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Exploring Social-Based Discrimination Among Nursing Home Certified Nursing Assistants

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Abstract

Certified Nursing Assistants (CNAs) provide the majority of direct care to nursing home residents in the United States and, therefore, are key to ensuring optimal health outcomes for this frail older adult population. These diverse direct care workers, however, are often not recognized for their important contributions to older adult care and are subjected to poor working conditions. It is probable that social-based discrimination lies at the core of poor treatment towards CNAs. This review uses perspectives from critical social theory to explore the phenomenon of social-based discrimination towards CNAs that may originate from social order, power, and culture. Understanding manifestations of social-based discrimination in nursing homes is critical to creating solutions for severe disparity problems among perceived lower-class workers and subsequently improving resident care delivery.

Keywords

older adult; nursing home care; residential care; health inequities; racism; discrimination; caregivers

The influx of older adults seeking nursing home care in the United States over the years has intensified the demand for personnel who will provide direct care for this population (U.S. Bureau of Labor Statistics, 2016). Focal to the care of the older adult is support with activities such as bathing, dressing, eating, and ambulating (Harris-Kojetin, 2013; Wergeland, Selbæk, Bergh, Soederhamn, & Kirkevold, 2015; Zimmerman et al., 2013).

Greater than 50% of this specified work is assumed by racial/ethnic minorities and/or immigrants intending to make a living for themselves, their families, and their loved ones and over 90% are women (Probst, Baek, & Laditka, 2010; Stacey, 2005). Unfortunately, this essential direct care workforce (hereafter referred to as certified nursing assistants [CNAs]) is generally viewed as “low-paid service workers” and treated as such (Paraprofessional Healthcare Institute, 2016; Scrimgeour, 2015). For example, a large majority of CNAs are underpaid, undervalued, undertrained, and subjected to conditions of heavy workload and verbal and physical abuse (Dodson & Zincavage, 2007; Walton & Rogers, 2017). Inadequate resources and restrictions on the ability to voice opinions are additionally common to the tenure of CNAs in the nursing home setting (Castle, Wagner, Ferguson-Rome, Men, & Handler, 2011; Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000; Kim, Harrington, & Greene, 2009). As the need for CNAs continues to grow, the unfavorable treatment towards this group—whether from professionals or residents—remain unchanged. Moreover, without attention towards the ideologies underpinning CNA practice and critically reflecting on how issues of various social attributes inherent within the CNA profession are reproduced – or disrupted - in practice, we risk depleting and defeating a workforce already highly stretched in a time where their demand is becoming the greatest. Not only is this an unjust situation for these care providers but vulnerable older adults in need of the care provided by CNAs are also at risk for suffering (Paraprofessional Healthcare Institute, 2016).

Background

Critical social theory (CST) provides a perspective that assists in the analysis of how social attributes ascribed to the CNA contribute to their contentious work experiences in the nursing home setting. Dating back to the early 1900s, this metatheoretical framework was named by the founders of the Frankfurt School (Calhoun, 1995; Fay, 1987). Tenets central to CST revolve around “unequal power relations and oppressive structures within society and an emancipatory project that seeks liberation from constraints and domination arising from social, political, economic, and ideologic conditions (Browne, 2000).” According to a CST perspective, several historically engrained societal views may lead to continual domination and oppression towards the working class (Calhoun, 1995; Fay, 1987; Manias & Street, 2000). CST has been used in the past by nurse scholars as a theoretical and philosophical orientation to science that refocuses attention on the socio-political and historical context of health and health care (Browne, 2000). This review provides context to the problem of what may be termed social-based discrimination experienced by CNAs in the United States nursing home setting using perspectives from CST. Social-based discrimination is defined as unfavorable treatment of an individual or individuals on the basis of social class/ characteristics (UNESCO, n.d.). Herein we operationalize social-based discrimination as disproportionate offenses towards individuals or groups as a result of tensions inherent within proposed tenets of CST which include social order (race, immigration, gender), hierarchical position of power (as it relates to CNAs and other members of the organizational team), and culture.

Our review begins by situating this contemporary phenomenon of social-based discrimination within a historical context that highlights how current ideologies

underpinning experiences of discrimination among CNAs engaged in resident care labor reflect past experiences of discrimination among various social groups. We specifically draw on the exposure of immigrants and racial/ethnic minorities to indentured servitude and slavery, revisit nurses' experiences of oppression and free labor, and summarize gendered norms that are inherent in United States society. Constructs from CST: social order (race, immigration, gender), power, and culture, that are found to inhibit or advance the CNAs' caregiving role are subsequently critiqued. Based on review findings, we conclude with strategies and recommendations that may serve as an action plan for change to improve the work environment for CNAs (Fay, 1987).

Historical Context

Indentured servitude.—Four centuries ago, during the time of the “New World,” natural resources were abundant and the need for cheap labor was high (Galenson, 1984). To meet this demand, indentured servitude was created as a way to provide immigrants with passage to the new world in exchange for work in the American colonies for a contracted term (Galenson, 1984). With the hope of gaining better lives for themselves and their families, these immigrants relinquished many of their rights, including the right to marry and the right to travel freely. Moreover, the lives of most indentured servants were filled with harsh restrictions, punishment, and abuse, with little or nothing to show for it at the end of their term (Bilder, 1996).

Slavery.—Not long after the introduction of indentured servitude, land owners found that Black slaves brought to the United States from Africa were much more economical to work the plantations (Wilson, 2012). They were living longer than they used to and cheaper to own. Like indentured servants, Blacks experienced abuse, punishment, and restriction (Galenson, 1984). Unlike indentured servants, Black slaves were less likely to be granted freedom, and their motivation to work was not the guarantee of freedom but rather the desire to remain alive (Bilder, 1996; Galenson, 1984).

Nursing oppression.—Nursing's roots in powerlessness and oppression reach back to the time when it first became a recognized profession through Florence Nightingale's efforts (Brann, 2010). While nursing was not initially intended to be oppressive to nurses, within time systematic changes were implemented that very much did that. For example, exploitation of nursing students became routine as hospitals used this workforce as unpaid staff to care for patients, thus leaving professional nurses unemployed or compelled to seek private duty care as their only option for work (Ruby, 1999; Wagner, 1980). Into the 21st century, this predominantly female profession continues to be placed in inferior positions to males (i.e., physicians) reproducing gender-based hierarchies within these professions. (Duchscher & Myrick, 2008; Fletcher, 2006; Roberts, 1983; Roberts, Demarco, & Griffin, 2009; Witt, 1992). Viewed as responsible for supporting medicine in much the same way as women are expected to support men, nurses' experiences of disenfranchisement have led to feelings of low self-esteem and low job satisfaction among this profession. Moreover, their constricted efforts to overcome past traditions resulted in horizontal violence and passive aggressive behavior (Fletcher, 2006; Matheson & Bobay, 2007; Roberts et al., 2009). The cyclical nature of nursing's failure to unite as a profession has additionally made it difficult

for nurses to define their identity and clarify what the profession does beyond its stereotypical portrayal (Hoeve, Jansen, & Roodbol, 2014; Meleis & Trangenstein, 1994). Attempts to address these issues around nursing oppression and elevating the profession have been implemented over a number of decades and include initiatives such as moving nursing education from hospital-based programs into academic institutions, building a scholarly body of literature to underpin nursing practice, promoting advanced practice, and more recently efforts such as the Magnet Program, the Future of Nursing's pivotal report, and the ongoing practice of self-reflection among nurses to interrogate and overcome historically-based oppressions through dialogue and self-awareness (Dong & Temple, 2011; Hickson, 2013; Roberts et al., 2009; Schwartz, Spencer, Wilson, & Wood, 2011; Shalala et al., 2011).

Gendered norms.—Gendered oppression intersects with each of the other oppressions described previously. It rests on assumptions and norms embedded in society that subsequently restrict the progression of certain groups because of their gender. This restricted progression can be seen in the form of inequitable jobs, pay, power, respect, and treatment. Women are often the victims of gendered oppression and suffer its effects both in predominantly female and male professions. The professions of nursing and medicine have been ascribed certain gendered characteristics which also contribute to power differentials in the workplace. When analyzing gendered oppression, theorists such as Crenshaw and others have suggested the analysis be conducted in consideration of other social oppressions and inequalities (Crenshaw, 1991; Duffy, 2005).

The 21st Century CNAs and Nursing Homes

Given the large representation of racial and ethnic minority groups, immigrants, and women in the CNA workforce, the historically-based ideologies regarding marginalized populations seemingly inform the contemporary treatment of CNAs (Khatutsky et al., 2011; Probst et al., 2010; Stacey, 2005; Walton & Rogers, 2017; Yamada, 2002). CNAs in today's nursing home settings share many similar details of the accounts of indentured servants, Black slaves, nurses, and women, including exploitation, restriction, abuse, oppression, and control by superiors (Brooks, 1996; Glenn, 1992). In many cases, their safety is threatened and their needs and well-being are ignored (Hurtado, Sabbath, Ertel, Buxton, & Berkman, 2012; Paraprofessional Healthcare Institute, 2016; Walton & Rogers, 2017). Inevitably, the historical image of the minority and immigrant woman servant to those of the White race persists.

In 2014, there were approximately 15,600 nursing homes in the United States with 1.4 million individuals residing in these facilities (National Center for Health Statistics, 2017). In each nursing home, a CNA maintains a minimum of 75-hours of one-time training and can be responsible for the day to day care for over 15 residents depending on the shift and existence of state mandatory staffing ratios (Harrington et al., 2012). During their 8-hour shift, CNAs are expected to get the majority of these residents up for the day; wash, dress, toilet, and feed them among many other tasks (Harris-Kojetin, 2013). For toileting and feeding alone, these residents typically are in need of toileting every 2–4 hours and can require 35–40 minutes of feeding assistance three times a day depending on the complexity

of their care (“Nursing Home Care for Residents with Incontinence: Questions to Ask”, n.d.; Simmons & Schnelle, 2006). The social needs of residents tend to be left unattended to because of the CNAs’ demanding schedule and CNAs themselves rarely have time to take a break.

Overseeing CNAs are typically registered nurses as well as licensed practical/vocational nurses which only one of these professionals are required to be present on each shift (Harrington et al., 2012). Moreover, these licensed nurses have their own responsibilities to resident care in addition to their supervisory responsibilities and in some states such as Arizona, can be responsible for over 80 residents each (Harrington et al., 2012). Reports of better quality of care, sufficient staffing, and support from nurses and upper management are most common in cases when the nursing home is being inspected and appear to be lacking in many other cases (Castle, 2008; Centers for Medicare and Medicaid Services, 2001; Kash, Hawes, & Phillips, 2007; Lowenstein, 2014; Paraprofessional Healthcare Institute, 2016). In several blogs, CNAs report routinely returning home upset at the end of their shifts because of their experienced abuse, injuries, neglect, and inability to provide adequate care to their residents. Moreover, the work of CNAs is considered unskilled, disrespected, and unimportant (Paraprofessional Healthcare Institute, 2016; Walton & Rogers, 2017).

Although slavery and indentured servitude were finally abolished in the 19th and 20th centuries, respectively, and nursing and women have fought to create a voice for themselves in recent decades, it is important to examine how conditions for those working in nursing homes, specifically CNAs, continue to share conditions of indentured servitude, slavery, and oppression even a century later (Galenson, 1984; Hurtado et al., 2012; National Archives, 2016; Walton & Rogers, 2017). A plausible explanation for this inquiry is social-based discrimination and lack of attention to its manifestations, both overt and covert, in the nursing home setting.

Many worthy efforts have been put forth to correct these historical social injustices: the passage of the Thirteenth Amendment (abolishment of slavery), Fourteenth Amendment (citizenship rights and equal protection), and Fifteenth Amendment (right to vote despite color) to the U.S. Constitution, the Civil Rights Act of 1964, nursing’s strides in moving the profession forward, initiatives advanced under the Women’s Rights Movement, and the election of the first Black president (“The Civil Rights Act of 1964 and the Equal Employment Opportunity Commission,” n.d.; “Primary Documents in American History,” n.d.; Whitehouse.gov, n.d.). However, social-based discrimination related to social order (race, immigration, and gender), power, and culture remains robust and persistent in our current era (King, 2015; Nesbit, 2015).

Given the belief that social differences produce an inherent superiority of a particular social order, power role, or cultural affiliation, social-based discrimination manifests itself in hospitals, education systems, housing, outpatient care, and the workplace, among many other settings (Blanchett, 2006; Feagin, 1999; Fox & Stallworth, 2005; LaVeist, Nickerson, & Bowie, 2000; Moody-Ayers, Stewart, Covinsky, & Inouye, 2005). Women continue to receive lower pay than men for the same positions, and those in a lower social class are segregated into communities with poor living and working conditions and minimal access to

healthy food, safe neighborhoods, and adequate healthcare, compared to those in a higher class (Cooper-Patrick et al., 1999; Oliver, Wells, Joy-Gaba, Hawkins, & Nosek, 2014; Williams & Collins, 2001). In addition to being unfair and unjust, subjection to social-based discrimination is detrimental to one's health and well-being (Harrell, 2000). Early mortality, increased morbidity, and variant access to needed healthcare services, in conjunction with deleterious effects on mental health, stress level, coping ability, and wealth, are additional areas in which affected individuals are profoundly impacted by the effects of social-based discrimination (Clark, Anderson, Clark, & Williams, 1999; Harrell, 2000; Moody-Ayers et al., 2005; Pieterse & Carter, 2007; Williams, 1999; Williams, Yu, Jackson, & Anderson, 1997; Wyatt et al., 2003).

Experiences of social-based discrimination surface to varying degrees among staff and residents in institutional settings such as nursing homes (Christian, Lapane, & Toppa, 2003; Degenholtz, Arnold, Meisel, & Lave, 2002; Hurtado et al., 2012; Smith, Feng, Fennell, Zinn, & Mor, 2007). Exposure to social-based discrimination has been reported as more continually present and at higher levels in such institutional settings compared to non-institutional settings (i.e., home and community-based settings). Staff who provide the majority of direct care to institutionalized nursing home residents (i.e., CNAs)—who also happen to be more than 50% racial/ethnic minorities and foreign-born and greater than 90% female (Squillace et al., 2009)—are relegated to subordinate positions that resemble conditions of past servitude and plantation work (e.g., violence, abuse, harmful exposures, difficult labor). Because social-based discrimination may restrict necessary resources for CNA workers and negatively affect their ability to perform assigned duties efficiently, acts of social-based discrimination that CNAs experience may be a primary determinant of poor resident care delivery and subsequent poor health outcomes.

In a climate where several government entities have prioritized achieving health equity for all and creating a more diverse workforce (2014 National Healthcare Quality and Disparities Report, 2015; Department of Health and Human Services, 2015; HealthyPeople.gov), it is necessary to acknowledge social-based discrimination in institutionalized settings and consider it thoroughly in order to address recurrent and future issues related to inequities experienced by CNAs and, subsequently, older adults. Furthermore, it is critical that those responsible for developing and implementing healthcare reform, policies, and strategies consider social-based discrimination and the existence of a “discriminative healthcare system” as plausible causes of health disparities that are pervasive in nursing homes. This integrative review thus explores different forms of social-based discrimination in nursing homes to facilitate a deeper understanding of what social-based discrimination in this setting looks like and the many ways CNAs may be affected by social-based discrimination in poor working conditions.

Critical Social Theory

Social-based discrimination experienced by nursing home CNAs is explored in this review through the lens of CST. Drawing on perspectives from CST, this paper presents plausible explanations for the relationship between social differences among CNAs and their subsequent treatment through an integrative review of the literature. It further highlights how

CST can advance nursing science towards progressive emancipatory objectives related to CNA treatment in nursing homes. These issues are examined through social order (race, immigration, gender), power, and culture. Specific attention is placed on empirical data along with experiential encounters provided by CNAs and other workers who describe the CNA work environment in the nursing home setting.

Search Strategy

The Medline database was searched in July 2017. Criteria for article selection included: (a) studies conducted in the United States and Canada and (b) a focus on examining CNA discrimination in the nursing home setting. The search yielded 390 articles; MESH search terms included oppression, power, racism, discrimination, culture, diversity, feminism, social class, prejudice, certified nursing assistant, and nurse aide. Articles were excluded, first, by a review of the title and, second, if the studies were based on resident outcomes, were a resident intervention, did not include CNAs, or did not take place in the United States or Canada after abstract or full text review. Additional articles were added after a review of reference lists within the articles. The predetermined themes that were explored included social order (race, immigration status, gender), power, and culture.

Results

Consistent with current frameworks detailing racism, oppression, and marginalization, social-based discrimination towards CNAs in nursing homes was reflected in material conditions and variant access to power. Moreover, it related to acts of prejudice and discrimination, in which assumptions or actions were made based on one's social status. Twenty articles between the years 1995 and 2017 were found to reflect these issues (Table 1). Each of the themes, social order (race, immigration status, gender), power, and culture are discussed separately in the following sections.

Race

Race was a dominant factor in explaining social-based discrimination towards CNAs. When asked about experiences of racism in the nursing home, 56% of CNA respondents had experienced racism from nursing home residents, 23% from family members of residents, and 40% from fellow staff (Berdes & Eckert, 2001). Moreover, biases and assumptions held by nursing home residents, family members, and staff translated into poor treatment of CNA staff members from racial/ethnic minority backgrounds. CNAs were often victims of racial epithets delivered by residents and/or their family members (Berdes & Eckert, 2001; Ramirez, Teresi, & Holmes, 2006; Ryosho, 2011). Words such as “coon” and “jigs” and messages from residents such as “[I] don't want that nigger touching me” have become part of everyday work life for many CNAs (Berdes & Eckert, 2001; Mercer, Heacock, & Beck, 1994). Residents even went as far as referring to CNAs as “colored servants” who are “uppity” and “insolent” (Berdes & Eckert, 2001), further emphasizing the role history, entitlement, and superiority may play in the behavior of White residents towards CNAs of minority backgrounds (Allen & Cherry, 2006).

Unfortunately, CNAs commonly attribute these acts of discrimination to the residents' health state or the times in which they were born if they feel as if the resident is unaware of what they are saying (Ryosho, 2011). Various studies found that CNAs typically ignored these behaviors, even though nearly a third of CNAs in Berdes and Eckert's (2001) study asserted that racism in the nursing home was worse than racism outside of the nursing home. As a result, CNAs who internalized these experiences could also reach the conclusion that they have no voice in the nursing home setting because of their racial and/or social position (Holmberg et al., 2013; Jakobsen & Sorlie, 2010; Jervis, 2002; Mercer et al., 1994; Ryosho, 2011; Travers, 2015).

Families and residents have additionally been known to refuse resident care from CNAs who are racially and ethnically diverse and limit communication with minority and foreign-born CNAs (Berdes & Eckert, 2001). Berdes and Eckert (2001) described this action through qualitative analyses as families ignoring minority CNAs (the majority of which were African-American and Caribbean) as if they had not seen them until they actually needed something from them. Regarding their own expectations, the CNAs felt that the families of the residents held varying expectations of minority staff (staff of color) and White staff. Families went to minority staff for menial tasks, but requested status reports and problem solving from White staff (Berdes & Eckert, 2001). By contrast, however, Abrahamson and colleagues (2011) and Ryosho (2011) found that race did not directly predict either conflict with family members or poor treatment from family members for nursing assistants who cared for a predominantly White resident population (Abrahamson, Pillemer, Sechrist, & Sutor, 2011; Ryosho, 2011).

Reports of other staff members perpetuating a racially abusive environment were provided in the reviewed studies. Acts of racial discrimination along with negative comments and attitudes from staff members were specific to the racial/ethnic minority CNA experience (Berdes & Eckert, 2001; Jervis, 2002; Parker & Geron, 2007). While administrators have acknowledged being aware of these racial occurrences by residents, families, and staff members, they have either chosen not to support CNAs or simply lacked the competence to address the occurrence (Dodson & Zincavage, 2007; Foner, 1994; Holmberg et al., 2013). Such ignorance results in comments from supervisory staff such as "Well, that's what you get paid to deal with" (Parker & Geron, 2007). In turn, these weak efforts only lead CNAs to feel unsupported, stressed, and burned out (Holmberg et al., 2013). Moreover, staff who feel mistreated are more likely to miss work and/or not perform to their full potential at work, which in turn negatively affects resident care when turnover increases and staff burnout has the potential to culminate in resident abuse and/or neglect (Ejaz, Noelker, Menne, & Bagaka's, 2008; Holmberg et al., 2013).

Feelings of being treated as "nothing" and receiving differential negative treatment based on race were expressed by CNAs. As one CNA stated in a mixed-methods study reporting on race in long-term care facilities, "If White CNAs work on the unit, it's supposed to be like four [CNAs per unit] but they put five [CNAs on the unit, thus reducing the workload] because it's White people. If you Black, they'll put three. They don't care about you" (Dodson & Zincavage, 2007).

Immigration Status (Immigrants/Foreign-born Workers)

Given the low appeal of the CNA role by direct care workers, immigrants and foreign-born workers from the Philippines, Haiti, Latin America, Africa, and the Caribbean have been specifically recruited to fill the large gaps in this workforce (Acker, Pletz, Katz, & Hagopian, 2015; Khatutsky, Wiener, & Anderson, 2010; Leutz, 2007; O'Shea, Bourgeault, Spenser & Martin, 2011). Despite being an important resource for the nursing home workforce, however, those of immigrant status have been found to experience worse discrimination in the form of racism, compared to those who are racial/ethnic minorities born in America (Berdes & Eckert, 2001; Khatutsky et al., 2010; Priester & Reinardy, 2003). Analyzing data from the National Nursing Assistant Survey, Khatutsky and colleagues (2010) found that immigrant CNAs were nearly three times more likely than non-immigrants to report being discriminated against at work due to race or ethnicity (17.4% and 6.0%, respectively).

Common challenges that immigrants and foreign-born workers face include language-related communication barriers, difficulties in adapting to a new culture, and job insecurity (Novek, 2013; Ryosho, 2011). Opportunities to improve language skills, acculturate, and remain in a position with high stability such as the CNA role have attracted immigrants and foreign-born workers to these positions (Novek, 2013). However, differences in language have also opened the CNA to increased discrimination. For example, Acker and colleagues (2015b) found that one administrator reported problems with communication between the CNA and a resident which led to "abuse allegations [requiring] the facility to suspend [the employee], pending investigations." The administrator described these allegations as a misinterpretation of body language and the resident's belief that the CNA did not understand him/her (Acker et al., 2015). In this same study, among facilities whose administrators reported communication issues attributable to cultural and/or religious differences, 68% offered some form of education training, with 83% offering English language training.

Tension between immigrant CNAs and non-immigrant CNAs has also been reported and suggested to be racism (Berdes & Eckert, 2001; Ryosho, 2011). One CNA in a study by Berdes and Eckert (2001) noted in particular, "Even my own co-workers, they're Black too, but I think it's racism, when they tell you 'Why do you come to my country, go back where you come from?'" As the proportion of foreign-born workers increased in a facility, the authors found that administrators were more likely to report such issues with their employees. In general, however, immigrant CNAs were found to be better educated than non-immigrants and worked in facilities that had a 4- or 5-star rating (Acker et al., 2015; Khatutsky et al., 2010).

Gender

Regarding gender, immigration status was found to intersect with gender roles, further amplifying the occurrence of discrimination. For example, Acker and colleagues (2015b) found that "male African employees did not like having female supervisors" and tension was apparent when "Filipino male versus female issues [arose] (Acker et al., 2015)." Exploring the intersection of gender, race, ethnicity, and class, Ryosho (2011) additionally discusses the many experiences of oppression faced by CNAs as a result of being a predominantly

female workforce. CNAs' perceived subordinate status as power and gender differences led them to feel powerless and hopeless to advocate for change in this qualitative study. Using a feministic approach, Ryosho recommends that CNAs work together towards achieving desired solutions.

Power

In the articles reviewed, power struggles were evident among CNAs, nurses, and administrators in the nursing home setting and influenced by race, ethnicity, immigration, and gender. A hierarchical system that equates to a "racial and social class" system in nursing homes has been proposed (Bullock & Waugh, 2004; Jervis, 2002). Registered nurses (RNs) and licensed practical nurses (LPNs) customarily have administrative duties in nursing homes (e.g., paperwork review and completion) or are focused on carrying out resident assessments and/or medication administration. By contrast, CNAs provide the majority of direct care to residents, including toileting, cleaning, feeding, and ambulating activities (Harris-Kojetin, 2013). In one study, Jervis (2002) found that 100% of the top-level RN staff were White, while LPNs and trained medication aides were a mix of White and Black, and CNAs were nearly all Black.

This chain of command broken up by race and class relegates CNAs to a subordinate position, creating tension between CNAs and other nursing staff. For example, researchers found that senior-level staff strongly emphasized the need for RNs and LPNs to "discipline" CNAs and enforce the rules of the nursing home (Lopez, 2006; Mercer et al., 1994). In these two studies, CNAs were described as not being permitted to engage in similar "leisures" as the RNs and LPNs; were frequently placed in compromising positions (e.g., low staffing and high resident load); and received insufficient training, supplies, and resources that essentially affected resident care (Mercer et al., 1994). In the qualitative study conducted by Mercer and colleagues (1994), one CNA described how a fellow CNA went to administration to discuss the need for more direct care workers to provide better care to their residents. The reality of discipline, power differentials, and restriction of voice quickly became apparent to this participant: given the expectation that CNAs did not have a voice and would experience consequences for challenging one's position or superiors, the fellow CNA was fired the next day.

To facilitate and improve resident care, supervisory staff routinely hold care discussions among key nursing home personnel. Although CNAs spend the majority of their time with the residents and supervisory staff admit that CNAs are most familiar about their care, CNAs are often not included in these discussions (Iowa Better Jobs Better Care Coalition, 2004). When surveyed, only 50% of administrators reported having the time to work with CNAs as a team, although three-quarters did believe it was important for CNAs to contribute their ideas to care plans (Iowa Better Jobs Better Care Coalition, 2004). Supervisory staff contrarily reported that CNAs did not have time to participate in these critical discussions (Dodson & Zincavage, 2007). Unfortunately, limited recognition of the key role played by these perceived low-ranking workers and their contributions to optimizing care delivery for nursing home residents may perpetuate poor resident care delivery and outcomes. When exploring how various roles of power can impact satisfaction, Mullins et al. (1988) found an

increase in rewards, decrease in coercive power, and increase in motivation to be significantly correlated with satisfaction among non-supervisory personnel (Mullins, Nelson, Busciglio, & Weiner, 1988).

Culture

Culture was referred to as both the level of cultural competency maintained by the facility and the facility's organizational culture. Using Cross's (1989) definition, cultural competency is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations (Cross, 1989)." Moreover, cultural competence is considered critical in order to meet the needs of a diverse workforce and patient population. A qualitative study by Parker and Geron (2007), describing a research and intervention project to enhance the cultural competence of a nursing home staff, revealed five cultural competency concerns: (a) uneven staff awareness of cultural differences among residents; (b) challenges in both verbal and nonverbal communication; (c) minimization/generalization of recognized differences; (d) overtly discriminatory actions/comments; and (e) inadequate organizational response to discriminatory actions/comments (Parker & Geron, 2007). When predominantly non-White foreign-born nursing assistants in a study by Allensworth-Davies and colleagues (2007) perceived higher organizational cultural competence ($p = .0005$) and employee autonomy ($p = .001$) within the nursing home, job satisfaction increased. A comfortable work environment for employees of different races/cultures additionally emerged as the strongest organizational cultural competency factor ($p = .04$) in this study (Allensworth-Davies et al., 2007).

Barriers to changing organizational culture were described by Scalzi, Evans, Barstow, and Hostvedt (2006) and included exclusion of front-line workers from culture-change activities, perceived corporate emphasis on regulatory compliance and the "bottom line," and high turnover of administrators and caregivers. Enablers included a critical mass of "change champions," shared values and goals, resident/family participation, and empowerment at the facility level (Scalzi, Evans, Barstow, & Hostvedt, 2006).

Discussion

Meeting the demands of a rapidly aging frail population in the United States has become paramount to the growing long-term care needs of our society (Hagen, 2013; Kwak & Polivka, 2014). Meeting this care demand requires advocating for the sufficient delivery of long-term care services by nursing home staff. Sufficient delivery of long-term care services can be operationalized as care provided by staff who are knowledgeable, quality driven, and adequately resourced working in a viable operating environment (American Health Care Association, 2006). Unfortunately, the prevailing environment routinely subjects those providing direct care to older adults to discrimination because of their defined social order (race, immigration status, and gender), position of power, and cultural affiliation—constructs of inquiry guided by our CST perspective. As a result, not only is our vital workforce being harmed by such treatment, but also the residents for whom they care for.

As determined by this review of 20 articles, CNAs were discriminated against by residents, families, colleagues, and staff because of their race/ethnicity, place of birth, manner in which they spoke, and the nature of the work they performed. American history has a legacy of such inappropriate behaviors towards vulnerable groups through the experiences of servitude and slavery. Today, unfortunately, a historically-rooted ideology of social-based discrimination continues to ignore the importance of a diverse workforce, particularly CNAs, their contributions to older adult care; and instead, penalizes them for their unique contributions. This workforce is not appreciated for their work, regarded for their capabilities, and leveraged for their unique input in resident care. Nurse professionals themselves have viewed the expansion of the CNA role as an encroachment on their own profession—despite the record number of older adults requiring various levels of long-term care, with very few qualified professionals available to provide this care (Porter, 2017). Adequate resources, education, training, and support to CNAs is also lacking (Castle, Engberg, Anderson, & Men, 2007; Stone & Dawson, 2008). When turnover is at an all-time high, the need for CNAs is abundant, and it will only escalate in the coming years, given the expected demographic shift toward greater numbers of older adults in need of such care, making it critical to focus on better treatment and attention towards CNAs (Castle et al., 2007; Stone & Dawson, 2008). Redefining their roles, recognizing and emphasizing their value, amplifying their voices, and respecting their position are all imperatives.

A common thread in the stigmatization and devaluation of the work of CNAs is evident, as are other types of work that are assumed primarily by racial/ethnic minorities, immigrants, and a perceived lower class (e.g., housekeeping and environmental services work). Workload is high, pay is poor, benefits are limited, insurance is costly, and respect by others is minimal (Iowa Better Jobs Better Care Coalition, 2004; Probst, Baek, & Laditka, 2009). Increased stress and workload common to socially diverse direct care workers affect care delivery to residents and prompt an increased number of CNAs to leave the field (Centers for Disease Control and Prevention, 2008). The most commonly cited reason by the National Center for Health Statistics for why CNAs left their job was poor pay (37.2%); the third most common reason was problem with the facility or poor working conditions (15.6%) (Centers for Disease Control and Prevention, 2008). This high turnover among direct care workers has been reported to be as much as 400%; leading to constant issues with short staffing and does not allow for person-centered care prioritized by several national entities (Dodson & Zencavage, 2007; Rakovski & Price-Glynn, 2010). Moreover, residents experience adverse effects, both physically and emotionally from interruptions in care, inexperienced temporary workers, and low dedication of care staff (Castle & Engberg, 2005).

Medicaid and its low payments is one conceivable explanation for this differential access to sufficient staffing and other resources that further inhibit CNAs from providing optimal resident care (Fennell, Feng, Clark, & Mor, 2010). Reimbursement from Medicaid is controlled by individual states and, on average, nursing homes lose \$22 per Medicaid-paying resident per day to cover the actual cost of delivering resident care (Pruitt Jr, 2013). This shortfall only reflects allowable costs from Medicaid and not operating costs, thus resulting in an even greater loss. In order for nursing homes to survive financially, facilities must control the case-mix of residents and limit the number of admitted Medicaid residents (Meyer, 2001; Mor, Zinn, Angelelli, Teno, & Miller, 2004). By contrast, nursing homes that

freely open their doors to Medicaid residents struggle to obtain adequate resources for sufficient care to their residents. This lower Medicaid reimbursement is subsequently associated with lower staffing and poor resident outcomes (Grabowski, 2001; Grabowski, Angelelli, & Mor, 2004).

In for-profit institutions, CNAs are also working in understaffed conditions. These institutions are driven by both profit and stakeholders, some of whom fail to prioritize staffing (Aaronson, Zinn, & Rosko, 1994). The CNA's work, contrarily, is seen as best performed by racial/ethnic minorities and immigrants who, stakeholders feel, can withstand the heavier labor requirements and are naturally caring; characteristics discussed as being inherent to their culture (Acker et al., 2015; Duffy, 2007). While this review did additionally reveal resident reports of better quality of care from CNAs who were immigrants, this stated reality does not eliminate the need to provide CNAs with adequate resources and optimal conditions that include sufficient staffing numbers (Acker et al., 2015). Moreover, in a qualitative study by Dodson and Zincavage (2007), the majority of CNAs interviewed earned between \$9 and \$14 per hour, which they said was not enough to cover monthly bills. The Bureau of Labor Statistics reports the 2016 average wage for CNAs work in nursing care facilities to be \$12.79 (Bureau of Labor Statistics, 2016). To cover basic expenses, CNAs typically have to work additional shifts and/or jobs, despite the increased risk of injury in the CNA occupation when working long-hours and when fatigued (Dodson & Zincavage, 2007; Mercer et al., 1994).

While many articles in this review are dated from the 1990s and early 2000s, several published in the past 10 years discussed similar issues CNAs are facing. As such, the provision of quality of care in nursing homes requires an overhaul of the current long-term system and how CNAs are viewed and treated. CNAs are an untapped population in terms of what they can contribute but are not yet contributing to reach their full potential. CST suggests the processes of enlightenment, empowerment, and emancipation to overcome the domination and oppression experienced by working class groups such as CNAs (Browne, 2000; Manias & Street, 2000). Enlightenment refers to awareness of the oppression which this review has begun to execute. Awareness also entails a practice of critical self-reflection. The practice of critical reflection is often aided through a process of sharing experiences with others, which often leads to recognizing commonalities in experiences rooted in structural inequalities rather than the personal. Most importantly, culture change in response to awareness must be viewed as a critical conscious effort with one first examining their own cultural background to then understand their biases and assumptions towards other cultures (Pitner & Sakamoto, 2005). Within a framework of understanding the process of developing critical consciousness there are several components at play. Firstly, one must acknowledge one's social identity and their role within that identity (i.e., agent vs. target or privileged vs. oppressed), and how it might lead to selective and biased information processing. Next, awareness of social locations and recognizing how our worldviews influence our acknowledgement of diversity and difference is key. Empowerment relates to motivation to work toward change, especially in groups, and motivating others to work towards improving their situation. Emancipation involves people being able to overcome social-based discrimination, both the internalized sense of power/lack of power and taking actions to more fully contribute to the benefit of all (Fay, 1987).

Recommendations

Without policy changes directed at improving the work environment for CNAs, the long-term health care workforce will lack the capacity (in both size and ability) to meet the growing needs of nursing home residents in the future (Committee on the Future Health Care Workforce for Older Americans, Institute of Medicine [IOM], 2008). Significant improvements are needed in how we view the work of CNAs, how we treat the CNA workforce, and how we meaningfully engage CNAs in resident care long-term. Updated research is additionally necessary to identify best strategies that improve the nursing home workplace for CNAs. The voices of CNAs must be used to inform future research and policy recommendations. Below are evidence-based recommendations on how we might begin to transform the complex CNA work environment and, inevitably, long-term care delivery. These recommendations are embedded in the CST processes of enlightenment, empowerment, and emancipation.

Education, Cultural Competency, and Training

Presently in the 21st century, providing education on equal treatment for all remains a critical obligation of nursing homes. Because these efforts tend to fail when not instituted properly, education and training initiatives on issues of social-based discrimination must start with those serving in senior-level positions and flow throughout the ranks. An environment of diversity and inclusion must be cultivated with policies that support zero tolerance for acts of racism and other forms of social-based discrimination (Badger, Clarke, Pumphrey, & Clifford, 2012; Ramirez et al., 2006). Highly important, as Ryosho (2011) indicated, CNAs need to work together to voice their needs and find solutions for the future.

While techniques are not specific, the cultural competency of a facility should work towards cultural humility by forming on-going discussion groups among CNAs and across staff. In addition, staff must be educated on what discriminative behavior entails, how to report it when it takes place, and how to be sensitive to one's differences (Priester & Reinardy, 2003). Moreover, facilities should empower staff to support each other and seek support, introduce intercultural workshops to understand differences, allow staff to share parts of their culture through methods such as food and music, provide communication and language resources to staff from all cultural backgrounds, and develop relevant teaching and training tools (Allensworth-Davies et al., 2007; Eriksson & Fagerberg, 2008). Processes need to be put in place so when issues of social-based discrimination are identified by staff, they are taken seriously and handled appropriately by administration.

Comprehensive training for CNAs coordinated by the nursing home facility is also warranted (Sloane, Williams, & Zimmerman, 2010). This group is responsible for providing care to residents with wide-ranging ailments, but they lack the tools and skills to provide this care efficiently (Travers, 2015). Offering individualized training for CNAs beyond the required 75 hours and allowing them more opportunities to become involved in learning essential skills such as the English language are important as well (Badger et al., 2012). Based on Federal regulations, nine tasks have been identified as allowable for CNAs and include: "(1) personal care skills, (2) safety/emergency procedures, (3) basic nursing skills, (4) infection control, (5) communication and interpersonal skills, (6) care of cognitively

impaired residents, (7) basic restorative care, (8) mental health and social service needs, and (9) residents' rights (McMullen et al., 2015).” While these tasks are critical to the care of nursing home residents and mark the basic level of care that all CNAs should be providing, these responsibilities of the CNA are not presented nor regarded as such. Instead the responsibilities of CNAs are downplayed and CNAs are not positioned effectively to provide this comprehensive care. As CNAs request additional training to carry out their work responsibilities with greater success, a concerted response from administration is necessary to address these needs. CNAs would be equipped with more tools placing them in alignment with future goals of expanding scope of practice for CNAs and authorized duties, subsequently improving resident care (McMullen et al., 2015). Moreover, high job satisfaction has been associated with acquiring new skills along with work-life skills and receiving organizational support for caring labor (Han et al., 2014; Rowden & Conine Jr, 2005). CNAs should be included in resident care planning thus recognizing their contributions and value.

Advancement and Incentives

Treating CNAs as if they are low-class citizens is not viable when considering the field's high rates of turnover, low staffing, and poor morale (Rakovski & Price-Glynn, 2010). The care that CNAs provide is critical to improved resident outcomes and this concept should resonate with residents, family members, staff, and administration. CNAs should be motivated, made to feel they are important, and receive incentives (including adequate compensation) and advances in their position with time and good performance (Gordon, 1982; Paraprofessional Healthcare Institute, 2016). A 40-year meta-analysis conducted by Cerasoli, Nicklin, and Ford (2014) found that both intrinsic motivation and extrinsic incentives jointly predicted performance related to quality and quantity (Cerasoli, Nicklin, & Ford, 2014). Clinical ladder choices for CNAs were also found to reduce turnover and improve wages for CNAs (Dumas, 2009). This model has become known as the Extended Care Career Ladder Initiative (ECCLI), in which more than 170 long-term care employers have implemented career ladder programs, resulting in new skills, opportunities for advancement, and increased wages for more than 7,500 workers since 2001. Other benefits have included improved communication, teamwork, and mutual respect among frontline staff, nurses, clients, and family. Another example of how the CNA role is currently being elevated is through professional organizational efforts that equip CNAs with education, new skills, and additional training that empower them and provide a platform of support (NAHCA, n.d.; “National Network of Career Nursing Assistants,” n.d.).

Nursing Home Resources

Regarding resident care and outcomes, it is important to focus on underfunded nursing homes that are known for their poor quality and insufficient resources and, subsequently, serve a high number of racial/ethnic minorities. Traditionally, these institutions have been high Medicaid-serving facilities, for-profits, and nursing homes with a large concentration of Black residents (> 50%) and/or located in highly segregated residential areas (Grabowski et al., 2004; Gruneir, Miller, Feng, Intrator, & Mor, 2008; Howard et al., 2002; Mor et al., 2004; Travers, 2017). State policies related to Medicaid reimbursement have been shown to

improve resident outcomes (Mor et al., 2011). Understanding the needs of these facilities and how best to support them is additionally necessary for optimizing resident care delivery.

Conclusions

Social-based discrimination is embedded in the nursing home environment and influences inequitable treatment of direct care staff, specifically CNAs. Using perspectives from CST, this review shed light on the social order, power, and cultural forms of social-based discrimination pervasive in the nursing home. Recommendations were provided that may improve the CNAs' work environment. Acknowledging the existence of discrimination in nursing homes is the first and most important "next step" to creating solutions to severe disparity problems.

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Table 1.

List of Articles Reviewed and their Association with Critical Social Theory

Author, year, title	Construct of Critical Social Theory addressed
Abrahamson et al., 2011 Does race influence conflict between nursing home staff and family members of residents?	Race
Acker et al., 2015 Foreign-Born care givers in Washington State nursing homes characteristics, associations with quality of care, and views of administrators	Immigration status
Allen et al., 2006 Race relations in the nursing home setting	Race
Allensworth-Davies et al., 2007 Country of origin and race-ethnicity: Are there differences in perceived organizational cultural competency and job satisfaction among nursing assistants in long-term care?	Race, immigration status
Berdes et al., 2001 Race relations and caregiving relationships: A qualitative examination of perspectives from residents and nurse's aides in three nursing homes	Race
Dodson et al., 2007 "It's like a family" caring labor, exploitation, and race in nursing homes	Race
Duffy et al., 2005 Reproducing labor inequalities: Challenges for feminists conceptualizing care at the intersections of gender, race, and class	Race, gender
Duffy et al., 2007 Doing the dirty work gender, race, and reproductive labor in historical perspective	Race, gender
Jervis, 2002 Working in and around the 'chain of command': Power relations among nursing staff in an urban nursing home	Power
Khatutsky et al., 2010 Immigrant and non-immigrant certified nursing assistants in nursing homes: How do they differ?	Immigration status
Leutz, 2007 Immigration and the elderly: Foreign-born workers in long-term care	Immigration status
Mercer et al., 1994 Nurse's aides in nursing homes: Perceptions of training, work loads, racism, and abuse issues	Race
Mullins et al., 1998 Job satisfaction among nursing home personnel: The impact of organizational structure and supervisory power	Power
Novek, 2013 Filipino health care aides and the nursing home labour market in Winnipeg	Immigration status
Parker et al., 2007 Cultural competence in nursing homes	Culture
Priester et al., 2003 Recruiting immigrants for long-term care nursing positions	Immigration status
Ramirez et al., 2003	Culture

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Author, year, title	Construct of Critical Social Theory addressed
Demoralization and attitudes toward residents among certified nurse assistants in relation to job stressors and work resources: Cultural diversity in long term care	
Ryosho, 2011 Experiences of racism by female minority and immigrant nursing assistants	Race
Scalzi et al., 2006 Barriers and enablers to changing organizational culture in nursing homes	Culture
Sloane et al., 2010 Immigrant status and intention to leave of nursing assistants in US nursing homes	Immigration status