FAMILY PERCEPTION OF QUALITY IN NURSING HOME CARE: IMPACT OF

GENDER, LEVEL OF INVOLVEMENT, AND UTILIZATION OF

EMPOWERED CNA TEAMS

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As the United States' baby boom generation ages, the future of nursing home care becomes increasingly important. Through this study the researcher seeks to understand quality in nursing home care from the family's perspective. Surveys were collected at one North Texas nursing home, and data were analyzed to determine how gender and level of family involvement impact their concept of quality. Further, the information in this study is aimed at clarifying if interventions, specifically empowered CNA teams, have an impact on how family members view quality. Findings are identified and recommendations for future study are made.

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CHAPTER I

INTRODUCTION

Background of the Problem

Aside from the historical presence family has had in caring for our elderly,

nursing homes have been established as a common way to address care in later life.

The nursing home concept came about because of the need to house and care for the

aging members of our population, especially those members who did not have family

that would or could care for them. This need was first addressed with almshouses

(Haber, 1993). These facilities housed, not only seniors, but also the poor, homeless, or

mentally ill (Haber, 1993). Later, it was deemed necessary to separate the seniors from

the rest of the people needing services. This reform, in addition to other legislation and

the return of troops from World War II, transformed the senior care setting from the

almshouse to the nursing home (Collopy, Boyle, and Jennings, 1991; Haber, 1993).

As this change occurred, family members remained consistent participants in the

nursing home care setting. Our population continues to age and Abel writes that while

the elderly were just 4% of the population in 1900, this number is expected to increase

nearly 13 points (to 17%) by the year 2020 (1991, p. 6). Further, the "old old," or those

age 85 and above are the fastest growing segment of the population (Abel, 1991). Few

studies have considered families' opinion of high quality care in the nursing home.

However many seniors, especially the ever increasing "old old" population, continue to

rely on their family to help them make decisions regarding their care. Although nursing

homes are considered a common choice for care in later life, studies completed in the

1990s show a resident population of about 2 million total (Abel, 1991; Gabrel, 2000;

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Ray, 2000). As other types of care become more and more popular (in-home services, family care, etc.), this study may help nursing homes remain a prominent choice for seniors.

Statement of the Problem

Recognizing and understanding family perceptions about a loved one's nursing home care is the primary goal of this study. Family members often feel they abandon their loved one in an institution. And to confirm this feeling, some of the comments in our survey responses, and other sources presented in the literature review indicate that visiting the nursing home can often be a negative experience. Further, nursing homes are often the last resort for family members (Abel, 1991, p. 132). Tobin in Smith, Tobin, Robertson-Tchabo, and Power (1995) suggests that involvement of the family is very important, "because it affirms not only the ties that bind aging families together but also the concerns of families for their members, regardless of age" (p. 25). As our American population becomes older, we should seek to ensure families are as involved as they can be in nursing home care. The information in this study will provide a greater understanding of families' opinions, especially regarding quality care. Hopefully this will provide them with a greater sense of control, and therefore more incentive to stay involved.

Rationale for the Study

The information in this study adds to the research available about what family members are looking for in a nursing home. More and more, family members are being considered important stakeholders in nursing home quality. Many times they hold a

crucial place in the decision of where a family member will go when he or she is no longer able to care for him- or herself. Therefore, it is helpful for facility administrators to know the opinions of family members when deciding where they will focus their improvement efforts. Secondly, this study can help further our knowledge of how the intervention of empowered certified nurse aide (CNA) teams, in nursing home settings, affect perception of quality. A final rationale for the study is to further our understanding of how to code written narratives generated in response to open-ended questions and process the reliability of multiple coders, specifically for sociological studies.

Purpose of the Study

The purpose of this study was to examine the opinions of family and/or significant others, specifically family of nursing home residents at one nursing home in North Texas. I sought to understand their conceptualization of high quality care in any nursing home. Specifically, this research was conducted to test three research hypotheses. These included evaluating how the response differed by gender, how responses changed depending on the frequency of family/significant other visits, and how responses about quality changed after the implementation of empowered CNA teams.

Research Hypotheses

This research is guided by the following three hypotheses:

1) Women and men will have different opinions of how "high quality care in any nursing home" is defined.

2) Respondents will define "high quality care in any nursing home" differently depending on how frequently they visit.

3)	Respondents will define "high quality care in any nursing home" differently before the empowered CNA team intervention than after.

Definitions

Person in Care v. Patient or Resident

Typically we call persons receiving services the "patient," "resident," or sometimes "client." As pointed out in Meyers (2006), this reinforces an attitude of separation – disconnecting us, the healthy one, the researcher, etc. from "them," the person on the receiving end of care. In an effort to appreciate the quality of life of those we are studying here, I refer to long-term care recipients as "persons in care." However, one exception was made. Since the coding procedures were completed using "resident" as a title, that wording is retained when coding information is represented.

Nursing Home

The unit of measurement in the study is friends and family members of people in care at a specific nursing home facility. Since the unit of measurement is specific, the primary term used in this study is "nursing home." Long-term care facilities are defined by the government to include nursing homes (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 2007). It should be understood that nursing homes are a type of long-term care and therefore any research reference to long-term care is also a reference to nursing homes.

Certified Nurse Aide (CNA)

Individuals wishing to become employed as a CNA are required to meet certain conditions set by individual state's legislators. Since this study was completed in Texas, only the rules by this state will be discussed. According to the Texas Administrative Code a nurse aide is,

> An individual providing nursing or nursing-related services to residents in a facility under the supervision of a licensed nurse who has successfully completed a [Nurse Aide Training and Competency Evaluation Program or] NATCEP approved by the state or has been determined competent by waiver or reciprocity and is listed as active on the Nurse Aide Registry (Texas Office of the Secretary of State, 2008, para. 20).

The NATCEP is overseen by the Department of Aging and Disability Services (DADS) (Texas Office of the Secretary of State, 2008, para. 22).

Family Member

For the purposes of clarification, I categorize any family member or significant other survey respondent as a "family member" rather than continuing to make a determination between "family" and "significant others." This is also consistent with researchers Yeatts and Cready (2007).

Intercoder Reliability

Since coding is essential to this study, the reliability of the coding is taken very seriously. Validity is compromised when the intercoder reliability is not tested (Lombard, Synder-Duch, & Bracken, 2005). "Intercoder" refers to the presence of multiple people coding one dataset. The "reliability" refers to the likelihood that these multiple coders will code the same dataset in the same way (Shoemaker, 2003). Lombard, Synder-Duch, &

Bracken (2005) define it as, "the extent to which independent coders evaluate a characteristic of a message or artifact and reach the same conclusion" (para. 2). "Interrater" is sometimes substituted for "intercoder." However, in this thesis, the term "intercoder" is used extensively.

Organization of the Study

The following thesis document is organized into five chapters. In chapter one I introduce the study and include the background of the problem, statement of the problem, rationale for the study, and purpose of the study. In this chapter, I also present my research hypotheses, and definitions of terms used. The literature review comprises Chapter II. This includes the theoretical framework, followed by the review of literature regarding nursing home origins, current nursing home demographics, and family involvement in care. Nursing home quality and innovations in care are also discussed, followed by a summary. Chapter III outlines the methods used. The data analysis techniques are detailed, with specific attention given to the coding of the two datasets (baseline and follow-up). Intercoder reliability is also discussed, as more than one person coded the dataset. In Chapter IV the findings of the study are revealed. Presented with the findings are the descriptive characteristics of the sample and results of the hypothesis testing. The conclusion of the chapter includes a summary of the findings. Chapter V concludes the thesis with a study summary, conclusions, limitations, and a discussion of future research.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

To begin, symbolic interactionism is presented and role theory is discussed as a theoretical framework for the study's hypotheses analysis. It includes an attempt to understand why the family members would define high quality care in any nursing home differently. Also in this first section is a discussion of the theoretical framework used to conceptualize the qualitative coding of the data. Following the discussion of the theoretical framework, a review of the literature is presented. It is organized into five sections:

- Nursing Home Origins

- Current Nursing Home Demographics

- Family Involvement

- Nursing Home Quality

- Innovations in Nursing Home Care and Quality

The first three sections present information on nursing home demographics, including characteristics of the nursing home, the people in care, and their families. In the first section, groundwork is laid for understanding the origins of the nursing home and how this model of care was developed. This section also presents a look at the historical development of the attitudes that surround the term "nursing home" and what that means for those involved. The second section describes current nursing home demographics, including the characteristics (gender, race, socioeconomic status, etc.) of the average nursing home population. One study even portrays the origins of people

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prior to their admission, and where they are discharged to when they leave (Gabrel, 2000). The third section describes how family members have been historically involved in the care of their elderly loved ones, and what researchers tell us they are doing.

The final two sections focus on quality, with the fourth section containing an outline of the ways nursing home quality is defined, assessed, and ensured. The fifth section describes care innovations; how nursing home care is changing and what it might look like in the future. Changes could include those that modify the nursing home's physical environment, as well as how personnel are managed and care decisions are made.

Theoretical Framework

Symbolic interactionism is the theoretical framework used to analyze the relationships between variables in this study. The concepts behind symbolic interactionism (called a conceptual framework, rather than specific theory by Nye and Berardo, 1966) first began to emerge with the writings of C.H. Cooley and William James, in the early 1900s (Longmore, 1998). John Dewey, W.I. Thomas, and G.H. Mead are also credited with contributing to the framework. Longmore (1998) describes two important philosophies that influenced the development of symbolic interactionism. The first influence includes concepts from the Scottish Enlightenment: communication, sympathy, imitation, habit, and customs (Longmore, 1998). The second influence described is American pragmatism, particularly the view that the human mind is malleable, and particularly open to influences of the social world (Longmore, 1998). From these influences, a framework that valued "meaning, self, identity, and their

relationships to behavior" arose (Longmore, 1998, p. 44). Next, I look more closely at the use of role theory by this conceptual framework of symbolic interactionism.

Role theory was utilized differently by two sociological approaches, structural functionalism and symbolic interactionism. To structural functionalists, roles are "prescribed and static expectations of behavior…these prescriptions derive from the society's culture" (Abercrombie, Hill, & Turner, 2000, p. 302). Within the framework of symbolic interactionism, roles are developed, instead of prescribed, through a process of interaction (i.e. children's imaginative "role-playing" and "role-taking") (Abercrombie, Hill, & Turner, 2000). Further, in this school, roles are not static but can change through interactions with others and with other roles (Abercrombie, Hill, & Turner, 2000).

For the first hypothesis, role theory guided my interpretations of why men and women vary in the way they interpret "high quality care in any nursing home" (wording taken from the family survey instrument used to generate the responses analyzed in this thesis). This hypothesis is based on how the domestic labor is divided by gender. Women's traditional role in American society is to provide care for the family (aka. domestic labor) (Abel, 1991, p. 4; Gould, 1999, p. xv; Olson, 2003). Men, however, take on different types of domestic responsibilities. Abel considers several sources and quotes Berk, "husbands are more likely to undertake those household tasks that have clear and identifiable boundaries (such as mowing the lawn) [and] tasks that have greater discretion in both how and when to complete them" (as cited in Abel, 1991, p. 5). Traditionally men also develop the role of financially providing for the needs of his family (Olson, 2003). This may be one reason why, as Abel describes, men are more

likely to bring in outside services for their senior family members, than are women (1991, p. 5).

Berger sets the tone of role theory by describing society as a "sort of reality agreed upon *ad hoc* by those who participate in it, or more exactly, those who do the defining of the situation" (1963, p. 94). He goes on to explain that society works because a majority of the societal participants agree with a majority of the decisions made about definitions of what is "acceptable" behavior (Berger, 1963). Social conflict then occurs when there is too much disagreement about what is acceptable or not (Berger, 1963). This gives societal participants a lot of power in determining their reality. In regard to nursing home care, this seems to ring true. As is discussed in detail later, the nursing home concept began with "almshouses" which housed the poor and elderly; those unable to provide for themselves (Collopy, Boyle, & Jennings, 1991; Haber, 1993; Morris, 1995). Almshouses were criticized for a poor standard of quality and they were typically operated by private companies (almshouse in Encyclopædia Britannica, 2007). Later, when almshouses transformed into nursing homes, or places for medical care, standards increased (Collopy, Boyle, & Jennings, 1991). Today's standards include employing appropriately trained staff, ensuring safety, and meeting the needs of people in care (Chandra, Smith, & Paul III, 2006).

Berger also explains that roles provide a structure for how an individual is to act (1963). These roles ensure that all facets of society are accounted for – i.e. the man provides for the family by means of work; the woman cares for the health and emotional needs of the family and others. Of course, these expectations of thoughts and behaviors, while socially constructed, are also "socially sustained and socially

transformed" (Berger, 1963, p. 98). Here, it seems multiple roles are impacting each other. The socially constructed and sustained role of a nursing home (to provide medical care and housing for the sick, elderly, and/or disabled) is established by social actors playing out their own role (man, woman, daughter, son, etc.). Through this study, I am trying to determine the differences of opinion men and women have with regard to quality nursing home care, yet together, the opinions of the two groups make up the standard of care expected in our current society.

Simplifying identities of a man and woman in this way (i.e. man provides; woman cares) certainly does not provide us with a full explanation of their being, and as Berger states, "the person is perceived as a repertoire of roles, each one properly equipped with a certain identity" (1963, p.105). However, this simplification does allow us to see why different standards of quality appear and how they work to create the whole.

George Herbert Mead, along with Charles Horton Cooley and W.I. Thomas are credited with laying groundwork for role theory (Berger, 1963; Collins, 1994). Mead presents self-identify (or one's definition of his/her own roles) as being developed by internalized conversation (Mead in Collins, 1994). During this "internalized conversation" a key component is the "generalized other" or playing the part of another person or role (Mead in Collins, 1994). A simple visualization of this manifests when children engage in "play," such as assuming the role of a teacher in a game of "school" (Mead in Collins, 1994). As Mead states, "the attitudes of the other players which the participant assumes organize into a sort of unit, and it is that organization which controls the response of the individual" (Mead in Collins, 1994, p. 298). The "generalized other" would be the "teacher" in the child's game and the manifestation of that role would come about based

on the interactions that child has with others and what their reactions are to the role he/she is playing.

As role theory would suggest, sons and daughters are influenced by the gender roles their parents play out. Thereby, Abel suggests, "sons take responsibility for tasks they can perform whenever they choose. Daughters, however, often assume responsibilities that keep them on call twenty-four hours a day [including personal health care]" (Abel, 1991, p. 5). These role descriptions imply that children are role-taking based on the expectations they see imposed on their parents, as well as the expectations their parents impose on them.

Mead's development of self and therefore, the development of one's attitudes come from interactions with others. While teachers, mothers, fathers, etc. are typically part of every individual's life, some symbol of behavioral norm has been developed in our minds for people in these roles. However, not everyone has been exposed to the nursing home setting. Therefore, their norms of behavior for the workers, people in care, etc. may not have been fully established. It seems that the more time a person (in this study's case, a family member or friend) spends in the setting, the more complex their development of behavioral norms for an individual will be. This more complete development and understanding would then lead to a different definition of nursing home quality. Therefore, the second hypothesis predicts that those friends/family who do not more fully develop their understanding of nursing homes via interactions (here in study counted as "number of visits") will portray high quality differently than those who are more involved.

We can also consider the role that certified nurse aides (CNAs) have in the nursing home setting and how that impacts perceptions of quality. Their role is to provide assistance with activities of daily living, including bathing, dressing, toileting, etc. This role in the nursing home setting is very specific and limited to certain tasks. It was established from a need for a professional, differentiated from the higher paid and more educated registered nurse, who would be willing to participate in personal care-taking tasks. Salary and education are linked in our society and both money and education are highly valued. Therefore, how they are treated based on their role, impacts their personal feelings and performance. One would think a change in power (as is utilized by the empowered CNA work teams implemented by Yeatts and Cready, 2007) will have an impact on their performance and the way they are perceived by those participating in the nursing home experience.

In addition to using theory to assist in understanding the hypotheses, I used grounded theory as a basis for the coding of the survey data. The qualitative tradition of "grounded theory" aided in the coders' development of categories within the data. Grounded theory is defined as, "a qualitative research method that uses a systematic set of procedures to develop an inductively derived theory about a phenomenon" (Strauss and Corbin, as cited in Neuman, 2006, p. 60). While I did not seek to create new theory from the data, the inductive approach was used when assessing the responses to open-ended questions. The other coders and I respected the voice of the respondents by developing a codebook from the responses, rather than molding the responses into a pre-established codebook. These categories were then used in

quantitative analysis. By using this approach, I sought to confirm or not confirm pre-determined hypotheses as identified in the previous chapter.

Next I will look at how and why nursing homes developed as a way of caring for our seniors. This discussion of the origins will help lay the groundwork for understanding how and why family members are involved in nursing home care, and why we assess their quality the way we do. It may also aid in understanding why we are moving forward with the different nursing home innovations, as outlined in the last section of this chapter.

Nursing Home Origins

When looking at nursing home origins one must consider society's association with nursing homes. To obtain a current view of this association I sought recent feedback on nursing homes. Internet blogs are becoming more and more popular as a sort of diary or place to share feelings. They are another way of exploring the candid thoughts of individuals throughout the world. According to Dearstyne in his article "Blogs, Mashups, & Wikis Oh, My!" blogs are, "user-generated web journals that offer opinions and information and that may include text, images, and links" (2007, p. 27). A recent search of "nursing home" using the Google Blog Search feature, found these blog postings regarding the nursing home setting:

- "The place had the feeling of a hospital ward, and the people who lived there seemed so sad that each night I came home from volunteering I cried my eyes out. Lots of people just seemed to stick their parents there and never even visit, which is detestable" (AmpiezzaDiVedute, 2007).

- "Nursing homes make me uneasy. They are such a sad and depressing place" (toya121, 2007, para. 1).

- "She lives in the nursing home, and let me just say that that is a sad place. I don't know why, but for some reason that day... there were so many residents in the hallways etc., that were in a vegetative state, hooked up to oxygen, or sitting by the nurse's desk crying" (Jamimania, 2007, para. 1).

- "The ceilings are low and it's dark. Everything is quiet except for the odd outbursts by frustrated residents" (conquer the mind, 2007, para. 5).

- "There is the smell of the place. Of old skin. And sickness. Liniments and medicines, rubber gloves and tubing. Alcohol, urine *and tears"* (LowerManhattanite, 2007, para. 12, emphasis by author).

While not every blog posting read featured a negative view of nursing homes and/or nursing home care, most often pessimism was presented, whether it was because a loved one's health had deteriorated so much that a nursing home was the only option, or because the physical state of the nursing home was considered unbearable. Either way, nursing home stays were considered the last resort; where one goes to die; a place of great sadness, both by people in care at the nursing home and by family members portrayed in the blog postings. Collopy, Boyle, and Jennings (1991) confirm this negative view and explore its tie to cultural values, "This negative image is reinforced by some deep-seated cultural values. For a society passionate about personal independence and self-sufficiency, nursing homes are too easily seen as habitations for diminishment and dependency" (p. 5). To more fully understand the cultural values explained here, a historical look at the development of nursing homes is helpful.

In the past, family has been the most common source of care for aging or sick loved ones (Morris, 1995). Other sources of care, especially for those who were abandoned by family or in the low income bracket, included hospice shelters created by religious groups, and almshouses for the poor (Collopy, Boyle, & Jennings, 1991;

Haber, 1993; Morris, 1995). The almshouse is defined by the Encyclopædia Britannica as, "a locally administered public institution for homeless, aged persons without means" (2007). The link between low income elders and almshouses is key to our understanding.

This connection between the aging and almshouses (also called poorhouses) aided in the development of the negative attitude that American society has toward today's nursing homes. As stated in the article by Carole Haber, "Although the old were still assumed to be natural and rightful recipients of assistance, they fell victim to the authorities' antagonism against the idle young, foreign poor, and "vicious," (1993, para. 6). Also according to Haber, the mid-nineteenth century in America brought about welfare reform that sought to separate the "needy" based on "age, need, and character" (1993). Encyclopædia Britannica also confirms, "[the almshouse] incurred widespread criticism after the turn of the 20th century for its failure to provide differentiated treatment for the varying problems presented by residents" (2007). Further, reformists desired to encourage independence in those "idle young [and] foreign poor," yet the aged, being neither able to work or care for themselves, remained institutionalized (Haber, 1993).

In the 1920s, spurred by an influential study by Lucille Eaves (entitled "Aged Clients of Boston's Social Agencies"), society began to view *all* those of old age as needing assistance, not just those with a low income (Haber, 1993). This created reform which sought to improve the physical aspects of the almshouse, "By renaming the institution, and redecorating with flowers and plants, they tried to present the asylums as natural "homes" for the old" (Haber, 1993, para. 17). This reform, along with the

Social Security legislation and approval of pension benefits, brought an end to the almshouse concept, explains Haber (1993). By the 1950s, family care was again at the forefront and private care homes (in place of the publicly funded almshouse) began to flourish (Haber, 1993; almshouse in Encyclopædia Britannica, 2007).

Despite this historical look at the transition from almshouse to private care home, one key link is missing – the "nursing" aspect of nursing homes. Collopy, Boyle, and Jennings explain that the post World War II period brought about increased funding of hospital construction which was "expanded to include voluntary (nonprofit) nursing homes" (1991, p. 4). During this period, hospitals became further associated with "short-term, acute care" and nursing homes associated with long-term care (1991, p. 4). The nursing home also took many dementia patients from mental hospitals during the "deinstitutionalization" period of the 1950s and 60s (1991, p. 4). Collopy, Boyle, and Jennings also describe how the negative image of nursing homes continued to thrive because of "substandard and negligent care, outright abuse of residents, and a wide range of fiscal malfeasance" (1991, p. 4). While government regulation aided in reducing the amount of indignities, the negative characterization of nursing homes still exists. And, as Collopy, Boyle, and Jennings state, "This negative image is powerful not only for the elderly but also for families who face the pain and stigma of "institutionalizing" one of their members" (1991, p. 5). This sustained attitude is again supported by the negative postings of the blog search results.

The nursing homes at present are those which focus on several levels of care, including nursing care, short-term and long-term rehabilitation (Chandra, Smith, & Paul III, 2006, p. 33). As Chandra, Smith, and Paul III state, "The nursing homes of today

have a highly structured environment, with residents being able to participate in activities, such as outings, socials, pet therapy, religious services, exercise classes, and crafts, while still receiving necessary medical care" (2006, p. 33). This is a far cry from the simple shelter and bed provided by almshouses and the convalescent homes of the mid-twentieth century.

Next I will consider the demographics present in today's nursing homes. This discussion helps us to understand who is utilizing the nursing home as a form of senior care. A presentation of the current demographics will also lead to a later comparison of the thesis study's demographics with national trends.

Current Nursing Home Demographics

So what typifies a person in care at today's nursing home? A study published in 2000 analyzed data from the 1997 National Nursing Home Survey giving us insight into the qualities of people in care at nursing homes, specifically those over the age of 65 years (Gabrel, 2000). This study found that an average 1.5 million elderly resided in nursing homes on any given day in 1997 (Gabrel, 2000). Ray (2000) comparably presented that 1.6 million persons resided in nursing homes in 1996. Most of the people in Gabrel's research were white (88%), widowed (63%) women with functional dependencies (75% needed assistance with three or more "activities of daily living") (Gabrel, 2000). Those of Hispanic origin were the least likely residents with only 2% of the people in care identifying in this way. About 9% of people in care identified as "black." The study also found that over half (about 65%) of people in care at nursing homes (65 years and older) lived in proprietary (versus "voluntary nonprofit "or "government and other") nursing homes (Gabrel, 2000, p. 2). Eighty-five percent of

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people in care were certified by both Medicare and Medicaid. The South was the region with the most people in nursing home care, nearly 33% of those studied, and the Midwest had the second most with 31% (Gabrel, 2000, p. 2). They were varied in age, with half of the people in care being 85 years or older (Gabrel, 2000).

A study out of Brown University (2006) also confirms that most long-term care is utilized by those 85 and older. They call this age the "height of long-term care use" (Miller & Mor, 2006, p. 4). Most of the people in nursing home care were admitted from a hospital (44%) or their private residence (32%) (Gabrel, 2000). While their "primary diagnosis at admission" varied widely, the highest frequency had "diseases of the circulatory system" at 26%; these included hypertension, heart disease, or cerebrovascular diseases (Gabrel, 2000, p. 6). "Mental disorders" were the second highest diagnosis with 16% (Gabrel, 2000). This study gives us a good idea of the characteristics of people over the age of 65, in care at nursing homes in the United States.

The Gabrel study also looked at nursing home discharges for people 65 years and older (2000). The average length of stay was 290 days (with a standard error of 15.3 days). The median length of stay was only 63 days (this increased to 69 days for women) (Gabrel, 2000). The large difference in mean and median probably accounts for outliers, or the residents that live in nursing homes for several years. Over one-quarter (27%) were discharged at death (Gabrel, 2000). Most discharges were hospital admissions (28%) (Gabrel, 2000).

While 1.5 million people on any given day seems to be a lot (US population on July 1, 1996 came in at over 265 million) (U.S. Census Bureau, 2000), Miller and Mor

indicate a decrease in nursing home usage (2006). Their data applies to Medicare and

Medicaid insured people only. However, Gabrel (2000) presented that the majority of

people residing in homes are covered by one of these two national health care plans,

therefore the information, though limited, is relevant here. Miller and Mor state,

"although the actual number of people using nursing homes has increased…the number

of nursing home residents per the population aged 65 or over has declined" (2006, p.

16).

However, with the first "baby boomer" (deemed so by being born in the early

hours of January 1, 1946) having just signed on for social security benefits, it is unlikely

that the number of residents per population over 65 will continue to decline (Rutherford,

2007). Murtaugh, Kemper, and Spillman (1990) emphasize that long-term care policy

will continue to be a huge issue into the 2020s. They state,

> The estimated risk of using a nursing home is high, even allowing for some
> uncertainty about changes in the patterns of nursing home use in the future.
> Almost a third of men turning 65 in 1990 and just over half of women can be
> expected to use a nursing home sometime before they die. (p. 960)

While Murtaugh, Kemper, and Spillman (1990) open our eyes to the fact that the

demand for nursing home care will only increase, they also try to reconcile why there

are gender, race, and regional disparities among those in nursing home care.

For race, the discussion is somewhat limited since they focus on the differences

between whites and blacks only. Nevertheless, they suggest that blacks are less likely

to receive nursing home care for two reasons (Murtaugh, Kemper, & Spillman, 1990).

First, because that population is more likely to be "low-income," and second because

they "have more extensive social networks than others and, therefore, those who

become chronically disabled are more likely to have the information support necessary

to remain in the community" (Murtaugh, Kemper, & Spillman, 1990, p. 958). They cite an article by Gibson and Jackson (1987) that confirms a larger support network for blacks. They end the discussion of racial differences by suggesting that there are probably other reasons for this disparity, although they did not elaborate.

In the article written by Murtaugh, Kemper, & Spillman (1990), the reasons for the large gender differences were also hypothesized. In their study, 45% of women over age 65 utilized nursing home care at least one time before death, compared to only 28% of men (Murtaugh, Kemper & Spillman, 1990). In the Gabrel (2000) study, described above, 75% of the people in nursing homes (for the 1997 National Nursing Home Survey) were women, compared to 25% men. It is a known fact that the life expectancy for women is higher than for men. This would explain why, in Gabrel's article describing the 1997 National Nursing Home Survey, women accounted for a higher percentage of those 85 years and older (2000). Along these same lines, Murtaugh, Kemper and Spillman suggest that women are less likely to have a spousal caregiver, therefore are more likely to need out-of-home care (1990). They also cite a study by Manton (1988) who found that "the conditions causing disability among elderly women tend to be less lethal than the causes of disability among men" (Murtaugh, Kemper and Spillman, 1990, p. 957). Again, this would play into our understanding of longevity and build upon the reasons why women live longer than men.

Finally, the article by Murtaugh, Kemper, and Spillman describes several reasons why there is a difference in usage by region (1990). In the time of their article (early 90s), more nursing home use occurred in the West and North Central compared to the South and Northeast regions of the United States. The 1997 National Nursing Home

Survey data differed from this; they found that most resided in the South and Midwest. While the regions are broken up in different ways for each study, the disparity in statistics may aid in Murtaugh, Kemper, and Spillman's argument. They suggest that availability of alternative forms of long-term care, the ability to purchase services, and state policies are probable factors for why there are regional differences in nursing home use (1990). The changes in services, policy, etc. in regions between 1990 and 1997 may account for the inconsistent opinion of which region has the highest usage.

Murtaugh, Kemper, & Spillman's study was helpful in aiding our understanding of why there are differences in gender, race, and region among those who receive care at nursing homes. Nevertheless, the resource disparity is not justified. Further study and policy change should occur to ensure that those who want to receive nursing home care can. It is also important to ensure that nursing home care is not the only type of care available. Next we will look how family members are involved in the care of their loved ones.

Family Involvement

Noell avows, "a physical environment for older people must be designed to celebrate life, promote health and wellness, enhance the abilities of older adults, and encourage social interaction with friends, family ties, staff, and the community at large" (1995, p. 14) For the purposes of this study, it is important to understand, not only who is receiving care at nursing homes, but also how their families are involved. Family involvement in care for the aging is often looked upon negatively. When nursing homes are not involved, financial, physical, and emotional well-being of family is often questioned. To address this, our society should offer assistance for those who provide

care for their elder family member(s); assistance in the form of financial resources and respite, as a start. Unfortunately, our society expects familial involvement, but does not value it. As Kittay states, "Society does not see caregiving as work in its own right, but rather as a familial obligation" (2005, p. 15).

In response to this, many family members decide they cannot or do not want to face the challenges of providing direct care to their elder. In this case, families along with their loved one, choose from the alternatives, including assisted living, in-home care, and nursing homes. Choosing a nursing home for long-term care is tough for many (Keefe & Fancey, 2000). As I saw in the blog postings, and as Kittay (2005) states, "nursing homes conjure up a depressing and joyless image: lots of discarded old folks receiving kindly but barely adequate care" (p. 15). As discussed in Kittay's article, the decision between familial care and nursing home care often frames family disputes and results in alienation (2005).

Once the decision to utilize a facility has been made, much work is involved in the actual placement. Cooper et al. (1999) suggest several steps,

> Ask for references; obtain a copy of the state licensing survey; visit the location several times and at different times; ask if the facility provides individual care plans; request information about the staff-to-patient ratio; [and] check it out yourself, and continue to be vigilant. (p. 132)

This is only the beginning of successful family involvement in a loved one's nursing home experience.

In support, Keefe & Fancey suggest that institutionalization is often used as a "last resort" (2000). They found that many residents were cared for by family before nursing home admission, and those same family members continued to be involved in care post admission (Keefe & Fancey, 2000). Most commonly, the involvement after

placement took the form of visits. They found that 45% of adult children visited their

parent at least once per week (Keefe & Fancey, 2000, p. 235). They also found that

family members choose not to visit because of their unease about nursing homes and

because of the lack of activities available to participate in with their loved one (Keefe &

Fancey, 2000, p. 236).

Tobin (1995) recognizes the importance of family involvement in nursing home

care, for the benefit of the family member and person in care. They suggest ways to

foster that essential involvement. Through a nursing home policy analysis, they

identified several interventions necessary to get family members more involved. These

interventions are,

> 1) Reducing apprehension and anxiety of family members; 2) face-to-face visiting
> that enhances the sense of self of residents, particularly of Alzheimer's victims; 3)
> sharing by family members in the caring for residents; 4) facilitating cooperation
> and interdependence between family members and nursing assistants; 5)
> furthering an identification with the facility as a caring community. (Tobin, 1995,
> p. 32)

The way they see these interventions being met are through "family counseling, family

support groups, educational programs for family members and fundamental changes

regarding institutional staff and policy" (Tobin, 1995, p. 32).

Of course these and other family interventions typically take place when the

family member is physically present. Long-distance caregiving is a popular

phenomenon, especially with our mobile society, explains Cooper et al. (1999, p. 129).

Confirming this, Rosenblatt and Van Steenburg (2003) state, "An estimated seven

million Americans provide or manage care for a relative or friend over the age of 55 who

lives at least an hour away" (Getting the Lay of the Land section, para. 1). Despite the

limiting of in-home visits, family members who care for a loved one from a distance can

still be an active participant by communicating with the patient in care and the facility

staff on a regular basis, and developing a local "team" (be it family, friends, professional

services, such as social workers or ombudsmen) who can assist them (Rosenblatt &

Van Steenburg, 2003; Cooper et al., 1999).

Research also tells us that those family members who visit often are more likely

to engage in tasks that involve their family member (tasks described as "managing

money, shopping, transportation, writing letters and providing extras") (Keefe & Fancey,

2000, p. 235). A 1988 study by Bowers suggests that family members active in their

loved one's care typically engage in "preservative caregiving" which includes informing

nursing home staff about the unique needs of their person in care.

While family member involvement is suggested to be positive for the health of the

person in care, studies have also shown a conflict between family and staff in the

assignment of tasks (Bowers, 1988; Dempsey & Pruchno, 1993). As outlined in the

Keefe and Fancey article, families feel responsible for technical and non-technical

aspects of care (2000). Dempsey & Pruchno describe technical aspects of care as

those that are quantified by Medicare (including toileting, eating, bathing, dressing,

getting in and out of bed, etc.) (1993, p. 135). They describe non-technical tasks as

"managing money, shopping, putting plants and extras in the room, writing letters for the

parent," etc. (1993, p. 135). Further, family members also feel inclined to monitor,

oversee, and evaluate the staff (Keefe & Fancey, 2000). Keefe and Fancey go on to

explain,

> The primary responsibility for medical, housekeeping, dietary, patient care, and
> security tasks were perceived to be staff, while families were viewed as having
> primary responsibility for transportation and providing extra items. Family and

staff disagreed on who should perform tasks related to personal care, activities, family relations, and supplies. (p. 236)

Overall, Keefe and Fancey's study found that family member responsibilities are broken up into two categories -- direct and indirect responsibilities (2000). Direct responsibilities are characterized "in terms of the activities that they *do* for him/her" (p. 239). Indirect responsibilities "refer to the responsibilities of the family member to ensure that the activity gets done for the elderly resident" (p. 239). In other words, direct indicates doing and indirect indicates advocating for the doing. They found that the only type of responsibility that increased, during their elder's long-term stay, was indirect responsibility (Keefe & Fancey, 2000).

In their study, Keefe and Fancey attempt to create an understanding of how family members' caregiving activities change post nursing home admission, and what family members perceive their responsibility to be, both directly after admission and over their elder's long-term stay. Although their results were limited and not found to be statistically significant, they found women to be the primary family member involved. They also assessed how distance from the facility affected the relationship between prior and current caregiving tasks, but no significant relationship was identified.

While researchers still seek to determine how family members and nursing home staff feel about their role in care, these findings are interesting for the purposes of this study. Perception of responsibility could play a role in what items family members determine are important in high quality nursing home care. Since to answer this question they are evaluating the success of a nursing home, they will most likely look at tasks they perceive the staff to be responsible for.

The final two sections of this chapter assess nursing home quality, and how current perceptions of quality, or lack thereof, are being utilized to make changes.

Nursing Home Quality

There is no shortage of literature describing and attempting to evaluate the quality of nursing homes. Most often discussed aspects of quality include cleanliness, medical care, and staff interactions (or sometimes referred to as "customer service" aside from location and cost). Further, quality is one of the most important determining factors used when elders and/or their loved ones choose a facility. Chandra, Smith, and Paul III (2006) list some of the current federal and state nursing home requirements. These include having a Licensed Nursing Home Administrator who has been through training, a director of nursing with a Registered Nurse license, meeting sanitation standards as set by the health department, ensuring safety, and make certain the staff meet medical, social, spiritual, and emotional needs (Chandra, Smith, & Paul III, 2006). Finally, they note a long-term care ombudsmen must be accessible.

Long-term care is an expensive service and therefore a profitable business. Companies have caught on and try to make money by assisting those involved in the choice. Companies like Devon Hill Associates in La Jolla, California use "mystery patients" and other techniques to determine the quality of long-term care facilities (Orlovsky, 2006). Others provide booklets or websites aimed at helping with the choice. But, who better to tell you of quality than those who experience it for themselves. It has been found that the experience of the person in care is very important in determining the quality of a facility. As stated by Grant, Reimer, and Bannatyne, "the opinions of residents are particularly important because the care received affects the quality of life"

(1996, p. 469). Mitchell and Koch (1997) also suggest "the perspectives of older people are often ignored…" (p. 454). And while it is argued that resident's opinions of care can be affected by mood, disposition, and/or level of mental cognition (Bowers, Fibich, & Jacobson, 2001; Larsson & Larsson, 1999; Mitchell & Koch, 1997), Grant, Reimer, and Bannatyne argue that regardless of mild or moderate mental impairment, their opinions are still important and should be elicited using a variety of techniques (1996).

It seems they may have a valid argument. The person in care is often referred to as the "consumer" in literature on quality. Bowers, Fibich, and Jacobson state,

> Defenders of the use of consumer quality assessment, however, citing studies show good agreement between consumer assessments and a "gold standard" of expert assessment, assert that consumers *are* able to make competent judgments about the technical components of care. (2001, p. 540)

Family members are another population used by researchers to determine the level of quality, or what it should be. Research in this area is a bit more limited. Nevertheless, extant research shows us that this population can help address some of the concerns about mood, disposition, and mental impairment (especially in a severe form) of those receiving care. Loved ones who are actively involved in care can help to illustrate the person-in-care's experience. As stated by Grant, Reamer, and Bannatyne, "people who are significantly involved in the everyday life of a resident provide a further source of data particularly for those who are unable to speak for themselves" (1996, p. 470). With this thesis I evaluate how loved ones define quality in any nursing home. I then compare that to other definitions of quality in nursing home care. It is important to understand the aspects of quality that motivate these loved ones when it comes to helping their elder make the choice about long-term care.

Family members' opinions should be important to facility administrators simply for ensuring success of the nursing home's business. Another essential group to satisfy is the workers. Nursing home worker turnover has been a big problem for many years and continues in the current nursing home environment (Ray, 2000; Yeatts, Cready, Ray, DeWitt, & Queen, 2004; Yeatts & Seward, 2000). Ray states in 2000, "tightening of the fiscal screws on nursing homes has…worsened an already grim staffing environment" (p. 1152). Yeatts & Seward (2000) support Ray's claim, "nursing homes have historically had high levels of turnover, especially among those who work most closely with the residents" (p. 358). Further, Yeatts et al. (2004) see nurse aides' satisfaction as a key component to reduced turnover and absenteeism, and improved resident satisfaction. Yeatts and Cready (2007) and Cready, Yeatts, Gosdin and Potts (2008) find that innovations, such as empowered CNA work teams in nursing homes, can aid in improving the nursing home experience for staff, persons in care, and family members.

I have now considered how quality can be defined and assessed by people in care, loved ones of people in care, and nursing home employees, specifically CNAs. Ray (2000) exposes another way in which quality is assessed; through reports of the physical health of those in care. He suggests that instead of using raw data alone, researchers should analyze outcomes such as "inappropriate use of psychoactive drugs, physical restraints, or catheters, and preventable bedsores" (Ray, 2000, p. 1151). He suggests that typically we focus on the use of psychoactive drugs, restraints, catheters, etc., not considering that some of these interventions may be preventable, and therefore should not be factored into the statistics when determining quality (Ray, 2000). Either way, Ray's ideas help us see the full spectrum of what plays into quality in

any nursing home. Satisfaction of people in care, their family members and friends, as well as the quality of medical care and medical decisions, all influence overall quality in important ways.

It is not useful to choose one method of defining and assessing quality, but rather we need to utilize all of these methods to get an adequate picture of quality in a nursing home. In this section, most discussed is how to define and assess quality. In the final section, on innovations, we'll see some of the ways in which new ideas are being used to ensure quality.

Innovations in Nursing Home Care and Quality

In Post World War II, nursing home care facilities rose from an increased funding of hospitals, which was expanded to include non-profit nursing homes (Collopy, Boyle, and Jennings, 1991). Since then, the medical model "which emphasizes the hazards, risks, and disabilities associated with aging" has dominated the way in which nursing homes have been facilitated (Ladwig, Fee, & Brown, 2006, p. 1163). Since the on-set of nursing home care, a new term has been developed, "long-term care." Long-term care, according to the U.S. government, includes a variety of services, including community-based services, home health care, housing for aging and disabled individuals, board and care homes, assisted living, continuing care retirement communities, and nursing homes (US Department of Health and Human Services (USDHHS), Centers for Medicare & Medicaid Services, 2007). In this study, I focus on nursing homes as long-term care facilities however, I understand it is just one of many ways in which seniors and the disabled receive care.

Long term care, here, focusing on care in nursing home facilities, is undergoing changes. As Meyers (2006) points out, care under what she calls the "old culture" allows people to be "treated as objects because the focus is on body parts, systems, and functional limitations" (p. 273). She also emphasizes that "care, services, and treatment of the person" are the main priority under the old culture, rather than the emotional needs and peace of mind of the individual person (2006, p. 273). She generates a "new culture" idea and challenges fellow social workers to "normalize life, celebrate life, create opportunities for people to live life to the fullest, figure out ways to make lives better, and help people grow to become all they can be" (Meyers, 2006, p. 274).

Yeatts and Cready (2007) also suggest there is a need for a change in nursing home culture, and not just among social workers. As stated in their discussion, "there is an urgent need to improve the care provided to nursing home residents. This is particularly the case when one is concerned for the residents' quality of life and life satisfaction as well as health" (Yeatts & Cready, 2007, p. 336). The 1990s saw a flourish of activity in the development of new models of care and design in nursing homes. Yeatts and Cready (2007) list several initiatives developed during this time, including the Pioneer Network, the Eden Alternative, and the Wellspring Model. The Pioneer Network is still active today, based in Rochester, New York. They state their mission as, "The Pioneer Network advocates and facilitates deep system change and transformation in our culture of aging" (Pioneer Network, 2007, Our Mission section, para. 1). The Eden Alternative is also still an active not-for-profit (Eden Alternative, 2007). They operate from the view that aging is just part of the development process

and that old age does not have to be all about decline (Eden Alternative, 2007).

Actively, the organization is "seeking to remake the experience of aging around the world" (Eden Alternative, 2007, Welcome to Eden section, para. 2). They host trainings and conferences to further this mission. The Wellspring Institute has developed from the Wellspring Model of care. This organization, which began as a core group of 11 independent, not-for-profit nursing home facilities in Wisconsin, is also active in training and consulting with care providers according to their ideas that, "the unique combination of resident-directed care concepts, staff empowerment, and a clinical component has been shown to successfully change facility climate and culture" (Wellspring Institute, 2007). Together these organizations (and others), along with continued support for research, has helped to change and improve nursing home care and quality.

In addition to patient empowerment, staff empowerment has been identified as being a huge part of ensuring quality care in any nursing home. As suggested by Yeatts and Cready (2007), direct care nursing home staff (they identified as CNAs) have the most in-depth understanding of the person-in-care's needs and desires. Yeatts and Cready decided to focus on CNA teams to determine if they "improved performance, job attitudes, and turnover" (2007, p. 324). The reason they chose to implement CNA empowered work teams in five nursing homes was because this concept has been encouraged by recent initiatives, however has not been widely implemented or tested. They found that more research needs to be done, however CNA work teams "can have positive effects on CNA empowerment and performance" (Yeatts & Cready, 2007, p. 337). These positive effects on their performance will then trickle down to the people in care because their primary care givers will be more engaged and educated. Yeatts and

Cready are two researchers that are seeking to test the suggestions given by current advocates of changes for nursing home care. For instance, the Wellspring Institute identifies three essential elements, "1) Care decisions need to take place closest to the resident; 2) A substantial knowledge base is required by all staff to enable participation in decision making; 3) An empowered workforce increases resident and employee satisfaction and reduces staff turnover" (Wellspring Institute, 2007, para. 2). Through CNA empowered work teams, those employees with the closest interaction to the person in care are taking part in the decisions about their care, the CNAs are able to take part in decision making (through the team meetings), and they are more empowered to make decisions. All three of the essential elements presented by the Wellspring Model are being tested in their study. The analysis in this thesis seeks to understand if a noticeable difference in family member definitions of high quality is achieved after implementing the CNA teams. This difference would be shown if the family members' responses change after the intervention is implemented.

It is the hope of some that, along with the "new culture" of professional philosophy behind care, there will also be a reinvention of the physical environment, or design, of nursing home facilities. As stated by Noell in her 1995 article, "It is obvious that we have a long way to go if we are to bring a "zest for living" into our nursing homes – to create a place that grandchildren want to visit" (para. 1). Noell compares the need for a shift in nursing home design to the shift that occurred with the birthing process to bring about today's "birthing centers" (1995). She also sees the need to move away from the medical philosophy that fosters the idea of isolation and dependency (Noell, 1995). An article by Powers (1995) outlines the changes in nursing home design

envisioned by interior design students in 1993. They felt that the physical design of the buildings themselves could improve the quality of life of people in care and their family members. Some recommendations they included were, "sloping the ceilings in the residence rooms to create a greater expanse above bed-ridden patients," "expanding an interior wall in the residence rooms to allow flexibility in the placement of beds," and "designing a separate sleeping niche in each room where a family member or friend might spend the night." (Powers, 1995, para. 11). Noell presents several organizations that are addressing these issues of nursing home design, including The National Citizens Coalition for Nursing Home Reform, the Society for the Advancement of Gerontological Environment and the Center of Design for an Aging Society.

Currently, changing the culture and physical environment are still priorities. In January 2007, the Robert Wood Johnson Foundation (RWJF) released grant results for their pilot study on the "Green House" model of nursing home care. This study included a small group, residential setting developed by William H. Thomas, M.D. and his wife Judith Meyers-Thomas. Four of these settings were created in Tupelo, Mississippi between January 2002 and January 2006. Each Green House created a home for six to ten residents with private bedrooms, bathrooms, and central living and eating areas (RWJF, 2007). Dr. Thomas and his wife created this concept of care to address three central problems he saw in the nursing home where he worked (Thomas in RWJF, 2007). These three problems were loneliness, helplessness, and boredom (Thomas in RWJF, 2007).

The aforementioned Eden Alternative, with its philosophy of adding plants, animals, and children to the nursing home environment, was Dr. Thomas's first idea

(RWJF, 2007). The Green House concept goes even further in redesigning the nursing home environment. In this model, Dr. Thomas also empowers the "nursing aide" giving them a key role in care management with specialized training and setting them up into self-managed work teams (RWJF, 2007). His work team ideas were similar (although multidisciplinary) to those tested by Cready, Yeatts, Gosdin & Potts, 2008, Yeatts & Cready, 2007, Yeatts, Cready, Ray, et al., 2004, and Yeatts & Seward, 2000, with those results being previously discussed.

According to the Robert Wood Johnson Foundation grant results, the findings of the Green House pilot were positive for residents, their family, and the staff members. Resident satisfaction, quality of life, and physical functioning were higher than the two comparison groups (RWJF, 2007). At the time of publication in January 2007, "21 Green House projects in 18 states were in some stage of development" (RWJF, 2007, p. 10). At this time, other organizations were also exploring the possibility of implementing Green Houses.

No matter if it is extra training and new strategies for nursing home staff or large-scale facility reconstruction and change in philosophies, what is most important is that there is a continued effort to provide elders and their loved ones with choices for long-term care. The Green House model of care will probably not be ideal for every person who needs care, or for every nurse aide. However, the fact that there are these and other choices is important. Hopefully we will continue our efforts to bring new, innovative solutions to long-term care.

Summary of Literature Review

It is the hope that through this study, family and friends will help identify future

needs regarding innovations in care. As seen in the discussion of nursing home quality,

it is very important to listen to those who are on the receiving end of the care. In many

cases, this includes, not only the person in care at a nursing home, but also his/her

family. In other instances, the person in care is no longer able to convey their feelings

and beliefs about high quality care in a nursing home. Hopefully through a discussion of

the theoretical framework, as well as nursing home history, demographics, existing

quality, and current or future innovations, the reader has gained a fuller understanding

of the elements that influence nursing home quality today. In their article on challenges

we face with our currently aging society, Lamm and Blank aptly describe yesterday's

baby boom, as today's "grandparent boom" (2005, p. 23). Now is the time for social

scientists, researchers, advocates, care providers, and family members to come

together to understand and develop the best ways in which to care for our seniors.

In Chapter III, this thesis study is discussed. Specific methods of data collection,

coding and reliability testing are presented. In Chapter IV I present the findings of this

research. In the final chapter, I will refer back to this literature review to see how this

study's characteristics compare with those presented in existing literature.

CHAPTER III

METHODS

Introduction

We get a call every time she falls or is ill. We feel their help is very competent and is concerned about health. They try their best to take care of the older people. They show lots of concerns to both their physical and emotional needs. (excerpt taken from the family member survey data)

This quote portrays the types of responses analyzed by those coding the data. This methods section, which encompasses Chapter III, presents the way the other coders and I interpreted the data presented by the qualitative responses, such as the one above. The chapter also details how the data were collected and how hand-coding was accomplished to preserve the true meanings of the participants' responses, a key component to qualitative research (Wint and Frank, 2006). Further, intercoder reliability and code category collapsing is also discussed.

Survey Methods

For the purpose of this analysis, I used data collected from a larger study, described by Yeatts and Cready (2007) and approved by the University of North Texas (UNT) Institutional Review Board. This initial data included a "baseline" and "followup" survey. Baseline data were collected, by survey instrument, from CNAs, nurses, family members, and people in care in ten nursing homes in north Texas. After baseline data were collected, empowered CNA teams were implemented in five of the nursing homes, called the "experimental" or "team" nursing homes; the other five nursing homes served as "comparison" nursing homes. Data were also collected from each experimental or team nursing home and its corresponding comparison nursing home on average about

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16-17 months after the implementation of the intervention—empowered CNA teams—in the team home.

In particular, the study completed for this thesis analyzed family member data from one nursing home, the largest of the five "team" nursing homes. This particular nursing home was chosen due to its size. As indicated above, the larger study was longitudinal and I utilized both waves of the family member data from the nursing home of interest. At both baseline and followup, the family member questionnaire was mailed by the researchers to only one family member per person in care at the nursing home. Included in the mailing of the questionnaire was a stamped return envelope addressed to the researchers and a cover letter explaining the study, inviting participation, and insuring confidentiality. The baseline family member response rate for the nursing home was 67%, and the followup response rate was 63%.

I chose two sets of responses on the returned family member survey instrument to code and analyze. One of the two questions was open-ended asking, "What do you consider to be the best example of high quality care in any nursing home?" Following this question on the survey was an item asking the respondents to rate their loved one's nursing home. Along with the ordinal rating was an open-ended question, "Please explain." The responses to this "please explain" question were also included in this research study. It was identified as pertinent because many times the respondent continued giving relevant information to the "high quality care" question that was asked directly above it. The response to the ordinal rating was not utilized. To obtain a visual understanding of what questions were used, see the survey instrument (and example cover letter) in Appendix A.

Data Analysis Techniques

I was concerned with qualitatively analyzing responses to the two items described above on the returned family member surveys. To do so, I worked with two other researchers (my major professor and a UNT Ph.D. student) also concerned with this study. The assignment was to process the answers to the open-ended questions and assign each unique response a label or "code." The coding steps were iterative with multiple trial and error processes.

As introduced in the literature review, I used qualitative methods to analyze and code the dataset. Neuman (2006) describes qualitative coding as a process that, "frees a researcher from entanglement in the details of the raw data and encourages higher-level thinking about them…it also moves him or her toward theory and generalizations" (p. 460). Thereby the researcher will pull relevant data from responses without forcing those responses into pre-set categories. To explain let me re-introduce the survey response shared at the beginning of this chapter,

> We get a call every time she falls or is ill. We feel their help is very competent and is concerned about health. They try their best to take care of the older people. They show lots of concerns to both their physical and emotional needs.

This survey response was interpreted into five codes, these included 1) "family notification of incidents/ changes/ problems;" 2) "capable/ competent/ qualified/ well-trained staff;" 3) "staff concerned with resident health/ resident health needs met;" 4) "resident physical needs met;" 5) "staff concerned with resident happiness/ resident emotional needs met." These five categories were represented by numerical codes that could then be entered into a statistical software program for analysis. While the end result was numerical codes

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that could be analyzed quantitatively, the coders utilized a grounded theory approach to analyze the responses and develop the codebook.

Initial coding steps were completed by all three coders. Later steps were only completed by one other coder (i.e., my major professor) and myself. The following explains the coding methods for both the baseline and followup dataset.

Coding the "Baseline" Dataset

To begin, a blank codesheet was created and distributed to all three coders. The codesheet headings included the facility's number (arbitrarily assigned by the researchers of the larger study), the wave number (two waves of data have been collected to date, hereafter called "baseline" and "followup"), a unique family member identification number (arbitrarily assigned), five blanks for assigning codes to the open-ended quality responses, a sixth coding blank used to identify if more than five quality codes could have been assigned to the response, and finally a column for notes. Along with this codesheet, each coder was given a document containing all family member responses to the open-ended quality questions in the baseline survey for the nursing home. This document was titled "Comments on Family Member/Significant Other Questionnaires" and listed the family member responses to the questions by his or her unique family member identification number.

The coding was completed separately, with each coder having the opportunity to create her own, unique codebook for the open-ended responses. The codebook was established by going response by response and assessing the respondents' answers to the items in question. The coders could have used information about family members' perceptions of high quality in any nursing home (if available in the literature) to pre-

develop a codebook, however to preserve the qualitative, grounded theory approach, we only based their codes on the responses given.

Coders were instructed to create numerical codes along with a definition. For example, code 01 was defined as "good/ proper medical care." The coders were instructed not to discuss coding questions or concerns with one another. To begin, they were to code the first 50 responses (arbitrarily chosen). These responses included any returned surveys, even if a particular survey respondent did not answer the questions being analyzed by this study. If a survey was returned, but the assessed questions were not answered, then a code of "99" or "missing" was given.

After each coder had completed coding the first 50 responses, they met to discuss the data and their codebooks. At the meeting the three coders went response by response, comparing their coding choices and coming to a consensus on the best choice, if there was disparity. Typically, if two coders had the same coding choice and the third one differed, majority would rule. However, the coders were given a chance to argue for their decision, even if it was not in the majority. The coders also created a unified codebook to use for subsequent coding. This unified codebook had 45 codes. At this meeting it was also decided that there needed to be more than five blanks for codes on the codesheet, as many of the open-ended responses contained more than five examples of high quality care. It was then agreed that we would code the first ten examples and use an eleventh coding blank to identify if more than ten quality codes could have been assigned to the response. Space for ten codes seemed to encompass most questionnaire responses. Since the first round of independent coding had been completed with only room for five codes (and then a sixth blank to identify if there were more possible), the

coders left the meeting and individually re-coded those in the first 50 responses that required more than five codes. To do so, they used the newly created codesheet which gave room for ten quality codes. (See Appendix B for an example of the finalized codesheet).

After the restructuring of the codesheet, the three coders met again to finalize the first 50 questionnaire responses. Afterwards they again individually coded the rest of the baseline survey. One coder updated the file with the agreed upon codes for the first 50 responses and updated the codebook. These updates were sent out to all three coders to use when proceeding to coding the remaining quality responses in the questionnaire. They were instructed to code the remaining responses in the baseline dataset.

Again, for this second round of coding, the coders did not discuss coding decisions with one another. Although the coders were using a unified codebook to begin this round of coding, they were able to create additional codes as needed. Once the rest of the baseline study was coded individually by each coder, they again met to discuss and establish agreed upon coding decisions and a codebook. At the meeting it was determined that only two of the coders had completed coding the responses to the baseline dataset. One coder had an incomplete version of the document with the response data, therefore she did not realize she needed to code more. Because of this, the coders were only able to compare the next 51 responses, leaving 28 responses left to be coded in this baseline dataset.

One coder was designated to type the newly unified codebook and to send out along with a codesheet including the first 100 agreed upon codes per respondent. Once again the coders did not communicate with one another regarding coding decisions

while coding the remaining 28 responses. A final meeting was held for the baseline

dataset and the coders agreed upon coding decisions and a new codebook. During this

session it was determined that prior to moving on to the followup dataset coding rules

should be created, especially to differentiate between established codes that were

similar in meaning. At conclusion, the codebook contained 62 numerical codes with

definitions.

Coding the "Followup" Dataset

Following the completion of coding the baseline dataset, it was decided that two

coders would be sufficient to code the followup dataset, so the third researcher

discontinued her participation in coding. Coding rules were established and distributed.

Two coders independently coded the followup using the most up to date codebook. It

was still acceptable to create new codes. Following the coding of the followup dataset,

the coders met to discuss their decisions and any discrepancies. At this point, a final

codebook with 70 codes (including the seven added while coding the followup) and

additional coding rules were established for those difficult decisions found in the

followup (see Appendix C for final codebook and Appendix D for final coding rules).

Final Coding of the Baseline and Followup Dataset

Upon completion of the first round of coding the baseline and followup datasets,

the coders felt it important to recode both using the finalized codebook and coding rules.

This ensured that the coding was consistent between both waves of data. Re-coding

also follows methods explained by Carey, Morgan, and Oxtoby (1996), "…initial coding

instructions often yield poor agreement. In our study, two coders independently coded

the 320 text segments two times. The purpose of the first coding comparison was to pretest and remedy problems with the code book" (p.3). With this study as a guide, the baseline and followup were recoded giving all 70 codes a chance at being selected. Upon completion, the coding decisions were entered into the SPSS software program for analysis. The two coders' decisions for the followup dataset were compared to assess intercoder reliability, discussed next.

Intercoder Reliability

As guided by Weston et al. (2001) intercoder reliability was calculated for several reasons, including to build a team of coders that had a common understanding of the phenomenon being studied (in this case, families' perceptions of high quality care in a nursing home) (p. 394). Another, more practical reason for establishing coder reliability was to make certain individual coders interpreted the passages and applied the codes consistently (Weston et al., 2001, p. 394). For the purposes of this study, intercoder reliability was statistically assessed in two different ways, percent agreement and Cohen's kappa. For both reliability calculations, only the followup dataset was used. For clarification, the coders were labeled "A" and "B." The coders used for reliability testing included myself and another coder (my major professor) who had been working with me throughout the entire coding process.

Percent Agreement

The most basic form of intercoder reliability analysis was percent agreement, a widely used method because of the ease in calculation (Lombard, Snyder-Duch, & Bracken, 2005). For this measure, the sets of codes assigned by the two coders were

compared. The sets were considered the same, and therefore agreement obtained, if all codes within the set were identical and in the same order. For example, if coder A assigned codes [01, 02, 03, 04] to a survey response, then coder B must have assigned the same four codes in that order for agreement to be obtained. Agreement would also be absent if coder B had assigned a fifth code. Coding decisions for all 115 survey responses in the followup dataset were compared in this way. If coder A and coder B assigned a code of 99 to the response, then that coded response was also counted as an agreement obtained.

In the first wave of coding for the followup dataset, agreement was 53.0%. This percentage was obtained by taking the total number of identical code sets (in this case 61 sets) and dividing that number by the total number of sets (115). I determined that further refining of the codebook and coding rules was needed in order to establish an acceptable level of agreement. Further, the two coders also had an in depth discussion of decisions and rules, going response by response, in order to refine the decision making process. After these steps, the coders independently recoded the responses in the followup dataset. Percent agreement was calculated at 83.5%, an improvement of more than 30.5 percentage points. This percentage was calculated by taking the total number of identical code sets (96) and dividing it by the total number of responses (115). Comparing this to other studies led us to the determination that it was an acceptable value for percentage agreement.

Cohen's Kappa

Unfortunately, percent agreement does not assess agreement due to chance and therefore can be misleading (Lombard, Snyder-Duch, & Bracken, 2005). To assess

intercoder agreement or reliability, Cohen's kappa (commonly shortened to "kappa") is a widely acceptable tool (Carey, Morgan, & Oxtoby, 1996; Dewey, 1983; MacQueen, McLellan, Kay, & Milstein, 1998; Shoemaker, 2003) and was chosen for this research study. Kappa is most appropriate for two coders; Shoemaker (2003) suggests using other methods if three or more coders are involved. Kappa is described as measuring "true" agreement because, unlike percent agreement, it considers agreement occurring simply by chance (Sim & Wright, 2005, p. 258). Since the responses to the 115 text passages (in the followup dataset) were categorized into 70 codes, I followed the kappa calculation methods suggested in Carey, Morgan, and Oxtoby (1996), who similarly calculated kappa for a high number of codes (over 150 in their study).

To begin, 2-by-2 contingency tables were created for each of the 70 codes. Two of the four table cells showed coder agreement: the upper left cell denoted the number of times both coders assigned the code, and the lower right cell showed the number of times both coders did not assign the code. The other two cells, the upper right cell and the lower left cell showed disagreement among the coders, or indicated the number of times one coder assigned a code, but the other did not. I then went code by code filling in the tables. Upon completing the contingency tables, 21 of the 70 codes had to be thrown out of reliability testing. Twenty of the codes were not assigned to any of the responses in the followup dataset, therefore kappa could not be calculated due to zeros in the 2-by-2 table margins. Kappa yielded a negative (and therefore invalid) number for another code because the observed agreement was less than the calculated agreement due to chance. This meant that the never agreed on when to use the code, but did disagree. This left 49 codes for which kappa was calculated. I used the Cohen's kappa

formula to calculate all values by hand, and double checked the calculations for accuracy.

Cohen's kappa values range from 0.00 to 1.00, with 0.00 denoting no agreement and 1.00 implying total agreement. Acceptable kappa values are not standardized, with most researchers deciding what is satisfactory. Especially considered in this decision are the number of categories (or codes) and number of subjects in the study. The more codes a coder has to choose from, the harder it is to establish agreement. Landis and Koch (1977) provide the following scale: a kappa value of 0.00 = poor, 0.01 to 0.20 = slight agreement, 0.21 to 0.40 = fair, 0.41 to 0.60 = moderate, 0.61 to 0.80 = substantial and 0.81 to 1.00 = almost perfect (with 1.00 being perfect). Sim and Wright state that while this scale is not universally accepted, "similar formulations exist, but with slightly different descriptors" (2005, p. 264). Reference to Carey, Morgan, and Oxtoby (1996) was heavily used in this study, so it is useful to note that they did not specify a target kappa range. However, in their pre-test phase, they did seek to improve the use of any codes with a kappa value of less than 0.90.

Of the 49 kappas calculated for this study, I obtained a value of 1.00 for 28 (nearly 60%) of the codes. Kappa values greater than 0.90 encompassed nearly 75% of the codes. Only a little more than one-fourth of the codes (26.6%) had a kappa value of 0.89 or less. Table 1 shows the complete distribution of calculated kappa values.

Table 1

Distribution of Calculated Cohen's Kappa Values for Codes used in Followup Dataset

Kappa Range	Frequency	%	Cumulative%
1.000	28	57.1	57.1
0.99-.090	8	16.3	73.4
0.89-0.80	5	10.2	83.6
0.79-0.70	5	10.2	93.8
0.69-0.60	2	4.1	97.9
0.59-0.50	1	2.0	99.9
Less than 0.50	0	0.0	99.9
N	49	99.9[a]	

[a] Percentages do not total 100.0 due to rounding error.

Although the value ranges used here are not completely congruent with Landis and Koch (1977), it may still be useful to look at these results using their scale. In this study, almost 98% of the codes accomplished at least "substantial" agreement. Nearly 84% were considered "almost perfect." Considering the coders had 70 codes to choose from, these kappa values were considered sufficient for this study.

Overall, I was satisfied with the results obtained from both the percentage agreement and Cohen's kappa reliability tests. This concluded the intercoder reliability testing and laid the foundation for further data analysis. Next, I consider the process I used to collapse the original 70 codes.

Codebook Condensing Procedures

Since I used grounded theory in the original coding process for the baseline and

followup datasets, any response that was considered unique was given a new code. This included differentiating between "cleanliness" (no specifiers), "cleanliness of resident," and "clean room/ facility/ environment." Assigning three codes to these responses allowed me to have data at the most rudimentary level. However, as can be surmised, hypothesis testing with 70 codes is impossible. Because of this, the 69 codes had to be condensed or collapsed into manageable categories (the 70th code labeled, "99 - missing," was not included in the collapsing because the responses were counted as "missing").

To make the research findings as constructive as possible, I decided to use pre-existing categories into which the codes would be collapsed. A comparable study, published by Bowers, Fibich, and Jacobson (2001), assessed open-ended responses about quality from the person in care's perspective. They collapsed the data into three categories: care-as-service, care-as-relating, and care-as-comfort (Bowers, Fibich, & Jacobson, 2001). Aspects of the care-as-service category included a focus on the technical or instrumental aspects of care (for example, how well, quickly, or consistently the nursing home staff's work is completed) (Bowers, Fibich, & Jacobson, 2001, p. 541-542). For this category, people in care considered themselves purchasers of a service and felt they had the authority to instruct the staff and have an active role in evaluation (Bowers, Fibich, & Jacobson, 2001, p. 541-542). Aspects of the care-as-relating category included a focus on the relationships that staff and people in care had with each other, rarely mentioning the actual task of care-giving (Bowers, Fibich, & Jacobson, 2001, p. 542). This category also considered the caregivers' motivation for the work they do and the reciprocity in sharing personal information (Bowers, Fibich, &

Jacobson, 2001, p. 542-543). Finally, care-as-comfort focused on the person in care's physical comfort rather than the medical care they received or the staff's performance of routine tasks (Bowers, Fibich, & Jacobson, 2001, p. 543).

Although Bowers, Fibich, and Jacobson (2001) assess quality from the person in care's perspective, their three categories seemed to appropriately fit most of the 69 codes in this study. I did find a need to expand the definition of the categories in some instances. This was due to a larger sample size than the originating study, therefore resulting in more quality identifiers. Next, I assess the ways in which the collapsing decisions were made.

I began the condensing process by thoroughly analyzing the Bowers, Fibich, and Jacobson (2001) quality categories (using descriptors in their article) and making a chart (see Appendix E to view the chart). I then went code by code and assigned one of the three care categories to each. I also had a second coder (my major professor who had been involved throughout the entire coding process) use the chart to collapse the 69 codes. We then met to compare our results and made final decisions regarding the collapsing.

The code condensing was based on the spirit of the categories described in Bowers, Fibich, and Jacobson (2001), however as mentioned above, the categories had to be expanded for this research study. For the care-as-service category, original codes that dealt with expected nursing home tasks (such as good/ proper medical care, medical records up to date, or adequate staffing) were included. For the care-as-relating category, I expanded the Bowers, Fibich, and Jacobson description to include not only people in cares' relationships with staff, but also people in cares' relationships with each

other, and the staff's relationships with people in cares' family members. Finally, the care-as-comfort category included any non-essential (as far as health) physical comforts, including lack of odor/ smell, dressed/ groomed residents, structured day, and more. One code was thrown out due to its inexplicit nature, making it hard to collapse. This code was "the people, staff, not specified." Two other codes were also tossed out because they simply did not fit into any of the three categories, but were not used enough to justify a new category. These codes were "resident self-chooses facility based on experience," and "non-resident opinion of the home." Table E.1, in Appendix E, shows the three new categories and which of the original codes were included in each.

This concludes the Methods chapter of this thesis. In the next chapter I present the findings of the research, including characteristics of the nursing home, its people in care, and their families. I also offer information on the results of the hypotheses testing.

CHAPTER IV

FINDINGS OF THE RESEARCH

Introduction

For the purposes of analyzing the findings of this study, I used both the uncollapsed and collapsed coding categories. The uncollapsed data, encompassing all 69 quality codes (the 70th being code 99 and considered "missing"), provided an in-depth understanding of what the families' perspectives on high-quality nursing home care means. It also allowed for some basic comparison. The collapsed data comprised of three codes, made cross-tabulation and hypotheses testing more meaningful. Data for the sample characteristics, as well as the first two hypotheses came solely from the baseline dataset. The third hypothesis did incorporate data from the both the baseline and followup dataset. The following presents this information, as well as describes the characteristics of the sample, including the nursing home in question, the people in care, and their family members.

Sample Characteristics

To try and answer the questions suggested by the hypotheses, it is useful to first present information about our sample population. This information was collected in the baseline and followup studies; however I used only the baseline dataset for one of the five "experimental" or "team" nursing homes for this part of the analysis. This nursing home is a large, non-profit, church-related nursing home in north Texas, and was chosen for this thesis study because of its size, with nearly 200 certified beds at the time of the baseline survey. While the facility's size yielded a sufficient number of family member responses, I must note that its size is greater than the average size of nursing

homes in Texas and nationwide, which is slightly under 100 in both cases (Medicare

nursing home comparison website, U.S. Department of Health and Human Services

(USDHHS), 2008).

However, according to the baseline survey data, the distribution of age, sex, and

race/ethnicity in the nursing home is similar to nursing homes nationwide. For example,

67.2% of this nursing home's residents were age 85 or older. Ninety five percent of

people in care were over the age of 65 years. This is typical of most nursing homes, as

show in the chapter II literature review. Gabrel (2000) suggests that half of people in

nursing home care are over the age of 85 years. A Brown University study also confirms

that "most" long-term care is utilized by people over age 85, and Miller and Mor (2006)

call it the "height of long-term care use" (p. 4). See Table 2 for a complete picture of the

age distribution.

Table 2

Distribution of Age of People in Care at Nursing Home of Interest

Age in years	Frequency	%	Cumulative%
100+	3	2.5	2.5
85-99	77	64.7	67.2
65-84	33	27.8	95.0
Less than 65	6	5.0	100.0
N	119	100.0	

Again, according to family member responses to the baseline survey, all but one

resident was described (by family members) as being "white" (99.2%). The other

resident was described as "African American," and while there was the opportunity to

choose "Hispanic" or "Other," neither was chosen by the survey respondents. This is consistent with information presented in the chapter II literature review. Other researchers suggest that blacks are less likely than whites to receive nursing home care (Murtaugh, Kemper, & Spillman, 1990).

Gender information was similar to race, in distribution. Most of the residents were female (90.5%). This is also consistent with the 1997 National Nursing Home study that suggests women outnumber men in nursing homes, with 75% of the residents in that study being women (Gabrel, 2000). Other studies also found women to be the predominant users of nursing home care (Murtaugh, Kemper, & Spillman, 1990; Manton, 1988).

Finally, it is important to look at the characteristics that describe the family members who responded to the survey. In regards to gender, 67.8% of family members were female. Of these, daughters were the largest category, representing exactly half of the respondents. Sons were the second largest, making up 19.0% of respondents. Husbands were the third highest, with 10 respondents representing this group (7.9%). Ninety-six percent of respondents were "family" meaning related by blood or marriage, and the remaining 4.0% were "non-family" including "friend" or "other." As mentioned in the introductory chapter, rather than breaking it into "family" and "significant other," I called all respondents "family members" throughout this study. Table 3 shows the full range of the relationships.

Table 3

Distribution of Relationships of Respondents to People in Care

Relationship	Frequency	%	Cumulative%
Child	91	72.2	72.2
Spouse	15	11.9	84.1
Sibling	8	6.4	90.5
Niece/Nephew	3	2.4	92.9
Other	3	2.4	95.3
Parent	2	1.6	96.9
Grandchild	2	1.6	98.5
Friend	2	1.6	100.1
N	126	100.1 [a]	

[a] Percentages do not total 100.0 due to rounding error.

This study considers the level of family involvement and how it affects their perception of high quality care in a nursing home. Level of involvement was conceptualized as frequency of visit (an item captured by the survey). For clarity purposes, I made this a dichotomous variable with two categories, "visits once a week or more," or "visits less than once a week." A majority of respondents visited once a week or more (61.3%) and the rest visited less than once a week (38.7%). Visits are possibly linked to distance family members traveled to the nursing home. It was determined that most of the respondents traveled 11 to 50 miles to the nursing home (71.4%). About 12.2% of the respondents traveled 10 miles or less to visit their loved one. The remaining respondents traveled more than 50 miles to the nursing home for visits.

The uncollapsed coding categories were also utilized to understand the most often mentioned high quality indicators. Of all 69 quality indicators mentioned by family in this study, the most important quality indicator was a "caring/ compassionate/ kind/ loving staff" (38 respondents or 36.2%). General "cleanliness" and "clean room/ facility/ environment" topped the second and third ranking (31.4 and 20.0% respectively). Table 4 below provides a visual representation of the top ten quality indicators.

Table 4

Distribution of Top Ten High Quality Indicators Given by Respondents

High Quality Indicator	Frequency	%
Caring/compassionate/kind/loving staff	38	36.2
Cleanliness	33	31.4
Clean room/facility/environment	21	20.0
Alert/responsive/attentive/observant staff	16	15.2
Personal/one-on-one attention	14	13.3
Staff concern/care for resident(s), not specified	14	13.3
Clean resident(s)	12	11.4
Odor/smell	11	10.5
Happy/comfortable resident(s)	11	10.5
Good/hot/variety of food	10	9.5

Research Hypotheses

Next, I assess the findings that are central to each of the three research hypotheses. These findings were assessed using the condensed (or collapsed) and

non-condensed high quality categories, as appropriate. The reason and process for condensing the codes is described in the methods chapter of this thesis. Data to examine the first two hypotheses come from the baseline survey of family members in the nursing home. Data to examine the third hypothesis come from the baseline and followup surveys of family members of persons who were in care at the time of both surveys.

Hypothesis 1: Women and men will differ in opinion about how "high quality care in any nursing home" is defined.

In order to test this hypothesis, I used several statistical tests. To begin, I ran a crosstabulation for each high quality variable (total of 69) and calculated it against gender. While this is not helpful for testing the statistical significance of the variables' relationship, it does provide some interesting information about the relationship gender has with definition of high quality, as well as give us some idea of the percent agreement between gender and the quality variables. As is shown in Table 5, there is not a lot of variation in definition by gender. Both men and women found caring/ compassionate/ kind/ loving staff and cleanliness to be of utmost importance when defining high quality. Women took their definition of cleanliness further and identified not only general cleanliness, but also cleanliness of the facility and of the person in care. These more specific definitions of cleanliness were not on the top ten list for men. Also on the women's list, but missing from the men's are odor/ smell and staff engagement. Men however, considered good/ proper medical care and good/ hot/ variety of food a top indicator of high quality, while women did not.

Table 5

Distribution of Top Ten High Quality Codes by Gender

High Quality Code	Frequency/ Percentage	
	Men	Women
1. Caring/ compassionate/ kind/ loving staff	11 34.4%	26 36.6%
2. Cleanliness	10 31.3%	22 31.0%
3. Alert/ responsive/ attentive/ observant staff	6 18.8%	18 25.4%
4. Staff concern/ care for resident(s), not specified	5 15.6%	10 14.1%
5. Good/ proper medical care	4 12.5%	10 14.1%
6. Good/ hot/ variety of food	4 12.5%	9 12.7%
7. Personal/ one-on-one attention	4 12.5%	9 12.7%
8. Personal safety of resident/ measures to prevent injury	4 12.5%	8 11.3%
9. Happy/ comfortable resident	3 9.4%	8 11.3%
10. Capable/ competent/ qualified/ well-trained staff	3 9.4%	7 9.9%

Using the uncollapsed codes, I was also able to identify which ones had the largest differences between genders. The code "clean room/ facility/ environment" achieved the highest difference, with 25.4% of women identifying it as a quality indicator, and only 9.4% of men (a difference of 16.0%). Staff engagement also had a high instance of disagreement; men did not identify this as a high quality indicator, however 9.9% of women did (a difference of 9.9%). On the other hand, women did not

mention quality as "homey/ home-like/ family-like/ treating resident(s) like family," and 9.4% of men did.

Men and women agreed most for the codes "personal /one-on-one attention" (0.2% difference), "cleanliness" (0.3% difference), and "happy/ comfortable resident(s)" (1.9% difference). Overall there was a lot of agreement. Some of the percentage comparisons were not useful due to small frequencies.

Next, I will describe the gender differences based on information obtained using the collapsed codes. As described in the Methods chapter, each of the 69 codes (with three codes being tossed out, leaving 66) were conceptualized into one of three categories, care-as-service, care-as-relating, and care-as-comfort. These three condensed categories were made into dependent variables. This resulted in three bivariate tables for each independent variable, including gender. Table 6 represents the results of the gender and high quality care-as-service crosstabulation. In this table we see that 71.8% of women characterized high quality care-as-service, compared to 75.0% of men. This is only a difference of 3.2 percentage points; however men did tend to specify care-as-service at a slightly higher rate than women.

Table 6

Crosstabulation of Gender and High Qualilty Care-as-Service

High Quality Indication	Gender	
	Male	Female
Did not characterize high quality as service	8 25.0%	20 28.2%
Did characterize high quality as service	24 75.0%	51 71.8%
N	32 100.0%	71 100.0%

Chi-square was the test of statistical significance used for this study. The null hypothesis was identified as, "In the population of family members from which the sample was drawn, gender and high quality care-as-service are unrelated." For gender and high quality care-as-service, the obtained chi square value was 0.009, with 1 degree of freedom. The p-value of 0.924 was greater than the pre-selected rejection level or alpha of 0.05, therefore I failed to reject the null hypothesis of no association. This tells us that there is no statistically significant relationship between gender and choosing service as an indication of high quality care in any nursing home.

Since these nominal variables are dichotomous, gamma was used as the measure of association. However, since the chi square value revealed no association between the variables, reporting gamma is not useful.

A similar process was conducted for the other two high quality care variables. Table 7 shows us the results of the gender and high quality care-as-relating crosstabulation. Again, the results are comparable, with 56.3% of women characterizing high quality care-as-relating, compared to 43.8% of men. This gender difference is 12.5 percentage points, this time with women more often choosing the relating category.

Table 7

Crosstabulation of Gender and High Quality Care-as-Relating

High Quality Indication	Gender	
	Male	Female
Did not characterize high quality as relating	18 56.3%	31 43.7%
Did characterize high quality as relating	14 43.8%	40 56.3%
N	32 100.0%	71 100.0%

Calculating chi-square (with a value of 0.942 and 1 degree of freedom) for gender and high quality care-as-relating resulted in a *p*-value of 0.332. Again this was greater than the alpha of 0.05. The decision was to fail to reject the null hypothesis and conclude that there is no statistically significant association between gender and choosing service as an indication of high quality care in any nursing home. Since the chi square value revealed no association between the variables, gamma is not reported.

Finally, we considered gender and high quality care-as-comfort, with the crosstabulation shown in Table 8. Here women were 11.3% more likely to specify high quality in terms of comfort. This difference is slightly less than that of gender and high quality care-as-relating, with both comfort and relating being more frequently chosen by women.

Table 8

Crosstabulation of Gender and High Quality Care-as-Comfort

High Quality Indication	Gender	
	Male	Female
Did not characterize high quality as comfort	13 40.6%	24 33.8%
Did characterize high quality as comfort	19 54.9%	47 66.2%
N	32 100.0%	71 100.0%

Statistical significance was calculated using chi-square. The resulting *p*-value of 0.656 was greater than the alpha of 0.05, therefore we failed to reject the null hypothesis of no association. The obtained chi-square value was 0.199 with 1 degree of freedom. This leads to the conclusion that there is no statistically significant difference

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between gender and choosing comfort as an indication of high quality care in any nursing home.

This concludes the statistical testing of gender and the high quality care variables of service, relating, and comfort. A discussion of what these findings mean will be conducted in the final chapter of this thesis. Next I will look at the second hypothesis and describe the relationship of those variables.

Hypothesis 2: Respondents will define "high quality care in any nursing home" differently depending on how frequently they visit.

Another question concerning this study was how level of family involvement (quantified by "frequency of respondent's visit") was related to definition(s) of high quality care. Again, uncollapsed data was utilized to gain an understanding of the relationship at a more specific level. As can be seen in Table 9, cleanliness and caring/ compassionate/ kind/ loving staff were still top indicators of high quality care for both those who visit frequently and those who visit less frequently. Overall, the lists looked similar. Looking at the categorical differences between the top ten lists, those who visited less seemed more likely to be concerned with staff attributes (mentioned capable/competent/ qualified/ well-trained staff, good/ proper medical care, and adequate staffing). For those who visited more often, they more frequently specified quality indicators that involved patients (such as clean resident and happy/ comfortable resident).

Table 9

Distribution of Top Ten High Quality Codes by Frequency of Visit

Visit at least once per week (≥1/wk)		Visit less than once per week (<1/wk)	
High Quality Code	Frequency/ Percentage	High Quality Code	Frequency/ Percentage
1. Caring/ compassionate/ kind/ loving staff	22 33.3%	1. Cleanliness	17 44.7%
2. Cleanliness	16 24.2%	2. Caring/ compassionate/ kind/ loving staff	16 42.1%
3. Clean room/ facility/ environment	13 19.7%	3. Clean room/ facility/ environment	8 21.1%
4. Alert/ responsive/ attentive/ observant staff	12 18.2%	4. Personal/ one-on-one attention	6 15.8%
5. Staff concern/ care for resident(s), not specified	11 16.7%	5. Capable/ competent/ qualified/ well-trained staff	5 13.2%
6. Clean resident(s)	10 15.2%	6. Good/ proper medical care	4 10.5%
7. Personal/ one-on-one attention	8 12.1%	7. Odor/ smell	4 10.5%
8. Happy/ comfortable resident	8 12.1%	8. Alert/ responsive/ attentive/ observant staff	4 10.5%
9. Odor/ smell	7 10.6%	9. Adequate staffing	4 10.5%
10. Good/ hot/ variety of food	7 10.6%	10. Good/ hot/ variety of food	3 7.9%

Although both groups considered cleanliness a strong indicator of high quality

care, it was also the category with the greatest degree of difference and it was inversely

related. About 24.2% of those respondents who visited once a week or more

characterized quality as cleanliness, while about 44.7% of those who visited less than once per week specified care in this way. This means that those who visited less listed it as an indicator 20.5% of the time more often than did those who visited more. There were other differences. For example, staff engagement was chosen as a quality indicator by 10.6% of those who visited at least once a week. No one visiting less than once a week specified staff engagement. In addition, clean resident was chosen by 15.2% of the more frequent visitors. The percentage-point difference between categories was 9.9%. In contrast, the odor category was specified almost equally by both categories within frequency of visit (with only a 0.1 percentage point difference).

To use the collapsed code categories, I again constructed crosstabulations on frequency of visit and the high quality care variables of service, relating, and comfort. To begin, let us look at the relationship between frequency of visit and high quality care-as-service. Table 10 shows the comparison. Over three-fourths (77.3%) of those respondents who visited at least once per week specified service as a high quality indicator. This indicator was mentioned by only 63.2% of respondents who visited their loved one less often.

Table 10

Crosstabulation of Frequency of Visit and High Quality Care-as-Service

High Quality Indication	Frequency of Visit	
	(≥1/wk)	(<1/wk)
Did not characterize high quality as service	15 22.7%	14 36.8%
Did characterize high quality as service	51 77.3%	24 63.2%
N	66 100.0%	38 100.0%

The variables in this comparison are nominal and ordinal; therefore chi-square was again used as the test of statistical significance. The null hypothesis was identified as, "In the population of family members from which the sample was drawn, frequency of visit and high quality care-as-service are unrelated." For this variable comparison the obtained chi-square value was 1.739 with 1 degree of freedom, and the *p*-value was calculated at 0.187. This *p*-value was greater than the alpha of 0.05, therefore I failed to reject the null hypothesis of no association. This tells us that there is no statistically significant relationship between frequency of visit and high quality care-as-service.

Next, I looked at frequency of visit and high quality care-as-relating (Table 11). For this care variable, the response difference was 8.7 percentage points, with those visiting at least once per week indicating it more often.

Table 11

Crosstabulation of Frequency of Visit and High Quality Care-as-Relating

High Quality Indication	Frequency of Visit	
	(≥1/wk)	(<1/wk)
Did not characterize high quality as relating	29 43.9%	20 52.6%
Did characterize high quality as relating	37 56.1%	18 47.4%
N	66 100.0%	38 100.0%

Statistical significance, using chi-square revealed an obtained chi-square value of 0.424 with 1 degree of freedom and a *p*-value of 0.515. This *p*-value was again greater than the alpha of 0.05, and we fail to reject the null hypothesis of no association.

This informs us that there is no statistically significant difference between frequency of visit by family members and their tendency to characterize high quality care-as-relating.

The final high quality condensed variable is comfort. It was also compared against frequency of visit, with the results presented in Table 12. This table produced the largest difference among visitors. Here, over half (57.6%) of those who visited once a week or more characterized high quality care-as-comfort. An even larger percentage of the less frequent visitors (76.3%) indicated high quality care-as-comfort.

Table 12

Crosstabulation of Frequency of Visit and High Quality Care-as-Comfort

High Quality Indication	Frequency of Visit	
	(≥1/wk)	(<1/wk)
Did not characterize high quality as comfort	28 42.4%	9 23.7%
Did characterize high quality as comfort	38 57.6%	29 76.3%
N	66 100.0%	38 100.0%

Calculating chi-square for gender and high quality care-as-comfort resulted in an obtained chi-square value of 2.923 with 1 degree of freedom and a *p*-value of 0.087 and. This *p*-value calculation approached significance, but was not quite enough to reject the null hypothesis. Therefore, the variables were not deemed statistically significant and we failed to reject the null hypothesis.

This ends our statement of findings for the second stated hypothesis of this thesis. Again, we did not use the gamma calculation as a measure of association because the chi-square values revealed no association for all three variable

comparisons. Finally, we will take a similar look at the third and final hypothesis. The

relationship between the variables time (quantified as before and after the empowered

CNA intervention) and high quality care in any nursing home.

Hypothesis 3: Respondents will define "high quality care in any nursing home"
differently before the empowered CNA team intervention than after.

For this final analysis the independent variable is "time" and the dependent

variables are high quality care (collapsed and uncollapsed categories). Here, the time

variable is used to conceptualize family member responses from both the baseline and

followup datasets. To be considered for this analysis a family member for a resident had

to fill out both the baseline and followup survey. Thereby we were able to capture data

on the family member of the same person in care at two different points in time. There

were a total of 50 respondents that completed both surveys. The two previous

hypotheses only utilized information from the baseline dataset. However, for this

analysis I wanted to consider how responses changed after the implementation of the

empowered CNA team intervention. As mentioned earlier, the details of this intervention

are thoroughly outlined in Yeatts and Cready (2007) and are described in the literature

review chapter of this thesis.

I assessed the findings of the crosstabulations for the time variable and the three

collapsed high quality care variables of service, relating, and comfort. The first bivariate

table, illustrated in Table 13, shows us the difference in characterization of quality as

service for before and after the CNA intervention. Approximately 78.0% of respondents

before the CNA intervention characterized high quality as service. This compared to the

56.0% of those same respondents that characterized high quality care-as-service after

the intervention. Therefore, service was identified as high quality care 22.0% more often before the intervention than after.

Table 13

Crosstabulation of Time and High Quality Care-as-Service

High Quality Indication	Time	
	Before CNA Intervention	After CNA Intervention
Did not characterize high quality as service	11 22.0%	9 44.0%
Did characterize high quality as service	38 78.0%	29 56.0%
N	50 100.0%	50 100.0%

For these dichotomous, nominal variables, gamma was the measure of association used to interpret the relationship. For time and high quality care-as-service, the gamma statistic was -0.472, or a moderate, negative relationship. Respondents completing the survey before the CNA intervention were more likely to characterize high quality in terms of service. Using time of survey to predict high quality care-as-service will reduce the error of predicting high quality care-as-service by 47.2%.

Chi-square was used to determine statistical significance. The obtained chi-square value was found to be 4.523 with 1 degree of freedom. The *p*-value for the test of these variables was 0.033, less than the set alpha value of 0.05. Thus, the sample gives us enough evidence to reject the null hypothesis of no difference in the characterization of high quality care-as-service before and after the implementation of the intervention. This means that there is a statistically significant relationship between

time and high quality as service; after the empowered CNA work team intervention, family members tended to be significantly less likely define high quality care-as service.

Next I consider the crosstabulation of time and high quality care-as-relating (Table 14). A little over half (52.0%) of the respondents characterized high quality as relating prior to the CNA intervention. After the CNA intervention this percentage increased 76.0%.

Table 14

Crosstabulation of Time and High Quality Care-as-Relating

	Time	
High Quality Indication	Before CNA Intervention	After CNA Intervention
Did not characterize high quality as relating	24 48.0%	12 24.0%
Did characterize high quality as relating	26 52.0%	38 76.0%
N	50 100.0%	50 100.0%

The gamma value was 0.490, which revealed a moderate, positive relationship between time and high quality care-as-relating. This means that responses after the team intervention more often characterized high quality as relating. This differs from the previous set of variables (time and high quality care-as-service) which had a negative relationship of about the same strength. Using time to predict high quality care-as-relating reduces the error of predicting high quality care-as-service by 49.0%.

The chi-square statistic (a value of 5.252 with 1 degree of freedom) showed a statistically significant relationship between time and high quality care-as-relating. The

p-value of .022 is less than the alpha value of 0.05, therefore we can reject the null hypothesis of no association.

To conclude the findings of the research I look at the final crosstabulation for time and high quality care (Table 15). This time we are considering high quality care-as-comfort. In contrast to results presented in Tables 13 and 14, the percentage comparisons in Table 15 did not reveal a huge difference before and after the CNA intervention. Before the intervention, 68.0% of respondents classified high quality care-as-comfort, however after the intervention the likelihood of classifying it in this way only went up by 2 percentage points to 70.0%.

Table 15

Crosstabulation of Time and High Quality Care-as-Comfort

High Quality Indication	Time	
	Before CNA Intervention	After CNA Intervention
Did not characterize high quality as comfort	16 32.0%	15 30.0%
Did characterize high quality as comfort	34 68.0%	35 70.0%
N	50 100.0%	50 100.0%

The chi-square test of statistical significance resulted in a value of less than 0.000 and a *p*-value of approximately 1.000. This is much higher than the alpha value of 0.05, therefore we fail to reject the null hypothesis. This means that there is no statistically significant relationship between time and high quality care-as-comfort. For these variables the gamma value was not used, due to no association found between the two variables using the chi-square statistic.

Summary of Findings of the Research

This completes the presentation of the findings of the research. I began the chapter by looking at the sample characteristics, including the nursing home, people in care, and their family members. I also assessed the statistical significance of the relationships between each of my independent variables (gender, frequency of visit, and time) and the dependent variables of high quality care categories. To do so I used percentage agreement (by means of crosstabulations presented in a bivariate table), gamma, and chi-square. Each of the measures was appropriate for my nominal and ordinal dichotomous variables.

In the final chapter I summarize these findings and assess their meaning with regards to policies, procedures, and future research. This chapter also includes a discussion of the limitations of the study.

CHAPTER V

SUMMARY, CONCLUSIONS, LIMITATIONS, AND FUTURE RESEARCH

Summary

The purpose of this study was to examine the relationships between high quality care in any nursing home and how family's definition of high quality was influenced by gender, level of family involvement, and time (absence or presence of an intervention). The research was guided by the following three hypotheses:

1) Women and men will have different opinions of how "high quality care in any nursing home" is defined.

2) Respondents will define "high quality care in any nursing home" differently depending on how frequently they visit.

3) Respondents will define "high quality care in any nursing home" differently before the empowered CNA team intervention than after.

The data used were collected via survey instrument, prior to my introduction to the research. I used data from the completed surveys to carry out my analysis. To establish the dataset I first had to code the family member's responses to two survey questions identified for this research. I used symbolic interactionism, specifically role theory, as a lens for which to examine the responses given by family members.

The findings revealed that gender and level of involvement do not play a statistically significant role in how high quality care is defined by family members. However, the findings did uncover a statistically significant difference between time, that is, before and after the team intervention was implemented, and two of the high quality

care variables. Conclusions drawn from the findings of the research are presented in the next section.

Conclusions

As was outlined in the findings, the sample characteristics drawn from the dataset were for the most part comparable to the more general information about nursing homes, and the people in their care. While the nursing home is larger on average than other nursing homes in Texas and nationwide, it is comparable in size to nursing homes studied by other researchers (e.g., Dempsey and Pruchno in 1993). In addition, the average age of the people in care also matched the current literature. About 67.2% of the people in care were age 85 or older. The 2000 article by Gabrel informs us that about half of the people in care in nursing homes, in the United States, are age 85 or older. Gender findings were also comparable to the overall gender distribution in nursing homes. Other studies suggested that women are the primary users of nursing home care (Gabrel, 2000); Manton, 1998; Murtaugh, Kemper, & Spillman, 1990). This study was no different, 90.5% of the people in care were identified as female.

Although the information on family members was limited, I was able to assess the distribution of relationships, as well as identify the gender of the family member respondents. As was presented in the literature review, women are traditionally expected to care for the family and provide domestic labor (Abel, 1991; Dempsey & Pruchno, 1993; Gould, 1999; Keefe & Fancey, 2000; Olson, 2003). This research upheld that statement; well over half (67.8%) of the family members in this study were

women. Keefe and Fancey (2000) found that 67% of their family members were female and Dempsey and Pruchno (1993) observed that 72.8% of their respondents were women.

Looking at the respondent's relationship with the person in care, a majority in this study were daughters (50.0% of all respondents). Sons made up 19.0% and spouses 11.9%. Keefe and Fancey also report their distribution as 40% daughters, 21% sons, and 7% spouses (2000, p. 238). The breakdown of respondents in this study was very similar.

The findings of this thesis did not support the first hypothesis concerning the effect of gender. I found that while there were slight gender differences in the characterization of high quality nursing home care (care-as-service, care-as-relating, and care-as-comfort), these differences were not statistically significant. Thus, while most respondents were women, and their traditional role in society is to be the care taker, this does not seem to have any bearing on how they interpret high quality care in a nursing home, at least as compared to men.

However, upon further consideration, it may be possible that I was looking at gender from the wrong perspective. The primary role of the nursing home and its staff is to care for the people that live there. Therefore, traditional gender roles, as seen acted out in society, are not really applied here. Instead, family members who participate in nursing home care, whether they be male or female, will be participating in the role of caretaking.

Gender of the nursing home staff could also be considered. But here again, gender would not vary a great deal because the typical direct line nursing home staff

member (nurse or nurse aides) is female. So as can be seen, gender and the roles typically associated with it, do not vary much in this specific setting - the nursing home. This helps explain why the relationship between gender and the high quality care variables were not statistically significant.

The findings for the second hypothesis were similar to that of the gender comparison. Decisions based on chi-square failed to reject the null hypothesis for frequency of visit and each of the three high quality care variables. This is interesting because the research indicates that frequent visits by family members gets them more involved in their loved one's care (Dempsey & Pruchno, 1993; Keefe & Fancey, 2000). However, level of involvement does not seem to make a significant difference on how family members judge nursing home care. Keefe and Fancey also assessed how the distance traveled to the facility affected the relationship between families' prior and current caregiving tasks (2000). No significant relationship was identified in their study either.

However, what is interesting is the idea that family members and staff have differing opinions on what tasks they should take on with regards to caring for their loved one in the nursing home (Bowers, 1988). Those tasks that family members deemed appropriate for staff would most likely be the tasks that they are judging the nursing home on. In other words, the presence or absence of the "non-technical aspects of care" would most likely be absent from their definition of high quality care in any nursing home because they themselves feel responsible for them. When assessing the raw data I felt like some aspects of care were missing from the family member's perceptions. I jotted down a few of these as I coded, including person in care's

independence, aspects of their room, relationships with other people in care, and their ability to make choices. At first I thought the lack of inclusion was because of the survey instrument creator's bias. The survey instrument is lengthy and asks the family member about many aspects of care. Most of the survey items are multiple choice, but the questions I was analyzing for this study were toward the end and open-ended. Therefore, it would make sense that their answers are somewhat influenced by previous questions on the survey. However, after taking a second look at the survey instrument, I realized that independence and decision making were definitely a part of the survey instrument. Therefore, if responses to the open-ended survey item of interest were influenced by the previous questions, then independence and decision making would be present.

Looking back on these "missing" aspects of care, I realized that most are part of the non-technical aspects of care that family members typically feel responsible for. Because of this, they would not be included as a part of their conceptualization of high quality care in any nursing home, because the question assumes respondents look at the care provided by the nursing home, thereby its' staff. But taking family members on outings are part of the non-technical description, and this could be considered independence. Bringing or providing for "extras" are also in the family's self-made job description; this could explain why few respondents deemed room specifications as part of high quality care. Family members also consider it part of their responsibility to help their family member make decisions. Therefore this would not factor into their definition. While survey instrument bias may still play a part in guiding the responses to late-in-

survey open-ended questions, it seems likely that this conceptualization of duties also plays a role; no matter if they visit frequently or not.

There was one exception worth of discussion. Level of involvement and high quality care as comfort did approach statistical significance. The crosstabulation revealed that less involved family members (those that visited less than once a week) were more likely to indicate high quality care as comfort than those who visited more frequently. This would suggest that those more frequent visitors are less concerned about their loved one's comfort, possibly because they are there to see to it. This would also support the idea of family member's roles in care. Those family members that are visiting often take it upon themselves and are there to see to the non-essential aspects of care that characterize the high quality care-as-comfort category. Since the less involved family members are not there to see to them, they would likely be more concerned about the level of comfort provided.

Another thing to consider regarding level of involvement, is that the overall level of involvement probably did not vary much. Overall, one would expect respondents to respond to the questionnaire because they *are* involved in their loved one's care. Further, the statistics showed that most of the respondents visited once a week or more (61.8%). Further, most of the respondents (71.4%) of family members lived within 50 miles of the nursing home. This shows that overall the level of involvement by those who responded is fairly high. Therefore, the level of involvement variable probably did not vary much overall.

Measures computed to test the statistical significance of the variables involved in the third hypothesis did depict a moderate relationship between the variables in two

instances (time as it affects decisions about high quality care-as-service and care-as-relating). For both of these variable comparisons the *p*-value for chi-square was low enough to reject the null hypothesis of no association. This means that family members' opinion of high quality care in any nursing home was significantly different before and after the CNA team intervention. The first crosstabulation looked at high quality care-as-service. For this variable, family members were less likely to specify it as high quality after the intervention.

What this means is that the CNA intervention decreased the focus on care-as-service (high quality descriptors from the data included proper medical care, capable/ competent staff, resident's needs, family notification and communication, adequate staffing, etc.) and increased the focus on relating (high quality descriptors included caring staff, friendly staff, personal attention, happy employees, staff engagement, treating residents with respect, and more). Restated from the literature review, Yeatts and Cready say, "there is an urgent need to improve the care provided to nursing home residents. This is particularly the case when one is concerned for the residents' quality of life and life satisfaction as well as health" (2007, p. 336). It seems like their CNA team intervention did change the focus of the family's concern from health/service/technical aspects of care to the non-technical aspect of staff/patient in care relationships.

Overall, this shows that the role CNAs play in the nursing home does have an impact on care, and perception of care. While care provided by the registered nurses, and other health care professionals is important, this study also shows that the assistance in activities of daily living, as provided by CNAs has an impact. This gives

relevance to the need to continue studying the impact that changes in the CNA role has on nursing home quality.

Limitations of the Study

This study is limited by geographical location. Further, only one nursing home was evaluated. Future studies could evaluate the responses collected from multiple nursing homes in multiple locations to make the research more generalizable.

Another limitation may be the placement of the open-ended questions toward the end of the family survey instrument. While comparing the survey instrument and the family responses to the open-ended high quality care questions, I became aware that many of their responses seemed to reflect content asked in the previous items of the questionnaire. I wondered if perhaps some of the open-ended responses may have been influenced by the earlier items. On the other hand, as the same instrument was used in both the baseline and followup family surveys—i.e., before and after the implementation of empowered CNA teams—and a comparison of open-ended responses between the two time periods found significant differences, there is some evidence to suggest that family responses to the open-ended questions were not unduly influenced by their placement in the instrument. However, if there was in fact some researcher bias on the survey instrument used in this study, it was helpful that the researchers left the responses open-ended. This allowed family members to describe quality in multiple ways that were specific to them and their own experience.

This study does aid in our understanding of nursing home quality. However it seems likely that the family members were only describing high quality care based on

the job of the nursing home staff members. Future studies could collect data on what family members perceive to be high quality care, including both technical and non-technical aspects of care (as described in Dempsey & Pruchno, 1993).

Need for Future Research

Ray (2000) pinpoints some of the major reasons to continue studying the quality of care in any nursing home. In his article, he points out that many people needing care and their family members are turning to alternative long-term care facilities (such as assisted living, in-home services, or adult day care) (Ray, 2000). In support of Ray, a 1970 book by T.A. Routh includes a chapter entitled, "The desperate need for research" (p 129). Routh calls for research by nursing home administration in order to "materially enhance their own professional self-image, and above all, secure the end for which they exist – better and more comprehensive nursing home services to sick, suffering, helpless and dying humanity" (1970, p. 133). While these words were written nearly 40 years ago, they are still pertinent to the current situation. The nursing home concept, while not the best or only option for everyone, is useful. Further study should lead to continued increase in quality of nursing homes so that they become even more beneficial to people needing care, and their families.

Comprehensive survey instruments (like the one used in this study) that solicit a large amount of different information from subjects are very helpful in acquiring a lot of data at one time. Future studies using such instruments are needed to determine the optimal placement of open-ended questions. In addition, a comparison of results generated by studies using these instruments with those generated in future studies

using focus groups and/or semi-structured personal interviews of family members seems warranted. Such a comparison would likely give us a better understanding of their perceptions/definitions of high quality care in a nursing home.

The problem of needing care for our society's elderly and disabled is not going away. The aging of the baby boom generation will only add to the increasing need for long-term care. Wilging suggests that quality of nursing home care is one of the most "socially critical" issues facing our society (cited in Mitty, 1992, p. 13). He goes on to comment, "complicated by the likelihood of personal impoverishment, long-term care issues become even more problematic and worthy of understanding, analysis, and action" (cited in Mitty, 1992, p. 13). This is a reminder that nursing home quality should be important to us, not only for the sake of our loved ones, but also for our own sake. We must continue striving to understand nursing home quality, how it changes, and how it impacts our lives.

APPENDIX A

EXAMPLE COVER LETTER AND FAMILY MEMBER/SIGNIFICANT OTHER

QUESTIONNAIRE

<DATE>

Dear Family Member (or Significant Other):

  The managers of **<NAME OF FACILITY>** are joining with faculty at the University of North Texas (UNT) to look for ways of helping the nurse aides be as effective as they can be in caring for the residents. It is hoped that the information we gather will help the managers to improve resident care and will be used by the faculty members in their study of nursing homes and nurse aides. As part of this study, we would like to get your thoughts on a number of different issues.

  Attached are questions that ask for your opinions on the care that is provided. Your answers will be kept completely confidential and only the UNT researchers will know how you have answered. If you choose not to participate no one will in any way be penalized. When we have received the questionnaires back from all of the family members (and significant others) and have surveyed the residents who are willing and able, all of the answers will be combined to give a summary of the opinions provided. In this way, the management will learn how family members, significant others, and residents feel but will not know any one person's answers to the questions.

  Please take time to complete this survey (about 10 - 15 minutes) and place it in the addressed envelope provided. No postage is needed. If you have any questions about the survey, please feel free to call us at the numbers listed below.

Sincerely,

Dale E. Yeatts, Ph.D.   Cynthia M. Cready, Ph.D.
Professor and Chair   Assistant Professor
Department of Sociology   Department of Sociology
940-565-2238 (work)   940-369-8791 (work)

Who is your family member/significant other?

What is your relationship to her/him

How often do you visit her/him (circle one)?

a. almost never   e. once a week
b. less than once a month   f. more than once a week
c. once a month   g. every day
d. a few times a month

Please use the following scale when completing the questions below.

1.   **yes always,**
2.   **yes, sometimes**
3.   **unsure, cannot decide**
4.   **no, not usually**
5.   **no, never**

_____Can she/he decide when to go to bed?

_____If she/he wanted to stay up late, would she/he be allowed to do this?

_____Can she/he decide when to get up in the morning?

_____If she/he wanted to sleep late in the morning, would she/he be allowed to do this?

_____Can she/he choose the clothes that she/he wears?
_____Can she/he decide when to take a bath or shower?
_____If she/he wanted to change her/his normal bath or shower time, would she/he be allowed to do this?

_____Can she/he eat a meal whenever she/he wants to?
_____If she/he wanted to eat breakfast late in the morning, would she/he be allowed to do this?

_____Is she/he able to practice her/his religion whenever she/he likes?
_____Is she/he able to have privacy whenever she/he wants?

Communication and Companionship

_____Do the people who work at the nursing home spend time talking with her/him?

1. **yes always,**
2. **yes, sometimes**
3. **unsure, cannot decide**
4. **no, not usually**
5. **no, never**

_____Do the people who work at the nursing home listen to what she/he says?
_____Do the people who work at the nursing home ever do anything to show they care
    about her/him?

Is she/he friends with anyone who works at the nursing home (circle one)? Yes or No?

(If yes) How many employees would you say she/he is friends with (circle one):
   a.   many
   b.   some or
   c.   a few

Do the people who work at the nursing home like their job (circle one below)?
   a.   yes, most do
   b.   some do, some don't
   c.   no, most don't
   d.   unsure, cannot decide

Food Service and Activities

_____At meal times, does she/he have a lot of different types of foods to choose from?
_____Is there plenty of food available at meal times?
_____Is the food fresh?
_____Does the food seem to taste good to her/him?
_____Does she/he get assistance with her/his meal, if needed?
_____Are you satisfied with the food provided to her/him at the nursing home?

Activities

_____Are the activities at the nursing home things that she/he likes to do?
_____Does she/he have enough different activities to do at the nursing home?
_____Are there staff who will help her/him get to the activities, if she/he needs help?
_____Do the employees try to make her/him do activities that she/he doesn't want to
    do?

1. **yes always,**
2. **yes, sometimes**
3. **unsure, cannot decide**
4. **no, not usually**
5. **no, never**

How often does she/he have visitors, including yourself (circle one)?

a. almost never
b. less than once a month
c. once a month
d. a few times a month

e. once a week
f. more than once a week
g. every day

Direct Care
Now we would like you to think about the help she/he needs and the people working at the nursing home who provide her/him with help.

_____Do the people who work at the nursing home check on her/him to see if she/he is comfortable? (for example, if she/he needs a blanket, a drink, or change in position)

_____When she/he needs help, does she/he have to ask for it more than once?

_____Does she/he need help from employees to take a bath?
_____**(If yes)** Do the employees help her/him take a bath?

_____Does she/he need help from employees to put on her/his clothes?
_____**(If yes)** Do the employees help her/him to get dressed?

_____Does she/he need help from employees to go to the toilet?
_____**(If yes)** Do the employees help her/him with this?

_____Does she/he need help from employees to brush her/his teeth or clean her/his dentures?
_____**(If yes)** Do the employees help her/him with this?

_____Do the employees spend enough time helping her/him with her/him needs?

_____Do the employees help her/him keep her/him room as clean as she/he would like?

_____Do the employees help her/him keep the bathroom clean?

_____Do the employees let her/him do as much as she/he would like to do for herself/himself?

1. **yes always,**
2. **yes, sometimes**
3. **unsure, cannot decide**
4. **no, not usually**
5. **no, never**

_____Does the facility provide a home-like environment?

_____When she/he has a complaint, is something done about it?

_____When you have a complaint, is something done about it?

Safety and Security

_____Do the employees knock on her/his door before entering her/his room?

_____Do the employees ever get angry at her/him?

_____Do the employees handle her/him gently?

_____Does she/he feel safe in the nursing home?

_____Are her/his personal belongings safe in the nursing home?

General Satisfaction
The next few questions are about your overall satisfaction with the care she/he receives.

_____Overall, are you satisfied with her/his freedom to make her/his own choices?
_____Overall, are you satisfied with the care that she/he receives from the employees?
_____Overall, are you satisfied with the friendliness of the employees?
_____Would you recommend this nursing home to a family member or friend?

What do you consider to be the best example of high quality care in the nursing home?

On a scale of 1 to 10, how would you rate the nursing home on this (circle one)?

Low/Poor   **High/Excellent**
  1   2   3   4   5   6   7   8   9   10

Please Explain:

How far must you travel to get to the nursing home?

How would you describe your financial situation (circle one)?

      a. always difficult   d. rarely difficult
      b. usually difficult   e. never difficult
      c. sometimes difficult

The last few questions are demographic ones:

Does your loved one intend to live at the nursing home (circle one):
    1.   permanently or
    2.   for a short time–say a few months?

How long has she/he lived at this nursing home?

Is she/he married? 1. yes   2. no

    (If yes) Does her/his spouse live in the same nursing home? 1.yes 2. no

Does she/he have a room mate?

What is the highest grade she/he has completed in school?

What is her/his gender? 1. female   2. male

What race?

What year was she/he born?

How does he/she currently pay for the nursing home? (If more than one applies, please select the source of payment that pays the majority of the nursing home costs)

a. personal funds   c. Medicare (social security)
b. Medicaid (government) d. nursing home insurance

If you would like to share anything else, please do so on the back of this page. Thank you for your help. Again, your responses will be kept completely confidential.

APPENDIX B

CODESHEET SAMPLE

facility	wave	so_q_no	qual1	qual2	qual3	qual4	qual5	qual6	qual7	qual8	qual9	qual10	qualo	NOTES
07	01	5001												
07	01	5002												
07	01	5003												
07	01	5004												
07	01	5005												
07	01	5006												
07	01	5007												
07	01	5008												
07	01	5009												
07	01	5010												

APPENDIX C

CODEBOOK

High Quality Codes

Questions:
What do you consider to be the best example of high quality care in any nursing home?
On a scale of 1 to 10, how would you rate the nursing home on this? Please explain:

Codes for QUAL1 – QUAL10

01   "good"/ "proper" medical care
02   "caring"/ "compassionate"/ "kind"/ "loving" staff
03   "friendly"/ "nice" staff
04   "personal"/ "one-on-one" attention
05   "capable"/ "competent"/ "qualified"/ "well-trained" staff
06   cleanliness
07   clean resident(s)
08   clean room/ facility / environment
09   resident physical needs met
10   "good" / "hot" / "variety of" food
11   "cheery"/ "friendly"/ "pleasant"/ "happy" atmosphere
12   adequate staffing at mealtimes
13   odor/ smell
14   bright colors
15   happy employees
16   "happy" / "comfortable" resident(s)
17   "activities"/ "stimulation" for mind
18   "activities"/ "stimulation" for body
19   resident needs met
20   "dressed"/ "groomed" resident(s); "personal hygiene" of resident(s) (including dental hygiene)
21   family notification of "incidents"/ "changes"/ "problems"
22   adequate staffing on weekends
23   "balance in medication"/ "correct drug administration"/ "medicine on time"
24   proper therapy
25   consistent care (including consistent assignment of staff to residents - "keeping the same staff on the same halls")
26   staff engagement with residents
27   helping residents do things they cannot do
28   nurse engagement with residents
29   treating resident with "dignity"/ "respect"
30   treating resident gently, tenderly
31   Alzheimer's units
32   "good" attitude from staff / "dedicated"
33   "alert"/ "responsive"/ "attentive"/ "observant" staff
34   staff concerned with resident health/ resident health needs met

35	staff concerned with resident "happiness"/ resident "emotional needs" met
36	good attending physician
37	"well-fed"/ "nutritious" food / "appropriate diet"
38	low staff turnover
39	resident mental needs met
40	security of resident belongings
41	good staff-family communication
42	personal safety of resident/ measures to prevent injury
43	structural features of resident room (e.g., "size")
44	resident privacy
45	adequate staffing
46	staff "concern"/ "care" for resident[s], not specified
47	"respect engagement of family members"
48	resident hydration
49	adequate diaper change, toileting care of resident[s]
50	nurse care of resident[s]
51	aide care of residents[s]
52	structured day
53	activities
54	resident relationships
55	well-supervised staff
56	"homey"/ "home-like" / "family-like" / "treating resident(s) like family"
57	health of resident
58	resident[s] in common area
59	staff work as a team
60	resident self-chooses facility based on experience
61	the "people", staff, not specified
62	medical records up to date
63	structural feature of bathroom (e.g., "location")
64	non-resident opinion of home
65	structural feature of facility (e.g., "age")
66	management responsive, "solves problems"
67	environment, not specified
68	orderly, organized
69	laundry service
99	Missing

CODES for QUALO

1	More than 10 "examples" of "high quality" care listed.
0	10 or fewer "examples" of "high quality" care listed.
9	Missing

APPENDIX D

CODING RULES

**Rules for Coding for Open-Ended "High Quality" Question,
Family Member Questionnaire,**

Codes 04 v. 19 v. 33

Use Code 04 or "personal/one-on-one attention" when:

- Respondent discusses attention given to the needs of patient/resident (mentions them in a singular tense, not as in patients/residents in general)

- Respondent refers to patients/residents receiving attention based on their individual or specialized needs

- Respondent refers to personal care (of patient/resident by staff)

Use code 19 or "resident needs met" when:

- Respondent mentions that patients/residents needs are met, or that staff is taking care of their needs (needs of patients/residents in general, not individually)

- Refers to the treatment of patients/residents in general terms (i.e. "treatment of residents" determines quality)

Use code 33 or "alert/responsive/attentive/observant staff" when:

- Respondent speaks about attributes of the nursing home staff members…specifically if staff is "alert," "fast in response"/"prompt," "attentive"/"notice change/"observant," "check patient(s)"

- Attentive v. attention – attentive is being observant and responding to something; attention, as used in code 04, is not a response

Codes 01 v. 34 v. 57

Use code 01 or "good/proper medical care" when:

- Respondent refers to the quality of the medical or health care that the patient/resident is receiving

- When respondent expresses that medical care is offered or available to patients/residents

Use code 34 or "staff concerned with resident health/resident health needs met" when:

- Respondent specifies that the *staff* is concerned specifically with health needs

95

- Respondent specifically mentions health needs (rather than needs in general, physical needs, etc)

Use code 57 or "health of resident" when:

- Respondent suggests that the quality of the patient's/resident's physical health directly affects the quality of the nursing home.

Codes 46 v. 02 v. 29

Use code 46 or "staff "concern"/ "care" for resident[s], not specified" when:

- Respondent speaks about the act of caring for patients/residents
- Respondent mentions patient care in general terms
- If mentions individualized or personal care, should use code 04

Use code 02 or "caring"/ "compassionate"/ "kind"/ "loving" staff" when:

- Respondent speaks about the personality attributes of the nursing home staff members…specifically if mention staff is "caring," "compassionate," "kind," or "loving"

Use code 29 or "treating resident with "dignity"/ "respect" when:

- Respondent specifically mentions treating resident with "dignity" or "respect"
- Respondent uses other words that symbolize dignity or respect, such as politeness, consideration, making resident feel important, etc.

Codes 32 v. 15

Use code 32 or "good" attitude from staff / "dedicated" when:

- Respondent specifically mentions the attitude of the employee or mentions they are dedicated
- Respondent suggests the staff is sincere about their work and seem to feel that working with the elderly is their calling or profession

Use code 15 or "happy employees" when:

- Respondent mentions employees seem jovial about their work environment; happy to see residents, family members…

Codes 41 v. 47 v. 21

Use code 41 or "good staff-family communication" when:

- Respondent mentions that staff listens
- Respondent mentions that staff contacts family members, as appropriate (but not specific to events or incidents, then use code 21)

Use code 47 or "respect engagement of family members" when:

- Respondent portrays staff as open to decisions, ideas, suggestions of family members or loved ones
- Respondent indicates that staff make meetings/communication convenient for family

Use code 21 or "family notification of "incidents"/ "changes"/ "problems" when:

- Respondent mentions that staff contacts them when a change or incident occurs with their family member/loved one

Codes 01 v. 36

Use code 01 or "good"/ "proper" medical care" when:

- Respondent refers to the quality of the medical or health care that the patient/resident is receiving
- When respondent expresses that medical care is offered or available to patients/residents

Use code 36 or "good attending physician" when:

- Respondent specifically mentions care by a physician or doctor

Codes 25 v. 38

Use code 25 or "consistent care (including consistent assignment of staff to residents - "keeping the same staff on the same halls")" when:

- Respondent mentions staff longevity and how that affects care

Use code 38 or "low staff turnover" when:

- Respondent mentions staff longevity, turnover in general

APPENDIX E

CODE COLLAPSING GUIDE AND RESULTS

Collapsing Data using Bowers, Fibich, and Jacobson (2001) categories:

Care-as-service
- Passing food trays
- Making beds
- Assisting with bathing and personal care
- Focus on technical/instrumental aspects of care (i.e. how well, quickly, consistently work is completed)
- Perceived as purchasers of service and compare with other instances when paid for a service
- Comments suggest patient's have "rights"
- Patients feel they have the authority to instruct staff and should be active in evaluation

Care-as-relating
- Focus on relationship with staff
- Rarely mention actual care-giving tasks
- Affects of caregivers
- Caregivers motivation ("really likes work" or "cares about people")
- Signs of individualized affection…care…etc
- Reciprocity - esp in sharing personal information

Care-as-comfort
- Physical comfort
- Good relationship to ensure timely service
- Physical comfort rather than medical treatment, safety, or routine tasks (make bed, bathe, clothe, etc)
- Focus on little things dealing with comfort (i.e. moving leg into better position)

Reference:

Bower, B.J., Fibich, B., and Jacobson, N. (2001). Care-as-service, care-as-relating, care-as-comfort: Understanding nursing home residents' definitions of quality. The Gerontologist, 41 (4), 539-545.

Table E.1

Collapsed Categories for High Quality Care Codes

Category	Original Code
Care-as-service	01 "good"/"proper" medical care
	05 "capable"/ "competent"/ "qualified"/ "well-trained" staff
	12 adequate staffing at mealtimes
	17 "activities"/ "stimulation" for mind
	18 "activities"/ "stimulation" for body
	19 resident needs met
	21 family notification of "incidents"/ "changes"/ "problems"
	22 adequate staffing on weekends
	23 "balance in medication"/ "correct drug administration"/ "medicine on time"
	24 proper therapy
	25 consistent care (including consistent assignment of staff to residents - "keeping the same staff on the same halls")
	31 Alzheimer's units
	32 "good" attitude from staff / "dedicated"
	33 "alert"/ "responsive"/ "attentive"/ "observant" staff
	34 staff concerned with resident health/ resident health needs met
	36 good attending physician
	37 "well-fed"/ "nutritious" food / "appropriate diet"
	38 low staff turnover
	39 resident mental needs met
	40 security of resident belongings
	42 personal safety of resident/ measures to prevent injury
	45 adequate staffing
	46 staff "concern"/ "care" for resident[s], not specified
	48 resident hydration
	49 adequate diaper change, toileting care of resident[s]
	50 nurse care of resident[s]
	51 aide care of residents[s]
	53 activities
	55 well-supervised staff
	57 health of resident
	59 staff work as a team*
	62 medical records up to date
	64 non-resident opinion of home
	66 management responsive, "solves problems"
	68 orderly, organized
	69 laundry service

Care-as-relating	02 "caring"/ "compassionate"/ "kind"/ "loving" staff
	03 "friendly"/ "nice" staff
	04 "personal"/ "one-on-one" attention
	15 happy employees
	26 staff engagement with residents
	28 nurse engagement with residents
	29 treating resident with "dignity"/ "respect"
	30 treating resident gently, tenderly
	35 staff concerned with resident "happiness"/ resident "emotional needs" met
	41 good staff-family communication
	47 "respect engagement of family members"
	54 resident relationships
Care-as-comfort	06 cleanliness
	07 clean resident(s)
	08 clean room/ facility/ environment
	09 resident physical needs met
	10 "good"/ "hot"/ "variety of" food
	11 "cheery"/ "friendly"/ "pleasant"/ "happy" atmosphere
	13 odor/ smell
	14 bright colors
	16 "happy" / "comfortable" resident(s)
	20 "dressed"/ "groomed" resident(s); "personal hygiene" of resident(s) (including dental hygiene)
	27 helping residents do things they cannot do
	43 structural features of resident room (e.g., "size")
	44 resident privacy
	52 structured day
	56 "homey"/ "home-like" / "family-like" / "treating resident(s) like family"
	58 resident[s] in common area
	63 structural feature of bathroom (e.g., "location")
	65 structural feature of facility (e.g., "age")
	67 environment, not specified
	*High quality codes 60, 61, and 64 were thrown out of the collapsed coding procedures for reasons described in the Methods chapter

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