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PERCEIVED LEVEL OF CLIENT SATISFACTION AT ACADEMIC NURSE MANAGED CENTERS

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by

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ABSTRACT

PERCEIVED LEVEL OF CLIENT SATISFACTION AT
ACADEMIC NURSE MANAGED CENTERS

by Chris McKinstry

This thesis describes client satisfaction of nursing care rendered by student nurses at academic Nurse Managed Centers. Utilizing a survey research design, data were collected from community-dwelling elderly clients (N=53) at two urban Nurse Managed Centers in northern California. Nursing care was evaluated in three domains.

The analysis indicates a high level of client satisfaction in trusting and educational relationships. The specific nursing interventions of "foot care" and "emergency services" received high levels of client satisfaction in the technical-professional domain. Although there was no evidence of dissatisfaction, it was difficult to document client satisfaction in the technical-professional domain due to the numerous responses of "does not apply." Further research on the reliability and validity of the questionnaire is recommended. Review of the data suggests general guidelines for developing curricula in community nursing.

ACKNOWLEDGEMENTS

To my daughters,

Nicole and Cari,

for their patience, love, and support.

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Chapter 1

INTRODUCTION

Background

This study focused on client satisfaction of student rendered care in academic Nurse Managed Centers (NMCs). Customer satisfaction is one component of quality nursing care and has received increased attention in the last few years (Andresen & McDermott, 1992). Health care consumers are becoming more aware of health care issues and are no longer passive recipients of services (Bagwell, 1987). Consumers want to participate in health care decisions and wish to evaluate services. An understanding of client satisfaction may have implications for future nursing care in Nurse Managed Centers. This study described the perceived level of client satisfaction at two NMCs that provide care to elderly clients living in the community.

NMCs have been in existence since the 1970's and began primarily in response to needs associated with schools of nursing (Barger & Bridges, 1990; Lang, 1983). Barger and Bridges (1990) identified 45 nursing centers across the United States. Two years later, Gray (1992) stated that there were 250 community nursing centers in operation providing health care services to an estimated 118,000 Americans. Gray's information was based on a study by the National League for Nursing but the time period was not

identified in either of these studies. When the National League for Nursing conducted a national study on nursing centers (for a presentation at the Third Primary Care Conference, Atlanta, Georgia, January 1-12, 1993), a total of approximately 170 community nurse managed care agencies were identified (Barger & Rosenfeld, 1993). Various authors operationalize the concept of NMCs differently. To date, the exact number and location of academic nursing centers has remained undocumented.

NMCs began in response to the need to provide nursing students with a site for community nursing practice (Barger & Bridges, 1990). The centers also provided faculty with a site for professional nursing practice, a site for research, and an avenue to provide service to the community nationwide (Fehring, 1989).

Problem

In the past, nursing care has been based on tradition, however, quality nursing care has remained a goal of nursing services (Pulliam, 1991). At the university NMCs reviewed in this work, evaluations were conducted by students at the end of the semester for program content and faculty effectiveness. Evaluation of student care by the clients receiving the service at the NMC sites had not been formally conducted up to this time. A formalized method to review student rendered services was needed. Such a review would be useful in setting standards evaluating client

satisfaction (Pulliam, 1991). This study of client satisfaction could have application to a continuous process of evaluation for elderly clients receiving student rendered care and result in continuous improvement of nursing care.

The concept of continuous evaluation is the dynamic feature of the nursing process. Continuous evaluation and reevaluation have been the keys to constant improvement and development of contemporary health care. Contemporary health care has shifted to a corporate orientation with a focus on performance, productivity, and service (Gillem, 1988). Schools of nursing must be cognizant of this shift and begin to seek feedback from clients who receive student rendered care. Evaluating client satisfaction is one method to measure outcomes of service (Pulliam, 1991). The positive response to student intervention in caring for the elderly has been a source of information for nursing schools to validate the need for non-traditional settings as a place to provide nursing care and instruction. The information obtained on client satisfaction will provide nurses with a strong rationale for using NMCs to meet the health care needs of the ever increasing elderly population in this country and will be important in the assessment of the effectiveness of NMCs in meeting those needs.

Purpose and Need

There is a need for a method to measure student rendered care at academic based NMCs offering services to

elderly clients (Anderson & McDermott, 1992). Little information has been available on client satisfaction for care delivered by students, and there has been little data available on satisfaction levels of clients of NMCs (Anderson & McDermott, 1992; Katzman, Holman, & Ashley, 1993). As part of the assessment process, client satisfaction has been one measure of quality care. Informal methods of feedback and evaluation of student care have been employed by nursing faculty to measure the quality of care at the academic NMCs in this research. This study was intended to initiate a formal process by which elderly clients can evaluate the quality of care rendered by student nurses.

Research Question

The research question was: What is the perceived level of client satisfaction at academic Nurse Managed Centers? The results of this research could be used as a bench mark for setting standards for quality nursing care.

Definitions of Terms

For the purpose of this study, the following definitions applied:

1. Nurse Managed Center (NMC), or Nursing Center, is a site in a community location where health care is provided by professional nurses, students, and/or faculty, who are fully accountable and responsible as providers.

2. Academic NMC is a NMC affiliated with a university

nursing program where health care is provided by student nurses under the supervision of faculty.

3. Students are persons enrolled in an academic nursing program to study, practice, and investigate nursing issues.

4. Faculty are registered nurses with advanced degrees and teaching experience employed in formal collegiate nursing institutions.

5. Elderly clients are persons between the ages of 60 and 95 seeking health care services.

6. Client satisfaction is the condition of the person being content with the health care services being received.

7. Service is defined as those components of nursing functions delivered to a population of clients.

8. Outcomes are results or consequences of an event or nursing intervention at the NMC.

Summary

The purpose of this study was to measure the current level of client satisfaction as perceived by elders receiving student rendered nursing care at two academic NMCs. Results may have direct impact on the faculty that supervise nursing students in community settings. Results may also have implications for future plans for elder care and viability of NMCs.

Client satisfaction is an important element for health care providers. NMCs provide learning experiences for

students outside the auspices of hospitals, and they provide nursing care for the elderly clients. By exploring the client satisfaction levels, nurses can make an impact on the future of NMCs and nursing. Implications for future services can be discovered. Faculty can be more effective in formulating strategic health care plans and defining issues related to the elderly.

Client satisfaction levels can be used to measure outcomes of service. Nurses in all professional areas can continue to promote high level care by documenting these outcomes and utilizing the information to continuously improve quality. This concept can be examined through a total quality management framework.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

Introduction

Many people believe our existing health care system is not adequate. Institutions of our nation continue to look at plans for improving quality, access, and cost of health care. This chapter discusses the conceptual framework of Total Quality Management (TQM) and how this philosophy of continuous quality improvement may be useful at nurse managed centers (NMCs). The literature review explores client satisfaction as one measure of quality at NMCs.

Conceptual Framework

The success of Japanese industries is due in part to the TQM philosophy (Arikian, 1991). W. Edwards Deming developed the TQM theory and applied it to Japanese industries (Deming, 1982; Masters & Schmele, 1991). In the post-World War II period, Deming went to Japan to help Japanese managers improve the quality of Japanese products (Kirk, 1992). The Japanese philosophy of continuous quality improvement is termed kaizen which is the continuous search for opportunities to improve (Berwick, 1989). Based on the success of kaizen in Japan, an effort is underway in the United States to translate this success in manufacturing industries to the service industries such as health care (Gillem, 1988). Nursing managers can utilize the TQM

conceptual framework to build quality into service and achieve the organization's mission by utilizing the clients' contributions, opinions, and suggestions.

TQM is a process for managers to generate continuous quality improvement in a customer responsive environment (Kirk, 1992). It is based on a 14-point system developed by W. Edwards Deming (1982). These 14 points are presented in Table 1. These 14 points may be summarized in the definition for TQM as "to do the right thing right the first time, on time, all the time and to strive always for improvement and customer satisfaction" (Masters & Schmele, 1991, p. 8).

Client satisfaction was the element of quality from the TQM philosophy used as a framework for this research. Since the needs of the client are always changing, it is important to continually monitor and evaluate the client and the services (Masters & Schmele, 1991). "The results of this monitoring and evaluation are then applied to new ways to continue making improvements" (Masters & Schmele, 1991, p. 10). This monitoring and evaluating leads to quality health care and client satisfaction.

Documenting client satisfaction is one way to measure student rendered care at NMCs. Client feedback is a necessary component of providing quality nursing care. "Quality improves as those served (the customers) and those serving (the suppliers) take the time to listen to each

Table 1

Deming's 14 Points

1. Create constancy of purpose for service improvement.
2. Adopt the new philosophy.
3. Cease dependence on inspection to achieve quality.
4. End practice of awarding business on price alone--make partners out of vendors.
5. Constantly improve every process for planning, production, and service.
6. Institute training and research.
7. Institute leadership in problem solving and focus on teamwork.
8. Drive out fear.
9. Break down barriers between staff areas.
10. Eliminate slogans, exhortations, and targets for the work force.
11. Eliminate numerical quotas.
12. Remove barriers to pride of workmanship.
13. Institute a vigorous program of education and self-improvement for everyone.
14. Put everyone to work on the transformation.

Note. Adapted from "Building TQM into Nursing Management" by M. L. Masters and R. J. Masters, 1993, Nursing Economics, 11(5), pp. 275-278.

other and to work out their inevitable misunderstandings" (Berwick, 1989, p. 55).

TQM sends the message that quality, not quantity is the goal. A client feedback loop is one way to achieve continuous improvement and incorporate quality into service before it is delivered. The methods of measuring and tracking client satisfaction can be used to achieve a TQM ideal.

Review of Literature

The literature review is presented in three relevant topic areas. Nurse Managed Centers will be examined, then client satisfaction, and finally quality management.

Nurse Managed Centers (NMCs)

Many nursing centers have roots in visiting nursing agencies and public health nursing (Barger & Rosenfeld, 1993). The existence of nursing centers was documented in the literature beginning in 1973 when academic institutions began reporting descriptive accounts of the development of nursing centers to include the purpose, population served, location, and the experiences of the faculty (Jones, Pagel, & Wittman, 1973; Thibodeau & Herbert, 1978). Most centers were linked to schools of nursing (Barger & Bridges, 1990; Higgs, 1988). At that time, nursing centers were created primarily to provide academic institutions a site for nursing practicum (Barger & Bridges, 1990; Lang, 1983). However, not all NMCs are affiliated with an academic institution.

The American Nurses' Association (1987) identified nursing centers as those affiliated with universities, service institutions such as hospitals and home health agencies, or as freestanding businesses. The American Nurses' Association defined nursing centers as organizations committed to providing holistic, reimbursed, and client centered services whereby accountability and responsibility remain with the nurse.

Defining Nurse Managed Centers

Fehring, Schulte, and Riesch (1986) have worked extensively toward gaining consensus for a definition of NMCs. A Delphi survey method was used with participants at the Second Biennial Conference on NMCs to derive a definition. The Delphi method entails developing a questionnaire addressing the definition of NMCs and through repeated rounds of questionnaires, analysis, and feedback, an autonomous consensus is gained (Burns & Grove, 1987). Fehring, Schulte, and Riesch (1986) suggested that NMCs should (a) provide direct access for clients to professional nursing, (b) be part of a strong referral network, (c) base services on client participation, and (d) provide holistic treatment. Disagreement among respondents focused on three areas: (a) the educational preparation for practice in NMCs, (b) the use of the medical model of physician as team leader, and (c) the relationship of the nurse to NMCs in regards to diagnosing and treating medical problems.

Lang (1983) described (a) the purpose of NMCs, (b) client population, (c) providers, and (d) methods of funding. While nursing centers served many purposes, Lang (1983) contended that the purpose of NMCs was to provide patients' care that was completely managed by nurses and included education and research components. The recipients of nurse managed care were primarily students or clients living in inner-city communities close to a school of nursing campus. The educational preparation of providers at nursing centers was diverse and ranged from associate to master's program levels. Master's level nurses may be best suited for the specialty practice needed with NMCs because of their added experience with community agencies and ability to make appropriate referrals (Andresen & McDermott, 1992; Barger & Rosenfeld, 1993; Lang, 1983). Funding methods included support from the government, private foundations, health care agencies, and school of nursing funds. Lang (1983) stressed the importance of seeking third party reimbursement through political avenues.

Another purpose and use of NMCs as described by Fehring (1989) is that NMCs offer nurses the opportunity to practice their skills and to take primary responsibility for health problems without dependence upon another profession. In NMCs, nurses take the lead in dealing with health problems associated with the homeless, the indigent, and the elderly populations at both ends of the wellness-illness continuum.

Key issues for NMCs involved independent practice and role modeling for student nurses in a setting that fostered research and innovation (Fehring, 1989). Nurses practicing in NMCs had the opportunity to advance the profession of nursing and to take a stronger leadership role in meeting the major health needs of the country. An example is the leadership role in the care of the homeless and indigent. The health care of sick and well elderly clients can be seen as another emergent health care issue.

Gloss and Fielo (1987) also reported on alternative methods for health care delivery by describing the establishment of a community based nursing center. The feasibility study revealed that the area where the center was to be located was a densely populated area of 110,000 and 11% of the population was over age 65. In addition, there existed a reluctance on the part of this population to use existing bureaucratic systems and institutional services. A general need for health care services was found within this census tract. The local social service agency and the community senior center formed an alliance with faculty from a local school of nursing and a new multidisciplinary, collaborative approach to elder care was established. A nurse managed, community based nursing center was the result of this alliance, offering a wide range of health services to a neglected segment of the community.

Gray (1992) discussed the current status of NMCs and findings of a 1990 study conducted by the National League for Nursing (NLN). This study concluded that 52% of NMCs were affiliated with (a) retirement communities, (b) public health departments, (c) home health agencies, and (d) hospitals.

Most of the affiliated centers were partly funded by schools of nursing. Ten exemplary nursing centers were identified and methods of payment for services rendered at NMCs were stated: (a) the primary method of payment (27%) was out-of-pocket payments by the clients, (b) private insurance payments accounted for 19% of revenues, and (c) other methods of payment included Medicare and Medicaid (Gray, 1992). At NMCs, nurses became primary providers and were totally accountable and responsible for the health care of clients. The majority of nurses who operated these NMCs were Nurse Practioners (NPs). The centers were not only helpful to the community, but the NPs also acted as role models for nurses in independent practice.

The future of nursing practice may involve NMCs as an avenue to provide cost-effective primary care while meeting the needs of a community for health care combined with student nurse teaching centers. The establishment of NMCs could be mutually beneficial to communities and universities as well as offering an option to expand health care delivery models (Lang, 1983). Gray (1992) hypothesized that the

solution to the problem of cost effective primary care in America rested in part with NMCs.

Academic NMCs. It is difficult to uniquely identify the period when academic NMCs were first established due in part to the lack of a concise definition of an NMC. Many centers began as sites for nursing instruction and were not labeled as nurse managed centers (Barger & Rosenfeld, 1993).

The beginning of an academic NMC was described by Kuckelman-Cobb, Kerr, and Pieper (1980). In response to a need for placement of graduate nursing students into community health settings, a proposal was developed for a NMC at a midwestern university. The proposal was an attempt to blend the individual clinical approach of nursing with the aggregate approach of public health. Nursing care in this era was undergoing an expansion into new areas of responsibility. Kuckelman-Cobb, Kerr, and Pieper (1980) concluded that NMCs could assist students with the practical and administrative aspects of health care. NMCs could also provide more flexible settings for innovative nursing leaders.

Gresham-Kenton and Wisby (1987) described the operation of NMCs from a problem-oriented approach. Eight NMCs were operated by a midwestern university to serve the needs of the elderly in the local community. The authors discussed the development of the NMCs and the implementation of health care services. The critical element in the development of

the NMCs was consultation with other nurses experienced in wellness programs. Services included (a) hypertension and diabetes screening, (b) routine physical examinations, (c) counseling for personal problems, (d) teaching for specific health problems such as heart disease and arthritis, (e) clarification of medication regimens, and (f) community referrals to other health professionals. This NMC philosophy was based on independent practice and alternate care delivery methods.

Other NMCs also promoted independent nursing practice. Thibodeau and Hawkins (1987) reported the evolution of a nursing center used to promote independent practice and service to older adults not under the regular care of a personal physician. This center was operated by an eastern university and received funding from a contract with the United States Public Health Service. Senior citizens and local volunteers donated space, supplies, and labor. Nursing center goals, operational procedures, physical facilities, payment methods, and costs were established. The NMC continued service after the expiration of the contract due to the dedication and collaborative spirit of representatives from the small rural town, the senior center, and the university.

Higgs (1988) conducted a survey of nursing schools to identify NMC locations and common characteristics. Telephone interviews with 77 schools were conducted and 65

NMCs were identified. The survey revealed many of the issues involved in planning, developing, and maintaining NMCs. The primary purpose of NMCs remained the provision of clinical instruction for students. Secondary purposes included provision for community service and faculty practice sites. Research had a limited scope. Issues needing resolution related to community support, institutional support, academic policies, and program financing. Many respondents noted that efforts are necessary in the political arena to seek direct reimbursement for nursing services in order to fulfill the potential for NMCs to provide cost effective health care. This strategy was determined as crucial to maintain program viability and stability. Higgs (1988) briefly discussed the concurrent movement of entrepreneurial NMCs that are being developed as private, for-profit businesses.

Continuing with single experiences of various schools of nursing, Igou, Hawkins, Johnson, and Utley (1989) described a nursing center initially funded by a grant. When the grant ended 37 months later, the center continued to function based on funding from third-party reimbursement, donations, and out-of-pocket charges based on sliding-scale methods. This venture began and ended as a collaborative effort between a local senior center and a school of nursing. Care was provided by nurse practitioners (NPs) and nursing students.

Katzman, Holman, and Ashley (1993) designed an 18-item client satisfaction survey for a primary care clinic to assess client attitudes toward the staff, clinic accessibility, and quality of care. The respondent profile (N=102) was of a female (73%) between 19-25 years old (27%) who was white (91%) and employed (75%). The results were that client satisfaction was high on all items.

Barger and Bridges (1990) gave a comprehensive review of current NMCs' with regards to demographic data and an assessment of NMCs ability to accomplish the purposes for which they were created. Data compiled from questionnaires indicated that a typical nursing center was most often (a) serving populations in a general community, (b) located within a college or school building, (c) funded by the school of nursing itself, and (d) in existence for 5.5 years. The majority of NMCs supported the purposes of student education and community service. However, less than half the centers provided opportunities for faculty practice and nursing research. Barger and Bridges (1990) reported that perhaps NMCs have not reached their full potential. The next step would be to deal with the education-service gap, intraprofessionally. The authors suggested that promotion of NMCs within smaller geographic areas could aid in providing quality, cost effective health care at a time of desperate need. Berger and Bridges (1990) conclude that by making student nurses aware of the value of NMCs, the

nursing profession might become a more innovative, independent, and collaborative profession.

Hospital Sponsored NMCs. Smith and Sorrell (1989) described a wellness center for senior citizens with roots in a federally subsidized residential complex. The authors established the NMC for a population of seniors who expressed a need to strengthen ties between the community and the local hospital. Smith and Sorrell (1989) found that the NMC removed the health access barriers of (a) mobility, (b) transportation, (c) clinic waiting time, and (d) impersonal or hurried service.

Tatarowicz and Wisby (1990) reported a similar approach to elder care whereby gerontology nurses from a large, urban, midwestern hospital managed 2 part-time clinics in senior residential buildings. The authors operated a community based wellness center that provided, among others, direct nursing care for (a) sleeplessness, (b) foot problems, (c) back problems, (d) eye problems, and (e) problems of memory loss. The researchers report nearly 100% client satisfaction with nursing services.

Client Satisfaction

Cleary and McNeil (1988) stated that the measurement of client satisfaction levels could be extremely useful as an indicator of quality care. These researchers found that higher levels of satisfaction were associated with more personal care. Patients who received care from

practitioners in smaller organizations and those having a long term relationship with their individual provider tended to report higher satisfaction levels. Good communication skills, empathy, and caring resulted in increased patient involvement and improved quality of care. Cleary and McNeil (1988) also stated that continued client satisfaction research is needed using comprehensive standardized instruments on a routine basis.

Hsieh and Kagle (1991) studied client satisfaction based on the assumption that there existed a direct relationship between a client's experience with health care and the client's evaluation of health care. According to Hsieh and Kagle (1991), clients who were satisfied with their health care were more likely to comply with a medical regimen and the client's expectations were the best predictors of satisfaction. Health status, personal characteristics, and health system characteristics were not strong predictors of satisfaction. The findings suggested that client expectations varied from one socioeconomic group to another. The researchers contended that by understanding factors that influenced client satisfaction, health care providers could improve the provision of health care to the client as well as affect their quality of life (Hsieh & Kagle, 1991).

Client Satisfaction and Nurse Managed Centers (NMCs)

Andresen and McDermott (1992) first studied client

satisfaction with student nurse rendered care at a nursing center in 1984. The authors utilized an instrument developed by Risser (1975) to measure patient satisfaction with nurses and nursing care in primary care settings. The instrument measured interpersonal and technical-professional dimensions of nursing on three subscales: (a) trusting relationship, (b) educational relationship, and (c) technical-professional relationship. Andresen and McDermott (1992) adapted the tool to reflect actions common to community health settings such as safety in the home and referrals to community resources. The survey also included a section for demographic information and an area for open ended questions regarding the strengths and weaknesses of the nursing center.

Andresen and McDermott (1992) did a 5-year follow up and replication study of client satisfaction with student nurse rendered care at the same nursing center affiliated with the university school of nursing. In the replication study, Andresen and McDermott (1992) found that responses in the trusting relationship area were all positive. In the subscale assessing the educational relationship, clients were consistently satisfied with both the nurses' ability to answer questions and the ability of the nurse to explain things at a comfortable level of understanding. A deficit noted in the technical-professional area was related to the inability of student nurses to utilize community resources.

Students lack the experience to readily identify appropriate community resources. Faculty guidance was needed to overcome this deficit. The next problem became one of matching resources with finances once available resources were identified.

The results of the Andresen and McDermott (1992) survey had direct implications for supervising faculty at academic NMCs. Faculty enhanced continuity of care by using as assessment tool to evaluate activities of daily living. This tool served students from one semester to the next so as to denote improvements and/or deterioration in a patient's condition. Faculty also developed a medication teaching protocol directed towards elderly clients. These implications, as suggested by the researchers, permit faculty to improve NMC programs and affect quality nursing care.

Bagwell (1987) described results of a client satisfaction survey from 75 participants of services provided by a university nursing center. Care at this center was provided by community nurses, dieticians, nutritionists, consulting physicians, and faculty as well as students. Responses to the questionnaire ranged from satisfied to very satisfied with nursing care received. Significant differences in levels of satisfaction were found between groups of various ethnic backgrounds and groups with varying roles such as adults and parents. Blacks were more

satisfied than whites with the nurses' interest in the overall health status of the client. Adults were more satisfied than parents with courtesy and suggestions for health improvements. The study suggested that satisfied clients (a) were more likely to comply with treatment, (b) could be advocates of nursing center services, and (c) were able to evaluate their own health care and make suggestions for improvement (Bagwell, 1987).

Quality Management

According to Pulliam (1991), outcome evaluation is necessary for NMCs to survive in a competitive health care market. Client satisfaction is a method to evaluate outcomes and could be used to set standards of total quality management. As a first step in this evaluating process, interviews were conducted at NMCs focused on care for an elderly population. The interview consisted of a 1 1/2 hour focus group discussion, lead by a sociologist, and it was based on 9 research questions. Participants believed that the nursing center had done an excellent job of meeting the psychological and social needs of the clients. Services and characteristics of the nursing center that were most valued were identified. Podiatry services, exercise programs, nutritional education, and student nurse health teaching and therapeutic listening were among those services cited as most valuable. Clients saw the purpose of the center based on the services provided; therefore, recommendations for the

future services were made by the clients. These services included programs for coping with depression, arthritis, alcoholism, and stress. The focus group participants also expressed a need for increased social interactions between men and women. It was suggested that the center's coordinator role be expanded to assist clients in finding and using outside resources. This finding was consistent with the same finding of Andresen and McDermott (1992) that identifying community resources was a documented need of clients at NMCs.

Summary

Quality of care is becoming a prevalent topic in the health care industry (Masters & Schmele, 1991). Total Quality Management (TQM) is the conceptual framework that measures quality care as doing things right the first time, on time, all the time, and always striving for improvement and client satisfaction. Client satisfaction is only one element of quality nursing care, but it is the component studied in this research with NMCs.

Nurse Managed Centers (NMCs) may have roots in visiting nursing agencies and public health nursing; however, a NMC can be an alternative method of health care for a community (Barger & Rosenfeld, 1993). The purposes of NMCs include: (a) student education (Barger & Bridges, 1990; Fehring, 1989; Lang, 1983), (b) community service (Fehring, 1989; Gresham-Kenton & Wisby, 1987; Lang, 1983), (c) independent

nursing practice (Gresham-Kenton & Wisby, 1987; Thibodeau & Hawkins, 1987), and (d) nursing research (Fehring, 1989; Lang, 1983). NMCs are often affiliated with a school of nursing and retirement communities or public health departments or home health agencies or hospitals. Because NMCs often have subsidized funding from the government, university, hospital, or direct reimbursement, they can be a cost effective method of providing quality nursing care (Lang, 1983). Measurement of client satisfaction can be useful in measuring this quality care (Cleary & McNeil, 1988).

Andresen and McDermott (1992) revised the questionnaire developed by Risser (1975) and used this instrument to measure client satisfaction in a community health setting. Their original study was in 1984 and it was replicated in 1992 as a follow up. Clients were consistently satisfied with the nurses in the areas of trusting and educational relationships. The inability of the student nurse to identify community resources caused some deficiency in the technical-professional area.

As the institutions of this country continue to look for ways to improve quality, access, and reduce the cost of health care, nurses affiliated with NMCs may have further opportunities to advance the profession of nursing and take a strong leadership role in cost effectively meeting the health needs of the community (Fehring, 1989). Total

Quality Management can provide the framework for NMCs to meet the challenges facing health professionals today. The TQM philosophy of problem prevention rather than problem correction could make health care more cost effective (Masters & Schmele, 1991). Measurement of client satisfaction is an important outcome measure under the rubric of TQM. Increased client satisfaction is one guage of the quality of the nursing care (Cleary & McNeil, 1988).

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

Research Design

This descriptive research used a survey research design. A survey questionnaire developed by Andresen and McDermott (1992) was modified to denote current sponsorship. This design allowed data to be collected from clients receiving student rendered care at academic NMCs. The design was selected for the study because this approach served as an effective method of gaining more information about an identified population. This type of survey is frequently used to determine beliefs, attitudes, and opinions about known situations (Burns & Grove, 1987). The survey was used to describe the perceived level of client satisfaction at two academic NMCs.

Setting and Sample

The setting for the study was at two NMCs affiliated with a large state university in northern California. One NMC (NMC-1) was located in a city-owned dwelling. Elders received student rendered care primarily through home visits in single-family households. Some clients received nursing care in group settings through local institutions such as adult day care centers. The second NMC (NMC-2) was located within a large, residential complex. Some clients received student rendered care within the center's treatment rooms

and others received nursing care from students visiting individual apartments within the complex. A list of clients was obtained from faculty at both NMCs and the population was identified as 79 clients ranging in age from 62 to 94. A convenience sample was obtained by asking clients receiving student rendered nursing care to participate on a voluntary basis. Clients with poor vision and writing handicaps were excluded from the sample. Non-English speaking clients were also excluded because interpreters were not available. Thirty questionnaires were returned from NMC-1, of which 3 were returned late and not included in the sample. Twenty-six were returned from NMC-2. There were 53 (67%) questionnaires in the final usable sample.

Data Collection

After approval from the university Human Subjects Institutional Review Board (Appendix A), the faculty members who worked at NMC-1 and NMC-2 were contacted and informed about this research project. At NMC-1, class time was scheduled. Class time for student instruction and explanation regarding the project. NMC-2 clients were recruited by the researcher in a group.

Research packets contained (a) letter of introduction (Appendix B), (b) explanatory consent letter (Appendix C), (c) survey questionnaire (Appendix D), and (d) self-addressed, stamped envelope. The letter of introduction was addressed to the clients and elicited participation as well

as offered instructions and indicated sponsorship. The explanatory consent letter described (a) client involvement, (b) risks, (c) benefits, and (d) identified responsible parties for questions, complaints, and subjects' rights. During a scheduled conference at NMC-1, the senior nursing students were appraised of the study and its purpose. The researcher distributed the research packets to the student nurses who in turn handed out research packets to the clients with a brief introduction. The return of the questionnaire indicated consent to participate in the study. Clients from NMC-1 mailed completed questionnaires to the researcher in postage paid envelopes. No coding of the questionnaires was done; therefore, anonymity was maintained.

At NMC-2, clients were recruited as a group during an on site evening meal at the residential complex. The secretary introduced the researcher who then appraised the clients of the purpose and need for the study. Packets were distributed by the researcher and an assistant to 37 residents receiving student rendered care. The contents of the packet were identical to the packets delivered to clients at NMC-1 except the self addressed, stamped envelope was omitted; an envelope was provided without a stamp but labeled with researcher's name and address. Clients completed the questionnaires and returned them to the researcher in sealed envelopes. Some respondents returned

the questionnaires immediately following the meal. Other respondents returned questionnaires to a collection box placed at the administrative office of the complex for this purpose.

Instrument

The instrument was a 34-item questionnaire (Appendix D) adapted from the one developed by Andresen and McDermott (1992) and was used with their written permission (Appendix E). The questionnaire does not have a title, however, the instrument was modified to denote current sponsorship by identifying the university and school of nursing in the place for the title.

Andresen and McDermott (1992) developed their questionnaire from an instrument introduced by Risser (1975) to collect descriptive data on patient satisfaction with nurses and nursing care in primary care settings. Andresen and McDermott (1992) adapted the Risser (1975) instrument for the home visit setting, reflecting integral community health nursing interventions.

Reliability and Validity

A reliability coefficient was reported on the Risser instrument as Cronbach's alpha of .91 (Risser, 1975). Risser (1975) stated that although subscale intercorrelation coefficients were determined on this instrument, further testing for validity of the scale is needed.

After the instrument was adapted for the home visit setting by Andresen and McDermott, content validity was established by evaluation of the tool by doctorally prepared community health nursing faculty. No other information was available on validity or reliability.

Content of Questionnaire

The questionnaire was printed in large print and included questions in 3 subscales: (a) trusting relationship, (b) educational relationship, and (c) technical-professional competency. The trusting relationship subscale assessed the clients' perceptions of the nurses' sensitivity and genuine interest in their welfare. The educational relationship subscale assessed the clients' perceptions of the quality of the nurses' instructions and explanations. The technical-professional subscale measured the clients' perceptions of the competency of the nurse to provide nursing care. The instrument for data collection asked clients to respond to 34 items based on a Likert-type scale of 1 to 4. The choices of answers for each question with the numerical value were: (a) 1 = "never", (b) 2 = "sometimes", (c) 3 = "always", and (d) 4 = "does not apply".

Demographics

In addition to the usual data on age, gender, and marital status, the instrument collected demographic data and information related to (a) living arrangements,

(b) length and frequency of student nurse visits, and (c) methods of referral to the NMC. Three closed-ended questions dealt with general information regarding (a) student qualifications, (b) personal physician support, and (c) monetary values assigned to student nurse visits.

Data Analyses

Copies of the entire questionnaire from each respondent were mailed to a consultant statistician. Frequency scores were computed for each item using the Statistical Package for the Social Sciences (SPSS) software. Descriptive statistical procedures were used to compute frequencies, percentages, and ranges for demographic and other study variables.

Chapter 4

ANALYSES AND INTERPRETATION OF DATA

Introduction

The purpose of this study was to measure client satisfaction as a method to evaluate quality of nursing care given by student nurses at two academic NMCs. A formal process for the elderly clients to evaluate their nursing care could be initiated at these NMCs.

This chapter is a summary of the data collected from the survey of elderly clients receiving care from student nurses. The first section describes the demographics. The second section describes the responses to the three subscales of the questionnaire developed to measure client satisfaction by Andresen and McDermott (1992).

Demographics

Data were collected to identify age, gender, marital status, and living conditions of those who responded to the questionnaire. The majority of respondents were in the age range of 80-89 (43%) or just younger at 70-79 years of age (31%) as seen in Table 2. The mean age of respondents was 79.2 with a range from 62 to 94 years of age. The standard deviation was 8.45 with median age 81 and mode 78.

Most of the respondents were female (73%) which left 27% to be male. Table 3 shows that 55% of the sample were widowed, 29% were married, and 16% were divorced or

Table 2

Subject Age Categories by Frequency and Percentage (N=53)

Age Category	n	Valid %
62-69	8	16
70-79	15	31
80-89	21	43
90-94	5	10
Missing	4	0
Total	53	100

single. Of the respondents, 69% reported that they lived alone.

Respondents were asked about services from the student nurses. Thirty-three percent had received services from the student nurse for 4 or more years. Respondents stated that services were rendered primarily weekly (43%) or bimonthly (41%).

Fifty-five percent of the respondents stated that they were referred to NMC student services by someone other than a social worker, home health nurse, or doctor; however, the questionnaire did not list other specific options. Sixty percent of the respondents stated that their doctor was aware of the student nurse visits. The majority (81%) of

the respondents believed the student nurses were qualified to offer the assistance that was needed.

Table 3

Subject Marital Status and Living Conditions by Frequency and Percentage (N=53)

Category	n	Valid %
Marital Status		
Single	2	4
Married	15	29
Widowed	28	55
Divorced	6	12
Missing	2	0
Total	53	100
Living Conditions		
Alone	35	69
Not Alone	16	31
Missing data	2	0
Total	53	100

The final closed-ended question of the demographic section of the survey asked respondents to assign a monetary value to the home visit. At the present time, there are no monetary charges to the clients. Of the 53 total

respondents, 19 (36%) failed to answer the query. However, 30% of the respondents assigned the value in the $6-10 range and 27% assigned the value in the range of $1-5. Fifteen percent of respondents valued the visits in the ranges of $21 or more. Other ranges of $11-16 and $16-20 received responses of 12% and 3%, respectively.

Findings from Questionnaires

Trusting Relationship Subscale

The trusting subscale measured the sensitivity of the student nurse toward clients (Items 1-10) as seen in Table 4. The questionnaire presented a series of statements aimed at assessing the perceived level of nurse interest in the general welfare of the respondents. Answers favorable to client satisfaction were dominant.

Ninety percent of the respondents stated that the nurse's presence was always reassuring (Item 1). The respondents (91%) stated that the nurse always showed an interest (Item 2). Ninety-two percent of the respondents reported that the nurse was always trustworthy (Item 5). Most of the student nurses (96%) always treated the client in a courteous and respectful manner (Item 6), and 81% of the respondents always felt better after talking with the nurse (Item 7).

Items 8, 9, and 10 in this subscale received a high percentage of favorable answers. Of 53 respondents, 43 (81%) said that the nurse did not take up too much of their

time as indicated by the negative response. Eight-two percent of respondents stated the nurse did not impose

Table 4

Trusting Relationship by Frequency and Percentage (N=53)

Items	Never n	%	Sometimes n	%	Always n	%	Does not apply n	%
The Student Nurses:								
Presence reassuring	0	(0%)	3	(6%)	44	(90%)	2	(4%)
Showed interest	1	(2%)	3	(6%)	48	(91%)	1	(2%)
Understood situation	1	(2%)	3	(6%)	44	(85%)	4	(7%)
Free to talk about feelings	2	(4%)	4	(7%)	45	(85%)	2	(4%)
Trustworthy	1	(2%)	1	(2%)	49	(92%)	2	(4%)
Courteous and respectful	1	(2%)	0	(0%)	51	(96%)	1	(2%)
Made me feel better	0	(0%)	7	(13%)	42	(81%)	3	(6%)
Took too much time	43	(81%)	4	(7%)	2	(4%)	4	(8%)
Imposed own ideas	42	(82%)	5	(10%)	2	(4%)	2	(4%)
Helpful, worthwhile	2	(4%)	5	(9%)	40	(76%)	6	(11%)

Note. Percentages were rounded to the nearest whole number.

personal ideas upon them. Overall, 76% of the sample reported that the student nurse visits were always helpful and worthwhile. All items within this subscale except "took up too much time" received a majority of "always" responses.

Educational Relationship Subscale

Table 5 listed the five questions (Items 11-15) on the survey that asked the client's perceptions of the quality of

Table 5

Educational Relationship by Frequency and Percentage (N=53)

Items	Never n	%	Sometimes n	%	Always n	%	Does not apply n	%
The Student Nurses:								
Used simple language	3	(6%)	2	(4%)	45	(85%)	3	(6%)
Care demonstrated lack of continuity	27	(59%)	9	(20%)	0	(0%)	10	(22%)
Used clear explanation	3	(6%)	3	(6%)	27	(53%)	18	(35%)
Demonstrated understanding	0	(0%)	4	(8%)	39	(75%)	9	(17%)
Answered questions	0	(0%)	7	(14%)	34	(65%)	11	(21%)

Note. Percentages were rounded to the nearest whole number.

the nurse's explanations and instructions. These items presented statements aimed at assessing the student's ability to satisfy the client's questions regarding treatments, procedures, and continuity of care.

Eight-five percent of the respondents stated that the nurse always explained things in simple, understandable language. Respondents reported the nurse always (53%) explained new procedures or treatments and checked for understanding 75% of the time.

The educational subscale measured student knowledge and ability to teach at a level easily understood by the clients. All responses within this subscale were generally positive except "lack of continuity". Since quality care would not lack continuity, this was the desired response.

Technical-Professional Competence Subscale

The technical-professional subscale focused on the competency of the student nurse in providing nursing care (Items 16-34). Each item of the questionnaire listed a possible nursing intervention. Some of these interventions included: (a) personal care, (b) diet, (c) exercise, (d) safety, (e) referral to community resources, and (f) assistance with prescribed treatments. Respondents were asked to note if they had received these interventions from their student nurse. A "does not apply" category was included.

In 17 of the 19 interventions listed, the "does

not apply" category was the most frequent (89%) response choice. Some interventions received identical numbers of responses in two categories and were reported as tied.

Of the 19 nursing interventions listed in this subscale of the questionnaire, "does not apply" was the most frequently used response except for the nursing interventions with "foot care" and "emergency measures." "Always" was the most frequent response to the nursing intervention of "foot care", and "does not apply" was the second most frequent response to this intervention. There were an equal number of "always" and "does not apply" responses for the nursing intervention for "emergency measures."

"Always" was the second most frequent response to the nursing interventions of (a) "treatment assistance" and (b) "medication instruction"; "always" and "sometimes" tied as the second most frequent response for the intervention of "safety measures". "Sometimes" was the second most frequent response to the nursing interventions of (a) "diet instruction", (b) "exercise instruction", (c) "sleeping problem discussion", (d) "social resource identification", (e) "recreational therapy discussion", and (f) "community resource identification."

Interpretation

Sample Characteristics

The results of the data analyses suggest a profile of

the clients. The respondents ranged in age from 62 to 94. Most were female, widowed, and lived alone. Student nurse visits had taken place for 4 or more years and visits occurred most often on a weekly basis. The second most frequent visitation schedule occurred on a twice monthly basis.

Over one-half of the respondents stated that they were referred to the student services program by someone other than a social worker, home health nurse, or doctor. However, over one-half of the respondents stated that their doctor was aware of the student nurse visits. A large majority of clients felt that the student nurse was qualified to offer needed assistance.

When asked to assign a monetary value to the home visit, the majority of respondents placed that value in the $6-10 range. The second most frequent range was $1-5. Currently, clients are not charged a fee for the home visit.

The sample used in this study could be considered representative of the greater population of elderly clients receiving services at two academic NMCs affiliated with a School of Nursing at a large, urban university. However, the sample was not representative of the entire urban elderly population surrounding the university. This sample also was not representative of clients with sight or writing impairments nor Non-English speaking clients.

Trusting Relationship

Responses indicated the majority of clients were satisfied with the trusting relationship that developed between the student nurse and the respondent. Except for one item within this subscale, the predominant response was the "always" category when describing the trusting relationship. Findings revealed that students "never" took up too much of the client's time. All findings within this subscale were positive both in this study and the Andresen and McDermott (1992) study.

Faculty were concerned about the frequent rotation of students practicing at the NMCs. Every 15 weeks, new students were assigned to a community health nursing clinical course conducted at a NMC. Faculty for each NMC remained fairly constant. The trusting relationship may be enhanced by the fact that faculty are known to the client. A high level of client satisfaction may be based on the continuity of care provided by faculty.

In addition, there was a faculty concern regarding the transition process faced by students in moving from an inpatient to an outpatient arena. Students were afforded a level of control within a structured environment in the inpatient setting that was very different from visiting clients in their homes. The students were able to demonstrate behaviors fostering a trusting relationship. Community health nursing in part focuses on health promotion

interventions in an effort to facilitate client movement toward the desired end of wellness on the illness-wellness continuum. By establishing a positive trusting relationship, the student nurse can assist the client toward that end.

Perhaps another reason for the positive responses in this subscale may be based on the image of nursing. Nurses were perceived as caring individuals. This image may have set the stage for the evolution of a trusting relationship. The nurses portrayed an attitude of sensitivity and general concern for the welfare of the clients.

Educational Relationship

All respondents again reported responses that were positive when assessing the educational relationship between the student nurse and the client except for Item 12 which was stated negatively and "never" was the best response. Findings revealed that student nurses always preserved a sense of continuity in delivering nursing care. Clients consistently expressed their high level of satisfaction by their responses to questions regarding the quality of the nurse's explanations and instructions.

The community health nursing course allowed the expansion of primary care nursing from the traditional inpatient setting to the outpatient setting. The students were seniors in the nursing program and had a broader knowledge base at this point in their education. Clients

were able to evaluate the student nurses in their ability to help them with their educational needs in the home.

Technical-Professional Competence

The technical-professional competency subscale was measured by a list of nursing interventions possible within the home care setting. In assessing the technical-professional subscale, the majority of respondents utilized the category "does not apply." Therefore, interpretation of data related to the competence of students performing a nursing intervention was difficult.

The intervention of "foot care" received a majority of responses in the "always" category. Perhaps the reason for this lies with the unique program offered by the School of Nursing. The School provided the clients with an intensive foot care program that was well attended. Clients were able to receive foot care at the NMC for a small fee. Clients at NMC-1 made appointments for foot care on a regular basis. Clients of NMC-2 attend foot care clinics in a group setting or on an individual basis within their private home. Foot care clinics represented a direct nursing intervention perceived as valuable to the clients and may account for the positive response. The positive response indicated a high level of satisfaction with the intervention. The nursing action also provided an avenue for communication and teaching. Thus, the intervention was actually more than one task and served as a positive experience for both client and student.

A second intervention included teaching of actions to take in an emergency, and it received a high volume of responses in both categories of "does not apply" and "always." The student nurses were able to satisfy the needs of elderly clients living alone in the home setting.

As stated earlier, most respondents selected the "does not apply" category as the primary response. However, as a second most frequent choice, the respondents chose different answers to the 19 interventions. Seven interventions were reported as never having been performed. Students neither assisted with personal care, bowel and bladder care, nor skin care. Respondents also reported that community nursing interventions such as discussions regarding (a) living arrangements, (b) spiritual beliefs, (c) insurance coverage, and (d) referrals to doctors or dentists were tasks never completed. The specific interventions not performed may be explained by unique circumstances of the NMCs in this study.

The identification of individual characteristics of each NMC may account for the differences. NMC-1 was a senior residential complex sponsored by a religious group. This fact may explain the "does not apply" responses reported at second highest frequency for two interventions, discussion of spiritual beliefs and living arrangements. Regarding insurance coverage, most elderly clients in the United States possess Medicare as their primary insurance carrier. The student nurse may have assumed a discussion of

health insurance was unnecessary based on the age of the sample or a lack of understanding.

In addition, lack of knowledge regarding specific physicians and dentists may explain the perceived lack in the item related to medical referrals. Both NMCs were located in a large urban area offering many diverse and accessible services. Knowledge about physicians and dentists within the immediate area was difficult based on the geographical size and location. The majority of clients had a private physician and may not have needed a referral.

Again, based on second highest frequency of response choice, other interventions in which clients were satisfied included assistance with treatments and assistance in understanding the medication regime. The respondents reported a high level of satisfaction with the intervention of promoting and maintaining safety with the home. Discussions regarding transportation to and from health care services received a positive response when assessing interventions. These interventions were directly related to a required course for these senior students on community health nursing theory.

The items in this subscale measured student nurse competence based on a list of nursing interventions. The high preponderance of responses in the "does not apply" category may cause concern for faculty at both academic NMCs. The 19 nursing interventions were adapted to the home

care setting by Andresen and McDermott (1992) but may not have reflected tasks performed by the students at the two NMCs involved in this study.

Summary

The client satisfaction questionnaire from Andresen and McDermott (1992) was used to survey clients receiving student rendered care at two academic NMCs (N=53). Demographic data produced a profile of a female between 70 to 89 years old who was widowed and lived alone. Responses on the trusting and educational relationship subscales revealed a high level of client satisfaction. The technical-professional subscale revealed high levels of client satisfaction for services related to "foot care" and "emergency measures." Other responses did not show dissatisfaction, however, it would be difficult to document client satisfaction because of the large number of "does not apply" responses. The responses of "does not apply" to many of the services listed on the questionnaire may reflect that the client perceived that these services were not offered by student nurses or that these services were provided by other sources. Further research is needed to rule out a deficit in the research tool.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

Utilizing TQM as the conceptual framework, the purpose of this study was to determine the perceived level of client satisfaction with student rendered nursing care at two academic NMCs. The 53 respondents surveyed represented elderly clients who received nursing care in the community. The students were seniors enrolled in a community health nursing clinical course. The findings indicated that a majority of respondents were satisfied with student rendered care provided by both academic NMCs.

Client satisfaction can be a strong indicator of quality care (Cleary & McNeil, 1988). Based on survey results, the students provided quality care. According to Hsieh and Kagle (1991), patients who are satisfied with their health care are more likely to comply with a medical regime. The highly satisfied clients of the 2 NMCs studied by this researcher were able to enhance wellness based on care provided by student nurses.

The use of a survey questionnaire about client satisfaction can become a formal process by which faculty begin the feedback loop to assure continuous quality improvement. Faculty have the difficult task of satisfying objectives of many customers. The survey can be used to

measure client satisfaction and offer evidence on which to modify curricula to improve students' learning experiences and enhance quality care. This study provided documentation that the clients at two academic NMCs were highly satisfied.

Conclusions

A majority of respondents reported high satisfaction on the trusting relationship and educational relationship subscales. An overwhelming majority of respondents felt the student nurses were qualified to provide needed care. Respondents also indicated a high degree of satisfaction with the student nurses' quality of explanations and instructions for treatments and procedures.

The absence of negative responses on the technical-professional subscale indicated that client dissatisfaction had not occurred; however, "does not apply" was a predominant response, and this made evaluation difficult. One component of the technical professional subscale measured the students' ability to assist clients in identifying appropriate resources within their geographical area. This task is a common component of community health nursing. However, due in part to the urban area in which the research was conducted, a plethora of specific services were available for community-dwelling elders. Therefore, the technical-professional subscale measured interventions which may have been offered by other sources.

Other interventions measured by the technical-

professional subscale were related more to direct patient care. These interventions included (a) personal care, (b) diet and exercise instruction, and (c) skin care. These interventions may not be a component of community health nursing or may not have been required by this sample of elders. This may indicate that the survey questions did not address the services performed by the student nurses at this time and questions the content validity of the instrument.

Comparison with Andresen and McDermott (1992) Study

A comparison of this study's finding to those of Andresen and McDermott (1992) revealed similar responses in many areas. The results of both studies clearly indicated a high degree of client satisfaction on both the trusting and educational subscales. Andresen and McDermott (1992) reported negative findings on the technical-professional subscale regarding items of community resource referral and provision of personal care. They attributed the technical-professional low score to the inexperience of students.

Both studies reported a similar respondent profile. Andresen and McDermott (1992) stated the median age of respondents was 70. This study stated the median age of respondents was 81. The sample in both studies was primarily female, living alone.

Scope and Limitations

The sample size in the current study was small but representative of elderly clients who received student

rendered care at two academic NMCs. The total client population at both NMCs numbered 112. However, generalization cannot be made beyond the target population.

The sample was selected from dissimilar NMCs which may have skewed findings. Residents in single family dwellings (NMC-1) demonstrated different needs than residents in the senior housing facility (NMC-2). Residents in single family dwellings were responsible for living accommodations, food preparation, and transportation needs. Clients living in the senior housing facility may demonstrate less concern with home owner responsibilities, meal preparation, and transportation issues. These services were provided in various forms by the complex and monitored by the administrators. The questionnaires were not separated by facility for data analyses. This was a limitation of the study.

The success of questionnaire distribution may have been influenced by unforseen events. Another questionnaire was received by residents of the senior housing complex earlier during the same week of data collection. The presence of two questionnaires confused many clients. Clients were concerned that both questionnaires surveyed identical factors. However, a simple explanation by the complex administrator helped the residents understand the difference between the two studies.

Within the demographic section, the method of referral

to the NMC had limited response choices. The study failed to define those persons other than social workers, home health nurses, or physicians who were in a position to suggest NMC services. There were no responses to the answer of "other."

This study was limited by the lack of rigorous reliability and validity testing of the questionnaire. Further, the format of the instrument may have evoked superficial answers and biased findings.

Recommendations

This study outlined the perceived level of client satisfaction at two academic NMCs. A review of the literature indicated limited research on client satisfaction with student rendered care at NMCs. Additional research using the instrument is recommended for the following reasons: (a) to continue the formal process by which elderly clients evaluate the quality of care rendered by nursing students and (b) to continue validity and reliability testing of the tool. Further refinement of the tool could include selection of more pertinent nursing interventions.

This topic should be studied further with a larger population. Therefore, the study should be repeated at other academic NMCs. Attention should focus on the special needs of the elderly. It is recommended that researchers provide interpreters for non-English speaking clients.

Researchers should include clients with physical barriers such as poor vision and writing handicaps.

To improve marketing strategies, the questionnaire should be expanded to investigate the method by which clients are referred to NMCs. Word of mouth is possibly the most frequent method of NMC referral. Investigation of the elderly clients' expectations and perceptions of quality care presents a unique challenge for all nurses. The future of NMCs may be dependent on the knowledge of referral sources.

In addition, it is recommended that faculty examine the current components of the community nursing clinical course and seek expansion of nursing actions into other realms. Andresen and McDermott (1992) suggested that future curricula might include further evaluation of nursing actions such as (a) assessing dysfunctional behaviors, (b) implementing teaching strategies aimed at behavior change, (c) methods of contracting to set health goals, (d) assistance in decision making processes, (e) motivational strategies, (f) understanding the role of change agent, and (g) comprehending group dynamics. Curricula evaluation must be a continuous process to meet the changing needs of community-dwelling elderly clients.

Summary

Client satisfaction is important for evaluating quality. A high level of client satisfaction improves

compliance with the medical regime and assists clients in attaining an improved state of health. The measurement of client satisfaction in relation to TQM can provide faculty with evidence of quality by which to negotiate the continuance of NMCs. This information provides important feedback to the nursing student for professional growth.

The marketing of professional services has become popular in today's society. Understanding the means to please new market segments is imperative to the future success of any health care industry (Shank, Rupich, Griffin, & Avioli, 1992). Elderly clients constitute an expanding segment in the current health care marketplace. As the profession of nursing continues to develop autonomy and accountability for its contribution to the health care delivery system, evaluating client satisfaction is one way for nursing service to measure outcomes. The positive response of elderly clients validated the need for non-institutional settings to meet the health care needs of the increasing elderly population.

According to Cleary and McNeil (1988), high levels of satisfaction are associated with care deemed more personal. Health care services that foster good communication skills, empathy, and concern are considered more personal. Clients who receive health care from individual practitioners in smaller organizations and those who have long standing relationships with their providers are thought to possess a

higher satisfaction level and become more involved with their treatment plan (Cleary & McNeil, 1988). NMCs represent service within a small organization and provide the opportunity for long standing relationships, especially with the faculty.

The concept of TQM captures the customer feedback, quality improvement loop directly connected to personalized service. Armed with research results from this study, faculty can have an effect upon future services directed toward quality care to elderly clients. The elderly population presents a unique set of challenges awaiting the health care planner. Future research on client satisfaction could enhance services at the NMCs.

The results of this study indicated that elderly clients at two academic based NMCs exhibit a high degree of satisfaction in 2 of 3 subscales. Clients were satisfied with the trusting relationship and the educational relationship they experience as a result of student rendered care. The technical-professional subscale failed to demonstrate satisfaction with the competence of the student nurses as indicated by a lack of responses to many items.

This study has investigated client satisfaction with student rendered care at NMCs as a non-institutional setting for health care delivery to the elderly population. High satisfaction levels evoke a positive experience for both clients and student nurses. Further research is indicated

to continue the exploration of satisfaction levels among elderly clients receiving care at academic NMCs.

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APPENDIX A

Institutional Review Board Letter

To: Chris McKinstry
40841 Valero Drive
Fremont, CA 94539

From: Serena W. Stanford
AAVP, Graduate Studies and Research

Date: March 25, 1993

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Client Satisfaction in Academic Nurse-Managed Centers"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have questions, please contact me at 408-924-2480.

CC: Jayne Cohen

APPENDIX B

Letter of Introduction

Dear Patient:

Your help is needed. You have been selected to participate in a study about the nursing care you receive at Nurse Managed Centers, I am a graduate student at the San Jose State University and the sponsor for this project. **I need your assistance and appreciate your time.**

If you wish to participate in my study, please read the enclosed consent form and keep it for your records. It should take approximately 30 - 45 minutes to answer the questions. Please read each question carefully. Please mail the completed survey in the enclosed envelope.

Sincerely,

Chris McKinstry, R.N.

enclosure

APPENDIX C

Consent Letter

Agreement to Participate in Research

Responsible investigator: Chris McKinstry

Title of protocol: A descriptive study of the perceived level of client satisfaction at nurse-managed centers.

I have been asked to participate in a research study exploring the level of satisfaction with student-rendered nursing care at the Nurse Managed Centers. The results of the study should help faculty evaluate care and offer suggestions for the future.

I will be asked to complete a questionnaire. The possible risks of the study are none. The possible benefits of the study are none. The results of the study may be published but any information from the study that can be identified with me will remain confidential and will be disclosed only with my permission or as required by law.

Questions about the research will be addressed by Chris McKinstry (510) 657-4317. Complaints about the research may be presented to Dr. Jayne Cohen, Nurse Managed Center Coordinator at San Jose State University (408) 924-1325. Questions or complaints about research, subjects' rights, or research-related injury may be presented to Dr. Serena Stanford, Associate Vice President of Graduate Studies and Research (408) 924-2480.

I understand that no service of any kind, to which I am otherwise entitled, will be lost or jeopardized if I choose not to participate in the study. My consent is given voluntarily. I may refuse at any time to participate in the study or in any part of the study. I may withdraw from the study at any time without prejudice to my relations with San Jose State University or any other participating institutions.

I have received this consent form for my records.

THE RETURN OF THIS SURVEY INDICATES AGREEMENT TO PARTICIPATE IN THE STUDY.

THE SIGNATURE OF THE RESEARCHER ON THIS DOCUMENT INDICATES AGREEMENT TO INCLUDE THE SUBJECT IN THE RESEARCH AND AN ATTESTATION THAT THE SUBJECT HAS BEEN FULLY INFORMED OF HIS OR HER RIGHTS.

DATE_____ Investigators Signature_____

APPENDIX D

Questionnaire

SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING

FOR THE FOLLOWING QUESTIONS PLEASE CIRCLE THE RESPONSE THAT MOST DESCRIBES YOUR FEELINGS. USE THE FOLLOWING SCALE:
1. NEVER 2. SOMETIMES 3. ALWAYS 4. DOES NOT APPLY

	never	some times	always	does not apply
1. The presence of student nurses was reassuring to me.	1	2	3	4
2. The student nurses showed interest in me.	1	2	3	4
3. The student nurses understood my situation.	1	2	3	4
4. I felt free to talk about my feelings with the student nurses.	1	2	3	4
5. The student nurses were trustworthy.	1	2	3	4
6. The student nurses treated me in a courteous and respectful manner.	1	2	3	4
7. Just talking to the student nurses made me feel better.	1	2	3	4
8. The student nurses took up too much of my time.	1	2	3	4

TECHNICAL/PROFESSIONAL AREA, Contd.

	never	some-times	always	does not apply
9. The student nurses imposed their own ideas on me.	1	2	3	4
10. The student nurses visits were helpful and worthwhile.	1	2	3	4
11. The student nurses explained things to me in simple language that was easy to understand.	1	2	3	4
12. The student nurses asked a lot of questions; however, after he/she received the answers, nothing was done.	1	2	3	4
13. The student nurses explained all new procedures and treatments before they were done.	1	2	3	4
14. The student nurses checked to see if I understand what was said.	1	2	3	4
15. My questions about procedures and treatments were answered by the student nurses.	1	2	3	4
16. The student nurses helped me with the treatments that were ordered for me by the M.D.	1	2	3	4
17. The student nurses helped me with personal care (bathing etc.)	1	2	3	4

TECHNICAL/PROFESSIONAL AREA. Cont.

	never	some times	always	does not apply
18. The student nurses helped me plan my diet.	1	2	3	4
19. The student nurses helped me with exercise activities.	1	2	3	4
20. The student nurses talked with me about elimination habits such as bowel movements and urination.	1	2	3	4
21. The student nurses helped me to promote and/or maintain safety in my home.	1	2	3	4
22. The student nurses taught me what to do in case of an emergency.	1	2	3	4
23. The student nurses helped me with understanding how to take my medications.	1	2	3	4
24. The student nurses talked with me about sleep problems.	1	2	3	4
25. The student nurses helped me to identify people in my home and/or community who could help me, such as family and friends.	1	2	3	4
26. The student nurses showed me how to take care of my skin.	1	2	3	4

TECHNICAL/PROFESSIONAL AREA, Cont.

	never	some times	always	does not apply
27. The student nurses showed me how to take care of my feet.	1	2	3	4
28. The student nurses talked to me about my present and/or future living arrangements.	1	2	3	4
29. The nurse talked with me about my spiritual and religious beliefs.	1	2	3	4
30. The nurse talked with me about engaging in recreational or fun activities.	1	2	3	4
31. The student nurses discussed transportation to and from health care services.	1	2	3	4
32. The student nurses discussed insurance (Medicare).	1	2	3	4
33. The student nurses gave me referrals, if necessary, to doctors, dentists, etc.	1	2	3	4
34. The student nurses helped me to identify community resources.	1	2	3	4

IV. DATA:

(1) PLEASE LIST YOUR AGE: _____Years

(2) PLEASE CHECK YOUR SEX:

_____Male

_____Female

(3) CHECK YOUR MARITAL STATUS:

_____Single

_____Married

_____Widowed

_____Separated

_____Divorced

(4) DO YOU LIVE ALONE?

_____Yes

_____No

(5) IF YOU DO NOT LIVE ALONE, WHO DO YOU LIVE WITH (Check all that apply).

_____Spouse

_____Sister

_____Brother

_____Mother

_____Father

_____Son

_____Daughter

_____Friend

_____Other
(Please explain)

_____

(6) HOW LONG HAVE SAN JOSE STATE UNIVERSITY NURSING STUDENTS BEEN COMING TO YOUR HOME?

_____6 MONTHS OR LESS

_____7 TO 12 MONTHS

_____1 TO 1 &1/2 YEARS

_____2 YEARS

_____3 YEARS

_____4 YEARS OR MORE

(7) HOW OFTEN DID A SAN JOSE STATE UNIVERSITY NURSING STUDENT COME TO SEE YOU?

_____Twice a week

_____Once a week

_____Twice a month

_____Once a month

(8) HOW WERE YOU REFERRED TO THE SAN JOSE STATE NURSING SERVICE?

_____Santa Clara County Handbook
_____Home Health Nurse
_____Social Worker
_____Doctor
_____Neighbor
_____Other (Please explain)
_____Family Member
_____

(9) DOES YOUR DOCTOR KNOW THAT A SAN JOSE STATE UNIVERSITY NURSING STUDENT HAS BEEN VISITING YOUR HOME?

_____Yes _____No

(10) DO YOU THINK THE NURSING STUDENT IS QUALIFIED TO OFFER THE ASSISTANCE YOU NEED?

_____Yes _____No

(11 HAVE YOU BEEN HOSPITALIZED DURING THE PAST THREE YEARS?

_____Yes _____No

IF YES, FOR HOW LONG _____

(12) HAVE YOU EVER STAYED IN A NURSING HOME DURING THE PAST THREE YEARS?

_____Yes _____No

IF YES, FOR HOW LONG_____

(13) IN ADDITION TO OUR SERVICE, HAS ANY OTHER HOME HEALTH AGENCY PROVIDED SERVICES TO YOU IN THE PAST THREE YEARS?

_____Yes _____No

IF YES, FOR HOW LONG_____

V. GENERAL

(1) I HAVE HAD TOO MANY VISITS FROM THE STUDENT NURSES.

_____Yes _____No

(2) I HAVE HAD TOO FEW VISITS FROM THE STUDENT NURSES.

_____Yes _____No

(3) WAS THERE ANYTHING THAT THE STUDENT NURSE SAID OR DID AT ANY TIME THAT YOU DID NOT LIKE?

_____Yes _____No

PLEASE EXPLAIN _____

(4) I FOUND IT DIFFICULT TO HAVE A NEW STUDENT NURSE EVERY 15 WEEKS.

_____Yes _____No

PLEASE EXPLAIN_____

(5) DID YOU EVER HAVE CONTACT (TELEPHONE OR PERSON) WITH A NURSE FACULTY MEMBER FROM THE NURSING CENTER?

_____Yes _____No

(6) IF IT WERE POSSIBLE,. WOULD YOU LIKE THE NURSING STUDENT TO CONTINUE VISITING YOU?

_____Yes _____No

(7) ARE YOU AWARE THERE IS NO FEE FOR THEIR SERVICE AND WE ARE NOT PLANNING TO CHARGE; HOWEVER, WE ARE INTERESTED IN WHAT YOU FEEL THE VISIT BY THE STUDENT IS /WAS WORTH TO YOU?

_____$1-$5 _____$16-$20

_____$6-$10 _____$21-$25

_____$11-$15 _____$More than $25

(8) WHAT ELSE COULD THE STUDENT NURSE HAVE DONE TO HELP YOU AND THOSE YOU LIVE WITH?

(9) WHAT DID YOU LIKE BEST ABOUT THE VISITS FROM THE STUDENT NURSES FROM THE SAN JOSE STATE UNIVERSITY NURSING CENTER?

(10) WHAT DID YOU LIKE LEAST ABOUT THE VISITS FROM THE STUDENT NURSES FROM THE SAN JOSE STATE UNIVERSITY NURSING CENTER.

(11) PLEASE GIVE US ANY ADDITIONAL SUGGESTIONS OR COMMENTS ABOUT THE SAN JOSE STATE UNIVERSITY NURSING CENTER.

APPENDIX E

Permission Letter

March 3, 1993

Chris McKinstry
40841 Valero Drive
Freemont, California 94539

Dear Ms. McKinstry,

We understand you are interested in using the Patient Satisfaction Survey which was developed by us and referred to in our article published in Nurse Educator, May-June, 1992 issue. We give our permission for you to use this survey and hope it will be of contribution to you and your research project.

Sincerely,

Pamela Andresen
Mary Ann McDermott

Pamela Andresen, Ph.D., RN
Mary Ann McDermott, Ed.D., RN