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# Physical Assault of Special Care Aides: Let's Take a Look - A Study Report

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## In Brief

### Introduction

The purpose of this study was to investigate Special Care Aides' (SCAs) experiences of physically aggressive behavior from residents, including their perceptions of the causes of the aggressive behavior. SCAs represent the largest group of caregivers in long-term care (LTC) facilities and provide the majority of hands-on care to residents. Behavioral disturbances such as physical aggression are common in dementia and are significant reasons for LTC placement. The prevalence of dementia is increasing in Canada, and as a result SCAs are caring for growing numbers of LTC residents with dementia. Previous research has shown that most physical aggression from residents occurs during personal care, thus SCAs are at higher risk of physical aggression from residents than other caregivers. Some studies have shown that SCAs experience assault on a daily basis.

### Study Results - Key Messages

- SCAs are discouraged and frustrated that physical assault has received so little attention and concern. It appears to them that assault has become accepted as "part of the job" for SCAs. Their perception that SCA assault is not taken seriously is interpreted as evidence that they are not valued care team members.
- SCAs' interactions with residents are determined by multiple interacting factors that are outside of their control yet have a profound influence on SCAs' ability to use their knowledge and skills to provide appropriate resident-centered care, and to avoid assault.
- Many SCAs have given up reporting all but the most severe physical aggression incidents because they are not aware of any investigation and follow-up, and because the most common response to reports of aggression is to question the caregiver about their approach. Rather than being supported and validated when assaulted, SCAs feel blamed for causing the incident.
- Reducing SCAs' exposure to physical assault will require a multi-faceted approach that includes SCAs as part of the problem-solving process, and an examination of organizational factors that produce the conditions for SCA assault.

## Why look at assault from the SCA's perspective?

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*"I write up incident reports and the first thing is 'What was your approach?' It is always 'What did you do wrong?'"*

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*"They never come up with a solution. When we say the resident needs more pain control, they say 'this is all we can do'."*



Because of SCAs' key role in providing care to LTC residents, and the potential impact of physical assault on their physical and emotional well-being, it is important to understand these events from the SCAs' perspective. This information can be helpful in planning interventions to reduce SCAs' exposure to aggression, improving the work environment, and enhancing the quality of life of the residents.

In this report we use the term "aggression" to refer to the resident behavior and "assault" to refer to the outcome. These terms do not imply intent to harm on the resident's behalf.

The impetus for this study came from earlier research in rural LTC facilities, which identified a high rate of physical assault for SCAs compared to other caregivers, and an association between more frequent assault and higher job stress.<sup>1,2</sup>

## Where was the study done?

Rural facilities were studied because little research has been done in rural LTC facilities, which tend to be smaller than urban facilities, and have less access to specialized programs and personnel.

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*"It's part of the job as aides, but not for someone else."*

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*"We are exposed to this daily, hourly. It is an issue"*

Eleven rural LTC facilities in Saskatchewan that ranged in size from 59 to 157 beds were studied. Eight of these facilities had separate special care units (SCUs) for the care of residents with dementia, with permanently assigned SCAs. We tried to match each of these facilities to a same-sized rural nursing home that did not have a SCU, but matches were available for only 3 facilities. All SCAs in the facilities studied were eligible to participate.

## How was the study done?

### ***1st Phase - Aggression “diary”***

A structured log or diary was developed and tested with SCAs in two rural LTC facilities that were not part of the final study group. This diary was then used by SCAs in the 11 participating facilities to document all incidents of physical aggression during 144 consecutive hours of work. On-site meetings were held in each facility to meet with as many SCAs as possible to explain the nature of the study and to distribute packages containing the diary, information sheet, and stamped envelope to return the completed diary directly to the researchers. We explained that data were confidential and no information could be linked to individual participants. This phase was conducted in 2005.

For each incident recorded in the diary SCAs provided information about:

- the resident
- the circumstances
- the behavior
- themselves

### ***2nd Phase - Focus Group Interviews with SCAs***

In the second phase of the study we planned to conduct face-to-face meetings with SCAs to allow for in-depth discussion of issues related to caring for physically aggressive residents and to explore findings from the diary phase. The focus group interviews were conducted in 2006.



## Response rates tell their own story

The most important findings of this study were discovered in an unexpected way. Response rates for the aggression diary ranged from only 8% to 30% across the 11 facilities -- 19% overall. Although the research literature reports that these rates are not unusual, we were surprised. We have had good response rates in our previous survey research with staff in rural LTC facilities in Saskatchewan. In the two facilities involved in pilot testing two versions of the diary for this study, 77% to 95% of SCAs participated. To help us understand why we suddenly had low response rates, we conducted nine focus group interviews in five of the 11 facilities, exploring factors influencing study participation. In the remaining six facilities we reverted to our original study plan, and conducted 10 focus group interviews to discuss issues related to care of physically aggressive residents. Surprisingly, similar themes emerged from both sets of focus groups, in which 138 SCAs participated.

The main reasons given for not participating in the study were fear that the information would be “used against them” and interpreted in a way that “proved” that SCAs were to blame for causing the incidents. The historical lack of action in response to incident reports was also a factor -- many SCAs believed that nothing would happen as a result of taking part in the study. They wanted a guarantee that taking part in the study would result in change. This report gives voice to the SCAs by reporting their views, using their own words.

In exploring these issues with the SCAs we learned about their experiences in caring for physically aggressive residents -- the original intent of the study -- but the process was different from what we had anticipated.

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***“This is our line of work and I just have to deal with it— that’s what we’ve been taught to accept. Not much is done about it.”***

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***“You are trained that it is part of your job, you deserve it because you work with older people and that is how they are.”***

## Physical assaults - Let's take a look

Pages 4 to 6 report on SCAs' responses to questions in the aggression diary. A total of 495 incidents of aggression were documented by 115 SCAs. The majority (88%) involved a resident with dementia. These 411 incidents are the focus of this report. Just over half of the incidents involved a male resident (57%).

### Location

The largest proportion occurred in residents' rooms (Figure 1).

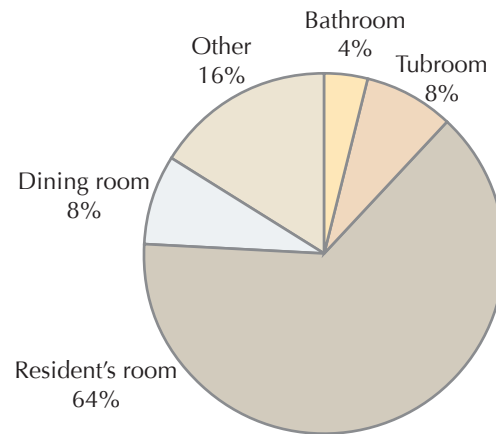


Figure 1: Location

### Activity involved

Dressing, transferring or positioning, and toileting were the most common activities taking place when the assaults occurred. Those three activities accounted for almost 60% of assaults. (Figure 2).

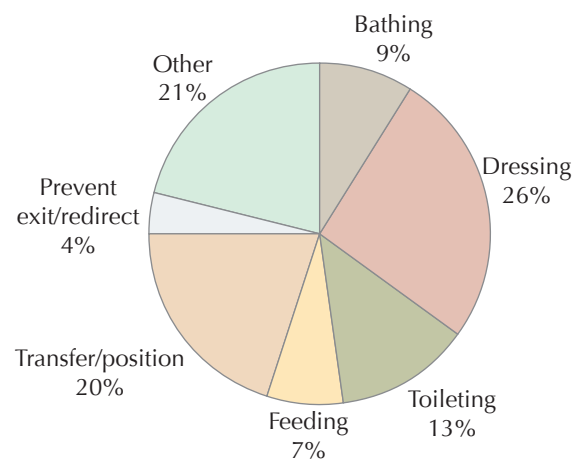


Figure 2: Activity

### Type of aggressive behavior

The most frequent aggressive behaviors exhibited during the assault incident are shown in Figure 3. Some incidents involved multiple behaviors so numbers add to more than 100%. Slapping was the most frequent behavior reported at 44% of incidents.

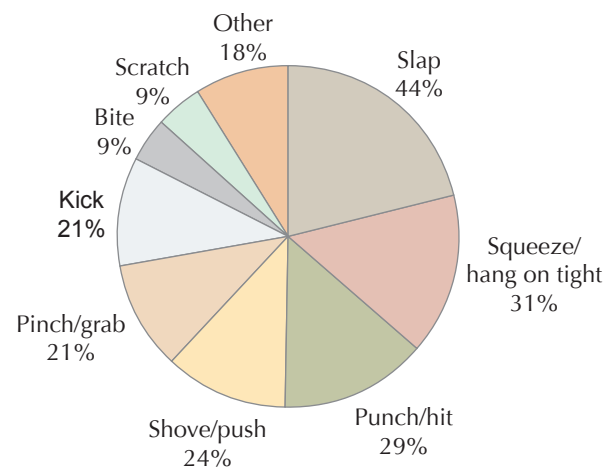
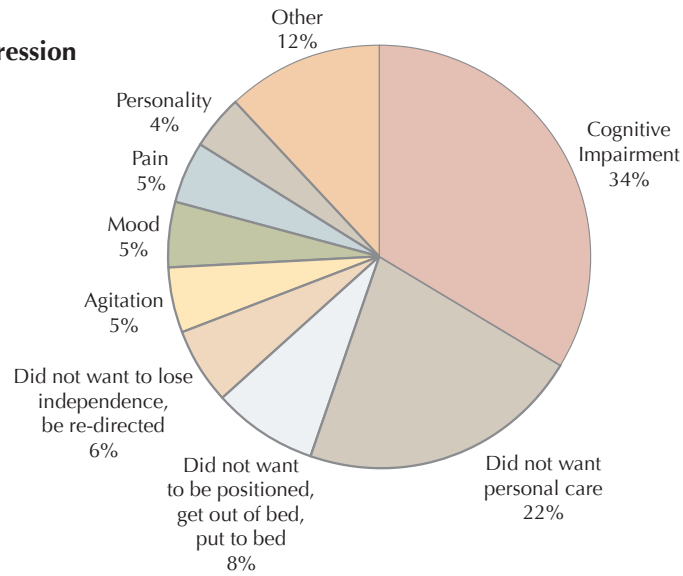


Figure 3: Aggressive behavior

## Causes of the aggression

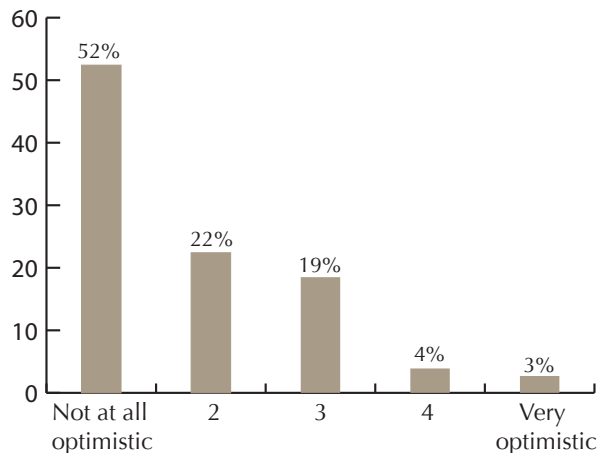
For each incident documented, SCAs were asked “Why do you think the resident was aggressive in this situation? In your view, what was the main underlying cause of the aggression in this incident?” Cognitive impairment and not wanting care were the most common causes identified by SCAs (**Figure 4**).

**Figure 4: Causes of the aggression**

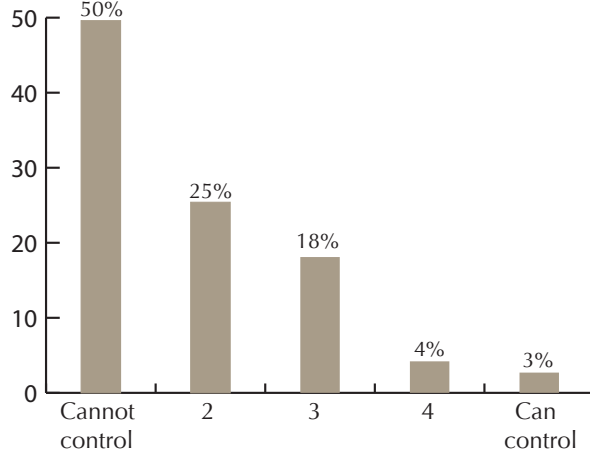


## Perceived ability to prevent aggressive behavior

For most incidents, SCAs were not optimistic that anything could be done to prevent the resident from being aggressive in the future (**Figure 5**), and rated their ability to control the cause of the behavior as low (**Figure 6**).



**Figure 5: How optimistic are you that this behaviour can be prevented?**



**Figure 6: To what extent were you able to control the cause of the resident's aggression?**

## How did SCAs feel?

SCAs were asked to report their first emotional reaction when they were assaulted. The most frequent emotions were frustration, “nothing”, and nervousness/fear (Figure 7). In the focus groups SCAs explained that not acknowledging their feelings was a coping mechanism. They had to control their emotions in order to continue providing care and remain in a professional role.

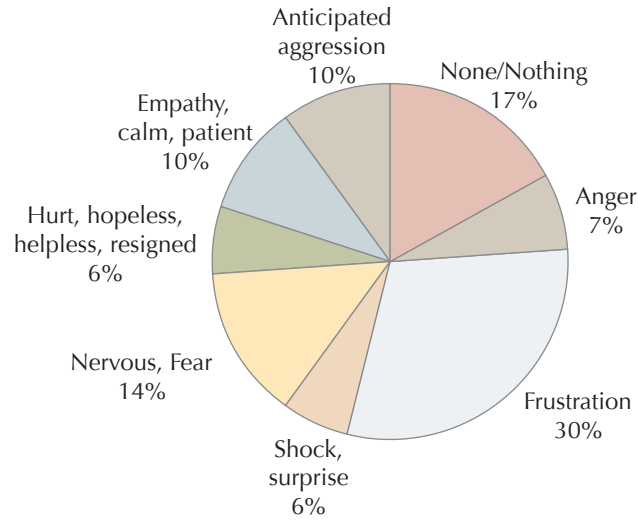


Figure 7: Emotion

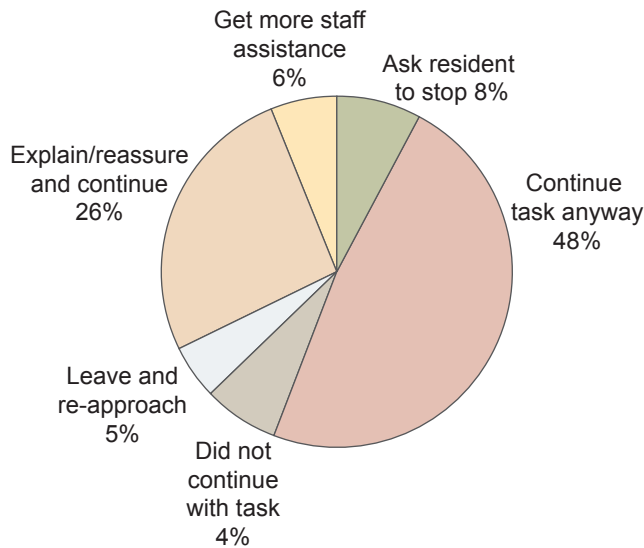


Figure 8: How they handled it

## What did they do?

When asked how they handled the situation, most SCAs reported in the diaries that they continued to provide care despite being hit (Figure 8). In the focus groups SCAs stated that they continued care because it is their job and they are concerned about residents’ safety and dignity.

## Working under time pressure

In the diaries the majority of SCAs reported that they always or frequently work under the pressure of time (Figure 9). In the focus groups rushing of care due to low staff:resident ratios was described as an underlying cause of many incidents of aggression.

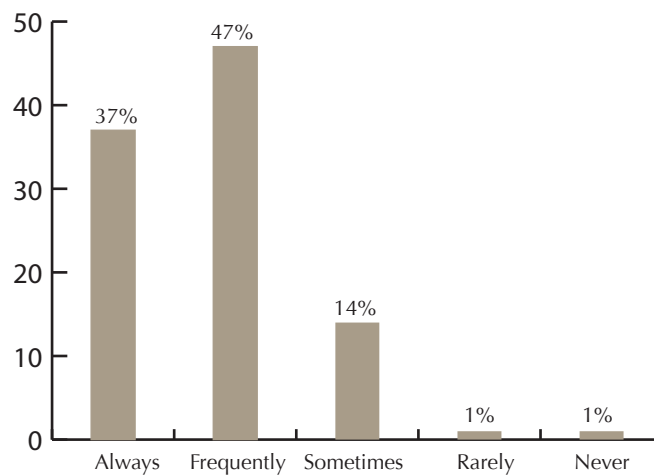


Figure 9: How often do you work under the pressure of time?

## Focus group themes

### Response to reports of physical aggression

SCAs stated that being hit by a resident, and then being blamed for it, was distressing. They would like their experience to be acknowledged, be reassured that they are good caregivers, and consulted about what happened. SCAs stated that assault seems to be perceived as “part of the job” for SCAs but not others. In their view there is an expectation that SCAs will be subject to aggression and that they should accept it.

*“I would like the focus to be taken off the aides—it is all in how they communicate. You don’t say to a woman that was battered, ‘what did you do to provoke it?’ Don’t assume that I did something wrong.”*

*“NAs need to be told ‘it is okay, you did your best’, not ‘how did you approach them?’ That says you made a mistake. They need to be told they are okay, ‘you are not a bad person, you are a good person, we need you here.’ Later—you can look at the situation and see what can be done, but right now they need to be validated.”*

*“What bothers me is that it is expected that I take it ... It is not acknowledged as an issue .... I don’t come to work to get hit—it is not part of my job.”*

### Little acknowledgement and action in response to reports of aggression

The lack of response to reports of aggression has further reinforced SCAs’ perceptions that others expect them to quietly tolerate these incidents, that they are the bottom of the organizational hierarchy, and that their work is not valued.

*“It [incident report] gets to management and that is the end. We really don’t know where it goes.”*

*“It [report] goes to the RN, she takes it to the nurse manager. I think then it goes to the city—not sure. We never get any feedback.”*

*“Reporting needs to go on, something should be done right away, people are getting hit, nothing is changing.”*

*“We aren’t supported enough—we feel there is no end to it.”*

### Desire for respect and involvement

SCAs believe that they are not respected and valued for their knowledge and skills. Many stated that they are systematically trained to be at the bottom of the hierarchy. Organizational practices that exclude them from participating in decision-making reinforce their perception of their low status.

*“Sometimes we feel the higher-ups don’t listen. We are at the bottom of the totem pole.”*

*“There is a medical hierarchy. It is like the army. It works well to keep us in our place. It [hierarchy] is doctor, nurse, LPN, special care aide. It is drilled into your head—you report to a certain person. We are trained as underdogs.”*

*“For example, pain—if I think Mrs. Smith needs more pain medication. We are told we are not qualified to say she needs pain medication.”*

*“It is hard being the brunt of it. We are not taken seriously by doctors, nurses, management, family.”*

### Inability to change organizational risk factors for assault

SCAs identified organizational factors that influenced their behavior and put them at risk for assault, including workload and rushing of care, lack of flexibility regarding routines, limited access to specialized personnel and programs for behavior management assessment, and inadequate dementia training at all levels.

*“You are rushed, you have less than 6 minutes in the morning to get them up.”*

*“We have to get residents up, washed, pad changed, and to the table in 9 to 11 minutes. The resident doesn’t have a clue what is going on—they aren’t even awake yet. With Alzheimer’s Disease, you need to be slow, gentle. But we don’t have time.”*

*“There is exactly 4 minutes to dress, lift, wash, shave, get teeth done, and get them into their chair.”*

*“Routine is out of our hands. We don’t make the rules.”*

*“We don’t know where to turn to benefit ourselves.”*

## What do the findings suggest?

The purpose of this study was to learn about physically aggressive behaviors from the SCAs' perspective. We wanted to understand their experiences of caring for physically aggressive residents and to identify potentially modifiable problems that, if addressed, would decrease their risk of assault. Data from the aggression diaries and focus groups provided complementary information about SCAs' experiences and their perceptions about resident aggression.

SCAs are exposed to frequent assault from residents, most of which they do not report because they perceive that it will not result in any action to prevent future assault, and because they are afraid of being blamed for causing the incident. SCAs stated that some aggression may be inevitable when caring for nursing home residents, especially those with dementia, but are upset when others view it as acceptable for SCAs to be assaulted in their work.

In the aggression diaries, the causes of the incidents were described in terms of the resident (e.g., cognitive impairment, not wanting care, agitation, pain), with most SCAs reporting that they could not control the cause of the aggression.

In the focus groups, however, many organizational factors emerged that had an impact on the ability of SCAs to provide quality care and to avoid assault. SCAs indicated that they did not have the authority to change these broader organizational factors.

A strong theme in the study was that SCAs perceived themselves as being at the bottom of the organizational hierarchy and having little control over their work and little input into decision-making at all levels. This situation increased their risk of physical assault and had a negative effect on their job satisfaction.

## A model for understanding SCA assault in long term care.

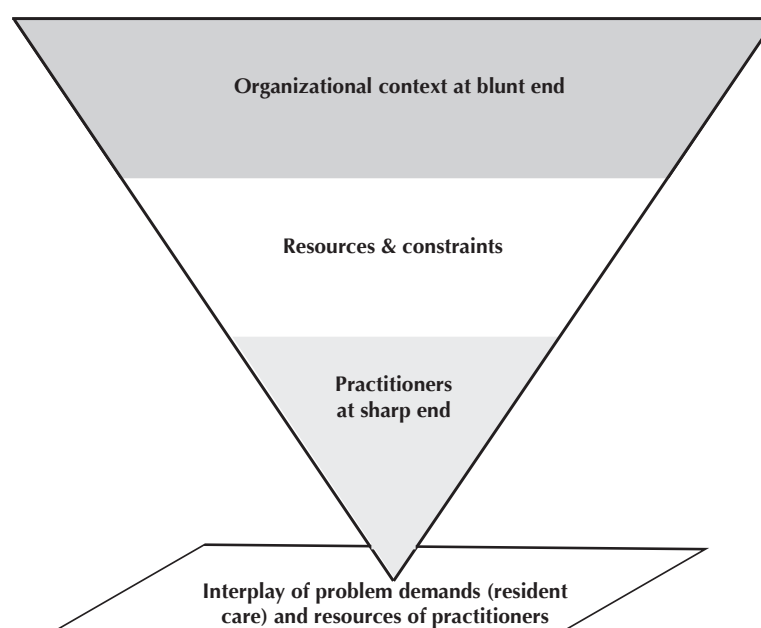
The study findings can be represented using a model that has been used to understand "accidents," "errors," or "failures" in a wide range of circumstances, from the aviation industry to health care.<sup>3,4</sup> The quotation marks are used to indicate that these events are often wrongly attributed. Although the current study was focused on resident aggression, and not caregiver "errors," the SCAs in this study stated that their reports of assault were often viewed as SCA errors.

The framework (**Figure 10**) depicts complex systems as having a sharp end and a blunt end. At the sharp end, practitioners interact with the underlying process—in this case, SCAs providing care at the front lines. At the blunt end of a system is the broader organizational context (e.g., where resources are controlled, policy set) that affects practitioners at the sharp end.



This model highlights a frequent problem within large complex organizations-- when negative events occur, the search for causes tends to stop with the individual or group closest to the situation. This simplistic approach prevents an examination of the organizational context external to the individual that influences the way they do their work.

The belief that negative events are the result of mistakes made by individuals masks the deeper story of multiple contributors that create the conditions within which individuals work. Focusing on workers at the front line often leads to ineffective “blame and train” responses directed at the sharp end, rather than examining how organizational contexts shape practitioner’s actions.



**Figure 10: The sharp and blunt ends of a large complex system such as long-term care.**  
Adapted from Cook and Woods (1994) and Reason (1990)

Earlier research on incident reporting by health-care practitioners has identified limitations of the incident reporting approach in understanding the true volume of these incidents and the system-wide risk factors behind them.<sup>5,6</sup> Reporting tends to focus on people rather than on organizational structures and work contexts. The recommendation coming from this field of research is that the focus of blame should be removed from individuals and directed toward proactively improving organizational processes and work environments.

## What are the implications of the findings?

Physical assault of SCAs is a serious occupational health and safety issue. The first step in addressing the problem is recognizing and acknowledging that it exists. It is also important to recognize that this problem is not unique to the facilities included in this study. The issue of resident aggression in nursing homes has been reported in the research literature for decades.

Dementia care, especially the management of behavioral symptoms such as aggression, is very challenging. The perceived lack of attention to the problem may be a reflection of the very real difficulties in managing aggression, and the limited resources available to address it. SCAs feel helpless about preventing aggression, and it may be that other care providers do as well.

## Recommendations

The concerns described by SCAs are not solely related to their experiences in caring for physically aggressive residents - however, these experiences have contributed to SCAs' perceptions that they are not valued team members. Addressing these complex problems will require a multi-faceted approach involving a cooperative effort between stakeholders. To be successful, the focus must move away from looking at just the SCA-resident interaction, to examine the broader organizational context. Efforts need to be focused on enhancing the work culture, as well as directly addressing the issues related to physical assaults.

- **Initiate a province-wide consultation process to create supportive work environments for SCAs and reduce SCA exposure to physical assault.** Participants should include: representatives of all occupational groups employed in long-term care settings, including SCAs; facility directors, managers, and administrators; regional health authority directors; organizations providing SCA training, health union leadership, occupational health and safety personnel, and representatives from government departments with responsibility for LTC.
- **Good communication and relationships were identified as important in creating a positive work environment and a culture of safety where SCAs can feel supported and comfortable reporting aggression.** In the US, significant advances have been made in conducting research and developing programs to address the high turnover rates for frontline nursing home staff.<sup>7</sup> This work has identified similar problems to those identified by nursing aides in the current study. A number of intervention programs have been developed to address these issues. They involve increasing opportunities for learning and advancement, involvement in workplace change, training in problem-solving, empowerment of aides, emphasis on communication and team-building, and training in supportive supervision for nurses and other supervisors.
- **Implement transparent and specific procedures for reporting and most importantly following up on formal and informal reports of resident aggression.** SCAs should be consulted about their perceptions of barriers to reporting. Facility and system-level barriers also need to be identified.
- **Conduct regular reviews of incidents, including those not formally reported, focusing on the systemic issues that may contribute to events.** Incident reports by themselves do not suggest clear solutions. SCAs must be fully involved in these reviews, to ensure that their knowledge and insight is used.
- **All providers involved in the care of nursing home residents with dementia require access to continuing education.** Best practices for dementia care and behavior management are continually evolving. Education should not be targeted to SCAs alone. For effective collaboration and problem-solving to occur, all team members need to be working from a common knowledge base toward the same goals.
- **Organizational commitment, support, and change are required to successfully implement new skills and care practices.** Education and training alone are not effective.<sup>8</sup>
- **Staffing levels must reflect the growing numbers of LTC residents with dementia.**<sup>9</sup> SCAs know the consequences of rushing when caring for individuals with dementia, but often they see no other option for completing care in the time available.
- **Specialized resources, programs, and personnel are needed for the effective management of resident aggression.** These supports should be readily accessible. Care providers, including SCAs, need to know where to go for assistance and support when faced with difficult care situations. Follow-up is important because development of management strategies is often a process rather than a one-time consultation.

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## Talk to us!

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