Are Nutrition and Food Security Concerns a Priority of Certified Nursing Assistants in Work and Family Environments?

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HUMAN NUTRITION, FOODS, AND EXERCISE

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Abstract

Are Nutrition and Food Security Concerns a Priority of Certified Nursing Assistants in Work and Family Environments?

Certified Nursing Assistants (CNAs) are responsible for the care of America’s aging population. CNAs are paid a miniscule amount of money and are often ineligible for medical benefits through their employers. CNAs bathe, change, feed, and help toilet the residents of long-term care facilities. The stressful work and personal lives of CNAs leads to many problems such as high turnover rates, absenteeism, health problems, and elder abuse. In the United States, food insecurity is a concern for many of the uninsured working poor. The purpose of this study was to assess the overall perceived concerns, barriers, and solutions of CNAs in both their work and family environments, identify where nutrition and food security fits into the priorities of CNAs, and identify educational strategies to improve their health and overall quality of life. Twenty-nine CNAs participated in six focus groups across the state of Virginia. Triangulation techniques were used to compare both qualitative (focus groups) and quantitative (participatory activities and questionnaires) research. Participatory activities showed that the top home concern of CNAs was money management. CNAs ranked keeping their family healthy fourth (9.6%), and they ranked preparing fast easy meals eighth (1.7%). The top work concern of CNAs was time management. Staying healthy at work ranked fourth (12.9%), while packing a nutritious lunch was sixth (3.4%). The preferred methods of education for the participants were watching videotapes, attending classes at a central location, and having a mentor to help them with their problems.
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CHAPTER I: INTRODUCTION

Certified Nursing Assistants (CNAs) are considered the “front-line” in health care, because they provide 90% of direct patient care in long-term care facilities as well as most of the direct patient care in home health services (Eustis et al., 1994; Hoffman, 1996). CNAs make up 71% of the full-time nursing staff in America’s nursing homes (Segal et al., 1999). The residents of these long-term care facilities are directly affected by the quality of care they receive from the CNAs. The close staff-resident relationships forged make CNAs indispensable to the health care system.

In the United States the population of older adults age 65 and over is projected to grow from 12.5% of the population in 1990 to 14% of the population by 2010 (Schlenker, 1998). The demand for trained CNAs is even more important as they are a major contributor to health care of our aging population. In the past, CNAs have been largely overlooked as a means of improving the care given in long-term care facilities, although the turnover rate of CNAs approaches 100% in many facilities (Hoffman, 1996). Limited efforts have targeted the improvement of the work and family situations of CNAs. Addressing the CNAs’ work and family concerns including the turnover rate, stress, health, and personal relationships may help improve the quality of life for the CNAs and nursing home residents in America.

CNAs are considered part of the working poor in America due to their meager incomes (Adler, 1999). The working poor are defined as persons who average 40 hours of work per week, without benefits such as health care coverage (Craypo & Cormier, 2000). The working poor make up about 40% of the population in America, but they earn only 15.7% of the income in the United States annually (Navarro, 1990). These low-income individuals and families are less likely to be covered by health insurance than more affluent individuals and families. American families that earn less than $25,000 a year are three times more likely to be uninsured (Service et al., 1999). In 1997, 67% of uninsured families had an income of less than 200 percent of the poverty line (McBride, 1997). It is this lack of health insurance that often prevents people from obtaining the proper preventative care necessary to prevent chronic diseases like cancer (JAMA, 1998). Typically, the uninsured working poor are not able to afford health insurance or health care costs.

In America, health insurance is primarily provided through employers. Unfortunately, not all employees are eligible for health care coverage. Employees who
work less than 40 hours per week and/or earn very low wages are often ineligible for or cannot afford employer-based health insurance. Over thirty percent of the uninsured working poor are in service occupations such as health care. In 1995, 11 million low-income Americans were uninsured (US Census Bureau, 1996). In the year 2000, uninsured Americans comprised 14% of the population or 38.7 million people (US Census Bureau, 2001). Half of the uninsured are the working poor. (Business & Health, 1999). The Center for Studying Health System Change cited cost as the main reason why the uninsured working poor do not have health care coverage. Employees who earn less than $7 an hour are expected to pay an average of $130 a month for their families to have health insurance. While employees who earn twice as much are only asked to contribute $84 a month for their families to be covered by health insurance. The national average hourly pay for a CNA in 1999 was $7.51 (Adler, 1999).

According to the results of the National Health and Nutrition Examination Survey (NHANES III), 4.1% of all Americans experience food insecurity (Alaimo et al, 1998). In 1999, the USDA estimated that 10.1% of American households experienced food insecurity (USDA, 2000). In Virginia, 8.3% of households experienced food insecurity in 1998 (Nord et al, 1999). Low-income populations are particularly susceptible to food insecurity because of its relationship to poverty status. Over 10% of individuals living below 185% of the poverty line reported in the NHANES III not getting enough food to eat (Alaimo et al, 1998). The USDA estimated in 1998 that 36 million Americans lived in food insecure households (Nutrition Today, 2000).

Food insecurity is associated with many major health problems for people of all age groups. Food insecure people are more likely to suffer from obesity (Jeffrey & French, 1998; Kendall et al, 1995). Even low levels of obesity contribute to an increased risk of death in adults (Manson et al, 1995). A lack of adequate food leads to a lack of proper nutrient intake (Rose et al, 1997). The working poor are at a higher risk of chronic diseases, such as cancer and heart disease, because of their low socioeconomic status (Colhoun et al, 2000; Brewster et al, 2001).

Virginia Cooperative Extension (VCE) is committed to enabling people to improve their lives through an educational process focused on issues and needs (VCE, 2000). VCE has the educational resources needed to make an impact on this underserved population. VCE can provide programs on how to stretch food dollars, provide CNAs with sound nutritional advice, and provide other resources to help improve their work and
family situations. Nationwide, Extension programs may help this population have healthier lifestyles and provide better care in our long-term care facilities.

CNAs suffer from food insecurity, low wages, and a lack of health insurance. This low-income population is in need of interventions that will help improve their overall quality of life. Extension can provide programs to target this specific population in order to better meet their needs. Collecting research data related to the concerns of CNAs will help Extension to define and develop curriculum that may meet their specific programmatic needs to improve their quality of life.

The purpose of this study is to assess the overall perceived concerns, barriers, and solutions of CNAs in both their work and family environments, identify where nutrition and food security fits into the priorities of CNAs, and identify educational strategies to improve their health and overall quality of life. In the future, it may be possible for VCE to develop a collaborative Family and Consumer Science education curriculum that may improve the quality of life of CNAs at home and work.

RESEARCH QUESTIONS:

1. What are the major sociodemographic and other characteristics of CNAs that might affect their health, nutrition, food security, and preferences for learning?

2. What overall concerns, barriers, and solutions do CNAs have regarding their work and family situations?

3. To what extent are CNAs concerned about nutrition and health issues compared to other work/family concerns?

4. To what extent do CNAs perceive food security as a concern?

5. What type of educational strategies do CNAs perceive as the most useful for learning about foods and nutrition?
CHAPTER II: LITERATURE REVIEW

The following research describes the problems facing the working poor in America. In particular, it focuses on the CNAs, who are responsible for providing the majority of direct patient care in our long-term care facilities. The literature examines the (a) food insecurity concerns, (b) health concerns relating to nutrition, (c) health concerns relating to lack of insurance, and (d) work and family concerns of CNAs.

Food Insecurity Concerns

Food insecurity is a major health concern for our nation, which affects over 4% of the population (Alaimo et al, 1998). Food insecurity is not a welfare problem. More than half of households that experience food insecurity have a working head of household. The working poor who lack health insurance are at risk of food insecurity according to the NHANES III (Alaimo et al, 1998). Over 15% of low-income adults, surveyed by the NHANES III, reported suffering from food insecurity. Food insecurity leads to obesity and vitamin and mineral deficiencies amongst these populations (Alaimo et al, 1998).

With the exception of some minority subgroups, the United States is considered to be a food rich country, but many diseases related to food insecurity still exist (USDA, 2000). Obesity is a growing problem in the United States where more than half of all adults are overweight (Obesity Trends, 2001). Surprisingly, food insecure households are no exception (Kendall et al, 1995). Kendall and colleagues (1995) researched obesity in family households by dividing them into four groups according to level of food security: (a) food secure, (b) household insecure (ran out of food and compromised meal quality), (c) individual insecure (adults experiencing hunger), or (d) child insecure (hungry children). The body mass index (BMI) of the participants was measured to determine body composition. BMI is an anthropological method of calculating weight for height. The researchers found that BMI was significantly higher in the household insecure adult females than in the food secure adult females (p < 0.05). Also, researchers revealed that women who experienced household food insecurity were an average of 2 BMI units heavier than women from food secure households (p = 0.06).

In 1996, Jeffrey and French had similar findings related to food insecurity and obesity (Jeffrey & French, 1996). These researchers studied a group of 20 to 45-year old women with the hopes of accounting for differences in body composition. They found that women whose income fell below $10,000 per year were two times as likely to skip...
meals as compared to higher income women. The women implicated food insecurity as a reason for meal skipping. Although they were unsure of the cause, Jeffrey and French (1996) concluded that low economic status contributes to the incidence of overweight in low-income women.

Obesity is a serious medical problem leading to morbidity and mortality. A study by Manson et al, (1995) pointed out that, in women, a mean increase of only 2 BMI units was associated with a 25% increase in risk of death.

Also, food insecurity issues affected children’s health. A study by Alaimo and colleagues (2001) investigated the incidence of obesity in children of low-income families who suffer from food insecurity. The researchers found that an increased prevalence of overweight occurred in low-income non-Hispanic white children from food insecure households. The obesity associated with low-income food insecure households is an important factor when examining areas in which health of the working poor can be improved.

Health Concerns Relating to Nutrition

Lack of adequate food is related to low intakes of proper nutrients. These inadequacies can lead to significant health problems for the affected low-income population. Rose et al, (1997) studied the nutrient intakes of individuals from food insecure households. Intakes among women from food insecure households were below 67% of the Daily Recommended Intake (DRI) in kilocalorie intake, calcium, iron, vitamin E, magnesium, and zinc. Elderly persons from food insecure households experienced intakes of below 67% of the DRI for kilocalories, calcium, vitamin E, vitamin B6, magnesium, and zinc. Across all age groups the researchers noted that mean nutrient intakes were lower for food insecure households. Food insecure women were found to have 1.4 times the likelihood to have an energy intake of less than 50% of the RDA as compared to food secure women.

One potential cause of food insecurity is the lack of skills in organizing a budget and food resources to last throughout the month. In a study of low-income populations by Emmons et al, (1986), Caucasian participants consumed significantly lower percentages of the RDA for macronutrients as well as micronutrients during the fourth week of the month as compared to the first week of the month (p < 0.05). Poor food choices may play a role in the lack of nutrients consumed during week four. The researchers noted that the Caucasian sample had the highest soft drink consumption and
the lowest dairy food consumption ($p < 0.01$). Consumption of high-protein foods, fruits, vegetables and soft drinks declined in the African-American group as the month progressed. This group increased the amount of beans consumed toward the end of the month. Improving the working poor’s access to food and nutrition information may help them to make better choices and improve their health (Bagwell et al, 2000).

The Expanded Food and Nutrition Education Program (EFNEP) is a program that teaches low-income participants improved nutrition and dietary habits with the aim of reducing chronic diseases (VCE, 1999). A cost benefit analysis of EFNEP revealed a $10.64 savings for every $1.00 spent. This program shows that it is possible to improve the health of low-income participants in an effort to reduce disease through educational programming (Rajgopal et al., 2002).

Health Concerns Relating to Lack of Insurance

In the last five years, there has been an increase of 27.7 million Americans that are uninsured (US Census Bureau, 1996; US Census Bureau, 2001). This dramatic increase of uninsured families has affected their quality of health and preventive care options. The president of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), S. A. Fryhofer, MD, FACP, stated, “With proper access to health care, a woman’s risk of death from heart disease can be significantly reduced by treating high blood pressure, lowering cholesterol, and opening clogged arteries.” Her remarks are reiterated in a study published in the Journal of the American Medical Association (JAMA) in 1998. The study reported that women are more likely to report having had a mammogram if they have health insurance (JAMA, 1998). The researchers concluded that an increase in health care coverage amongst uninsured women is needed in order to increase the early detection of breast cancer and possibly reduce its incidence in the future.

Children of the working poor are undoubtedly affected by a lack of health insurance. A study by Rodewald et al, (1997) showed that an insurance plan for children increased the rate of childhood immunizations by 5-7%. According to a study by Guendelman & Pearl (2001), children of the working poor are subject to uninsurance rates of 22% as compared to children of the nonworking poor (12%) and children from moderate to affluent families (5%). Children of the working poor were far less likely to receive regular dental care than children of the nonworking poor or affluent children ($p<0.01$). Significantly greater numbers of children of the working poor were noted to be
in less than excellent health, nor had they visited a physician in the previous year (p<0.05).

Another problem the uninsured working poor face is an increased risk of some chronic diseases. Chronic diseases are responsible for over 70% of the deaths in the United States (CDC, 2001). Colhoun et al, (2000) found that blue-collar workers suffered from a significantly higher prevalence of coronary artery calcification by the age of 30 than more affluent subjects (p = 0.04). Those subjects that discontinued full time education before age 19 also experienced a higher prevalence of coronary artery calcification (p = 0.01). A study by Winkleby et al, (1998) showed that women of low socioeconomic status have significantly more cardiovascular risk factors, such as smoking and obesity, than do men regardless of race (p < 0.001).

A study by Brewster et al, (2001) examined the influence of socioeconomic status on when patients with cancer sought their first medical intervention. The researchers found that women of low socioeconomic status were more likely to have a more advanced case of ovarian cancer when they first sought medical care than women of more affluent backgrounds.

Work and Family Concerns of Certified Nursing Assistants

Limited literature exists that examines the problems of CNAs. Researchers agree that an average of $7.51/hr is too low to support a family above the poverty line (Adler, 1999). CNAs are expected to endure physical and verbal abuse regularly from residents (Goodridge et al, 1996). CNAs are frustrated by low wages, lack of career advancement opportunities, and lack of respect (Segal et al, 1999). The turnover rate for the CNA profession is excessive. Problems facing CNAs include high turnover rates, lack of respect from their superiors, lack of money, physical and verbal abuse, and a lack of communication between nursing assistants and their superiors (Painter, 1999).

Annually, the nationwide CNA turnover rate is 93% (Hoffman, 2001). CNAs perform a high-stress job for very little money. Painter (1999) studied a group of CNAs in South Carolina. He found that lack of money is the number one problem facing CNAs. In a study by Waxman et al, (1984) older CNAs complained that the new hires are making the same amount of money as those who have more experience. Waxman et al, (1984) also found that CNA turnover is due in part to the lack of training and the absence of a career ladder. CNAs studied by Segal et al, (1999) claimed that lack of input and
respect contributes to the high turnover rates. Addressing the problem of CNA turnover rates is integral to improving the quality of the long-term care provision in facilities.

Absenteeism, associated with high turnover rates, is another problem faced by CNAs. When one CNA misses his/her shift, the others must take care of more residents than is usual to pick up the slack. Inadequate childcare is the number one reason CNAs are absent from work, yet daycare is lacking in long-term care facilities (Segal et al, 1999). The possibilities of providing reasonably priced childcare for employees of nursing homes should be explored to further improve the quality of patient care. Segal et al., (1999) also found that poor health of CNAs and their families also contributes to the high rates of absenteeism in the field. A more recent study by Bagwell (2000), suggested that increases in health promotion activities among nursing assistants may help decrease absenteeism.

Another concern of CNAs is physical and verbal abuses. Residents of long-term care facilities are sometimes confused and can become combative when the CNAs try to help them with their activities of daily living. According to Goodridge and colleagues (1996) on average, CNAs are physically assaulted by long-term care residents 9.3 times per month and verbally abused by residents 11.3 times per month. In a study by Braun et al, (1997), thirty-nine percent of the CNAs reported being abused by the patients and/or supervisors at least once a day. More than half of CNAs reported that the abuse they experienced was physical as opposed to psychological. Without proper training and credit, the morale of the workers is low and contributes to the high turnover rate (Braun et al, 1997).

Because CNAs provide the vast majority of direct patient care, it is important to note the rate of elder abuse to determine if CNAs are contributing to the problem. A study by Braun et al, (1997) asked CNAs to comment on the type and amount of abuse they saw occur in the nursing home where they worked. Fourteen percent of the CNAs reported having seen abuse or neglect occur daily to residents. Another eleven percent reported seeing abuse or neglect occur at least once a week. The CNAs mostly witnessed psychological abuse and neglect. Physical abuse was the least often reported type of abuse. An earlier study by Pillemer and Moore (1989) found that thirty-six percent of CNAs reported seeing at least one abuse incident in the prior year. Pillemer and Moore (1989) also found that a stressful personal life increased the risk of a CNA committing an
act of abuse or neglect against a resident. Those results were later corroborated by another study in 1997 by Braun et al.

Lack of adequate training is another source of stress for CNAs (Waxman et al, 1984). In a recent study, Hoffman (2001) challenged health care administrators to develop ongoing training for CNAs. Training needs should focus on the development of interpersonal skills vital for CNAs, as they are the only link between the residents and other nurses and doctors. CNAs are capable of observing mental and physical health changes in patients and reporting those changes to the appropriate health care provider. In turn, the health care provider devises a care plan for each patient; it is the CNA’s job to carry out the plan. Open communication must exist between the CNA and the nurses and residents, and the CNA must be capable of facilitating this communication.

A study by Burgio et al, (2000) examined the best ways to improve communication between nursing home residents and CNAs assigned to care for them. CNAs were taught to use resident personalized memory books and increase the frequency of positive statements they make to improve communication with residents. CNAs that did well were rewarded. CNAs in the treatment group significantly increased their use of positive statements ($p = 0.06$), and their general communication skill levels rose. Stevens et al., (1998) showed that providing CNAs with on-the-job training in behavior management increases the quality of care the residents receive. CNAs in this study also benefited from a formal staff management system that included self-monitoring of CNAs, supervisory monitoring, feedback, praise, and incentives.

Lack of communication with their superiors is a source of frustration for CNAs (Segal et al, 1999). Segal et al (1999) found that CNAs wanted to meet with administrators periodically and participate in the communication regarding policies that directly affected their work. The CNAs who participated in the study by Segal et al (1999) felt that increasing the communication between CNAs and administrators will give CNAs a feeling of input and respect and reduce turnover. The researchers found that both the CNAs and the administrators were committed to improving work conditions as well as the quality of patient care.

CNAs are key in providing information and communicating to nurses and doctors about patient progress. A study by Boockvar et al, (2000) looked into the ability of CNAs to detect residents’ behavior changes that precede illnesses. The CNAs were asked to fill out a 12-item assessment of behavioral and functional status changes for
each resident with whom they had direct contact during their shift. In this study, nursing assistants observed changes in the patient’s behavior an average of 5 days before a finding was recorded in the patient’s chart. This study shows that nursing assistants are valuable tools in predicting clinical outcomes for nursing home patients. Nursing assistants approved the assessment tool because it did not take up too much of their time and they perceived an increase in communication with the nursing staff as a result of recording their assessment of their patients’ progress.

A study by Engle et al, (2001) studied a group of Licensed Practical Nurses (LPNs) and CNAs to determine the accuracy with which they estimate the pain a nursing home resident is feeling. The researchers found that nursing assistants were more accurate than LPNs at estimating the nursing home residents’ intensity of pain. CNAs proved themselves to be a valuable resource in direct patient care.

A lack of career advancement opportunities contributes to the low morale and high turnover rate associated with CNAs. A study by Segal and colleagues (1999) consisted of a forum to evaluate the needs of CNAs and a brainstorming session to generate goals for improving the situation of CNAs. A program by Integrated Health Systems (IHS) was implemented to increase the rate of retention of current CNAs (Hoffman, 2001). The program included monetary rewards only to those CNAs who participated in the career ladder and mentoring programs. The program included peer mentoring for new CNAs. IHS estimates that it costs $4000 to train each new CNA. Thus a savings of $4000 is realized for every CNA that retains his/her job throughout the year.

CNAs want to be praised and recognized for their work. They are responsible for changing residents’ clothes, feeding them, bathing them, and helping them go to the bathroom. These chores are thankless and difficult, and CNAs would appreciate the recognition of the nursing home’s administration. Although monetary recognition would be appreciated, the CNAs studied focused on verbal praise. In the CNA retention program implemented by IHS, public recognition was given to those CNAs that completed the Career Growth program (Hoffman, 2001). This public recognition served to enhance the CNAs’ work experience.
CHAPTER: III METHODOLOGY

This chapter addresses the methods used to conduct this research. The chapter includes (a) an overview of the research design, (b) a sample description and selection process used, (c) focus group procedures, (d) pilot focus group, and (e) data analysis procedures.

Overview of Research Design

Focus groups were chosen for this exploratory study so the information provided by the participants would not be limited. Focus groups allowed us to understand the situation CNAs face. As Krueger (1994) stated, “The focus group is unique; it allows for group interaction and greater insight into why certain opinions are held.” Both qualitative and quantitative methodologies were used to determine the health and food security concerns of the certified nursing assistants in Virginia. CNAs participated in focus group discussions, participatory activities, and completed two questionnaires. Research questions were linked to the focus group questions, participatory activities, and questionnaires (Table 4.1). This study was approved by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University.

Sample Description and Sample Selection Process

Virginia Cooperative Extension agents in the southwestern portion of the state of Virginia were asked to volunteer in recruiting CNAs and hosting the sessions. The sessions were focused in corporate nursing homes as well as private nursing homes. The agents contacted long-term care facilities in their communities to find CNAs that were willing to participate in the discussions. CNAs were recruited by the Director of Nursing at the centers where they were employed (Krueger, 1994). Krueger (1994) recommends focus groups have anywhere from 4-12 participants. This study pursued a smaller sample size in order to target CNAs during a shift change. Six focus group sessions were conducted for the purpose of collecting data. Three of the groups were held at corporate facilities and three of the groups were held at private facilities. The Extension agents were responsible for securing a meeting room for the groups.

Focus Group Procedures

The focus group sessions were approximately an hour of engaging discussions and participatory activities. All of the participants had an opportunity to be heard. During the focus groups, the participants had an opportunity to participate in the
discussions led by the moderator, who was also the primary investigator for this study. Less talkative participants were able to express their views through questionnaires and participatory ranking activities.

Participants were welcomed to the session by the hosting Extension agent. Refreshments were provided in an attempt to make the participants feel comfortable and relaxed during the focus group. The participants were told what to expect during the session and rules were announced according to Krueger (1994). Each participant signed a consent form before the group began. Focus groups were conducted according to standards set by Krueger (1994). All sessions were moderated by the principal investigator to avoid interviewer bias. The moderator followed the Focus Group Interview Guide (Appendix A). All focus group sessions were tape recorded to capture all of the comments and disclosures.

The assistant moderator and Extension Agent took notes and made observations about each group. It was the job of the assistant moderator to operate the tape recorder, administer questionnaires, and ensure that the session ran smoothly. After the last discussion question, the moderator began the first participatory ranking activity. Each participant was given a group of numbered and colored index cards. Pictures and their descriptions were hung on the wall of the meeting room. The pictures represented educational solutions to the home and work concerns of CNAs. The moderator reviewed the pictures and asked the CNAs for additional topics. Additional topics were added when necessary before the participants ranked the items. Participants ranked each picture according to their needs and preferences. The goal of the ranking activities was to give every participant a chance to be heard as well as to give them a break from discussion. Participants were asked to return to their seats when they completed the activity and were given directions for the next activity. When the participants were all seated after the participatory activities, the assistant moderator passed out the Cornell/Radimer Food Security Scale questionnaire (Appendix B). The moderator explained the directions, read the questions out loud, and allowed the CNAs time to answer them individually. When the CNAs completed the Food Security Scale questionnaire, the assistant moderator collected it and passed out a demographics questionnaire (Appendix C). Participants were asked to fill out the survey and the moderator and assistant moderator answered any questions from the CNAs. Participants were thanked for their help and given small thank you gifts at the end of each session. Helpers were thanked for their contribution.
At the end of each session, the moderator, assistant moderator, and Extension Agent debriefed by discussing what they saw and heard. They discussed the themes, summarized the findings, and agreed on areas of questioning that needed improvement (Krueger, 1994). Participatory activity results were tabulated at this time.

Pilot Focus Group

A pilot focus group was conducted on November 26, 2001 in Buena Vista, Virginia. The purpose of the pilot focus group was to familiarize the moderators and assistants with the procedures, identify potential problems with the questions, and if needed, change the questions in a way that would make them more easily understood (Krueger, 1994). Five female CNAs from Buena Vista, VA attended this focus group. The focus group format was modified as a result of this pilot study to include a separate Cornell/Radimer Food Security Scale questionnaire (Appendix B). Two questions were dropped in favor of probes for an earlier question to avoid repetition. These data were not be used in the study.

Data Analysis Procedures

Triangulation methods (Denzin & Lincoln, 1994) were used to compare the quantitative data from the surveys with the qualitative data from the focus group discussions. Using thematic analysis, the data from each focus group were analyzed (Krueger, 1994). According to Krueger (1994), the data was reviewed many times to identify themes across the focus groups and themes that relate to participants with similar demographic characteristics. The audiotapes were made into written transcripts. These transcripts were then read over several times to look for themes. The noted themes were organized into an outline for easier interpretation. Several graduate students from the Human Nutrition Foods and Exercise Department of Virginia Tech were recruited to look over the transcripts and validate the emerging themes (Krueger 1994).

The participatory activities were examined for frequency of responses to the choices presented. Participants were asked to rank preferences during the participatory activities. A first choice preference received three points; second choice received two points, etc. Points were tallied to determine the top priorities among the participants. This showed how food and nutrition concerns fit into the overall problems of CNAs.

The questionnaires were examined question by question and results were tallied for examination. Questionnaire results were compared for a more quantitative measure of health and nutrition concerns of nursing assistants. The questionnaires allowed us to
quantify the percentage of nursing assistants that are concerned about health and nutrition as well as food security issues.

The Cornell/Radimer Food Security Scale questionnaire was used to assess food security. The Scale consists of eleven statements and are considered positive if they are answered “often true” or “sometimes true.”

A household is:

1. food secure if none of the answers to the 11 items are positive.
2. food insecure if one or more answers are positive.
3. individual insecure in one or more of items 6 to 11 are positive.
4. individual hungry if one or more answers to items 6 to 8 are positive and one or more answers to items 12 to 13 or 9 to 10 are positive.

The percentage of food insecure CNAs was measured.
CHATER IV: RESULTS

Quantitative and qualitative research data were collected using focus group discussions, participatory ranking activities, and questionnaires. The research data results from the focus group questions, participatory activities, and questionnaires are discussed in this chapter. Table 4.1 shows how the five research questions are linked to the focus group questions as well as the participatory activities and questionnaires. Thematic responses to the focus group questions were organized into outline form and presented in Table 4.2. Quotes from participants were included to emphasize important and recurring themes. Quantitative data from the Cornell/Radimer Food Security Scale questionnaire and the demographics questionnaire are presented and discussed.
Table 4.1
Research Methods Linked to Research Questions

| RQ 1 | What are the major sociodemographic and other characteristics of CNAs that might affect their health, nutrition, food security, and preferences for learning? |
| FGQ 1: | Why did you choose this type of work? |
| FGQ 2: | What are typical tasks that you perform when providing care to residents? |
| SQ: | Demographic Questionnaire |

| RQ 2 | What overall concerns, barriers, and solutions do CNAs have regarding their work and family situations? |
| FGQ 3: | What do you like about your job? |
| FGQ 4: | What don’t you like about your job? |
| FGQ 5: | What could help you be a better CNA? |
| FGQ 6: | What are your concerns for personal and family life? |
| FGQ 7: | What do you need to help improve your personal and family life? |
| PA 1: | Rank top work concerns/educational solutions. |
| PA 2: | Rank top home concerns/educational solutions. |

| RQ 3 | To what extent are CNAs concerned about nutrition and health issues compared to other work/family concerns? |
| FGQ 6: | What are your concerns for personal and family life? |
| PA 2: | Rank top home concerns/educational solutions. |

| RQ 4 | To what extent do CNAs perceive food security as a concern? |
| FGQ 8: | What concerns do you have for you and your family about having enough food to eat? |
| SQ: | Complete Cornell/Radimer Food Security Questionnaire |

| RQ 5 | What type of educational strategies do CNAs perceive as the most useful for learning about foods and nutrition? |
| FGQ 9: | Where do you get your nutrition and health information? |
| PA 3: | Rank these types of learning situations according to your top three preferred learning styles |
| PA 4: | Rank the three program lengths according to your preference. |

**Note:** RQ = Research Question; FGQ = Focus Group Question; PA = Participatory Activity; SQ = Survey Questionnaire
Table 4.2
Summary of Predominant Themes and Sub-themes from Focus Groups

Research Question 1: What are the major sociodemographic and other characteristics of CNAs that might affect their health, nutrition, food security, and preferences for learning?
I. FGQ: Why did you choose this type of work?
   A. Enjoy older people
   B. Job Security
II. FGQ: What are the typical tasks that you perform when providing care to residents?
   A. Activities of Daily Living
   B. Enduring abuse

Research Question 2: What overall concerns, barriers, and solutions do CNAs have regarding their work and family situations?
III. FGQ: What do you like about your job?
   A. Residents
   B. Hours
IV. FGQ: What don’t you like about your job?
   A. Understaffing
   B. Low Pay
   C. Lack of Respect
   D. Lack of Adequate Benefits
   E. Resident Deaths
V. FGQ: What could help you be a better CNA?
   A. More Staff
   B. More Input In Our Work Policies
      i. Days off when needed
      ii. More functional sick leave policies
VI. FGQ: What are your concerns for personal and family life?
   A. Contagious Diseases
   B. Bringing Stress Home
VII. FGQ: What do you need to help improve your personal and family life?
   A. Training for a new job

Research Question 3: To what extent are CNAs concerned about nutrition and health issues compared to other work/family concerns?
VI. FGQ: What are your concerns for personal and family life?
   A. Bringing Stress home
   B. Contagious Diseases

Research Question 4: To what extent do CNAs perceive food security as a concern?
VIII. FGQ: What concerns do you have for you and your family about having enough food to eat?
   A. Stretching Money
   B. Eating During Work

Research Question 5: What type of educational strategies do CNAs perceive as the most useful for learning about foods and nutrition?
IV. FGQ: Where do you get your nutrition and health information?
   A. Facility Nurses
   B. Family Doctor
   C. Internet
   D. Magazines
Research Question 1: What are the major sociodemographic and other characteristics of CNAs that might affect their health, nutrition, food security, and preferences for learning?

A demographics questionnaire and two focus group questions were used to determine background information on each of the participants.

Participant’s Characteristics

A total of 29 participants, 3 males and 26 females, were recruited to participate in six focus groups. Five of the 29 participants were African-American and the rest were Caucasian. Demographic information including age and education level was collected via a questionnaire. Sixty-five percent of the participants were under the age of forty. Only one participant was over the age of sixty, and one was under the age of twenty. Table 4.3 below lists the ages of participants.

**Table 4.3**

<table>
<thead>
<tr>
<th>Age</th>
<th>Stuart N (%)</th>
<th>Buena Vista n (%)</th>
<th>Clifton Forge n (%)</th>
<th>Richmond n (%)</th>
<th>Pulaski n (%)</th>
<th>Madison n (%)</th>
<th>CNAs n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>20-30</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>3 (10%)</td>
<td>9 (31%)</td>
</tr>
<tr>
<td>31-40</td>
<td>3 (10%)</td>
<td>1 (3%)</td>
<td>0</td>
<td>3 (10%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>9 (31%)</td>
</tr>
<tr>
<td>41-50</td>
<td>2 (7%)</td>
<td>0</td>
<td>2 (7%)</td>
<td>0</td>
<td>1 (3%)</td>
<td>0</td>
<td>5 (17%)</td>
</tr>
<tr>
<td>51-60</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>60+</td>
<td>0</td>
<td>1 (3%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Totals</td>
<td>7 (24%)</td>
<td>4 (14%)</td>
<td>5 (17%)</td>
<td>4 (14%)</td>
<td>4 (14%)</td>
<td>5 (17%)</td>
<td></td>
</tr>
</tbody>
</table>

CNAs in this study were employed in corporate or privately run nursing homes across the state of Virginia. Some of the rural counties did not have any corporate nursing home facilities. The facilities in Stuart, Richmond, and Madison were private nursing homes, and the facilities in Buena Vista, Clifton Forge, and Pulaski were corporate nursing homes. Stuart was the largest facility with 182 residents and 70 CNAs. The facility in Pulaski housed 60 residents and employed 35 CNAs, while the Clifton forge facility had 127 residents and 42 CNAs.

A majority of the participants were middle-aged women. Fifty–eight percent of the participants had no education past high school. Three women were enrolled in school to become Licensed Practical Nurses (LPNs) to advance their nursing careers. Ten
percent of the participants had less than a high school degree. Table 4.4 illustrates the education level of participants.

**Table 4.4**
Education Level of CNAs

<table>
<thead>
<tr>
<th>Education level</th>
<th>Stuart (%)</th>
<th>Buena Vista (%)</th>
<th>Clifton Forge (%)</th>
<th>Richmond (%)</th>
<th>Pulaski (%)</th>
<th>Madison (%)</th>
<th>Total CNAs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>1 (3%)</td>
<td>1(3%)</td>
<td>1 (3%)</td>
<td>0</td>
<td>0</td>
<td>1 (3%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>High School/GED</td>
<td>3(10%)</td>
<td>2(7%)</td>
<td>2 (7%)</td>
<td>3 (10%)</td>
<td>4(14%)</td>
<td>3(10%)</td>
<td>14(48%)</td>
</tr>
<tr>
<td>More than High School</td>
<td>2 (7%)</td>
<td>1(3%)</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
<td>0</td>
<td>1 (3%)</td>
<td>6 (21%)</td>
</tr>
<tr>
<td>Two-year College/Associate’s Degree</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Four-year college/Bachelor’s Degree</td>
<td>1 (3%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Participants were asked to specify the number of children in their families. Although many participants (27.6%) were childless, the range extended from zero to five or more children. A number of participants disclosed that their children were grown and out of the house. The total number of children belonging to participants is listed in Table 4.5 below.

**Table 4.5**
Number of Children of CNAs

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>CNAs N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8 (27.6%)</td>
</tr>
<tr>
<td>1</td>
<td>6 (20.7%)</td>
</tr>
<tr>
<td>2</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>3</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>4</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>5 or more</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>
CNAs were asked to tell how long they had worked at their current facility. The majority (58.6%) of participants had worked at their current facility for more than one year. Of those participants the average length of time the person had been at the facility was 11.6 years. The range extended from as little as one year and eight months at a facility to as many as thirty-one years. Participants that had been employed by a facility less than one year comprised forty-two percent of the group. The range of employment for this group was from one month to one year. The length of time each CNA has been at his/her current facility is shown below in Table 4.6.

**Table 4.6**
Length of Time CNAs have been with Current Employer

<table>
<thead>
<tr>
<th>Time at Current Facility</th>
<th>CNAs n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 month</td>
<td>0</td>
</tr>
<tr>
<td>1 – 3 months</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>4 – 6 months</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>7 – 9 months</td>
<td>5 (17%)</td>
</tr>
<tr>
<td>10 – 12 months</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>&gt; one year</td>
<td>17 (58.6%)</td>
</tr>
</tbody>
</table>

The majority of participants (62.1%) worked between 31 and 40 hours per week. Only two of the twenty-nine participants reported being employed part-time. Among the full-time group, the number of hours worked per week varied considerably. Another twenty-seven percent worked between 41 and 50 hours a week. One participant reported working 75.5 hours every week. The number of hours typically worked in a week is shown in Table 4.7 below.

Participants were asked to write-in the type of work they did before they worked in their current position. Many had either been CNAs or worked in factories. Other jobs that were listed included housekeeping, clerical work, bakery work, and fast food employment.
Table 4.7
Number of Hours CNAs Worked per Week

<table>
<thead>
<tr>
<th>Hours per Week</th>
<th>CNAs n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 or less</td>
<td>0</td>
</tr>
<tr>
<td>21 – 30</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>31 – 40</td>
<td>18 (62.1%)</td>
</tr>
<tr>
<td>41 – 50</td>
<td>8 (27.6%)</td>
</tr>
<tr>
<td>50 or more</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Participants were asked to report the number of double shifts they typically worked. A majority (72.4%) of participants claimed that they do not typically work double shifts. The highest number of double shifts worked in a typical week was three and this was reported by only one participant. The number of double shifts typically worked by participants are recounted in Table 4.8 below.

Table 4.8
Number of Double Shifts CNAs Work per Week

<table>
<thead>
<tr>
<th>Number of Double Shifts</th>
<th>CNAs n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>21 (72.4%)</td>
</tr>
<tr>
<td>1</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>2</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>3</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Two questions on the questionnaire asked how many residents a CNA is directly responsible for in one shift and how many residents the CNA was responsible for during the shift he or she last worked. Most of the participants responded that they typically are responsible for twenty or fewer residents per shift and yesterday they took care of twenty or fewer patients. Thirty-four percent of participants reported that they typically cared for eleven to fifteen residents per shift, while thirty-seven percent responded that they cared for between one and ten residents in their previous shift. One CNA was responsible for every resident in the building when she worked because her job consisted
of weighing and taking blood pressure readings from each of the residents. The number of residents a CNA is responsible for during a shift is listed below in Table 4.9.

**Table 4.9**  
Number of Residents per CNA per Shift

<table>
<thead>
<tr>
<th>Number of Residents per CNA per Shift</th>
<th>Average Shift n (%)</th>
<th>Yesterday’s Shift n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 10</td>
<td>8 (27.6%)</td>
<td>11 (37.9%)</td>
</tr>
<tr>
<td>11 – 15</td>
<td>10 (34.5%)</td>
<td>6 (20.7%)</td>
</tr>
<tr>
<td>16 – 20</td>
<td>7 (24.1%)</td>
<td>8 (27.6%)</td>
</tr>
<tr>
<td>21 – 25</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>26 – 30</td>
<td>2 (7%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>31 – 35</td>
<td>1 (3%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>36 – 40</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>40 or more</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Participants were asked if they had another job in addition to being a CNA. The majority (82.8%) did not have a second job. About 17.2% of participants did have a second job, and of those, 80% of the second jobs were part-time. The results of this question are shown below in Table 4.10.

**Table 4.10**  
Do Participants Keep a Second Job?

<table>
<thead>
<tr>
<th>Job Status</th>
<th>CNAs n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Second Job</td>
<td>5 (17.2%)</td>
</tr>
<tr>
<td>No Second Job</td>
<td>24 (82.8%)</td>
</tr>
<tr>
<td>Full-time</td>
<td>1 (20%)</td>
</tr>
<tr>
<td>Part-time</td>
<td>4 (80%)</td>
</tr>
</tbody>
</table>

Focus Group Question 1: Why did you choose this type of work?

Two major themes emerged regarding the participants’ decisions to become CNAs. These included (a) enjoying working with older people and (b) job security. All
of the focus group participants agreed that the residents make the hard work of being a CNA worth it. Many participants shared experiences of wanting to help people and take care of them. These CNAs expressed their particular situations:

I wanted to work with handicapped children ever since I was a little girl and the opportunity just never came up and then my sister is a nurse here, so she kind of got me started and I realized the elderly are handicapped too, so it’s still in there and I love doing it.

I wanted to do something to help people, so they will someday help me

You’re wore out when you go home, but then you know you did something good that day. You go home and maybe you feel dirty, but you say ‘hey, I did something for somebody today’ and that’s sometimes worth more maybe than the money that you get paid.

Many participants from five of the six focus groups felt that compared to other jobs available to them, such as factory work, being a CNA has its perks. Many of the participants in both the rural and urban settings agreed that they would rather be a CNA than work in a factory. One participant expressed the feelings of many CNAs:

At the time, I was working in factories and they was laying off and you work there forever before you get benefits, and but this [being a CNA] is guaranteed benefits, a guaranteed job. Plus I had surgery and people thought I was going to die and I wanted to give back, so I thought getting into this field and then someday elevating to LPN, RN.

I got into it cause I was working in a factory and my husband died of brain cancer and I had one daughter in college, a son working, one daughter was married living in North Carolina and I had a three and a five year old at home, so I took 5 years off to take care of them until they got kind of big. Then a girlfriend talked me into doing this rather than going back and doing what I was doing, and I like this a lot better.

**Focus Group Question 2: What are typical tasks that you perform when providing care to residents?**

All participants listed many of the chores they typically perform such as, bathing, feeding, exercising, dressing, and making beds. One CNA remarked, “We never have a typical day. Everyday is different.” More participants shared their views on daily tasks:

[We] try to entertain them while we’re working to keep them calm and secure.
You become their advocate if they’re not feeling well, if they’ve got a sore spot developing.

You become what they can’t do. You become their arms, their ability to go to the bathroom, and everything else that they can’t do for themselves. Emotional support, physical support, you’re their everything and they really depend on us.

The second most prominent theme noted in every focus group was that the CNAs endure abuse by the residents on a regular basis. One participant shared how her experience made her feel; “Last week I had a resident beat on me. I was so upset that I was crying and carrying on.” Another CNA shared, “You become their punching bag when they’re mad and when they say ‘I’m so sad’ you’re the one that gives them a little peck on the cheek and make them feel better.”

Research Question 2: What overall concerns, barriers, and solutions do CNAs have regarding their work and family situations?

To understand the work and family situations faced by CNAs, several focus group questions were asked. In addition, two participatory activities were administered that allowed the CNAs to rank their top home concerns as well as their top work concerns.

Focus Group Question 3: What do you like about your job?

Participants responded to this question with three main themes (a) residents, (b) the scheduling/hours, and (c) co-workers. Respondents agreed that the close bonds with residents and other CNAs made their jobs worthwhile. One CNA remarked that he/she enjoys, “Helping somebody go to bed or get a bath and they always say ‘thank you’.”

Special feeling towards the residents was a predominant theme that was captured in the statements made by several CNAs in every focus group discussion:

This is our family away from our family. It’s like we have fifty grandmas.

It teaches a lot of history [being around older people] that they know about that’s not in the history books. They was around; they knew what was really going on.

Then you got a few special ones that you spoil, and you cry when they die. Certain ones just stand out and they are special.

The second theme was suitable hours to work, which helped them enjoy their jobs. This feeling of satisfaction with the hours was specific to private facilities and was only a theme at four of the six focus group sessions. Privately run nursing home CNAs
reported more flexibility and satisfaction with their hours than those that worked in corporately run facilities. Participants with children to care for were able to choose day shifts and be home with their children after school. One participant expressed the views of many in the private nursing homes, “I choose my hours during the day because it goes well with my kids’ school schedule.” One participant summed up the views:

The flexible schedule because you have things that you need to do during the week and you’re allowed to have a day off during the week. I like knowing that I’m going to have every other weekend off.

The last theme was that participants at several facilities agreed that they rely on their co-workers for support and understanding that they can’t find elsewhere. One participant captured the sentiments of many CNAs: “We talk to each other because we’re all we really have. You can’t go up there [front office] and say anything.”

Focus Group Question 4: What don’t you like about your job?

The main themes that most displeased the CNAs regarding their jobs were: (a) understaffing, (b) low pay, (c) a lack of respect, (d) lack of benefits, and (e) resident deaths. The first two themes were predominate in every discussion. Understaffing is a problem that plagued all of the participants. Many of the facilities visited required CNAs to work long shifts and extra hours to make up for the lack of or absent staff. Participants were discouraged by the extra long days and time away from their families. These extra hours were particularly a problem in the corporate run facilities where the policies tended to be more rigid. One participant shared her experience, “My son doesn’t like it when I work a double because he’s still young and he doesn’t get to see me that day or the next morning.” Several participants expressed the views of many CNAs related to the policies administrators at their facilities impose upon them:

Here they have a system where you are ‘starred’ [twice a month] if you are full-time. And what starred means is that you have to stay after four hours after working your eight-hour shift, and that happens a lot. So, that’s really hard when you come to work and you never know what time you’re going to get off. Your relief never shows up and you can’t abandon these people; you have to stay until you can get someone to come in.

Average is forty hours, but everybody says that they’re [administration] constantly coming short when they make the schedule so they’ll put it in front of you and say hey you want to pick up extra time, and I’m one of those that I feel
that I have to say yes to some of them. So, I’m supposed to be [working] 8 days in a two-week period, and I’m afraid it’s going to end up being more like 12 days.

I’ve been down to the beach and everything else at the corporate headquarters and they still tell me that in the state of Virginia there is no minimum number of aides that must be assigned to a certain number of residents. Here 6 aides can barely take care of 50 people, and we have 3 aides taking care of 50 people on a wing. You can’t do - you’ve got to give a bath in 5 minutes…it’s like an assembly line.

It used to be a whole lot different – you had enough help, you had three shifts and you had enough time to sit down and roll someone’s hair or paint their fingernails, and now you barely have time to wash their butt and get them going.

The second most common theme expressed by CNAs was that they are not paid enough money to keep them above the poverty line and support another person at the same time. Although many CNAs claim that they’re ‘not in it for the money’, this was a predominant theme in all of the focus group discussions. One CNA captured the mood relating to pay when she said, “And if you’re in this business for the money than you’re in it for the wrong reasons ‘cause there’s no money in it!” Another CNA was incited by the issue, “CNAs don’t get paid crap, but we take a lot of crap. We run the building.”

Other participants agreed:

We are employees and they’re [administration] trying to cut corners and see where they’re going to save money for their budget, everything that gets cut gets cut from us. The nurses’ money is going to go up because nurses are at such a high demand because there’s such a shortage to get nurses; they get the money. It’s like pulling teeth for us to get any more money.

They have to work like a dog to make ends meet. People still have to go home and do the family stuff, cook, clean, but they’re living in here to make ends meet.

The third theme that emerged was the lack of respect from the administration, the nursing staff, or both. This issue was a recurrent complaint of the participants in all but one focus group. Participants perceived that they were not valued for their hard work and dedication to the residents. They reported feeling uninvolved in the policies that directly affect them. One participant shared, “Another thing I don’t like is some of the nurses belittle you.” Several participants expressed the views of many CNAs:

There should be a better cooperation. The administration should have more compassion towards nursing assistants. We are they’re eyes, they depend on us for whatever’s going on that they can’t see. We’re with the patients every single
day and we see things that they might not see because they might not come down here but once every 3-4 months. I feel like they don’t have no compassion for what we do. We work the hardest, 10 patients or more.

More respect. The nurses will come and tell you 3 different patients need something and they expect it all to be done at the same time. And the way an aide does it, they do the most important thing first. A nurse doesn’t see it that way, that nurse wants all things done at the same time. There’s no way you can do that. I think they need an extra course in what a CNA does.

If they [administration] sought programs and thought about how it would better help their staff. It’s like the administration we had before was very hands on with the staff, this was a very homey type place. The administrator had an open door policy you could come in talk about personal issues whatever it stayed in the office. But then for me it switched to a closed-door policy where you may see the administrator every now and then and he’s very hands off. I don’t feel that they do things in the best interest of us.

The way they do the scheduling is: morning is your busiest time. You have to get everyone up, bathed, dressed and fed, make beds. And that’s when they have the shortest group. Nine times out of ten all we’ve had is 6 aides in the building. At 3pm we’re running over each other. We can’t seem to get it through their head that morning is when we need the most help. If we go and say can we advise that this be done this way you know they don’t listen. It’s their way or no way.

The lack of adequate benefits awarded to CNAs was the fourth theme that emerged. The only groups that did not voice concern over this issue were those with other sources of support for health and life insurance. Some CNAs decided not to accept the insurance benefits claiming it takes up too much of their paycheck. Several CNAs expressed their personal situations:

The insurance used to be really good, but this year they revised it and it’s not worth it now, $100 per payday. If you make $500 every 2 weeks and I support 6 people. They take $130 out.

I don’t have insurance because I can’t afford to have it taken out of my check. Last year they were taking $61/payday and this year it went up to $94. There’s a $350 deductible. Dental is extra. And then if you want eye care that’s extra too.

Health insurance. You spend your whole day taking care of people and when you get sick you can barely afford just being out of work. You know. With our health insurance if you end up in the hospital god forbid, you have to pay $250/day for the first 5 days. We don’t make that kind of money.
The last theme expressed by CNAs was dealing with resident deaths. Many of the participants expressed sadness over losing residents that they had special feelings toward. One CNA vocalized what many felt, “You got a few special ones [residents] that you spoil and you cry when they die.” One participant told of her personal experience:

Day before yesterday I was working this hall and one of my residents died and then today I was working and another one died, so I need some nerve pills.

Focus Group Question 5: What could help you be a better CNA?

Two major themes emerged from participants when they were asked what they needed to make them better CNAs. These were (a) more staff, and (b) more input into facility policies. Many comments indicated that the CNAs felt tired when they were overworked and under appreciated. One participant expressed the concerns of many CNAs, “And they wonder why these people are coming up with bedsores, falling, there’s not enough help in here to watch them.” Another CNA gives her personal perspective, “I lost two of my personal days ‘cause they ain’t got nobody to work while I’m gone.” Another participant recounted her experience:

When I worked here in 99, I left because my father, mother and grandmother were all sick and with in a year’s time they all passed. And I went through something terrible about coming back into this because at home it was so personal what I went through with them and then to come back in here in this mass production of bodies. They promise them a whole lot when they come in, but the reality is we don’t have the staff.

Participants in most focus groups had problems with the policies enforced by the facilities where they worked. This was the second theme that emerged relating to helping participants be better CNAs. Two clear sub-themes emerged from the policy issue those included (a) being able to get days off when they need them and (b) more functional sick leave policies. CNAs comments regarding the first sub-theme was that it would be better if their schedules would allow them more freedom. Many participants recounted stories of being unable to have a day off work to be sick, care for a sick family member or attend to any personal business. The following quotes are representative of the participants’ sentiments:
OK, you’re not allowed to get sick, if you got children they say you should have planned for someone to take them. This [work] is supposed to be our priority and we’ve been told that have we not.

You can’t be off if your children are sick. You can find someone to be there. Mommy doesn’t need to be there for an 8-year-old child for heavens sake. This [work] is more important.

They’re cutting our hours and one day I had to get off a couple of hours early because my husband had lost his job and I needed to talk to a bill collector, so I asked off 2 hours early to take care of some business and they absolutely refused for me to leave, but it’s ok when it suits them.

I used to go to bible study every Wednesday but now I’m only off every other Wednesday and we have a family thing for fun on Fridays that I can’t go to anymore because I work 3pm-11pm.

For the second sub-theme, participants related that better sick leave policies would make them feel more respected by their employers. One participant recounted her views of the company’s sick leave policy; “You’re not allowed to get sick, yet they work you to death.” The participants expressed disdain for the lack of compassion they feel from the administration.

When you do get sick, you have to be sick and out for a full 7 days before you can ever collect on your sick time. And you have to have a doctor’s note. Say you have something that keeps you out of work for 2 or 3 days, you’re just out of luck, doctor’s note and all!

You get written up if you get sick. If you don’t have a doctor’s excuse you get written up and after 2 times in one month you get 3 days off without pay. I don’t care if you just have a stomachache, you have to go to the doctor’s and pay $75 so you can come back and tell them you had a stomachache.

I had, 5 years ago, I came into work at 6am, got 10 people up, went to the desk and told the nurse that I was having a pain in my chest and I thought I was having a heart attack, come to find out my eyeballs had turned yellow down in the bottom. And I was told, do you think that you can work out the rest of the day? [by the director of nursing] My gallbladder was about to rupture, I had to go into the hospital and have surgery that morning. They are just ignorant. I got wrote up for having my gallbladder out.
Research Question 3: To what extent are CNAs concerned about nutrition and health issues compared to other work/family concerns?

Focus Group Question 6: What are your concerns for personal and family life?

Two themes predominated the discussions of CNAs’ personal and family lives. These included (a) contagious diseases, and (b) bringing stress home. The fear of bringing contagious diseases to their families was a predominant theme in almost every discussion. One participant spoke for many, “It makes things hard at home. I came here 2 months ago and in the first 2 weeks, boom, I caught one of the first bugs going around this place. I was out for 4 days.” When asked how they know if a resident is contagious, one CNA replied, “You hear it through the grapevine.” Another participant expressed her concerns about contagious diseases:

I know one thing that worries me is that we’ll go to work with a resident and someone will say ‘be careful, better have your gloves I heard they had such and such’ and I feel like they need to tell us more when someone comes in here a new resident that ‘hey, they have a highly contagious disease’. You’re supposed to always use precautions, but there are times when you are rushed and you know you might run in there and forget that glove.

Stress was a secondary predominant theme for many CNAs that feel they bring stress from their job into their home environment after work. One CNA told of her personal stress response, “You don’t get the proper sleep you need either because if I know I have to go to work the next day, I’m up and down all night.” Another participant expressed a more general concern:

It’s so bad in here, that you take it home. I think they need in every nursing home, a place like this right here, that you can go and unwind that you can go and talk to somebody and not be afraid to say what’s on your mind.

In addition to the focus group questions, participants ranked their top work concerns and their top home/personal life concerns that could be developed into an educational program to help them. Participants responded that the top three home concerns/educational solutions were being able to stretch their money to last throughout the month (24.9%), developing time management skills (23.7%), and reducing the amount of stress that their jobs bring to their personal lives (14.1%). CNAs ranked keeping their family healthy fourth (9.6%), and they ranked preparing fast easy meals
eighth (1.7%). The top home concerns/educational solutions of CNAs are shown below in Table 4.11.

**Table 4.11**
Top Home Concerns/Educational Strategies of CNAs

<table>
<thead>
<tr>
<th>Item</th>
<th>Males</th>
<th>Females</th>
<th>Black</th>
<th>White</th>
<th>Total n (%)</th>
<th>Total Rank n=29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stretching Money</td>
<td>7</td>
<td>37</td>
<td>9</td>
<td>35</td>
<td>44 (24.9%)</td>
<td>1</td>
</tr>
<tr>
<td>Time For Work/Family</td>
<td>7</td>
<td>35</td>
<td>5</td>
<td>37</td>
<td>42 (23.7%)</td>
<td>2</td>
</tr>
<tr>
<td>Less Stress</td>
<td>2</td>
<td>23</td>
<td>2</td>
<td>23</td>
<td>25 (14.1%)</td>
<td>3</td>
</tr>
<tr>
<td>Healthy Family</td>
<td>0</td>
<td>17</td>
<td>7</td>
<td>10</td>
<td>17 (9.6%)</td>
<td>4</td>
</tr>
<tr>
<td>Keeping House In Good Condition</td>
<td>0</td>
<td>15</td>
<td>3</td>
<td>12</td>
<td>15 (8.5%)</td>
<td>5</td>
</tr>
<tr>
<td>Getting Along With Friends/Family</td>
<td>3</td>
<td>11</td>
<td>1</td>
<td>13</td>
<td>14 (7.9%)</td>
<td>6</td>
</tr>
<tr>
<td>Personal Development (Job Training)</td>
<td>0</td>
<td>13</td>
<td>2</td>
<td>11</td>
<td>13 (7.3%)</td>
<td>7</td>
</tr>
<tr>
<td>Fast Easy Meals</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3 (1.7%)</td>
<td>8</td>
</tr>
<tr>
<td>Parenting Skills For Kids</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2 (1.1%)</td>
<td>9</td>
</tr>
<tr>
<td>Older Adults And Relationships</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2 (1.1%)</td>
<td>9</td>
</tr>
<tr>
<td>Parenting Skills For Older Adults</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 (0%)</td>
<td>10</td>
</tr>
</tbody>
</table>

Participants ranked their top concerns regarding their work environment that could be developed into educational programs to help them. Time management (28.7%) was the number one work concern facing CNAs. CNAs were also concerned with stress management (25.8%) and communicating with their co-workers and management (19.7%). Staying healthy at work ranked fourth (12.9%), while packing a nutritious lunch was sixth (3.4%). These results are similar to their top three home concerns, which also included stress reduction and time management and can be seen in Table 4.12 below.
Table 4.12
Top Work Concerns/Educational Strategies CNAs

<table>
<thead>
<tr>
<th>Item</th>
<th>Males</th>
<th>Females</th>
<th>Black</th>
<th>White</th>
<th>Total n (%)</th>
<th>Total Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Management</td>
<td>8</td>
<td>43</td>
<td>7</td>
<td>44</td>
<td>51(28.7%)</td>
<td>1</td>
</tr>
<tr>
<td>Stress Management</td>
<td>4</td>
<td>42</td>
<td>9</td>
<td>37</td>
<td>46(25.8%)</td>
<td>2</td>
</tr>
<tr>
<td>Communicating: Co-workers/Management</td>
<td>3</td>
<td>32</td>
<td>3</td>
<td>32</td>
<td>35(19.7%)</td>
<td>3</td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>2</td>
<td>21</td>
<td>4</td>
<td>19</td>
<td>23(12.9%)</td>
<td>4</td>
</tr>
<tr>
<td>Communicating: Residents’ Families</td>
<td>0</td>
<td>13</td>
<td>3</td>
<td>10</td>
<td>13(7.3%)</td>
<td>5</td>
</tr>
<tr>
<td>Nutritious Lunch</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>6(3.4%)</td>
<td>6</td>
</tr>
<tr>
<td>Childcare Options</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4(2.2%)</td>
<td>7</td>
</tr>
</tbody>
</table>

Focus Group Question 7: What do you need to help improve your personal and family life?

Training for a different job was the only theme for this question. Many of the participants wanted to advance in the health care industry or change fields entirely. One CNA expressed the feelings of many by responding to the question with, “A different field. I’m burnt out. I was doing patient care here and at home.”

Research Question 4: To what extent do CNAs perceive food security as a concern?

Focus Group Question 8: What concerns do you have for you and your family about having enough food to eat?

Participants agreed that the major concerns for having enough food for their families included (a) the ability to stretch their budgets to buy food and (b) eating during work. CNAs expressed problems with having enough money to buy food for their homes:

After you pay your bills you don’t have much leftover after you pay your rent and phone bill, what you have leftover has to last you for the next 2 weeks.

Making enough money to buy really lean meats and all that; the stuff that’s healthy costs more.

Eating at work also presented problems for the participants. CNAs shared similar problem with their facilities’ lunches:
You get 30 minutes for lunch and you get interrupted constantly and our break room is right here and all year long you’ve got residents families and residents walking by hocking and spitting and you’ve got residents families saying ‘did momma have enough mucous to eat this morning?’ You’re trying to eat your lunch. For 30 minutes, we need a place for us.

You have to clock out for 30 minutes, but by the time you clock out and go get something and then you don’t have time to eat.

You can eat here, but they take a dollar out of your check and it’s not great.

My problem is just getting something to eat while I’m working. You get so busy, you know that some one needs a shower and you think, God I’m so hungry, but if I go eat that’s going to put me another half hour behind what I need to get done. We’re supposed to get a 15 minute break too, but I never get one.

**Food Security Questionnaire**

The Cornell/Radimer Food Security Scale Questionnaire (Appendix B) was administered. This questionnaire was correlated to focus group question eight, and it was used to gather data on the food security status of the participants. Each participant was handed a questionnaire enclosed in a manilla folder for privacy. The moderator or co-moderator read each question aloud and gave the participants time to answer before moving on to the next question.

Food security was assessed at the individual as well as the household level. The questionnaire determines food security based on the prevalence of positive responses to each item. Positive responses included “often true,” “sometimes true,” or “yes”. Individuals were considered food insecure if they had one or more positive responses. Less than half (45%) of the respondents were food secure. Most of the participants (55%) were food insecure according to their answers to the questionnaire. Twenty-one percent of the participants were even ‘Individual Hungry’, and one participant was categorized as child hungry. This information was not mentioned by the participants during the discussion, but was disclosed by way of the questionnaire with a cover sheet to prevent co-workers from looking at each other’s answers. The range of food security issues is depicted below in Table 4.13.
Table 4.13
Prevalence of Hunger and Food Insecurity Among CNAs

<table>
<thead>
<tr>
<th>CNAs n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Secure</td>
</tr>
<tr>
<td>13 (45%)</td>
</tr>
<tr>
<td>Food Insecure</td>
</tr>
<tr>
<td>16 (55%)</td>
</tr>
<tr>
<td>Individual Insecure</td>
</tr>
<tr>
<td>14 (48%)</td>
</tr>
<tr>
<td>Individual Hungry</td>
</tr>
<tr>
<td>6 (21%)</td>
</tr>
<tr>
<td>Child Hungry</td>
</tr>
<tr>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

For each of the first 11 questions on the Cornell/Radimer Food Security Scale Questionnaire, the participants are asked to place a check below the numbered statement as to whether the statement is often true, sometimes true or never true. The first statement on the questionnaire is: “I worry whether my food will run out before I get money to buy more.” Twenty-four percent of participants answered that this was often true in their household, and twenty percent responded that this was sometimes true in their household. That is almost half of participants worry about running out of food. The exact responses are shown below in Table 4.14.

Table 4.14
CNAs Responses To Food Security Question One

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>6 (20.7%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>16 (55.2%)</td>
</tr>
</tbody>
</table>

The second question was: “I worry about whether the food that I can afford to buy for my household will be enough.” Twenty-four percent of the CNAs questioned answered that this was often true for them, and thirty-one percent of them responded that this was sometimes true. More than half of the CNAs questioned worry about the
inadequacy of the amount of food they can afford to buy. Responses are recorded in the table below.

**Table 4.15**
CNAs Responses To Food Security Question Two

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>9 (31%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>13 (45%)</td>
</tr>
</tbody>
</table>

The third statement was: “The food that I bought just didn’t last, and I didn’t have money to get more.” Twenty-four percent of participants believed this to be true in their households sometimes, and 13.8% thought this was often true in their homes. A full 39% of participants reported having trouble making their food last throughout the month. Table 4.16 below shows the participants responses.

**Table 4.16**
CNAs Responses To Food Security Question Three

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>4 (13.8%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>18 (62.1%)</td>
</tr>
</tbody>
</table>

The fourth statement was “I ran out of the foods that I needed to put together a meal and I didn’t have money to get more food.” Another 17.2% reported they often run out of foods they need, while 24% reported that they sometimes run out of necessary food items. The responses are listed in table 4.17.
Table 4.17  
CNAs Responses To Food Security Question Four

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>5 (17.2%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>17 (59%)</td>
</tr>
</tbody>
</table>

Statement five was, “We eat the same thing for several days in a row because we only have a few different kinds of food on hand and don’t have money to buy more.” Only 10% of the participants reported that this was often a problem for them, but 31% reported that this was sometimes an issue in their households. That’s 43% of participants that don’t eat a variety of foods due to lack of money. Table 4.18 below shows the participants’ responses to the question.

Table 4.18  
CNAs Responses To Food Security Question Five

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>9 (31%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>17 (59%)</td>
</tr>
</tbody>
</table>

The sixth statement was, “I am often hungry, but I don’t eat because I can’t afford enough food.” Three percent of the participants reported being often hungry, while 17.2% of the participants reported hunger sometimes. The participants’ responses were recorded in table 4.19 below.
Table 4.19
CNAs Responses To Food Security Question Six

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>5 (17.2%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>23 (79.8%)</td>
</tr>
</tbody>
</table>

Statement seven was, “I eat less than I think I should because I don’t have enough money for food.” Seven percent of the participants agreed this was often true for them, and another 24% agreed that this was sometimes true for them. This means that over 30% of the participants were restricting their food intake due to lack of money. Table 4.20 below shows the responses of the participants.

Table 4.20
CNAs Responses To Food Security Question Seven

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>20 (69%)</td>
</tr>
</tbody>
</table>

The eighth statement was, “I can’t afford to eat properly.” Twenty-four percent of respondents believed they often couldn’t afford to eat properly, while another 24% of them believed that sometimes they couldn’t eat properly. Together that’s almost half of the participants that believe they can’t afford to eat properly. Table 4.21 shows the participants’ responses.
Table 4.21
CNAs Responses To Food Security Question Eight

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>7 (24%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>15 (52%)</td>
</tr>
</tbody>
</table>

Statement number nine was, “My child (ren) is (are) not getting enough because I just can’t afford enough food.” Only three percent of respondents believed that she often could not afford enough food to feed his/her child(ren). The other 97% of the participants marked that this was never true in their households. Responses are listed below in table 4.22.

Table 4.22
CNAs Responses To Food Security Question Nine

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>28 (97%)</td>
</tr>
</tbody>
</table>

Statement ten was, “I know my child (ren) is (are) hungry sometimes, but I just can’t afford more food.” None of the participants believed that this was often true for them, but 2 (7%) of the participants believed that this was sometimes the case in their households. Shown below in table 4.23 are the participants’ responses.
Table 4.23
CNAs Responses To Food Security Question Ten

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>27 (93%)</td>
</tr>
</tbody>
</table>

Statement number eleven was, “I cannot afford to feed my child (ren) a balanced meal because I can’t afford that.” None of the participants believed that this statement was often true for them, but over 17% thought that this was sometimes the case in their homes. The table below (4.24) shows the responses.

Table 4.24
CNAs Responses To Food Security Question Eleven

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“often true”</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>“sometimes true”</td>
<td>5 (17.2%)</td>
</tr>
<tr>
<td>“never true”</td>
<td>24 (82.8%)</td>
</tr>
</tbody>
</table>

The last two statements were to be answered with a ‘yes’, ‘no’ or ‘I don’t know’, and again, positive or ‘yes’ responses indicate food insecurity. Statement number twelve was, “Sometimes people lose weight because they don’t have enough to eat. In the past year, did you lose weight because there wasn’t enough food?” Ten percent of the respondents agreed that ‘yes’ this is possible. None of the participants answered indecisively. The participants’ responses are shown below in table 4.25.
Table 4.25
CNAs Responses To Food Security Question Twelve

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“yes”</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>“no”</td>
<td>26 (90%)</td>
</tr>
<tr>
<td>“I don’t know”</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

The last statement, number thirteen, was, “In the past year, have you had hunger pangs but couldn’t eat because you couldn’t afford food?” Only one participant agreed that they had experienced hunger pangs because they couldn’t afford enough food. None of the participants answered indecisively. Table 4.26 below shows the participants’ responses.

Table 4.26
CNAs Responses To Food Security Question Thirteen

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Number of Responses n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“yes”</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>“no”</td>
<td>28 (97%)</td>
</tr>
<tr>
<td>“I don’t know”</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Research Question 5: What type of educational strategies do CNAs perceive as the most useful for learning about foods and nutrition?

Focus Group Question 9: Where do you get your nutrition and health information?

The participants listed a number of sources from which they choose to get their health and nutrition information. These included (a) family doctor, (b) facility nurses, (c) Internet (d) magazines, and (e) the health department. One participant expressed her
preference, “Magazines – Woman’s World, Good Housekeeping – they have good recipes. I read all of the time.”

Participants were asked to rank their top three preferred methods of learning as well as their most preferred program length. Videotapes (22%) were the number one preferred learning method of the participants. Participants also ranked classes at a central location (21.3%) and having a mentor (19.9%) as other preferred methods of learning. The preferred methods of learning as ranked by participants are shown below in Table 4.27.

**Table 4.27**
Preferred Learning Method of CNAs

<table>
<thead>
<tr>
<th>Learning Method</th>
<th>Males</th>
<th>Females</th>
<th>Black</th>
<th>White</th>
<th>Total n (%)</th>
<th>Total Rank n=29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video Tapes</td>
<td>4</td>
<td>27</td>
<td>4</td>
<td>27</td>
<td>31 (22.0%)</td>
<td>1</td>
</tr>
<tr>
<td>Classes at a Central Location</td>
<td>0</td>
<td>30</td>
<td>2</td>
<td>28</td>
<td>30 (21.3%)</td>
<td>2</td>
</tr>
<tr>
<td>Mentor</td>
<td>0</td>
<td>28</td>
<td>3</td>
<td>25</td>
<td>28 (19.9%)</td>
<td>3</td>
</tr>
<tr>
<td>Learn at home</td>
<td>2</td>
<td>18</td>
<td>6</td>
<td>14</td>
<td>20 (14.2%)</td>
<td>4</td>
</tr>
<tr>
<td>Brochures</td>
<td>1</td>
<td>13</td>
<td>3</td>
<td>11</td>
<td>14 (9.9%)</td>
<td>5</td>
</tr>
<tr>
<td>Computer Learning</td>
<td>2</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>12 (8.5%)</td>
<td>6</td>
</tr>
<tr>
<td>Audio Tapes</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>6 (4.3%)</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>132</td>
<td>27</td>
<td>114</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For the final participatory activity, participants chose one of three preferred program lengths: (a) thirty-minutes, (b) forty-five minutes, or (c) sixty-minutes. One participant did not complete the activity. Thirty-five percent of the participants agreed that a sixty-minute program would best suit them, while 32% each responded that a 30 or 45 minute program would be best. Table 4.28 shows the preferred program lengths of participants.
Table 4.28
Preferred Length of Program CNAs may Attend

<table>
<thead>
<tr>
<th>Length of time</th>
<th>Males</th>
<th>Females</th>
<th>Black</th>
<th>White</th>
<th>Total n(%)</th>
<th>Total Rank n=29</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 min</td>
<td>0</td>
<td>10</td>
<td>1</td>
<td>9</td>
<td>10 (35.7%)</td>
<td>1</td>
</tr>
<tr>
<td>45 min</td>
<td>1</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>9 (32.1%)</td>
<td>2</td>
</tr>
<tr>
<td>30 min</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>9</td>
<td>9 (32.1%)</td>
<td>2</td>
</tr>
</tbody>
</table>
CHAPTER V: SUMMARY AND CONCLUSIONS

This research was conducted to assess the overall perceived concerns, barriers, and solutions of CNAs in both their work and family environments, identify where nutrition and food security fit into the priorities of CNAs, and identify educational strategies to improve their health and overall quality of life. Focus group discussions were triangulated with participatory activities and two questionnaires to gather qualitative and quantitative data. The conclusions are summarized and presented in this chapter in relation to the five research questions, the limitations of the study, and recommendations for future studies.

Triangulation of Methodologies

The triangulation of qualitative focus group discussions and quantitative participatory ranking activities and questionnaires data was used to assess the priorities of CNAs with regards to their personal and family situations. These methods were also used to assess where nutrition and food security rank among the concerns of CNAs. Using both qualitative and quantitative methodologies was useful in gathering data. Some participants were very talkative, and they shared many ideas during the discussions. Some participants responded better to the discussions, while more information was obtained from other participants through the questionnaires and ranking activities. Other participants were quieter, so triangulation of methodologies ensured that those participants would also be heard. Some topics were sensitive with the CNAs, so using participatory activities and questionnaires gave them the opportunity to answer the questions without having to share their fears and problems with their co-workers. The participatory ranking activities helped the CNAs vocalize their concerns in order of their priorities.

Triangulation of methodologies was used to assess food security among the CNAs. A focus group question was asked, and The Cornell/Radimer Food Security Scale questionnaire was administered. The food security questionnaire was handed to each participant in a folder so they could cover their answers and feel secure in answering the questions honestly. The CNAs did not share any food security concerns during the focus
group discussion, but their food security concerns were clearly revealed in their answers to the questionnaire.

Using three different methodologies to collect results was effective with this group. Those that didn’t feel comfortable speaking their minds during the discussion had an opportunity to be ‘heard’ with their answers to the questionnaires and their participation in the participatory ranking activities. Triangulation of methodologies maximized the responses from every participant.

Research Question 1: What are the major sociodemographic and other characteristics of CNAs that might affect their health, nutrition, food security, and preferences for learning?

CNAs are members of the working poor. These people work an average of 40 hours per week, but they often cannot afford benefits associated with full-time employment (Adler, 1999). Most of the participants were women. Some of the women were older with no dependents, and some of them were younger with or without children.

Low pay and extra work shifts have an impact on the health and nutrition practices of CNAs. CNAs receive very low wages and often have other family members to support. CNAs in this study reported that more money would help them meet the nutritional need of their families better. These results are supported by the research of Goodridge and colleagues (1996), who reported that CNAs are frustrated by low wages. One CNA spoke for many when she said, “The stuff that’s healthy costs more.” Another CNA reported, “Usually you try to fill up the refrigerator and the cabinets with what [money] you’re working with as opposed to eating good all of the time.”

Many CNAs reported that working extra shifts made them want to go home and rest. After working twelve or sixteen hours straight the last thing they wanted to have to do when they got home was cook. CNAs reported not caring about their diet when they were that tired. These long hours make it difficult for CNAs to get the medical attention they need for themselves and their families. Many CNAs reported that they lack the time off from work to see a doctor. Lack of adequate health care can have a deleterious effect on their health.

Research Question 2: What overall concerns, barriers, and solutions do CNAs have regarding their work and family situations?

The CNAs had many concerns as well as solutions that would help them perform better at work and at home. First, focus group questions and participatory activities were
conducted to understand their work conditions and how these impact their personal/family lives and the development of educational programs. Their concerns included understaffing and not enough pay. Their top three work concerns/educational strategies were time management, stress management, and communicating with co-workers and management. Nutrition and health were not top priorities. The CNAs ranked staying healthy as their fourth work concern, and they ranked packing a nutritious lunch as their sixth work concern.

Understaffing caused significant problems for the CNAs. Lack of adequate staff meant that current CNAs have to work longer hours and take care of more residents per shift. This added stress gave CNAs very little time to take care of things in their personal lives, and it makes them feel as though they are not doing justice to the residents. Understaffing was more of an issue at corporate run facilities as opposed to the privately run community facilities, but all of the CNAs agreed that it was a problem.

Stress management and communicating with co-workers and management were the other top work concerns/educational solutions for CNAs. Physical and verbal abuse from residents, lack of respect from the administration, and the physical stress of their jobs makes better coping skills a necessity for CNAs. Segal and colleagues (1999) showed that an increase in communication with their superiors enhanced the CNAs work experience by making them feel more respected.

The participants came up with several solutions to the problems of understaffing, poor money management skills, and the high level of stress they take from their jobs. All except two of the groups agreed that the facilities should hire more staff. No matter how few residents were assigned to each CNA, they thought it was too much for one person to accomplish in eight hours. There was constantly a feeling of not having done enough to help the residents. The participants all agreed that higher pay would help them afford better nutrition.

Ideas for reducing stress came in many forms. One group of CNAs enjoyed the focus group session and expressed a desire for a room that they could go to if they needed to ‘debrief’ before going home to their families. The focus group made up of Mennonite volunteers recognized the value of debriefing because they all lived at the nursing home and could discuss any difficult work situations with each other anytime of day. A CNA
in one focus group hoped being a CNA would help her feel less stress because she enjoyed the work much more than her previous job.

**Home Concerns**

The top three home concerns/educational solutions that CNAs ranked were money management, time management, and stress management. During the focus group discussions, CNAs agreed that risk of contagious diseases and bringing stress home to their families were their top concerns.

The ability to make their money last between paychecks was ranked as the number one home concern. Money management skills would help alleviate some of their more pressing family concerns. Painter (1999) conducted research that pointed to money as the number one concern faced by CNAs. Participants commented that they could not make their money last for the entire month. Many participants acknowledged the difference between the fixed expenses and the flexible expenses in their budget. One CNA expressed the sentiments of many, “After you pay your bills you don’t have much leftover after you pay your rent and phone bill; what you have leftover has to last you for the next two weeks.” CNAs agreed that food was a flexible expense and that sometimes it was difficult to set aside enough money to buy food for an entire month.

Many CNAs were concerned with the amount of stress they take home from their jobs to their families. Stress management was the number three home concern of participants and the number two work concern of participants. Many participants confided that they would often snap at their co-workers and/or their family members because of the stress they felt from their job. It is important to help CNAs in this area because CNAs with a stressful personal life are more likely to commit an act of abuse against a resident (Pillemer & Moore, 1989). One participant shared the feelings of many, “I don’t like going home feeling like I do and I take it out on my family; my poor husband!”

CNAs offered no educational solutions for their personal and family lives. Participants cited training for a new job as the only solution to the stress they feel at home. This indicates that the CNAs are not aware that they are capable of learning better coping skills for the stress they feel and money management skills to help them get the
most out of their paychecks. The CNAs also acknowledged through the ranking activities
that being able to stretch the income they currently receive would help them.

Research Question 3: To what extent are CNAs concerned about nutrition and health
issues compared to other work/family concerns?

Nutrition and health did rank in the participatory activities. Stress management
and time management ranked much higher in the priorities of CNAs than health and
nutrition. CNAs rated keeping their families healthy as their fourth home concern.
Preparing fast and easy meals ranked eighth in home concerns. CNAs discussed that they
were too tired and stressed to worry about cooking after working a long, busy shift.

Participants rated staying healthy as their fourth work concern, while packing a
nutritious lunch ranked sixth. The results of the ranking activities were consistent with
the focus group results. Participants indicated during the discussions that they often
skipped lunch at work because there was not enough time to sit down and eat. These
results indicate that the CNAs were concerned with nutrition and health, but their money,
time, and stress concerns are higher on their priority lists than nutrition and health. These
results indicate that the way to teach this population about nutrition and health is to
market the educational programming to their highest priorities, stress management,
money management, and time management.

Research Question 4: To what extent do CNAs perceive food security as a concern?

The focus group questions regarding food security yielded very little discussion.
Participants were hesitant to discuss food security in front of their friends and co-
workers. These results were contrary to the results of the food security questionnaire,
which indicated that about half of the participants had some food security concerns.
After the pilot, participants were given folders to conceal the answers on their food
security questionnaires from their neighbors.

The Cornell/Radimer Food Security Scale questionnaire was used to gain further
understanding of the food security concerns that CNAs face (Kendall et al., 1995). The
questionnaire was linked to research question number four. Some of the participants had
young children at home, while others had grown children and lived alone or with a
spouse.

The questionnaire also measures hunger. Positive responses to one or more of
certain questions on the survey indicate whether a participant is individual hungry or if
they have a hungry child in their household (Kendall et al., 1995). Hunger occurs when the individual or child actually goes without food when they are hungry because they cannot afford to purchase the food they need. Twenty-one percent of participants were considered individual hungry and one participant believed that he or she had a hungry child in their household.

The extremely low pay of CNAs makes it difficult for them to afford a variety of nutritious foods that last throughout the month. The participants reported lack of money management skills makes buying and keeping healthy food between paychecks even more difficult. This presents an opportunity to teach CNAs to better manage their finances in order to be able to feed their families more consistently.

Research Question 5: What type of educational strategies do CNAs perceive as the most useful for learning about foods and nutrition?

A participatory ranking activity was used to assess the CNAs’ preferred methods of learning. Participants ranked video-tapes, classes at a central location, and having a mentor to help them as their top three preferences in that order. Lessons should be tailored to the schedules that CNAs keep because they often have other family commitments or other jobs that keep them busy.

CNAs ranked preferred program lengths very closely. CNAs ranked 30-minute and 45-minute classes with 32.1% of the points each and 60-minute classes with 35.7% of the points. More CNAs should be polled to obtain a better understanding of the optimum program length.

Recommendations for Educational Programs

There are clearly many ways in which nutrition educators can help this population. It is important for nutrition professionals to keep in mind that the approach should be multifaceted. The CNAs in this study were barely interested in nutrition and health programming, but they did express concerns in money management and stress management. Nutrition plays a role in each of these areas.

Virginia Cooperative Extension has the educational resources to help this population learn to manage their money better, reduce stress and improve their health and nutrition. Extension specialists in the areas of Family and Human Development,
Management, Housing, and Consumer Education, and Nutrition and Wellness should collaborate to provide programs that will help improve the quality of life for CNAs.

Programs aimed at helping participants stretch their paychecks to cover all of their expenses would benefit this population. The participants expressed an interest in learning to handle their money better. This will improve their nutrition because they can learn how to stretch their food dollars as well. Learning to be thriftier in the food store and knowing how to save money to spend on food for the entire two-week period between paychecks may help reduce food insecurity in this population. Also, improving good eating habits can have a cost-benefit on health care. One group of researchers (VCE, 1999) was able to prove a cost savings of $10.64 in health care for every $1.00 spent on nutrition education through the Expanded Foods and Nutrition Education Program in Virginia.

Programs that are designed to help participants reduce their level of stress will help this population. Stress reduction is a top priority of CNAs. Nutrition and health play a major role in any stress reduction program. Any type of reduction in stress should have positive effects on the individual’s general state of health.

Educational programs for CNAs should be accessible to be effective. CNAs often work long hours and have many family commitments to attend to when they leave work. CNAs in this study preferred to learn by video-tapes, classes at a central location, and by having a mentor to work with. The educational programs should take these methods into consideration.

Extension programs aimed at reducing stress and time management for this population should be coordinated with the Directors of Nursing in Virginia facilities to be used during CNA training classes. Not only will this practice help CNAs cope better with their jobs, but also it will introduce them to Virginia Cooperative Extension programs. Through VCE programs, such as financial mentors, the CNAs may receive more help with their personal and work concerns.

In addition, nursing home facilities that employ CNAs should make an effort to help them to improve the quality of patient care. CNAs want to be included in policymaking, improve their communication with co-workers and management, and to be
rewarded and respected by the administration. Segal and colleagues (1999) found that health promotion activities among CNAs help to decrease absenteeism.

Facility administrators should consider using a reward system to help motivate the CNAs. Research shows that CNAs respond positively when rewarded for their accomplishments (Stevens et al., 1998). All of the participants in this study were rewarded once a year with an appreciation lunch or periodically with free pizza. None of the CNAs were singled out for any job well done, so there was no incentive to do better. Another researcher agreed that public recognition for a job well done enhances the work experience of CNAs (Hoffman, 2001).

Researchers have found that an increase in communication gave CNAs a feeling of input and respect from the administration (Segal et al., 1999). The CNAs in this study felt that they did not have an input into policies that affect them, and they all agreed that as CNAs they were not respected by the administration. One example given by a participant was that the administration would not listen when the CNAs expressed a need for more workers to be scheduled in the morning when they were most busy and fewer to be scheduled in the afternoon when they were less busy.

It is important that nutrition educators use a multifaceted approach to help improve the health and nutrition concerns of CNAs. Nutrition and health are not among the top three home or the top three work concerns of participants in this study. Using money management and stress management, both top priorities of CNAs in this study, educators can teach health and nutrition by helping reduce stress in the lives of CNAs as well as by teaching them to make their money last enough to buy the foods they need for themselves and their families.

Research Limitations

A number of factors limited the scope of this research. The factor, which had the largest impact on this research, was the difficulty in recruiting participants. There were also factors that affected the CNAs input into the discussions and factors that affected the analysis of the data.

Recruiting Participants

There was a great deal of difficulty in convincing nursing facilities to allow their CNAs to participate in the study. Virginia Cooperative Extension Agents from across the
state were asked to use a contact they had made at local nursing home facilities to persuade the administration to allow their CNAs to participate in this study for one hour. Some facilities allowed the CNAs to come to the sessions during their shift, while others made the CNAs stay late or come in early in order to participate. The extension agents asked for 6-8 participants, but most centers could only spare four or five. One center agreed to host a group and backed out at the last minute. Several centers expressed concern over the types of questions that would be asked of the CNAs. The centers that were most difficult to get into were those that were run by corporations. These centers had far more residents per CNA, and were least willing to allow the CNAs to take time during their shift to participate in the study. The privately run facilities were easier to work with and most of them allowed their CNAs to participate during their shift.

Factors Affecting Input

Some CNAs were more hesitant to answer than others. Often this depended on the group dynamics. During the first focus group, there was a lot of diversity: two men and five women. Most of the participants answered all of the focus group questions, but there were one or two that mostly nodded at other’s remarks rather than sharing their opinions. All of the participants completed the ranking activities.

The second group was smaller and consisted of four women. All of the women shared their views and this group ran smoothly.

The third group was made up of five women. The women in this group all participated to a good extent. One woman was louder and more dramatic than the others, but as a whole, the group was clearly close-knit and they shared many ideas. All of these women had been CNAs for many years.

The fourth group consisted of four CNAs. Two of the women had been CNAs for more than two years and the other two women had only been CNAs for two months. One member of this group, a new CNA, was very quiet. When asked questions directly, this particular participant simply shrugged and grunted. She did make one comment about not enjoying her job, but she was difficult to hear and she refused to expound on her statement. The remaining three participants were talkative and informative.
The fifth group was made up of four women. This group was slow to begin talking, but after one or two answered the second question explaining why they enjoy their job, the other two chimed in and kept talking throughout the discussion.

The final focus group session consisted of five participants at a Mennonite run nursing home. Four of the participants were young Mennonite volunteers that worked nine hour days, six days a week, and the fifth participant was a young woman that was paid and was a member of the local community. Because four of the participants were unpaid volunteers that were housed and fed by the nursing home administration, it was difficult to get the employed CNA to comment on her personal and food security concerns.

Factors Affecting Data Analysis

The problems that occurred with data analysis were mostly due to the tape recording equipment. All of the participants completed the first three participatory activities. Only one participant failed to complete the fourth activity. All of the participants completely answered the questionnaires.

The first focus group discussion was held in a large room with no table, so the recorders were placed on the floor in the middle of the group. Unfortunately, the voices did not carry enough to be recorded onto the tapes, so there was no transcription available for this group. One participant in this group failed to participate in the final participatory activity.

During one session some of the phrases are difficult to understand because of the thick German accent of the participants. These problems made it clear that two tape recorders are a necessity when conducting focus group research.

Recommendations for Future Research

The improvement of future research with this population group is important. Multiple data collection methods worked well on this population because some methods were more sensitive to their situations than others. For example, although they did not discuss food security concerns with their co-workers during the discussions, the Cornell/Radimer Food Security Questionnaire results clearly showed that more than half of the participants worried about having enough food to eat. It is important for
researchers to be sensitive to topics that CNAs may not feel comfortable discussing with
the group.

There were only two situations when it seemed as though participants were
holding back their comments. In one situation, the participant was the only CNA in the
group that was a paid employee and had to be responsible for her personal life and
finances, so she never mentioned any financial concerns in front of the younger
participants that were volunteers and didn’t have any further financial obligations. It was
not clear why the second participant was not comfortable talking. In all of the focus
groups the participants asked to be reassured that the administration would not hear what
they were going to say, for example, the doors to the focus group sessions were kept
closed. It was evident that some of the CNAs did not feel comfortable disclosing their
problems with their jobs. Researchers should be sensitive to this discomfort in order to
obtain honest answers from the participants. Key informant interviews may be a better
way to obtain information from this population group. The participants may be more
willing to divulge their opinions in a one-on-one situation.

Surveys may be an opportunity to gain a great deal of information from this
population in a short amount of time. CNAs work hard and are often not willing to stay
around after work to help with research. Surveys can be administered during a thirty-
minute lunch break without interrupting the flow of their day, and this approach may
appeal more to the administration.

One question on the demographics questionnaire was confusing for participants
and should be revised before further research is conducted. Question number seven
asked CNAs to place a check beside which types of benefits they receive with their work.
This question was confusing because the participants were unsure whether to check
which benefits they were offered or which ones they actually received. CNAs in this
study were required to pay extra money if they opted to receive benefits. It would have
been less confusing if the idea was changed into two questions. The first question should
read, “What types of benefits does the company offer you?” The second question should
follow, “Which benefits must you contribute money to the company in order to receive
them?”
Finally, researchers should take into account the type of facility where CNAs are employed. Research should be aimed at either corporate or private facilities, or contain an equal number of participants from each. This practice will avoid biasing a study based on corporate and private differences in the industry.
References


(2001). The American College of Physicians Online available at www.acponline.org/uninsured


Hoffman, R. (1996). CNAs As Today’s Key To A Successful Survey: Staff-Resident Relationships Have Moved To The Center Of OFRA’s Attention. *Nursing Homes, 45*, 14-16.


Hello and welcome to our session. Thank you all for taking the time to participate in our discussion. My name is Amanda Holsinger and I will be the moderator today. This is Kathleen Stadler and Pamela Teaster, and they are here to represent Virginia Cooperative Extension, the Department of Human Nutrition Foods and Exercise of Virginia Tech, and the Center for Gerontology at Virginia Tech. They will be taking notes and helping with some of our activities.

Today, we will be using first names only. When we write up the reports generated by these sessions, we will omit names, so your name will not accompany your comments. Everything you say will be kept confidential. The tape recordings will only be used to prepare a summary of the sessions. The consent form you are about to sign is for your protection and that of VA Tech. It ensures that we will keep your identity confidential. There are no risks to you as a participant in this study, and we hope it will help generate ideas for ways to improve the work and family lives of CNAs.

There is a need to better understand the work conditions and family situations faced by nursing assistants. We also need to be made aware of the ways you prefer to learn about issues that concern you and may help you perform better at home and/or at work. We have invited you to participate in this session because we believe you can help us better understand these issues.

We encourage everyone to feel free to express yourself today because each and every one of you has opinions and beliefs that are important for us educators to understand. There are no right and wrong answers. We would like to learn about the issues you feel are most important. Please remember that it is ok to share your ideas even if they differ from the others in the group. Everyone’s ideas are important, and it doesn’t matter if yours are positive or negative comments.

It will be my job to ask questions and listen to the answers. I will not participate in the discussion. Feel free to talk to one another. Remember that it is important that we hear from everyone because you all have different beliefs, opinions and experiences. If I see that someone has not said much, I may ask for your opinion, and if you are sharing a lot, I may ask to hear what the others have to say.

Please ask questions at any time. If you need a break, let us know. Are there any questions? Let’s begin.

Today, we will be discussing your concerns regarding your work and family situation as well as any concerns you might have about food and health. Please answer honestly and remember that there are no right or wrong answers.
Let’s start by introducing ourselves. Let’s go around the table and give your first name and how long you’ve been a CNA.

1. Why did you choose this type of work?

2. What are typical tasks that you perform when providing care to residents?

3. What do you like about your job?

4. What don’t you like about your job?

5. What could help you be a better CNA?
   Probes: Training (specific topics)  
   Pay/Benefits
   Work Hours
   Facility Rewards
   Family Care/Support

6. What are your concerns for your personal and family life?
   Probes: Stress
   Health (physical and mental)
   Eating Right
   Finances
   Child Care
   Different or Another Job
   Home Environment

7. What do you need to improve your personal and family life?

8. What concerns do you have for you and your family about having enough food to eat?
   • Getting a variety of different foods
   • Getting nutritious foods

9. Where do you get your nutrition or health information?
Participatory Ranking Activities

10. Please rank your top three topics related to home issues.

   ____ Preparing Fast and Easy Nutritious Foods
   ____ Keeping my Family Health
   ____ Keeping Calm/ Stress Management
   ____ Stretching Your Money Until the End of the Month
   ____ Finding Time for Work and Relaxing/ Balancing Work and Family
   ____ Keeping Your Home in Good Condition
   ____ Getting Along With Family and Friends/Communications
   ____ Parenting Skills for Young Children
   ____ Parenting Skills for Older Adults
   ____ Older Adults and Relationships
   ____ Having Another Person to Help Me With Problems
   ____ Other (please specify)

11. Please rank your top three topics related to work issues.

   ____ Stress Management
   ____ Staying Health
   ____ Packing a Nutritious Lunch
   ____ Time management
   ____ Communicating with Co-workers and Management
   ____ Communicating with residents’ families
   ____ Childcare options
12. Rank the three methods that you would prefer when receiving educational information or training related to your personal life or work related issues? Rank the top three methods you prefer. 1 = most preferred method, 2 = preferred method, and 3 = least preferred method.

___ Learn-at-Home Newsletter Series (regular mailing)
___ Brochures or Leaflets – 1 topic or several topics
___ Audio Tapes
___ Video Tapes
___ Learning by using a Computer
___ Classes at a central location or the work site (e.g., church, Extension Office).

13. Rank the length of class time that you prefer.
   30 minutes
   45 minutes
   60 minutes
Appendix B
Cornell/Radimer Food Security Questionnaire

I’m going to read you a series of statements that people have made about their food situation. Place a check mark beside the statement that fits your individual household.

1. I worry whether my food will run out before I get money to buy more.

[ ] Often true [ ] Sometimes true [ ] Never true

2. I worry about whether the food that I can afford to buy for my household will be enough.

[ ] Often true [ ] Sometimes true [ ] Never true

3. The food that I bought just didn’t last, and I didn’t have money to get more.

[ ] Often true [ ] Sometimes true [ ] Never true

4. I ran out of the foods that I needed to put together a meal and I didn’t have money to get more food.

[ ] Often true [ ] Sometimes true [ ] Never true

5. We eat the same thing for several days in a row because we only have a few different kinds of food on hand and don’t have money to buy more.

[ ] Often true [ ] Sometimes true [ ] Never true

6. I am often hungry, but I don’t eat because I can’t afford enough food.

[ ] Often true [ ] Sometimes true [ ] Never true

7. I eat less than I think I should because I don’t have enough money for food.

[ ] Often true [ ] Sometimes true [ ] Never true

8. I can’t afford to eat properly.

[ ] Often true [ ] Sometimes true [ ] Never true

9. My child (ren) is (are) not getting enough because I just can’t afford enough food.

[ ] Often true [ ] Sometimes true [ ] Never true
10. I know my child (ren) is (are) hungry sometimes, but I just can’t afford more food.

[ ] Often true      [ ] Sometimes true     [ ] Never true

11. I cannot afford to feed my child (ren) a balanced meal because I can’t afford that.

[ ] Often true      [ ] Sometimes true     [ ] Never true

For the next two questions, please answer yes or no.

12. Sometimes people lose weight because they don’t have enough to eat. In the past year, did you lose weight because there wasn’t enough food?

[ ] Yes     [ ] No     [ ] Don’t Know

13. In the past year, have you had hunger pangs but couldn’t eat because you couldn’t afford food?

[ ] Yes     [ ] No     [ ] Don’t Know
# Certified Nursing Assistants Survey

1. What is your age?
   - Below 20
   - 20-30
   - 31-40
   - 41-50
   - 51-60
   - 61-70
   - Over 70

2. What is your gender?
   - Female
   - Male

3. What is your educational level?
   - Less than High School
   - High School Graduate/GED
   - Some Training Past High School
   - 2 Years of College/Associate Degree
   - 4 Years of College/B.S. or B.A.

4. How many children do you have?
   - None
   - 1
   - 2
   - 3
   - 4
   - 5 or more

5. What type of work did you do before accepting your position at this facility?

6. How long have you worked as a CNA at this facility?
   - Less than 1 Month
   - 1-3 Months
   - 4-6 Months
   - 7-9 Months
   - 10-12 Months
   - If More Than a Year, Specify Years and Months: _________

7. What types of benefits do you receive with your work? (Check all that apply).
   - Health Insurance
   - Dental Insurance
   - Family Leave
   - Sick Leave
   - Vacation Leave
   - Retirement
   - None

8. On average, how many hours each week do you work?
   - 20 hours or less
   - 21-30 hours
   - 31-40 hours
   - 41-50 hours
   - If over 50, Specify: _________

9. Are you considered:
   - Full time
   - Part time

10. During an average week, how many double shifts do you work?

12. Yesterday, for how many residents did you
None
1
2
3
If 4 or more, Specify: _____

11. On an average shift, for how many residents are you responsible?
   Between 1-10
   Between 11-15
   Between 16-20
   Between 21-25
   Between 26-30
   Between 31-35
   Between 36-40
   If over 40, Specify: ______

provide direct care?
   Between 1-10
   Between 11-15
   Between 16-20
   Between 21-25
   Between 26-30
   Between 31-35
   Between 36-40
   If over 40, Specify: ______

13. Do you work another job in addition to this one?
   Yes       No
   If yes, is it part time or full time? (check one)
   full time  part time

14. Please provide any comments about being a CNA that you would like to make.
VITA

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