

University of Tennessee at Chattanooga

UTC Scholar

Honors Theses

Student Research, Creative Works, and
Publications

12-2022

Sexual harassment in an overlooked occupation: experiences of CNA and the influence of nurses

Audrey Pennington

University of Tennessee at Chattanooga, cqq351@mocs.utc.edu

Follow this and additional works at: <https://scholar.utc.edu/honors-theses>



Part of the [Psychology Commons](#)

Recommended Citation

Pennington, Audrey, "Sexual harassment in an overlooked occupation: experiences of CNA and the influence of nurses" (2022). *Honors Theses*.

This Theses is brought to you for free and open access by the Student Research, Creative Works, and Publications at UTC Scholar. It has been accepted for inclusion in Honors Theses by an authorized administrator of UTC Scholar. For more information, please contact scholar@utc.edu.

**Sexual Harassment in an Overlooked Occupation:
Experiences of CNA and the Influence of Nurses**

Audrey M. Pennington

Departmental Honors Thesis
The University of Tennessee at Chattanooga
Psychology Department

Examination Date: 11/21/2022

Dr. Christopher J. L. Cunningham
Guerry Professor and UC Foundation Professor
Thesis Director

Dr. Kristen J. Black
Associate Professor of Psychology
Department Examiner

Dr. Brian J. O'Leary
Associate Professor of Psychology
Department Examiner

Abstract

The prevalence of sexual harassment (SH) in health care facilities has been documented in previous research, but few studies have focused on Certified Nursing assistants (CNA; Burgess et al., 2018; Dean, 2020; Deery et al., 2011; Hibino et al., 2006). The purpose of this study is to explore SH that CNA experience from their patients and what influence supervising nurses may have in impacting the negative outcomes of SH. Participants ($N = 95$) were recruited to take an online survey through social media and snowball recruiting. The hypotheses of this study were not supported by the data, but results may be limited due to sample-related limitations. A significant finding of this study was that 64% of participants reported experiencing SH within the last 12 months from a patient. Significant correlations were found with negative affect and reporting SH. Organizational implications are discussed related to promoting awareness, policy improvement, and simplifying the reporting process.

Introduction

Previous research has studied and documented sexual harassment (SH) in the health care field that workers receive from their patients (Dean, 2020; Deery et al., 2011; Hibino et al., 2006). Studies have also documented the culture around SH specifically with health care workers (HCW) as a phenomenon that is largely viewed as “part of the job.” Individuals are often expected to be able to handle incidences of SH from patients independently, or they may risk being seen by their coworkers and supervisors as being incapable of working in the field (Burgess et al., 2018; Nielsen et al., 2017). However, SH should be viewed as an organizational issue, not a personal one. Properly addressing and taking preventive steps may be beneficial to organizations as SH has been tied to poorer individual health, negative effects on job satisfaction, job performance, and organizational commitment (Deery et al., 2011; Grigorovich & Kontos, 2020; Sojo et al., 2016; Willness et al., 2007).

The focus of this study was on Certified Nursing Assistants (CNA) who work in long term care and SH they may receive from their patients. Researchers wanted to assess how SH may impact CNA personal well-being, and workplace attitudes. Additionally, researchers wanted to study if perceived support from supervising nurses may impact the negative effects of SH on CNA. Researchers hoped to come away from this project with a better understanding of how organizations can better support CNA and what improvements can be made on an organizational level in regards to preventing and responding to SH.

Sexual Harassment

Sexual harassment is defined as unwanted attention or behavior that is sexual in nature, including nonverbal looks and gestures, jokes or comments about one’s body, questions about one’s sexual activity, massages, and pressuring someone for sexual favors (NASEM, 2018). In

one survey of American women, 81% of participants reported having experienced SH at some point in their lives, with 38% saying they had experienced it at work (Chatterjee, 2018). SH at work can occur in high stress, high intensity situations, but it is believed that SH is most often experienced on a spectrum of recurring, low intensity situations (Welsh, 2000).

It is difficult to know precisely how often these situations occur because reporting of SH at work is believed to be low (Welsh, 2000). Further, it is believed that individuals are more willing to report and disclose SH, a culturally stigmatized topic, when they feel supported by those around them (Filipas & Ullman, 2001; Keplinger et al., 2019). Previous research has shown that frequent low intensity harassment can have equally detrimental effects as harassment in more intense forms (Sojo et al., 2016). Experiencing SH can lead to depression, anxiety, and PTSD symptoms, as well as negative health outcomes, such as an increased risk for illness. In the workplace specifically, SH has negative effects on job satisfaction, job performance, organizational commitment, and mental health (Deery et al., 2011; Grigorovich & Kontos, 2020; Sojo et al., 2016; Willness et al., 2007).

Sexual Harassment in Healthcare

People have the right to a safe workplace that is free from discrimination, including SH (OSHA, 1970; US EEOC, 2015). Healthcare workers are at risk of experiencing workplace violence; in 2020, nurses and HCW had an incident rate of 21.8 out of 10,000 workers for injuries in their workplace related to violence from others. This rate is five times higher than the average incident rate of all workers in the United States (BLS, 2020). A study of nurses from 2007 found non-physical violent events, including threats, SH and verbal abuse, occurred at a rate of 38.8 per 100 nurses a year (Nachreiner et al., 2007).

Many researchers have found that nurses are victims of SH from their patients (Dean, 2020; Deery et al., 2011; Hibino et al., 2006). CNA often experience more direct patient interaction than other HCW, such as nurses, but they are not usually the occupational population that is the focus of research and intervention attention (Burgess et al., 2018; Grigorovich & Kontos, 2020; Nielsen et al., 2017). In addition, CNA may be at a higher risk for serious consequences associated with SH from patients because they have less power in an organization, tend to spend the most time directly with patients, and must frequently provide an intimate level of care for patients who need it (e.g., baths, using the restroom, changing clothes; Burgess et al., 2018; Deery et al., 2011). Research has also demonstrated that administrators in health care settings tend to be unaware of the extent of inappropriate sexual behaviors that are directed toward their staff (Burgess et al., 2018).

Despite negative health outcomes of SH to individuals and organizations, health care culture typically views SH as a problem for individuals to manage independently (Burgess et al., 2018; Nielsen et al., 2017). As a result, HCW rarely receive SH training and may be viewed as incompetent for reporting SH (Madison & Minichiello, 2004).

The Present Study

The objectives for this project were to learn more about CNA experiences with SH from patients, how CNA may be impacted differently than other HCW, and to determine if CNA perceptions of SH are buffered by perceived support from supervising nurses, with whom CNA work alongside throughout their shifts. The decision to focus on these nurses as opposed to individuals who may be in more official positions of administration was made because these nurses may play an important role in CNA reporting and documenting of SH. If nurses internalize SH as “part of the job” and believe CNA should effectively and independently handle

such incidents, combined with the real or imagined organizational power over CNA, then there is little room for a CNA to formally report instances of SH, leaving administrators unaware of these situations.

Researchers chose to make CNA the focus population, where previous studies may have included CNA along with other HCW such as nurses. This decision was made because there may be unique differences between CNA and other HCW such as the nature of CNA work being especially hands on with patients, while nurses may at times be more “in and out” with medication. Other differences include power and resources as CNA typically have lower levels of education, pay, and organizational ranking. Additionally, researchers chose to focus on long term care (LTC) facilities, as opposed to hospitals or other health care settings. This decision was made because there may be differences in the patient care giver relationship related to the duration of stay in LTC. In LTC patients often stay for weeks, months, or years depending on their care needs and circumstances. A hospital stay has the potential to be long, but most patients likely stay for a shorter period in a hospital than they would in LTC. Furthermore, patients in LTC may frequently be cared for by the same CNA, this would create a much different patient-care giver relationship than if you were only patient for a few days.

The hypotheses for this study were:

H1: SH is negatively correlated with general personal well-being and general positive work attitudes.

H2: There is a negative correlation between supervisor and coworker support, and turnover intentions.

H3: Supervisor support is positively associated with likelihood to report SH.

H4: The relationships between SH and general personal well-being and work-related factors are weaker when CNA perceive more support from their nursing supervisors.

Method

Participants

The ultimate data for analysis included responses from 69 CNA. The mean age of respondents was 28.91 years ($SD = 7.53$) and most respondents were between the ages of 19 and 51. The years of CNA work experience for these respondents ranged from 1 to 33 years with 31.5% of participants reporting 2-3 years of experience. The range of organization tenure was 1-34 years with 33.6% of participants reporting being at their organization for 2-3 years. With respect to work schedule, 53.7% of participants reported working day shift, 13.7%-night shift, and 24.7% reported often working both. Regarding work setting, 73.65 of participants reported working in long term care (either nursing home or rehabilitation) while 14.7% reported working in short term care rehabilitation.

Female participants made up 56.8% of respondents while males made up 30.5%. 63.2% of the participants reported being straight, 8.4% asexual, 7.4% bisexual or pansexual, and 7.4% gay or lesbian. White participants made up 38.9%, black or African American 29.5%, Hispanic, Latino/a/é, or Spanish 7.4% and American Indian or Alaska Native 7.4%. 14.9% of participants selected a second race or ethnicity. The ethnicity and race demographics for this sample may be reasonably representative of CNA in the United States. According to the Centers for disease control and Prevention (2008), the racial makeup of CNA working in nursing homes from 2004-2005 was white 53.4%, black 38.7%, and Hispanic or Latino 9.3%. The level of education within

this sample was: 5.3% with a high school degree/GED, 24.2% with some college/associate degree, and 41.1% with a bachelor's degree. In terms of marital status, 31.6% of our sample reported being married or living with a partner, 26.3% were never married, 13.7% were widowed, 12.6% were divorced, and 5.3% were separated. As for dependent care responsibilities, 12.5% of the sample reported living with one dependent under the age of 5, 11.6% lived in the same household as one dependent 6-12 years old, 21% of participants reported living with 1-2 dependent adults. The most frequently reported household income of respondents was \$50,000 to \$74,999 (33.7%), with 61.9% of the sample reporting a household income between \$20,000 and \$74,999.

Materials

Sexual harassment was measured using the Sexual Experiences Questionnaire (SEQ) (Fitzgerald et al., 1995). This is a 17-item scale made up of three subscales including gender harassment $\alpha = .82$, unwanted sexual attention $\alpha = .85$, and sexual coercion $\alpha = .42$. Instructions for this scale were adapted to read "While working as a CNA have you ever been in a situation where a patient you were caring for. . ." An example question from the gender harassment subscale was "made offensive remarks." Participants responded to these statements on a 5-point Likert scale ranging from "never" to "constantly." A higher score on this scale indicates more experiences of SH. SH was also measured using a single item measurement from the NIOSH worker well-being questionnaire (NIOSH WellBQ). This yes/no response item was adapted for this study to read "In the past 12 months, were you sexually harassed by a patient while you were on the job?" (NIOSH WellBQ, 2021).

General personal well-being was measured using several scales and single item measures. Four single item measures from NIOSH WellBQ (2021) were included to measure life

satisfaction, overall health, physical health, and psychological health. High scores on these items indicated a higher level of satisfaction or health. An 8-item scale from NIOSH WellBQ (2021) was included to measure unhealthy strategies for coping with demands. One example item asked the participant to indicate how often they “Consume additional caffeine to try to stay energized.” Participants responded to these items on a 5-point Likert scale ranging from “never” to “always.” High scores on these items indicated a high level of unhealthy coping strategies.

General positive work attitudes were measured using a series of scales and single item measures. The Oldenburg Burnout Inventory (OLBI) was included with the intention of measuring the subscales of disengagement and exhaustion within this scale as separate items (Demerouti et al., 2003). Participants responded to the OLBI using a 5-point Likert scale ranging from “strongly disagree” to “strongly agree” with a reliability of $a = .87$. Job engagement was measured on a 3-item scale (NIOSH WellBQ, 2021). Participants responded to the engagement statements on a 7-point Likert scale ranging from “never” to “Always (everyday).” An example engagement item as “My work inspires me.” A higher score on the engagement scale indicates more engagement at work. Additionally, two single items from the NIOSH WellBQ (2021) were included to measure work overload and job satisfaction. Participants responded to both single item measures on a 4-point Likert scale. Finally, a 5-item short form of the Psychological General Well-being Index (Grossi et al., 2006) was included. This scale has a reliability of $a = .80$. Participants responded to these items using a 6-point Likert scale ranging from “all of the time” to “none of the time.”

Perceived supervisor support was measured using a 5-item supportive work culture scale and one single question measure (NIOSH WellBQ, 2021). While responding to these items, participants were instructed to “think carefully about the nurses that you work most closely with

while caring for your patients." The 5-item scale was adapted so that all items would read "My supervisor. . ." as opposed to "My organization. . ." An example statement was "My supervisor treats me with respect." Participants responded to the scale and single item measure with a 4-point Likert scale ranging from "strongly disagree" to "strongly agree." with a higher score indicating more perceived supervisor support.

Perceived coworker support was measured using a 4-item scale (Haynes et al., 1999). An example item reads "Count on your colleagues to back you up at work? Participants responded using a 5-point Likert scale ranging from "not at all" to "completely." In the original validation this scale had a reliability among nurses of $\alpha = .90$. A higher score on this scale indicates more perceived coworker support.

Turnover intentions were measured with a 3-item scale created by Michael & Spector (1982). An example item for this measure was "I often seriously consider leaving my current job." participants responded using a 6-point Likert scale ranging from "strongly disagree" to "strongly agree." A higher score on this scale indicates high turnover intentions

Qualitative and demographic questions made up the final part of the survey. Ten qualitative questions were included to learn more about existing policies, enforcement trends of policies, how organizations could reduce SH, experiences with and thoughts toward reporting SH. At the end of the survey, participants answered standard demographic questions along with questions about CNA tenure, organization tenure, typical shift, facility type, and positive and negative affect.

Procedure

In order to take part in the online survey, participants were required to have work experience as a CNA in LTC. To recruit participants, researchers pursued contact with 15 long term care facilities in Chattanooga by email and phone communication. Ultimately, no facilities that were contacted ever allowed direct recruitment with the respecting facility. Participants for this study were recruited through social media and snowball sampling. Individuals who chose to take this online survey were first presented with an informed consent where they could agree to participate or request to be taken out of the survey. Before beginning the survey, participants could choose to enter themselves into a drawing for one of 15, \$50 amazon gift cards. Funding for this project came from UTC's SEARCH award. Participants were not required to enter the drawing and could enter the drawing without having to respond to the rest of the survey. A total of 299 responses were recorded with 95 being used in the final data set. Participants were eliminated based on repeat responses, excessive missing data, nonsensical responses to qualitative questions, poor response to attention check question, low ReCAPTCHA scores, or low time duration as recorded in Qualtrics.

Once data had been cleaned, a frequencies test was run to understand demographics of the sample. Several scale items were then reverse coded as instructed by the original articles. Alpha levels of all multi-item scales were run. Unhealthy strategies with coping, psychological well-being, and subfactors of OLBI (disengagement and exhaustion) were excluded due to low alpha levels. A correlation matrix was created with the remaining scales, single measure items and demographics. After determining alpha levels and correlations, the factors of general personal well-being, and general positive work attitudes, and SH were aggregated to simplify the analysis. The final composition of these aggregated indicators was as follows. **General personal well-being** was made up of the separate measures of life satisfaction, overall health, and general

health (physical and psychological). **General positive work attitudes** included job satisfaction and engagement. Finally, the scale measure of SH included an aggregation of the three subscales within the Sexual Experiences Questionnaire to measure the degree of SH. These subscales were not initially aggregated because it was considered that the sexual coercion subscale may not perform well within the context of this survey. Participants responded to statements in the sexual coercion subscale such as “experiencing consequences for refusing” or “subtly bribed you.” It was thought that coercion may be less common in the context of a patient-caregiver relationship compared to statements such as “crude sexual remarks” or “staring, leering at you” in the gender harassment and unwanted sexual attention subscales respectively. In contrast to this suspicion, all three subscales of this measure demonstrated strong intercorrelations with each other. For this reason, these sub scores were aggregated to provide a single overall indicator of the degree of SH that we used in the hypothesis tests and descriptive statistics (see Table 1).

To facilitate the testing of Hypothesis 3, responses to the qualitative question "Do you feel like you could report an incident of inappropriate sexual behavior from a patient if you wanted to?" were assigned a yes/no code and used in the final correlation matrix. This question reads as follows: "Do you feel like you could report an incident of inappropriate sexual behavior from a patient if you wanted to?" Hypotheses 1, 2, and 3 were tested using the final correlation matrix. Hypothesis 4 was tested using a hierarchical/moderated multiple regression analysis.

Results

Descriptive statistics

Descriptive statistics and the final descriptive statistics and correlations for this study are summarized in Table 1. From these correlations we can see that CNA tenure is strongly and significantly correlated to organizational tenure ($r = .93^{**}$). These factors also had similar

descriptive statistics where the range of number of years as a CNA or at an organization was similar. Neither organizational tenure nor CNA tenure were significantly correlated to either measure of SH used in this study.

Several non-hypothesized trends were found within the data that will be discussed. The scale measuring degree of SH was positively correlated with negative affect ($r = .50^{**}$), perceived supervisor support ($r = .50^{**}$), perceived coworker support ($r = .61^{**}$), and turnover intentions ($r = .43^{**}$). In relation to the dichotomous measure reporting SH, 64% of participants indicated they have experienced SH in the last 12 months. As previously stated, there was a significant correlation between reported SH experiences and turnover intentions, such that those reporting SH were significantly more likely to report higher turnover intentions. Perceived supervisor support ($r = .67^{**}$) and perceived coworker support ($r = .64^{**}$) were significantly and positively correlated with general positive work attitudes. Similarly, perceived supervisor support ($r = .73^{**}$) and perceived coworker support ($r = .70^{**}$) are significantly and positively correlated with general personal well-being.

Negative affect was significantly and positively correlated with degree of SH, as measured by the multi-item scale ($r = .50^{**}$). Negative affect was negatively but not significantly correlated with the dichotomous measure of reported SH ($r = -.11$). A significant positive relationship was observed between positive affect and degree of SH ($r = .32^{**}$), and there was a positive but not significant correlation with reported SH ($r = .21$). Positive affect was correlated with perceived supervisor support ($r = .53^{**}$) and perceived coworker support ($r = .55^{**}$), as well as reported well-being ($r = .52^{**}$) and positive work attitudes ($r = .55^{**}$).

Table 1:

	<i>M</i>	<i>SD</i>	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. CNA tenure	7.71	7.59										
2. Organization tenure	6.88	7.39	.93 **									
3. Positive affect	4.17	0.97	.15	.01								
4. Negative affect	4.08	0.92	-.18	-.09	.23							
5. Degree of sexual harassment	43.77	15.29	.05	.09	.32 **	.50 **						
6. Reported sexual harassment	1.33	0.48	-.05	-.14	.21	-.11	-.34 **					
7. General personal well being	-0.12	0.75	.03	-.04	.52 **	.37 **	.54 **	-.01				
8. General positive workplace attitudes	-0.11	0.78	.27 *	.11	.55 **	.13	.41 **	.04	.68 **			
9. Perceived supervisor support	2.59	0.66	.10	.08	.53 **	.30 *	.50 **	-.01	.73 **	.67 **		
10. Perceived coworker support	3.11	0.85	.24 *	.12	.55 **	.33 **	.61 **	-.02	.70 **	.64 **	.67 **	
11. Turnover intentions	3.02	1.08	-.10	.05	.02	.35 **	.43 **	-.21	.21	-.12	.24 *	.26 *

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

N = 69

Hypothesis Tests

To test H1, the scale measuring degree of SH along with the yes/no question of reported SH by a patient in the last 12 months were used in the correlation matrix. Counter to what was hypothesized, review of the bivariate correlations indicated that the scale measuring degree of SH results were significantly correlated with general well-being ($r = .54^{**}$), and with general positive work attitudes ($r = .41^{**}$). Similarly, the dichotomous indicator of reported SH was not correlated with general well-being ($r = -.01$), nor with general positive work attitudes ($r = .04$).

Contrary to H2, perceived supervisor support was positively and significantly correlated with turnover intentions ($r = .24^*$), likewise, perceived coworker support was significantly and positively correlated with turnover intentions ($r = .26^*$).

The correlations in this data did not support H3. Perceived supervisor support was not significantly correlated with reported likelihood of reporting SH ($r = .240$). This correlation was run separately from the full matrix summarized in Table 1 because of the very low response rate to the question regarding likelihood of reporting SH (the sample size for this analysis was 36). As a result of this small sample size, this analysis was underpowered, so it is still important to note the observed positive correlation here approaches a moderate effect size.

The data collected in this sample also did not support H4, there was no evidence of a significant interaction of perceived supervisor support on the relationship between degree of SH and general well-being. A significant main effect of perceived supervisor support was observed ($b = .45$), and the overall model explained a significant amount of variance in general well-being (*adjusted R-squared* = .59, $p < .05$). Similarly, there was no evidence of a significant interaction of perceived supervisor support on the relationship between degree of SH and general positive work attitudes. A significant main effect of perceived supervisor support was observed ($b = .48$), and the overall model explained a significant amount of variance in general positive work attitudes (*adjusted R-squared* = .39, $p < .05$). The full results of these analyses are summarized in Tables 2 and 3.

Table 2:

<i>Predictors</i>	Well-being	
	β	
	Step 1	Step 2
Constant	-0.10 *	-0.14 *
Perceived supervisor support	0.45 *	0.48 *
Degree of sexual harassment	0.18 *	0.15 *
Perceived supervisor support x Degree of sexual harassment		0.06
	ΔR^2	.01
	ΔF	1.39
	Adjusted R^2	.59 *
	F	61.45
		41.62

Note. $N = 85$; * $p < .05$

Table 3:

<i>Predictors</i>	Positive attitudes	
	β	
	Step 1	Step 2
Constant	-0.14 *	-0.15
Perceived supervisor support	0.48 *	0.48 *
Degree of sexual harassment	0.05	0.05
Perceived supervisor support x Degree of sexual harassment		0.01
	ΔR^2	.01
	ΔF	1.39
	Adjusted R^2	.39 *
	F	28.66
		18.89

Note. $N = 85$; * $p < .05$

Discussion

Several of the findings related to the hypotheses were unexpected. The first odd finding is the positive correlation between degree of SH and general well-being and positive work attitudes. This finding would suggest that degree of SH experiences increase along with increases in general well-being and positive work attitudes. It is possible that this result in the data is due to our small sample size or is just an anomalous finding. It could also be possible that an individual who is of better general well-being may be more willing to think about and report on SH experiences.

Regarding H2, perceived supervisor support is significantly and positively correlated with turnover intentions. A possibility for why this finding would occur could be if your supervisor is encouraging you to grow and is validating legitimate complaints within an organization, you may look for another job where you will be better treated by an organization. The significant and positive correlation between perceived coworker support and turnover intentions is similarly an abnormal finding. An explanation could be if coworkers find support from each other through complaining about work together. In a work environment that may

increase turnover intentions, coworkers may be able to connect and relate over the workplace challenges.

Although H3 was not a significant correlation there was a moderated positive effect. It is possible that this effect was weakened by the small sample that responded to these measures. Future research should consider retesting this hypothesis with a larger sample as this may make the correlation significant. The hypothesized buffering effects of perceived supervisor support outlined in H4 were not supported by the data. Perceived supervisor support was however correlated with general well-being and general positive work attitudes, indicating that this may be an important factor in individuals. Like the other hypotheses, the interaction of perceived supervisor support moderating the effects of likelihood to report SH may be worth studying with a larger sample size.

Another finding within the results was the correlation of negative affect with degree of SH. An interpretation is that those who have stronger negative affect are more likely to focus on or remember experiences with SH. Future research could further explore the relationship between reporting experiences of SH with negative affect.

As previously stated, the initial response total for this survey was 299, all of which came from Facebook or snowball sampling. At the beginning of the recruiting process approximately 70 participants were recruited by snowball sampling from a post on a personal Facebook profile. To increase the participant rate, the survey was also posted on a public CNA Facebook page. Although this second post did quickly increase the initial sample size, many of the participants recruited from this page had to be removed from the final data set. Online recruiting can be helpful in reaching many people with relative ease, but the experience in this study was that large public pages made it more difficult to end with a genuine sample. When there is such a high

number of questionable responses, as there were in this initial sample, it can be challenging to know if illegitimate responses have been eliminated thoroughly to not influence the true results of the study. In the future researchers should focus on in-person recruiting methods.

Ideally this study could be repeated, and recruitment could be done outside of social media to obtain a larger sample of CNA and see if the findings remain consistent. This study chose to focus on SH, however there are other types of violence that have been documented in health care facilities. Future research could focus on other types of violence such as physical, verbal abuse, or bullying as well as policies and prevention strategies specifically related to these issues. This study also chose to look at LTC facilities, future research could expand to hospital settings, doctors' offices or other places CNA work. Future research could also include more comparisons of experience based on the shift an individual works. Lastly, future research could explore the relationship found in this study between negative affect and reporting SH.

One relevant cultural implication related to this project is the Centers for Medicare & Medicaid Services (CMS) 5-star satisfaction ratings. The CMS ratings were first launched in 2016 and allow patients and their family members to respond to a satisfaction survey. The data from these surveys are combined to create a total score ranging from 1 to 5 stars. The purpose of this score is to assist individuals in picking a facility that best fits their needs (CMS, 2022). These scores affect government funding and may additionally affect an organizations income by significantly impacting enrolment levels (Bissitt, 2022). A concern regarding this satisfaction rating is that it increases the patient's power within the health care system, where some people are already abusing their patient status to exploit workers. These scores may also make it more difficult for organizations to prioritize worker safety and rights in the patient care giver dynamic because funding is directly tied to patient satisfaction.

The report of 65% of participants responding that they had experienced SH from a patient within the last 12 months demonstrates that this is a prevalent phenomenon. The presence of this issue implies that facilities should be prepared to respond to incidences of SH by having clear policies outlining a proper organizational response, as well as how CNA can report incidences. Administrators and supervisors should be aware that this is a prevalent phenomenon and that it should be addressed on an organizational level. Administrators should also consider preventative actions they can take within their facility. CNA should receive training on how to best respond to and document SH.

Conclusion

Having a safe working environment is a human right, this includes a working environment that is free of SH. In the past, the culture of health care has seen SH as a problem for individuals to handle independently, when in reality this is an issue for organizations to address (Burgess et al., 2018; Nielsen et al., 2017). Although the four original hypotheses were not supported by the data in this study, but there were significant findings specifically with negative affect and reporting SH as well as the frequency of reported SH. Future research is needed and should aim to increase sample size as well as explore other types of preventable violence within health care work. Organizations may be able to make improvements in part by increasing awareness, improving policies, and simplifying the reporting process. Individuals should be reminded that SH is an organizational issue, not a personal one, and employers have a responsibility to provide a physically and psychologically safe working environment.

Reference

- Bissitt, G. (2022). *What is CMS star rating? - millions of dollars are at stake*. Blue Relay.
Retrieved November 29, 2022, from <https://www.bluerelay.com/blog/what-is-cms-star-rating/>
- U.S. Bureau of Labor Statistics. (2020). *Fact sheet, workplace violence in healthcare, 2018. April 2020*. U.S. Bureau of Labor Statistics. Retrieved November 29, 2022, from <https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm>
- Burgess, E. O., Barmon, C., Moorhead Jr, J. R., Perkins, M. M., & Bender, A. A. (2018). “That is so common everyday... Everywhere you go”: Sexual harassment of workers in assisted living. *Journal of Applied Gerontology*, 37(4), 397-418.
- Centers for Disease Control and Prevention. (2008). *NNHS - Nursing assistant tables - estimates*. National Center for Health Statistics. Retrieved November 29, 2022, from https://www.cdc.gov/nchs/nnhs/nursing_assistant_tables_estimates.htm
- Centers for Medicare & Medicaid Services. (2022). *Home Health Star Ratings*. CMS.gov.
Retrieved November 29, 2022, from <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/hhqihomehealthstarratings>
- Chatterjee, R. (2018). A new survey finds 81 percent of women have experienced sexual harassment. *National Public Radio*.
- Dean, E. (2020). Report and support: Addressing sexual harassment at work: No nurse should view sexual harassment by patients or members of the public as ‘part of the job’. new

RCN guidance aims to empower staff to recognise and report it. *Nursing Standard*, 35(11), 14-17. <http://dx.doi.org/10.7748/ns.35.11.14.s10>

Deery, S., Walsh, J., & Guest, D. (2011). Workplace aggression: The effects of harassment on job burnout and turnover intentions. *Work, Employment and Society*, 25(4), 742-759.

Demerouti, E., Bakker, A.B., Vardakou, I. & Kantas, A. (2003). The convergent validity of two burnout instruments: A multitrait-multimethod analysis. *European Journal of Psychological Assessment*, 19, 12-23.

Filipas H. H., & Ullman S. E. (2001). Social reactions to sexual assault victims from various support sources. *Violence and victims*, 16(6), 673–692. pmid:11863065

Fitzgerald, L. F., Gelfand, M. J., & Drasgow, F. (1995). Measuring sexual harassment: Theoretical and psychometric advances. *Basic and Applied Social Psychology*, 17(4), 425-445. doi:http://dx.doi.org/10.1207/s15324834basp1704_2

Grigorovich, A., & Kontos, P. (2020). Problematizing sexual harassment in residential long-term care: The need for a more ethical prevention strategy. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 39(1), 117-127.

Grossi, E., Groth, N., Mosconi, P., Cerutti, R., Pace, F., Compare, A., & Apolone, G. (2006). Development and validation of the short version of the Psychological General Well-Being Index (PGWB-S). *Health and Quality of Life Outcomes*, 4(1), 88.

Haynes, Wall, T. D., Bolden, R. I., Stride, C., & Rick, J. E. (1999). Measures of perceived work characteristics for health services research: Test of a measurement model and normative

data. *British Journal of Health Psychology.*, 4(3), 257–275.

<https://doi.org/10.1348/135910799168614>

Hibino, Y., Ogino, K., & Inagaki, M. (2006). Sexual harassment of female nurses by patients in Japan. *Journal of Nursing Scholarship*, 38(4), 400-405. <http://dx.doi.org/10.1111/j.1547-5069.2006.00134.x>

Keplinger, K., Johnson, S. K., Kirk, J. F., & Barnes, L. Y. (2019). Women at work: Changes in sexual harassment between September 2016 and September 2018. *PloS one*, 14(7), e0218313.

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress*, 19(3), 192-207.

Madison, J., & Minichiello, V. (2004). The contextual issues associated with sexual harassment experiences reported by registered nurses. *Australian Journal of Advanced Nursing*, 22(2), 8-13.

Michaels, C. E., & Spector, P. E. (1982). Causes of employee turnover: A test of the Mobley, Griffeth, Hand, and Meglino model. *Journal of Applied Psychology*, 67(1), 53-59.
[doi:http://dx.doi.org/10.1037/0021-9010.67.1.53](http://dx.doi.org/10.1037/0021-9010.67.1.53)

Nachreiner, N. M., Gerberich, S. G., Ryan, A. D., & McGOVERN, P. M. (2007). Minnesota nurses' study: perceptions of violence and the work environment. *Industrial health*, 45(5), 672-678.

National Academies of Sciences, Engineering, and Medicine (NASEM). (2018). Sexual harassment of women: climate, culture, and consequences in academic sciences, engineering, and medicine. *Washington, DC: The National Academies Press.*
<https://doi.org/10.17226/24994>.

Nielsen, M. B. D., Kjær, S., Aldrich, P. T., Madsen, I. E., Friberg, M. K., Rugulies, R., & Folker, A. P. (2017). Sexual harassment in care work—Dilemmas and consequences: A qualitative investigation. *International Journal of Nursing Studies, 70*, 122-130.

NIOSH [2021]. NIOSH worker well-being questionnaire (WellBQ). By Chari R, Chang CC, Sauter SL, Petrun Sayers EL, Huang W, Fisher GG. Cincinnati, OH: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 2021-110 (revised 5/2021),

Occupational Safety and Health Administration [OSHA], 1970

Sojo, V. E., Wood, R. E., & Genat, A. E. (2016). Harmful workplace experiences and women's occupational well-being: A meta-analysis. *Psychology of Women Quarterly, 40*(1), 10-40.
doi: 10.1177/0361684315599346

United States. Equal Employment Opportunity Commission. (1992). EEOC compliance manual. [Washington, D.C.] :U.S. Equal Employment Opportunity Commission.

Welsh, S. (2000). The Multidimensional Nature of Sexual Harassment. *Violence Against Women, 6*(2), 118–141. <https://doi.org/10.1177/10778010022181750>

Willness, C. R., Steel, P., & Lee, K. (2007). A meta-analysis of the antecedents and consequences of workplace sexual harassment. *Personnel Psychology*, 60(1), 127-162.
<https://doi.org/10.1111/j.1744-6570.2007.00067.x>