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The Effects of Reminiscence Therapy on the Elderly Client's Satisfaction with Nursing Care

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THE EFFECTS OF REMINISCENCE THERAPY ON THE ELDERLY CLIENT'S SATISFACTION WITH NURSING CARE

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ABSTRACT

THE EFFECTS OF REMINISCENCE THERAPY ON THE ELDERLY CLIENT'S SATISFACTION WITH NURSING CARE

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This study tested if reminiscence therapy would improve client satisfaction with nursing care. An experimental post test only design was used on 39 clients in a moderate sized home care agency in the Midwest. Ages ranged from 65 to 98. A single, one-on-one reminiscence session was done with 22 subjects in their homes after a routine nursing visit. The control group subjects did not receive the reminiscence intervention. The groups were homogeneous except for the number of hospitalizations experienced in the past year. The control group had a significantly higher number.

The Forbes Patient Satisfaction Questionnaire, modified for the home setting, was used to test client satisfaction. A t-test for independent sample did not support the hypothesis ($t = 1.95$; $df = 26$; $p = .06$). Mean scores on the questionnaire showed the experimental group tended to score higher ($M = 75.41$) on satisfaction than the control group ($M = 71.06$). Continued study on the use of reminiscence therapy as a valid intervention to affect client satisfaction is indicated.

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CHAPTER ONE

INTRODUCTION

There are some important factors in the nursing care of the homebound elderly client that indicate the profession's need to develop interventions that will have an impact on client satisfaction. First, the elderly are the largest consumers of health care (Garnick & Short, 1985). They presently consume 35 percent of the total health care resources (Taeuber, 1992). Secondly, they have to adjust to many different care providers in the home. Thirty-five percent report activity limitations due to illness. Three percent of people age 65 or older in 1990 needed help in performing one or more activities of daily living. The percentage increases to ten percent after age 75 (Darnay, 1994). Adjusting to various care providers is an additional stressor for clients who are already dealing with activity limitations, sensory deficits, and health changes that occur with aging. Feeling satisfied with both care given and care providers lightens some of the emotional load the elderly may feel every day.

Clients' satisfaction with their care has been recognized as an important measure of the success of their health care (Bond & Thomas, 1991) and can be used to evaluate the delivery of nursing care (Chang, Uman, Linn, Ware, & Kane, 1984). Donabedian (1980) discussed the importance of clients' satisfaction when measuring outcomes of health care. He argues that meeting the expectations of clients is one important factor that can affect their satisfaction with care.

Fosbinder (1994) found that clients' satisfaction with nursing care depends on the interpersonal skills and interactive style of the nurse as much as his or her technical skills. She found that clients almost always describe the interactive style of the nurse as most important when asked, "What does the nurse do for you" (p. 1087). The nurse needs to effectively use interventions which will utilize interaction and interpersonal skills that will assist in assuring the client's satisfaction with care.

The lack of developing a positive nurse-client relationship has been shown to affect a client's perception of care (Morse, 1991). Numerous studies have shown that the relationship goes through stages (Fosbinder, 1994; Ramos, 1992; Poole & Rowat, 1994). These stages can be worked through in one encounter or many encounters with the nurse.

When the client feels the relationship is secure, he or she can relax and trust. The result is a positive relationship where the client and nurse form a level of comfort with each other so optimal nursing care can occur, and the client is satisfied.

The nursing profession considers its care providers interchangeable, with one nurse the same as another (Morse, 1991). This is true in hospital nursing as well as in home care. Scheduling client care with this assumption increases the number of nurses a client will see throughout his or her illness. The interaction between the client and nurse is, therefore, short term with mostly technical care done by the nurse. The development of a positive relationship needs more than just this type of care. "In a caring relationship, caregivers cannot be interchangeable" (Morse, 1991, p. 464).

To affect clients' satisfaction with nursing care means meeting their expectations of what makes a good nurse. Interactive style and interpersonal skills are perceived by clients to be important when evaluating nursing care. A profession which considers care providers interchangeable but also requires effective interaction needs interventions that will help form a positive relationship between nurse and client.

An intervention which may help form this positive relationship is reminiscence therapy. Sherman (1991) described reminiscing as a sensory experience which "enhances the mood of the elderly person and puts him or her in a positive frame of mind" (p. 32). Research of reminiscence therapy indicates that it has adaptive functions, such as assisting the elderly client to adjust to losses, improving mood and morale, and decreasing stress in threatening situations (Sherman, 1991; Haight, 1988; Rybarczyk & Auerbach, 1990). These adaptive functions are important for the formation of a positive relationship, and the results may affect client satisfaction with nursing care.

Purpose

The use of reminiscence therapy has been shown to assist elderly clients with adaptation. Therefore, it seems appropriate to use this intervention when clients have to adapt to numerous nurse caregivers in the home setting. It affords the nurse the opportunity to interact with the client and use interpersonal skills. The positive relationship developed is an important part of nursing care affecting client satisfaction. The purpose of this study is to examine the effects of reminiscence therapy on the elderly client's satisfaction with nursing care.

CHAPTER TWO

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

The Roy Adaptation Model of nursing (1991) was used as the conceptual framework supporting this study. The interdependent mode of this model was utilized to support developing the nurse-client relationship. The reviewed literature relates the importance of developing a positive nurse-client relationship to client satisfaction with nursing care. Research on reminiscence therapy, client satisfaction, and the nurse-client relationship are reviewed.

Conceptual Framework

Roy's (1991) Adaptation Model supports using reminiscing as an intervention to improve client satisfaction with nursing care (Figures 1 and 2). In this model, the client is viewed as a holistic system which can influence the environment or adapt to it. Stimuli from the internal and eternal environment cause adaptive or maladaptive responses shown by effective or ineffective behaviors on the part of the client.

Figure 1

Roy Adaptation Model

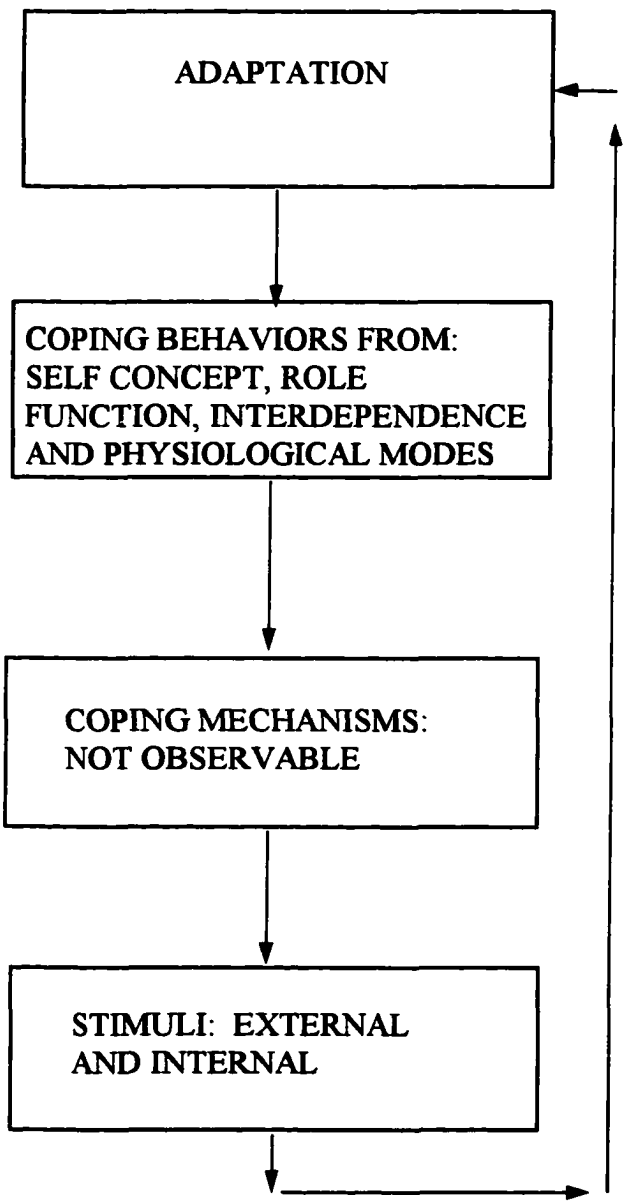
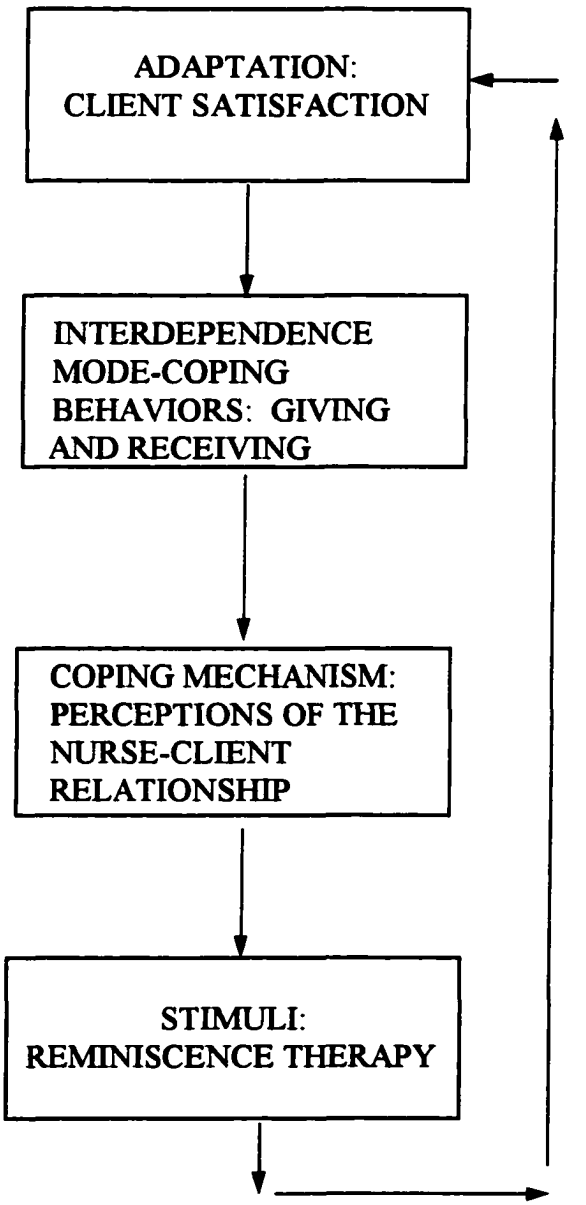


Figure 2

Roy Adaptation Model Using Reminiscence Therapy



Stimuli are of two types in this model (Roy, 1991). Focal stimuli are what is most immediately confronting the person. In this study, it was a nurse who was not a regular care provider giving care to an elderly client in the home setting. Contextual stimuli are present in the internal and external environment. They affect how the person reacts to the focal stimulus. Possible sensory deficits from the aging process would be an example of internal environmental stimuli. A television turned on loudly during the nurse's visit would be an example of external environmental stimuli.

Coping mechanisms and behaviors explain a person's response to his or her environment (Roy, 1991). Coping mechanisms are not observable. Coping behaviors are observable and are labeled as output from the system. They are divided into four adaptive modes. These four modes are the physiological, the self-concept, the role function, and the interdependence modes. Within each mode, the person has basic needs that have to be met in order for adaptation to occur. The nurse's role is to assist the person in meeting his or her needs so effective coping behaviors can occur, resulting in adaptation.

The part of the Roy Model utilized to support this study is the interdependence mode. The basic need underlying this mode is affectional adequacy, defined as

"the feeling of security in a nurturing relationship with others" (Roy, 1991, p. 386). This need is met through social interaction with a significant other and a support system. Reminiscence therapy was the stimulus that provided the social interaction that gave the client a feeling of security with the nurse.

The nurse is a support system for the client in the interdependence mode. Support systems are defined as "persons, groups or animals that help meet a person's need for love, respect and value but are not of the same intensity as a relationship with a significant other" (Roy, 1991, p. 388). Support systems help meet the need for affectional adequacy; thus they contribute to the client's adaptation to the environment. A positive therapeutic relationship is an interdependent relationship in which the nurse is a support system for the client.

Adaptive responses in the interdependence mode are called receiving and giving behaviors (Roy, 1991). Receiving behaviors show a person is accepting nurturing, such as expressing appreciation or allowing another to care for him or her. The client accepts the interest of the nurse during reminiscing. The nurse can express appreciation of the story told. Giving behaviors (such as touching, listening and physical care) supply nurturing to a

person. During reminiscing, giving behaviors can be expressed by the nurse. The client also gives by revealing a part of his or her past. These are reciprocal behaviors between a person and the support system.

An elderly person experiencing stress from numerous care providers, illness, and loss of mobility and/or function has increased need for acceptance, respect, and affirmation to assist with adaptation. The nurse uses interventions that will assist the person in meeting his or her interdependence needs by forming a nurturing relationship that is supportive and affirming. For the elderly client, reminiscence therapy allows him or her to give by sharing a part of himself or herself. The client can receive acceptance, respect, and affirmation from the nurse. Reminiscence therapy also allows the nurse to show nurturing behaviors and give of herself in the form of time, interest, and mutual sharing. Positive interaction and reaction occurs. The need for affectional adequacy is met.

In summary, the focal stimulus for this study was a nurse who was not a regular care provider and used reminiscence therapy with the elderly client. The coping behaviors in the interdependence mode were giving and receiving behaviors that occurred during reminiscence

therapy. Adaptation was evident by the client expressing satisfaction with the care.

Review of the Literature

The literature review relates the importance of using a reminiscence intervention to affect the nurse-client relationship positively. It includes studies which support the importance of the nurse-client relationship on client satisfaction. Reminiscence therapy is reviewed, followed by client satisfaction, and the nurse-client relationship.

Reminiscence

The various conceptualizations of the phenomenon of reminiscence make it difficult to summarize current research to support it as a clinical intervention. Life review, a psychotherapeutic form of reminiscing which Butler (1963) described, and simple reminiscing, or the recall of a pleasurable experience (Merriam, 1989), have been used interchangeably in past research. These variations in conceptualizing reminiscence are one of the reasons why the results have been mixed. Several studies support its effectiveness as an intervention (Lewis, 1971; Scales, Randolph, Gutsch, & Knight, 1986). Others have not supported its ability to assist with adaptation (Brennan & Steinberg, 1983). Several studies have supported the positive effect it has on the adaptive functions of

enhancing mood state and handling stress (Fallot, 1980; Rybarczyk & Auerbach, 1991).

The phenomenon of reminiscence is a complex cognitive process. Sherman (1991) described different functions of reminiscence. The elderly client may use it for a number of purposes such as enjoyment, working through a current life situation, or integrating past experiences. The process of the reminiscence varies according to its function. The research on reminiscence shows it has adaptive functions such as coping with problems and changes in the present (Revere & Tobin, 1980; Haight, 1988). It also serves to enhance mood and morale (Lewis, 1971; Barnes, Saxby, & Ehlert, 1987).

Rybarczyk and Auerbach (1991) studied the effect of reminiscing as stress management for elderly clients about to undergo surgery. An experimental design was used. Pre and post-tests of the State Trait Anxiety Inventory (STAI) were given to 104 male surgery patients. Four groups were used. One-on-one reminiscing was done with each subject in two of the groups. One group received a challenge reminiscence session. The subjects were encouraged to remember a time when they accomplished something they were proud of. The second group did a simple reminiscing session. The third group of subjects received an interview

where only current events were discussed. No intervention was used in the control group.

The hypothesis that reminiscing would decrease anxiety was strongly supported ($p \leq .05$). Results of the STAI post intervention showed the groups that received the challenge reminiscence and the simple reminiscence sessions had a significant decrease in anxiety. The challenge reminiscence group's mean score on the STAI pretest was 7.0; post-test was 6.0. The simple reminiscence group's mean score pretest was 6.9; post-test was 5.3. The two other groups scored higher in anxiety from pre to post-test. Reminiscing helped decrease stress in this threatening situation in which the client could not take physical action to control the threat but needed to use emotional strategies to control his feelings to the threat (Rybarczyk & Auerbach, 1991).

The weaknesses of this study were that only male subjects were used, so its generalizability to a larger population is not possible. Also, there was a lack of standardization as many interviewers were used, and the training sessions were brief.

Brennan and Steinberg (1983-84) studied if there was a relationship between reminiscing, social activity level and moral in a convenience sample of 40 elderly female subjects. The subjects were selected from a pool of volunteers. The

subjects were ambulatory, in good physical health, with a mean age of 73. Three interviewers were used who were unaware of what was being tested.

One-on-one reminiscence was done after a pre-test Social Activities Subscale (SAS) and a Life Satisfaction Index (LSI) were administered. Ten items were added to the SAS to determine change in social activity. The reliability of the modified SAS in the present study was not obtained. The LSI was used to measure morale and no modifications of the original instrument were made. The Cronbach's alpha for the LSI was .73.

After a reminiscence intervention, a Satisfaction With the Past Test was administered. An ANOVA was performed to measure the effect of the interviewers on the dependent variables. No significant differences were attributable to interviewer characteristics.

It was found that elderly people who report a change (either a decrease or an increase) in social activity reminisce easier and at greater length than those who did not report a change in social activity (Brennan & Steinberg, 1983-84). The quantity of reminiscing and social activity was positively correlated ($r = .30$, $p \leq .05$). Reminiscing was not positively correlated to morale ($4 = .08$), but morale was positively correlated to social activity

($r = .35$, $p \leq .01$). Brennan and Steinberg (1983-84) concluded that any alteration in the level of social activity may prompt an individual to review the past more frequently.

An experimental design study done by Fallot (1980) tested if reminiscing had an adaptive function by having an effect on mood. The hypothesis was that verbal reminiscing would have a positive effect on mood. The four interviewers used were unaware of what was being tested, and each interviewer conducted two sessions. The sessions were taped and a script was used to set up the reminiscing and non-reminiscing sessions. The sessions consisted of one reminiscence hour and one non-reminiscence hour. These were balanced by one-half of the subjects reminiscing in the first session and the other half reminiscing in the last session. Each subject completed the Mood Adjective Check List (MACL) before and after each session.

Thirty-six females were used in the study with a mean age of 65. They all lived in their own homes and were in the upper middle socioeconomic status. The results showed a marked decrease in negative mood state when a group reminisced than when they only discussed present and future topics.

The limitations of this study were the subjects being all female, again putting constraints on the generalizability of the findings. The interviewers were all young and the setting more of a serious interview type in nature. One wonders if the subjects would have had a different response if they had been reminiscing with their peers.

Client Satisfaction

Pasco (1983) defined client satisfaction as the health care receiver's reactions to important aspects of his or her care. Donabedian (1987) also argues that "the consumer is unable to judge technical aspects of care but is of primary importance in defining what satisfies him or her in terms of interpersonal processes of care" (p. 23). The dimensions of clients' reactions to important aspects of care and what interpersonal processes are satisfying to them need to be tested to determine satisfaction with care.

Nursing research measuring client satisfaction with nursing care often does not include the client's evaluation of interpersonal processes. The literature addresses how the following affects client satisfaction: Educational interventions for patients, educational instructions for nurses and if the nursing care done after this education affected client satisfaction, and technical care and changes in the delivery of nursing care such as primary nursing

versus team nursing (Wong & Wong, 1985; Milne, 1986; Eriksen, 1987; Bond & Thomas, 1991). These are what health care providers consider important to client satisfaction.

Instruments used to measure nursing care quality do not often contain a component where satisfaction with the interpersonal process between nurse and client is addressed. The dimensions most frequently measured are satisfaction with technical care, teaching, professional skills, trust of nursing staff, and attitudes to specific aspects of nursing care. Furthermore, the vast majority of these are used and developed for the acute care client.

Mangen and Griffith (1982) tested the components of a therapeutic relationship as one dimension in their study of patient satisfaction with community psychiatric nursing versus psychiatrist intervention. Seventy-one subjects were randomly assigned into two groups. One group was followed by a community psychiatric nurse. The other group was followed by a psychiatrist in the outpatient clinic. A subject self-report questionnaire modified from a consumer satisfaction questionnaire was used. Reliability and validity of the questionnaire was not addressed. The results showed a higher degree of satisfaction with the therapeutic relationship with the nurse versus the therapeutic relationship with the psychiatrist. "Nurses

were considered easier to talk to, kinder, more caring, more interested and pleasanter" (Mangen & Griffith, 1982, p. 479).

One weakness of this study was the lack of differentiating the number of follow-up visits done by the nurse versus the psychiatrist. Also, it was unknown if the follow-up visits done by the nurse were done in the home setting or the clinic.

Eriksen (1987) studied the relationship between quality of nursing care process and client satisfaction with nursing care. Subjects were randomly selected from a large medical center. The nonphysical needs of the client were measured with two instruments. The Methodology for Monitoring Quality of Nursing Care (MMQNC) was used to measure quality and nursing care process. Of six scales used in the MMQNC, the third scale addresses the nonphysical needs of the patient, including psychological, emotional, mental and social needs. The second instrument was the Patient Satisfaction With Nursing Care checklist (PSWNC). The relationship between the scores on the nonphysical care needs scale of the MMQNC and the level of patient satisfaction on the PSWNC was not statistically significant ($r = .07$, $p = .44$).

The limitation of the Eriksen (1987) study was that the measure of quality of nursing care relating to emotional and psychological care was of a general nature. The questions related to social courtesy, privacy, orientation to the hospital setting, family inclusion in care, and assisting with psychological well-being. One question asked, "Was the nurse polite to me?" More specific questions need to be asked about client satisfaction to evaluate the actual interpersonal interaction between the nurse and the client.

Client satisfaction represents "the care provider's success at meeting the expectations of the client that the client feels is important" (Donabedian, 1980, p. 25). Research shows that affective emotions the client has toward the nurse influence satisfaction with nursing care. Nursing research is limited in addressing this salient part of nursing care when measuring client satisfaction.

The Nurse-Client Relationship

The nurse-client relationship is central to professional practice (Ramos, 1992). Research findings indicate that personal interactions between care providers and clients influence client satisfaction (Peterson, 1989; Cleverly, 1990). The nursing research that measures client satisfaction does not address personal interactions between care providers and clients. Furthermore, the vast majority

of research on the nurse-client relationship addresses that relationship in the acute care setting.

Carl Rogers (1959) theorized a therapeutic relationship by describing the person as the totality of experiences that are occurring from within the person and in the external environment. Freedom from inner stress occurs when the self and the external environment are congruent--or the "I," which is the internal self, and the "me," how one sees oneself in relation to others' views, is congruent. A positive therapeutic relationship with the client needs unconditional acceptance of the client by the nurse for this congruence to happen. A helping relationship must have a climate of acceptance, warmth, and genuine caring.

Fosbinder (1994) examined nurse-client interactions in the hospital setting using an ethnographic approach. Data were analyzed using a constant comparison approach. She found four processes that occurred for a relationship to be positive. The first process was translation, when the nurse gives information to clients about expectations, their condition, and care. The second process was when personal sharing and friendliness occurs in the interaction. The third process was establishing trust, when the client feels the nurse is competent at doing the work that needs to be done. The last process was a description of the nurse who

provided care beyond the minimum expectations and whom the clients felt could be a friend.

Interpersonal communication was found to be valued most by clients. They almost always described the interpersonal communication of the nurse as the primary focus of their comments when asked, "What happens when the nurse takes care of you" (Fosbinder, 1994, p. 1087). Fosbinder suggests behaviors the nurse can use to enhance interactions with clients, thus forming a positive nurse-client relationship. Some of these behaviors include explaining, personal sharing, listening, humor, friendliness, and anticipating needs. The importance the client places on interpersonal communication with the nurse points to the value of using interventions that assist with this.

Morse (1991) identified four levels of mutual relationships in a study which used grounded theory techniques to describe the development of the nurse-client relationship. The four levels were clinical, therapeutic, connected, and over-involved. The level of the relationship is the result of interaction and negotiation. Behaviors in clinical relationships were found to be superficial, courteous conversation, and technical care only. The therapeutic relationship involved behaviors of routine teaching, technical care, and meeting routine psychosocial

needs. The connected relationship is when the nurse and client share parts of each other. The nurse gives more time, listens, and does extra things for the client. The nurse sees the client first as a person and second as a patient. The nurse shows sensitivity, appreciation, and concern for the individual. The client trusts the nurse and is able to verbalize feelings and problems. The over-involved relationship may occur when the professional relationship turns into a personal one. It was found that there could be interplay between each of the first three levels in one visit or over time.

The previously reviewed studies are supported by others which have found that nursing care behaviors which are most highly associated with client satisfaction are in the affective dimension (Bader, 1988). Morse (1991) also described what aspects the client assesses in the nurse to decide whether he or she is a good person. The client asks questions to determine "is this nurse a good person, is she a good nurse, and can I trust her competence and concern" (p. 460).

Summary and Implications for Study

The growth of home care has increased in the past ten years (Miller & Daley, 1996). Nurses are the largest professional group of providers in elderly home care

(Barkauskas, 1990). The few studies which evaluate the nurse-client relationship as a dimension of client satisfaction have been done in the acute care setting. Nurses need to research interventions which affect client satisfaction of nursing care in the home and include this dimension in the testing as their presence in this environment increases.

The literature also supports the premise that clients place more importance on interpersonal and interactive episodes with the nurse than on technical skills. The interpersonal dimension of the nurse-client relationship has been neglected when measuring client satisfaction with nursing care. This dimension appears to be one of the most important in the client's evaluation of what constitutes quality nursing care.

The Brennan and Steinberg (1983-84) study showed an alteration in social activity was related to an increase in reminiscence activity. Elderly clients who need home health care have experienced a change in health. Social activity is often affected adversely. The need to reminisce is increased when social activity is affected. The nurse doing a home visit has the opportunity to use reminiscence in this situation to improve morale.

Research by Rybarczyk and Auerbach (1991) supported the positive effect reminiscing had on managing a stressful situation. A stressful situation for the elderly client is having to adjust to numerous nurse care providers who come into his or her home. The client also often has no control over what nurse will be caring for him or her. This stress needs to be dealt with emotionally.

Fallot (1980) concluded there was a marked decrease in negative mood state when subjects reminisced than when they only discussed present and future topics. A positive mood state assists with adapting to a new situation. The elderly client needs tools to assist him or her with adapting to new care providers who come into the home.

Specific interventions to develop the nurse-client relationship in the time the nurse has to give care need to be tested. Reminiscence therapy has been shown to decrease stress and help decrease negative mood states which affect how we relate to other people. Reminiscence is an implementation of the affective dimension of care. It gives the client the opportunity to assess the nurse through her reactions to him or her as an individual. Interaction and interpersonal communication occurs with reminiscing. Reminiscence therapy, which shows acceptance, warmth and

caring, provides the nurse and client with a mechanism to develop a positive relationship.

Hypothesis

The hypothesis for this study is: Elderly clients who receive a reminiscence intervention will express more satisfaction with nursing care than those not receiving such an intervention.

Definition of Terms

The terms defined for this study include a positive nurse-client relationship, reminiscence intervention, the elderly client, home environment, and client satisfaction.

1. A positive nurse-client relationship is when the client experiences an inner state of "feeling good" about the encounter with the nurse (Chang et al., 1984).
2. A reminiscence intervention is when the nurse gives the elderly client cues to assist him or her in remembering a story about the past. The client then demonstrates four elements during reminiscing including: Selection where a topic is chosen, immersion when they are in the experience during the telling, withdrawal or finishing the story, and closure when a moral is told or the client relates the story to the present time (Merriam, 1989).

3. The elderly client is a person over 65 who has needed help with activities of daily living (ADL) or instrumental activities of daily living (IADL). The client has been admitted to a home care agency and received a minimum of one week of home visits by a registered nurse. Activities of daily living are defined as the functional status which addresses self-bathing, dressing, feeding, transfers, continence, and ambulation. Instrumental activities of daily living address housekeeping, shopping, using transportation, the telephone, and taking medicines.
4. Home environment is living at home alone or with a consistent family or friend caregiver.
5. Client satisfaction is defined by Pascoe (1983) as a health care receiver's reaction to salient aspects of his or her service experience. It is a cognitive evaluation and emotional reaction to services.

CHAPTER THREE

METHODS

Research Design

This study used a post-test-only experimental design. A self-report instrument with a Likert scale tested if a reminiscence intervention affected client satisfaction with care. The one test only design was practical for this population. It did not test for the subject's level of satisfaction before the reminiscence intervention. It was hypothesized that clients who reminisced would show greater satisfaction with nursing care than those who did not reminisce.

Sample and Setting

The sample for this study was 39 subjects selected from a moderately sized home care agency in southwest Michigan. The nonprobability convenience sample was randomly assigned to experimental and control groups. All subjects had been admitted to the agency a minimum of one week prior to participating in the study. All could read, write, and speak English.

The subjects were 65 to 98 years old (M = 80). The sample was 72 percent female and 28 percent male. Thirty-one (79.5 percent) had been in the hospital from one to sixteen times in the past six months (M = 2). The number of times the subjects needed help from other people to assist them in their homes with ADL and IADL for a period of three months before the study ranged from 0 to 90 (M = 13.8). Those needing assistance with ADL was 79 percent. Assistance with IADL was needed for 90 percent of the subjects. Twenty-four lived with a spouse, family or friend, and 15 lived alone. The number of physician appointments for a period of three months before the study ranged from 0 to 18 (M = 5). The race of the subjects was 94.5 percent Caucasian and 5.5 percent African American. Scores on the Mini-Mental State Exam were 22 or higher, indicating unimpaired cognitive function (M = 27.7).

Gender of the subjects was reflective of the general population in relation to elderly females being represented in larger numbers. The living arrangements of each subject were also representative of the larger population. More subjects in the study lived with a spouse or family member and 38 percent lived alone. The majority of subjects needed assistance with ADL and/or IADL. Darnay's (1994) data states 10 percent of people over age 75 need help in

performing one or more ADL. The percentage was higher for the subjects in this group, but clients who qualify for home care have chronic or acute health care problems which also affect their general functioning.

Instruments

One of the instruments used in this study was the Forbes Patient Satisfaction Questionnaire (FPSQ) developed by Forbes and Brown (1995). Also used was the Mini-Mental State Exam (MMSE) developed by Folstein, Folstein and McHugh (1975). A demographic questionnaire was also used.

Forbes Patient Satisfaction Questionnaire, Modified (FPSQ)

Permission to use the FPSQ was obtained (Appendix A). The original FPSQ was developed for use in the outpatient surgical center (Appendix B). The FPSQ uses four constructs for measuring patient satisfaction. These include caring, continuity of care, competence of nurses, and education of patient and family. It measures the client's perceptions of care rather than the provider's definition of what quality care is. It is a 20-item questionnaire using a Likert-type scale. It also has three open-ended questions.

Forbes and Brown (1995) reported that reliability for this instrument was measured using the test-retest method. They computed Pearson product-moment correlation coefficient to determine the strength of the relationship between each

question in the pretest and retest measures. However, the choice of using this statistic to compute two measures at the ordinal level is incorrect.

Internal consistency for the total instrument using Cronbach's alpha coefficient was .83 (Forbes & Brown, 1995). Forbes and Brown (1995) reported that the alpha coefficient ranged from .19 to .80 for the subscales. The alpha for each subscale is not reported. Validity was determined using the Delphi technique to survey expert nurses.

For the current study, the FPSQ was modified to better reflect the home setting (Appendix C). Four items were omitted from the original FPSQ. One addressed pain relief post-surgery. Three were related to questions that explored how the client felt after the surgical procedure, which does not apply in this setting. The words "before surgery" omitted in two items. The word "nurses" was made singular throughout the questionnaire.

Two of the open-ended questions were modified. The first was changed to ask if the nurse's visit was easier because the client felt comfortable with her. The FPSQ item asked if recovery from surgery was easier because of what the nurse did. The second question explored how a nurse could meet the client's needs better if he or she returned. This was modified to ask, "If you used home care again, what

could nursing do to meet your needs better?" Hence, the modified FPSQ consists of 16 Likert-type questions and three open-ended questions.

Responses to the modified FPSQ were scored on a five-point scale. An answer of five designated always satisfied with care and an answer of one designated never satisfied with nursing care. The range of possible total scores was 16 to 80. The higher the score, the greater the satisfaction.

The four domains of caring, continuity of care, competence of nurses, and education of patient and family were tested in the modified instrument. Items 1 through 6 were in the caring domain. The domain of continuity contained items 7, 9, and 10. Competence items were 8, 11, 14, and 16; and the domain of education included items 12, 13, and 15.

Content validity was established for this study based on feedback from three expert nurses. Reliability of the modified FPSQ was examined using data collected from this study. The alpha coefficient for the total instrument was .74. The reliability coefficient for each subscale was low with the exception of the education of patient and family subscale. The alpha coefficient for the subscale of caring was .52, continuity of care was .53, competence of nurses

was .15, and education of patient and family was .74. The low reliability coefficients may be partly due to the small number of items in the subscales.

Mini-Mental State Exam

MMSE (Appendix D) was used to test each client's cognitive function. The MMSE concentrates on cognitive aspects of mental functioning, excluding mood and abnormal mental experiences (Folstein, Folstein, & McHugh, 1975). It is divided into two sections. The first section requires verbal answers to test orientation, memory, and attention. The second section tests the ability to name, follow oral and written commands, and write and copy a complex figure. There are 11 items on the test, with a maximum score for each item. The range of possible scores is 0 to 30, with scores of 21 or less suggestive of dementia.

Test-retest reliability coefficient was r = .89 on scores obtained when the test was given 24 hours apart to the same person. There was no significant difference when the test was given 28 days apart with the product moment correlation coefficient for test one versus test two at .98 (Folstein, Folstein, & McHugh, 1975). Validity was measured by giving the test to three different diagnostic groups and a control group (Folstein et al., 1975). The mean score for the dementia group was 9.7, depression with cognitive

impairment was 19.0, uncomplicated affective disorders was 25.1, and the control group was 27.6. The instrument has been found useful in quantitatively estimating the severity of cognitive impairment and is quick to administer (Folstein et al., 1975).

Demographic Information

Demographic information was developed by the researcher based on a literature review of what affects client satisfaction. Demographic data (Appendix E) were collected to determine if the subjects had numerous care providers in the past year in the home. The use of the health care system, including hospital stays and number of doctor appointments, was included in the data collection. The possibility of numerous care providers from these arenas affecting client satisfaction was compared by these items. Comparisons were made in relationship to gender, age, and race. Who is living with the client and if that is a factor in his or her satisfaction was also explored with the demographic data.

Data Collection Procedure

Prior to data collection, permission to perform the study was obtained from the Human Research Review Board at Grand Valley State University (Appendix F) and the research committee of the home care agency which was utilized for the

study. Data collection and intervention was done in the client's home. Ten subjects were selected every two weeks from a list of clients at the agency who met the same selection criteria.

The section criteria included a client, age 65 or older, who had been admitted to the home care agency for a minimum of week. The subject was living in the home setting alone, with a family member, or with a consistent caregiver. The researcher, as part of the selection process, assessed the cognitive status and ability of the subject to read, write, and speak English by consulting with the primary nurse before the initial contact was made with the client.

Of 52 potential subjects, 39 people (75 percent) were used. Thirteen potential subjects were not included in the sample for the following reasons. Two questionnaires were sent back unanswered. Two subjects were acutely ill during the visit and were not used. Four questionnaires were not returned even after a follow-up phone call. One subject in the control group reminisced spontaneously, and two subjects did not score 22 or higher on the MMSE. Two subjects were not used because engaged reminiscing did not occur.

A table of random numbers was used to assign subjects into experimental and control groups. Subjects were contacted by phone to request their participation in the

study. A phone script was used (Appendix G). The subjects were told the questionnaire was short and they only had to circle an answer. Confidentiality, anonymity, freedom to withdraw, and voluntary participation was explained. Subjects were also informed they would need to sign a consent form (Appendix H), and the researcher would make a home visit within a week or two of the phone conversation.

For consistency, the researcher visited both experimental and control group subjects. A routine home visit was made to those subjects who consented to participate. At the home visit, subjects were asked to sign the consent form. For the control group, technical care was provided to the client with client teaching during or directly following, if needed. The MMSE was administered after care and teaching was provided. Conversation after care was limited to current events only. The procedure was the same for the experimental group except reminiscence therapy was added after technical care, teaching, and the MMSE was done. No client displayed a negative emotional reaction towards the intervention itself.

Visits ranged between 30 minutes to one hour. A cover letter (Appendix I) was given to each client at the end of the visit with the instrument. The client was instructed to fill out the modified FPSQ within two days and return it in

a self-addressed, stamped envelope. The researcher assisted ten clients in filling out the demographic information. A phone call was made to 22 clients on the third day following the visit because the questionnaire had not been received. Only questionnaires postmarked within five days following the visit were used in the data collection.

A level of reminiscence tool (Appendix J) was developed by the researcher to grade the level of reminiscence reached by each subject. The tool was based on work done by Merriam (1989) in which she describes levels of reminiscence. As stated earlier, two subjects were not included because engaged reminiscing did not occur. Engaged reminiscing has four components as described by Merriam (1989). The first component is selection and is prompted by a cue. The cue could be the nurse commenting on an old picture or asking the client to describe a happy past experience. The client then selects an event in which he or she is the center and/or in which the event involves strong emotions. Immersion occurs when the person who is reminiscing immerses himself or herself in the event. The description has colorful detail that includes a sensory description. There is also an emotional component where pleasure, fear, or joy is remembered. Withdrawal is the third component, when the person reminiscing gradually distances himself or herself

from the memory. Usually this occurs by comparing the story to the present or generalizing the specific story to one's life overall. Closure occurs when the client sums up the memory by giving a moral or summarizing the event.

All of the experimental group subjects talked about an episode in his or her past. Also, the physical comfort and energy levels of the elderly clients in the experimental group were such that reminiscing did occur when cues were given by the researcher. Baldwin (1986) mentions the client who rambles during reminiscing, and rambling does not constitute a therapeutic reminiscence experience. One subject in the control group began reminiscing spontaneously. Hence, this subject was not included in the study.

CHAPTER FOUR

RESULTS

This study was undertaken to determine if reminiscence therapy would affect the elderly client's satisfaction with nursing care. Reminiscence therapy was used by a nurse who was unfamiliar to the client, in the home setting, during a routine visit. Data analysis was done using the Statistical Package for Social Sciences (SSPS) software.

Comparison of Experimental and Control Groups

Homogeneity of the experimental and control groups was verified using the chi-square test to compare some demographic and psychosocial variables. A t-test for independent sample compared the two groups in relation to interval demographic variables. The two groups were not significantly different from each other with respect to gender, living situation and the need for assistance with ADL and IADL ($p \leq .05$) as shown in Table 1.

Findings of a t-test for independent sample indicated homogeneity of the groups in relation to the variables of age, number of MD appointments, number of people needed to assist in the home, and scores on the MMSE (Table 2). The

number of hospitalizations in the past three months was significantly higher in the control group than in the experimental group ($p \leq .05$).

Table 1

Variables of Gender, Living Situation, and Assist with ADL and IADL (N = 39)

	GROUPS				
	Control n = 17		Experimental n = 22		
Variables	n	%	n	%	X^2 (P)
Gender					
Male	6	15.4	5	12.8	0.75
Female	11	28.2	17	43.6	(.38)
Living Situation					
Alone	7	17.9	8	20.5	0.14
Spouse	6	15.4	9	23.1	(.93)
Friend or Family	4	10.3	5	12.8	
Assistance with ADL					
Yes	14	35.9	17	43.6	0.15
No	3	7.7	3	7.7	(.69)
Assistance with IADL					
Yes	15	38.5	20	51.3	0.074
No	2	5.1	2	5.1	(.78)

One subject in the experimental group reported needing help 90 times in a three-month span to assist with ADL and IADL. Using this amount, the variable had a range of 0 to 90 (M = 13.8). Using the statistical mean to adjust for this outlier, the range became 0 to 60 (M = 9.4).

Table 2

Comparison of Two Groups in Age, Number of MD Appointments, Amount of Help in Home, Number of Hospitalizations, and MMSE Scores (N = 39)

	GROUPS					
	Control n = 17		Experimental n = 22			
Variables	M	SD	M	SD	t	p
Age	78	8.5	82	8.1	1.43	.16
Number of MD Appointments	5	4.3	4.4	3.2	0.40	.69
Number of people to assist in home	6	7.4	9.4	14.0	0.81	.42
Number of hospitalizations	2.5	2.5	1.0	0.8	2.44	.02
MMSE scores	27.7	2.2	27.0	2.4	0.85	.40

Hypothesis Testing

The hypothesis tested was: Elderly clients who receive a reminiscence intervention will express more satisfaction with nursing care than those not receiving such an intervention. Client satisfaction was measured using the modified FPSQ (Forbes & Brown, 1995) on the sample subjects. The scores were examined to determine if client satisfaction was greater in the group who received the reminiscence therapy.

The means and standard deviations of the total satisfaction scores and subscale scores of the two groups are presented in Table 3. Scores on the modified FPSQ

Table 3

Comparison of Experimental and Control Groups Scores

	GROUPS					
	Control n = 17		Experimental n = 22			
Scores	M	SD	M	SD	t	p
Total Satisfaction	71.05	8.03	75.41	5.10	1.95	.06
Caring	27.64	3.22	29.09	2.09	1.61	.12
Continuity	14.35	1.05	14.63	0.65	1.03	.31
Competence	18.41	1.62	19.00	1.77	1.07	.29
Education	10.64	4.78	12.68	2.35	1.61	.12

ranged from 56 to 80 for the control group (M = 71.06). The experimental group scored from 66 to 80 (M = 75.41).

A t-test for independent sample showed no significant difference in client satisfaction between the control and experimental groups ($t = 1.95$; $df = 26$; $p = .06$). The experimental group did score higher in satisfaction than the control group, but this difference was not statistically significant. Based on this, the hypothesis was rejected. Also, the four subscale scores within the FPSQ showed no significant difference between the groups ($p \geq .05$).

Other Significant Findings

There were three open-ended questions in the questionnaire. The responses to them contained many comments in the affective dimension. Fosbinder (1994) found that clients judge the nurse using interactive and interpersonal episodes more than technical care given. The responses in this questionnaire supported this. The following gives some examples of the responses to the three open-ended questions contained in the questionnaire.

The first question asked what the most important concern was that the client had regarding his or her nursing care. The majority of comments related to reassurance, "helping to problem solve problems," and nursing competence. The second question covered what the client felt the nurse

could do to meet client needs if he or she used home care again. This question elicited problems the subjects had with the agency used. Responses were "a more reliable answering service," "more consistent nurse," and scheduling issues. The third question asked what clients found most helpful during the visit. Again, the responses were reflective of the affective dimension. Technical expertise of the nurse was mentioned once. Some examples of the responses included "encouragement," "comfort," "caring," "friendliness," and "listening."

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

Discussion of the Hypothesis

The data obtained from this study did not support the hypothesis that elderly clients who reminisce during a nursing visit would show greater satisfaction with nursing care than those who did not reminisce. However, the experimental group satisfaction scores tended to be higher overall than the control group scores in this study. Although the difference was not statistically significant, it does point to the possibility of the hypothesis being supported if a larger sample size and improved measurement were used in future research.

The experimental and control groups were homogeneous in all demographic and psychosocial variables tested except for number of hospitalizations. The control group had a significantly higher number of hospitalizations ($M = 2.59$) than the experimental group ($M = 1.04$). The lack of homogeneity related to this variable points to possible future research to measure if the frequency of

hospitalizations experienced by clients has an effect on their satisfaction with home care.

Based on the total number of items, the reliability coefficient for internal consistency of the modified instrument was adequate at .74. Furthermore, the computed reliability of the subscales of the modified instrument was low. Again, this may be related to the small sample size and number of items in each subscale. Attempting the research again with further modification of the FPSQ or use of a different instrument is indicated.

Conceptual Framework

The Roy Model of Adaptation explains, in the interdependence mode, that the feeling of security in a nurturing relationship is the basic need that must be met for adaptation to occur (Roy, 1991). Reminiscing does give the opportunity for giving and receiving behaviors between the nurse and the client. There is also a possibility the giving and receiving behaviors are not balanced enough in this intervention. If clients perceive themselves as giving more than they are receiving from the nurse, adaptation may not occur. Client satisfaction may not improve with the intervention.

The relationship between reminiscence therapy and improved client satisfaction was not supported in this

study. The feeling of security in a relationship is necessary so positive interaction can occur (Roy, 1991). This relationship of feeling secure so positive interaction can occur is supported in works done by Rogers (1959) and Thorne and Robins (1988). Reminiscence also may not foster feelings of security with an unfamiliar nurse in only one visit. Therefore, utilizing this framework for supporting a study similar to this one or after modifications of this study may still be appropriate.

Relationship to Previous Research

Previous research that measures client satisfaction has not had a consistent definition of what constitutes satisfaction. Also, a question posed but not answered by Fitzpatrick (1990) is, do clients in different settings or with different characteristics look at different things to evaluate satisfaction? This question is important because the vast majority of client satisfaction questionnaires are formulated for the acute care setting, whereas this study measured client satisfaction in the home setting. Therefore, measuring satisfaction in the home may need a measurement tool specifically developed and tested for that setting.

Empirical studies on the nurse-client relationship support the interpersonal interaction as very important to

both clients and nurses. Reciprocal actions are an important component of this relationship (Hosking, 1993; Thorne & Robinson, 1988). Reminiscence offers the opportunity for reciprocity to occur. The nurse has the opportunity to give information about herself also during reminiscence. Reciprocity may also be a variable to study in relation to using reminiscence as an intervention.

Limitations and Recommendations

This study was limited to a small sample size and one geographical setting. Therefore, the findings cannot be generalized to the larger population. A larger sample size with a more diverse ethnic population would have assisted in greater generalizability.

The threat to external validity was the possibility that just by participating in the study, the subject would be more responsive to the nurse. To control for this, the subjects were randomly selected and were not told what the intervention was. In the experimental group, a cue was used or a question was asked to trigger a memory. Ethically, it was necessary to inform all subjects that they were part of a research project.

Threats to internal validity such as history, mortality, and selection were minimized or not valid. Statistical regression was controlled for in as much as some

subjects were not used because of their weakened conditions or difficulty with pain control. Hospice clients were not used in the study to control for this. Clients who had been admitted to the agency for less than one week were not used in order to omit subjects who may have had decreased energy levels post acute illness or hospitalization. The researcher instructed each subject to fill out the questionnaire at a time when the subject was not tired or in pain.

The threat of what Talbot (1995) calls an equalization of treatment was difficult to control for. This is where the researcher provides a beneficial treatment to the control group the elicits the same effect as the intervention. Because of the homebound nature of all of these clients, many of them have a need for socialization. The nurse's visit, no matter what topic is discussed, is looked forward to and is a beneficial treatment for some.

There may have been actions the researcher could have used to control for this equalization of treatment effect. The researcher attempted to be pleasant and make all clients at ease during each visit. There was not a script used during the home visit. Topics were limited to current events only with the control group. A script could have been used to control for the inevitable spontaneous

conversation that takes place when a home visit is done. Another method to assist in controlling for an equalization of treatment effect could have been for the researcher to practice a script on video before the project. This would have assisted in being more consistent in how each subject was approached.

Use of the post-test only design was appropriate for the population. Because of the topic, the effect of the pretest would have tended to influence the post-test measurement. To minimize this, the subjects could have been given the pretest a week before the post-test visit.

There were disadvantages to using the post-test only design. Randomization to groups with respect to the dependent variable of patient satisfaction could not be determined. Without the pretest measure, it was not possible to control the effects of the pretest on the post-test measure by statistical analysis. Measuring if the subjects in the control group started out being more satisfied with nursing care than the subjects in the experimental group before the intervention was not determined. Therefore, the post-test only was weaker than if the pretest post-test design had been used.

Implications for Future Research

The use of reminiscence therapy to test its effect on other client outcomes is indicated. The research to date shows its potential in assisting with client outcomes. Research to support using it as a short-term intervention in other situations is also indicated.

Research needs to be done to test the effects of reminiscence on increasing client comfort with the unfamiliar nurse, its impact on client response to teaching, improving client satisfaction with nursing care, and assisting clients in handling upcoming stressful procedures. Research using reminiscence in the above situations would add to the data supporting the use of this intervention in nursing.

Specific definitions of the reminiscing variables should be done in future research. After an integrated review of reminiscence research, Haight (1991) concluded a "clear and specific definition of the reminiscing variables was lacking." Research using this intervention should clearly define the type of reminiscing, frequency of the reminiscing variable, and the effect it has on a more narrow age group of subjects. More research on using the short-term, one-on-one reminiscing intervention to support its use

for the nurse and client in the hospital and home setting is indicated.

Implications for Nursing

There is an increase in the importance of using interventions that can assist the nurse to be more effective in meeting client outcomes. Home care has seen a tremendous increase in growth in the past ten years. Changes in governmental regulation of home care because of economic factors may necessitate a decrease in the number and length of home care visits that can be done. These facts point to the importance of using interventions that can assist the nurse to be more efficient and effective with clients in reaching agreed upon outcomes. The client also needs to remain responsive to teaching and participate in his or her care to achieve outcomes in a shorter period of time.

Previous research on reminiscence supports its use in assisting with adaptation by having a positive effect on mood, helping in stressful situations, and improving morale in elderly clients. Merriam (1993) also identified reminiscence as having a therapeutic function. A 17-item Uses of Reminiscence Scale was administered to 288 older adults ages 60 and 80. The dominant function of reminiscence that emerged in both age groups was therapeutic. Therapeutic included coping with life problems, under-

standing oneself, and putting life in order (Merriam, 1993). The use of it as a therapeutic intervention has been supported in past research.

The adaptive functions of reminiscence support its use in the formation of a positive nurse-client relationship. This relationship is important to clients' perceptions of good nursing care. The results of a positive nurse-client relationship will then affect client satisfaction of that care. Reminiscence therapy should be utilized by the nurse to enhance this relationship to assist the client in achieving agreed upon outcomes.

APPENDIX A

April 10, 1997

Nancy Strong
5500 Dougias Avenue
Kalamazoo, MI. 49004

Dear Nancy:

I give you written permission to use *The Forbes Patient Satisfaction Survey*, in your research as part of your masters degree requirement.

Sincerely,

[redacted]

Marita L. Forbes, RN, MSN

APPENDIX B

FORBES PATIENT SATISFACTION QUESTIONNAIRE

We value your opinions!

Please circle the response that describes the nursing care you received during your hospital visit.

1. The nurses treated me with respect.

   Always Often Sometimes Seldom Never

2. The nurses treated my family with respect.

   Always Often Sometimes Seldom Never

3. The nurses listened to me.

   Always Often Sometimes Seldom Never

4. The nurses met my needs without my asking.

   Always Often Sometimes Seldom Never

5. The nurses showed concern for my comfort.

   Always Often Sometimes Seldom Never

6. The nurses showed concern for the comfort of my family.

   Always Often Sometimes Seldom Never

7. The nurses asked me if I understood the information given to me.

Always Often Sometimes Seldom Never

8. The nurses were confident in giving me care.

Always Often Sometimes Seldom Never

9. My questions were answered by the nurses.

Always Often Sometimes Seldom Never

10. Before surgery, the nurses told me what I needed to know.

Always Often Sometimes Seldom Never

11. After surgery, the nurses told me what I needed to know.

Always Often Sometimes Seldom Never

12. I received information about each procedure before surgery.

Always Often Sometimes Seldom Never

13. I received information about each procedure after surgery.

Always Often Sometimes Seldom Never

14. I was prepared to care for myself because of the instructions I received from the nurses.

Always Often Sometimes Seldom Never

15. My family was included in the instructions I received.

Always Often Sometimes Seldom Never

16. My fears were decreased before surgery due to the explanations given to me.

Always Often Sometimes Seldom Never

17. The explanations given by the nurses decreased my fears after surgery.

Always Often Sometimes Seldom Never

18. I understood the procedures after the nurses explained them.

Always Often Sometimes Seldom Never

19. The nurses explained how I could relieve pain after I went home.

Always Often Sometimes Seldom Never

20. My recovery after surgery was easier because of the nurses instructions.

Always Often Sometimes Seldom Never

SHARE YOUR THOUGHTS

21. List the most important concern you have regarding your nursing care.

_____

_____

22. If you return, what could nursing do to meet your needs?

_____

_____

23. What did you find to be most helpful during your visit?

APPENDIX C

ID#_____

Forbes Patient Satisfaction Questionnaire - Modified

Please circle the answer that describes the nursing care you received by the last nurse who visited you.

It is important that you answer according to how you actually feel and not how you think you should feel or how you think we want you to answer.

---

1. The nurse treated me with respect.

Always Often Sometimes Seldom Never

2. The nurse treated my family with respect.

Always Often Sometimes Seldom Never

3. The nurse listened to me.

Always Often Sometimes Seldom Never

4. The nurse met my needs without my asking.

Always Often Sometimes Seldom Never

5. The nurse showed concern for my comfort.

Always Often Sometimes Seldom Never

6. The nurse showed concern for the comfort of my family.

Always Often Sometimes Seldom Never

7. The nurse asked if I understood the information given to me.

Always Often Sometimes Seldom Never

8. The nurse was confident in giving me care.

Always Often Sometimes Seldom Never

9. My questions were answered by the nurse.

Always Often Sometimes Seldom Never

10. The nurse told me what I needed to know about my condition.

Always Often Sometimes Seldom Never

11. I received information about why the care by the nurse was needed.

Always Often Sometimes Seldom Never

12. I was prepared to care for myself because of the instructions I received from the nurse.

Always Often Sometimes Seldom Never

13. My family was included in the instructions I received.

Always Often Sometimes Seldom Never

14. My fears were decreased due to the explanations given to me.

Always Often Sometimes Seldom Never

15. I understood the procedure after the nurse explained it.

Always Often Sometimes Seldom Never

16. The nurse's visit was easier for me because she helped me feel comfortable.

Always Often Sometimes Seldom Never

17. List the most important concern you have regarding your nursing care.

_____

_____

18. If you used visiting nurses again, what could nursing do to meet your needs?

_____

_____

19. What did you find to be most helpful during the visit?

_____

_____

Thank you for your participation in this study. Please check to make sure all items are completed.

APPENDIX D

ID# _____

Mini-Mental State Exam

Client Name _____
Date _____
Instructions: Ask all questions in the order listed and score immediately. Record total number of points.

Maximum	Score	Activity
5	_____	Ask the patient to name the year, season, date, day and month. (1 point each)
5	_____	Ask the patient to give whereabouts, state, county, town, street, floor. (1 point each)
3	_____	Ask the patient to repeat three unrelated objects that you name. Repeat them and continue to repeat them until all three are learned. (1 point each)
5	_____	Ask the patient to subtract 7 from 100, stopping after five subtractions, or to spell the word "world" backwards. (1 point each)
3	_____	Ask the patient to repeat the three objects previously named. (1 point each)
2	_____	Display a wristwatch and ask the patient to name it. Repeat this for a pencil. (1 point each)
1	_____	Ask the patient to repeat this phrase: "No ifs, ands or buts." (1 point)
3	_____	Tell the patient to follow a three-point command such as: "Take a paper in your hand, fold it in half, and put it on the floor." (1 point each)
1	_____	On a blank piece of paper write, "Close your eyes." Ask them to read it and do what it says. (1 point)
1	_____	Ask the patient to write a sentence on paper. It must be written spontaneously. Score correctly if it contains a subject and a verb and is sensible. Correct grammar and punctuation are not necessary. (1 point)

ID# _____

1	_____	Ask the patient to copy a design you have drawn on a piece of paper. Two intersecting pentagons with sides about one inch. (1 point)

Maximum Score: 30 Total Score: _____

Folstein, Folstein, & McHugh (1975)

APPENDIX E

ID# _____

Demographic Information

Please complete the following information.

1. Age _____

2. Gender: 1) Female _____ 2) Male _____

3. Race: 1) African American _____

   2) Asian/Pacific Islander _____

   3) Caucasian _____

   4) Hispanic _____

   5) Other (specify) _____

4. Number of times in the hospital in the past year? _____

5. Number of doctors' appointments in the past six months? _____

6. Have you needed help with personal care in the past six months such as bathing, dressing, going to the toilet, feeding and/or transferring?

   1) Yes _____ 2) No _____

7. Have you needed help with errands in the past six months, such as shopping food preparation, housekeeping, laundry, transportation, handling finances and/or assistance with taking medications?

   1) Yes _____ 2) No _____

8. Approximate the number of people you have used to help you with personal care and errands in the past six months. _____

9. Do you live:

   1) Alone _____

   2) With spouse _____

   3) With family or friends _____

Appendix F

1 CAMPUS DRIVE • ALLENDALE MICHIGAN 49401-9403 • 616/895-6611

June 12, 1997

Nancy Strong
5500 Douglas Ave.
Kalamazoo, MI 49004

RE: Project #97-67-H

Dear Nancy:

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, "***The Effects of Reminiscence Therapy on the Elderly Client's Satisfaction With Nursing Care***", 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,

[redacted]

Paul Huizenga, Chair
Human Research Review Committee

APPENDIX G

Phone Script

This is Nancy Strong, and I am a registered nurse at the Visiting Nurses. I am doing a study as part of my masters degree requirements for nursing and am looking for volunteers to participate. The study I am doing consists of you filling out a short questionnaire of 16 questions. I will make a visit in place of your regular nurse and do the things she usually does. If you would be interested in being part of the study, your name would not be used in the study. You would be free to withdraw at any time, and your care will not be affected in any way. I will also have you sign a consent form if you are interested in participating. Would you be interested in participating?

APPENDIX H

Consent Form

The study you are being asked to participate in is testing a nursing intervention to determine if it has an effect on patient satisfaction. If you choose to volunteer as a participant, you are being asked by the researcher for permission to gather information from you by means of a questionnaire after a routine nursing visit The questionnaire will be given to you after the visit is completed. You will need to fill it out and mail it in the self-addressed, stamped envelope provided.

Your confidentiality will be protected. All data collected will be number coded, and no names will be attached. Results will be reported in a group format. It is not anticipated that you will be harmed in any way by participating in this study. The nurse researcher will be available to answer questions should they arise or refer you to appropriate sources. You may withdraw from this study at any time without changes in your plan of care or nurse visits.

The personal benefits to you are limited. The results of this study will help determine if a specific nursing intervention will improve patient satisfaction of nursing care.

This study is being conducted by Nancy Strong, RN, a graduate student at Grand Valley State University, as a requirement for her masters degree in nursing. If you have any questions, she can be contacted at (616) 344-0691, or a message may be left at (616) 343-1396. You may also contact Dr. Paul Huizenga. Chairman of Grand Valley State University Human Research Review Committee at (616) 895-2472.

I have read and understand the information provided and consent, of my free will, to participate in the study.

_____	_____
Participant	Witness
_____	
Date	

APPENDIX I

Cover Letter with Questionnaire

Research in the field of nursing is important for the solution of clinical problems and for establishing nursing as a professional discipline. You, as the patient, are the receiver of care by the nurse and, as such, have important information to add to our knowledge base. Your participation is voluntary and will not affect the care you receive from the Visiting Nurses Association.

Please complete the questionnaire within 24 hours after the nurse's visit and at a time when you are not tired or feeling ill. Please mail the questionnaire using the self-addressed, stamped envelope. You may be assured of complete confidentiality. The questionnaire has a number on it for mailing purposes only. This is so we may check your name off the list when it is returned.

If you are interested in the results of the survey, please put your name and address on the blank 3 x 5 card provided and return it with the questionnaire. Do not put this information on the questionnaire itself.

Please feel free to call with any questions. Thank you for your participation.

Nancy Strong, RN
(616) 343-1396 or (616) 344-0691

APPENDIX J

ID# _____

Reminiscing Level Scale

X denotes score given.

1 _____ **Selection**

Selects an event in which he or she is the center or involves strong emotion.

2 _____ **Immersion**

Detail, sensory description, emotional component to the story.

3 _____ **Withdrawal**

Distances self from story, compares, generalizes.

4 _____ **Closure**

Moral, summary.

Developed by Nancy Strong. (1998).
Adapted from Merriam, S. (1989). The structure of simple reminiscence. The Gerontologist, 29, 761-767.

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