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Patient Compliance-Gaining: A Look At Care Facility vs. Home Health

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Patient Compliance-Gaining: A Look At Care Facility

vs. Home Health

(TITLE)

BY

Merideth Mayberry

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THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
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Abstract

The patient compliance-gaining strategies employed by health care providers in the care facility and home health environments were investigated. Each participant completed a two-page, open-ended survey. A content analysis, and more specifically a thematic analysis of the research, allowed for similarities and differences between the two settings to be compared to current literature. Results indicated that participants used similar strategies to those suggested by researchers in the field. The results showed that strategies applied by health care providers in this particular study are effective for gaining patient compliance.

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Patient Compliance-Gaining: A Look At Care Facility vs. Home Health

Merideth K. Mayberry

B. S., Eastern Illinois University, 1996

M. A., Eastern Illinois University, 1997

M. A., Eastern Illinois University, 1999

As the millennium draws near, America is experiencing a new awareness in the health care field. We are beginning to understand the importance of health care in a society that is becoming increasingly older. Manton and Soldo (1992) report that the elderly population is expected to reach 36.3 million by next year and 67.3 million by the year 2040. In only 40 years the elderly population may virtually double. This increase in the number of elderly is certainly going to force America to reconsider its outlook on health care.

Beisecker and Thompson (1995) cite the 1991 U. S. Senate Special Committee on Aging which reveals that people age 65 and under average five visits per year to their health care provider. Five visits seems like a large number until we compare it to the 65 and over population's eight visits per year to their health care providers. Manton and Suzman (1992), as cited by Beisecker and Thompson (1995), explain that these numbers are only going to increase. More specifically, individuals age 65 to 74 are expected to increase their number of provider visits from 100 million to 186 million between the years of 1980 and 2040. Those who fit the 75 and over age group are expected to see an increase of 66 million visits in 1980, 115 million visits in 2000, 144 million visits in 2020, and 241 million in 2040. Obviously, these numbers reveal a great deal of interaction time between a patient and her/ his health care provider. The numbers also show that Health Communication

is worthy of attention today as well as in the future.

Individuals visit their health care provider in search of a cure or treatment for their illness, but they do not always comply with the provider's recommendations after the consultation. What happens during the patient-provider consultation that causes patients to ignore health care recommendations? It is essential to examine the areas of patient-provider interaction, patient satisfaction, and patient compliance according to the available literature to understand how these three go hand in hand to affect the medical encounter and the patient's health.

Patient-provider interaction

Ruben (1993) surveyed 3,868 patients for his research on patient recollection of the health care encounter. He found that 46.7% of patients surveyed remembered how they were treated over all other aspects of the medical encounter. These results mean that patients recalled more information about their interpersonal involvement with the provider or personal treatment over information regarding policies, procedures, facility accommodations, etc. For instance, Ruben received responses such as the following: "The friendly attitude makes you feel relaxed when you are tense," and, "Many technicians, in my opinion, lacked compassion and concern. They also had no respect for my dignity or modesty. A friendly smile would have helped. They did what they were trained to do and that's all" (p. 102). Ruben's research shows us that patient-provider

interaction deserves closer attention than it has received. It is important to understand patient-provider interaction by examining causes of miscommunication, the role of power in the medical encounter, and interaction among staff and residents in nursing homes.

Miscommunication

Communication is "the process through which symptoms are described and interpreted as well as the means through which treatment is provided and compliance encouraged" (Ruben, 1993, p. 99). For the purposes of my research, I will operationally define miscommunication as the point at which the receiver interprets the sender's message in a way other than the sender intended for it to be interpreted. Miscommunication may result due to professional versus personal interpretations of the medical encounter, communicator style, ageist beliefs, and physical impairment.

Personal vs. professional interpretations.

The patient and the provider naturally have different interpretations of the medical encounter. It is interesting that almost half of the individuals surveyed by Ruben (1993) evaluated their medical encounter based on the kind of interpersonal treatment they received. This research reinforces that fact that patient-provider interaction plays an important role in the medical encounter. A struggle in this relationship emerges due to differing perceptions of intimate information exchanged between the

patient and the provider. Street and Wiemann (1988) note the uniqueness of this relationship in that it contains personal characteristics (e. g. intimate self-disclosure, access to the body, etc.) that occur during a professional encounter. The authors go on to say that this relationship should be viewed as a professional interaction, not a personal one. The confusion begins because the patient may perceive this encounter as personal (Ruben 1993). Ruben's (1993) research included the following quotation: "Many technicians, in my opinion, lacked compassion and concern" (p. 102). This quotation shows that patients may walk into the medical encounter with the preconceived notion that it should be conducted on a personal rather than professional level. Health care providers attempt to avoid this confusion by stressing the professional aspect of the encounter and ignoring the interpersonal aspect completely (Street & Weimann, 1988).

Patient communicator style.

Differing opinions of personal versus professional aspects of the medical encounter are not the only cause of miscommunication. The communicator style of the patient may send unintended signals to the provider. Norton (1978) defines communicator style as "the way one verbally and paraverbally interacts to signal how literal meaning should be taken, interpreted, filtered, or understood" (pp. 99). The patient and the provider may be speaking the same language, literally, but not understand one another. This

conflict in communicator style may be seen in two ways.

First, King's (1985) research shows that patients may refrain from discussing questions or concerns during the medical visit because they are afraid of "wasting the doctor's time" (p. 94). The provider may believe that the patient understands the information due to the lack of questioning when, in fact, the patient is unable to express concerns. The patient may believe that the provider is explaining information that should already be understood. He/ she does not want to waste the provider's time by asking questions that they believe has obvious answers. This timid communicator style displayed by the patient sends the signal that the patient understands all necessary information. The interaction results in miscommunication between the patient and the provider.

Second, King's (1985) research also shows that patients refrain from questioning for fear of "looking foolish" (p. 94). Patients may allow semantic distractions to interfere with effective communication. For example, patients fail to ask for clarification of medical terminology, jargon, etc. used by the provider, and as a result, do not understand recommendations and other valuable information discussed in the medical encounter (Skopek, 1979). Ultimately, the unassertive communication strategies applied in both cases imply that the patient has no concerns. King (1985) suggests that providers have to become better at evoking patient concerns. The medical consultation as a result will

become more beneficial for both parties involved.

Ageist beliefs.

Ageist beliefs may cause miscommunication during the patient-provider encounter. Butler first coined the term "ageism" in 1968 and defined it as "a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender" (Butler, 1975, p. 12). Other researchers contribute to this definition by explaining that ageism categorizes everyone age 65 and above together by applying a similar set of false beliefs (Greene, Adelman, Charon, & Hoffman, 1986; Haug & Ory, 1987). Unfortunately, ageism occurs in the medical setting (Adelman, Green, Charon, & Friedman, 1992) and may be unknowingly directed toward a particular group or culture by the provider (Hooyman & Kiyak, 1988). When the provider unknowingly applies stereotypes during a medical encounter, it obviously affects interpersonal communication in a negative way. For example, Hummert (1994) explains that negative stereotypes are often automatically and unknowingly associated with the elderly who are sick, slow moving, physically handicapped, forgetful, slow thinking, etc. A provider may inadvertently apply negative stereotypes to an elderly individual during the medical encounter when the individual displays one or more of these characteristics. Ryan, Meredith, MacLean, & Orange, (1995) note this behavior in their "Communication Predicament

Model" (p. 91). The authors advocate their "Communication Enhancement Model" in an attempt to eliminate stereotypes and generalizations (p. 96). People not associated with the medical profession may believe that health care providers should recognize negative stereotypes and therefore, be able to avoid them within the medical encounter. Actually, Greene, Adelman, Charon, and Hoffman (1986) note that health care providers "may be more susceptible than the lay public to develop such ageist assumptions" (p. 113) because their daily interactions with this population occur due to illness, confusion, hospitalization, etc. Age and health are automatically associated with one another in medical as well as non-medical settings (Coupland & Coupland, 1994). For instance, I can remember asking my grandfather, "How are you?" He often responded with, "Not bad for an old man," which obviously reflected his age.

Aging and illness have been associated with one another for years. Coupland and Coupland (1994) call it the expectation of "normal decrement" and explain that even health care providers may perceive the elderly patient as experiencing health problems that are simply a result of aging (p. 92). Mulley (1997) explains that the concept of normal decrement may foster negative feelings or behaviors toward the elderly population (see also Hummert & Garstka, 1995). Edwards and Giles (1998) note that stereotyping on the part of the provider as well as the patient may interfere with intergenerational communication. The

stereotypes are usually negative (Harwood, 1998), and may affect the outcome of the interaction. For example, a provider interacting with a significantly older patient may believe interaction is difficult because the elderly become less competent as they age (Ryan, See, Meneer, & Trovato, 1994). The normal aging process brings with it a decline in vision, hearing, memory and speed, to name a few (Taylor, 1994), but these declines are often generalized to the entire elderly population creating stereotypes, ageism, and confusion about what counts as normal decrement. Providers may incorporate any of these into their medical encounters without realizing it. At any rate, negative stereotypes or generalizations negatively affect patient-provider communication (Mulley, 1997; Hummert & Garstka, 1995; Edwards & Giles, 1998; Ryan, Meredith, MacLean, & Orange, 1995). Kosberg (1983) notes negative attitudes toward the elderly are slowly changing. In the meantime, Kosberg (1983) expresses the importance of screening staff. It is easier to educate staff on the physical needs of the elderly than it is to change their attitudes toward them.

Research supports the argument that generalizations, whether applied purposefully or unknowingly, negatively affect patient-provider interaction. They may cause negative attitudes to be displayed during the medical encounter (Ryan, Meredith, MacLean, & Orange, 1995). For example, Adelman, Greene, and Charon (1991) show in their research that older patients (age 65 and older) received

more abrupt, condescending treatment than patients under the age of 65 (as cited in Beisecker & Thompson, 1995). This abrupt treatment can result in less time spent with elderly patients (Haug and Ory, 1987) as well as the elderly receiving less respect, less patience, and less opportunity to share in decision making (Adelman, Greene, Charon, & Friedman, 1990, 1992). Time may not be a factor if the provider has experience working with elderly patients. For example, Radecki, Kane, Solomon, Mendenhall, & Beck (1988) note that providers who have more experience working with elderly patients spend just as much time with them as they do the rest of the population (65 and under).

Physical impairment.

Pichora-Fuller, Johnson, and Roodenburg (1988) explain that older patients may possess a hearing loss that affects comprehension of the message. This hearing loss is age-related (also known as presbycusis) and is often the reason for miscommunication. The acoustics of a room may cause distortion of a message. The words become jumbled together and difficult to understand. It is essential for the health care provider to pay attention to these issues to ensure the effective patient-provider communication.

Power

The role of power is an interesting part of the patient-provider interaction. To understand its role in the patient-provider relationship we must first define the

term, and then apply it to the relationship. Weber (1947) defines power as "the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests" (p. 152). All individuals, therefore, hold some degree of power (Tawney, 1931). In the medical encounter, most of the power usually lies with the provider. At times, patients who choose an active role in their medical consultation challenge power distribution. For example, Beisecker (1990) notes that patients confront the doctor during the meeting and may suggest particular treatment options. This confrontation may be because the patient desires control over the situation or illness, not control over the provider and health recommendations. Demonstrating their independence is one way that patients learn to cope with situations.

Nursing home interaction

The amount of patient-provider interaction in a nursing home setting is less than one might think. Grainger (1995) discovered through her research that most of the small interaction time is spent talking about tasks. She explains that inadequate communication skills training of staff members is a common explanation for the low level of patient-provider interaction. In the nursing home setting it may be easy for staff to resort to some of the aforementioned stereotypes rather than initiate interpersonal interaction. Even during some interpersonal

communication, the interaction may be ineffective due to the staff implementing strategies such as patronizing talk to the residents (see Hummert, 1994; Hummert & Shaner, 1994; Hummert, 1994; Thimm, Rademacher, & Kruse, 1998; Hummert, Shaner, & Garstka, 1995; Giles, Fox, Harwood, & Williams, 1994; O'Connor & Rigby, 1996; Ryan, Hamilton, & See, 1994; Sachweh, 1998; Whitbourne, Culgin, & Cassidy, 1995; Whitmer & Whitbourne, 1997).

Patient Satisfaction

Effective communication has been identified as a prerequisite to patient satisfaction with the medical encounter (Korsch, Gozzi, & Francis, 1968; Woolley, Kane, Hughes, & Wright, 1978). In order to examine patient satisfaction, we must first define the term. I will adopt Buller and Street's (1991) definition which explains that patient satisfaction is "the evaluation of the quality of care delivered by the practitioner and clinic" (p. 236). Now, we can examine how patient satisfaction is affected by patient-provider interaction during the medical encounter.

Provider communicator style

Patient satisfaction can be affected by the communicator style of the health care provider. Norton's (1978) definition of communicator style can be applied to the provider as well as to the patient. Norton assigns communicator style the following ten variables: dominant, dramatic, contentious, animated, impression leaving,

relaxed, attentive, open, friendly, and communicator image. Why is provider communicator style an important area to examine? The answer lies within Ruben's (1993) research where he found that patients remembered more concerning how they were treated rather than any other part of the consultation (e. g. policy, procedure, facility information).

A majority of the research concerning preferred provider communicator style supports the notion that patients desire a provider who is attentive, relaxed, empathetic, and uses a moderate amount of dominance (Cardello, Ray, & Pettey, 1995; Buller & Buller, 1987; Street, 1989; Street & Wiemann, 1987; van Servellen, 1997). Patients also report greater satisfaction with those who use verbally unaggressive strategies (Burgoon, Parrott, Burgoon, Coker, Pfau, & Birk, 1990; Burgoon, Pfau, Parrott, Birk, Coker, & Burgoon, 1987; Evans, Stanley, & Burrows, 1992) and show more compassion or friendliness (Ruben, 1993).

Providers may strengthen patient satisfaction by expressing interest and concern, explaining appropriate information, and displaying adequate basic communication skills during the introduction or conclusion of interactions (Evans, Stanley, & Burrows, 1992; Comstock, Hooper, Goodwin, & Goodwin, 1982; Falvo & Smith, 1983; Korsch et al., 1968; & Korsch & Negrete, 1972; King, 1985). For example, skills such as making the patient feel more at

ease and obtaining historical information are basic interaction skills that providers need to make the medical encounter an effective one (Evans, Stanley, Burrows, & Sweet, 1989; Pendleton, Schofield, Tate, & Havelock, 1984; Evans, Stanley, & Burrows, 1992; Novack, 1985).

The preference for a particular provider communicator style differs among patients. Although the literature presented thus far describes the importance of friendliness, warmth, etc. of the provider, some literature suggests the opposite. Waitzkin (1984) cites the research of Carter, Inui, Kukull, et al. (1982) as an example. They found that patient satisfaction levels increased when the patients were nervous or tense, and when the health care providers were perceived as tense. More specifically, patients showed higher satisfaction levels when the provider seemed tense during discussion of delicate information regarding the patient's condition. The patients also showed higher levels of satisfaction when they were able to express tension while discussing the information with the provider.

Ultimately, Street and Wiemann (1987) say that it is up to the provider to adapt to the individual needs of each patient to achieve a greater satisfaction. This puts a lot of pressure on the provider with the variety of styles encountered during each consultation. It is difficult for the provider to adapt to the hundreds of styles he/she encounters every day. This is especially true when patient-

provider styles and perceptions conflict.

Patient compliance

Haynes (1979) refers to compliance as "the extent to which a person's behavior (in terms of taking medications, following diets, or executing lifestyle changes) coincides with medical or health advice" (as cited by Epstein & Cluss, 1982, p. 951). Patient compliance is the desired goal of the medical encounter. A way to achieve patient compliance (and ultimately, successful healthcare) is through the use of effective communication strategies (Buller & Street, 1991; Burgoon, et al., 1990). King (1985) points out that providers must become more effective with their basic communication skills (e. g. eliciting questions, concerns, responses) and more open to modifying treatment so that patients are treated as individuals with different needs.

Klingle and Burgoon (1995) studied positive, negative, and neutral regard strategies used by male and female health care providers in the initial medical encounter. Klingle (1993) defines these three regard strategies in the following manner (as cited in Klingle and Burgoon, 1995). Positive regard strategies are "positive reinforcers that motivate individuals to increase or maintain an appropriate behavior" (p. 3). Negative regard strategies are "negative reinforcers that motivate individuals to adopt or increase appropriate behaviors to eliminate the aversive stimuli"

(p. 3). Neutral regard strategies do not motivate toward any specific behavior. Klingle and Burgoon (1995) discovered that male health care providers were able to use both positive and negative regard strategies when treating patients. Patients evaluated negative regard strategies used by male providers in the initial encounter as more appropriate than negative regard strategies used by female providers. In addition, male providers were perceived as more persuasive when they employed either negative or positive regard strategies with patients. Female providers were perceived as persuasive only when they used positive regard strategies. These results shed some light on the gender issue of patient-provider communication. Klingle and Burgoon's research shows us that in order to achieve better health care outcomes, male and female providers need to be aware of patient reactions so that they can implement appropriate communication strategies for their patients.

Inevitably, health care providers treat patients who do not adhere to their suggested medical regimens. Comstock, Hooper, Goodwin and Goodwin (1982) note that patient characteristics such as age, sex, socioeconomic type, educational status and type of disease seem to affect compliance (p. 110). We can see that compliance is an issue in need of attention by looking at two different studies. Comstock, et al. (1982) reveal that at least 30% of patients do not comply with directions for oral medication. For example, the label on the bottle may recommend three

pills per day for ten consecutive days. The patient takes three pills per day for only three consecutive days because he/she feels better after the third day. Epstein and Cluss (1982) show that almost 50% of patients with chronic diseases do not comply with their suggested medical regimen. This compliance percentage often times has to do with the length of the suggested medical regimen.

King (1985) poses an argument well worth investigation. She attempts to uncover why people ignore medical advice when they are fully aware of the repercussions of their actions. Her research examines health beliefs of the patient that interfere with effective treatment. Three major factors affect patient compliance: length of the medical regimen, the patient's existing health beliefs and the communicator style of the patient. We must examine these areas more closely to understand why they affect patient compliance or noncompliance.

Length of the medical regimen

Health care providers place patients on either long-term medical regimens or short-term medical regimens. Long-term medical regimens receive a lower amount of adherence because they may entail a drastic lifestyle change for the remaining twenty or thirty years of a patient's life. Patients attempting long-term regimens may follow them for a while, but often fall back on their old ways because permanent lifestyle changes are difficult to make. Short term medical regimens, which may require lifestyle changes

for only a few weeks or months, may seem more feasible (Klingle & Burgoon, 1995, Bloom, Cerkoney, & Hart, 1980; Epstein & Cluss, 1982).

Patient health beliefs

The patient's existing health beliefs may interfere with medical treatment. King (1985) notes that some patients hold beliefs about their health which have no medical basis. She also refers to the "Health Belief Model" which "is based on psychological theories of learning, attitude, and motivation" (p. 89). The model states that four factors exist which determine whether a patient will adhere to the medical advice of their health care provider or ignore the advice. First, the patient must have the drive to stay healthy. Second, the patient must believe that he or she is susceptible to the condition. Third, the patient must believe that his or her health could be in danger if the condition remains untreated. Finally, the patient must believe that there are more advantages to receiving treatment than disadvantages.

Patient communicator style

Another element that may affect patient compliance deals with the communicator style of the patient. Since the interaction involves both the patient and the provider, we cannot simply always blame the provider for ineffective communication during the consultation. Again, King (1985) explains that patients may not discuss their concerns with a provider because they may be afraid, nervous, or possess

a fear of looking foolish. King also states in her article that patients may refuse to address concerns because they feel they are wasting the provider's time. Although these concerns may not become verbalized, it is possible to detect the patient's concern through nonverbal signals such as facial expressions (Bush, 1985; Argyle, 1975; Ekman, Friesen, & Ellsworthy, 1972). Health care providers should become more aware of the patient's nonverbals and implement flexibility in the medical regimen if possible to better meet the needs of each patient (King, 1985).

Relationship between patient-provider interaction, patient satisfaction, and patient compliance

Now that we understand more about patient-provider interaction, patient satisfaction and patient compliance, we must determine how these three are related. One way to explain the relationship among the three is to first, examine how patient-provider interaction is related to both patient satisfaction and patient compliance and second, discuss how patient satisfaction and patient compliance are interrelated.

First, patient-provider interaction can be connected to patient satisfaction and patient compliance (Cardello, Ray, & Pettey, 1995). We discussed earlier that communicator style of the provider is an extremely important factor in patient-provider interaction (Ruben, 1993; Evans, Stanley, & Burrows, 1992; Ben-Sira, 1976; Buller & Buller, 1987; Doyle & Ware, 1977). Ben-Sira (1976), Buller and Buller

(1987), Doyle and Ware (1977), Korsch, Gozzi, and Francis (1968), and Woolley, Kane, Hughes, and Wright (1978) found that the communicator style of the provider is related to both patient satisfaction and compliance. The authors show that 65% of the patients surveyed expressed satisfaction with a bad medical care outcome. Some patients stated, "he did his best," referring to their physician (p. 127). This statement reinforces the argument that patients who are happy with the provider's communication efforts are more satisfied with their medical treatment. In fact, Doyle and Ware (1977) show that the provider's conduct was the most important factor in determining satisfaction with the medical encounter. Buller and Buller (1987) also reveal the importance of the provider's communicator style. Their research shows a higher evaluation of the medical encounter when the patient expressed higher satisfaction with the provider's communicator style (see also Comstock, Hooper, Goodwin, & Goodwin, 1982). These results suggest that patients may associate communication competence with medical care competence.

Next, we can see that patient satisfaction and patient compliance are interrelated (Korsch & Negrete, 1972; Buller & Buller, 1987). Korsch and Negrete (1972) provide an example that is occurring more often in today's medical setting. A mother seeks medical attention for her son because his cough is not going away. The physician gives the mother his recommendations without explaining the

child's problem and asks to see the child in a few days. The mother does not understand how the prescriptions will cure her son's cough, so she buys over-the-counter medication and does not return for the follow-up examination. The mother was dissatisfied with the treatment she received from the provider and therefore, did not comply with the suggested medical regimen. Buller and Street (1991) state that the patient and the provider must work as a team to achieve the best medical outcome. This requires a closer examination of communication styles by the patient and the provider. Both individuals must adjust to one another to achieve higher levels of satisfaction and compliance.

With a better understanding of patient-provider interaction, patient satisfaction, and patient compliance and the relationship among them, we can see their impact on health communication. My specific interest lies in provider communication strategies applied to elderly individuals, resulting in patient compliance or non-compliance. I am curious to see what kinds of strategies are used when confronting patients with various needs and whether these strategies are consistent with recommendations from current literature. The following research questions apply to my particular area of interest.

RQ1: How do provider compliance-gaining strategies differ according to the patient's sex?

RQ2: How do provider compliance-gaining strategies

differ according to the patient's diagnosis?

RQ3: How do provider compliance-gaining strategies differ according to the patient's health condition?

RQ4: What barriers cause low levels of patient compliance?

RQ5: What methods most effectively gain patient compliance in the care center environment?

Method

Setting

The study was conducted at a long-term care facility in Charleston, Illinois. The facility is certified for Medicare (public aid), Medicaid (private aid), Veteran's Affairs, and hospice care (home health care). At the time of the study, the facility housed 110 residents and employed approximately 80 staff members.

Instrument

The instrument (Appendix A) used for my research was a two-page survey consisting of nine open-ended questions. Space was provided immediately after each question to enable participants to respond directly on the survey with which they were provided. Completion time of the survey totaled approximately 20 minutes depending on the complexity of the responses.

Participants

Thirty-one individuals volunteered to be part of this study. The participants were divided into two groups. Group I consisted of 13 individuals (2 males; 11 females) who provide care within a long-term care facility (nursing home). The participants represent a variety of positions at the facility. Of the 13 participants from the care facility, five have previous experience in either the home

or hospital environment. All 13 currently provide services for the care facility only. The majority of participants for this group range from 22 years to 53 years of age. Two individuals (1 male; 1 female) did not note their ages on their surveys. See Appendix B for more information regarding Group I.

Group II consisted of 18 individuals (18 females; 0 males) who provide care for those requiring assistance at home. Three participants did not specify their sex on the form, however, only females attended the inservice where I distributed the surveys. Of the 18 people surveyed, one has experience in a setting other than home care. Sixteen participants consider themselves as homemakers. One titles herself as Chore-housekeeper. The last participant titles herself as homemaker of free assistance/ private care giver. The majority of participants for this group range from 37 years to 69 years of age. Four individuals in this group did not specify their ages on their surveys. Appendix C provides further information regarding Group II.

Procedure

Participants from Group I were given surveys by the Director of Admissions in April 1999. She distributed the surveys to the staff individually and had them return the surveys at their convenience. The Director of Admissions

distributed the surveys to Group I and collected the information for three reasons. First, I felt that the rapport between the Director of Admissions and the staff may receive a quicker return rate. Next, arranging one large meeting with the staff of the facility was not possible within the time constraints of my study.

I personally distributed surveys to Group II in May 1999. Group II received surveys from me directly for two reasons. First, a required, monthly inservice for home health care providers allowed distribution of surveys at one large meeting. This meeting provided the opportunity for an immediate return rate with the surveys. Next, I wanted to be available for questions from the group. I hoped that my presence would encourage the group to obtain clarification on any aspect of the survey that they did not understand.

Methodology

Krippendorff (1980) defines content analysis as "a research technique for making replicable and valid inferences from data to their context" (p. 21). Hicks, Rush, and Strong (1985) go on to say that content analysis is "a procedure for identifying those attributes of a message which have the greatest likelihood of leading to an accurate inference of the intention of the message" (p.

58). Hicks, Rush, and Strong (1985) explain that communication is "a system for sending and receiving observable signals (messages)" (p. 58). The word "observable" recognizes that a variety of individuals may observe different parts of an interaction. Krippendorff (1980) discusses two connotations of his definition that better define "observable."

First, he explains that "messages do not have a single meaning" (p. 22). It is impossible for a message to mean the exact same thing to all receivers of that message. They (messages) may always be observed from different perspectives whether the different perspectives stem from one receiver or a number of receivers. Second, Krippendorff (1980) notes that "meanings need not be shared" (p. 22). In a world composed of different races, religions, cultures, etc. shared meanings among the whole are nonexistent.

Content analysis allows us to detect themes from participants and analyze those themes according to the contexts from which they came. A theme is "an assertation about a subject matter" (Budd, Thorp, & Donohew, 1967, p. 47). Content analysis allows for the detection of motivational, psychological, or personality characteristics of spoken or written conversation. These characteristics

may or may not be a result (direct or indirect) of the individual's demographic history.

Content analysis, and more specifically, thematic analysis, is appropriate for my study because of the qualitative nature of the open-ended questions in my survey instrument. The purpose of my research was to uncover particular compliance-gaining strategies used in encounters with the elderly population. My research questions encompass differing approaches to compliance-gaining according to sex, diagnosis, and health condition as well as barriers and most effective methods for gaining patient compliance. Thematic analysis lends itself to this study because it allows us to visually observe strategies that are most and least often applied to patients. In regards to this particular study, thematic analysis provides future researchers with a starting point in the area of compliance-gaining in the care facility and home health environments.

Reliability

Stability, reproducibility, and accuracy are all components of reliability. Stability is defined by Krippendorff (1980) as "the degree to which a process is invariant or unchanging over time" (p. 130). Stability, as applied to this study, is difficult to determine due to

time constraints. Testing and re-testing numerous times during the course of one year is a difficult task to execute.

Krippendorff (1980) defines reproducibility as "the degree to which a process can be recreated under varying circumstances, at different locations, using different coders" (p. 131). This study was conducted in two different environments - a care facility and the home health setting. Three coders, in addition to myself, reviewed the data. Both of these components increase reliability.

Accuracy is "the degree to which a process functionally conforms to a known standard, or yields what it is designed to yield" (Krippendorff, 1980, p. 131).
Accuracy was achieved in this study by comparing its results to those that the current literature suggests. The results from this study were similar to those discovered by previously mentioned researchers. Similar results among this study and current literature suggest that my research is accurate.

Validity

Budd, Thorp, and Donohew (1967) explain validity as "actually measuring what the researcher says he is measuring" (p. 66) or producing "the desired information" (p. 68). Krippendorff (1980) says that validity "designates

that quality of research results which leads one to accept them as indisputable facts" (p. 155). In order to assess the validity of my research, I will take a closer look at data-related validity and its two components, semantic validity and sampling validity.

Krippendorff (1980) offers the following definition for data-related validity: it "assesses how well a method of analysis represents the information inherent in or associated with available data" (p. 157). Data-related validity may be determined by examining semantic validity and sampling validity. Krippendorff (1980) says that semantic validity "assesses the degree to which a method is sensitive to the symbolic meanings that are relevant within a given context" (p. 157). My research results are only applied to the settings from which they were received. They are not to be generalized to all care facilities and home health environments. These results represent a starting point for future research in the same area. The emerging data remain within the contexts of the Charleston, Illinois care facility and home health environments surrounding Charleston.

Krippendorff (1980) says that sampling validity "assesses the degree to which available data are either an unbiased sample from a universe of interest or sufficiently

similar to another sample from the same universe so that the data can be taken as statistically representative of that universe" (p. 157). This definition has two components that are both addressed with my research. The first part of the term's definition, "the degree to which available data are an unbiased sample from a universe of interest," was controlled by my thesis committee reviewing my work. My committee reviewed the data and emerging themes to ensure that the results revealed no bias. The remaining half of the definition was addressed by comparing my results to those of current literature. It is noted within my research that the emerging themes from this study do not hold true in every patient's case. However, the emerging themes in this study are representative of the majority of cases I encountered while doing background research on the topic.

Results

The appendix section will be useful when examining the results of this study. Appendix B serves as an information guide for the demographic information of Group I. Participants were assigned letters A through M to make coding easier. The following information may be found in Appendix B: current job title, age, sex, years of service, current place of work, and relevant degrees and/ or certifications. Appendix C serves as an information guide for the demographic information of Group II. Participants were assigned letters AA through RR for easier coding and better distinction from Group I. The same demographic information was asked of Group II as it was for Group I.

Appendix D lists the responses of Group I. The first page of Appendix D depicts question #1 at the top of the page. Every participant's response to question #1 is located directly underneath the question and to the right of the appropriate participant's designated letter. Questions #2 through #9 repeat the same pattern. The question is located at the top of the page; responses are directly underneath and to the right of their appropriate participant. Appendix E uses the same format to display the responses of the participants. The letters AA through RR designate participants for Group II.

Appendix F displays themes from both groups condensed onto the same page. Each question is located at the top of the page with the themes directly beneath. Again, each question is placed on a separate page.

Appendices G and H depict the responses to questions 1 through 9 for each individual. Appendix G is devoted to individual care facility responses while Appendix H is devoted to home health individual responses. These appendices represent a condensed version of the two-page survey that participants originally completed.

Question #1: How do cues such as voice intonation, pitch, & rate affect patient compliance?

In regards to question one, four themes emerged from the data of Group I (care facility). The four themes were voice intonation, pitch, rate, and volume. Participants A, B, and C explained that voice intonation needs to remain friendly and/or pleasant. Participant A also mentioned that appropriate voice usage depends on individual patient preferences; however, most residents prefer friendly cues. Participants H and F mentioned that a medium pitch is most appropriate for the environment. Regarding rate of speech, participants L and I noted that a slower rate of speech gains more compliance from residents. Participants D, E, F, K, and M stated that a soft volume gains more compliance

from residents. The two remaining participants' (G, J) responses were categorized into unclear/ miscellaneous because the answers did not relate to question one.

Responses from Group II (home health) were categorized into four themes, answers that were unclear or unanswered, and noteworthy responses. Participants II and JJ explained that using the same tone of voice as usual gains compliance. One participant (QQ) commented that a medium pitch is the most appropriate for their setting. Participant BB stated that a slower rate works most appropriately for gaining patient compliance. Finally, regarding volume, three participants (BB, GG, HH) felt that using a loud volume assisted in gaining patient compliance (BB, GG, HH). One participant (QQ) felt that a soft volume worked most appropriately. Seven individuals' responses were categorized into the unanswered or unclear category. Four participants (AA, MM, OO, PP) commented on treatment of the elderly in the home health environment. Participant AA explained that compliance levels are higher when the health care provider avoids using pet names such as "honey" or "sweetie." Participant MM stated that using dominance with a patient causes resistance from that patient. Participant OO noted the importance of recognizing individual patient needs. Finally, participant PP stated

that building rapport with the patient helps gain patient compliance.

Question #2: What factors determine the amount of time you spend with a patient?

Several themes were discovered from question two. Answers from Group I focused on the major theme of care required. Participants C, F, I, K, H, L, B, J, and A noted that a patient's mental and/ or physical need for care determine the amount of time that they spend with their patients. Next, participants A, E, and G noted that resident compliance determines how much time they spend with their patients. Participants D and A responded by saying that outside interference or other duties affects how much time they spend with a patient. Participant (M) explained that patient-provider time depends on how the day is going.

Group II responses were divided into two major themes: plan of care and medical need. First, nine participants (AA, BB, GG, HH, II, JJ, NN, OO, RR) noted that the plan of care determines how much time is spent with a patient. More specifically, participants noted that the case worker schedules the amount of time. Next, four participants (FF, MM, PP, QQ) stated that medical need, such as health

condition and diagnosis, plays a role in patient-provider time.

Question #3: How do the patient compliance strategies you use differ according to the diagnosis of the patient? (For example, Alzheimer's, Schizophrenia, etc.)

Group I responded with answers that formed three major themes. First, four participants (B, D, M, F) in this group stated that they use the same strategies for compliance gaining with any diagnosis. Next, four participants (A, E, I, J) explained that they use differing strategies. Three participants (C, G, H) pointed out that they use different strategies to accommodate a patient's mood, need for motivation, lack of patience, or need for verbal cues.

Fourteen participants (DD, FF, GG, HH, JJ, KK, MM, NN, OO, PP, EE, CC, BB, RR) from Group II left the question unanswered or responded with answers unrelated to the question. Two individuals (II, LL) noted that it is important to use understanding with the patient. Participant AA explained that patients with Alzheimer's or dementia work better with direct commands. Participant QQ explained that strategies differ for patients with Alzheimer's and schizophrenia. Alzheimer's patients need to feel needed and like to help the health care provider with

small tasks. Patients with schizophrenia need frequent subject changes from the health care provider.

Question #4: How do the patient compliance strategies you use differ according to the sex of the patient?

Seven (M, G, I, E, F, L, C) out of 13 participants from Group I said that they use the same strategies for both males and females (Appendices F). Three (A, D, J) noted that they use different strategies between the sexes. Participant A chooses to "beat around the bush" with women and address males without "beating around the bush." Participants D and J explain that they use touch more with females than with males. Three (K, B, H) responses were unclear or unanswered.

Group II answered question four with the following themes emerging. Participants PP and QQ stated that they use the same strategies for patients whether male or female. Participants GG, HH, and AA discussed different strategies used due to the patient's gender. For instance, participants GG, HH, and LL noted that males are more difficult to work with. Participant AA noted that female clients are more particular and that she takes charge with male clients. Participants BB, CC, DD, EE, FF, II, JJ, KK, MM, OO, and RR either did not respond or gave answers that were unclear.

Question #5: How do the patient compliance strategies you use differ according to the health condition of the patient? (For example, poor health, good health, etc.)

One major theme emerged in Group I. Health care providers (B, C, D, H, I, J, L) explained that the best way to achieve compliance is to use realistic expectations. For example, patients in poor health are given less active activities while patients in good health receive more active activities. Three participants noted that they use the same strategies for all health conditions. More specifically, participants M, E, and G explained that they use appraisal to gain compliance. Participant A stated that she uses different strategies based on the personality of the patient, not the health condition of the patient.

Only two responses from Group II could be categorized into themes. The rest of the responses fell into the category of unclear or unanswered. One participant (LL) explained that she uses the same strategy (sympathy) for each patient. Participant QQ noted the use of different strategies. For example, she uses encouragement and praise for patients in poor health and lets the patients in good health help with small tasks.

Question #6: What kind of communication training have you received in the following areas? a. Formal b. On the job.

Participants A, C, D, H, and I of Group I received formal communication training. CNA classes (A), nurse's training (C), and college courses (D, H, I, L) were mentioned as specific areas where communication training occurred. Participants A, C, D, and H noted that they received on-the-job training. Responses such as an inservice, therapy, and on-the-job experience were given. Participant K received training as a plumber's apprentice. Participants B, G, and J responded to the question by number of years. Participants E, F, L, and M fit into the category of unclear or unanswered responses.

Group II responses for communication training were as follows. Participants AA, MM, NN, and QQ stated that they received formal communication training. More specifically, training such as college courses, nurse's aide training, and LPN training were listed. Participants AA, BB, GG, HH, and QQ discussed on the job communication training such as inservices and many hours of patient-provider communication. Two participants (NN, PP) responded by a number of years. Three individuals stated that they had received no communication training. Participants GG and HH

reported no formal training and participant LL reported no training formally or on the job. Most responses for this question fit into the unclear or unanswered category. Ten individuals (BB, CC, DD, EE, FF, II, JJ, KK, OO, PP) were unclear for formal training and ten participants (CC, DD, EE, FF, II, JJ, KK, MM, OO, RR) were unclear for on-the-job training.

Question #7: What barriers cause low levels of patient compliance to health care recommendations?

The following themes for Group I were discovered: patient barriers, provider barriers, unclear/ unanswered, and noteworthy responses. Patient barriers such as cognition (G, I, J), physical condition/ attribute (G, K), depression (A), hearing impairment (F), and patient attitudes (D) were reported. Provider barriers such as poor teaching of treatment plan (F, L, M), demanding/ ordering (H, E), and unrealistic goals (I) emerged from the data. Responses for participants B and C were placed into the unclear/ unanswered category.

The same major themes emerged from Group II. Patient barriers such as adapting to change (NN, PP), hearing impairment (LL, OO), and medical directions (AA) were reported. The only provider barrier mentioned was medical directions and it was mentioned by participant AA. Most

responses for this group were categorized into unclear or unanswered as revealed by participants BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, MM, QQ, and RR.

Question #8: What methods most effectively gain patient compliance in the care center environment?

Several different responses emerged from the data on this particular question. Three participants (A, F, L) mentioned that explanation of care most effectively gains compliance. Three more participants (H, K, M) expressed that kindness is most effective. Developing rapport (F, M), compromise (C, I), and encouragement (G, I) all received mention by two participants. Participant B did not reply to the question. Finally, noteworthy responses to the question include environment (J) and being straight with the patient (E).

Participants AA, DD, FF, GG, HH, II, JJ, KK, LL, PP, QQ, and RR either responded with answers that were unclear or they did not respond to the question at all. Participants CC, EE, and MM noted that allowing patients to feel more in control most effectively gains patient compliance. Responses mentioned by one participant each are being understanding to patients' needs (NN), projecting a good attitude (BB), and showing patience (OO).

Question #9: What percentage of your time with a patient is spent. . . a. building rapport b. discussing his/ her personal issues?

Nine participants (B, C, D, E, F, I, K, L, M) from Group I spend 0 - 50% of their time building rapport with their patients. Three (G, H, J) spend 51 - 100% of their time building rapport with their patients. Participant A explained that building rapport occurs in passing or during care. Twelve individuals (B, C, D, E, F, G, H, I, J, K, L, M) spend 0 - 50% of their time discussing a patient's personal issues. None of the participants stated that they spend 51 - 100% of their time discussing a patient's personal issues. Participant A noted that discussion of personal time occurs during care or idle time.

Of the 18 participants in Group II, six (AA, II, JJ, KK, LL, PP) spend 0 - 50% of their time building rapport with their patients. Two (GG, MM) spend 51 - 100% of their time building rapport with their patients. Participant BB did not specify a percentage. Seven participants (GG, II, JJ, KK, LL, MM, PP) spend 0 - 50% of their time discussing a patient's personal issues. One participant (AA) spends 51 - 100% of her time discussing personal issues. Participants BB, CC, DD, EE, FF, HH, NN, QQ, and RR did not specify a percentage.

Discussion

My interest lies in the similarities and differences between compliance gaining strategies used in the care facility and home health environments. The research questions investigated provide a solid foundation for future research regarding this area of health communication. From this research we may learn which strategies are similar or different and why.

RQ1: How do the patient compliance strategies you use differ according to the sex of the patient? (Appendix F; Question #4)

Seven out of 13 participants from Group I and two out of 18 participants from Group II stated that the compliance gaining strategies they use do not differ according to the sex of the patient. Three participants from Group I and four participants from Group II noted that they use different compliance gaining strategies for males and females (see Appendix F, question 4).

These compliance-gaining strategies are one aspect of the provider's communicator style. Referring back to Ruben's (1993) research, we can see that patients remembered more about the interpersonal relationship with the provider than they did any other part of the consultation. The question we need to ask at this point is,

"Is it appropriate to use the same compliance gaining strategies for both males and females?" If we look back to the work of Street and Weimann (1987), we can see that the highest levels of patient satisfaction occur when the provider adapts to individual patient styles. Assumptions should not make their way into the patient-provider encounter because of the sex of the patient. Instead, compliance-gaining strategies should depend on the patient as an individual, not the patient as a male or female.

RQ2: How do the patient compliance strategies you use differ according to the diagnosis of the patient? (For example, Alzheimer's, Schizophrenia, etc.) (Appendix F; Question #3)

Four participants from Group I explained that the strategies they use are the same no matter the diagnosis of the patient. These participants (B, D, M, F) stress the importance of using patience, kindness, and firmness with their patients. Four participants (A, E, I, J) stated that they differentiate between diagnoses. More specifically, they mentioned Alzheimer's and schizophrenia (most likely because these were the ones specified on the survey). Regarding Alzheimer's, these participants specify things such as using agreement, breaking down tasks into smaller pieces, remaining patient, and limiting choices. Regarding

schizophrenia, the participants recommend things like emphasizing safety/ trust, speaking calmly, and knowing when to back off.

Three participants (C, G, H) stated that strategies are based on patients as individuals, not necessarily according to the diagnosis of the patient. For example, participant C explained that the mood of the patient determines the kinds of compliance gaining strategies used. Participant G focused on motivating patients and participant H talked about patient needs.

Fourteen of the 18 responses for Group II were categorized into the unclear/unanswered category. Two participants (II, LL) said that providers should be understanding with their patients. Participant AA stated that patients with Alzheimer's or dementia perform better when given direct commands. The only participant to express differences between Alzheimer's and schizophrenia patients was participant QQ. She stated that compliance is better gained for Alzheimer's patients if the provider allows them to help with small tasks. For patients with schizophrenia, the provider should change subjects often.

In both Group I and Group II, it appears that female providers use positive regard strategies as mentioned by Klingle and Burgoon (1995). Positive regard strategies used

by these groups refer to tactics such as "motivation," "TLC's" (tender loving care's), and "understanding." The compliance gaining strategies used in this study reflect the most effective strategies defined in current literature. Klingle and Burgoon (1995) discovered that female providers were perceived as more persuasive when they employed positive regard strategies. Because they were more persuasive, they received higher levels of compliance from patients when positive, rather than negative, regard strategies were applied.

RQ3: How do provider compliance gaining strategies differ according to the patient's health condition? (Appendix F; Question #5)

The major theme among Group I answers was to use realistic expectations for the patient. Seven of the 13 participants of Group I suggested this response. (This theme is categorized by itself in Appendix F, Question #5; however, it could be placed within the theme of using different strategies for compliance-gaining). More specifically, health care providers said that they employ less physically active activities for patients in poor health and more physically active activities for those patients in good health. Participant A, whose response is listed under different strategies in Appendix F, stated

that the compliance gaining strategies she uses depends on the personalities of the patients. One participant (QQ) from Group II stated that she uses different strategies to gain compliance. She recommended using encouragement and praise for patients in poor health and allowing patients in good health to help with small tasks.

The methods these participants use follow the recommendations of Street and Wiemann (1987). The authors note the importance of adapting to the individual needs of the patient. Obviously it is difficult for a provider to completely meet the communication needs of every patient encountered; however an attempt must be made in order to achieve patient satisfaction and ultimately patient compliance. The provider's use of effective communication strategies can determine whether the outcome of healthcare is successful or not (Buller & Street, 1991; Burgoon, et al., 1990).

Three individuals from Group I and one participant from Group II stated that they use the same strategy for compliance gaining no matter the health condition of the patient. Group I participants are referring to applying TLC's to all patients. Participant LL from Group II stated in her response that she uses sympathy because it gets results.

Although the majority of research on patient satisfaction and compliance shows us that patients prefer providers who are verbally unaggressive (Burgoon, Parrott, Burgoon, Coker, Pfau, & Birk, 1990; Burgoon, Pfau, Parrott, Birk, Coker, & Burgoon, 1987; Evans, Stanley, & Burrows, 1992), relaxed, empathetic, attentive (Cardello, Ray, & Pettey, 1995; Buller & Buller, 1987; Street, 1989; Street & Wiemann, 1987; van Servellen, 1997), friendly, and compassionate (Ruben, 1993), Carter, Inui, Kukull, et al. (as cited by Waitzkin, 1984) provides research showing the opposite. The authors explained that patient satisfaction levels increased when the patient him/herself was tense and/or perceived the provider as displaying tension. The providers are correct, in most cases, to apply the TLC's. It is still important to keep in mind that particular patients may not respond to the use of TLC's because they prefer a different style, as the previously mentioned literature suggests. The surveys received from both groups seemed to indicate that the staff members get to know their patients well enough to understand their health care needs. The TLC's may be appropriate for all of the patients assigned under these participants' care.

RQ4: What barriers cause low levels of patient compliance? (Appendix F; Question #7)

Both Groups I and II responded with answers that were divided into two categories: patient barriers and provider barriers. Under patient barriers, the groups had two subtopics in common: hearing impairment and medical directions. I find it interesting that only three participants mentioned hearing impairment since it is one of the three most commonly reported chronic problems of those 65 years and older (NCHS, 1987). In fact, Schow and Nerbonne (1980) report that approximately 70-80% of institutionalized elderly and approximately 30% of noninstitutionalized elderly are affected by a hearing loss. We can see the increase in reported hearing loss by looking at an age and percentage breakdown. In 1987, 33% of individuals 65 to 74 years of age, 45% of persons 75-84 years of age, and 62% of persons over 85 years of age reported a hearing problem (NCHS, 1987).

Regarding medical directions, participants stated that patients sometimes misunderstand the directions given to them by their health care professional. Group I listed other patient barriers such as cognition, physical condition/ attribute, depression, and attitude. Group II also listed adapting to change as a patient barrier.

If we look to King's (1985) research, we can uncover two possible reasons for why some patients may

misunderstand medical directions from their health care provider. The patient may have a more timid communicator style, which prevents them from asking questions. The patient may perceive their concerns as a waste of the provider's time, therefore choosing to remain silent when asked if there are any questions. King (1985) also shows us that the patient may fear "looking foolish" in front of the provider (p. 94). This fear stems from semantic distractions during the medical encounter. For example, medical terminology or jargon may confuse the patient. The patient does not know whether he or she should have prior knowledge of the language used by the provider. Skopek (1979) shows us that the patient avoids looking foolish by avoiding questions and as a result, risks misunderstanding vital health care recommendations.

Groups I and II shared a common subtopic for provider barriers. Participants (F, L, M, AA) noted that health care providers sometimes fail to properly explain medical instructions to their patients. More specifically, participant L noted that patients are sometimes informed regarding one option, but left unaware of other options. When patients are not properly educated on their medical situation, it seems obvious that providers may fail to obtain the compliance they are seeking. Participant AA

provided the following suggestion that may reduce misunderstandings. She stated that it would be beneficial for another party, such as a family member, to be present while the provider is covering medical instructions.

Group I listed other barriers such as demanding/ ordering and unrealistic goals. Two participants from Group I (H, E) mentioned that demanding or ordering a patient is not an effective way to receive compliance. These results concur with the current literature regarding communication style of the provider. The research of Cardello, Ray, and Pettey (1995), Buller and Buller (1987), Street (1989), Street and Wiemann (1987), and van Servellen (1997) shows that patients prefer the provider's style to be attentive, relaxed, empathetic, and uses moderate amounts of dominance. Further research shows greater satisfaction levels from patients when they encountered health care professionals displaying compassion, friendliness, and verbally unaggressive strategies (Ruben, 1993; Burgoon, Parrott, Burgoon, Coker, Pfau, & Birk, 1990; Burgoon, Pfau, Parrott, Birk, Coker, & Burgoon, 1987; Evans, Stanley, & Burrows, 1992).

RQ5: What methods most effectively gain patient compliance in the care center environment? (Appendix F; Question 8)

For Group I, three participants responded that explanation of care most effectively gains patient compliance and three participants stated that kindness most effectively gains compliance. Developing rapport, compromise, and encouragement were all mentioned by two participants each. One participant stated that a happy/ cheerful environment most effectively gains patient compliance. Finally, participant E explained that being straight with the patient most effectively gains compliance.

The two responses mentioned most, explanation of care and kindness, have been shown to strengthen patient satisfaction (Ruben, 1993; Evans, Stanley, & Burrows, 1992; Comstock, Hooper, Goodwin, & Goodwin, 1982; Falvo & Smith, 1983; Korsch et al., 1968; Korsch & Negrete, 1972; King, 1985).

Three of the 18 participants for Group II explained that allowing the patient to feel more in control most effectively gains patient compliance. According to participants CC, EE, and MM, allowing the patient to do tasks for themselves helps them to feel more in control and boosts self esteem. Group II also noted methods such as being understanding to patient needs (NN), projecting a good attitude (BB), and being patient with their clients

(OO). Klingle and Burgoon (1995) define methods for motivating individuals to comply with health care recommendations as regard strategies.

Limitations

First of all, this research is based on a fairly small sample. Group I (care facility) consisted of 13 participants and Group II (home health) consisted of 18 participants. The return rate for this study, however, was particularly high. For Group I, 13 out of 30 surveys were returned, making a 43% return rate. This return rate is high, but could have been higher if the surveys were collected immediately rather than at the participants' convenience. This was the most efficient manner, however, for collecting surveys for Group I. Participants were staff members with varying schedules which made it difficult for scheduling a meeting time.

Group II had a 100% return rate. I was able to collect the surveys immediately since the participants completed them at a monthly inservice. The small numbers for both groups reflect unforeseen circumstances that occurred during the course of my research. Participants from the original groups scheduled to complete the surveys were unable to do so due to structural changes in the health

care institution. I recreated the instrument to fit two new groups at the beginning of April 1999.

The second limitation concerns brief responses and the high number of unanswered questions. Both groups contained surveys in which participants eliminated questions. For example, in Group I, one person eliminated question 3; one person eliminated question 5; one person eliminated question 6; one person eliminated question 7; and one person eliminated question 8. This was especially true for Group II (home health). Six people eliminated question 1; two people eliminated question 2; ten people eliminated question 3; nine people eliminated question 4; ten people eliminated question 5; eight people eliminated question 6; 12 people eliminated question 7; 12 people eliminated question 8; and four people eliminated question 9.

The high number of unanswered questions for Group II appeared to be due to the environment in which the surveys were distributed. The surveys were distributed at a continuing education monthly inservice for the staff members. These women had been participating in the discussion and lecture parts of the inservice for approximately an hour and a half. The surveys were distributed during their thirty-minute break between sessions. It seemed as though the participants were ready

to relax and converse with one another after the long session. It would have been more beneficial to distribute the surveys at a different time.

The third limitation is the environment. Group I was given the surveys at work. The person distributing surveys instructed the participants to complete them and return them as soon as possible. The surveys were distributed on an individual basis since a mutual meeting time could not be determined. Using a different structure for this group could have lessened the number of unclear answers or unanswered questions.

Group II completed surveys during their break at a monthly inservice for continuing education. The environment was not conducive for concentration since they were breaking after an hour and a half of lecture/ discussion. They gathered outside in the patio area for refreshments. I was allotted time during their 30 minute break to explain the surveys and distribute them. The participants were completing the surveys as they were talking and enjoying their refreshments. It appeared that the social time inhibited their ability to elaborate on questions. Designating a different time for survey distribution may have enabled a higher number of clearly answered questions.

The fourth limitation reflects the design of the instrument. I received comments that the participants were not accustomed to completing surveys with open-ended questions. Instead, they are usually given surveys reflecting a Likert scale where they only need to choose from listed answers.

Suggestions for future research

First, the number of participants should increase for both groups. The small samples used in this study still prove significant, but increasing the numbers will create higher reliability and validity. Second, the environment in which the surveys are completed should be more structured. If possible, a mutual meeting time for Groups I and II individually should be arranged so that there is an immediate return of surveys. This meeting may also allow for questions or concerns regarding the survey itself. Also, a focus group could be held immediately after so that the researcher can obtain clarification on vague answers. Finally, I recommend using a mixture of open and closed questions. With their busy schedules, health care professionals do not have a great deal of time to spend on questions. Open-ended questions are important for details on the subject at hand, but too many can make the survey time consuming. Using both open and closed questions may

break the monotony of writing paragraphs for every answer. It may even be more beneficial to make the survey mostly objective with only a few open-ended questions for clarification.

Conclusion

I had originally planned to focus only on my research questions. After categorizing the data into themes I felt that it would be more beneficial to future research to discuss the themes emerging from each of my survey instrument questions. This baseline data provides a starting point for future research on patient compliance-gaining. The descriptive nature of my study allows us to see how this particular facility and home health staff attempt to gain patient compliance.

The results of this study support the recommendations of current literature. The majority of participants from both the care facility and home health environments appear to be implementing the most effective communication strategies for gaining patient compliance. The health care providers from both groups mentioned the importance of attending to the individual needs of the client. For example, providers noted the importance of recognizing personality differences among their clients. A number of patients may have experienced a stroke, but each of those patients must receive his or her own individualized treatment plan to ensure optimal care and ultimately, higher levels of compliance.

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Appendix A

Dear Participant:

Thank you for volunteering to be a part of my research! I sincerely appreciate your taking the time to complete the following survey. The information you provide will be applied to graduate level thesis research as well as an article regarding health behavior and compliance with Dr. Melanie Mills and Dr. Julie Dietz who are directing my research. I have a M. A. in Gerontology and am working toward an additional Master's degree in Speech Communication in the area of Health Communication. The information you provide is vital to furthering our knowledge concerning patient compliance.

I assure you that all of your answers will remain anonymous. Please fill out the survey as completely and honestly as possible so that I receive accurate information for my research. The survey may take approximately 20 minutes to complete. The space provided under each question should allow enough room for your answer. Please return the survey to Sandra Long as soon as you are finished.

If you are interested in obtaining a copy of the results or becoming part of a focus group, please indicate so at the bottom of this page. Also, you may wish to separate this sheet from the rest of the survey so that your answers remain anonymous.

Again, thank you for volunteering your time. I greatly appreciate your input.

Sincerely,

Merideth Mayberry

Encl: survey

Check the appropriate response(s).

____I would like a copy of the research results.

____I would like to participate in a follow-up focus group.

Name:_____Phone:_____

Address:_____

Current job title:_____

Years of service: (home care):_____ (hospital care):_____ (care facility):_____

You currently provide services for (circle all that apply): Home Hospital Care Facility

Sex: M F *Age*:_____

Please list your relevant professional degrees or certifications: _____

_____

Please answer the following questions as honestly as possible.

1. How do cues such as voice intonation, pitch, & rate affect patient compliance?

2. What factors determine the amount of time you spend with a patient?

3. How do the patient compliance strategies you use differ according to the diagnosis of the patient? (For example, Alzheimer's, Schizophrenia, etc.)

4. How do the patient compliance strategies you use differ according to sex of the patient?

5. How do the patient compliance strategies you use differ according to the health condition of the patient? (For example, poor health, good health, etc.)

6. What kind of communication training have you received in the following areas?

   a. Formal education:

   b. On the job:

7. What barriers cause a low level of patient compliance to health care recommendations?

8. What methods most effectively gain patient compliance in the care center environment?

9. What percentage of your time with a patient is spent. . .

   a. building rapport?
   b. discussing her/ his personal issues?

Appendix B

Care Facility Demographics

CF = Care Facility Environment
Home= Home Environment
Hosp = Hospital Environment
√ = unspecified # of years of service

Part	Current job title	Age	Sex	Years of Service	Current work	Degrees/ Certifications
	Certified Nursing Aide (CNA)	22	F	Home √ CF √	CF	CNA
B	Activities Assistant		F	CF 19	CF	
C	Case Manager	37	F	CF √	CF	RN/ CCM
D	Activity/ Social Service Assistant	40	F	CF 10	CF	College Courses
E	CNA	39	F	Home ½ CF 1½	CF	CNA
F	LPN (Licensed Practical Nurse)	34	F	CF 7	CF	LPN Certificate I. V. certified
G	Licensed Physical Therapist Assistant	51	F	Home 8 Hosp 8 CF 15	CF	Belleville Area College (1984) Inservices past 10 years on Elderly & Orthopedics
H	Admissions Director	48	F	Hosp 9 CF 3	CF	A.S. - Home Ec. B.S. – Family Services M.A. – Gerontology M.S. Ed. S. (thesis to do) – Guidance & Counseling
I	Occupational Therapy Assistant	50	F	CF 3	CF	Certified & licensed Occupational Therapy Assistant with Associate degree in applied science
J	Activities Director	53	F	CF 2	CF	Certified Activity Director
K	Maintenance Supervisor		M	CF 2	CF	Union Cement Mason – Plumber Apprentice
L	LPN/ CPC (Care Plan Coordinator)	29	F	Home 1 CF 8	CF	Certificate – LPN
M	CNA	30	M	CF 2	CF	CNA

Appendix C

Home Health Demographics

CF = Care Facility Environment
Home = Home Health Environment

√ = unspecified number of years

Part	Current job title	Age	Sex	Years of Service	Current work	Degrees/ Certifications
AA	Homemaker of free assistance/ Private Care Giver	37	F	Home 15 CF 4	Home	
BB	Homemaker	42	F	Home 2	Home	
CC	Homemaker	51	F	Home √		
DD	Homemaker	59	F	Home 6	Home	
EE	Homemaker	64	F	Home 3	Home	
FF	Homemaker	63	F	Home 7	Home	None
GG			Circled both	Home 1	Home	
HH	Homemaker			Home 13	Home	None
II	Home maker	44	F	Home 10	Home	CPR
JJ	Homemaker	63	F	Home 5 ½	Home	CPR
KK	Home maker	69	F	Home 13	Home	CPR
LL	Homemaker	70+	Circled both		Home	
MM	Chore-housekeeper	45	F	Home 1	Home	CNA
NN	Homemaker	46	F	Home 3	Home	CNA/ activity director
OO	Homemaker	58	F	Home √	Home	
PP	Homemaker	49	F	Home 6	Home	Mother and homemaker for a lot of years.
QQ	Homemaker	65	F	Home 10	Home	Wavered LPN
RR	Housekeeping	In the Eightys	F	Home 3		none

Appendix D

Question #1: How do cues such as voice intonation, pitch, & rate affect patient compliance?

Participant	Response
A	That depends on the resident. While most prefer friendly cues, while some prefer a tired-hard worker. These cues can communicate your mood to the resident. In knowing the resident, you can convey a certain mood which will cause the resident to comply. Empathy has helped with problem residents more than enough.
B	Most people re-act better to soft, friendly voice
C	Happy tone used to encourage
D	Soft calm voices work best
E	If you go into a room in a hurry & talking hateful the resident reacts to it, badly & then they will in turn be hateful toward you. You must talk softly & nice & have a happy face & smile
F	A calm voice (even pleasant) brings out better compliance from patients. A calm voice is not threatening. A ↑ pitch is harder for some elderly to hear. A calm med tone pitch is best heard – for better understanding & therefore more chances for compliance from patient/ resident.
G	Assist c progress of pt. esp. c gt, ex. & balance. Pt understands instructions.
H	If you do not speak at a normal average tone and medium pitch the resident will sometimes not be able to understand you or else they can become frustrated and angry
I	Resident's all have a tone & pitch level that is the most appropriate for them individually when speaking to them. It is often appropriate to speak a little slower to them so they have time to understand what you are saying.
J	This is probably one of the most important cues we use. What we give out will set the pattern for resident response.
K	If your voice is cross, or harsh they will react that way. Your voice must be steady and calm and reasoning.
L	You must present the pt's. options in a positive way with a good knowledge of topic. Self-confidence goes a long way. Don't rush through explanations – take your time & be thorough – especially c serious topics.
M	If your friendly usually the Res is more compliance use a soft tone of voice.

Care Facility

Question #2: What factors determine the amount of time you spend with a patient?

Participant	Response
A	availability of supplies, compliance of resident, resident's degree of mobility, outside interference, & conditions of environment.
B	health, mental condition
C	patient load, acuity of patient
D	Bookwork & other duties
E	If they are dirty or handicapped and also if they cooperate with you.
F	The amount of care required Some patients require more services than others. Such as patients c O2 or G-tubes require more monitoring, more time spent c & more documentation. A critical resident requires more time than a "stable" resident. Also depends on if there are any treatments (dressings etc.) to be done.
G	Pt's dx. Pt's body language and pt's determination.
H	I spend as much time is needed for the resident to comprehend what I am trying for them to understand.
I	The pt's endurance level and the diagnosis of that pt. determines the time spent with a pt. The pt. also has the right to end a therapy session at any time.
J	According to their assessment.
K	According to their need and what I'm in their room for, also their ability.
L	Thier overall condition – worse = more time/ good health = less Compliance c Tx regimen – compliant = more time non-compliant = less time
M	How the day is going

Care Facility

Question #3: How do the patient compliance strategies you use differ according to the diagnosis of the patient? (For example, Alzheimer's, Schizophrenia, etc.)

Participant	Response
A	Alzheimer's – agree with everything, show pity & sorrow for, comfort them & smile a lot! Schizophrenia – explain everything, emphasize safety & necessity. Reassure their safety in depending on you.
B	Patience, firmness, kindness. Some res. do activities of their choice very well
C	current mood affects the approach.
D	patience, firmness, kindness
E	For an Alzheimers patient you have to talk calmly, go along pretty much with what they are saying and try to get them to do what they need to do.
F	Alzheimers patients are unable to even realize for the most part if they are complying. But strategies are similar. Let the resident see you coming into the room – never walk up behind them always keep a 2 ft distance if possible between you & resident if combativeness is an issue.
G	Some pt's need motivation, some need verbal cues for instructions and some pt's need TLC's.
H	Each resident is an individual and some want things done quickly others are very impatient and do not care to understand so you usually have to talk to one of their loved ones.
I	A pt. who is schizophrenic needs to trust you before they will totally comply with therapy. An Alzheimer's pt. will need to have tasks broken down into smaller tasks such as sequencing in order to be able to understand. All pt's require patience & understanding of what they are & are not capable of doing.
J	Alzheimer's – lots of patience and not to offer to many choices. – Too confusing Schizophrenia – To encourage them to participate in what may interest them. Knowing when to back off.
K	
L	If an Alzheimers patient is non-compliant et confused I will spend more time than if alert & oriented & noncompliant.
M	they don't really

Question #4: How do the patient compliance strategies you use differ according to the sex of the patient?

Participant	Response
A	Female – tend to be more "angelic", nice & sweet. Smile alot! Hold their hands. May need to "beat around the bush". Male – try to be yourself. Just give it to them straight.
B	Yes, according to sex
C	Try to use things that they can relate to
D	Depending on the sex of the resident use different way. With women I can pat and hold their hand more than w/ men
E	Not a whole lot of difference. I smile at everyone & talk to them as a real person, not just a job.
F	Not much difference.
G	Treat different sex the same. Use motivation, appraisal & TLC's on both sex.
H	Males usually have a different approach and react differently to a male or female helper. Males usually react more compliant with female helpers.
I	There really isn't a lot of difference in males & females.
J	As a female I am careful how I position my self with a male – how I would touch them for comfort or encouragement
K	What I do is fix appliances and w/c and there beds, lights. Its at this point I'm interacting with the resident.
L	Sex of the patient doesn't change strategies. Cognitive status & compliance determine time & approach.
M	Dosn't matter I use the same

Question #5: How do the patient compliance strategies you use differ according to the health condition of the patient? (For example, poor health, good health, etc.)

Participant	Response
A	Frankly it doesn't depend on health conditions, but on personalities. the fact is some resident's won't like you no matter what you do.
B	Poor health, less active activities
C	Use realistic expectation
D	Try to get the ones in poor health to do activities that they are able to do.
E	If someone is in poor health, you have to be sympathetic & caring, but even the same for good health. Smile & be happy.
F	Patients in poor health may have a more difficult time understanding their plan of care related to their weakness at the time.
G	Poor health – appraisal on what they do. Fair health – give pt's confidence & appraisal Good health – motivation & confidence during the treatment. All three get TLC's.
H	If a resident is in poor health a slower, patient interaction is needed. If the resident is in good health you still need to be patient with them but sometimes they need more interaction to do things.
I	Each pt. is on a program that is individualized according to the persons strengths & weaknesses. It is important that goals are within the pt's ability to complete so that they can be encouraged when they make gains.
J	According to their cognitive status and their physical condition.
K	
L	If I have a terminal Pt., comfort is more important than if I have a rehab Pt. rehab Pt's must work toward thier goal. Terminal Pt's shouldn't not have to work. Thier goal is comfort.
M	If they are really sick I try to be extra nice I talk low I put myself in there shoes. if there well I'm still nice I try to put myself in there shoes

Care Facility

Question #6: What kind of communication training have you received in the following areas?

Participant	Response
A	Formal: CNA classes On the job: Inservice in depression, therapy with individuals
B	Formal: 12 yrs On the job: 19 yrs
C	Formal: nurse's training On the job: inservicing
D	Formal: college courses On the job: on the job experience & training
E	
F	Formal: (circled) On the job: (circled)
G	Formal: 5 yrs On the job: 15 yrs
H	Formal: B. S. family services degree classes. Classes in gerontology & guidance & counseling. On the job: psychiatric unit at Sarah Bush hospital. Care center inservices.
I	Formal: Associate Degree in applied science – 2 yrs with courses on pt communication/ ethics On the job: Learn as you go
J	Formal: 14 yrs. school On the job: 2 yrs
K	Formal: 12 yrs. sch. - 2 yrs. Apprentice training as cement mason On the job: 2 yrs. plumber helper - 2 yrs. with the electrician
L	Formal: very little On the job: every day
M	Formal: On the job: (circled)

Care Facility

Question #7: What barriers cause a low level of patient compliance to health care recommendations?

Participant	Response
A	Depression, previous unsuccessful recommendations, personality, upbringing, religion, personal values or moral, self-esteem, ect...
B	
C	not enough
D	Their attitudes
E	If you tell a resident they have to do something now or shove food at them, rush them around cause your the one in a hurry.
F	Hard of hearing Poor communication Poor patient teaching or understanding of Tx plan
G	Medical complication & mental status
H	Demanding Ordering No patience in interactions
I	1) Decreased cognition 2) Unrealistic goals or recommendations 3) Decreased motivation (depression)
J	Cognitive status.
K	What the residents physical condition will allow.
L	Poor Pt. understanding of options. Pts are sometimes poorly informed of thier options or are very informed regarding 1 option and unaware of other options.
M	attitude tone of voice approach explaining well

Care Facility

Question #8: What methods most effectively gain patient compliance in the care center environment?

Participant	Response
A	Show or tell the resident why something is being done, include who requires it, reassure it wouldn't be done if it wasn't considered necessary, & inform them that you are just doing your job, not trying to cause them unnecessary pain or annoyance.
B	
C	Understanding, compromise
D	Using a kind & patience voice
E	Talk to the resident straight forward, tell them how good they look & smile & be a happy person
F	Develop a rapport c your patient Show empathy. Understanding & provide good pt-teaching
G	confidence, motivation & determination.
H	Kindness Patience Trust
I	1) Pt. respect by others 2) Letting the pt have input into their goals 3) Encouragement 4) Family support
J	Happy - cheerful surroundings.
K	Kindness and soft spoken attitude.
L	Alert & oriented residents - knowledgeable explanation taking time to address res concerns. Confused residents - gaining residents trust. Family members help with this.
M	a smile e being very nice. If they like you they do more for you.

Care Facility

Question #9: What percentage of your time with a patient is spent. . .
a. building rapport? b. discussing her/ his personal issues?

Participant	Response
A	a. on-going process (mostly in passing or during care) b. during care or idle time
B	a. 50 b. 20
C	a. 5 b. 5
D	a. 30 b. 50
E	a. 50% of day b. other 50% of day
F	a. 50 b. 50
G	a. 90 b. 10
H	a. 90 b. 10
I	a. 25-30 b. none unless therapy related as to areas the pt. can be helped. However often it does help for the pt to air personal issues but they should be brought up by the patient & not the therapist. Some issues are turned over to Social Service.
J	a. 80 b. 50
K	a. 10 b. 2
L	a. 10 b. 25
M	a. 50 b. 50 (circled this one)

Care Facility

Appendix E

Question #1: How do cues such as voice intonation, pitch, & rate affect patient compliance?

Participant	Response
AA	Clients seem to pay attention better if a caregiver doesn't use "Honey, sweetie" and other pet names.
BB	A lot of my clients are hearing impaired. If I speak loudly & slowly looking directly at them we do all right.
CC	
DD	I have learned that you have to use different tones of voice with different people. Some are hard of hearing – some are hard to convince when it comes to bathing etc. and take a firmer tone of voice.
EE	
FF	
GG	Sometimes you have to raise your voice
HH	Sometime they will listen if you rise your voice alittle
II	If you talk mean to client they won't respond very nicely.
JJ	Try to use the same tone of voice even though sometimes it is very hard to do when they are upset or angry with someone else.
KK	
LL	
MM	Tone of voice plus body movements affect any person. If you act in a dominant manner you will receive resistance.
NN	If you are spoken to harshly by your patient you will usually know patient is not in a good mood
OO	Each P.T. is different. You have get know what they like.
PP	If you are completley honest and sincere with your client and you know each other well, you will be able to read each other and compliance will come naturally.
QQ	Most always talk in med soft voice They react & wants to do their best
RR	

Home Health

Question #2: What factors determine the amount of time you spend with a patient?

Participant	Response
AA	Plan of care
BB	After the chores are done I will spend last 15 or 20 mins talking with client.
CC	2-3 hours per day
DD	
EE	3-2-1 hrs
FF	What kind of health they have- Such as stroke patient, Alzeimer
GG	Whatever the case worker decides
HH	Caseworker determine the time we spend with client
II	CCU determines the hours by the client needs
JJ	Agency determine how many hours we spend
KK	
LL	1-3 hrs.
MM	The condition of health, mobility of client.
NN	Hrs we are given by our boss if extra hrs are needed we tell the problem & patient is re evaluated.
OO	We are given a hours of services sheets.
PP	Medical need and what the clients limitations are.
QQ	Health condition & deteration of mind & inability to do for thereselves & impairment
RR	Cooking & cleaning – 2 hrs & 1 hr.

Home Health

Question #3: How do the patient compliance strategies you use differ according to the diagnosis of the patient? (For example, Alzheimer's, Schizophrenia, etc.)

Participant	Response
AA	A client with Alzheimers or dementia sometimes do better with a direct command.
BB	I have a 65+ female who experiences hallucinations. She sees people walking thru walls. They make her nervous. I suggested that she ignores them & maybe they will be bored & give up & go away.
CC	Talk about things they like to do. and their favorite foods.
DD	
EE	They talk about things like to do
FF	
GG	
HH	
II	With alzheimers caregiver has to be more patient & understanding
JJ	
KK	
LL	Have to stay on their level of understanding
MM	
NN	
OO	
PP	
QQ	Alz- Need to have them help you do all the small task. They need to feel needed Schiz- Try to keep mind in peace ful way. Chg. subjects often
RR	None

Home Health

Question #4: How do the patient compliance strategies you use differ according to the sex of the patient?

Participant	Response
AA	With a male client, I always take charge. Women client's are more bossy and particular. Men seem to be happy with whatever you do for them.
BB	
CC	How to help them when they can't do it for them self. Work in a pattern so they can remember it
DD	
EE	The things I like in life
FF	
GG	Males are hard to work with. You must be use a different approach when working with males
HH	Male are harder to get to listen & do what you want them too.
II	
JJ	
KK	
LL	Women tend to be more cooperative
MM	
NN	Men can be very stubborn maybe because they feel they can't provide or do anything worth while anymore.
OO	
PP	I try to treat all clients equally.
QQ	Truthfully none -
RR	

Home Health

Question #5: How do the patient compliance strategies you use differ according to the health condition of the patient? (For example, poor health, good health, etc.)

Participant	Response
AA	I prefer to assist someone that is in poor health. I feel like they appreacite the help better.
BB	My clients have good days/ bad days. I will usually suggests different things such as leg elevation, feet soaking etc.
CC	
DD	
EE	
FF	
GG	
HH	Clients in good health are easy to get along & get yo
II	
JJ	
KK	
LL	Symphathy – gets results
MM	The patient will require more care & time if they're in poor health.
NN	
OO	A person in health do thing slower & be patient
PP	
QQ	If person in good health – They seem to want to help with small tasks. Poor health – do most every thing for them but give lots of encouragement & praise for what they do.
RR	Some poor health

Question #6: What kind of communication training have you had in the following areas?

Participant	Response
AA	Formal: communicating with Alziehimers patients – Lake Land College – certificate On the job: many hours of communicating with the difficult patient
BB	Formal: On the job: I used to work with Developmental Disabled people & used a lot of skills with my present clients.
CC	Formal: On the job: √
DD	
EE	Formal: On the job: On job
FF	Formal: On the job: (circled this one)
GG	Formal: none On the job: Staff training
HH	Formal: none On the job: Staff training once a month
II	Formal: On the job: (circled this one)
JJ	Formal: On the job: (circled this one)
KK	Formal: On the job: (circled this one)
LL	Formal: none On the job: none
MM	Formal: 1 yr. College. On the job:
NN	Formal: 36 college hrs plus CNA On the job: 3 yrs
OO	Formal: On the job: (circled this one)
PP	Formal: On the job: 6 yrs. of on job training
QQ	Formal: Nurses aide Training at Mattoon & LPN Training On the job: CCCDA
RR	Formal: I took some training On the job: yes

Question #7: What barriers cause a low level of patient compliance to health care recommendations?

Participant	Response
AA	Misunderstood directions about meds, Dr. orders etc... I feel someone should always go in the Dr.'s room with a client or get specific info from family member who did get care inf from Dr.
BB	
CC	That they should try to do things for themselves
DD	
EE	
FF	
GG	
HH	
II	
JJ	
KK	
LL	Hearing Attention span
MM	
NN	Most of my patients do not like change, ex. Moving their furniture
OO	There hearing might be bad, they don't understand what you are trieng to say
PP	Most clients do not adapt well to change
QQ	?
RR	

Home Health

Question #8: What methods most effectively gain patient compliance in the care center environment?

Participant	Response
AA	
BB	If you project good attitude, they will do same.
CC	Seeing how other people do things on their own and show how you care.
DD	
EE	How other patients like to do on their own
FF	
GG	
HH	
II	
JJ	
KK	
LL	?
MM	Letting the patient feel more in control of their health & progress, then in turn gains their self esteem.
NN	Being loving and understanding to your patients needs.
OO	Patients
PP	
QQ	?
RR	

Home Health

Question #9: What percentage of your time with a patient is spent. . .
a. building rapport? b. discussing her/ his personal issues?

Participant	Response
AA	a. 40 b. 60
BB	While I'm working I will always converse with clients. They like to hear about your life. At end of time, it is more 1on 1.
CC	
DD	
EE	
FF	
GG	a. 70 b. 30
HH	a. b. alot
II	a. 10 b. 10
JJ	a. 10 b. 10
KK	a. 10 b. 10
LL	a. 1/3 b. 1/2
MM	a. 90 b. 50
NN	a. lots b. lots I really enjoy my patients and like listening to them share their feelings.
OO	Same amount
PP	a. 50 b. 50
QQ	Depends with each person Time varies
RR	2 hrs & sometimes 1 hr. a. b. his health -

Appendix F

Question #1: How do cues such as voice intonation, pitch, & rate affect patient compliance?

Care Facility Themes

1. Voice intonation:	
Friendly/ pleasant	A, B, C
2. Pitch:	
Medium	H, F
3. Rate:	
Slower	L, I
4. Volume:	
Soft	D, E, F, K, M
5. Unclear/ Miscellaneous	G, J

Home Health Themes

1. Voice intonation:	
Use same tone of voice	II, JJ
2. Pitch:	
Medium	QQ
3. Rate:	
Slower	BB
4. Volume:	
Loud	BB, GG, HH
Soft	QQ
5. Unanswered/ Unclear	CC, EE, FF, KK, LL, NN, RR
6. Noteworthy responses:	
Pet names	AA
Dominance	MM
Individual likes	OO
Rapport	PP

Question #2: What factors determine the amount of time you spend with a patient?

Care Facility Themes

1. Resident Compliance	A, E, G
2. Care required: Mental/ Physical need	C, F, I, K, H, L, B, J, A
3. Outside interference/ Other duties	D, A
4. Miscellaneous	M

Home Health Themes

1. Plan of care	AA, BB, GG, HH, II, JJ, NN, OO, RR,
2. Medical Need: Health condition & Diagnosis	FF, MM, PP, QQ
3. Unclear/ unanswered	CC, DD, EE, KK, LL

Question #3: How do the patient compliance strategies you use differ according to the diagnosis of the patient? (For example, Alzheimer's, Schizophrenia, etc.)

Care Facility Themes

1. Strategies are the same	B, D, M, F
2. Differentiate between Alzheimer's & Schiophrenia	A, E, I, J
3. Strategies based on Patients as individuals	C, G, H
4. Unclear/ unanswered	B, D, M, F

Home Health Themes

1. Direct commands	AA
2. Understanding	II, LL
3. Unclear/ unanswered	DD, FF, GG, HH, JJ, KK, MM, NN, OO, PP, EE, CC, BB, RR
4. Noteworthy responses:	
Alzheimer's-help with small tasks	QQ
Schizophrenia-change subjects often	QQ

Question #4: How do the patient compliance strategies you use differ according to the sex of the patient?

Care Facility Themes

1. Use same strategies	M, G, I, E, F, L, C
2. Use different strategies: Beat around the bush with Women; with males, give it To them straight	A
Touch women more than men	D, J
3. Unclear/ unanswered	K, B, H

Home Health Themes

1. Use same strategies	PP, QQ
2. Use different strategies: Males are harder to Work with	GG, HH, LL
Take charge with males- Women are more bossy	AA
3. Unclear/ unanswered	BB, CC, DD, EE, FF, II, JJ, KK, MM, OO, RR,

Question #5: How do the patient compliance strategies you use differ according to the health condition of the patient? (For example, poor health, good health, etc.)

Care Facility Themes

1. Use same strategies: Appraisal	M, E, G
2. Use different strategies: Depends on personalities	A
3. Realistic expectations: Poor health (less active) To good health (more Active)	B, C, D, H, I, J, L
4. Unclear/ unanswered	K, F

Home Health Themes

1. Use same strategies: Sympathy	LL
2. Use different strategies: Poor health-use Encouragement and praise; Good health-patients help With small tasks	QQ
3. Unclear/ unanswered	AA, BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, MM, NN, OO, PP, RR

Question #6: What kind of communication training have you received in the following areas? a. Formal b. On the job

Care Facility Themes

1. Formal	A, C, D, H, I
2. On the job	A, C, D, H
3. Responded with years:	
Formal	B, G, J
On the job	B, G, J
4. No training:	
Formal	K
On the job	K
5. Unclear/ unanswered:	
Formal	E, F, L, M
On the job	E, F, I, L, M

Home Health Themes

1. Formal	AA, MM, NN, QQ
2. On the job	AA, BB, GG, HH, QQ
3. Responded with years	
On the job	NN, PP
4. No training:	
Formal	GG, HH, LL
On the job	LL
5. Unclear/ unanswered:	
Formal	BB, CC, DD, EE, FF, II, JJ, KK, OO, PP,
On the job	CC, DD, EE, FF, II, JJ, KK, MM, OO, RR

Question #7: What barriers cause a low level of patient compliance to health care recommendations?

Care Facility Themes

1. Patient barriers:	
Cognition	G, I, J
Physical condition/ Attribute	G, K
Depression	A
Their attitudes	D
Hearing impairment	F
Medical directions	F
2. Provider barriers:	
Medical directions	F, L, M
Demanding/ Ordering	H, E
Unrealistic goals	I
3. Unclear/ unanswered	B, C

Home Health Themes

1. Patient barriers:	
Adapting to change	NN, PP
Hearing impairment	LL, OO
Medical directions	AA
2. Provider barriers:	
Medical directions	AA
3. Unclear/ unanswered	BB, CC, DD, EE, FF, GG, HH, II, JJ, KK, MM, QQ, RR

Question #8: What methods most effectively gain patient compliance in the care center environment?

Care Facility Themes

1. Explanation of care	A, F, L
2. Develop rapport	F, M
3. Kindness	H, K, M
4. Compromise	C, I
5. Encouragement	G, I
6. Unclear/ unanswered	B
7. Noteworthy: Environment	J
Be straight with patient	E

Home Health Themes

1. Allow patient to feel More in control	CC, EE, MM
2. Unclear/ unanswered	AA, DD, FF, GG, HH, II, JJ, KK, LL, PP, QQ, RR
2. Noteworthy: Understanding to patient Needs	NN
Project good attitude	BB
Patients (misspelled)	OO

Question #9: What percentage of your time with a patient is spent. . . a. building rapport? b. discussing his/ her personal issues?

Care Facility Themes

1. Building rapport:	
0 - 50%	B, C, D, E, F, I, K, L, M
51 - 100%	G, H, J
other	A
2. Discussing personal issues:	
0 - 50%	B, C, D, E, F, G, H, I, J, K, L, M
51 - 100%	no responses match this
other	A

Home Health Themes

1. Building rapport:	
0 - 50%	AA, II, JJ, KK, LL, PP
51 - 100%	GG, MM
other	BB
2. Discussing personal issues:	
0 - 50%	GG, II, JJ, KK, LL, MM, PP
51 - 100%	AA
3. Unclear/ unanswered	BB, CC, DD, EE, FF, HH, NN, QQ, RR

Appendix G

Care Facility Individual Responses

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
A	Certified Nursing Aid (CNA)	22	F	Home √ CF √	CF	CNA

Survey Question	Response
1	That depends on the resident. While most prefer cues, while some prefer a tired-hard worker. These cues can communicate your mood to the resident. In knowing the resident, you can convey a certain mood which will cause the resident to comply. Empathy has helped with problem residents more than enough.
2	Availability of supplies, compliance of resident, resident's degree of mobility, outside interference, & conditions of environment.
3	Alzheimer's – agree with everything, show pity & sorrow for, comfort them & smile a lot! Schizophrenia – explain everything, emphasize safety & necessity. Reassure their safety in depending on you.
4	Female – tend to be more "angelic", nice & sweet. Smile a lot! Hold their hands. May need to "beat around the bush". Male – try to be yourself. Just give it to them straight.
5	Frankly it doesn't depend on health conditions, but on personalities. The fact is some resident's won't like you no matter what you do.
6	Formal: CNA classes On the job: Inservice in depression, therapy with individuals
7	Depression, previous unsuccessful recommendations, personality, upbringing, religion, personal values or moral, self-esteem, ect...
8	Show or tell the resident why something is being done, include who requires it, reassure it wouldn't be done if it wasn't considered necessary, & inform them that you are just doing your job, not trying to cause then unnecessary pain or annoyance.
9	a. on-going process (mostly in passing or during care) b. during care or idle time

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
B	Activities Assistant		F	CF 19	CF	

Survey Question	Response
1	Most people re-act better to a soft, friendly voice
2	Health, mental condition
3	Patience, firmness, kindness. Some res. Do activities of their choice very well
4	Yes, according to sex
5	Poor health, less active activities
6	Formal: 12 yrs On the job: 19 yrs
7	
8	
9	a. 50 b. 20

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
C	Case Manager	37	F	CF √	CF	RN/ CCM

Survey Question	Response
1	Happy tone used to encourage
2	Patient load, acuity of patient
3	Current mood affects the approach.
4	Try to use things they can relate to
5	Use realistic expectation
6	Formal: nurse's training On the job: inservicing
7	Not enough
8	Understanding, compromise
9	a. 5 b. 5

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
D	Activity/ Social Service Assistant	40	F	CF 10	CF	College Courses

Survey Question	Response
1	Soft calm voices work best
2	Bookwork & other duties
3	Patience, firmness, kindness
4	Depending on the sex of the resident use different way. With women I can pat and hold their hand more than w/ men
5	Try to get the ones in poor health to do activities that they are able to do.
6	Formal: college courses On the job: on the job experience & training
7	Their attitudes
8	Using a kind & patience voice
9	a. 30 b. 50

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
E	CNA	39	F	Home ½ CF 1 ½	CF	CNA

Survey Question	Response
1	If you go into a room in a hurry & talking hateful the resident reacts to it, badly & then they will in turn be hateful toward you. You must talk softly & nice & have a happy face & smile
2	If they are dirty or handicapped and also if they cooperate with you.
3	For an Alzheimers patient you have to talk calmly, go along pretty much with what they are saying and try to get them to do what they need to do.
4	Not a whole lot of difference. I smile at everyone & talk to them as a real person, not just a job.
5	If someone is in poor health, you have to be sympathetic & caring, but even the same for good health. Smile & be happy.
6	
7	If you tell a resident they have to do something now or shove food at them, rush them around cause your the one in a hurry.
8	Talk to the resident straight forward, tell them how good they look & smile & be a happy person
9	a. 50% of day b. other 50% of day

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
F	LPN (Licensed Practical Nurse)	34	F	CF 7	CF	LPN Certificate I.V. certified

Survey Question	Response
1	A calm voice (even pleasant) brings out better compliance from patients. A calm voice is not threatening. A ↑ pitch is harder for some elderly to hear. A calm med tone pitch is best heard – for better understanding & therefore more chances for compliance from patient/ resident.
2	The amount of care required Some patients require more services than others. Such as patients c O2 or G-tubes require more monitoring, more time spent c & more documentation. A critical resident requires more time than a "stable" resident. Also depends on if there are any treatments (dressings, etc.) to be done.
3	Alzheimers patients are unable to even realize for the most part if they are complying. But strategies are similar. Let the resident see you coming into the room – never walk up behind them always keep a 2 ft distance if possible between you & resident if combativeness is an issue.
4	Not much difference
5	Patients in poor health may have a more difficult time understanding their plan of care related to their weakness at the time.
6	Formal: (circled) On the job: (circled)
7	Hard of hearing Poor communication Poor patient teaching or understanding of Tx plan
8	Develop a rapport c your patient Show empathy. Understanding & provide good pt-teaching
9	a. 50 b. 50

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
G	Licensed Physical Therapist Assistant	51	F	Home 8 Hosp 8 CF 15	CF	Belleville Area College (1984) Inservices past 10 years on Elderly & Orthopedics

Survey Question	Response
1	Assist c progress of pt. Esp. c gt, ex. & balance. Pt understands instructions
2	Pt's dx. Pt's body language and pt's determination
3	Some pt's need motivation, some need verbal cues for instructions and some pt's need TLC's.
4	Treat different sex the same. Use motivation, appraisal & TLC's on both sex.
5	Poor health – appraisal on what they do. Fair health – give pt's confidence & appraisal Good health – motivation & confidence during the treatment. All three get TLC's.
6	Formal: 5 yrs On the job: 15 yrs
7	Medical complication & mental status
8	Confidence, motivation & determination.
9	a. 90 b. 10

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
H	Admissions Director	48	F	Hosp 9 CF 3	CF	A.S.-Home Ec. B.S.-Family Services M.A.-Gerontology M.S. Ed. S. (thesis to do)-Guidance & Counseling

Survey Question	Response
1	If you do not speak at a normal average tone and medium pitch the resident will sometimes not be able to understand you or else they can become frustrated and angry.
2	I spend as much time is needed for the resident to comprehend what I am trying for them to understand.
3	Each resident is an individual and some want things done quickly others are very impatient and do not care to understand so you can usually have to talk to one of their loved ones.
4	Males usually have a different approach and react differently to a male or female helper. Males usually react more compliant with female helpers.
5	If a resident is in poor health a slower, patient interaction is needed. If the resident is in good health you still need to be patient with them but sometimes they need more interaction to do things.
6	Formal: B.S. family services degree classes. Classes in gerontology & guidance & counseling. On the job: psychiatric unit at Sarah Bush hospital. Care center inservices.
7	Demanding Ordering No patience in interactions
8	Kindness Patience Trust
9	a. 90 b. 10

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
I	Occupational Therapy Assistant	50	F	CF 3	CF	Certified & licensed Occupational Therapy Assistant with Associate degree in applied science

Survey Question	Response
1	Resident's all have a tone & pitch level that is the most appropriate for them individually when speaking to them. It is often appropriate to speak a little slower to them so they have time to understand what you are saying.
2	The pt's endurance level and the diagnosis of that pt. determines the time spent with a pt. The pt. Also has the right to end a therapy session at any time.
3	A pt. Who is schizophrenic needs to trust you before they will totally comply with therapy. An Alzheimer's pt. Will need to have tasks broken down into smaller tasks such as sequencing in order to be able to understand. All pt's require patience & understanding of whay they are & are not capable of doing.
4	There really isn't a lot of difference in males & females.
5	Each pt. Is on a program that is individualized according to the persons strengths & weaknesses. It is important that goals are within the pt's ability to complete so that they can be encouraged when they make gains.
6	Formal: Associate Degree in applied science – 2 yrs with courses on pt communication/ ethics On the job: learn as you go
7	1) Decreased cognition 2) Unrealistic goals or recommendations 3) Decreased motivation (depression)
8	1) Pt. respect by others 2) Letting the pt have input into their goals 3) Encouragement 4) Family support
9	a. 25 – 30 none unless therapy related as to areas the pt. can be helped. However often it does help for the pt to air personal issues but they should be brought up by the patient & not the therapist. Some issues are turned over to Social Service.

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
J	Activities Director	53	F	CF 2	CF	Certified Activity Director

Survey Question	Response
1	This is probably one of the most important cues we use. What we give out will set the pattern for resident response.
2	According to their assessment.
3	Alzheimer's – lots of patience and not to offer to many coices. – Too confusing Schizophrenia – To encourage them to participante in what may interest them. Knowing when to back off.
4	As a female I am careful how I position my self with a male – how I would touch them for comfort or encouragement
5	According to their cognitive status and their physical condition.
6	Formal: 14 yrs. School On the job: 2 yrs
7	Cognitive status.
8	Happy – cheerful surroundings
9	a. 80 b. 50

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
K	Maintenance Supervisor		M	CF 2	CF	Union Cement Mason – Plumber Apprentice

Survey Question	Response
1	If your voice is cross, or harsh they will react that way. Your voice must be steady and calm and reasoning.
2	According to their need and what I'm in their room for, also their ability.
3	
4	What I do is fix appliances and w/c and there beds, lights. Its at this point I'm interacting with the resident.
5	
6	Formal: 12 yrs. Sch. – 2 yrs. Apprentice training as cement mason On the job: 2 yrs. Plumber helper – 2 yrs. with the electrician
7	What the residents physical condition will allow.
8	Kindness and soft spoken attitude.
9	a. 10 b. 2

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
L	LPN/ CPC (Care Plan Coordinator)	29	F	Home 1 CF 8	CF	CNA

Survey Question	Response
1	You must present the pt's. options in a positive way with a good knowledge of topic. Self-confidence goes a long way. Don't rush through explanations – take your time & be thorough – especially c serious topics.
2	Thier overall condition – worse = more time/ good health = less Compliance c Tx regimen – compliant = more time Non-compliant = less time
3	If an Alzheimers patient is non-compliant et confused I will spend more time than if alert & oriented & noncompliant.
4	Sex of the patient doesn't change strategies. Cognitive status & compliance determine time & approach.
5	If I have a terminal pt., comfort is more important than if I have a rehab pt. rehab pt's must work toward their goal. Terminal pt's shouldn't not have to work. Thier goal is comfort.
6	Formal: very little On the job: every day
7	Poor pt. understanding of options. Pts are sometimes poorly informed of their options or are very informed regarding 1 option and unaware of other options.
8	Alert & oriented residents – knowledgeable explanation taking time to address res concerns. Confused residents – gaining residents trust. Family members help with this.
9	a. 10 b. 25

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
M	CNA	30	M	CF 2	CF	CNA

Survey Question	Response
1	If your friendly usually the res is more compliance Use a soft tone of voice
2	How the day is going
3	They don't really
4	Doesn't matter I use the same
5	If they are really sick I try to be extra nice I talk low I put myself in there shoes. If there well I'm still nice I try to put myself in there shoes
6	Formal: On the job: (circled)
7	Attitude Tone of voice Approach Explaining well
8	A smile e being very nice If they like you they do more for you.
9	a. 50 b. 50

Appendix H

Home Health Individual Responses

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
AA	Homemaker of free assistance/ Private Care Giver	37	F	Home 15 CF 4	Home	

Survey Question	Response
1	Clients seem to pay attention better if a caregiver doesn't use "Honey, sweetie" and other pet names.
2	Plan of care
3	A client with Alzheimers or dementia sometimes do better with a direct command.
4	With a male client, I always take charge. Women client's are more bossy and particular. Men seem to be happy with whatever you do for them.
5	I prefer to assist someone that is in poor health. I feel like they appreacite the help better.
6	Formal: communicating with Alzhiehimers patients – Lake Land College – certificate On the job: many hours of communicating with the difficult patient
7	Misunderstood directions about meds, Dr. orders etc...
8	
9	a. 40 b. 60

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
BB	Homemaker	42	F	Home 2	Home	

Survey Question	Response
1	A lot of my clients are hearing impaired. If I speak loudly & slowly looking directly at them we do all right.
2	After the chores are done I will spend last 15 or 20 mins talking with client.
3	I have a 65+ female who experiences hallucinations. She sees people walking thru walls. They make her nervous. I suggested that she ignores them & maybe they will be bored & give up & go away.
4	
5	My clients have good days/ bad days. I will usually suggests different things such as leg elevation, feet soaking etc.
6	Formal: On the job: I used to work with Developmental Disables people & used a lot of skills with my present clients.
7	
8	If you project good attitude, they will do same.
9	While I'm working I will always converse with clients. They like to hear about your life. At end of time, it is more 1 on 1.

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
CC	Homemaker	51	F	Home √		

Survey Question	Response
1	
2	2-3 hours per day
3	Talk about things they like to do. and their favorite foods.
4	How to help them when they can't do it for them self. Work in a pattern so they can remember it.
5	
6	Formal: On the job: √
7	That they should try to do things for themselves.
8	Seeing how other people do things on their own and show how you care.
9	

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
DD	Homemaker	59	F	Home 6	Home	

Survey Question	Response
1	I have learned that you have to use different tones of voice with different people. Some are hard of hearing – some are hard to convince when it comes to bathing etc. and take a firmer tone of voice.
2	
3	
4	
5	
6	
7	
8	
9	

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
EE	Homemaker	64	F	Home 3	Home	

Survey Question	Response
1	
2	3-2-1 hrs
3	They talk about things they like to do
4	The things I like in life
5	
6	Formal: On the job: On job
7	
8	How other patients like to do on their own
9	

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
FF	Homemaker	63	F	Home 7	Home	None

Survey Question	Response
1	
2	What kind of health they have- Such as stroke patient, Alzeimer
3	
4	
5	
6	Formal: On the job: (circled)
7	
8	
9	

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
GG			Circled both	Home 1	Home	None

Survey Question	Response
1	Sometimes you have to raise your voice
2	Whatever the case worker decides
3	
4	Males are hard to work with. You must be use a different approach when working with males
5	
6	Formal: none On the job: Staff training
7	
8	
9	a. 70 b. 30

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
HH	Homemaker		F	Home 13	Home	None

Survey Question	Response
1	Sometime they will listen if you rise your voice alittle
2	Caseworker determine the time we spend with client
3	
4	Male are harder to get to listen & do what you want them too.
5	Clients in good health are easy to get along & get yo
6	Formal: None On the job: Staff training once a month
7	
8	
9	a. b. alot

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
II	Home maker	44	F	Home 10	Home	CPR

Survey Question	Response
1	If you talk mean to client they won't respond very nicely.
2	CCU determines the hours by the client needs
3	With alzheimers caregiver has to be more patient & understanding
4	
5	
6	Formal: On the job: (circled)
7	
8	
9	a. 10 b. 10

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
JJ	Homemaker	63	F	Home 5 ½	Home	CPR

Survey Question	Response
1	Try to use the same tone of voice even though sometimes it is very hard to do when they are upset or angry with someone else.
2	Agency determine how many hours we spend
3	
4	
5	
6	Formal: On the job: (circled)
7	
8	
9	a. 10 b. 10

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
KK	Home maker	69	F	Home 13	Home	CPR

Survey Question	Response
1	
2	
3	
4	
5	
6	Formal: On the job: (circled)
7	
8	
9	a. 10 b. 10

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
LL	Homemaker	70+	F		Home	

Survey Question	Response
1	
2	1-3 hrs.
3	Have to stay on their level of understanding
4	Women ten to be more cooperative
5	Sympathy – gets results
6	Formal: none On the job: none
7	Hearing Attention span
8	?
9	a. 1/3 b. 1/2

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
MM	Chore-housekeeper	45	F	Home 1	Home	CNA

Survey Question	Response
1	Tone of voice plus body movements affect any person. If you act in a dominant manner you will receive resistance.
2	The condition of health, mobility of client.
3	
4	
5	The patient will require more care & time if they're in poor health.
6	Formal: 1 yr. College. On the job:
7	
8	Letting the patient feel more in control of their health & progress, then in turn gains their self esteem.
9	a. 90 b. 50

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
NN	Homemaker	46	F	Home 3	Home	CNA/ activity director

Survey Question	Response
1	If you are spoken to harshly by your patient you will usually know patient is not in a good mood
2	Hrs we are given by our boss If extra hrs are needed we tell the problem & patient is re evaluated.
3	
4	Men can be very stubborn maybe because they feel they can't provide or do anything worth while anymore.
5	
6	Formal: 36 college hrs plus CNA On the job: 3 yrs
7	Most of my patients do not like change, ex. Moving their furniture
8	Being loving and understanding to your patients needs.
9	a. lots b. lots I really enjoy my patients and like listening to them share their feelings.

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
OO	Homemaker	58	F	Home √	Home	

Survey Question	Response
1	Each p.t. is different. You have get to know what they like.
2	We are given a hours of services sheets.
3	
4	
5	A person in health do thing slower & be patient
6	Formal: On the job: (circled)
7	There hearing might be bad, they don't understand what you are trieng to say
8	Patients
9	Same amount

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
PP	Homemaker	49	F	Home 6	Home	Mother and homemaker for a lot of years.

Survey Question	Response
1	If you are completeley honest and sincere with your client and you know each other well, you will be able to read each other and compliance will come naturally.
2	Medical need and what the clients limitations are.
3	
4	I try to treat all clients equally.
5	
6	Formal: On the job: 6 yrs. of on job training
7	Most clients do not adapt well to change
8	
9	a. 50 b. 50

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
QQ	Homemaker	65	F	Home 10	Home	Wavered LPN

Survey Question	Response
1	Most always talk in med soft voice They react & wants to do their best
2	Health condition & deteration of mind & inability to do for thereselves & impairment
3	Alz – Need to have them help you do all the small task. They need to feel needed Schiz – try to keep mind in peach ful way. Chg. subjects often
4	Truthfully none
5	If person in good health – they seem to want to help with small tasks. Poor health – do most everything for them but give lots of encouragement & praise for what they do.
6	Formal: Nurses aide Training at Mattoon & LPN Training On the job: CCCDA
7	?
8	?
9	Depends with each person time varies

Part	Current job title	Age	Sex	Years of Service	Current Work	Degrees/ Certifications
RR	Housekeeping	In the eightys	F	Home 3		none

Survey Question	Response
1	
2	Cooking & cleaning – 2 hrs & 1 hr.
3	None
4	
5	Some poor health
6	Formal: I took some training On the job: yes
7	
8	
9	2 hrs & sometimes 1 hr. a. b. his health -