrates how CNAs view their relationships with the residents as a priority in the theme *We are like family.*

This theme also reflects the unit staff’s understanding of The Home’s mission, based on the Eden philosophy, “to nurture life with vibrant caring life-affirming relationships.” Deutschman’s (2005) focused ethnographic study identified four areas of improvement needed to change the organizational culture: 1) increase awareness of the individual residents needs regardless of the institutional schedule, 2) employ CNAs who have had effective training and education related to the skilled nursing home resident, specifically focusing on the attitude, knowledge, and skills, 3) reinforce the mission, vision, and values of the nursing home, with role modeling by leaders, registered nurse
managers, including training and mentoring and 4) implement effective relationship development within the nursing home and throughout the community.

This current study demonstrates how the permanently assigned unit CNAs support Deutschman’s (2005) four areas of improvements leading to organizational change. The findings of the current study, which provided insight into the level of commitment these CNA participants have to their residents and the pride and sense of importance of their job, reflect Deutschman’s (2005) fourth area of improvement in the institutional culture, that of effective relationships.

Bishop et al. (2008) conducted an ethnographic study with the purpose of exploring the influence of the registered nurse manager on the CNA’s job commitment and how that commitment influenced relationships with residents. Findings from this study show that CNAs had greater job commitment when the CNA felt the manager demonstrated respect for the CNA’s work, knowledge, skills, and gave the CNA autonomy to make decisions. Within the theme of *We are like family* the CNAs verbalized the support they receive from the registered nurse managers, registered nurses, licensed practical nurses, and environmental service aides when providing care to the residents. Participant observation of the CNAs demonstrated how the registered nurses and licensed practical nurses trusted the CNAs to report to the nurses any issues or resident concerns they had or had observed with their residents during meals. This current study supports Bishop’s study of the CNAs’ interpretation that respect from the registered nurse manager provides the CNA with greater job commitment and study that is reflected in the theme *We are like family.*
Kane-Urrabazo (2006) examined the concept of the manager’s role influencing the understanding of the organizational culture for CNAs. Within this study organizational factors were defined as using a framework of power, role, task and person. The person part of the organizational framework looks at both the individual and the total of all employees of the organization. Each person in the organization contributed to the overall success of the organization and the culture. Factors that were identified as helping to maintain and continue to develop positive organizational culture included trustworthiness, trust, empowerment, delegation, consistency, and mentorship. These factors were seen as influencing the employee’s satisfaction in the organizational culture. The manager’s ability to integrate, demonstrate, and role model each of these aspects influenced the employee’s ability to assimilate the organizational culture as his or her own. There was value to the manager role modeling the positive attributes to reinforce organizational culture. Having the registered nurse manager, registered nurse, and licensed practical nurse (as the leaders on the nursing units) role model and reinforce the skilled nursing home’s mission, vision, and values supports the employee’s job satisfaction and improves residents’ satisfaction as a result of CNA’s satisfaction. This current study supports Kane-Urrabazo’s study of the manager’s role to help the CNA understand the organizational culture which is reflected in the theme *We are like family.*

Castle et al. (2007) conducted a quantitative study in 5 states randomly sampling 72 nursing homes and exploring CNA retention with a focus on job satisfaction. The study analysis demonstrated low job satisfaction, pay, and poor opportunity for job advancement were associated with higher intention to leave. CNAs were less likely to consider leaving their job if they felt a greater relationship to residents. Further analysis
examining factors of job satisfaction including work schedule, pay, opportunity for advancement, and training were scored highly as factors influencing the CNA’s decision to stay in the skilled nursing home. Castle’s study supported the importance of relationships between residents and CNAs and the influence of institutional culture, with CNAs in the study identifying they stayed at the job because of the residents. The theme of *We are like family* supports the findings of Castle’s study, the importance of CNA relationships with their residents and job satisfaction.

Parsons et al. (2003) conducted a quantitative study of certified nursing assistants focusing on “overall job satisfaction, work issues related to job satisfaction and dissatisfaction and analyzed associations between employees’ characteristics, work issues, turnover, and work satisfaction” (p.52). A questionnaire was used to explore work related issues and personal characteristics. Findings identified the greatest satisfactions with the job involved close relationships with residents and having a relationship with coworkers. Residents were the reason CNAs stayed at their job. The greatest dissatisfactions were with institutional and supervisory issues, pay, and benefits. Parsons et al. also found that the more valued the CNA feels on the job the more likely the CNA is to stay at the skilled nursing home. In this current study CNA participants shared stories reflecting a sense of belonging within The Home. This current study supports Parsons study identifying the importance the CNA participants place on their relationships with their residents.

As demonstrated in this theme of *We are like family*, the CNAs view their relationships with coworkers and residents positively. Having identified the importance of resident and coworker relationships on job satisfaction for the CNA, it would be
valuable to identify in the institutional culture any employees who may not be effectively
developing relationships with residents or staff. The subtheme of *Protecting family
to members from outsiders* discusses the issues identified by the CNA participants related to
poor relationships with the nursing staff and residents.

*Protecting family members from outsiders.* This subtheme emerged from shared the views of the CNA participants, and registered nurse managers, registered nurses, licensed practical nurses, environmental service aides, and cognitively intact residents regarding the frustration and concern of having nonpermanently assigned (per diem/float) staff care for residents on the CNA’s unit. Cognitively intact residents as well as the CNA participants expressed the frustration of some nonpermanently assigned (per diem/float) CNAs disregarding resident instructions or directions during care, or not physically caring for or treating the resident as the resident would like to be treated or as the permanently assigned CNA would treat the resident. Similar difficulties with nonpermanently assigned (per diem/float) CNAs were voiced by the registered nurse managers, registered nurses, licensed practical nurses, and environmental service aides. This issue may be reflective of lack of commitment by the nonpermanently assigned (per diem/float) CNA to the residents they are caring for on that shift, or a lack of commitment to the unit or to the skilled nursing home in general. During participant observation, all CNAs were observed working together to deliver resident trays, with instructions given to any nonpermanently assigned (per diem/float) CNA as needed to help a resident. This behavior may have been influenced by the presence of the researcher as the observer.
Tellis-Nayak and Tellis-Nayak (1998) identified four factors of institutional culture in the skilled nursing home that may influence how the nonpermanently (per diem/float) CNA interacts with permanently assigned nursing staff, registered nurse managers and residents. The four factors are viewing the skilled nursing home as the impersonalized old age business, suffering routine indignities, little comfort or gratitude, and personalizing the institutional problems. Views shared by the study CNA participants identified how some nonpermanently assigned (per diem/float) CNAs treated the residents impersonally when delivering care, or depersonalized their interactions with residents by not following the resident’s directions supporting Tellis-Nayak and Tellis-Nayak’s study. The registered nurse managers and CNA participants shared how some nonpermanently assigned (per diem/float) CNAs verbalized that they hated floating to their unit because they always got the hardest assignment, or were not included in unit activities such as unit meetings, or weren’t able to get help with transfers from the unit staff. These types of comments and witnessed behaviors of the nonpermanently assigned (per diem/float) CNA’s demonstrate the theme of Protecting family members from outsiders are reflective of the four factors identified by Tellis-Nayak et al (1998). While Tellis-Nayal et al. did not specifically identify the nonpermanently assigned (per diem/float) CNA in their study, there was reference to the temporary agency or new CNA not demonstrating the same level of caring for residents which may be related to lack of connection with the resident.

The lack of connection and commitment to the “family” of the unit staff and residents by the nonpermanently assigned (per diem/float) CNA may also be reflective of the nonpermanently assigned (per diem/float) CNA’s dissatisfaction with their job.
Weiner, et al. (2009) in a quantitative study explored organizational culture factors and discussed how certain factors, including wages, benefits, training, and organizational culture influenced the CNAs’ ability to effectively interact within the institutional culture. Findings identified that organizational culture was a factor that influenced the CNA’s ability to effectively interact within the institutional culture, as was the type of resident within the SNH. While the theme of *We are like family* supports Weiner’s study, the institutional culture may entice some CNAs to become a nonpermanently assigned (per diem/float) CNA related to difference in hourly salary. Nonpermanently assigned (per diem/float) CNAs are paid a higher hourly salary and do not receive vacation or sick time benefits. However, other nonpermanently assigned (per diem/float) CNAs’ choice not to be permanently assigned to a unit may be related to their social capital. The ability to develop connections with others may influence the CNAs level of commitment to the institutional culture as well as the ability to work with other coworkers. *Protecting the family from outsiders* identified the detachment of the nonpermanently assigned (per diem/float) CNAs to the culture of the nursing unit, the residents, the CNAs, and other coworkers on the unit. A contribution of this study to the literature is the recognition of the need to focus on the nonpermanently assigned (per diem/float) CNAs and their role in the institutional culture.

*We work Together (Teamwork).* The second theme that emerged from the data related to the institutional culture reflects the importance of working together and sharing information between the CNAs and coworkers. The CNA participants in the study expressed the necessity of working together as a team to meet not only the needs of the residents but that of the unit as well.
Anderson, Coranzzini, and McDaniel, (2004) completed a quantitative study with the purpose of focusing on climate and communication and the impact on nursing staff turnover in randomly selected nursing homes in Texas. This study explored the interaction between the institutional culture, communication patterns between the institutional culture and the CNAs, and the effect on CNA turnover rate. Working together involves communication between nurse managers, nurses, and CNAs to provide effective resident care and unit functioning. Anderson et al. (2004) identified specific factors that influence institutional culture and the CNA’s perception of the skilled nursing home. Knowledge of the institutional culture may influence how a CNA used cultural and social capital to effectively work in the skilled nursing home. The theme of *We work together (Teamwork)* demonstrated the importance CNAs place on having cooperation from coworkers and the necessity of having help from coworkers to meet the needs of the residents and unit supporting the Anderson et al. study.

Berdes and Eckert (2001) completed a focused ethnographic study with the purpose of exploring the effects of racial and ethnic differences between residents and CNAs in three skilled nursing homes. Three perspectives of racial and ethnic differences were examined: 1) skilled nursing home residents interviewed about their perspective of being cared for by a CNA of a different race, 2) CNAs were asked about their experiences with racism, if they had encountered racism, and how had they handled it, and 3) how ethnic diversity effected the CNAs.

Study findings revealed that a many of the CNAs had experienced racism mainly from a resident, or a coworker and less frequently from family members of a resident. As a result of the encountered racism, some CNAs distanced themselves from that particular
resident - other CNAs viewed the resident as not being fully aware of what he or she was saying. African American CNAs reported more incidents of racism than their counterparts, who in this study were black immigrant CNAs. The black immigrant CNAs did not perceive the racial comments as personal attacks.

Berdes et al. identify that race relations between staff members needs to be discussed to improve the ability for team work. If these topics are not discussed and racism was left unheeded in a facility, teamwork will mostly likely not occur. In this current study the concept of racism was not identified by the CNA participants, therefore Berdes & Eckert’s (2001) study was not supported related to the influence of racism on teamwork. Working together also demonstrated the ability of the CNAs and coworkers to share communication effectively, a reflection of the individual’s use of their social capital.

**Social Capital**

Social capital is defined as the connections in and between social networks of a person (Bourdieu, 1999). When looking at the data from a social capital perspective, the theme that emerged was *Communication skills which build relationships*. The theme of *Communication skills which build relationships* identified specific skills used by the CNAs to develop relationships including observation, listening, and humor. While the context of communication was discussed in the literature, the identification of specific communication skills was not identified related to social capital, filling a gap in the literature.

Anderson, Coranzzini, and McDaniel, (2004) quantitative study also focused on communication patterns between the institutional culture and the CNAs and the impact
on nursing staff turnover in randomly selected nursing homes in Texas. Communication patterns identified included the amount, clarity, openness and accuracy. Anderson et al. demonstrated how inclusion of these aspects in the communication patterns provided the CNA with greater opportunities to enhance connections between CNAs, other staff, and residents.

Kane-Urrabazo (2006) reviewed the concept of the manager’s role influencing the understanding of the organizational culture for CNAs. The theory of organizational culture was defined as using a framework of power, role, task, and person. The factor of power identified the need to have trust and communication between the leader and the employee to have consistent understanding and interpretation of role responsibilities. In this current study, the CNA participants identified use of a specific type of communication skill such as observation, listening, or humor to establish and maintain relationships. Use of one’s specific communication skill such as humor helped the CNA comfortably interact with residents and coworkers on the nursing unit. Insight into how the CNA felt comfortable in relating to another person such as listening to the other person first or sharing humorous stories was very useful in helping the CNA become comfortable in a new setting or caring for a new resident. CNA participants were frequently able to identify their best communication skill(s). Not all CNAs may be aware of their best communication skills and need help identify what skills they use and/or how to improve their use of those communication skills. Other CNAs may benefit from help in learning to use their communication skills consistently. During participant observation of mealtimes, CNAs were seen using a variety of communication skills which were influenced by the situation and the person with whom the CNA was interacting. The
significance of this finding is relevant to the CNA participants developing and maintaining connections with residents and coworkers. This current study does not support Anderson et al. (2004) or Kane-Urrabazo (2006) communication findings.

Parks-Yancy et al. (2006), conducted a phenomenological study of working and middle/upper class men and women from three states, with the purpose of exploring how use of an individual’s social capital may affect one’s career. The findings of this study identified four aspects including social capital resources, amount of social capital resources, strong, and weak ties, and career outcomes influencing the success of an individual obtaining a job. Parks-Yancy et al. (2006) also identified family members, friends, and immediate coworkers who were considered strong ties for social capital in helping to secure a job. Within this current study while CNA participants discussed caregiving role modeling in their family, the CNA participants did not discuss receiving help from their family to obtain their job. This current study does not support Parks-Yancy’s findings.

Cultural Capital

Cultural capital is defined as the rules and values an individual learns as a child in the family of origin (Bourdieu, 1986). The themes identified within cultural capital are Learning caring from Home and Lessons about being a worker. Georg (2004) conducted a longitudinal quantitative study with the purpose of exploring cultural capital’s influence on students’ school success. Three hypotheses were explored: the concept of indirect transmission of cultural capital from the parents, which affects the child’s educational attainment; cultural capital influencing educational achievement and occupational choices of the individual; and that cultural capital does not change over a
person’s lifetime (Georg, 2004). The results demonstrated those parents’ reading behavior and disposition toward reading influence cultural capital transmission to the child. Educational achievement was not influenced by cultural capital and there was no effect from cultural capital on occupational choice. However, Georg’s study did demonstrate that cultural capital tended to be stable over a long period of time and that parental focus on a specific task influenced the child’s view of that task, such as caregiving of an elder family member.

Georg’s study was supported in this current study in the theme of learning caring from home, where some CNA participants identified the influence of role modeling from family members, including parents or other close relatives, played in their choice of occupation. Other CNA participants shared stories of being involved in the care of a grandparent or witnessing their parents caring for a parent or other relative. The theme of learning caring from home is reflective of the CNA participants experience with their parents’ cultural capital of providing care-giving to grandparents, or other family members.

The expectation of the family that the child follow in the footsteps of the parents in assisting with or taking over the care of an older relative was shared by at least two of the CNA participants. Georg (2004) asserts that cultural capital does not change over a person’s lifetime, therefore it would be expected that the CNA participant who has witnessed, then been involved in caring for an aged or ill relative, to choose an occupation that was familiar and become a caregiver. The other aspect of cultural capital to consider in exploring why the individual would become a CNA as opposed to a nurse
is the CNA’s parents’ cultural capital and the influence the parents had on the CNA’s choice of job, education, and life’s expectations.

**Lessons about being a worker.** The second cultural capital theme was identified when the CNAs spoke of the influence of the parents’ views of work and following work rules. Laureau and McNamara Hovart (1999) conducted a case study identifying the ability to share cultural capital can be effective in any situation, as is the skillful use of cultural capital which may overcome disparities between individuals. The focus of this study was exploring how race influenced family-school interactions. Through observation and interviews the researchers identified the influence of race and cultural capital affecting the level of parental involvement with the school. The teachers interviewed thought they were being very welcoming to have parents participate in the school, but did not always receive a positive response from the parents. The parents’ perception was some teachers were not always willing to talk about a student who was difficult or to the parent if the parent was difficult. Parents who were able to positively interact with the teacher verbalized a greater sense of equality from the school than those parents who were not able to have this type of communication. Those black parents who had difficulty communicating with the teachers felt their children were treated differently than the white students and this influenced the parents’ ability to address issues with the school. This perception of different treatment from the teachers may have been related to socioeconomic class, past racial discrimination, and cultural capital. The findings of this study identify the importance of knowing both the overt and covert rules of interactions in a given setting (Lareau & McNamara Hovart, 1999).
Sharing one’s cultural capital or understanding how to behave in a given setting such as the work setting and how to be a “good” worker may help the CNA effectively interact within the skilled nursing home setting. Within the institutional culture, being on time for work or punctuality was a job requirement that was discussed with all new employees during general orientation and, identified in the employee handbook for The Home. Recognizing in other coworkers similar work styles and behaviors that reflect the CNA participant’s family cultural capital work rules may provide the CNA with a sense of security and comfort in the skilled nursing home setting.

Laureau and McNamara Hovart (1999) identified that the ability of the individual to verbalize or use cultural capital during an interaction varies and is influenced by that individual’s past experience of sharing cultural capital and perception of the rules within that given setting. An individual’s ability to share cultural capital can be effective in any given situation regardless of race or social class. This current study identified the significant influence the parent’s cultural capital and beliefs about having a job and the rules around employment were ingrained in the CNA participants supporting Laureau’s (1999) study.

CNAs and the Institutional Culture

The theme of *We influence each other becoming family* identified how the CNA participants used their cultural and social capital to traverse the institutional culture and develop lasting relationships with coworkers and residents. The CNA’s perception of the institutional culture influenced how the CNA interacted with coworkers and residents in the skilled nursing home’s institutional culture as identified by Allensworth-Davies et al. (2007). Allensworth-Davies et al. (2007) conducted a quantitative study exploring how
rario-ethnicity, culture, and language influence interactions that can lead to communication problems, negatively affecting resident care, and CNA’s job satisfaction in four SNHs. The CNAs studied were predominantly foreign born, non-white women of diverse ages from 10 nursing homes. Participants completed a survey exploring perceptions of organizational cultural competence and ratings of job satisfaction.

Findings of the study included:

- foreign born CNAs identified greater autonomy and satisfaction from doing a good job with residents than U.S. born CNAs,
- non-white CNAs viewed their facilities as less culturally competent, and more negatively racial than white coworkers reported.
- The greatest predictors of job satisfaction for CNAs were job autonomy and cultural competency of the organization.

If the CNA does not feel that they fit into the institutional culture the CNA may become self protective, and less willing to share their cultural and social capital. Feeling self protective may cause the CNA not to be willing to openly share or establish a relationship with a resident or coworkers in the institutional culture.

Within the current study the CNA participants were equally divided between white and black, with three participants identifying as other. However, the CNA participants did not support the first two findings of Allensworth-Davies. The CNA participants in the current study viewed the institutional culture positively and felt secure in sharing personal information and establishing relationships with residents and coworkers developing a sense of “family” which supports the third finding of Allenworth-Davies et al. (2007) study. Having the comfort and security to develop
personal relationships with residents and coworkers reflected the CNA’s social and cultural capital. This also demonstrated the effective communication of The Home’s institutional culture, and the acceptance, incorporation, and implementation of institutional culture by this CNA participant. Many of the CNA participants shared their views of how residents and coworkers were like family.

Lauzon-Clabo (2007) used Bourdieu’s (1977) theory as a framework for a qualitative focused ethnographic study on how the nurses performed pain assessment and the role of the unit’s environment on two nursing units. The purpose of the study was to determine what differences exist between the two nursing units in pain assessment practices and the influence of nursing unit culture on the nurse’s belief in what the patient was telling the nurse about their level of pain as opposed to what the nurse observed and learned through the pain assessment tool.

Findings of Lauzon-Clabo identified unit culture influenced the nurses’ assessment of patient’s pain behavior as was demonstrated in differences in pain assessment routine that emerged between units in the study. Unit culture was demonstrated on the units with identification of the nurses conforming to the unit’s routine regarding medicating for pain. It is possible for a nurse to make changes on a unit, but the potential of one nurse changing the beliefs and routines of the other nurses is limited and over time the change would be forgotten (Lauzon-Clabo). As demonstrated in this current study it is the influence of the CNAs cultural and social capital and their understanding of the institutional culture that is demonstrated through the theme of *We influence each other becoming family.*
Anderson, Ammarell, Bailey, Jr., and Colon-Emeric (2005) conducted a case study with the purpose of identifying how CNAs use life experience and personal decision making skills when providing care to residents. A small group of eight CNAs who were of diverse racial background and coworkers were interviewed and observed for their interactions with each other and residents. Findings of Anderson et al. demonstrated that certified nursing assistants use their own culture and experience to identify how to establish relationships with residents. Establishing positive relationships may improve outcomes for residents and provide the CNA with a greater sense of contributing to a positive skilled nursing home institutional culture. This current study identified how the CNA participants used their cultural and social capital to traverse the institutional culture and develop lasting relationships with coworkers and residents supporting Anderson et al. findings in the theme of *We influence each other becoming family.*

The idea of doing more to improve the situation the resident is in reflects the “striver” CNA as identified in Tellis-Nayak and Tellis-Nayak (1989). In their study Tellis-Nayak and Tellis-Nayak (1989) identify and define two types of CNAs, the “endurer” and the “striver.” The endurer is a CNA who tolerates whatever situation they maybe in. They may feel apathetic or no longer enjoy the job, having little attachment or relationship with the residents but continues to work as a CNA. The striver seeks to improve whatever situation they are in, and want to do better in their job. Many of the CNAs who chose to take part in this study appeared to be strivers. The endurers at The Home may have decided not to participate. CNA participants discussed how they did little “extra” things for their residents, taking pride in the fact that the resident enjoyed the activity or item(s) given by the CNA participant, supportive of Tellis-Nayak and
Tellis-Nayak’s concept of the striver. The CNA participants were modest when sharing what they had done for their residents, reminiscing about how good the resident felt as a result of what had occurred.

Finally, Emirbayer and Williams (2005) wrote a two-part essay discussing both the cultural and social capital as it applied to homeless shelter clients. Knowing the shelter’s director and culture of the homeless shelter provided the homeless client with information that could help that client get into the shelter for the night. The ability to make connections with the caseworker(s), or the director of the shelter can provide the homeless client with privileges that other homeless clients cannot access related to the other clients’ lack of social capital. Recognizing the culture of setting and the cultural capital of the individuals in the setting such as the nurses, CNAs or residents and being able to reflect the culture back to those individuals helps to develop relationships in the institutional culture. One person may be able to connect well with a certain person, while a different person might have difficulty connecting with that same person. This may be related to the person’s ability to effectively share their cultural and social capital as well as their understanding and interaction of and with the institutional culture. The theme of *We influence each other becoming family* supports the information in Emirbayer et al. (2005) essay.

**Limitations**

The limitations of this study mirror the limitations of many qualitative studies in that the limitations reflect this particular institution and this particular culture. All nursing units were not observed and there was a small turn out for participation in the study. There was very limited response to the letter of invitation from the CNAs who
were eligible for the study as a result the researcher had to approach CNAs who were eligible to be in the study. Of the possible 140 CNAs who were invited to participate in the study, 22 (18%) agreed to participate. This is a minority of individuals at this particular institution and therefore cannot characterize the CNAs at the institution as a whole. The lack of response by the CNAs to participate in the study may have been influenced by not understanding the importance of being involved in research, or not wanting to share personal information with the researcher, or fear of lack of confidentiality of information shared, or unwillingness to take time away from the job. There may have been other reasons why a CNA chose not to participate in the study, but the reasons were not shared with the researcher.

For the nurses focus groups there were a very small number of registered and licensed practical nurses who participated in the focus groups. Nine registered nurses and 30 licensed practical nurses on the day and evening shift who worked on the 40 and 42-bed units received an invitation to attend a focus group. Three (33%) registered nurses and four (13%) licensed practical nurses participated in the specific focus groups for each of the nurse groups. Low attendance in the focus groups may have been related to a variety of factors. The researcher asked individual nurses why they had not attended the focus group and responses included too busy at that time, the nurse forgot, something happened on the unit and the nurse needed to respond to the situation. The smaller number of participants overall from one institution is a limitation to generalizing any findings of this study to the experience of other CNAs within the institution. Due to the nature of this focused ethnography study the findings cannot be generalized to other institutions.
The timing of the member check was held early in the analysis of the data. A member check was done with a small number of the CNA participants early in the development of the themes from the data to determine if the data analysis presented the information intended by the CNA participants. While the CNA participants did respond positively to the member check, doing a member check with the CNA participants at the end of the data analysis would provide greater reliability of themes presented. Presenting the cultural inventory to the CNA participants during the member check would also provide further insights of the CNA participants, which could add to the reliability of the data analysis.

**Recommendations**

The results of this focused ethnographic study provide insight and a description of how some CNA participants view their cultural and social capital and how their cultural and social capital interacts within the institutional culture of this skilled nursing home. There are two sets of recommendations. The first set of recommendation are for the nonpermanently assigned (per diem/float) CNAs and the second set is for the established staff of permanently and nonpermanently assigned CNAs. The recommendations for the nonpermanently assigned (per diem/float) CNAs are:

A) for newly hired nonpermanently assigned (per diem/float) CNAs be required to attend specific classes focusing on the importance of and how to develop effective relationships with residents and coworkers the first six months of employment.

B) assign all nonpermanently assigned (per diem/float) CNAs to three or four specific units.
There are two recommendations from this study for the CNAs currently employed at The Home:

A) recognize the CNAs who are effectively supporting the mission of The Home, that of nurturing life with vibrant, caring life-affirming relationships.

B) provide consistent and ongoing feedback to all CNAs, permanently assigned and nonpermanently assigned, regarding the effective implementation of The Home’s mission and values reflecting family values of the nursing staff and residents on a quarterly basis.

A discussion of each of the recommendations follows.

The first recommendation for the nonpermanently assigned (per diem/float) CNAs focuses on the newly hired nonpermanently assigned (per diem/float) CNAs. Requiring the new nonpermanently assigned (per diem/float) CNAs to attend specific classes focusing on the importance of and how to develop effective relationships with residents and coworkers the first six months of employment. These classes will provide the nonpermanently assigned (per diem/float) CNA the opportunity to gain greater insight to The Home’s mission with specific classes focusing on identifying and discussing the CNAs family values and beliefs and how the CNAs values align with the skilled nursing home’s mission and values. The nonpermanently assigned (per diem/float) CNA will also participate in the quarterly feedback regarding application of The Home’s mission, providing reinforcement of the information presented in the training classes.

The second recommendation is based on the implication from this study that nonpermanently assigned (per diem/float) CNAs may feel detached from the nursing home, coworkers, the nursing units, or not desire to develop a connection to the residents.
Assigning the nonpermanently assigned (per diem/float) CNAs to three or four specific units will provide greater opportunity to develop connections with the nursing unit, coworkers and residents helping the nonpermanently assigned (per diem/float) CNA to apply The Home’s mission in their job.

The recommendations for the established CNAs are for the skilled nursing home in a cultural transition to the Eden philosophy or other analogous kinds of philosophies that are patient or resident centered care. The skilled nursing home entering a cultural transition from the medical model to the Eden philosophy must understand the need to educate and support learning about relationships and the development of the CNAs as the largest group in the skilled nursing home so that CNA can enact that kind of relationship with residents. The first recommendation stems from the finding that CNAs and residents have greater satisfaction in their work within the skilled nursing home setting when there are positive relationships with the CNAs, coworkers, and residents. Recognizing CNAs that are positively interacting with residents, coworkers and families provides the CNA with the feedback that their job is important and valued by the skilled nursing home.

Providing consistent feedback to all CNAs, the second recommendation, provides the CNAs, both permanently assigned and nonpermanently assigned (per diem/float), with the needed information regarding the CNAs behavior with residents and coworkers related to The Home’s mission. The feedback provides reinforcement of the significance of The Home following through with the importance of its mission, that the mission is expected to be “lived”. Providing feedback to the CNAs on a quarterly basis keeps the mission of The Home in front of the CNA, encouraging the CNA to apply the mission
everyday to all individuals the CNA may be involved. Involving all CNAs in the feedback process including newly hired CNAs brings life to the mission of The Home and identifies for the CNAs the importance of The Home’s mission.

Summary

In the United States, individuals in need of ongoing long term physical care related to age or disability may reside in a skilled nursing home (SNH). Nurses and certified nursing assistants (CNAs) are available to provide care for residents 24 hours a day. CNAs assist residents with activities of daily living such as eating, and dressing, and are expected to develop a therapeutic relationship with each resident.

Each staff member brings to the job a personal perception of the elderly and the SNH environment. Interactions within the SNH setting are a product of, or are influenced by, the institutional culture of the SNH and the cultural and social capital of the residents and each employee. Many aspects of CNA retention, as well as the influence of diversity on care have been studied, however, little information has been obtained about how the CNAs view their job or why CNAs interact with residents the way they do. Even with the implementation of federally standardized training and certification of nursing assistants the data on how CNAs develop therapeutic relationships with residents has not been previously studied.

The skilled nursing home setting for this study currently uses the medical model of care and is in the process of shifting the institutional culture to the social model of person-centered care using the Eden philosophy as the basis of the social model. In the person-centered care model, the resident and CNA work together to meet the residents’ expectations for daily living. The medical model of care primarily focuses on treating
disease processes and the physical health of the resident. Within this study, the term institutional culture is used to refer to both institutional and organizational culture. Institutional culture is defined as the way things are done in an organization, encompasses the philosophy of model of care, and includes the rules and regulations and employee behaviors (Clarke, 2006).

Bourdieu’s (1977) Theory of Practice provides the theoretical rationale for this study. The Theory of Practice attempts to describe and explain the relationships between people, why they do what they do, and the relationships between people and social structures such as skilled nursing homes. Bourdieu’s (1977) theory explores how an individual’s culture, traditions, and environmental background influences the individual’s behavior in society. In this study, culture capital is defined as the rules and values learned during childhood within the family of origin (Bourdieu, 1986). Social capital is defined as the connections between people (Bourdieu, 1999).

Cultural capital has been used to study a variety of situations including student success in schools, interpersonal interactions in homeless shelters, and interactions between nurses on patient care units. Social capital has been used to study how individuals obtain career and financial support from family and friends. The influence of CNAs cultural and social capital on their interactions with coworkers, residents, and the institutional culture has not been studied. The purpose of this focused ethnographic study is to understand the cultural and social capital of the CNA, and how this may provide insight to how a CNA interacts with the skilled nursing home institutional culture. The two questions in this study are: 1) How do certified nursing assistants (CNAs) describe
their cultural and social capital? and 2) How do these CNAs interact within the institutional culture of the skilled nursing home?

Current literature related to the CNA focuses on retention of the CNA in the skilled nursing facility. CNA studies focus on institutional culture climate and its effect on CNA turnover. Other CNA studies focus on the influence of the registered nurse manager as a role model for the institutional culture. An ethnographic study done by Tellis-Nayak and Tellis-Nayak (1989) shared how CNAs view institutional culture and how institutional culture influences the interaction of the CNAs with the residents.

Literature exploring the influence of the Eden philosophy, a person-centered care concept, discusses how the Eden culture improved CNA satisfaction as the institutional culture shifts to the social model. Within this study, CNAs talked about their satisfaction and commitment to their residents, demonstrating support of the Eden culture literature. CNAs discussed why they developed relationships with residents and how the residents became like family.

The method used in this study is focused ethnography. Focused ethnography explores a specific problem studied within a single setting with a limited number of individuals (Speziale & Carpenter, 2007; Richards & Morse, 2007; Morse & Fields, 1995). For this study, focused ethnography provides the researcher with the opportunity to observe the CNAs using their cultural and social capital in the institutional setting. The study began with letters of invitation to potential CNA participants via their unit mailbox. Potential CNA participants who met the study criteria (worked in the skilled nursing facility as a CNA for at least one year on the day or evening shift) were selected.
from the complete list of CNAs who work at The Home. Of the possible 140 CNAs invited to participate in the study, 21 (15%) CNAs agreed to be involved.

Individual CNA participant interviews provide direct access to the CNA’s understanding of the cultural and social capital. Focus groups were held with participants of the institutional culture, which included the registered nurse managers, registered nurses, licensed practical nurses, and the environmental service aides. Focus groups were specific to the roles in which the group members worked, allowing each individual to freely discuss their viewpoint of the CNAs in the institutional culture. The focus groups along with individual interviews with cognitively intact residents provided the researcher with views of the CNAs’ interaction within the institutional culture. Participant observations at mealtimes captured a snapshot of the interactions of CNA in the institutional culture.

Data analysis used Atlas ti™ and repeated review of data transcriptions for key words and phrases to determine themes. From the domain analysis, the larger categories in which the domains may belong were sorted to develop the cultural inventory. Development of a cultural inventory identified themes, and future research recommendations. Member check was done with a small group of CNA participants to review the cultural themes identified.

Themes that emerged from the data that the researcher connected to the guiding research concepts of institutional culture were *We are like family*, and *We work together (Teamwork)*. Within the theme of *We are like family* is the subtheme *Protecting the family from outsiders*. Social capital interacts with the institutional culture through the theme of *Communication skills which build relationships*. The cultural capital of the
CNAs was evidenced in the themes of *Learning caring from Home*, and *Lessons about being a Worker*. The theme of *We influence each other becoming family* demonstrates how the cultural and social capitals of the CNAs interact within the institutional culture.

This focused ethnographic study identifies the closeness developed between residents, CNAs, nurses, and environmental service aides as that of viewing each other as *family*. Also identified in the institutional culture is the level of closeness and interaction that CNAs and coworkers rely upon to develop *teamwork*. CNAs social capital skills demonstrated how CNAs use *communication skills which build relationships* with others. The cultural capital of the CNAs identifies key beliefs and values learned from the family of origin that are expressed by the CNA within the institutional culture.

The answer to the second research question of how the CNAs’ cultural and social capitals interact within the institutional culture identified the CNAs’ view of coworkers and residents as *We influence each other becoming family*. This theme identifies the depth of the relationships CNAs develop with their residents by including residents in the CNA’s daily life and activities. The desire of the CNAs to improve the lives of residents connects to the mission of the institutional culture, that of nurturing life with vibrant, caring life-affirming relationships. The CNA participants shared what they learned about developing and maintaining connections with others and how they use this information when interacting with the institutional culture.

There are four recommendations from this study, two for the nonpermanently assigned (per diem/float) CNAs and two for the currently employed CNAs, both permanent and nonpermanently assigned (per diem/float) CNAs. The recommendations for the nonpermanently assigned (per diem/float) CNAs are:
A) for newly hired nonpermanently assigned (per diem/float) CNAs be required to attend specific classes focusing on the importance of and how to develop effective relationships with residents and coworkers the first six months of employment.

B) assign all nonpermanently assigned (per diem/float) CNAs to three or four specific units.

Two recommendations for the CNAs, permanently and nonpermanently (per diem/float), currently employed at The Home are:

A) recognize the CNAs who are effectively supporting the mission of The Home, that of nurturing life with vibrant, caring life-affirming relationships.

B) provide consistent and ongoing feedback to all CNAs, permanently assigned and nonpermanently assigned, regarding the effective implementation of The Home’s mission and values reflecting family values of the nursing staff and residents on a quarterly basis.

Conclusion

In conclusion, this focused ethnographic study provides insight to how CNA participants who chose to participate in this study describe their cultural and social capital. Many of these CNAs describe similar family values, and job rules that guide their life in their work setting. These rules and values also provide guidance for these CNA participants in developing and maintaining relationships with residents and coworkers. The CNA participants along with the unit staff, which included the registered nurse manager, registered nurses, licensed practical nurses, environmental service aides,
and cognitively intact residents, identified the closeness and similar family values held as an institutional cultural theme of *We are like family*.

Finally, the ways that CNA participants use their cultural and social capital to interact with the institutional culture of the skilled nursing home identify the theme of *We influence each other becoming family*. This theme reinforces the CNAs’ need to establish, nurture, and maintain relationships with residents and coworkers. The results of this study provide new insight into a contributing factor of CNA retention in the skilled nursing home, that of well established relationships with residents and coworkers.
References


Institute of Medicine (1986). *Improving the quality of care in nursing homes.*


Appendix A

Synopsis of New York State Certified Nursing Assistant Training Manual
Synopsis of New York State Certified Nursing Assistant Training Manual

The Omnibus Reconciliation Act of 1987 enacted the certification of nursing assistants caring for residents of skilled nursing home facilities. Any skilled nursing home or community entity providing nurse aide training free of charge submits the training program to the New York State Department of Health; schools or community programs charging a fee for the training submit programs to the State Education Department. The curriculum for the Department of Health consists of 100 hours of classroom training, which includes 30 hours of supervised clinical training. The training focuses on basic skills of care, personal care skills, mental health and social service needs, care of the cognitively impaired, basic restorative services, and resident rights. Individuals who successfully complete the training and testing are deemed competent and listed in the State Registry (NYSNA Manual, 2000, p.67). Class content is specifically identified within the Nurse Aide Training Program Manual and must be included in the training. Additional content may be included with review of the additions by the Department of Health, however, none of the original curriculum can be deleted or altered. Clinical skills checklists provide the minimum clinical skills to successfully meet the requirements of the nurse aide training.

The New York State Nurse Aide Certification Program describes the nurse aide training program, directions for the program coordinator, the content outline, the required curriculum, and the clinical skills checklists. Throughout the program the concept of “core values” is presented. As identified in the Nurse Aide Training Program (NATP), these values are considered the foundation for all aspects of care influencing resident satisfaction and success of care regardless of the care setting. The New York State
Department of Health includes the core values in the Nurse Aide Training Program and identifies that the values need to be included in all care and services starting with the NATP and carried throughout the nurse aide’s career. The NATP identifies the core values as:

“the care and services provided in the facility must demonstrate are: (1) the dignity and worth of each resident as an individual; (2) respect for the range of diversity of individuals; (3) a demonstration of a therapeutic relationship. A therapeutic relationship between the care giver and the care receiver is defined as the value of autonomy and control, adapting to resident’s preferences and routines and limits, maintaining privacy and confidentiality, and encouraging individuals to be as independent as possible. The impact of the actual setting/environment on the resident and the resident’s adjustment to care must be understood and responded to throughout the program (New York State DOH NATP, 2006, p.72-3).”

The Nurse Aide Training Program for nurse aides in New York State is available from the New York State Department of Health.
Appendix B

Job Description
<table>
<thead>
<tr>
<th><strong>Job Title</strong></th>
<th>Certified Nurse Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reports to:</strong></td>
<td>Team Leader/NM/Supervisor</td>
</tr>
<tr>
<td><strong>Department:</strong></td>
<td>Nursing</td>
</tr>
<tr>
<td><strong>Position Summary:</strong></td>
<td>Provides direct care to residents under the supervision of a nurse.</td>
</tr>
<tr>
<td><strong>Qualifications:</strong></td>
<td>Good communication skills. Long term care experience preferred</td>
</tr>
<tr>
<td><strong>Education/Licenses/Certification Required:</strong></td>
<td>Current New York State Certification in long term care, High school diploma or equivalent.</td>
</tr>
<tr>
<td><strong>Responsibilities/Duties:</strong></td>
<td></td>
</tr>
</tbody>
</table>
Responsive to residents needs and preference. Consider residents satisfaction a priority.

Meet personal care needs: bathing, dressing, grooming, toileting, transferring, care of skin, teeth, hair, ears, nails; promotes self-care activities.

Makes occupied and unoccupied beds, care for personal belongings such as clothing, dentures, eyeglasses, hearing aids, prostheses.

Meets nutritional needs by passing trays, ice water, nourishments: assist in feeding, use adaptive equipment, tray monitoring.

Participate in bowel/bladder toileting programs, care for urinary drainage equipment, care for ostomies, urine testing.

Meet sleep and rest needs of residents by providing activity, exercise and rest.

Prevent contractures and skin breakdown by proper body alignment, turning, positioning, use of special aids, Range of motion.

Observe and report signs and symptoms of disability, illness, change in condition or behavior.

Participates in residents Comprehensive Care Plans.

Take, measure, record vital signs, height, weight, food/fluid intake/output.

Meet safety needs by reporting environmental hazards, proper utilization of restraints, observance of infection control measures, oxygen safety.

Meet needs of residents with special conditions such as mental impairment, behavior disorders, medical problems.

Care for dying residents including care of the body and personal effects after death.

Provide friendly helpful courteous service to residents, families, coworkers and all other departments.

Responsible for attending in-service programs that are provided to facilitate learning.
Will be expected to be supportive through the journey of the Eden Alternative.

May be required to do other duties as necessary.

**Physical Requirements:**

Stands, sits, walks most of the day. Frequent moving and lifting of residents.

Frequent moderate to heavy lifting.

**Exposure to Conditions:**

May be exposed to infectious diseases, odors, psychobehavioral problems.
Appendix C

Letter of Consent to Participate in CNA Interview or Focus Group for CNAs
Dear CNA,

I am inviting you to participate in my research study. The study is exploring three things;

1. How you make connections and develop relationships with the residents you care for and the people with which you work.
2. What things you, as a person, consider important in life and how you share those aspects in your job.
3. Your perception of the spoken and unspoken rules of the nursing home.

If you chose to participate in my study you will be asked to participate in individual interview(s) with me or a focus group with other CNA participants. I will also be on different resident units to develop a perception of different unit routine(s). All information from the interviews, focus groups and observations will be completely confidential. Once I am finished with my analysis of the data I have collected, you are also invited to hear how I have put the results together in a focus group and you are invited to provide me with feedback.

To become a participant in the study, please contact me at ext.1310 or come to my office on ground floor South building. Please contact me to participate by September 10, 2010. This study has been approved by the Institutional Review Board of St. John Fisher College. Thank You!

Linda M. Baier, Researcher
Appendix D

Interview/Focus Group Guide for CNA Participants
Thank you for taking time to talk with me about your job and relationship with residents and other staff. The concepts I will be asking you to talk about are how you view the ways things work, or the spoken and unspoken rules at the nursing home, the rules and values you were taught by your family and how you make connections with other people, such as how you decide who is a friend or a social contact, such as a coworker.

Review the purpose of the CNA participant to discuss what information, knowledge and skills are used to feel comfortable in the skilled nursing home and how connections are developed with residents in the skilled nursing home. The interview/focus group is being digitally recorded. Begin with the grand tour question: Please tell me – Tell me why you decide to become a CNA?

Follow with remaining questions:

1. Tell me about the “rules or information” your family gave you regarding a job, regarding interacting with older people?
2. What type of connections have you had with older people?
3. Describe how you connect with people.
4. How did you choose to work here?
5. Tell me about the unit you work on.
6. Anything you especially like about your unit?
7. Anything you dislike about your unit?
8. Tell me about a memorable resident?
9. What is your idea of an ideal CNA?
10. What are the characteristics of a CNA you would not want to be like?
11. What would you tell a prospective CNA about working here?
12. Is there anything else you would like to share with me?
Appendix E

Letter of Consent to Participate in Focus Group for Registered Nurse Managers, Registered and Licensed Practical Nurses, Environmental Service Aides and Individual Interviews for Cognitively Intact Residents
Dear Registered Nurse Manager,(Registered and Licensed Practical Nurse,
Environmental Service Aide, or Cognitively Intact Residents)

You are invited to participate in a focus group (or individual interview) on (date) to
discuss how CNAs develop relationships within the nursing home. The study is
exploring three things;

1. How do CNAs make connections and develop relationships with the residents
   they care for and the people with which they work.
2. What things do the CNA show as important in life and how do the CNA show
   that in their job.
3. How do the CNAs demonstrate their perception of the spoken and unspoken
   rules of the nursing home.

The focus group (individual interview) will be digitally recorded. Your name will not be
used in the discussion and no identifying information will be used in the analysis of the
data. You are asked to keep all information presented in the focus group (individual
interview) confidential. All information discussed in the focus group (individual
interview) will be confidential and used only for this study. The focus group (individual
interview) will last approximately an hour and no longer than an hour and 15 minutes.

Please fill in your name and sign the form to give your consent to participate. This study
has been approved by the Institutional Review Board of St. John Fisher College. Thank
You! Linda M. Baier, Researcher
Appendix F

St. John Fisher College
INFORMED CONSENT FORM
Title of study: Understanding how the Certified Nursing Assistants Social and Cultural Capital
Interacts within the Nursing Home Culture

Name(s) of researcher(s): Linda M. Baier
Faculty Supervisor: Dr. Mary Collins Phone for further information: 585-385-8397.

Purpose of study:
The purpose of this focused ethnographic study is to explore how the CNA’s cultural and social capital interacts with the institutional culture.

Approval of study: This study has been reviewed and approved by the St. John Fisher College Institutional Review Board (IRB).

Place of study: St. John’s Home Length of participation: 4 months

Risks and benefits: The expected risks and benefits of participation in this study are explained below:
Risk – The CNA participant may have concerns of sharing information that may be interrupted as the CNA not being effective at their job.
The resident may have concerns of sharing information and this be interrupted as complaining of care.
The Nurse Manager/nurse/Environmental Services Aide may have concerns of sharing information that may be interrupted as complaining about staff.

Benefits – This research provides the CNA participants with the opportunity to talk about their job, issues with residents, or concerns about relationship building with residents and their perceptions or concerns about the institutional culture.

Method for protecting confidentiality/privacy:
Your rights: As a research participant, you have the right to:
1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to you.
5. Be informed of the results of the study.
I have read the above, received a copy of this form, and I agree to participate in the above-named study.
Print name (Participant) Signature
Date
If you have any further questions regarding this study, please contact the researcher listed above. If you experience emotional or physical discomfort due to participation in this study, please contact the Office of Academic Affairs at 385-8034 or the Wellness Center at 385-8280 for appropriate
Appendix G

Demographic Data Collection Tool
The concepts I will be asking you to talk about are how you view the ways things work, or the spoken and unspoken rules at the nursing home, the rules and values you were taught by your family and how you make connections with other people, such as how you decide who is a friend or a social contact, such as a coworker.

Please check the correct answer for you.

**Marital Status:**

___ Single  ___ Married  ___ Divorced  ___ Widowed

**Children:**

How many children do you have? _______

What are the ages of your children? _______

**Parents History:**

What is the highest level of education your Mother completed:

___ did not finish high school  ___ high school graduate

___ some college

___ completed college  ___ post college education

What is the highest level of education your Father completed:

___ did not finish high school  ___ high school graduate

___ some college

___ completed college  ___ post college education

How long have you been a certified nursing assistant: _______ years

______ months.

How long have you work at this facility: ________years  _______ months.

**Race/Ethnicity:**
___ White  ___ Hispanic  ___ African American

___ Asian/Pacific Islander

___ Other: __________________________ (please identify)

Age:

___ 18 – 21  ___ 22-30  ___ 31-40  ___ 41-50  ___ 51-60  ___ 61-70
Appendix H

Focus Groups Questions for Registered Nurse Managers, Registered and Licensed

Practical Nurses, and Environmental Service Aides
Welcome Registered Nurse Managers/Registered and Licensed practical Nurses/ES Aides participants to the focus group.

Review the purpose of the focus group for the Registered Nurse Managers/Registered and Licensed Practical Nurses/ES aides to discuss how they see, hear or perceive the CNA using his/her personal information, knowledge and skills in the skilled nursing home and how the CNA develops connections with residents in the skilled nursing home.

- I am interested in hearing about the CNAs interactions on the unit. Things like:
  - How do CNAs fit in with the ways things are done here, or the spoken and unspoken rules at the nursing home,
  - What rules and values have you seen the CNA act upon?
  - In the interactions on the unit, can you see evidence of the CNA’s upbringing, or family values? coming from their family
  - I’m interested in how their upbringing may affect how the CNA makes connections with other people.

The focus group is being digitally recorded, if you are not comfortable with being recorded, you do not need to stay. Begin with the grand tour question: Please tell me about how the CNAs on the unit interact with you as a Registered Nurse Manager/Registered or Licensed Practical Nurse or ES aide?

Follow with remaining questions:

1. Please tell me about the CNAs interactions with others on the unit.
2. How do you expect the CNA to interact with you? With others?
3. Were your expectations met? If yes, how? If no, what was different?
4. Describe a CNA who sticks out for you (or is memorable for some reason).
5. What makes this situation so memorable for you?

6. Any other CNA’s come to mind?

7. Please share what you look for in a CNA to fit in on your unit.

8. How does the unit work with the CNAs to make a successful workplace for everyone?

9. Is there anything else you would like to share about CNAs interactions with you or anyone on the unit?
Appendix I

Interview Questions for Cognitively Intact Residents
Thank you to the cognitively intact resident for participating in the study and being willing to be interviewed regarding the CNAs that work on their unit.

Review the purpose of the interview with the cognitively intact resident to discuss how they see, hear or perceive the CNA using his/her personal information, knowledge and skills in the skilled nursing home and how the CNA develops connections with residents in the skilled nursing home.

- I am interested in hearing about the CNAs interactions on the unit. Things like:
  - How do CNAs fit in with the ways things are done here, or the spoken and unspoken rules at the nursing home,
  - What rules and values have you seen the CNA act upon?
  - In the interactions on the unit, can you see evidence of the CNA’s upbringing, or family values? coming from their family
  - I’m interested in how their upbringing may affect how the CNA makes connections with other people.

The interview is being digitally recorded, if you are not comfortable with being recorded the interview will be stopped. Begin with the grand tour question: Please tell me about how the CNAs on the unit interact with you as a resident?

Follow with remaining questions:

1. Please tell me about the CNAs interactions with others on the unit.
2. How do you expect the CNA to interact with you? With others?
3. Were your expectations met? If yes, how? If no, what was different?
4. Describe a CNA who sticks out for you (or is memorable for some reason).
5. What makes this situation so memorable for you?
6. Any other CNA’s come to mind?

7. Please share what you look for in a CNA to fit in on your unit.

8. How does the unit work with the CNAs to make a successful workplace for everyone?

9. Is there anything else you would like to share about CNAs interactions with you or anyone on the unit?
Appendix J

CNA Demographics
Demographic Description of Sample (n=21)

<table>
<thead>
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<th>Demographic Variables</th>
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</tr>
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<td><strong>AGE</strong></td>
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<td>18-21</td>
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</tr>
<tr>
<td>22-30</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>31-40</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>41-50</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>51-60</td>
<td>6 (29%)</td>
</tr>
<tr>
<td>61-70</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>10 (48%)</td>
</tr>
<tr>
<td>Married</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>4 (19%)</td>
</tr>
<tr>
<td><strong>Number of Children</strong></td>
<td></td>
</tr>
<tr>
<td>No children</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>1 child</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>2 children</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>3 children</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>4 children</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>5 children</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>6 children</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Did not identify number of children</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>Ages of Children</strong></td>
<td></td>
</tr>
<tr>
<td>1 year to 20 years</td>
<td>7 (38%)</td>
</tr>
<tr>
<td>21 years to 45 years</td>
<td>11 (52%)</td>
</tr>
<tr>
<td>No Children</td>
<td>3 (14%)</td>
</tr>
<tr>
<td><strong>Mother’s level of Education</strong></td>
<td></td>
</tr>
<tr>
<td>Did not finish High School</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>High School graduate</td>
<td>8 (38%)</td>
</tr>
<tr>
<td>Some college</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>Completed college</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Post college graduate</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>Father’s level of Education</strong></td>
<td></td>
</tr>
<tr>
<td>Did not finish High School</td>
<td>6 (29%)</td>
</tr>
<tr>
<td>High School graduate</td>
<td>8 (38%)</td>
</tr>
<tr>
<td>Some college</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>Completed college</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Post college graduate</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Did not know</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Demographic Variables</td>
<td>No.</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Length of time a certified nursing assistant</strong></td>
<td></td>
</tr>
<tr>
<td>2 years to 4 years 11 months</td>
<td></td>
</tr>
<tr>
<td>2 years</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>2 years 4 months</td>
<td>2</td>
</tr>
<tr>
<td>3 years &lt; 6 months</td>
<td>1</td>
</tr>
<tr>
<td>3 years &gt; 6 months</td>
<td>1</td>
</tr>
<tr>
<td>4 years &lt; 6 months</td>
<td>1</td>
</tr>
<tr>
<td>4 years 6 months</td>
<td>1</td>
</tr>
<tr>
<td>5 years to 9 years 11 months</td>
<td></td>
</tr>
<tr>
<td>5 years 6 months</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>5 years &gt; 6 months</td>
<td>2</td>
</tr>
<tr>
<td>7 years</td>
<td>1</td>
</tr>
<tr>
<td>9 years &lt; 6 months</td>
<td>2</td>
</tr>
<tr>
<td>10 years to 15 years</td>
<td></td>
</tr>
<tr>
<td>10 years &gt; 6 months</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>11 years</td>
<td>2</td>
</tr>
<tr>
<td>14 years</td>
<td>1</td>
</tr>
<tr>
<td>20 years plus</td>
<td></td>
</tr>
<tr>
<td>23 years</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>24 years</td>
<td>1</td>
</tr>
<tr>
<td>30 years plus</td>
<td></td>
</tr>
<tr>
<td>31 years</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Number of years worked at facility</strong></td>
<td></td>
</tr>
<tr>
<td>1 year to 4 years 11 months</td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>9 (43%)</td>
</tr>
<tr>
<td>1 year 2 months</td>
<td></td>
</tr>
<tr>
<td>1 year 3 months</td>
<td>1</td>
</tr>
<tr>
<td>1 year 4 months</td>
<td>1</td>
</tr>
<tr>
<td>1 year 10 months</td>
<td>1</td>
</tr>
<tr>
<td>2 years</td>
<td>1</td>
</tr>
<tr>
<td>3 years &lt; 6 months</td>
<td>1</td>
</tr>
<tr>
<td>4 years</td>
<td>1</td>
</tr>
<tr>
<td>4 years 5 months</td>
<td>1</td>
</tr>
<tr>
<td>5 years to 10 years &gt; 6 months</td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td>8 (38%)</td>
</tr>
<tr>
<td>5 years 6 months</td>
<td>1</td>
</tr>
<tr>
<td>5 years 8 months</td>
<td>1</td>
</tr>
<tr>
<td>6 years 4 months</td>
<td>1</td>
</tr>
<tr>
<td>Demographic Variables</td>
<td>No.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>7 years 10 months</td>
<td>1</td>
</tr>
<tr>
<td>8 years 1 months</td>
<td>1</td>
</tr>
<tr>
<td>9 years 5 months</td>
<td>1</td>
</tr>
<tr>
<td>10 years</td>
<td>1</td>
</tr>
<tr>
<td>11 years to 29 years</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>11 years</td>
<td>1</td>
</tr>
<tr>
<td>14 years</td>
<td>1</td>
</tr>
<tr>
<td>16 years</td>
<td>1</td>
</tr>
<tr>
<td>30 years +</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>31 years</td>
<td>1</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>9 (43%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
</tr>
<tr>
<td>African American</td>
<td>9 (43%)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>0</td>
</tr>
<tr>
<td>Other: Indian</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>2 (10%)</td>
</tr>
</tbody>
</table>
Appendix K

Cultural Inventory

Domain Analysis of Participant Observation

Domain - Participant Observation  - Mealtime Service –
Interaction during meal service – Bringing residents to Dining Room, Delivering trays to the residents, Feeding the residents, Taking the residents out of the Dining Room.

Staff involved with bringing residents into the Dining room
- CNAs
- Licensed Practical nurses

Staff involved with serving resident trays
- CNAs
- Licensed practical nurses

Staff involved with feeding of residents
- CNAs
- Licensed Practical nurses

Staff involved with delivering trays to the residents rooms
- CNAs

Domain – Mealtime
- Primary participant – CNAs
  - serving trays to residents
  - delivering trays to resident rooms
  - feeding residents
  - returning residents to their rooms
  - cleaning up the dining room
- Secondary participant – nurses
  - serving trays to residents
  - feeding residents

Domain – Feeding
- Primary participants – CNA
  - Knows the resident.
  - Knows the residents food likes and dislikes.
  - Knows how to safely feed the resident with the meal.
  - Focuses on getting the resident fed and the meal completed.
- Secondary participants – Licensed Practical nurses
  - Knows the resident.
  - Knows how to safely feed a resident with eating difficulties such as aspiration precautions.
  - Observes a resident for difficulties with swallowing during a meal.

Domain – Interaction with Others
- Primary participants – CNAs
  - Residents first
  - Other CNAs secondary interaction.
  - Nurses are the last to be communicated with if there are not problems.
If there is a problem with a resident, the nurse becomes the first in the line of communication.

Secondary participants – nurses
Other nurses first, then CNAs, then residents.

Domains from Data

<table>
<thead>
<tr>
<th>CNAs</th>
<th>Reg. Nurse Mgrs</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships with</td>
<td>Relationship</td>
<td>Relationship</td>
</tr>
<tr>
<td>RNNM</td>
<td>w/ CNAs</td>
<td>w/nurse</td>
</tr>
<tr>
<td>RNs/LPNs</td>
<td>CNA relationship</td>
<td>Relationship</td>
</tr>
<tr>
<td>Residents</td>
<td>w/nurses, residents, w/ other CNAs</td>
<td>w/res, other CNAs</td>
</tr>
<tr>
<td>Type of Relationships</td>
<td>Focus on how</td>
<td>Focus on how</td>
</tr>
<tr>
<td>Protective</td>
<td>relates w/res</td>
<td>relates to nurse &amp; res.</td>
</tr>
<tr>
<td>Territorial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family oriented</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LPNs</th>
<th>Residents</th>
<th>ESA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship w/nurses, w/res, w/other CNAs</td>
<td>Relationship w/CNA, w/other res, w/nurses</td>
<td>Relationship w/ESA, w/res.</td>
</tr>
<tr>
<td>Focus on how relates to nurse &amp; res.</td>
<td>Focus on how CNA relates to res.</td>
<td>Focus on how relates to ESA.</td>
</tr>
</tbody>
</table>

Domains Specific to CNAs
Personal Values – Family values,
- Importance of job
- Family perceptions of job behavior
- How to relate to other people
- How to relate to elderly people
Institutional values
- Eden values
- Coworker values
- Perception of Unit

Views of Resident - Factors that influence relationship
Listening to the resident

Views of Coworkers – Expectations of CNAs
Aspects of a “good” CNA
Job expectations
Expected interactions with coworkers
Expected interactions with residents

Theme Development from Data
Research Questions -
1) How do certified nursing assistants (CNAs) describe their cultural and social capital?
2) How do these CNAs interact with the institutional culture of the skilled nursing home?

<table>
<thead>
<tr>
<th>Themes – from March 2011</th>
<th>May 1, 11</th>
<th>May 29, 11</th>
<th>October</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSTITUTIONAL CULTURE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power</td>
<td>Theme eliminated, quotes not supportive. Subthemes – Role conflict – only one quote for support. Conflicting Work Ethics – Not enough to support being pulled out. Conflict of Employee Behavior and Work Ethics – not enough to support this subtheme.</td>
<td>Theme – Teamwork was described as overarching. No other themes for Institutional Culture were identified.</td>
<td>Theme – Teamwork was presented, identified as We Work Together. This theme was more reflective of CNAs words. Data supportive of theme.</td>
<td>Theme – We Work Together – was previously teamwork reflective of CNAs voices and data. NEW Subtheme – Frustrations within the Family. This is a new subtheme which is reflective of the CNAs voices and incorporates the former theme of Power.</td>
</tr>
<tr>
<td>Conflicting Work Ethics</td>
<td>Theme was changed to CNAs view of unit: likes and dislikes CNAs view of unit staff: likes and dislikes,</td>
<td>Second Theme Developed – Residents are like Family, treat with respect.</td>
<td></td>
<td>Theme – We are like Family. Theme reflective of data and CNAs voices. Theme – Treat</td>
</tr>
</tbody>
</table>
with a subtheme of Per Diems/Floats – this subtheme was eliminated as to negative. CNAs view of Facility (These themes were pulled from the interview questions of the CNAs)

<p>| Theme - CNAs view of unit – emerged. Likes – Not enough to support being pulled out Subtheme – Teamwork – more supportive data. Dislikes – not enough to support being pulled out. | Residents are like family has supportive data and is reflective of the CNAs voice. Treat with respect data not supportive of the concept of respect. (the word respect was interpretive from this researcher) | like Family. Reflective of CNAs voices and data. The concept of work ethic was moved to Cultural Capital. |</p>
<table>
<thead>
<tr>
<th>Theme - CNAs view of unit staff emerged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likes – one supportive quote</td>
</tr>
<tr>
<td>Dislikes – more reflective of teamwork</td>
</tr>
<tr>
<td>From these comments I see that teamwork makes a big difference within the institutional culture and that it is variable among the units</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme – CNAs view of Facility – carried forward</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SOCIAL CAPITAL</th>
</tr>
</thead>
</table>

| Interpersonal Skills | Theme stayed, pulled out specific skills – humor, listening, observation, trusts instincts. | Theme stayed described specific interpersonal skills under Social Capital. | Theme described in specific interpersonal skills – listening, observation and humor. | Theme changed to Skills to a build a relationship, describing the skills the CNAs used to develop relationship with others. |

<p>| Knowledge of elders | Theme changed to Strong Emotional Connections. Subtheme – Fiesty Elders and Family. | Theme of Empathy/Com passion moved into Cultural Capital. | Theme changed to Emotional Attachment to be more succinct and moved back to Social Capital. | Theme changed from Emotional Attachment to Building Relationships with Residents to reflect CNAs voice. |</p>
<table>
<thead>
<tr>
<th>Sharing on a deeper level</th>
<th>Theme changed to Compassionate/ Empathy with Elders.</th>
<th>Theme stayed as Empathy/compassion moved into Cultural Capital.</th>
<th>Theme incorporated into Emotional Attachment.</th>
<th>Theme incorporated into Building Relationships with Residents to reflect the CNAs voice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CULTURAL CAPITAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care giving Role</td>
<td>Subthemes – Becoming a CNA – described why a person became a CNA.</td>
<td>Themes changed to Role Modeling, Self Determination, Discernment and Empathy/Compassion moved into Cultural Capital. Self Determination and Discernment were themes looking at why a person would chose to become a CNA. These themes were eliminated, not reflective of CNAs voices.</td>
<td>Theme - Role Modeling from family, reflected CNAs voices bringing in the information from the CNAs as to the influence for becoming a CNA.</td>
<td>Theme – Role Modeling from within the family, reflective of CNAs voices about becoming a CNA. Subtheme – Caring for our own – reflective of CNAs voices about caring for own family members at home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New theme - Family Values – focused on the subthemes. Subthemes – Strong family ties – focused on family connections, Loyalty focused on caring for own family.</td>
<td>Theme changed to Family rules about a Job, reflective of CNAs voices.</td>
<td>Theme changed to Lessons about being a worker, reflective of the CNAs voices. This theme reflects work ethic, important to have a job, punctuality/attende</td>
<td></td>
</tr>
<tr>
<td>Wanted to Be a Nurse</td>
<td>Changed to Care giving theme.</td>
<td>Changed into Self Determination.</td>
<td>Theme of wanting to be a nurse and self determination incorporated into Role Modeling from within the family.</td>
<td>Within the theme of Role Modeling from within the family.</td>
</tr>
</tbody>
</table>

Respect for elders focused on what was learned from family about respecting elders, Elders have wisdom. One quote not supportive of cultural capital, Important to have a job, work ethic. Punctuality/attendance, Personal pride in job done, Treat as like to be treated, Treat as like to be treated was moved into Treat like Family in November themes of Institutional Culture. New Theme - Professional behavior with subthemes Responsible/accountable and Set Boundaries.

ndance and personal pride in job done.
<table>
<thead>
<tr>
<th>Work Ethics</th>
<th>Moved into Family Values.</th>
<th>Not reflected in this version.</th>
<th>Theme changed to Family Rules regarding a job to reflect CNAs voices.</th>
<th>Theme changed to Lessons about being a worker to reflect CNAs voices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL THEMES</td>
<td>Eliminated as an overarching theme. Concept incorporated into Role Modeling from within the family, and Lessons about being a worker under Cultural Capital.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIALIZATION</td>
<td>Moved from overarching theme to Cultural Capital and changed to Caregiving theme.</td>
<td>Renamed Role Modeling was not viewed as an overarching theme, moved into Cultural Capital</td>
<td>Stayed in Cultural Capital</td>
<td>Stayed in Cultural Capital.</td>
</tr>
<tr>
<td>ROLE MODELING</td>
<td>Eliminated an overarching theme. This theme reflected in Family Values within Cultural Capital.</td>
<td>Theme shifted became part of Role Modeling, was kept under Cultural Capital.</td>
<td>Theme incorporated into Role Modeling from the family and Family rules regarding a job under Cultural Capital.</td>
<td>This theme is reflected in Caring for our own as part of Cultural Capital.</td>
</tr>
<tr>
<td>PERSONAL EXPERIENCE</td>
<td>Eliminated as an overarching theme.</td>
<td>Eliminated and not considered as part of other themes.</td>
<td>Incorporated in theme of Emotional attachment with Social Capital.</td>
<td></td>
</tr>
<tr>
<td>INFLUENCE</td>
<td></td>
<td></td>
<td>Incorporated into theme of Building Relationships with Residents within Social Capital.</td>
<td></td>
</tr>
<tr>
<td>MAKING A</td>
<td>Eliminated as</td>
<td>Incorporated</td>
<td>Theme</td>
<td>Incorporated</td>
</tr>
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</table>

Final Themes and Quotes for Cultural Inventory

Institutional culture

*We are like family*

“it’s like family here (The Home), it’s a family oriented environment here (The Home) and the residents share their lives with you and you become like family.” CNA participant 1 stated “the elders you (CNA) get attached to them, you become like their family.”

CNA participant 18 “I like helping people when like their (residents) family can’t help them because we (CNAs) become their family when they don’t come as often as they should.”

Cognitively intact resident 1 “first of all they (CNAs) become like my family.”

CNA participant 14 “It’s like your home away from home, you spend so much time there, (it becomes) like your own family.”

Registered nurse manager 2 “(The CNA’s are) wonderful to the elders, to the families. I think of one particular aide (CNA) who’s worked for “The Home” a number of years, and she’s a fabulous aide. She loves, actually loves every one of her folks on her assignment and they love her too.”

LPN 4 stated, “I see them (CNAs) treat these residents and I’ve said it time and again, you treat them like they are your family members because that’s how you want your family to be treated, and I see that that’s what they do. They’re affectionate, they’re caring, they’re gentle, they have respect for their elders.”

LPN 2 “if you have the same girls (CNAs) taking care of the same people it gives them (residents) that personal connection with that person and they end up loving them.”

Environmental service aide 6 “I think we should be like one big family, everybody knows their positions, everybody knows what to do.”
Environmental service aide 1 “every month we have (a) meeting together so (we) get together, we get together like family.”

CNA participant 6 “It’s like family, it’s like family here. I mean everybody know(s) you, I told my husband the other day the security guard knows my name.”

CNA participant 1 “you’ve (CNA) got to treat them like they’re (residents) your own parents.”

“treat like you would like to be treated,”

“treat like you would like your family members to be treated if they were in the facility,”

“if you treat people the way you want to be treated, then you won’t have any problems.”

CNA participant 4 “If they’re (resident) asking me for something I will do everything what they want.”

CNA participant 12 “I tell brand new CNAs, treat people the way you want them to treat you and the way you want your family members if you ever have to put them in a facility to be treated.”

CNA participant 15 “The main thing that they (residents) want is for you to do what they want you to do. I mean as long as you can follow instructions and do what they want done it’s pretty good, they pretty much like you.”

Cognitively intact resident 6 “Just listen to me the way I tell them (CNAs) my grooming (needs) to be or whatsoever, or things that, like in my room, don’t move this or that because that there I like to stay that same way I got it or whatsoever, and we get along fine.”

Registered nurse manager 2 “The aides that are assigned to my floor they’re very respectful of everybody, doesn’t matter if it’s a nurse manager, the nurse or the secretary. They’re wonderful to the elders, to the families.”

Protecting the family from outsiders

CNA participant 2 “(CNA participant 2 dislikes other CNAs) being sharp with the residents, not cleaning them properly, neglecting them as far as what needs to be done with that resident, you watch all that go on and it’s very frustrating because the permanent aide is not there that day.”

CNA participant 3 “My difficulty is when there’s other staff members who aren’t nice to these people (residents).”
Registered nurse manager 3 “I have problems with floats a lot of times. They (CNAs) don’t have a relationship up on the floor.”
Registered nurse 1 stated, “They’re (regular CNAs are) concerned when there’s going to be somebody (float CNA) that doesn’t know the resident, taking care of them.”

CNA participant 3 “I used to go to a nurse manager or the nurse first and then the nurse manager and nothing was done so I just, I figured well let them (CNAs) get caught on their own.”

Cognitively intact resident 3 “I can talk and sometimes they (CNAs) don’t like it (when I tell them how I want something done). (The CNA will say) “I know, I know how to do that”, okay good, then let’s do it the right way then. Sometimes they make a few mistakes and I try (to correct them), they don’t like to be corrected too much.”

LPN 3 “I think most of the CNA’s (have a connection with their residents that they view their residents) like it’s my children you might say and that’s how the CNA’s feel about most of their residents, especially if they’ve had them (residents) for a long time. So they (CNAs) get territorial about their (residents) stuff.”

We work together (Teamwork)

Registered nurse manager 1 “the teamwork, the respect for each other, respect for all staff--- they (nursing staff) know that that’s the expectation.”

Registered nurse 1 “they (CNAs) have a safe environment to talk even though we do sometimes talk about things that are not pleasant to talk about, you can still come back and work as part of the team.”

Registered nurse manager 4 “We (registered nurse managers) all have some heavy duty things going on, but I think as long as people (nursing staff) know that the teamwork is there they feel better.”

Licensed practical nurse 2 “I found out it helps if you actually work along with them (CNAs).”

Registered nurse manager 3 “All new people are paired up with a CNA on every single cluster, regardless of the shifts they go to (work) during that time on days, because they need to know about everybody (residents). That also gives me the opportunity when I speak (to the new person), how are things going to get a truer picture of how that person is interacting with the staff, becoming part of the team.”
Environmental service aide 2 “I help them (CNA) like team work, and I ask them and they come and help me, very good teamwork on my floor.”

Cognitively Intact Resident 1 “Some of them (CNAs) they go together, some of them go by themselves. It depends, I just need one aide because I go on the ready stand, but when you get them (resident) on that Hoyer lift there has to be two (CNAs).”

Cognitively Intact Resident 9 “I think the willingness (of the CNAs) to help one another has been a biggie (important to meeting the needs of the residents).”

Social capital

*Communication skills to build a relationship*

CNA participant 16 “I usually observe first before I really open up to that person.”

CNA participant 10 “I’m just more the person that sits back and observes (when talking with a staff member).”

CNA participant 10 “Well with the elders it’s a lot different. I mean with them (residents) I can sit back and they can tell me tons of stories about the past and stuff that they went through, I connect like that.”

CNA participant 5 “I talk to them (residents) sometimes they just need that ear to listen to or if they want to go over and talk I don’t mind that either but I listen to them, if I can respond back I’ll give it, you know, I’ll respond back, and if I don’t have an answer I’ll be like well I’m going to come back as soon as I get done with the next visit I’ll come back and I’ll have an answer for you hopefully, if not that day maybe the next day.

CNA participant 15 “I tend to use a lot of humor when I first meet somebody, if they laugh at my jokes, then they’ll like me.”

CNA participant 20 “if they (resident) tell me something that I can relate with we’ll talk about that, or even if it’s something that is just kind of make light of it and joke about it and stuff. Have little inside jokes with them so they know that you’re not just there because you have to be.

Cultural capital

*Learning caring from Home*

CNA participant 4 “My aunt she’s been a nurse and when I was a little girl I used to just look at her uniform, she’d talk about (her work) and (how she) enjoyed her work. So that made me go that direction.”
CNA participant 2 “She (Mother) just told me to make sure I had respect for them (elders).”

CNA participant 5 “My grandmother, she taught us how to respect and to listen to your elders.”

CNA participant 3 “when I was younger my grandfather was in a nursing home and my father would pick me up every night and I would go with him and we would take care of my grandfather.”

CNA participant 3 “Our family was very close and I think that has a lot to do with it. We were all very close, both sides, and even my kids used to come with me when I used to take care of my grandmother and they just see that, and in fact they all get along with elderly people.”

**Lessons about being a Worker**

CNA participant 7 “I learned a good work ethic. My dad went to work whether he was sick or (had a high) temperature, throwing up, whatever; he was a manager so he was at work every day regardless of whatever and anything less was not looked well upon.”

CNA participant 10 “My mom always gets on me, you need to be on time for your job, she basically stresses attendance and being punctual is the main thing that my mom stresses.”

CNA Interaction within the Institutional Culture

**We influence each other becoming family**

Cognitively intact resident 1 “two of the CNAs who consistently care for her (she considers) as her “daughters.”

LPN 1 stated “They (CNAs) have their favorites, especially if they’ve had them for a long time. So they get territorial about their stuff.”

Registered nurse 2 “because they (CNAs) have primary assignments they really look out for them (residents) and actually even to the point of, helping the nurses with things that maybe they shouldn’t be helping with, but inquiring, can I (CNA) just do this they really need this.”

CNA participant 3 “They’re like friends, they’re not just residents, you know, and I think I’m their friend.”
CNA participant 18 “She (resident) used to call and check on me and she would call and check on my daughter and my cat.”

Cognitively intact resident 1 “I wanted to go to Wal-Mart cause I hadn’t been in a store since 2005. (The CNA said) Friday is my day off, if you want to get on the Lift Line I’ll meet you there and then I’ll be with you, and I said sure, that would be fine and thank you for giving up your day, she says I’m not giving it up because she says I do my grocery shopping in Wal-Mart.”

CNA participant 3 “He was like a son to me, and my other son was getting married and the wedding was at a close park. We invited J B (the resident), and his sister to come to the wedding and he came in his electric wheelchair, he was decked out in this black suit, purple shirt, he was so happy. He just couldn’t believe it that I invited him.”

Registered nurse manager 2 talked about a CNA participant who met a resident at a local department store and shopped with her on the CNA’s day off.

Registered nurse manager 3 talked about family members who praised the CNA who cared for their mother for being able to get her to eat when the resident wouldn’t eat for them, her own daughters.

CNA participant 1 “I had a resident she loved cream puffs, so I brought one in for her and laid it on her overbed table, I went in at breakfast time and half of it was gone and I go “what happened to the cream puff”, she said “well who brought it in”, I said “well I did”, “oh that was great she says”.

Miscellaneous data

List personal beliefs about the elderly, what information the CNA trainee is willing to share about one self, work beliefs shared by parents, and personal values of life. Once these items were recorded each participant will pair off and share with each other to compare similarities and differences. Finally, a group discussion will be held to discuss what each other learned identifying differences and the CNAs feelings about those differences and if the differences would cause the CNA to treat the resident differently. This type of exercise would help the CNA gain insight to personal beliefs and how those beliefs may influence their view of residents as well as coworkers.

Frustration within the institutional culture related to slow change over to Eden culture.
Ongoing frustration with having enough nursing staff on unit to meet resident needs.

Themes for future study.

How to help the per diem/float CNA become part of the unit “family”.

Identifying the “family values” of the unit staff, and deciding how to share those values with new or per diem/float staff.