A STUDY ON THE NATURE OF INTERACTIONS BETWEEN DIRECT-CARE STAFF AND PERSONS WITH DEVELOPMENTAL DISABILITIES IN INSTITUTIONAL CARE

Jenny Sau-lai Chan and Matthew Kwai-sang Yau

Introduction

As a result of the deinstitutionalisation movement in the past quarter of the century, many institutionalised residents with developmental disabilities in the United Kingdom and the United States have been transferred to community-based care settings. Despite the fact that institutional care has detrimental effects on the development of the language and communication abilities of people with developmental disabilities (Butterfield, 1967; Tizard et al., 1972), residents with high dependence and severe disabilities are unlikely to be transferred to community care (Farmer et al., 1993). The multitude of their problems dictates that long-term institutional care becomes the major service for this group of residents with complicated needs. The institutions often employ a large number of direct-care staff to carry out day-to-day care. Although these direct-care staff are typically the lowest paid and least professionally trained, they not only comprise the major workforce in the hospital but also become an important component of the immediate social environment for the residents (Hile and Walbran, 1991).

Over the last few decades, numerous studies have focused on the therapeutic value of interaction between staff and institutionalised residents with developmental disabilities. Dailey and his colleagues (Dailey et al., 1974) postulated that caring staff are an invaluable resource in making positive impacts on the institutional life of residents. Lau and Mackenzie (1996) suggested that the social stimulation provided by the staff available in the resident’s immediate environment could alleviate the resident’s sense of boredom. In addition, for those with limited communication skills, a functional

Jenny Sau-lai Chan, B.H.Sc., M.Sc., RMN.
Registered Nurse, Tuen Mun Hospital, Hong Kong.

*Matthew Kwai-sang Yau, B.App.Sc., M.Com., M.Sc.(Hons), Ph.D., O.T.R.
Assistant Professor, Department of Rehabilitation Sciences, The Hong Kong Polytechnic University, Hung Hom, Hong Kong.
Tel: +852 2766 6751 Fax: +852 2764 1435 E-mail: rsmyau@polyu.edu.hk

* For Correspondence
interpersonal relationship between staff and residents facilitates the obtaining of accurate and comprehensive information that benefits the ongoing formulation or evaluation of care plans (Kagan, 1990). Cullen et al. (1983) suggested that the quality of staff-resident interaction was important because the staff’s response to a resident’s behaviour may determine the resident’s future behaviour. Tizard and his colleagues (Tizard et al., 1972) also showed that the use of informative speech by the staff was a good predictor of the language comprehension abilities of the children in their care.

Research findings showed that the opportunities for social interactions of people with developmental disabilities and their degree of satisfaction with their lives were central to their sense of personal identity and their feeling that they belong somewhere (Jahoda et al., 1990). In addition, Thomas et al. (1982) pointed out that activities in an institution were important for residents to develop new and useful behaviour, especially during ‘free time’ because this was the time that could provide opportunities for practising learned skills from classroom teaching in daily living.

Furthermore, there have also been many studies looking into the frequency and the nature of staff-resident interactions in institutional settings. In a review of the observational studies, Repp et al. (1987) found that the staff-resident interaction rates were low across different residential settings, despite the increase in the staff-resident ratio. When interaction did occur, it was brief in duration (Moorse and Grant, 1976) and largely controlling in nature (Alaszewski, 1986). Jones (1975) also reported that different forms of control that were sought to maintain a smooth running of hospital routines shaped the interactions between staff and residents.

Kuder and Bryen (1993) found that more staff-resident interactions occurred in a structured environment, such as the classroom, than in an unstructured environment. Dailey and his colleagues (Dailey et al., 1974) also discovered similar results. They found that only a few of the staff-resident interactions occurred in the free time of the ward. Thus, findings of the previous observational studies suggested that staff-resident interaction rates were low. Veit et al. (1976) found that the direct-care staff were four times more likely to direct a command, request, or question to residents than to use a conversational declarative statement when they communicated with residents in institutional settings.

In addition, the characteristics of residents, such as their communication ability, affected the interaction process between direct-care staff and residents (Duker et al., 1989). Duker and his colleagues (Duker et al., 1989) studied the effects of different physical characteristics of residents on the staff’s interactive behaviour. They noticed that residents perpetually found in a lying position correlated positively with a high amount of custodial care such as feeding, washing, dressing and nappy changing. Staff also tended to approach this group of residents with neutral affect. Whereas, residents having a walking-standing position correlated positively with recreational and training activities; those residents who were alert were reported to have received more training and recreational activities but less custodial care than those residents who always fell asleep. Therefore, Duker et al. (1989) concluded that a resident’s mobility and alertness were the important determinants of staff-resident interaction.

Since few observational studies have been conducted in institutions for people with developmental disabilities in Hong
Kong, little is known about the features of the staff-resident interactions in these institutions. The objectives of this study were three-fold: 1) to observe and describe the frequency and the nature of staff-resident interactions in an institutional setting; 2) to explore the working experiences and perceptions of selected health care assistants (HCAs) about staff-resident interactions; and 3) to describe factors that have an influence on staff-resident interactions.

**Methodology**

Staff-resident interaction is a complex issue, which is subject to the interplay of a number of factors, involving the residents, the direct-care staff and the managerial practice in an institution. In order to achieve an in-depth understanding, the study, which was commenced in 1998, comprised a systematic observational method to collect data of staff-resident interaction patterns and semi-structured interviews of selected HCAs to collect their perspectives on staff-resident interactions. All observations were completed by the end of April after approval had been sought in February 1998. The interviews with HCAs were finished in September 1998.

The ‘Interaction Recording System’ (IRS) developed by Veit (1973, unpublished Master’s thesis) was used for a series of direct and systematic observations in wards to obtain the data on the staff-resident interactions. A staff-resident interaction was operationally defined as any behavioural episode involving an interchange between the resident and the direct-care staff member under observation (Veit, 1973). It was then followed by in-depth interviews of selected HCAs which focussed on their perspectives on work experiences and interactions with residents. The interviews were aimed at enhancing the understanding of the findings from the observations.

The IRS adopts a time-sampling technique to capture any staff-resident interaction which occurs in the first five seconds and records the data over the next ten seconds. In case there is a continuous interaction that lasts for more than 15 seconds, that interaction will also be recorded in the subsequent observation intervals until it is finished. Hence, a one-minute observation can yield four 15-second intervals. In addition, the IRS has four 12-minute observation blocks in an hour. This implies that the IRS can produce 192 observation intervals (4 X 48) in an hour’s observation session.

The IRS is a validated observation tool and has been used in different institutional settings for children with developmental disabilities, such as in a training school, a hospital, and a staffed hostel (Dailey et al., 1974; Harris et al., 1974; Veit et al., 1976). In addition, the IRS is suitable for observing residents with limited communication or vocal skills because no speech content between the target staff member and resident is recorded.

**The Institution**

The institution in the study has a capacity of 300 beds. It caters for adults, aged 16 or above, with severe developmental disabilities. It aimed to provide rehabilitation and infirmary service for people with developmental disabilities who lacked basic self-care skills and required intensive care and training. The institution comprised six wards and one training unit. One of the six wards
was specifically for residents with challenging behaviours. The training unit aimed at providing self-care and social skills training and recreational activities to the residents with higher functional skills. Though the aims of infirmary service were focused on care and protection, other paramedical services, like physiotherapy, occupational therapy, services providing prosthesis and orthotic, dental service, and so on were also available to maintain health and promote quality of life within the institution. As the authors could not obtain approval to access residents’ records, detailed information on the residents in wards was not available. However, according to a report prepared by the institution (Lim, 1992), the majority of the residents had more than one disability, including speech defects and physical disability (TABLE I).

Generally, for ease of management and provision of care from the staff, residents were classified into ‘big boys’ and ‘little boys’ on the basis of the levels of dependence. ‘Big boys’ were those residents with low dependence and good mobility while ‘little boys’ were those residents with high dependence and mostly bedridden or chair-bound. These two groups had different care management plans; for instance, ‘big boys’ would be scheduled for toileting, whereas ‘little boys’ would have diapers changed. Apart from professional staff, direct care staff constituted two-thirds of the total frontline workforce and were predominantly female. They included both the ward attendants (WAs), who had been in the system for a longer time, and the health care assistants (HCAs), a recently created job title. Professional staff usually took up a supervisory role while direct-care staff performed most of the basic physical care of residents. Every ward had a similar schedule of daily routine.

The qualification requirements for HCA included Form 3 or equivalent of secondary school education, ability to read and write Chinese and English, and ability to speak Cantonese and simple English. However, qualification exemption was offered to the existing WAs who wanted to be ‘promoted’ to a HCA position.

Before receiving the job title, HCA candidates were required to undergo a four-week training course on caring for people with developmental disabilities, which was entirely prepared and conducted by nursing staff of the institution under study. All qualified HCAs were required to take up special duties, like taking vital signs, i.e. resident’s body temperature, pulse and blood pressure and applying ointment when requested. In addition, HCAs were requested to perform the same duties as the WAs. Both HCAs and WAs performed most of the personal care tasks, such as bathing, toileting, dressing, and so on.

### TABLE I

<table>
<thead>
<tr>
<th>Disabilities</th>
<th>Percentage of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech defects</td>
<td>85%</td>
</tr>
<tr>
<td>Severely physically handicapped</td>
<td>50%</td>
</tr>
<tr>
<td>Epilepsy and psychiatric problems</td>
<td>50%</td>
</tr>
<tr>
<td>Bed-ridden or chair-bound</td>
<td>50%</td>
</tr>
</tbody>
</table>
**Procedure**

In the first phase of the study, the ward for residents with challenging behaviours was excluded from the study because of the atypical staff-resident interaction patterns caused by the residents' behaviours. Another ward was excluded as it had already been involved in an earlier pilot study to investigate the inter-rater reliability of the observation instrument. Hence the remaining four wards were chosen. When selecting subjects for observation and interviews, a convenient sampling technique was used. For instance, HCAs who were on duty during observational sessions were invited to be participants in the study. Once they gave their consent, they were observed according to the time schedule during the entire work shift. However, HCAs who were assigned for special cleaning or kitchen posts were excluded from observation because they were frequently occupied by domestic tasks that involved no residents. The sample of the interviewees was recruited from the observed HCAs.

The observation timetable included both structured and unstructured situations so that the typical patterns of staff-resident interaction could be obtained, with the exception of bathing time. The observations were conducted in each ward during the period of 9:30 am to 8 pm. During the observations, the observers took a position that provided a clear view of the target staff from a distance but created no disturbance to the subjects under observation. Moreover, the observers allocated the same time span for each observed HCA during a shift. For instance, if there was a two-hour observational session and four HCAs working in a shift, each HCA would be observed for a total half-hour. Each observation interval was kept to a 15-minute basis and rotated among the participants to ensure that the whole observation time span of each HCA was not continuously conducted to avoid misrepresentation of the individual's interaction patterns, especially when the observational session stretched over both structured and unstructured times.

**Data Analysis**

The interaction rate of an individual HCA was calculated by the percentage of the total frequency of staff-resident interactions observed over the total observations, in accordance with the following formula as described by Veit (1973):

\[
\text{Interaction Rate} = \frac{\text{Number of intervals having staff-resident interaction}}{\text{Total number of intervals being observed}} \times 100\%
\]

Staff-resident interaction refers to any contact between an HCA and a resident occurring during the observation interval. Although Veit (1973) did not explicitly define the non-occurrence of staff-resident (S-R) interaction, an observation that recorded either no interaction or no contact between an HCA and a resident was regarded as non-staff-resident (non-S-R) interaction. By counting the frequency of the non-S-R interactions, the proportion of time that an HCA spent not interacting with residents could be determined. Regarding the activities conducted by the HCAs during non-S-R observations, five categories were identified (Blindert, 1975; Veit, 1973), which included “unknown” or “out-of-sight”, non-interactive observation, interaction with other staff, ward
cleaning tasks and self-indulgent activities (e.g. idling or watching television).

Results

The study was carried out in the four wards, namely A, B, C and D. Each ward was observed for 12 hours, constituting 2304 observation intervals. Thirty HCAs were observed, i.e. 60% of the HCA employees in the unit under study. Of those only seven HCAs accepted the invitation to take part in a face-to-face interview. The following are the results:

1. General findings

In total of the selected four wards, 30 HCAs were observed over 9216 observation intervals, accounting for the total of 48 hours of observation. The interaction rates of individual HCAs varied from 14.5% to 70.1%. From the total of 9216 observation intervals, staff-resident interactions were recorded in 3431 intervals (37.2%), while non-interactions were noted in 5785 intervals (62.8%). Further analysis showed that the S-R interaction rate was significantly lower than the non-S-R interaction rate ($\chi^2 = 601.27$, df = 1, $p< 0.00001$). The S-R interaction rates also varied among the four wards, i.e. 39.7% (Ward B), 38.9% (Ward D), 35.9% (Ward C) and 34.5% (Ward A). In addition, the observational data also showed that the occurrence of S-R interactions changed over the day and an increased frequency was particularly observed in two periods of the day, i.e. at the two mealtimes.

Despite that HCAs with a special cleaning duty and kitchen duty were excluded from observations, analysis showed that the observed HCAs had still to carry out a certain amount of ‘domestic tasks’ such as handling linen, cleaning and tidying activities. These activities were labelled ‘ward tasks’ and constituted the major category of non-S-R interaction, i.e.19.2%. The next most frequent category of non-S-R interactions was ‘out of sight’ or ‘unknown’ (18.5%), i.e. the observer could not locate the target HCA during observation. The remaining three types of non-S-R interactions, i.e. self-indulgent activities, staff-staff interaction, and non-interactive observations, comprised 25.1% of the total. Overall, the non-S-R interactions accounted for 62.8% of the total number of interactions recorded.

2. The Interaction recording System (IRS) findings

The IRS has six dimensions, which are mutually exclusive (Veit et al., 1976). They are the ‘initiator’, ‘mode of communication’, ‘mand/tact’, ‘affect’, ‘interaction context’ and ‘response’. The findings for each dimension were as follows: the findings of the ‘initiator’ dimension (the person who initiated the interaction) indicated that most interactions were initiated by HCAs (98%) and that residents initiated only two percent of interactions. The findings of the ‘affect’ dimension (the emotional state of the initiator) showed that most interactions were ‘neutral’ (82.8%), i.e. the initiators were expressionless during the interactions, for instance, when an HCA fed a resident without any emotional exchanges. However, 13.3% and 3.9% of interactions contained positive and negative affects, respectively. Consistent with the general findings, the majority of interactions occurred in the ‘nursing care’ context. However, 17% and 17.3% of the total number of interactions took place in the
‘ward activity’ and ‘social play’ contexts, respectively; the context in which the least number of interactions occurred was ‘formal training’. The S-R and non-S-R interactions are compared and shown in TABLE II.

Nursing activities encompassed direct physical care such as oral cleansing, toileting, changing nappies, serving meals and recording vital signs. Social play involved verbal and non-verbal communication without a request for the resident’s compliance. Ward activity mostly consisted of maintenance of ward order, such as arranging seats for residents and instructing residents to behave appropriately or to stop undesirable behaviour. Formal training comprised training in self-feeding and walking and crawling exercises. Of these four categories, the frequency of interactions occurring in the nursing care context was significantly higher than the frequency of those occurring in the other three contexts ($\chi^2 = 2340.02$, df = 3, $p<0.00001$); ‘formal training’ was the context in which the least number of interactions occurred.

Regarding the content of interactions, 66.1% of the total number of interactions were recorded as ‘mand’ (the initiator demanded the compliance of residents), while ‘tact’ constituted 33.9% (the initiator did not ask for the respondent’s compliance). With respect to the ‘mode of communication’, most of the interactions were in the form of ‘physical’ contact only (63.8%), whereas 19% of the total number of interactions involved a verbal exchange. Other modes of communication such as physical-verbal (physical contact and verbal exchange took place simultaneously) and gestures (non-verbal behaviour of the initiator that conveyed a certain message to the respondent) constituted 14.3% and 2.9% of the total number of interactions, respectively.

The responses were of three types, namely to comply (66.4%), resist (2.1%), or ignore (31.5%). The findings of the IRS are tabulated in TABLE III. It appeared that HCAs initiated most of the interactions with residents in an emotionless tone and often requested the compliance of residents. In return, most residents were able to comply with the HCAs’ requests. The major form of communication was by physical contact.

Furthermore, the relationship between the affect and context dimensions was explored and the results showed that they were significantly associated with each other (Pearson $\chi^2 = 1463.21$, df = 6, $p<0.000$).

### TABLE II

<table>
<thead>
<tr>
<th>Staff-Resident Interaction</th>
<th>N</th>
<th>%</th>
<th>Non-Staff-Resident Interaction</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care</td>
<td>2054</td>
<td>22.3</td>
<td>Ward cleaning tasks</td>
<td>1771</td>
<td>19.2</td>
</tr>
<tr>
<td>Social play</td>
<td>593</td>
<td>6.4</td>
<td>Out-of-sight</td>
<td>1701</td>
<td>18.5</td>
</tr>
<tr>
<td>Ward activity</td>
<td>582</td>
<td>6.3</td>
<td>Self-engaged activities</td>
<td>871</td>
<td>9.4</td>
</tr>
<tr>
<td>Formal training</td>
<td>202</td>
<td>2.2</td>
<td>Staff-Staff interaction</td>
<td>862</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-interactive observation</td>
<td>580</td>
<td>6.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3431</td>
<td>37.2</td>
<td>TOTAL</td>
<td>5785</td>
<td>62.8</td>
</tr>
</tbody>
</table>
To sum, the overall staff-resident interaction rate of the present study was 37.2%. Most of the interactions were initiated by HCAs in the context of nursing activities, when tasks such as serving meals and changing nappies were performed. The most common mode of communication was by physical contact that contained few emotional exchanges with the residents. When not interacting with residents, HCAs were frequently engaged in other ward chores.

### 3. Comparison of the Observational Data and Interview Data

For the face-to-face interviews, seven HCAs were recruited, one male and six female. Only one of them had received basic personal care training before she worked in the institution under study. The average years of education were 10, equivalent to Form 2 or Middle 2. The age varied from 28 years to 44 years old; the mean was 39 years old. Their average years of service in the institution were 4½ years.

Most of the HCAs interviewed claimed that they would play or talk with those residents who had an adequate degree of mental function during non-programme times or show their concerns for those with a lesser degree of mental function by simply observing them. The perception of these HCAs differed from the findings of the observational data, but the reason for such discrepancy is uncertain. From the findings, there was no occurrence of an S-R interaction during almost two thirds of the observation times. Moreover, a nursing care context and neutral affect were

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Category</th>
<th>Frequency (N)</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiator</td>
<td>Direct-care Staff</td>
<td>3359</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>Resident</td>
<td>72</td>
<td>2</td>
</tr>
<tr>
<td>Affect</td>
<td>Neutral</td>
<td>2839</td>
<td>82.8</td>
</tr>
<tr>
<td></td>
<td>Positive</td>
<td>457</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>135</td>
<td>3.9</td>
</tr>
<tr>
<td>Context</td>
<td>Nursing care</td>
<td>2054</td>
<td>59.9</td>
</tr>
<tr>
<td></td>
<td>Social play</td>
<td>593</td>
<td>17.3</td>
</tr>
<tr>
<td></td>
<td>Ward activity</td>
<td>582</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Formal training</td>
<td>202</td>
<td>5.8</td>
</tr>
<tr>
<td>Mand/Tact</td>
<td>Mand</td>
<td>2268</td>
<td>66.1</td>
</tr>
<tr>
<td></td>
<td>Tact</td>
<td>1163</td>
<td>33.9</td>
</tr>
<tr>
<td>Mode of Communication</td>
<td>Physical</td>
<td>2189</td>
<td>63.8</td>
</tr>
<tr>
<td></td>
<td>Verbal</td>
<td>652</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Physical-verbal</td>
<td>490</td>
<td>14.3</td>
</tr>
<tr>
<td></td>
<td>Gesture</td>
<td>100</td>
<td>2.9</td>
</tr>
<tr>
<td>Response</td>
<td>Comply</td>
<td>2277</td>
<td>66.4</td>
</tr>
<tr>
<td></td>
<td>Ignore</td>
<td>1082</td>
<td>31.5</td>
</tr>
<tr>
<td></td>
<td>Resist</td>
<td>72</td>
<td>2.1</td>
</tr>
</tbody>
</table>

#### TABLE III

Summary of the Interaction Recording System Findings
dominant features in S-R interactions. Although most HCA interviewees claimed that they would smile and talk with the residents, this was not frequently observed. In addition, some HCA interviewees claimed that responsive and obedient residents would attract more S-R interactions than those residents without these characteristics; the observational data could not identify this relationship nor support their claims.

The possible reasons for most of the S-R interactions being initiated by HCAs in the observations were that the HCAs were aware of being the focus of observations and that most of the residents were bedridden and totally dependent. The residents' low functioning level made them less likely to initiate an interaction and their limited verbal utterances and gestures were often ignored because it was hard to distinguish whether these forms of behaviour were the initiation of an interaction or self-stimulating behaviour. In addition, as mentioned by the HCA interviewees, verbal communication was limited because most residents were unable to speak or were only able to communicate with one or two sentences, so that HCAs inevitably focused on the physical comfort of the residents, for instance, by providing a covering blanket. This suggests that interactions between HCAs and residents were mainly task-oriented. The observational data identified that the ‘nursing context’ was the major context in which S-R interactions occurred; these observations were congruent with the perceptions of the HCA interviewees that most of their interactions with the residents involved nursing care, such as feeding. In parallel, the activities which were perceived to be less important - training and social play - had correspondingly low interaction rates in the observational data. In addition to these findings, the results of the observations revealed that the most frequent non-S-R interaction activity was ward tasks (19.2%). This finding was compatible with the perceptions of the HCA interviewees, who complained that the daily routine was too intensive. Nevertheless, the combined non-operational activities, such as non-interactive observation, staff-staff interaction and self-indulgent activities comprised the majority of non-S-R interactions (25.1%).

Discussion

Literature review indicates that the therapeutic values of interaction between staff and resident promote the quality of life among long-term residents with severe disabilities in an institution. The staff-resident interaction is especially influential when it is initiated by the frontline or direct-care staff as they, among all staff, have the most contact with residents during their waking hours. Observational results showed that physical nursing care tasks formed the majority of S-R interactions. The nature of emotion attached to these interactions was largely neutral in affect. This refers to the fact that less emotional exchange occurred when direct bodily care activities were being carried out. Nevertheless, there appears to be no generally agreed on ideal S-R interaction rate in institutional settings for people with developmental disabilities, although Reuter et al., (1980) proposed that interactions with residents in the least-restrictive settings should take up about 40% of the resident's waking hours. Yet, there is little evidence to support this proposition because their suggestion was based on data of infant-mother interaction studies (Reuter et al., 1980). The interview
data from the HCA interviewees in the present study have provided insights into the possible explanations for the low S-R interaction rate.

1. Residents’ Physical Dependence

Interactions between HCAs and residents in the present study were largely based on nursing or personal care activities. This was perhaps due to the physical dependence of the residents. Most of the S-R interactions occurred in the two periods of the residents’ mealtimes. Thus, personal care activities, especially feeding, appeared to be the context in which most staff-resident interactions occurred.

2. Interaction Barriers

The interview data suggested that the interaction barriers of residents affected the interaction rate. The observational findings revealed that staff-resident interactions that took place during routine tasks seldom involved any verbal exchange. The HCA interviewees felt that interaction with residents was difficult; they felt that the residents’ lack of responsiveness and interaction content were two major interaction barriers. They further elaborated that they would interact more with residents with a greater degree of mental functioning than with residents with a lesser degree of mental function. Those with a lower level of function would just be checked regularly and approached only when routine care was needed. Hence, the lack of responsiveness and communication ability of the residents seemed to be the major hindrance to S-R interaction.

3. Prioritisation of Work Tasks

The quantity of domestic chores obviously affects the amount of time that direct-care staff can devote directly to the residents. Indeed, the observational data of the study showed that ‘ward tasks’ which also included cleaning and tidying activities accounted for the majority of the non-S-R interactions. They experienced competition of tasks for time, as they needed to accomplish all assigned duties, involving both direct and indirect care activities. The delivery of psychosocial care was seen as having the lowest priority among the four interaction contexts. Thus, the visibility of physical care benefits seemed to have overshadowed the relative invisibility of psychosocial improvement in a long-term institution.

4. Other Factors that may Potentially Affect the Staff-Resident Interaction

The interview data provided further insights into the HCAs’ working environment, which may interfere with their interactions with residents. Firstly, the interviewees revealed that they had experienced pressure to work as briskly as possible. This pressure to work speedily might have two origins. One was the increased workload of the HCAs as a result of their dual roles to perform the duties of a ward attendant, as well as the specific duties of a HCA, such as recording vital signs. During observations, relieving duty was common, especially when the co-worker was absent from the assigned post without the notice of nursing supervisors. In order to accomplish all the assigned or relieving tasks, the HCAs had to work fast. The other reason given was that they were trying to demonstrate their efficiency to their nursing supervisors and
to ward attendants of fear of being criticised as incompetent. Thus, they showed their competence by working quickly in order to minimise criticism and to meet the expectations of nursing supervisors. It is anticipated that if working quickly is a norm, therapeutic interaction will be unlikely to occur.

HCAs reported being involved in interpersonal conflicts with other direct-care staff, particularly with ward attendants. Faced with interpersonal conflicts with other direct-care staff, some of the HCA interviewees reported that they would direct their attention and time to working with the residents, instead of spending time with their co-workers. The quality of this kind of S-R interaction is doubtful if the intention was to avoid contact with co-workers.

In addition, it is likely that the increased workload would affect the motivation of the HCAs to initiate an interaction with a resident because they might prefer to take a short break rather than interact with residents after all their assignments were completed. Even when an interaction was initiated, it might prove to be disappointing because of the non-responsiveness of the resident. Hence, the quality of the staff-resident interaction was likely to be poor and further initiation of S-R interactions would be unlikely to occur.

In order to enhance staff-resident interaction, it was suggested that direct-care staff need sufficient time to initiate and to maintain interactions with residents. If the ward routines are too heavy and intensive, direct-care staff cannot afford the time to interact with residents therapeutically. Hence, the non-resident care activities should be minimised during residents’ waking times. A therapeutic staff-resident interaction does require a ward environment or culture that is conducive to the occurrence of such interactions.

Moreover, a clear delineation of job assignments between HCAs and WAs is necessary to avoid diffusion of responsibility. Since HCAs had gone through a four-week training programme, it may be more cost-effective to utilise their learned skills and knowledge in assisting with psychosocial care and rehabilitation programmes. Simply increasing the HCAs’ duties can only result in a task-based orientation in their care for the residents, which may then jeopardise the quality of that care. The therapeutic purposes of the assigned tasks should be made known to the direct-care staff when those jobs are being assigned so that quality interaction can be enhanced.

**Conclusion**

In view of unfavourable observational findings in the previous literature, this study used a multi-method design to obtain a high validity of results by studying staff-resident interaction from the perspectives of direct-care staff as well as from direct observation in an institution for people with profound to severe developmental disabilities. The observational data revealed that the staff-resident interaction rates were low. In general, the results indicated that the ‘work culture’ of direct-care staff encouraged them to engage in high visibility behaviours which included domestic chores and physical care activities; less importance was generally attached to training endeavours and social play. Furthermore, the interview data of the HCA interviewees revealed that the direct-care staff were having difficulties in interacting with residents with limited communication skills. Factors, like work
culture and functional abilities of the residents, have been identified as affecting the quality of staff-resident interaction. Measures should be taken into consideration when the institution is promoting the therapeutic values of staff-resident interaction, such as domestic tasks which should be kept to a minimum during waking hours of the residents. In addition, to enhance quality interaction between the direct-care staff and residents, training in communication and social skills should be provided for the direct-care staff. The therapeutic purposes of the assigned tasks should be also explained to staff when those jobs are being assigned.

Summary

This study aimed to explore the nature of the interactions between health care assistants (HCAs) and long-stay residents with profound to severe developmental disabilities, in an institutional setting. The daily interaction between HCAs and residents under their care was observed by using the Interaction Recording System (IRS) developed by Veit (1973). Analysis of the observational data showed that the staff-resident interaction rate was relatively low. Staff-resident interactions were predominantly found in the context of ‘nursing care’ activities, which mainly comprised feeding, nappy changing, oral cleansing, toileting and recording of vital signs, e.g. taking resident’s body temperature, pulse and blood pressure and applying ointment when requested. Most staff-resident interaction was initiated by the HCAs and their affect expressed in the interactions was largely neutral. Factors affecting the frequency and content of interactions were identified to include residents’ physical dependence, interaction barriers and hospital culture. It was proposed that to enhance staff-resident interaction, the non-resident care duties of the HCAs should be minimised during residents’ waking time. A clear delineation of job assignments should be established and the therapeutic purposes of assigned task to the direct-care staff have to be explicitly explained.

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