

1998

## Quality Nursing Care: The Nursing Home Residents' Perspective

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**QUALITY NURSING CARE - THE NURSING HOME RESIDENTS' PERSPECTIVE**

**By**

**Brenda L. Larsen**

**A THESIS**

**Submitted to  
Grand Valley State University  
in partial fulfillment of the requirements for the  
degree of**

**MASTER OF SCIENCE IN NURSING**

**Kirkhof School of Nursing**

**1998**

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## ABSTRACT

### QUALITY NURSING CARE - THE NURSING HOME RESIDENTS' PERSPECTIVE

By

Brenda L. Larsen

The purpose of the study was to determine what nursing home residents consider quality nursing care. The information obtained can provide nurses with knowledge about quality care perceptions in this population. Care thus could be planned and provided that would promote resident centered quality.

For this qualitative study a phenomenological approach was used. The investigator collected data via audio-taped interviews and field note observations. A grounded theory approach was used to uncover residents' perceptions of quality nursing care. The meaning was then disclosed by the process of description and thematic interpretation.

The shared experience of living in a nursing home allowed residents to identify components of quality nursing care with enough consistency to be organized into themes. The most frequent themes were: Staff who Care, Personal Care and Safety, Sociality/ Personal Recognition, Accommodations, Personal Choices, and Family.

## Acknowledgments

I would like to thank Dr. Emily Droste-Bielak, Grand Valley State University Kirkhof School of Nursing, not only for being the chairman of this thesis committee, a supporter of qualitative research, but also as my graduate school advisor. The other members of the committee, Dr. Phyllis Gendler, Kirkhof School of Nursing, for all the positive support and Dr. Margaret Proctor, Grand Valley State University School of Communication, for her expertise and belief in resident rights.

I would like to thank Vivian Kralka, Ph.D., R.N. for all the assistance with review of data. I would especially like to thank all of the residents who took time to share their views, and the nursing home staff who helped to facilitate the interviews. A special thank you to Doug for keeping me focused long enough to complete this project.

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## Chapter 1

### Introduction

#### Background Information

Over the past 25 years, both state and federal regulatory agencies have instituted multiple rules and controls to improve the quality of care for nursing home residents (Fretwell, 1992; Haviland, Jones, Pettengil & Sweeney, 1990). Many of the regulations implemented have changed and improved resident care. Most nursing homes now offer a level of "safe care" (Biedenharn & Normoyle, 1991).

However, Providers of Long Term Care, owners and administrators of nursing homes, are frustrated by continued complaints about lack of quality nursing care (Lorensen, 1992). Even homes that meet and exceed state and federal regulations still hear complaints about lack of quality care from residents, families, employees, and the general public (Loveridge & Heineken, 1988).

Various types of research studies have been conducted that demonstrate poor quality of care in nursing homes (Biedenharn & Normoyle, 1991; Fretwell, 1992; Maraldo, 1991; Tellis-Nayak, 1989; Walker 1991). Few of the researchers offer suggestions for ways to improve quality ( Michigan House Health Policy Committee, 1995; Tellis-Nayak, 1988).

The Michigan House of Representatives Health Policy Committee Report (1995) expressed concern that the federal regulation process is

actually preventing an improvement in quality nursing care. The report states "the survey process (federal regulation) allows control of funds from Medicare/Medicaid - the fear of loss of funds dominates the facility staff. The resident/customer takes second place to the survey process" (p.16). The report goes on to say this type of survey has shown that it neither measures quality of care nor leads to improvement in care in most cases. Evaluation of care gets lost because of the focus of details.

Tellis-Nayak (1988) suggests the problem may be that homes define quality care for residents according to state and federal regulations. So, although they offer "safe care", the residents may not consider it to be quality care. Families and significant other care givers may not use the same criteria to evaluate quality that the resident does (Laitinen, 1992). Laitinen (1992) suggests this may be related to differences in generational expectations. While the resident and family may share the same norms, values and general culture the progress in technology and knowledge increase each generation.

What does constitute quality nursing care in a nursing home or Long Term Care (LTC) setting? "The answer seems simple and commonsensical: you have high quality when the nursing home resident is satisfied with him/herself and the care received" (Tellis-Nayak, 1988, p. 5). Most people would readily agree with this general definition of quality care.

Federal Nursing Home regulations in the Omnibus Budget Reconciliation Act (OBRA) of 1987 focus on the quality of the resident's

life. OBRA views quality care as " . . . a resident achieving and/or maintaining his/her highest practicable level of physical, mental and psychosocial well being" (Haviland, Jones, Pettengill, & Sweeney, 1990). Health care literature supports the importance of providing quality care (Cleary & McNeil 1988; Leming, 1991; Louden, 1989; Michigan House Health Policy Committee, 1995; Munroe, 1990; Redfern & Norman, 1990; Walker, 1991). Certainly academics, politicians, residents in nursing homes and their families all advocate quality nursing care.

With all this attention focused on quality care, the public continues to reflect a concern that nursing home residents generally do not get good quality care. Several problems associated with measuring quality of nursing care may be adding to the general perception about quality concerns. For one, there is a lack of a clear definition about what constitutes quality. There is also a lack of consensus about who is best qualified to judge quality care. Third, quality is a concept that is not easily measured by usual quantitative research methods.

Cleary and McNeil (1988) developed a broad definition of quality care that may be useful to help understand why residents are the most appropriate to evaluate their own quality of nursing care. "Quality health care is a combination of the norms of scientific medicine and the ethics and values of a society or subculture" (p. 26). Residents living in a nursing home form a new subculture that may not be shared by family or friends.

For the purpose of this research, Quality Nursing Care was defined as what the nursing home resident says makes him/herself satisfied with

the care. This broad definition includes technical skills, interpersonal communication, management ability, or other aspects of nursing care.

#### Justification

The use of a qualitative approach to explore how nursing home residents perceive quality nursing care would expand our understanding of quality care, thus allowing identification of problems and solutions to providing quality care. As the primary providers of service in nursing homes, the nursing profession should assist in solving these problems (Peters, 1989). The data that would best serve the purpose are from the consumers of care, the residents (Swanson & Chapman, 1994).

Data have been collected that included patient/consumers' perceptions of health care. The hospital and clinic sites that collected patient satisfaction perception data found the results interesting, possibly useful for marketing purposes. However, patient data was not used to evaluate quality of nursing care, because the patients were not considered capable of evaluating a professional performance (Taylor, et al., 1981). Business departments also considered patient satisfaction surveys as good public relations. Satisfaction studies have been carried out in a variety of health care settings. Study sites include physician offices, oncology and cardiac units as well as acute care hospitals. Some of the researchers include Delbonco, 1992; Erwin-Toth and Spencer, 1991; Leming, 1991; Ludwig-Beymer, et al, 1993; and Pearson, Durant, and Punton, 1989. In a

literature review of consumer satisfaction, no studies were found that were completed in a nursing home.

Bond and Thomas (1992) reviewed the use of customer perceptions of nursing care. They found that data collected were usually used to influence service planning and improve public relations. Most data were used to measure the patient's overall (global) satisfaction, not the patient/consumer's view of quality nursing care. Most literature reflected a belief that consumers were not sophisticated or well enough educated to make decisions about quality care (Cleary & McNeill, 1988; Eriksen, 1987; Prehn, Mayo, & Weisman, 1989). While there is still disagreement about this point, experts are beginning to believe consumers are qualified to define quality care (Brannon, Smyer, & Cohn, 1992).

The medical paradigm in which patients defer all care decisions to the medical provider, without question, is fading because consumers are more sophisticated than ever before. Consumers expect health care providers to allow them to be more involved in decision making and to show greater concern for their needs and wants as individuals (Leming, 1991). Residents in nursing homes are also capable of defining more than global satisfaction. Alert residents, as the primary consumers of nursing care, are well suited to define quality nursing care in their living setting (Bliesmer & Earl, 1993).

Not only is quality care an issue for residents and family, but the concern about poor quality care is having a negative effect on nurses' decisions to enter the nursing home field. In 1989 there was a

63% shortage of nurses in nursing homes. It follows that the prediction of elderly population for 2030 demonstrates a 466% increased need for nursing home nurses (Kuehn, 1991). Data collected from nurses leaving the field cite frustration at not being able to provide the quality of care/quality of life they felt the residents deserved. This frustration was an important factor in their decision to leave (Maraldo, 1991).

In summary, the rationale for conducting this study included:

1. large and increasing numbers of people who need to receive quality nursing home care.
2. limited research available which includes residents' perceptions of quality nursing care.
3. residents, family and nursing staff expressing a lack of quality care despite the current system to improve care.
4. lack of information that would be useful to encourage/retain nurses in the Nursing Home Field.

### Purpose

The purpose of this study was to determine what residents currently living and receiving care in a nursing home, feel is quality care. The information obtained could provide nurses with knowledge about quality care perception in this population of residents. Care thus could be planned which promotes resident centered quality.

### Research Question

What do residents in nursing homes feel is quality nursing care?

## Chapter 2

### Literature Review

A review of literature was conducted to increase the knowledge base to carry out this research. Books, journal articles, documents and research studies were included in the review. Content areas included qualitative research, quality nursing care, perceptions of quality care, acute care settings, outpatient settings, and nursing home settings. A consumer of nursing care in a hospital or clinic is usually referred to as a patient. The consumer of nursing care in a nursing home is usually referred to as a resident. Depending on the research site, either term may be used in health care literature.

#### Quality Nursing Care

Entire books are devoted to the subject of quality nursing care. Several even focus on quality care in nursing homes (Maraldo, 1991; Peter, 1991; Tellis-Nayak, 1988). None of the books reviewed discussed the residents' perception of quality nursing care. Professional journals also included an enormous number of articles about quality care. However, most of the articles offered a definition of quality care, a theory of care, or a model for providing quality care. Only a handful of articles reported actual research on quality care perceptions. The studies published looked at a variety of factors involved with quality care but did not usually include the resident's point of view. Most of the studies were completed in acute care

hospital units and out-patient clinic sites. Only one study was found that was completed at a nursing home site.

Merry (1987) developed a model to measure quality care using both subjective (perceptual elements) and objective (clinical definition) elements. The model included six subjective elements to be rated by consumers and six objective elements to be rated by professionals using available data. The two scales were then combined to form a Perceptual/Clinical Excellence Grid. Health care providers were classified as High or Low on each scale and the results plotted on the grid. Merry selected the six elements for each scale yet stated a weakness in the model as a lack of national consensus for the elements that should be included. She concluded that health care providers (nursing home managers) who do not use both subjective and objective assessment measures may lose the edge in the competitive health care market. Use of both assessment measures should help improve quality resident care. As the health care consumer becomes more educated he/she will be more selective when choosing a nursing home and the home with the better quality will have "an edge" in attracting residents. This model was tested but there was no documentation on use after that.

Brannon, Smyer, and Cohn (1992) reported findings based on a round table discussion by nursing home experts. The discussion focused on obstacles to quality care delivery in nursing homes. The experts concluded that broad based practitioner/researcher collaborations are needed to promote usable research about quality care in the nursing home setting. Findings based on the round table discussion include three



themes about nursing home care. The first was a recognition of the dilemma nursing home staff face. Our society has conflicting expectations about nursing home care. Often the care needed by residents can no longer be provided by family or friends because of the high degree of technical care or continuous nature of the personal care needs. The need to have a family member in a nursing home often comes with a high degree of guilt, anger and concern for both quality and cost of care. The second theme was related to the high ratio of non-professional staff to the professional staff providing care. The third called attention to the power that supervision and leadership have to bring about positive changes in quality care. Brannon, Smyer, and Cohn (1992) support practitioner/researcher collaboration as the best way to promote usable research to improve nursing home quality care. This type of research is especially important because it would help policy makers identify the best practices in both structure and process that can improve quality care.

Some of the literature concluded that there is currently a shift from the medical paradigm to one of consumerism. According to Leming (1991) hospitals, clinics, and nursing homes are just beginning to make the move, while in general, nurses have responded by maintaining a close relationship with the consumer/resident. She concluded that nurses must act as change agents in this process. Resident research will be a necessary part of the process.

Particularly in the area of nursing homes, quality care remains unclear. The literature reflects that changes, made in the last ten

years, to improve quality have not made a significant difference in how consumers view quality care (Long & Krejci, 1991).

In the area of defining quality from the residents' perspective, Tellis-Nayak (1988) states "It is like love, you know for sure when you have experienced it, but you find it hard to describe" (p. 5). She concluded that like love, honor, and beauty, quality is an emotionally laden concept we are seldom objective about. Rather, we interpret it in a personal way.

### Perceptions of Quality of Care

A review of literature relating to patient/resident perception offers a diverse view about the role perception plays in defining quality care. Some researchers (Eriksen, 1987; Loudon, 1989; Oberst, 1987) feel patient/resident perception of quality care equates only to satisfaction. They feel patient/residents are not qualified to define quality care.

Several other research studies focused on residents' perceptions of quality. Cleary and McNeil (1988) completed a literature review on using patient satisfaction as an indicator of quality care. Their report summarized several general theoretical reasons for measuring resident satisfaction. They also noted problems with many satisfaction studies conducted in the past. Global (general) satisfaction was often measured, that included personal care and general feelings about disease states and life quality. The results of such research may not reflect the same outcomes as resident perceptions about quality nursing skills

and use of interpersonal communication. Overall, Cleary and McNeil found the research to indicate that quality nursing care is related to perceptions of technical skills, intelligence, and qualifications of the nurse. The research also indicated perceived interpersonal and communication skills of the health care providers generally account for more of the variation in patient satisfaction than technical skills. Measures of both interpersonal and technical aspects of care may tap a common dimension of satisfaction with quality care but specific instruments do not reliably measure both. Cleary and McNeil further concluded that findings in the literature support the importance of residents' perceptions and the desirability of maximizing resident participation in research studies. They also indicated that there is a relative lack of such studies.

Bond and Thomas (1992) completed a review of studies measuring resident satisfaction with nursing care in acute care and outpatient settings. They concluded there was a wide range of conceptualizations of quality and general lack of rigor in measurement. They further concluded that establishing criterion validity of resident satisfaction through relationships with other health care outcomes, while interesting, is a quantifiable measure of a subjective concept and will not increase validity. Only residents can relate their satisfaction and it will be different even from their families. Finally, Bond and Thomas suggest that where appropriate measures do not exist, the process of developing new forms of assessment may be warranted.

Lorensens' (1992) discussion of health and social support of elderly families came to a similar conclusion, with implications for nursing. She listed conducting research, theory development, and systematic data gathering from the resident's perspective as research areas nurses need to address.

A commentary by Prehn, Mayo, and Weisman (1989) noted that resident perceptions were a valid part of measuring quality care. They reasoned that since quality care is not well defined, residents are the ultimate authorities on all care in non-technical quality matters. However, the writers also support assessment by others, with resident assessment more valid in affective areas of care. Prehn, Mayo, and Weisman (1989) further reasoned: a resident who is satisfied will be more likely to return to the same provider or care setting and is more likely to follow treatment recommendations, further increasing quality care.

At least one third party payment source supports the increasing importance of resident perception of quality care. Starting in 1995, the Medical Services Administration - MSA (1994), of the Michigan Department of Social Services, started paying incentives for Medicare based on continuous quality improvements. The new plan was based on a "social model" versus "medical model" used in the past. A "social model" focuses on resident input and allows consumers of care to define outcome values about living conditions in a nursing home.

The remainder of this literature review includes quality studies in a variety of health care settings. Very few studies were found that were completed in nursing homes.

### Acute Care Setting

Jackson-Frankl (1990) completed a study using ethnographic/ethnoscience individual interviews and a demographic questionnaire. Her goal was to define the language and meaning of quality nursing care. The study participants were randomly selected members of a nursing department. A total of 15 participants were audio taped and a content analysis established based on which words were used to describe quality care. She found tangible (task based) and intangible (internal, value based) components which were carried out to varying degrees by nurses. The results showed nurses with less experience (6-18 months) were so focused on tasks that they were less able to provide intangible quality. Her conclusion has implications for nurse educators and administrators to establish collaborative educational programs that integrate realistic practice with needed theory. This study demonstrated a great diversity in the definition of quality even among professionals. It did not attempt to define quality from the consumer (patient) point of view.

Eriksen (1987) reported a descriptive correlational research study conducted to ascertain if there is a relationship between quality of the "nursing care process" and patient satisfaction. Patients and nurses from one medical center were included in the study. The quality of nursing care process was measured by the Methodology for Monitoring Quality of Nursing Care (MMQNC), developed by Jelinek, Haussmann, Hegyvary and Newman (1974). It looked at six objectives - 1) plan of care is formulated; 2) physical care is attended to; 3) the non-physical

needs attended to; 4) achievement of nursing care objectives is evaluated; 5) unit procedures are followed to protect all patients; 6) the delivery of care is facilitated by administration. Four randomly chosen registered nurses completed the MMQNC. Patient satisfaction was measured by The Patient Satisfaction with Nursing Care Check List (PSWNC) formulated by Abdellah and Levine (1957). One hundred thirty-six randomly selected patients from several units of a medical center completed the PSWNC. The results showed an inverse relationship in all six objectives of the MMQNC. In other words, "The results of this study do not support the presence of high positive and significant relationships between the quality of nursing care, as measured by MMQNC, and patient satisfaction with nursing care, as measured by the PSWNC" (Eriksen, 1987). Eriksen (1987) listed implications of the study as 1) Data from patient satisfaction should not be the sole evaluation of quality of nursing care. 2) Nurses in practice need to be concerned about extending social courtesy and service to patients. 3) Adhering to procedure and policy without individualizing care may result in dissatisfaction with nursing.

Laitinen (1992) reported on a qualitative study of 18 elderly hospital patients and seven family members in three different hospitals. The study was completed as a pilot for a three year action research project. The three aims of the study were 1) test reliability and validity of the measure used; 2) investigate current participation of caregivers in hospital care; 3) evaluate and compare the quality of care from both the patient's and caregiver's points of view. The last area

was of greatest interest for the proposed study. During the study patients were interviewed and informal (family vs. professional) caregivers were mailed questionnaires that covered five areas of care. The five areas measured were - 1) physical care; 2) physical and psychic; 3) mainly social; 4) psychic and spiritual, and 5) interaction, communication and social support. Statistically significant differences ( $p < 0.001$ ) were found between the patient and caregiver in the categories - social needs, and psychic and spiritual needs. According to Laitinen (1992), "the results support earlier findings that elderly patients are more satisfied with and do not criticize their care. The younger generation (i.e. their children) is more demanding and has precise perceptions about the care given". Laitinen goes on to suggest this trend could be related to shared common values and understandings of the sick role by the older age group (average 75 years). Since most studies do not reference the subjective experiences of care recipients or the extent to which the care they receive meets their needs, this study and the recommendations are meaningful. The study was small, 18 patients, but the tool used (a questionnaire administered by master's level nursing students) and reliability and validity of the measures were thoroughly carried out and explained (Laitinen, 1992).

Sellick, Russell, and Beckman (1983) reported on a study of patients' perceptions of care compared to nursing staff job satisfaction on a unit where primary nursing was the intervention. Twenty eight patients and 17 nurses on the primary care unit took part. A control

group of 31 patients and 20 nurses on a traditional, functional care unit also took part. Patient satisfaction was measured with a questionnaire. Staff satisfaction was measured with a likert scale of job satisfaction. The results provided some support for the hypothesis that patients nursed under a primary system were more satisfied (Sellick, Russell, & Beckman, 1983). Also mentioned in this study was the patient perception of more individualized care under the primary system. The nurses' job satisfaction was greater with primary care for the majority of items on the scales used. The researchers noted difficulty controlling for extraneous variables in exploring quality of care questions in the clinical field and felt the instruments they used fell short of providing the qualitative data they had hoped to collect (Sellick, Russell, & Beckman, 1983).

In Oxford, England, Pearson, Durant, and Punton (1989) completed an eight month study of 164 elderly (age 60 and above) patients. All had been admitted to an acute care hospital. Patients were randomly assigned to the treatment or control group. The treatment group was transferred to a unit where therapeutic nursing was the focus (n=84). The control group remained on the usual acute care unit (n=73). The researchers' goal was to determine quality of nursing care in a nursing unit that focuses on therapeutic nursing compared to the usual acute hospital unit. Three data collection visits were used to determine the perceptions of care as expressed by the patients. The first interview was at the time of discharge, then six weeks and six months after discharge. The researchers reviewed multiple instruments to measure



quality care. However, they felt none were adequate to measure the complex concept of nursing care. To improve the meaningfulness of the data collected, a selection of tools was used. The following measures were incorporated: a) a nursing audit applied retrospectively [Phaneuf, 1976, in Pearson, Durant, & Punton, 1989], b) a patient service checklist [Hall et al., 1975, in Pearson, Durant, & Punton, 1989], c) open-ended questions, d) a life satisfaction index [Neugarten et al., 1961, in Pearson, Durant, & Punton, 1989], e) a nursing dependency index [Garraway et al., 1980, in Pearson, Durant, & Punton, 1989], and f) unsolicited letters were also collected and compiled. Quantifiable data were computer analyzed and open ended replies and spontaneous comments were transcribed and categorized on the basis of common themes. The researchers felt the failings of one method would be compensated for by the advantages of the others. They termed this triangulation. At the conclusion of the study the researchers supported this type of combination assessment as the most appropriate to measure both process (patient interaction with nurse) and outcome (patient recovery and general satisfaction with care). Pearson, Durant and Punton (1989) made the following recommendations:

1. Measurement of quality should be based at least in part on the values and expectations of the customer (patient).
2. As the health care delivery system is altered to meet economic and personal needs, measures to monitor quality become increasingly significant.
3. Competent, caring nurses are essential for quality care.

This study supported the need for more qualitative research in the area of quality care.

#### Outpatient Settings

An outpatient enterostomal (ET) therapy clinic was the site for a study of patient perception of quality (Erwin-Toth & Spencer, 1991). Fifty-two volunteer subjects were asked to complete an 87 question instrument that was developed by a board-certified ET nurse. The questions were mostly multiple choice and several were open-ended. The questions were divided into three areas. The first section surveyed the time during hospitalization and included satisfaction with the pre- and postoperative teaching, counseling, and level of ostomy care at discharge. The second section reviewed the first six weeks postoperatively. Questions surveyed adjustment problems - both self-esteem and physical problems. The last section looked at current status. Areas surveyed included level of ostomy self care, return to normal activities, adjustment, and management difficulties. The survey also asked for the single factor most important to adjustment. The entire survey was completed at the clinic, while patients waited for the followup appointment. The conclusion showed two benefits for patients - the chance to assess their level of satisfaction and to air their concerns. Limitations of the study included small size, a lengthy survey form and the lapsed time between surgery and completion of the survey. The survey did not have established reliability as it was constructed to evaluate parameters at a particular institution. It was

found that answers to open ended questions yielded much information, but was hard to fit into the summary of the data.

Oberst (1984) completed a similar project with 20 patients receiving chemotherapy at an outpatient clinic. A six part questionnaire was used. Patient perception of quality was assessed by using five visual analogue scales. The scales asked: 1) did the overall care meet expectations, 2) were you satisfied with instruction for discharge, 3) were you satisfied with informing about your illness, 4) quality of nursing care, 5) quality of medical care. The mean analogue measurements for scale 1) 62.95; 2) 56.15; 3) 63.40; 4) 81.75; 5) 76. This means the higher the measurements, the greater the satisfaction level. Because of the small numbers involved, no tests of statistical significance were performed. The conclusion of the study indicated a need for patient expectation to be included in a quality review. The problems with this study were a lack of definition of quality care and the lack of established validity of analogue measures of patient satisfaction and perceptions. The researcher felt with more work, the analogue scales could be field-ready and a useful tool.

Delbanco (1992) reported on a study in progress. The study invited patient perceptions of seven dimensions of patient care in an office setting. The dimensions were chosen by health care professionals based on review of literature. The seven were reviewed by eight focus groups of patients and professionals to ensure the items were those most salient. The result was an instrument - Elements of the Patient Review. This survey instrument can be used to gather aggregate feedback

about the quality of provider practice. The author states the expected use as incorporation into the clinical encounter (office visit). The seven areas are: 1) respect for patient values; 2) communication and education; 3) coordination and integration of care; 4) physical comfort; 5) emotional support and alleviation of anxieties; 6) involvement of family; 7) continuity and transition. No data had been collected at the time of publication of the article. Delbanco (1992) did state reasons for the study as 1) need to individualize patient care and 2) to improve the quality of practices. Note that the dimensions were chosen by the professionals not the consumers of care (patients).

#### Nursing Home Setting

One of the few research studies carried out in a nursing home setting was by Bliesmer and Earle (1993). The study used 17 Quality Care Indicators (QCI's) identified in 1985 by the National Citizen's Coalition for Nursing Home Reform (NCCNHR). The specific quality indicators were the following: (a) good staff attitude, (b) prompt attention, (c) homelike atmosphere, (d) privacy in room, (e) variety in food, (f) broad range of activities, (g) daily activity choices, (h) physician availability, (i) privacy with physicians, (j) room cleanliness, (k) bathroom cleanliness, (l) strong administration, (m) practice of religion, (n) respect of rights, (o) opportunity for community activities, (p) vehicle transportation, and (q) problem resolution.

A total of 30 residents who were randomly selected from two nursing homes completed one of two similar instruments (5 point scales) to rank the importance of the QCI's. While the same QCI's were identified as in the NCCNHR study, the ranking was different. The indicators found most important by residents in this study were 1) good staff attitude; 2) bathroom cleanliness; 3) privacy in room; 4) prompt attention; 5) opportunity to practice religion. This study further compared the rankings by residents to staff and found significant differences in resident-staff perceptions. Fifteen staff (5 each registered nurses, licensed practical nurses and certified nurses aides) from each home (n=30) completed the same instrument as the residents. The indicators found most important by staff were: 1) homelike atmosphere; 2) good staff attitude; 3) opportunity to practice religion; 4) prompt attention; 5) privacy in room. The researchers stated the implication for nursing is achieving an understanding of what are true indicators of quality to residents. This is necessary to ensure that residents' perceived needs, not the needs of staff, are met. They further concluded that quality must be defined in specific terms, even though it is a product of many factors.

Redfern and Norman (1990) looked at quality of nursing care as it fits into the larger picture of "quality assurance," cost effectiveness, and allocation of resources and came up with the following definition. "Ultimately [quality care] is a social construct negotiated between providers of the service (health care professionals), recipients (patients or clients and their families), and those who control the resources (general managers, planners, and governments).

### Literature Review - Summary

Some experts feel a literature search in qualitative research should not be done prior to data collection. It was suggested that knowledge gained would introduce bias into one's analysis. However, Morse (1994), made a logical conclusion about the choice to do a literature search before a qualitative study. "How do you know if a problem research question is really a good question, if you do not search to see if anyone already knows the answer . . . Ignorance does not ensure insight." The present literature review supports the need for resident-centered definitions of quality nursing care. It also suggests that nursing is the appropriate discipline to carry out the research (Leming, 1991).

A review of this literature demonstrated a real concern by the researchers about the quality of care residents in nursing homes receive. It also revealed the importance of including resident/consumer perceptions in defining quality nursing care. The literature supports the importance of including resident-centered definitions as a way to improve quality nursing care. Some research reviewed looked at patient satisfaction. A few studies surveyed patient perceptions of quality care. The study settings were acute care and outpatient departments. Only one study was found that asked residents in a nursing home about their idea of quality care. In view of the very limited research from nursing home residents, it is appropriate to gather those data. Resident perceptions will help define nursing quality care for nursing home residents which can influence nurses to facilitate the changes necessary to improve quality.

## Chapter 3

### Design

For this qualitative research a phenomenological approach (Swanson & Chapman, 1994) was used to gather residents' perceptions of quality nursing care in a nursing home. A pilot study was completed to help determine an appropriate question to ask to assist residents to define quality nursing care. A random sample of 20 residents were asked either, "What three things would you say are most important to make good quality care in a nursing home?" (N=10) or "What three things would you say are most important to make good quality nursing care in a nursing home?" (N=10). In the first group, none of the top three responses were related to direct nursing duties. In the second group 2 of the top 3 responses were direct nursing care. All the responses could be related to nursing care when taken in the broader sense of nursing. The results seemed to demonstrate that alert residents who live in a nursing home are able to define quality nursing care for themselves (Larsen, 1994). The investigator then interviewed residents using a grounded theory approach to uncover the perceptions of residents related to quality nursing care.

Data were collected using audio-taped interviews and observation with field notes until a point of saturation was reached. Saturation was defined as data adequacy and operationalized as collecting data until no new information was obtained. The quantity of data in a category is not theoretically important to the process of saturation.

Richness of data is derived from detailed description, not the number of times something is stated. Researchers cease data collection when they have enough data to build a comprehensive theory, that is, when saturation occurs (Morse, 1995). The researcher used interpretive analysis of notes to discover similarities and differences among data and placed them into categories. The meaning was then disclosed by the phenomenological process of description and thematic interpreting.

#### Protection of Human Rights

Residents were given assurances that the choice to participate or refuse would in no way affect their care. Subjects were assured of anonymity by use of a number identification only. Confidentiality was maintained at all times and tape recordings were destroyed when the research was completed. All information was used for educational purposes only.

Risks were minimal using the procedure to protect human rights. A potential benefit to residents who participated in an interview was the increased self-esteem from being able to express their views. Another benefit was the potential to have their views improve care for others in nursing homes.

The major risks identified for subjects were use of their time and possible fatigue or anxiety related to possible repercussions because they expressed honest views. The interview would have been discontinued if a resident displayed any untoward symptoms (stated anxiety or fatigue). The interviewer was a registered nurse with twenty-five years of patient care experience. The interviewer's



education and experience with geriatric patient assessment and care allowed early detection of untoward symptoms detected in any subjects. Reassurance and nursing support were available, from the interviewer, as well as regular nursing staff, throughout the interview process. If symptoms had occurred, appropriate nursing actions would have been initiated (stop interview, offer reassurance, notify usual nursing staff). If the interview had been stopped related to anxiety response, fatigue, or any other reason, that subject's interview information would have been reviewed for appropriate inclusion in the research data. Residents' time and energy was conserved by limiting interviews to approximately 15 minutes in length. The 15 minute length was based on experience with a prior "mini study" that used resident interviews to collect data. Most residents completed their views in less than 15 minutes and were not fatigued. If a resident had more thoughts to express than possible in 15 minutes, the interview was extended as necessary to facilitate the data collection.

The consent form (see Appendix A) further assured residents of these protections. The consent was read to them, questions answered, and consent forms signed. Those who did not wish to participate were thanked for their time.

Approval for human subjects use was obtained from Grand Valley State University (see Appendix B). Written permission was then granted from the nursing home corporation (see Appendix C).

### Settings

Two Northern Michigan nursing homes were used for data collection. The settings were similar, small town to rural. Both homes are owned by

corporations and are for profit homes. Nursing care at both sites is provided by registered nurses (R.N.) and licensed practical nurses (L.P.N.) as charge nurses. Most of the direct care is provided by competency evaluated nurse assistants (C.E.N.A.). Other providers of care include activity and physical therapy staff as well as beauticians, dietary, housekeeping, maintenance, administrative staff and volunteers. Other care providers are included because the study was from the residents' perspective. It was found that residents often consider a broader group of care givers when they refer to nursing care.

Nursing home A had a 120 bed capacity. 118 were occupied during the interviews. Ages of the residents in home A were 57-98 years. Males comprised 39% (47) of the residents, females 61% (71). Nursing home B had a 70 bed capacity, 68 were occupied during the interviews. Ages of the residents in home B were 28-101 years. Males comprised 32% (21) of the residents, females 68% (47).

### Sample

The recruitment of subjects was arranged through a nursing consultant for a multi-nursing home corporation in Michigan.

Residents who met the eligibility criteria of 1) over the age of 60 years, 2) have lived in the nursing home a minimum of two months, 3) ability to understand the consent process and research question, 4) able to speak and read in English, 5) oriented to person, place and time, and 6) state of health not negatively affected by an interview were allowed to participate.

Because a purposive sample where subjects are picked to provide

the greatest range of differences was not possible, a convenience sample was sought. A total of thirty-two residents volunteered to be interviewed. Three were too young to meet the criteria, three refused when they were asked to sign a consent form for the interview. The total number of subjects sufficient to reach category saturation was 26, 73% were female and 27% were male. Interviewee ages ranged from 68-99 years. Twenty four residents were Caucasian, two were Native American. For characteristics of sample interviewed see Table 1.

### Procedure

Appropriate individuals at the facilities were informed of the research, including dates for data collection and staff and resident expectations. The investigator was introduced to potential subjects in Home A by the Activities Director and by nursing staff in Home B. Introductions were to small informal groups and individual residents. After consent was obtained, individual interviews were conducted in a setting agreed upon by the subject. Privacy was encouraged to empower the resident to speak freely. The researcher presented herself as a graduate nursing student who was gathering information about perceptions of quality nursing care in a nursing home.

The researcher asked one open ended question: What do you feel is quality nursing care in a nursing home? The interview then continued until the resident completed his/her view of the question. Positive interpersonal communication techniques were used by the interviewer to help the resident clarify his/her response.

This type of interview process is an interactionist approach in which the researcher seeks out claims, concerns, and issues of the

Table 1

## Characteristics of Sample Interviewed

| Characteristics                                      | Home A<br>Section 1<br>N=10 | Home A<br>Section 2<br>N=7 | Home B<br>N=9 |
|--|-----------------------------|----------------------------|---------------|
| Average Length<br>of Stay                            | 3.5 yrs                     | 2.5 yrs                    | 2.0 yrs       |
| Age Group  |                             |                            |               |
| > 90 yrs   | 7                           | 1                          | 1             |
| 80-89 yrs  | 1                           | 4                          | 8             |
| 70-79 yrs  |                             |                            |               |
| < 70 yrs   | 2                           | 2                          |               |
| Resident with<br>Greatest Number<br>of Years in Home | 32                          | 11                         | 24            |
| Race   |                             |                            |               |
| Caucasian  | 10                          | 7                          | 7             |
| Native American                                      | 0                           | 0                          | 2             |

residents. By using the interactionist approach, the researcher, through dialogue, is open to multiple realities of residents and their interpretation of the world (Swanson & Chapman, 1994). In qualitative research, prediction of variables, and preselection of methods or instruments is not possible because the variations are put forth by the resident, during the interview. What is required is observation and interaction by the evaluator. Interpretive analysis occurs concurrently with data collection (clue and cue) and the final product results from the process generated with the resident. The data can best be collected by using the presuppositionless interview of descriptive phenomenology. The meaning can then be disclosed by a combination of describing and thematic interpreting (Swanson & Chapman, 1994).

Each resident completed a single interview which was audio-taped. The interviewer made field notes during the interview. Field notes included a great variety of information, for example, sex, length of time in a nursing home, non-verbal expressions, time of day, where interview took place and who was present. While privacy was encouraged, each resident chose his/her own interview site. Interviews were held in private offices, resident rooms and central areas like the dining and activity areas. While most chose to have a private interview, several had family present and several others included roommates in their comments.

The data were collected during 3 days of interviewing. Ten subjects were interviewed on day one, Home A Section 1, N=10. Seven subjects were interviewed on day two, Home A Section 2, N=7. Nine subjects were interviewed on day three, Home B Section 3, N=9.

## Chapter 4

### Data Analysis and Results

#### Analysis

The taped interviews from Section one were transcribed and combined with the field notes. The data were analyzed, by the interviewer, using the constant comparative method. Responses were examined for key words or thoughts that described the concept of quality nursing care in a nursing home. Data bits were placed into groups that seemed to be similar. This was accomplished by color coding similar data bites. Each new group of data bits was then compared to previous data bits that seemed to be the same. As a theme of the group of like data bits began to emerge, a note was written to possibly explain the similarities in properties. The notes were found to add non-verbal emphasis residents often used to express the most heart felt responses. The process was repeated with two and three.

#### Peer Review

The reviewer, a doctorally prepared registered nurse familiar with qualitative research, was informed of the plan to use the constant comparative method. Unmarked transcripts of the taped interviews and field notes were provided one interview section at a time. At the conclusion of each section the reviewer identified common themes based on her grouping of data bites. The reviewer's groups and themes identified were then compared to those of the interviewer. Identified

themes were not always given the same label but data bite groups were found to be consistent with those of the interviewer. At completion of the second group the reviewer noted, "Major points keep coming up." To assure saturation had been reached a third group was interviewed and analyzed. It was agreed that category saturation had been met. The peer reviewer themes were compared to the themes independently identified by the researcher. It was found that the themes were very similar. See Table 2 for Themes Identified.

### Outcomes

Review of the data from the first two sections demonstrated similar groups of data bites. Themes were present. Had saturation been met? To assure saturation, the third section, from Home B was interviewed. No new data bite groups were found. Saturation had been met. Data bite groups were organized into six themes labeled as: Staff Who Care, Physical Care/Safety, Sociality/Recognition, Choices, Accommodations and Family. The nursing profession has long considered the first three themes part of nursing's role. Themes four through six have not usually been considered part of nursing. In a more global view of the nursing role, (in the residents' perception of nursing) they need to be included.

Accommodations was the most often mentioned theme, and often was the first area a resident would talk about. It seemed to be a "safe" area for residents to talk about whether positive or negative. Usually the comments were short. Examples of comments include, "I like being able to have my own phone." or "We need to have more bingo days."

Table 2

Themes Identified by Interviewer and Reviewer

| <u>Setting</u>              | <u>Interviewer</u>   | <u>Reviewer</u>  |
|-----------------------------|--|--|
| Home A<br>Section 1<br>N=10 | Roommate Choice<br>Family<br>Activities<br>Personal Care                                 | Choice<br>Being Needed<br>Independence<br>Respect                                |
| Section 2<br>N=7            | Feel Safe<br>Choices<br>Staff/Encouragement<br>Family<br>Social Contacts                 | Feeling Safe<br>Choices<br>Staff Who Care<br>Family<br>Independence              |
| Home B<br>Section 1<br>N=9  | Choices<br>Respected<br>Personal Care/Need Met<br>Staff Personalized Care<br>Cleanliness | Choices<br>Staff Who Care<br>Feeling Safe<br>Get out into<br>Community<br>Family |



Personal Care and Safety also covered a large area of content. This area was mentioned more often and in greater detail by the more physically dependent patients. Most residents cited increased safety at some level as a reason for being in a nursing home.

The importance of Sociality/Personal Recognition come from the number of comments but also from the lengthy, detailed accounts of even the slightest positive recognition.

Personal Choices were actual choices the resident made. Even more than the comments, the non-verbal (often defiant) expressions conveyed they were so proud about having the right to make a decision.

Family themes included the importance of family contact, the lack of it and suggestions for nurses to encourage more family contact with the residents.

Staff Who Care was a frequent theme. The stories related often brought tears or laughter as fond memories were relived. The number of data, length, and emotion shown demonstrated on many levels the importance of this theme.

#### Themes Defined and Supported

##### Staff Who Care

This theme refers to the therapeutic use of interpersonal communication, by the Staff, which promotes human dignity. The following are examples of how residents view this as quality nursing care.

A resident in the home eighteen month stated:

"The important thing is care. The kind of nurses they pull to take care of us. I can't say anything bad about it because the aids are so busy. They can't always come when you call. You have to wait but if they are nice that's okay."

A 91 year old resident who had live at the home about 10 years was eager to tell of he experience:

"I didn't feel like getting out but one of the male nurses here, I don't know his last name but he was so considerate of an older person, it was funny. They wanted us to get on a float in the parade. I said I wasn't nice enough, well he got me ready and even got me my own cushion for my wheelchair - see this blue one. We had great fun."

From a 90 year old who lived in the home two years:

"I don't mind (being here). The help is good, they help you out with things and the good ones ask you what is wrong or something like that. It makes it better."

A 65 year old resident of 4 months had this to add:

"The nurses themselves! It's a two way thing but their individual personality. I get along with most of them but not everyone is alike."

A 68 year old man who had been in the home about 9 months had this to add:

"They take good care of me. I tease and they tease back. That's what keeps me going some days. They are sort of a second family."

Other residents added these comments. "The nurses are real nice, most of them anyway." "Some of them are good, some of them aren't. I could teach some of them a few things." "What I think is one day is like the next but the nurses are nice, so I think that's about it."

"The nurses always come and help me out, even when it's night and they are tired." "The doctors are in and out but the nurses they care. They

take care of you, so I don't have any problems." "I know the help here is great. They are very good and very kind." "People here don't make you feel needy." "I can always talk to the nurses I like and I guess they like me too." "I knew the care was good, I know some people who were here so I knew a little about how the nurses work before I picked this place."

An 89 year old lady who lived in the home 6 months expressed her example of Staff who do not care, that did not leave her feeling very happy. It concerned wanting the bedspread only one thickness as the extra weight hurt her legs:

"She said (the nurse) 'we can't do that because your spread can't touch the floor.' I said well tuck it in then. I don't want double. So she is mad at me."

Some residents had negative experiences to relate about the staff who don't care. A 68 year old gentleman who had spent 24 years in nursing homes added this:

"One thing is the aides themselves. They just don't do things like for instance, leave the glass where you can reach it, they don't remember they leave you on the bed pan. They need someone to follow them. They (nurses) tell them - you do this, you do that and that's it. They don't follow them to see if they do it or not."

#### Personal Care and Safety

This theme refers to physical nursing care and the feeling of being secure or free from harm. There was noted a relationship between this theme being mentioned and the level of care needed to meet basic

needs. Residents who required more physical care mentioned this more often.

A resident in the home for 9 months who needs total care expressed quality nursing care like this:

"They take good care of you - keep me clean, a bath two days a week, I get to pick Tuesday. They shave me clean too. I don't have an appetite but they feed me. They try to get my bowels regular too - so I don't need an enema. The nurses turn me over too. I have some sores on my rear end. They are hard to heal and sore too. I had an air mattress but it didn't help so I told them and they got me a new pad. It really does feel a lot better - they really do care."

An 88 year old lady who is wheel chair bound added this comment. "The care is OK - but sometimes faster would be better. Sometimes it's kind of bad to wait to get by - you know like the toilet."

Another lady had lived in the home 2 years. She expressed sadness at moving away from her life long home to this area so she would be near her children. "Yeah, it's hard on me. It's better for me here, it's safe. The doctor comes here whenever I need and the help is good. It's much safer than when I was by myself."

Another female resident who needs a lot of physical care, has been in the home about 10 years and adds this idea. "This is a wonderful place. Sometimes the girls don't do what I think they should do. I report them too. It's OK, the nurses take care of it."

A 65 year old who could get around with a walker had different care in mind. "They take care of everything, I love it here. The beautician comes three days a week. They cook all the food too. So now I eat - at home I just couldn't."

One 70 year old lady who had lived in the home 3 1/2 years summed it up. "Well you have your food, you get your baths, you can do whatever you want to do, and if you are smart enough you can get real friendly with the nurses. The nurses are very nice, I think. They take care of my medicine. I just take it, I got a bunch of it."

Some other comments included - "I would rather be in . . . but my family is here and this is safer." "I don't have to worry about fixing my own meals." "I couldn't get a doctor where I was. I came here so I get the help." "They have been awful good and anybody helps with anything. She (indicates roommate) is always right here and we need things so we just call for help."

Even more negative comments related to this theme. "I need their help. I want to tell you about that one (points to another resident) he needed the toilet but they were running back and forth, he needed help too - so he fell trying. I know how he feels."

#### Sociality/Personal Recognition.

This refers to the association with others, or the desire to form social groups and to get special notice or attention.

An 83 year old in the home almost 10 years discussed what she thought was quality nursing care.

"You have somebody around all the time, at home you were usually alone. Especially at night. I had home nurses but its not like everyday. I stayed with my son - he had to work and my daughter sells Avon so she is gone all day too.

"I don't have too much family. A cousin in . . . , she helps out.

Mostly I have a lot of church people pop in. I've lived up here since '47 so I know a lot of people here," was the comment from a 91 year old who had lived in nursing homes since 1965.

A 91 year old lady who was busy making potholders and hats for a bazaar added, "You are important here. You have jobs to do."

A 94 year old gentleman, a resident for 4 years noted, "My family is kind of gone. I have one son, he is here too. We are in the same room. He has been here 10 years . . . . I don't care for people much but I sure like the dog."

A female resident who didn't like to go out of her room much excitedly showed me a picture and told her experience:

"I got to tell you. One day Kay come in here and the dog followed her naturally. I was setting on the bed and the dog jumped on the bed and laid down. I said that was all right. He cuddled up to me and I put my arms around him. Kay got her camera and took the picture."

A 76 year old gentleman in nursing homes 14 years excitedly showed me his keys and wallet. "I have a special employee badge. It's from the maintenance men. They let me help them. I even have a key to their office."

A lady remembered, "I had a recipe for a special cake I used to make - well the Speech Therapist took it home and made one for me. It was a surprise!"

One 68 year old male resident who is wheel chair bound talked about his interaction with another resident:

"I had one lady, she was 86, she brought me all the way to my room. She looked so old. I didn't want her to so I said you can't do that. She said 'I bet I can.' So she shoved me all the way, and then we both laughed."

One 83 year old man looked fondly over at his much younger, total care, roommate and said:

"He can't even talk. It's a dirty shame too, a young man like him. And his mother died. I promised her I would look after him the best I could. All I do is reach up and pull the cord if I hear him struggling to breathe. They come right in and pump him out."

Another resident smiled as she recalled, "they won't let the dog in the dining room but once in a while he will sneak in and somebody will feed him and by gosh, they don't forget." A bed bound patient also enjoyed the contact. "Kay comes in to visit me and she brings that big dog. He is strong and he is smart."

One resident noted how he felt about his care when he lacked personal recognition:

"If they take care of the little things the big things fall in place. (They) need to watch what they say like 'I'll be right back' and sometimes they never come back. It's hours and they say 'well I got busy with so and so and I couldn't come back.' Like you don't matter as much."

### Accommodations

This theme refers to things (other than personal care) supplied to satisfy resident needs (room, meals, activity, etc). The data bites for this theme were about equally positive and negative.

One 70 year old lady was listing various activities that made it a quality place: "My sister came down to see me the other day and I told her I felt like doing the funky chicken. I ain't that bad, I tell ya."

You wiggle your arms and feet. I told her we have pretty good time here at the dance we had at the pig roast."

An 83 year old in the home 10 months had this to say. "My family only manages to come once a week. They have things to do here to help pass the time, like playing bingo and things."

A 91 year old, a resident almost 10 years, quite excitedly told me what she thought made quality nursing care. "Oh yeah. I went with the bus load over to the fair in . . . and I came up from that ferris wheel!" Shakes her head and laughs, " And I was on the float in the parade, too, for the Fourth of July."

Other positive data include, "The accommodations, I have my own small refrigerator and my family brings in food. I have my own phone and chest too." "The big TV, especially football. That is real life." "Good meals, they have two of the best cooks in the Country." "Bingo, we have it 3 times a week but I would like it maybe 5 times." "I can read or go to the dining room. They always have something for to keep busy. That's it, something to keep busy." "If you can't get there by yourself, they take you in their company van. So it makes it easy." "I love the birds and the dog. We used to have fish but one of the wanderers broke the tank." "It's clean and it smells nice. The last place I was you would not believe." "The things brought from home. Like my bear and dresser." "It's important that I have a quiet place."

Some comments were more critical. A 94 year old male who had lived in several homes had this to say. "I worry all the time about my things. You need a way to lock some of it up. I've had a lot stolen,



like razors and socks. Not here but other places I've lived."

A very alert 83 year old lady commented on quality nursing care this way. "It's pretty good. Wanderers come in by your table and stuff once in a while but not too bad. You can look for that."

Another resident commented about the same concern. "We need more protection from wanderers. I woke up and one was sitting in my chair looking at me. I told her to 'go on' and she did."

A 68 year old confined to a wheel chair added this. "It's a pretty good place but the rugs. It takes me too long to get over them. And the dining room has a hump. I can't get up it. I have to get help every time."

A 90 year old who had been in other homes noted, "I liked my last home better, nurses, doctors and everybody was in the halls talking. But its so different here, everybody is to themselves. There are no places to get together to talk."

Some other general comments. "The rooms could be a little bigger, but I suppose that's out of the question." "Roommates are pretty important. I've had some they had to move out because they were just driving me up the wall." "The food is good. I don't like it they keep track of what I eat and they send me snacks." "It's hard to get used to the small space."

### Personnel Choices

This theme refers to the individual's power to select an option. Some resident references include, "My own doctor, he comes here once a month." "I don't like to go out so they let me be a homebody." "This

is a wonderful place, it makes a difference which home you're in, I guess."

A 70 year old who was a 3 year resident expressed his concern. "The most important thing was to get to pick the place. I had to know the area."

A 95 year old had been a resident just 4 months but had a 'bad experience' in a prior home, felt choice was very important:

". . . I knew someone here and they liked it here and everything, so it was a whole lot of things together to decide. It's near my daughters, it's clean, the food is good. I have my own doctor. Yep, this is the one his mother was in too. She was here. It's expensive but the conditions up there (a prior home) are not what you would like to live in, that's another thing."

A 65 year old lady in the home a few months felt quality nursing care meant choice.

"Oh yeah, I get even to stay up in the middle of the night, I want to stay up, I stay up. I want to lay down when I want to lay down and so on. I set my own schedule."

Another resident put it this way:

"My son thinks I love to get out and mingle with people but I don't know, I never was a big socializer and so I just can't get in crowds and do a lot of talking. I have a choice to go to activities or not. I don't. I like quiet times."

Another resident added:

"It's important you know, they give you a choice that if you don't want to do it, you can refuse but they still offer you stuff again, in case you want it."

One female resident put her view of quality nursing care this way, "Well, we do have a choice and that makes it kind of nice to be able to do that. I pick what I want and what I don't want. That's it for me. I don't know if it is for everybody, but for me it is."

### Family

The next theme may not be direct nursing care but when asked the research question, a large number of residents answered family. This refers to a group of people related by common bonds.

Following are some typical resident responses related to family. "I liked it where I was but my son wanted me to be closer to him. I agreed with him. Now he comes to see me every day." "Oh my God, it helps that we go out to lunch once in a while or like that you know. Yeah, with my girls." "My son moved me down here to be closer to him. It works out great. My son is here a lot and he takes good care of me." "My family brings me food." "I have people around, oh yeah, my family." "Family, they are important. Most of mine is gone. I have 2 nieces and 3 nephews. The one down by . . . has been awful good to me." "They take my clothes and bring them back all done up on hangers. My boys do that." "Oh my daughter comes and picks me up. My son comes and picks me up. Sometimes I go stay overnight." "I have got 2 sons and another daughter. They all manage to get in once a week."

Another theme mentioned by several residents were the attitudes of some of the other residents. Some residents lack the ability or willingness to make changes, the flexibility needed to live in a group setting. One even suggested new residents "need a lesson in positive attitude."

## Chapter 5

### Discussion and Conclusions

The subjects of this study were able to express and relate what they felt made quality nursing care in a nursing home. The categories that emerged involved a variety of perceptions which were labeled quality components. From the subjects' statements, it was evident that these components were instrumental in their choice of a nursing home, as well as how they perceived their current quality of care/quality of life. Subjects stated they sought nursing homes that met as many of the quality factors as they could find.

For subjects who required a high level of basic care, the theme most often identified was Personal Care/Safety. Residents in this group depend on nurses for assistance with bathing, toileting, eating, even position changes to relieve pain or to improve breathing. That may explain their perception of quality at the most basic level of human needs.

Accommodations received the greatest number of responses. This theme was very broad, covering many services that nurses may not consider part of nursing care. Possible explanations for this might include the non-threatening nature of this topic, or that basic accommodations are needed by all people.

Nursing has always considered the resident-family unit when planning care. However, when residents described the theme Family, residents described the nurses role somewhat differently. Residents perceived nursing involved in the process of maintaining, or even encouraging increased family interaction. Several residents counted

nurses as extended family, because they spent more time with them than real family. This theme seemed to reflect the residents need for belonging to some form of support system.

The theme Personal Choices was not so much related to what was chosen but the chance to make a choice. The perceptions residents described were how nurses had, (or had not) facilitated the chance for choice. When residents were allowed to make choices they noted increased self-esteem.

Residents' memories relating to the theme Sociality/Recognition often brought smiles to their faces. The stories recalled dealt with pleasant times where nurses had made the resident feel special by including them in plans or calling attention to the resident in a positive way. Residents expressed this as an important part of quality nursing care.

The theme residents identified in greatest detail and with the most emotion was Staff Who Care. Residents' perceptions of the highest quality care related to nurses (staff) who communicated the feeling, not only of willingness to give care but enjoyment in caring for the resident as a person.

As this researcher reflected, these themes appeared to be very similar to Abraham Maslow's Hierarchy of Needs. The themes PersonalCare/Safety, and Accommodations resemble the first two levels of Maslow's Hierarchy. Maslow's Levels 1 and 2 list meeting physical needs of food, air, water and physical security or shelter (Maslow, 1970). The data supporting the theme Family closely resembles Maslow's description of level 3, love and belonging. The themes Personal Choices, Sociality/Recognition, and Staff Who Care, were supported by

data resembling the 4th level of Maslow, self-esteem, self worth and recognition. No data was noted that support self actualization, the 5th level of Maslow's developmental theory. At an age where consideration of physical condition of the residents interviewed is very important this might not be an area residents would consider necessary to quality nursing care.

A review of studies about quality care in health care settings other than nursing homes, demonstrated that information gathered could be used to improve quality patient care. In 1987, Merry developed a model to measure subjective and objective elements of quality care. The subjective elements were to be rated by the consumers of care (residents). The model was tested with the conclusion that including the subjective elements should improve quality care. This study measured subjective elements of quality nursing care. Data not found in other studies was discovered. The new data can be used to improve quality nursing care. This supports the Merry (1987) study.

Delbanco (1992) developed an instrument - Elements of the Patient Review to gather feedback about quality care in an outpatient setting. The elements were identified by professions and patients working together. the seven areas identified were: 1) respect for patient values; 2) communication and education; 3) coordination and integration of care; 4) physical comfort; 5) emotional support and alleviation of anxieties; 6) involvement of family; and 7) continuity and transition. In this study of resident perceptions of quality nursing care, similar themes were found to be Family, Personal Care/Safety, and Sociality/Personal Recognition.

Few studies have been completed in a nursing home setting. One

study (Bliesmer & Earle, 1993) did collect resident perceptions about quality care. That study used a group of 17 Quality Care Indicators (QCI) and asked residents to score them by importance. The QCI included nursing and other global aspects of quality care. The QCI format did not allow the residents to freely identify any component they considered as part of quality nursing care. The current study allowed residents to freely identify the components of quality. The themes Choices, Accommodations, and Staff Who Care were similar to responses in the QCI. New themes that were not found in the Bliesmer and Earle (1993) study were Family, Sociality/Personal Recognition, and Personal Care/Safety. The research question in this study was purposefully focused on nursing care. The themes Staff Who Care, and Personal Care/Safety, form a group that reflected traditional nursing care. Sociality/Personal Recognition, Accommodations, Personal Choice and Family, form a second group of themes. The second group reflected areas that traditionally have not been considered part of nursing care, but can be influenced by nurses. This information was not reflected in the (1993) Bliesmer and Earle study.

### Trustworthiness

With grounded theory, all information comes from the data collected. Although a qualitative study cannot be replicated, the trustworthiness of the findings can be supported by meeting the criteria of credibility, transferability, dependability, and confirmability (Polit & Hungler, 1991).

Credibility addresses how confident one can be about the truth of the findings (Polit & Hungler, 1991). Peer review by an expert in the

field was used to independently examine the responses to identify themes. This doctorally prepared registered nurse who was familiar with qualitative research techniques reviewed unmarked transcripts for themes/categories relating to quality nursing care. These were independently compared to categories identified by the researcher for completeness of categories identified. To further assure credibility, when saturation had been met with 2 sections of interviews in Home A, a third section was completed in another nursing home.

Transferability was addressed by providing actual samples of data so others could make judgments about application of the findings (Polit & Hungler, 1991). Excerpts of the subjects' recorded interviews were used to accurately express the perceptions of subjects. The very limited cultural mix of subjects in the research could limit the transferability.

Dependability was supported by field notes written as data were collected (Polit & Hungler, 1991). The notes included the thought process of the researcher behind the grouping of data that led to themes identified.

Confirmability was addressed by the ability of the doctorally prepared nurse reviewer who examined the audit trail of notes, and written transcripts, and an examination of the written thought process used in the summation of findings section.

### Limitations

The convenience sample used did not allow for cultural differences, age, or generational differences. A major threat to this type of study, observer bias, was lessened by tape recording the



subjects' responses. Transcripts of the recorded responses were used to provide hard data and comments. Use of a tape recorded interview caused some problems with the low speech volume of some residents. Field notes were used to help complete affected interview records. It is a further limitation that stability of findings can not be tested over time.

### Implications

Quality care components involved in the traditional nursing care group were the most often mentioned by residents. Residents also consistently considered non-traditional nursing themes important to quality nursing care. It seems the nursing profession has an exciting opportunity to redefine the role of nursing in the practice setting of a nursing home. One implication for nursing practice could be to redefine the role using the quality themes identified by residents.

The broader nursing role in providing quality nursing care might include:

1. The nursing skills to complete a continuous assessment of residents' physical and psychosocial needs. The assessment would allow individualized care to be provided that would promote personal care and a feeling of security.
2. Nursing management of environmental factors to provide the feelings of comfort and safety.
3. Nursing management of quality of life issues that would increase a resident's feeling of personal recognition.
4. Support, education, and communication with family to foster an increased base of support for the resident.
5. The nurse's therapeutic use of him/herself to carry out the

nursing roles with a caring attitude.

6. Supervision and education of para professionals to support the broader scope of nursing care.

7. Nursing coordination of other professionals who are part of the resident care team, to provide holistic quality care.

Other implications for the nursing profession might include: a) use of the proposed broader nursing role to set a new standard of care, b) appropriate changes in nursing education to support the practice, c) public education and legislative work for support of the new standard of quality nursing care in a nursing home.

Nursing homes, as part of the health care business, could use this type of qualitative data to improve residents quality of care by setting new policies regarding staff expectations. The data could also be used to help form a resident (customer) driven business that could increase customer demand and thus increase revenue.

#### Recommendations for Research

Further qualitative studies using input from nursing home residents would add information that could support themes discovered or identify further themes of quality care. Further research could be done utilizing an instrument made up of the identified themes. This could be developed to collect quantitative data for an intervention study.

#### Items of Interest

Some experiences gained during this research project seemed to have possible value to future researchers doing qualitative studies. There are few qualitative studies in nursing to use as guidelines when

doing this type of research. Yet, the data gathered seems meaningful, is understandable and can be used immediately. It seems a good fit for many areas of nursing research. Nurse researchers need to pursue these studies despite the lack of guidelines.

Attaining saturation is sometimes a nebulous feeling. It is difficult to explain, but you will know when you get there. Even when I thought I had saturation, I added a third section to be sure I had reached it. For my own peace of mind, I also added a second setting to assure resident anonymity.

Sorting the many pages of transcribed interviews into themes seemed overwhelming. Color coding data was found to be an efficient method to arrive at themes.

### Summary

From this study it appears that residents who live in a nursing home have a shared experience. The experience of being a resident in a nursing home allowed the residents to identify components of quality nursing care. Whether components identified were within the traditional nursing roles or non-traditional roles, they were consistent enough to be organized into themes. The themes identified could be used to improve the quality of nursing care provided residents in a nursing home.

The nursing profession has an opportunity for growth provided by the application of quality themes identified in this research. As a profession nurses welcome the challenge to provide quality care as viewed by the consumers of care. As resident advocates, nurses welcome the views of the residents involved. Nurses are challenged as

professionals to educate themselves and monitor their performances.

While some nurses may instinctively provide care that meets the quality themes identified, the nursing profession can work to improve quality care by responding to the suggestions of the residents that nurses serve.

## APPENDICES

APPENDIX A

Informed Consent and Standard Release Form

## Appendix A

### INFORMED CONSENT AND STANDARD RELEASE FORM

Project Title: Quality Nursing Care - The Nursing Home  
Residents perspective  
RESEARCHER: Brenda L. Larsen, RN, BSN  
Phone: 517-728-5649

This study is being conducted to help nurses and other providers of care in nursing homes gain a better understanding of what the residents feel is quality nursing care. This information is needed before nurses can plan, provide, or direct quality care that truly meets the resident's needs. Interviews will last approximately 15 minutes. Questions will be asked about what you think is quality nursing care. These interviews will be tape recorded and coded with numbers for anonymity. The tapes will be destroyed at the end of the research. Confidentiality will be maintained by not identifying resident's quotations in the research report and potential publications. There may be no direct benefit to you, but a greater understanding may improve the nursing care which people receive in the future.

THIS IS TO CERTIFY THAT I, \_\_\_\_\_,  
HEREBY agree to participate in the above project. I understand that no health risks to me are anticipated as a result of my participation. I can stop at any time if I get tired or change my mind about participating and there will be no penalty to me. I further give my permission to Grand Valley State University, Kirkhof School of Nursing; 1) To utilize photographs, films, video or audio taped segments of self for educational purposes. 2) I understand that at the completion of research, these tapes will be destroyed. I understand that the information may be published, but that no names will be attached. I understand that I am free to not answer any questions. I have been given the opportunity to ask any questions I desire, and I have been assured that such questions will be answered to my satisfaction. I have been given the phone numbers of the researcher (517-728-5649) and Paul Huizenga, the chairperson of the Grand Valley State University Human Research Review Committee (616-895-2472). I may contact them at any time if I have questions.

Institution \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_

|                             |               |
|-----------------------------|---------------|
| Participant Signature _____ | Witness _____ |
| Name Printed _____          | Date _____    |



## APPENDIX B

### Human Research Review Committee Proposal Approval

Appendix B  
Human Research Review Committee Proposal Approval



1 Campus Drive  
Allendale, MI. 49401-9403  
Telephone (616) 895-6611

December 11, 1997

Brenda L. Larsen  
8383 Ora Lake Rd.  
Hale, MI. 48739

Dear Brenda:

The Human Research Review Committee of Grand Valley State University is charged to examine proposals with respect to protection of human subjects. The Committee has considered your proposal, *"Quality Nursing Care - The Nursing Home Residents' Perspective"*, and is satisfied that you have complied with the intent of the regulations published in the Federal Register 46 (16): 8386-8392, January 26, 1981.

Sincerely,

A black rectangular box redacting the signature of Paul Huizenga.

Paul Huizenga, Chair  
Human Research Review Committee

## APPENDIX C

### Nursing Home Permission for Data Collection

Appendix C  
Nursing Home Permission for Data Collection



**Tendercare (Michigan) Inc.**

Federal Hertiage Building

209 E. Portage Avenue / Sault Ste. Marie, MI. 49783

Telephone (906) 635-0020

Fax (906) 635-0212

Brenda Larsen, R.N.  
8383 Ora Lake Rd.  
Hale, MI. 48739

To whom it may concern,

Brenda Larsen, R.N. has permission of Tendercare (Mich) Inc. to interview residents and family in order to gather statistical and medical data from Tendercare Tawas City and Tendercare Rogers City for completion of her thesis.

Sincerely,

Diane Cataline, R.N.  
Tendercare Nurse Consultant

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