A Survey of Information Communicated to Adult Foster Care Providers in Relationship to Newly Admitted Residents

by

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Chapter I

This study focused on the type, adequacy, and timeliness of information given to foster care providers regarding residents recently admitted to an adult foster home by the referral source. Through clinical experience, this researcher observed an inconsistency in the type, amount, and adequacy of information given to foster care providers caring for older adults. Incorrect or inadequate information can result in an inappropriate placement of the resident, the inability of the foster care provider to meet the needs of the resident, and problems for the new resident in adjusting to their new environment.

Little research, if any, has focused on this topic. Therefore, this study was designed to describe what information is communicated to foster care providers in regard to newly admitted residents, and to explore the adequacy of this information, as perceived by the foster care provider.

Review of Literature

Older persons who are residents in adult foster care homes often have chronic illnesses and functional impairments which limit their ability to care for themselves. Foster care providers need a general level of knowledge about aging, chronic illnesses, special diets, medications, and functional impairments in order to give appropriate care to a resident. Additionally,

providers need specific information about each resident when the resident is admitted to foster care. No literature was found which focused directly on the information given to foster care providers regarding new residents. This gap in the literature is the focus of this study. Background information will be provided by a review of the literature in the following areas: (a) the nature of adult foster care, (b) the characteristics of adult foster care providers, (c) the characteristics of adult foster care residents, and (d) social policy and trends in adult foster care.

The Nature of Foster Care for Older Persons

Adult foster foster care is the provision of room and board and services, for compensation, in a private residence to small numbers of elderly, handicapped, or mentally impaired persons, by a nonrelative (Bradshaw, Vonderhaar, Keeney, Tyler, & Harris, 1976; Newcomer & Stone, 1985; Steinhauer, 1982). The development of adult foster care can be traced in the mental health and social science literature. It was first identified as a program sponsored by State Departments of Mental Hygiene and the Veterans Administration. Researchers initially described foster care as a treatment modality used to maintain deinstitutionalized, psychiatric patients in the community. The therapeutic outcome of these placements was the major focus of early studies (Handy, 1968; Linn & Caffey, 1977; McNeel, 1964; Molholm & Barton, 1941; Pollock, 1945; Risdorfer, Primanis, & Dozoretz, 1971). However, distinguishing

characteristics of foster care emerged in later studies: (a) small numbers of residents (1-5) were housed in private homes, (b) the care providers maintained a family atmosphere, and (c) the residents had an opportunity to be part of community life (Chouinard, 1975; Miller, 1977; Newman & Sherman, 1977, 1979, 1979-80; Sherman & Newman, 1977).

Characteristics of Adult Foster Care Providers

The characteristics of adult foster care providers, who care for elderly persons, have been analyzed in two major studies. Newman and Sherman (1977) interviewed a convenience sample of adult foster care providers (N=100), using an 85-item instrument, which had been tested for face validity. They reported that 93% of the providers were female, 58% married, and 29% provided a family atmosphere.

Bradshaw et al. (1976), using a convenience sample surveyed licensed foster care providers (N=183). Their results were similar to Newman and Sherman's findings. However, several additional characteristics were noted. Approximately 56% of the providers were white, 43% black, 43% had the equivalent of an eighth grade education or less, 35% had training related to nursing care, and 43% had worked in hospitals or nursing homes. Nearly one-fourth (23%) of the providers were caring for older relatives and this care of relatives was significantly related to the decision to operate a family care home $\chi^2(12, N=183) = 23.81, p<.05$. Further, whites were more likely to become providers for

financial reasons than blacks. Blacks were more likely than whites to become providers because of interest in the elderly. While these studies cannot be generalized to other populations of foster care providers, the researchers began the process of describing the characteristics of adult foster care providers, in an unlicensed program in New York (Newman & Sherman, 1977), and in a licensed program in Kentucky (Bradshaw et al. 1976).

Characteristics of Adult Foster Care Residents

The survey of foster care providers by Newman and Sherman (1977) described the residents (N=232) as 75% female, 50% widowed, 5% divorced, 4% married, and 25% aged 65 and over. Prior to foster care placement, 40% of the residents lived in their own homes.

Bradshaw et al. (1976) reported the following resident characteristics in his sample of 422 residents: 69% females, 32% males, 64% whites, 35% blacks, and 70% aged 65 and over. The length of stay varied from less than less than one year (34%), 1-2 years (17%), 2-5 years (31%), 5-10 years (15%), more than 10 years (2%). These results indicated that the resident population in Kentucky in the early 1970's was fairly stable.

Age of the residents was significantly related to their ability to walk and the length of time in the residence χ^2 (28, N=183)=57.94, p<.02. Eleven percent of the residents were nonambulatory and 7% were incontinent. These results implied that older residents were more impaired. Moreover, the provider continued to

provide care even though the needs of the resident changed. It may also be concluded that most foster care residents have chronic health problems or functional impairments and require supportive care.

Social Policy and Trends in Adult Foster Care

Adult foster care exists formally, under a variety of administrative auspices, and informally through the services of private individuals (Archbold & Hoeffer, 1981; Newcomer & Stone, 1985). It is often less visible than other alternatives for care and referred by a variety of terms. There is no standardization of adult foster care homes and the role of foster care providers, in relationship to the elderly, is not well defined (Deines, Bradshaw, & Blakely, 1976; Sherman & Newman, 1977; Steinhauer, 1982).

The Keys Amendment (1976) to the Social Security Act provides a federal mandate for states to establish safety standards for community residences where three or more Supplemental Security Income (SSI) recipients reside. However, the legislation does not stipulate the role of the federal government in setting or enforcing standards for adult foster care for residents who utilize other payment sources (Newcomer & Stone, 1985; Steinhauer, 1982).

During the last several years, policymakers have considered foster care as a housing alternative for elderly who needed supervision or assistance with activities of daily living (ADL'S) (Newcomer & Stone, 1985; Steinhauer, 1982). The idea of using adult foster

care to prevent or delay institutionalization also gained popularity (Chouinard, 1975; Sherman & Newman, 1977). Several complex, interrelated economic and quality of care issues were responsible for this notion: (a) increased pressure to deinstitutionalize nursing home residents (Allison-Cooke, 1982; Archbold & Hoeffer, 1981), (b) decreased lengths of stay for hospitalized patients who are released early into the community under the Medicare prospective payment system (Floyd & Buckle, 1987), (c) increased fiscal constraints on state and local governments in the provision of social and health care services (Reiss, 1983), (d) the trend toward maintaining elderly persons in the least restrictive living environment (Allison-Cooke, 1982; Miller, 1977; Newcomer & Stone, 1985; Steinhauer, 1982), and (e) the desire of states to maximize federal Medicaid contributions at all or most levels of care (R. Davison, personal communication, May 15, 1987). The consequence of these complex societal trends is that foster care providers are caring for increasingly impaired older persons. It is essential that they receive adequate information to provide care competently.

Summary

Residents of adult foster care homes are often chronically ill and/or functionally impaired. Foster care providers need a general level of knowledge about the care of older persons and specific information about the persons who become residents of a foster home. However, there is a lack of studies on the preparation

of foster care providers. Further, there is a lack of information on what types of information, about foster care residents, are transferred from the referral source to the foster care provider. Therefore, this study focused on the transfer of information, about elderly foster care residents, from the referral sources to the foster care providers.

Conceptual Framework

Foster care providers need information regarding a resident's health status, functional status, medication regime, personal preferences, and social support, in order to give quality care. Acquiring adequate information about a resident is an important aspect of determining the level of care needed by the resident, and the provider's ability to give the care required by the resident. Providers may also use information about a resident in: (a) screening for appropriate placement; (b) setting fees commensurate with the level of care required by the resident; (c) determining the compatibility of the new resident with the environment and other residents in the home; (d) determining the accessibility of services needed by the resident; and (e) assisting the provider in keeping accurate, useful records on the resident.

The conceptual framework for this study is presented in Figure 1. It depicts the transfer of information about a new resident from a referral source to the foster care provider. This model suggests that the different referral sources have, and communicate,

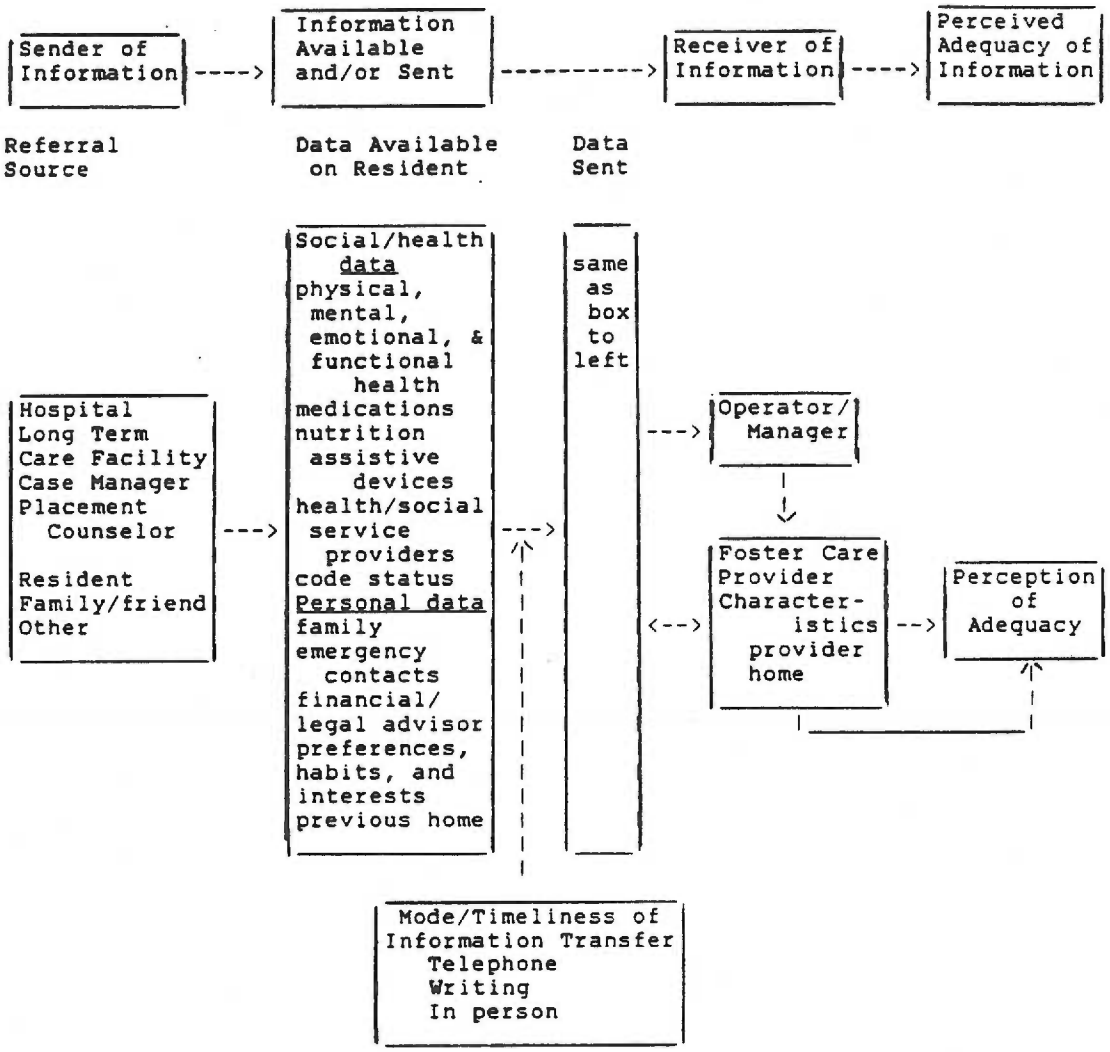

Figure 1. Conceptualization of information transfer from the referral source to the foster care provider.

different types of information about the new resident, and that the mode of information transfer may effect the information received and understood by the provider. The information about the resident needed by the provider may be channeled through another source (e.g., owner/operator), and this channeling may effect the quality of information the provider receives. Finally, the provider will evaluate the information s/he receives about the resident. Characteristics of the provider may influence the nature of the information received and the provider's perception of the adequacy of the resident information. This study focused on the data received by the foster care provider and his/her perception of the adequacy of the information.

Definition of Terms

Sender of Information/Referral Source

The sender of information is defined as the person(s) who are providing social, health, and personal data about the new resident. Among the referral sources listed, a case manager, who is a public employee, is the person responsible for organizing/coordinating all social/health/financial services for the foster home resident. A case manager, who is privately employed, coordinates and manages services for the foster care resident that are specified by the person who hires this case manager. These services often include social and health services. A placement counselor is a person who receives a request for assistance in locating and matching a resident to an adult foster home. Long term

care facility refers to facilities which provide sustained care in settings other than the resident's private home, a relative's home, or another foster care home (i.e., skilled nursing facility, intermediate care facility, extended care facility).

Information Available and/or Sent

The information available and/or sent about a new resident, is defined as the facts which are available and may be given to the adult foster care provider. These facts relate to the resident's physical, mental, emotional, and functional well-being, assistive devices, medications, as well as his/her personal care needs, interests, and preferences.

Mode/Timeliness of Information Transfer

The mode of information transfer is defined as the manner (e.g., by telephone, in writing, or in person) in which the information about a new resident is given to a foster care provider. Timeliness is represented by the time frame in which a provider receives information about a new resident from the sender of information.

Receiver of Information

The receiver of information is defined as the person to whom information about the new foster home resident is given. This person may be the operator who is licensed to operate an adult foster home, the manager who is directly responsible for the provision of care to the residents, or the provider who gives direct care to residents. One person may assume all three roles, or the roles may be performed by different persons.

Perceived Adequacy of Information

The perceived adequacy of information is defined as the adult foster care provider's perception of whether or not the information s/he received about the new resident is sufficient to enable her/him to provide appropriate care.

Statement of Purpose

The purpose of this study was to describe selected characteristics of the information about a new resident which was received by the foster care provider through contacts by telephone, in writing, or in person with the source of the information.

Research Questions

1. What referral sources provided information about the new resident to the adult foster care provider?

2. By what mode was information about the new resident transferred to the adult foster care provider?

3. When was the information about the new resident received?

4. What types of information (i.e., physical, mental/emotional health; medication regime; functional limitations; assistive devices; health providers; family/friends; personal preferences/interests) do adult foster care providers receive about new residents?

5. Did the adult foster care provider perceive the information received about the new resident to be adequate?

6. What were the characteristics of the adult foster care providers in this sample?

Chapter II

Methods

The purpose of this study was to describe selected characteristics of the information about a new resident which was received by foster care providers through contacts by telephone, in writing, or in person with the source of the information. An ex post facto survey design was used. The researcher contacted and screened all licensed adult foster care homes for the elderly in two large counties in a northwestern state. Foster care providers who gave direct care to residents in these licensed homes, who met the study's criteria, and were willing to participate were interviewed. Face to face interviews were conducted to obtain descriptive data regarding the nature of information received about new residents and the characteristics of adult foster care providers.

Setting and Subjects

The subjects for this study came from the population of adult foster care providers in all licensed adult foster care homes for the elderly in two large counties. The licensed adult foster care homes were identified by use of an adult foster care home registry obtained through the licensing agencies.

There were criteria for inclusion in the study, including specific characteristics of the foster care homes and of the foster care providers. The criteria for foster homes were: (a) homes providing foster care

for older persons, including persons with Alzheimer's Disease; (b) homes which excluded residents placed by programs for the mentally/emotionally disturbed (MED), the mentally retarded/developmentally disabled (MRDD), and the alcohol and/or drug dependent person; and (c) homes which had admitted an older resident (aged 65 and over) during the 30 day period prior to the initial contact by the researcher.

The criteria for the foster care provider's participation in the study included: (a) providers (owner/operator, manager, or employee) who actually gave direct care to the newly admitted resident; and (b) providers who were able to speak, read, and understand English, and were at least 21 years old.

Instruments

The researcher developed a structured interview for this study (Appendix A). Several methodological issues were considered in developing the survey instrument for this study. For example, the language of the instrument was geared to a person who had an eighth grade education since adult foster care providers come from a variety of backgrounds, experience, and education. In fact, one study reported that 43% of the providers had the equivalent of an eighth grade education or less (Bradshaw et al. 1976). In addition, the survey instrument was pre-tested on two occasions during it's development, with persons who gave care to impaired older persons. The instrument was reviewed by two social work and three nursing colleagues for clarity

of the questions. It was revised prior to the collection of data.

The organization of questions on the survey instrument was deliberate. It began with administrative data, such as the code number for the interview. Questions about the newly admitted resident followed. Demographic information was elicited at the end of the interview. Questions which asked for the opinions of the provider occurred in the middle. The purpose of formatting the instrument in this way was to put the provider at ease during the interview (Dillman, 1978).

The instrument contained 25 items, consisting primarily of close-ended and open-ended questions. Close-ended questions were used to elicit information about the referral source, the mode of information transfer, the type of information received about the new resident by the provider, and the timing of the information transfer. Finally, the foster care provider was asked to evaluate the adequacy of the resident information and to provide information about his/her motivation and preparation for becoming a provider. Information that could be used to identify the respondent or the foster home was not recorded on the instrument. The relationship of the conceptual domains, the questions on the survey instrument, and the research questions of the study are depicted in Appendix B.

Procedure

The procedures used to conduct this study are outlined in the discussion that follows. The researcher

obtained permission to conduct this study from the agencies that administer and regulate the adult foster care programs in their respective counties. The researcher gave a copy of the Research Protocol (Appendix C), and the a sample letter of endorsement to the administrators of the adult foster care programs in each county. The names of adult foster care homes were obtained from the adult foster care home registries maintained by the counties who participated. The researcher signed a statement of intent, which was provided by the counties, limiting the use of the registries to this study.

A letter was mailed to licensed adult foster care homes designated to care for older persons (Appendix D). This letter introduced the researcher, explained the study, and informed the provider that the researcher would be calling soon. In one county, foster care providers received this letter in a mailing done by the county (Appendix D). In the other county, the providers received a letter from the researcher (Appendix D), accompanied by a copy of a letter of introduction (Appendix D), which was prepared by the county and sent to the researcher.

A telephone call was made to the licensed adult foster care homes. During this call, the researcher asked the provider four screening questions to determine eligibility and willingness to participate in the study (see Appendix E for a script of the phone call). The screening questions were: (a) do you

actually give direct care to the residents of this home, (b) has a new resident moved into this home within the last 30 days, (c) are you at least 21 years old, and (d) do you understand and read English? If the provider or the home did not meet the study's criteria, the researcher thanked the provider for his/her time and terminated the call. If the provider was eligible for the study, the researcher obtained the verbal consent of the provider and made an appointment to visit the provider in the foster home of the newly admitted resident. If the provider was an employee of the adult foster care home, the provider obtained verbal consent to participate in this study from his/her employer.

On the day of the scheduled interview, a telephone call was made to the participating provider, to make sure that the time for the appointment was convenient. The researcher then went to the foster home and conducted the 45 minute interview.

The interviewer was a graduate nurse who was sensitive to both signs of anxiety in the respondent and the needs of the residents. The interview was discontinued or postponed if indicated by the clinical situation. This occurred in two cases: the death of a resident was imminent in one foster care home and there was confusion about the purpose of the interview in another foster care home. Finally, a summary of the significant findings of this study will be shared with the participating counties and/or providers at their request and by their consent.

Data Analysis

This descriptive study was designed to identify and describe the information received by adult foster care providers from referral sources. The results are described in Chapter III. The data were analyzed using descriptive statistics and content analyses.

Chapter III

Results

This section describes the sampling plan for this study and the findings. The findings will be presented according to the six research questions, and additional information gathered in the interview will be described.

Sampling Plan

The subjects for this study were selected from the population of adult foster care providers in two large counties in the northwest. A total of 379 adult foster care homes were identified by the two counties and letters about the study were sent to the owner/operator of these homes. Of these homes, 331 were licensed at the time of the study and were designated as foster care homes for elderly residents. When the remaining criteria for the study were applied to the sample, there were 66 eligible homes. Of these 66, interviews were conducted in 55 homes. The 11 individuals who refused to participate gave the following reasons: (a) too busy with caregiving (n=4), (b) family illness or family vacation (n=4), (c) lack of interest or understanding of the purpose of the interview (n=2), and (d) no reason stated (n=1).

Findings

The findings are organized by research question. The responses on the items for research questions #1, #2, and #3 are not mutually exclusive. Additionally, the categories used in research question #4, which asked about the resident's medical records (i.e., hospital

discharge summary, physician's orders, nursing care plan, and other), are not mutually exclusive.

Sender of information/referral source (research question #1). There were several referral sources who gave information about the new residents to the providers. Of the 55 providers interviewed, 83.64% (n=46) received information from a family member, 32.73% (n=18) from a private referral agent, 29.09% (n=16) from the resident him/herself, 27.27% (n=15) from a social worker, 15.54% (n=8) from a nurse or a nursing home staff member, 10.91% (n=6) from a friend, 7.27% (n=4) from a hospital discharge planner, and 7.27% (n=4) from another foster care operator. When a provider received information from more than one referral source, it most frequently was from the following combinations: (a) family member and private referral agent (n=7, 12.73%); (b) family member and social worker (n=6, 10.91%); and (c) resident, family member, and private referral agent (n=4, 7.27%).

Mode/timeliness of information transfer (research questions #2 and #3). Providers received information on the residents through three modes including: information given in writing, 54.55% (n=30); information given in person, 89.09% (n=49); and information given by telephone, 85.45% (n=47). When a provider received information by more than one mode, it was most often from the following combinations: (a) in writing, by telephone, and in person (n=21, 38.18%) and (b) by telephone and in person (n=21, 38.18%). Portions of the

information were received at various times. Most providers received pieces of information about the new resident in two or more time intervals, including 27 (49.09%) providers who received some information about their new resident 3-7 days before the resident moved in, 20 (36.36%) who received information 1-2 days before, 14 (25.46%) who received information the day of the move, 5 (9.09%) who received information 1-2 days after, 4 (7.27%) who received information 3-7 days after the move, and 20 (36.36%) who received information at another time.

Information available and/or sent (research question #4). Table 1 depicts the primary reason for the placement of the resident, according to the provider's perception. Ninety-one percent (n=51) of the providers gave reasons for the new resident's move into the foster care home. The remaining providers were either not told the reason (n=4, 7.27%) or were not sure of the reason for the placement (n=1, 1.82%).

The providers reported that the residents came from the following living situations: (a) the resident's own home (n=19, 34.55%), (b) the home of a relative or friend (n=10, 18.18%), (c) a nursing home (n=9, 16.36%), (d) another foster care home (n=9, 16.36%), (e) other (i.e., residential care facility or retirement home) (n=5, 9.09%), and (f) a lodge/hotel (n=1, 1.82%). Two providers (3.64%) were unsure of the resident's previous living situation.

There were 15 residents (27.27%) who came to the

Table 1

Primary Reason Given By Foster Care Provider for Placement of the New Resident (n = 51)

Reason[a]	n	%
Resident no longer able to live alone due to declining health, increasing physical limits or need for 24 hour supervision	24	47.06
Previous placement inappropriate or dissatisfactory	10	19.61
Relatives unable/unwilling to provide care in their homes	9	17.65
Relatives need a respite	4	7.84
Resident needed temporary supportive living environment during convalescence	4	7.84

[a]Categories mutually exclusive.

foster home directly from the hospital. Of those residents, 12 (80.00%) lived in their own homes prior to the hospitalization, and the remaining 3 (20.00%) lived in the home of a friend or relative, in a nursing home, or in a hospital-based extended care facility prior to hospitalization.

At least some portion of the medical records of those residents who came from the hospital (n=15, 27.27%) were sent to the foster care providers. Five (9.09%) providers received complete records (i.e., hospital discharge summary, physician's orders, nursing care plan). Of the remaining providers, eight (14.55%) received physician orders only, seven (12.73%) received hospital discharge summaries only, and six (10.91%) received nursing care plans only. However, two (3.64%) providers received only a list of medications when the new resident came from the hospital to their home. Three (5.45%) providers received hospital discharge summaries and physician orders even though their new resident had not been hospitalized immediately prior to this placement. An additional five (9.09%) providers stated that they received nursing home transfer forms.

The information received by the foster care provider on the resident's medical and social support network is described in Table 2. All the providers were told the name of the person to be notified in case of emergency. Nearly 90% were told the name of the resident's physician, however, only 29.09% (n=16) were told the code status of the resident. In addition,

Table 2

Information Received on Resident's Medical and Social Support Network

Category	Told		Not Told		Unsure		DNA	
	n	%	n	%	n	%	n	%
Medical Network								
Physician	48	87.27	5	9.09	1	1.82	1	1.82
Pharmacist*	31	56.36	10	18.18	1	1.82	--	--
Person to notify in case of emergency	55	100.00	--	--	--	--	--	--
Code Status	16	29.09	35	63.64	4	7.27	--	--
Social Support Network								
Next-of-kin	53	96.36	1	1.82	--	--	1	1.82
Guardian	18	32.73	13	23.64	13	23.64	11	20.00
Financial/Legal Advisor	46	83.64	5	9.09	1	1.82	3	5.45

*Note. Provider used own pharmacy (n = 13 23.64%).

providers were given the name of the pharmacist for just over half of the residents. Several providers (23.64%, n=13) indicated that they used their own pharmacy for all their residents, including the new resident.

The information received about the preferences and interests of the residents are described in Table 3. For example, 47.27% (n=26) of the providers were told about the resident's hobbies. In addition, most providers (87.27%, n=48) were told about the resident's food preferences, while only half (50.91%, n=28) were told of the resident's preference for smoking. Fifteen (27.27%) providers, who did not ask about the resident's smoking preference, designated their homes as nonsmoking homes.

Another category of information requested of the foster care providers related to the physical and health care needs of the resident. Providers were asked to identify the presence of chronic health problems in the new resident and to indicate whether or not they received information regarding the problem. Table 4 summarizes these findings. For example, 80.00% (n=44) of the providers identified the presence of chronic health problems in the resident. While 81.82% (n=36) said they were told of these health problems, 18.18% (n=8) said they were not told.

The providers were also asked about five other areas of information about the resident. The findings are summarized in Tables 5-9 and include: (a) the information on the resident's mental and emotional status as perceived by the foster care provider

Table 3

Percent of Providers Told About Resident's Interests and Preferences

Category[a]	n	%
Interests		
Hobbies	26	47.27
Community Activities	9	16.36
TV or Radio	30	54.55
Reading	26	47.27
Gardening	7	12.73
Visiting with Others	36	65.45
Other[b]	38	69.09
Preferences		
Smoking[c]	28	50.91
Food	48	87.27
Like/Dislike Children	34	61.82
Like/Dislike Pets	29	52.73
Like/Dislike Visitors	43	78.18
Church Attendance/Regular Clergy Visits	28	50.91
Be Alone	21	38.18
Sleep Habits	41	74.55
Expect Visitors	42	76.36

[a]Categories are not mutually exclusive.

[b]Examples include walking or helping with simple household tasks.

[c]Fifteen (27.27%) foster care homes were designated as non-smoking.

Table 4

Information on the Resident's Chronic Health Needs/Problems as Perceived by the Foster Care Provider

Category	Presence of Problem						If Present, Information Transferred[a]			
	Yes[a]		No		NS[b]		Yes		No	
	n	%	n	%	n	%	n	%	n	%
Chronic health problems	44	80.00	11	20.00	--	--	36	81.82	8	18.18
Allergies	10	18.18	42	76.36	3	5.45	8	80.00	2	20.00
Special equipment/ aides	31	56.36	24	43.64	--	--	29	93.55	2	6.45
Special diet	17	30.91	38	69.09	--	--	15	88.24	2	11.76
Special treatments	14	25.45	41	74.55	--	--	12	85.71	2	14.29
Other medical management problems	20	36.36	35	63.64	--	--	10	50.00	10	50.00
Taking medications	54	98.18	1	1.82	--	--	45	83.33	9	16.67
Told names of medications	--	--	--	--	--	--	44	81.48	10	18.52
Told reasons for giving medications	--	--	--	--	--	--	40	74.07	14	25.93
Told dosages and times to give	--	--	--	--	--	--	44	81.48	10	18.52

[a]Only those subjects who answered yes to presence of the problem were asked whether or not they were told the information.

[b]Not sure.

(Table 5), (b) information on the resident's physical problems as perceived by the foster care provider (Table 6), (c) information on the resident's functional limitations as perceived by the foster care provider (Table 7), (d) information about the equipment used by the resident as reported by the foster care provider (Table 8), and (e) information on the resident's need for help with activities of daily living as perceived by the foster care provider (Table 9).

Perceived adequacy of information (research question #5). Eighty percent (n=44) of the providers reported that the information they received about their new resident was adequate. However, 47.27% (n=26) of the providers stated they wished they had been given additional information about the new resident prior to placement. The providers indicated this specific information would have been helpful in identifying the appropriate level of care for the resident, in setting fees commensurate with the care needs, and in helping the resident adjust to the move.

Characteristics of the adult foster care provider (research question #6). The 55 subjects were foster care providers who were giving direct care to the elderly residents newly admitted to the adult foster care homes. The providers ranged in age from 20 to 65, with a mean age of 45 years. The educational levels of the providers varied: 7 (12.73%) completed less than a high school school education, 28 (50.91%) completed high school or the equivalent of a high school education,

Table 5

Information on the Resident's Mental/Emotional Status as Perceived by the Foster Care Provider

Category	Presence of Problem						If Present, Information Transferred[a]					
	Yes		No		NS[b]		Yes		No		NS	
	n	%	n	%	n	%	n	%	n	%	n	%
Resident depression	22	40.00	33	60.00	--	--	16	72.73	5	22.73	1	4.55
Resident confusion	26	47.27	29	52.73	--	--	17	65.38	8	30.77	1	3.85
Resident behavior problems	14	25.45	41	74.55	--	--	6	42.86	8	57.14	--	--
Resident wandering	8	14.55	47	85.45	--	--	8	100.00	--	--	--	--
Other mental/ emotional problems	31	56.36	24	43.64	--	--	14	45.16	17	54.84	--	--

[a]Only those subjects who answered yes were asked whether they were told the information.

[b]Not sure.

Table 6

Information on the Resident's Physical Problems as Perceived by the Foster Care Provider

Category	Presence of Problem						If Present, Information Transferred[a]					
	Yes		No		NS[b]		Yes		No		NS	
	n	%	n	%	n	%	n	%	n	%	n	%
Resident vision problems	27	49.09	26	42.27	2	3.64	17	62.96	10	37.04	--	--
Resident hearing problems	16	29.09	39	70.91	--	--	13	81.25	3	18.75	--	--
Resident speech problems	10	18.18	35	63.64	--	--	7	70.00	3	30.00	--	--
Resident urinary incontinence	17	30.91	37	67.27	1	1.82	6	35.29	10	58.82	1	5.88
Resident bowel incontinence	8	14.55	46	83.64	1	1.82	2	25.00	5	62.50	1	12.50
Resident - other physical problems	17	30.91	38	69.09	--	--	17	100.00	--	--	--	--

[a]Only those subjects who answered yes were asked whether they were told the information.

[b]Not sure.

Table 7

Information on the Resident's Functional Limitations as Perceived by the Foster Care Provider

Category	Presence of Problem						If Present, Information Transferred[a]			
	Yes		No		NS[b]		Yes		No	
	n	%	n	%	n	%	n	%	n	%
Resident totally bedridden	5	9.09	50	90.91	--	--	4	80.00	1	20.00
Resident partially bedridden	6	10.91	49	89.09	--	--	2	33.33	4	66.67
Resident unable to get in/out of bed without aid	20	36.36	35	63.64	--	--	11	55.00	9	45.00
Resident unable to get in/out of tub/shower without aid	38	69.09	15	27.27	2	3.64	32	84.21	6	15.79
Resident unable to walk without aid	19	34.55	36	65.45	--	--	12	63.16	7	36.84
Resident - other mobility problems problems	22	40.00	33	60.00	--	--	12	54.55	10	45.45

[a]Only those subjects who answered yes were asked whether they were told the information.

[b]Not sure.

Table 8

Information About the Equipment Used by the Resident as Reported by the Foster Care Provider

	Knew/Problem						If yes, Information Transferred[a]					
	Yes		No		NS[b]		Yes		No		NS	
Category	n	%	n	%	n	%	n	%	n	%	n	%
Resident uses wheelchair	12	21.82	43	78.18	--	--	10	83.33	2	16.67	--	--
Resident uses cane/walker	28	50.91	27	49.09	--	--	26	92.86	2	7.14	--	--
Resident uses catheter	--	--	55	100.00	--	--	--	--	--	--	--	--
Resident uses diapers/pads	19	34.55	36	65.45	--	--	11	57.89	8	42.11	--	--
Resident uses leg/arm braces	3	5.45	52	94.55	--	--	2	66.67	1	33.33	--	--
Resident uses O_2/breathing equipment	3	5.45	52	94.55	--	--	2	66.67	1	33.33	--	--
Residnet uses eye glasses	41	74.55	13	23.64	1	1.82	33	80.49	7	17.07	1	2.44
Resident uses hearing aid	6	10.91	48	87.27	1	1.82	5	83.33	--	--	1	16.67
Resident uses dentures	33	60.00	17	30.91	5	9.09	19	57.58	14	42.42	1	3.03
Resident uses other equipment	19	34.55	36	65.45	--	--	14	73.68	5	26.32	--	--

[a]Only those subjects who answered yes were asked whether they were told the information.

[b]Not sure.

Table 9

Information on the Resident's Need for Help with Activities of Daily Living as Perceived by the Foster Care Provider

	Presence of Problem						If Present, Information Transferred[a]					
	Yes		No		NS[b]		Yes		No		NS	
Category	n	%	n	%	n	%	n	%	n	%	n	%
Resident needs help with bathing	47	85.45	8	14.55	--	--	39	82.98	8	17.02	--	--
Resident needs help with grooming	36	65.45	19	34.55	--	--	27	75.00	7	19.44	2	5.56
Resident needs help with dressing	30	54.55	25	45.45	--	--	22	73.33	8	26.67	--	--
Resident needs help with eating	17	30.91	38	69.09	--	--	11	64.71	5	29.41	1	5.88
Resident needs help with all ADL's	11	20.00	44	80.00	--	--	6	54.55	4	36.36	1	9.09
Resident needs other help	16	29.09	39	70.91	--	--	7	43.75	8	50.00	1	6.25

[a]Only those subjects who answered yes were asked whether they were told the information.

[b]Not sure.

16 (29.09%) had post high school education, and 4 (7.27%) had completed graduate education. Eighty-nine percent (n=49) of the providers were female and 11% (n=6) were male. Of these, 94% (n=52) were white (non-Hispanic), 4% (n=2) black, and 2% (1.82%) Asian. Sixty percent (n=33) of the providers were married, 24% (n=13) were divorced or legally separated, 9% (n=5) were widowed, and 7% (n=4) were never married. Additional characteristics of the foster care providers are described in Table 10.

Additional information gathered in the interview. The size of the adult foster care home was described according to the number of residents being cared for by the providers at the time of the interview. Of the providers in the sample, 3.64% (n=2) were caring for 1 resident, 25.45% (n=14) for 2-3 residents, 69.09% (n=38) for 4-5 residents, and 1.82% (n=1) for more than 5 residents. There were no male residents in 45.45% (n=25) of the homes, and no female residents in 5.45% (n=3) of the homes.

Providers were asked whether the placement of the new resident was permanent or temporary and whether the reimbursement for care would be from the county or private individuals. There were 29 (52.73%) residents placed for permanent residence by private individuals, 15 (27.27%) placed for permanent residence by the county's senior services division, 8 (14.55%) residents placed for temporary respite care by private individuals (i.e., temporary relief for the family caregiver,

Table 10

Frequencies on Selected Characteristics of Foster Care Providers

Category	n	%
Provider's Primary Role:		
Owner-Operator	42	76.36
Resident Manager	10	18.18
Provider/Employees	2	3.64
Other	1	1.82
Length of Time Providing Foster Care:		
Less than 3 months	5	9.09
3 to 6 months	3	5.45
6 to 12 months	8	14.55
1 to 3 years	20	36.36
3 to 5 years	10	18.18
More than 5 years	9	16.36
Reasons for Becoming a Foster Care Provider[a]:		
Helped Relative/Friend in Foster Care Home	26	47.27
Lost/Quit Job and Needed Income Source	19	34.55
Provide Care for Elderly in Non-Traditional Setting	17	30.91
Wanted to be at Home	12	21.82
Loving/Liking the Elderly	11	20.00
Experience as Relative Caregiver	10	18.18

Table 10 continues

Table 10 continued

Category	n	%
Most Helpful Experience Providing Foster Care[a]:		
Certified Nurses' Aide or Nurses' Aide	15	27.27
Registered Nurse	4	7.27
Licensed Practical Nurse	3	5.45
Other Experiences Working in Health Care Environment	9	16.36
Caring for Ill Family Member	9	16.36
Working in People-Oriented Professions	7	12.73
Homemaker/Raising Children	4	7.27
Working in Another Foster Care Home	3	5.45
Providing Foster Care/Babysitting Children	2	3.64

[a]Categories not mutually exclusive.

temporary placement for resident while the family considered other care options, temporary placement for a resident convalescing from surgery), and 1 (1.82%) resident placed by the county's senior services division for respite care to receive medical treatment in a neighboring community. One (1.82%) provider was unsure of the plan for reimbursement for the new resident.

Chapter IV

Discussion and Summary

The major findings for the six research questions will be discussed, including a presentation of the themes from the open-ended questions posed to the foster care providers. The limitations of the study will be presented, followed by the implications for nursing practice and recommendations for future research. Finally, a summary of this study will be presented.

Discussion

The major findings are discussed according to the research questions, beginning with the referral sources who gave providers information about the new resident.

Sender of Information/Referral Source

The majority of the providers received information about the new resident from a family member (n=46, 83.64%). The next highest source of information was the private referral agent (n=16, 29.09%). Most foster care providers (n=51, 92.73%) received information about the resident from more than one referral source. Only four (7.27%) providers received information from a single source. Further, only 18.18% (n=10) of the residents gave information about themselves, during the placement, to the providers. This indicates that the new resident was often not involved in giving information to the provider during the placement. The resident may have been unable to provide information due to cognitive or communication deficits. On the other hand, the resident

may have been left out of the process of giving information to the foster care provider.

Foster care providers offered feedback on the methods for collecting information when asked who actually gave them information on the new resident. Several providers related that they had developed their own systems of soliciting information about new residents. Some providers interviewed family members of the new resident prior to the placement of the resident. At least 45% (n=25) of the providers gathered information from family members during the families' initial visit to the foster home. Additionally, seven (12.73%) providers reported that they made a personal visit to the prospective resident before the resident was admitted to the foster home.

Some providers also used forms developed by the licensing agencies to assist them in gathering information and keeping records for the residents. These forms included a sample of the contract agreement between the foster care provider and the resident, the resident's bill of rights, personal data forms, social and health history, daily medication records, and weekly progress notes. However, not all of the providers used these forms.

Mode/Timeliness of Information Transfer

The mode and timeliness of the transfer of information about a foster care resident has not been previously reported in the literature. In this study information was transferred through three modes with

"in person" or "by telephone" occurring the most frequently. The other mode of information transfer was "in writing". Due to the complexity and accuracy of information needed on the resident, it is recommended that all three modes of information transfer be utilized. This is not the current practice.

Foster care providers reported that they received information at a variety of time intervals. For example, some information about the new resident was sent one week prior to placement, some 1-2 days before placement, and some on the day of placement. In at least 36% (n=20) of the cases, providers reported getting some information about the new resident 8 to 45 days prior to placement. In contrast, other providers reported that they continued to receive information 2 to 4 weeks after the resident was placed. In reality, information is being transferred in an inconsistent time frame. Ideally, information should be transferred through a series of contacts, with screening information being transferred early in the process.

Information Available and/or Sent

Foster care providers reported seven categories of information about the new resident: (a) the resident's reason for moving into the foster care home; (b) the resident's previous living arrangement; (c) the resident's placement directly from a hospital; (d) information transferred through the resident's medical records, (e) the resident's health status, care needs, and care regime; (f) the resident's health providers and

family/friends; and (g) the resident's personal preferences and interests. Providers were able to give reasons for the new resident's move into foster care in 90.91% (n=51) of the cases. However, providers were not asked if they were told the reason for the resident's move into the foster home. Therefore, the response to this question represents the provider's perception of the reason for the resident's move.

The residents' previous living arrangements included, but were not limited to, their own homes, other foster care homes, and nursing homes. In this systematic sample, 34.55% (n=19) of the residents lived in their own home prior to moving into the foster care home. In comparison, Bradshaw et.al. (1976) used a convenience sample of 183 providers and reported that 40% of the 422 residents lived in their own homes prior to being placed in a foster care home.

There are no statistics available in the literature on the percentage of persons sent directly to a foster care home from the hospital instead of returning to their own home. In this study, 27.27% (n=15) of the residents were admitted to the foster home directly from the hospital. Eighty percent (n=12) of those admitted from a hospital had lived in their own homes prior to the hospitalization. Of these 12 residents, 9 were admitted to the foster home permanently. Early release from the hospital may have prevented some of these residents from returning home.

Finally, 16.36% (n=9) of the new residents came

from nursing homes. Only one (1.82%) of these residents was admitted from the nursing home to the hospital before placement in the foster care home. The providers identified several reasons for moving the residents from a nursing home to the foster care home including: (a) the resident's inability to live alone, (b) the resident's inability to manage his/her medications, (c) the families lack of knowledge about the alternative of adult foster care, (d) the resident's or family's dissatisfaction with nursing home care, and (e) the decisions by caseworkers that the resident no longer needed nursing home care.

The next category focused on the information transferred through the medical records of the new resident. Providers reported an inconsistency in the type, amount, or accuracy of the information transferred through the resident's medical records to the providers. Further, the information that was received was frequently inappropriate for foster care placement issues. Possible explanations for this problem include an ambiguity about the types of information that should be transferred to foster care providers, the inability of the foster care provider to utilize medical records information due to inadequate health care background, the providers lack of familiarity with how and where to access information, or the fragmentation and lack of complete information on the forms. For example, some providers received incomplete lists of the resident's medications. Other providers reported the omission of

all information on the medical record, except instructions describing the rehabilitation regime of a resident. Additionally, some providers asked physicians for information about a resident and the physicians refused to comply with the request.

The resident's health status, care needs and care regime were also explored at length. The health status and medical management of the residents in adult foster homes has not been reported in the literature. In the current study, providers were asked about the health status of their new resident. Providers were asked, "Does your new resident have a chronic health problem?" If the providers identified a problem, they were asked to indicate if they were told about the problem. The question did not measure whether the resident had been diagnosed with a chronic illness such as emphysema. Instead it measured the provider's perception of the resident's chronic health problems. Eighty percent (n=44) of the providers reported the presence of chronic health problems. Further, three (5.45%) providers stated that the resident did not have a chronic health problem even though they were told that the resident did. This may be due to the provider's lack of understanding of chronic health problems or the receipt of incorrect information.

In some cases, providers reported that the extent of the resident's chronic health problem was not told to them. For example, one provider was not told that the resident had a potential for skin breakdown associated

with their chronic illness. Some of the chronic health problems that providers identified in their residents were kidney failure, heart problems, seizures, chronic lung disease, stroke, diabetes, congestive heart failure osteoporosis, brain injury, and arthritis. In addition, several subjects were caring for residents in the terminal stages of cancer. Lastly, providers cited Alzheimer's Disease as a chronic health problem. However, many providers seemed to use this label to describe confusion or memory deficit problems of the new residents.

Providers reported a higher rate of not being told about the resident's confusion than not being told about the resident's depression (30.76% compared to 22.72%). Providers also identified other mental states in the residents, such as anxiety, or fear and sadness about the move to a foster care home. In 55% (n=17) of these cases the providers were not told about these mental states. Several providers indicated that they expected an adjustment phase in the resident's move and that the adjustment to a relocation was rarely addressed by social workers or family members.

In this study providers were not told of behavior problems in 57.14% (n=8) of the residents for which they experienced behavior problems after admission of the resident. Examples of these behavior problems included belligerence, noncompliance in taking medications and maintaining personal hygiene, throwing tantrums, screaming, being combative, and talking incessantly. In

contrast, at least five providers were told the resident would be volatile, a severe behavior problem, manipulative, belligerent, uncooperative, or have a tendency to wander; however, the behaviors were not observed by the providers. Finally, the providers reported that other behaviors also occurred (i.e., adjustment reaction to grief or relocation, chronic complaining, unwillingness of the resident to participate in their own care).

The providers were asked if they were told about the residents' incontinence. Nearly 31% (n=17) of the providers reported their resident had problems with bladder incontinence and 58.82% (n=10) were not told. Almost 15% (n=8) reported that their resident had bowel incontinence and 62.50% (n=5) were not told. Providers indicated that information about the resident's incontinence may not be shared for fear that the provider will refuse to admit the resident to the home.

The functional limitations of the residents were also explored. Providers were told about the resident's inability to get in and out of the shower/tub a greater percentage (n=32, 58.18%) of the time than other functional limitations. The mobility problems that providers reported not being told about most frequently was the resident's inability to transfer (n=9, 45.00%).

In Bradshaw's et al. (1976) study, providers reported that 11% of their resident were nonambulatory. In this study, 20% (n=11) of the residents were nonambulatory (i.e., 9.09% of the residents were totally

bedridden; 10.91% were partially bedridden, and in need of assistance with transferring). This may reflect an increase in the impairment level of the residents in adult foster care over the last 11 years.

In general, most of the providers were told about the new resident's needs for equipment/aides. However, providers were not told that the resident wore dentures in more than 42% (n=14) of the cases. Some providers indicated this lack of knowledge did not matter because they would eventually find out about the dentures. Other providers indicated not knowing about the dentures created problems with the oral hygiene of residents.

The providers also identified other equipment needs that were not measured with the survey instrument. Examples include bedside commodes, hospital beds, and trapezes for the hospital beds. In 26.32% (n=5) if the cases providers were not told of these equipment needs.

Twenty percent (n=11) of the new residents needed help with all of their activities of daily living (ADL'S). However, only 4 (54.54%) of the 11 providers were told that the resident needed help with all of their ADL'S. This discrepancy may support the opinion of the providers that families and/or hospitals want to expedite placement of residents who require heavy care and, therefore, do not share the total care needs of the resident. On the other hand, it may indicate that it is difficult for providers to assess the total care needs of the resident during the admission process.

Foster care providers were asked if they were told the names of persons in the resident's medical and social support network (e.g., health care providers, family members, friends). Additionally, providers were asked if they were told about the resident's personal preferences and interests. All of the providers were told the name of the person to be notified in an emergency and 96.36% (n=53) providers were told the name of the resident's next-of-kin. In 87.27% (n=48) of the placements, providers were told the name of the resident's physician. Finally, 56.36% (n=31) of the providers were told the name of the resident's pharmacist. However, 23.64% (n=13) of the providers used their own pharmacy.

Foster care providers were told of the resident's preferences for certain foods in 87.27% (n=48) of the placements. Additionally, providers were told about the resident's sleep habits (74.55%, n=41) and expectation for visitors (76.36%, n=42). Although 28 (50.91%) providers were told of their resident's preference for smoking, 15 (27.27%) providers had designated their home as non-smoking, and did not ask their resident about his/her smoking preference. Most providers considered the knowledge of the resident's food preferences extremely important. Finally, providers were told more frequently about their resident's interests in visiting (65.45%, n=36), television/radio (54.55%, n=30), reading (47.27%, n=26), and hobbies (47.27%, n=26).

Perceived Adequacy of Information

Although 80.00% (n=44) of the providers felt they received adequate information from the family members of the new residents in this study, at least 25.45% (n=14) of the providers indicated that, in general, family members were not good historians. These 14 providers also stated that family members tended to minimize the problems of the resident because the decline of their health was hard to accept. In addition, families were reluctant to discuss the extent of their relative's problems for fear of being assessed higher fees or refused admission by the foster care provider. Finally, providers indicated that some families were unaware of the extent of care their relative needed. It needs to be noted that these providers were not referring to the present sample of families, but instead to families of residents who were placed in these homes at other times.

The issue of accuracy of information was also raised in relation to other referral sources. Some providers (n=15, 27.27%) indicated that the amount, type and accuracy of information they received from hospitals and social workers was inconsistent. The researcher did not introduce the concept of the accuracy of information in the interview. However, the providers often made statements about the accuracy of information when adequacy of information was discussed. Further, the providers appeared more concerned about the accuracy of the information because they made placement decisions based upon the information they were given.

Characteristics of the Adult Foster Care Provider

The 55 providers gave several reasons for becoming a foster care provider. They (n=26, 47.27%) stated that they had helped a friend or relative, in foster care, and later decided to become a provider. Providers (n=19, 34.55%) indicated that they needed income and a job, which influenced the decision to become providers. Providers gave four additional reasons for becoming providers: being able to provide care for elderly in a nontraditional setting (n=17, 30.91%), wanting to be at home (n=12, 21.82%), liking/loving the elderly (n=11, 20.00%), and being a relative caregiver (n=10, 18.18%). Providers usually gave more than one reason for becoming a provider and the circumstances associated with their decision varied.

In this study, 89.09% (n=49) of the providers were women. In comparison, Newman and Sherman (1977) reported that 93% of their providers were women and Bradshaw et.al. (1976), reported that 99% of their providers were women. Women may become foster care providers more often than men because they have been socialized into caregiving roles. Further, there are limited opportunities in the workforce for women with a high school education. Some women in this study, wanted to combine their role as a homemaker with their role as a foster care provider.

On the other hand, providers who were men (n=6, 10.91%) became foster care providers for the following reasons: (a) their parents were operating foster care

homes in which they worked to make money (n=2, 3.64%); (b) they had experienced the loss or injury of a spouse and subsequently became foster care providers (n=2, 3.64%); and (c) they had worked with the elderly in other settings, one as an administrator and the other as a certified nurses aide. In addition, seven of the female providers had husbands who worked with them as foster care providers. Some of these husbands were retired, some worked full time in the foster home, and others held full time jobs outside the home.

The majority of the providers in this study had completed at least a high school education (n=28, 50.91%) and 36.35% (n=20) had post high school education. Forty percent (n=22) of the providers had training related to nursing care (i.e., nurses aide n=15, 27.27%; registered nurse n=4, 7.27%; and licensed practical nurse n=3, 5.45%). An additional 16.36% (n=9) of the providers worked in health related fields.

Most of the providers (n=52, 94.54%) interviewed were white (n=48, 87.27%). Only two providers were black and one was Asian. This distribution is similar to the general population in the area that the research was conducted.

Additional Comments about the Transfer of Information

Several providers expressed that they were not identified as professional caregivers by other health care providers. Generally, the providers reported the greater difficulty in getting information from the resident's physician than from other health providers.

Some providers suggested the use of a nurse liaison between the physician and the provider as a method for accessing information about the resident.

Additional Concerns Expressed by Foster Care Providers

In an open-ended question at the end of the interview providers expressed their concerns in four major areas: (a) the regulation of adult foster care homes; (b) the provision of respite for foster care providers; (c) the provision of foster care by the family who lives in the foster home with the residents versus the provision of care in a chain of foster homes managed by one owner, with multiple employees; and (d) the use of private referral agencies for placing residents in a foster home.

A few providers (n=8, 14.55%) stated that the additional regulation of adult foster care was needed. It was stressed by these six providers that regulation should be provided for the sake of the elderly.

Providers identified respite for providers as an essential issue that needs to be addressed. The providers reported a lack of qualified caregivers who could give respite to the providers. Many providers were responsible for providing care seven days a week, 24 hours a day. In addition to the lack of respite caregivers, providers indicated that it is expensive to hire respite caregivers and that the regulatory agencies placed unreasonable restrictions on providers in hiring other caregivers.

A few providers (n=6, 10.91%) expressed strong

sentiment against the trend to operate foster care homes as a business chain. These providers felt that it was inappropriate to place foster care outside the single family unit. It was stated that foster care will not be any different than a nursing home if the resident is "just put in a room". Providers wanted to protect the family atmosphere which sets foster care apart from other modes of housing placement options. Finally, providers felt it was important to include the resident in a family lifestyle, provide a caring, warm atmosphere, and encourage the resident's involvement in community activities when possible.

Some providers stated that the private referral agencies provided good screening of the residents for placement in the foster home. These providers relied on the agent to place residents which were compatible with the home. However, other providers indicated that agents did not match residents to the provider or the other residents in the home and compatibility was very important. In addition, providers thought that private referral agents charged high fees for placement services and therefore the success of the placement was very important. For this reason, providers felt that agents should provide follow-up visits to the foster home to evaluate the success of the match.

Limitations

The limitations of this study will be discussed and include sampling only licensed foster care homes, the way in which the letter of endorsement was mailed, and

measurement problems associated with the survey instrument.

Sampling

The findings of this study can be generalized only to the population of licensed adult foster care homes. An informal network of unlicensed foster care homes for the elderly does exist in which providers are not required to be licensed or do not know that they need to be licensed.

Letter of Endorsement

The way in which the letter of endorsement (Appendix D) was mailed appeared to have had an impact upon the refusal rate of the providers. Those providers, who received a letter which explained and endorsed the study from the local regulatory agency had a lower refusal rate (n=1, 5%) than those providers who received a letter of introduction directly from the researcher, without an endorsement of the study (rate of refusal n=10, 20%).

Instrument

There were some problems noted in the structure of questions in the instrument used in this study, including 9a and 10a through 10h (refer to Appendix A) Question 9a currently reads, "Can you tell me why your new resident moved into this home? Answer yes or no... if yes, explain." In this format, the researcher cannot determine if the provider was "told" the reason for the new resident's move or if he/she made assumptions about the reason for the move. The question should be changed

to read "Were you told why your new resident moved into this home? Answer yes or no...if yes, explain". This format would help distinguish between the transfer of information and the provider's perceptions of the reasons for the resident's move.

The researcher recommends reversing the order in which part one and part two of questions 10a through 10h were asked. For example, 10a currently reads, "Does your resident have chronic health problems? If yes, were you told?" In the reversed order the question would read, "Were you told that the new resident has chronic health problems? If yes, does the resident have chronic health problems?" The revised format would measure if the provider was told that the resident had a chronic health problems instead of the measuring the provider's perception that the resident had a chronic health problems.

The providers response to perceived adequacy of information may lack reliability. Although most providers (n=44, 80.00%) indicated that they received adequate information in question 11, their response seemed to indicate that they had enough information to "get by". However, the inadequacy and inaccuracy of information was discussed by providers in question 12 (i.e., anything they were not told) and question 23 (i.e., anything the subject would like to add). The reliability of the providers response to the perceived adequacy of the information may be increased by asking the providers about the adequacy of information for each

group of questions in 10a through 10h. For example, in 10a the next question would read, "Do you think information about the resident's medical problems is adequate?" In addition, the subjects' may be asked "Do you think the information about the resident's medical problems is accurate?" The provider's response to the accuracy of the information could then be quantified.

Lastly, the instrument included a question about the percentage of female and male residents in each home. It would also be helpful to ask the gender of the new resident.

Implications for Nursing Practice

Through clinical experience, the researcher observed an inconsistency in the type, amount, and accuracy of information given to adult foster care providers. This lack of information may have an impact upon the care of a resident in a number of ways including: the resident being placed in a home that cannot provide the appropriate level of care, the resident having a difficult time in adjusting to the new environment, and the provider being unable to set fees appropriate to the the level of care the resident needs.

Nurses are in strategic positions in the health care system to facilitate the flow of information to foster care providers. In addition, nurses have the skills to assess the level of care foster care residents need and can assist in the matching of residents to providers who have the skill to care for them. Further, nurses have the knowledge base to teach caregiving

skills to providers. Finally, nurses need to be involved in setting the guidelines which regulate care in the foster homes.

Nurses are often in a position to take an active role in the transfer of information to foster care providers. Nurses working in home care, nursing homes, and acute care settings come into contact with persons being transferred to foster care. They need to be cognizant of the information needs of the foster care providers, and work with the residents, families, other health care professionals, and foster care providers to assure accurate transfer of information.

Foster care providers should receive information about the new resident that describes the level of care the resident requires to meet his/her physical and emotional needs prior to the resident's move into the foster home. This type of information includes the resident's current physical state of health and their medical regime. The regime should include a current list of the resident's medications, dosages, and times to be given. Additionally, the provider needs to be informed of the resident's ability to manage their medication regime.

Another aspect of the resident's physical health status is functional limitations (i.e., the ability to walk, transfer, and toilet). The resident's self care deficits (i.e., inability to perform tasks related to feeding, hygiene, grooming, dressing) should also be described. The provider needs this type of information

to evaluate their own ability to give the care required to compensate for the residents self care deficits. Further, the provider needs information which describes a resident's behavior problems, depression, and/or confusion. The mental/emotional status of the resident influences the type of care he/she needs and milieu of the home.

Prior to the move, the provider should be told about the resident's preferences for kinds of food, smoking, age and gender of other residents, and a private room. This information allows the provider to evaluate the match of the resident to their home. Providers should also receive information about the resident's next of kin, medical and social network, funeral home, and code status on the day of the move. Providers should solicit information about the resident's personal interests, hobbies, family, and vocational background, religious practices and other information that would enhance the resident's adjustment to their new home. This information should be solicited within the first week after the resident's move into the home.

A standardized system for transferring information about new residents is needed among hospitals, social service agencies, private referral agencies, and foster care providers. However, it would be virtually impossible to put a single information transfer system into place due to the complexity and fragmentation of the health care system, the competition among private

agents, the competition among associations for foster care providers, and the inconsistency among providers in the ability to access and utilize standardized forms now available through the social service agencies. Therefore, this researcher recommends the following suggestions based upon her clinical practice and the findings of this research. Nurses can and should be actively involved in the development and implementation of these recommendations.

Foster care providers need to be trained to assess the new resident's needs and should receive support from nurses in assessing difficult situations. In addition, foster care providers need to be trained to elicit the appropriate types of information about the resident, including that which a referral source omits. A follow up visit by a nurse to the foster care home should take place, in which the success of the match is evaluated and information gaps are identified. Finally, families need to be educated to evaluate the safety, comfort, and care provided in a foster home, as well as methods to communicate appropriate information about their family member to providers.

The transfer of information is influenced by human factors as well. For example, the family who has experienced difficulty in placing their family member may be reluctant to share information which could jeopardize the placement. Social workers and private referral agents are often limited in the amount of time they can devote to the placement process. There is

pressure to discharge older persons from the hospital before they have convalesced enough to return to independent living. In these circumstances, information is often scant and the resident may need ongoing physical, speech, or occupational therapy, and care that is of a nursing nature which may be beyond the skill of the provider. In addition, foster care providers may accept a resident with little information because they cannot afford to maintain an empty bed in the foster home.

Because the foster care provider is the consistent person in the placement process, it is recommended that the provider conduct the interview of the resident and his/her family utilizing a standardized information transfer form. The interview should take place prior to the placement of the new resident. In addition, this form should contain the resident's name, address, and phone; family members names and phone numbers; and, a checklist which contains physical status and self care deficits. Examples of the most pertinent information about the resident's self care abilities are: ability to transfer without assistance, incontinence of bladder or bowel, level of confusion and ability to communicate, a list of current medications and ability to manage own medications, and any significant behavior problems.

In summary, nurses can make a difference in the transfer of information for foster care providers. Nurses need to develop educational programs that teach families, foster care providers and other referral

sources about the information transfer process, which includes an accurate nursing assessment of the health care needs of a foster care resident. In addition, nurses need to work with other professionals in the provision and regulation of adult foster care. This will enhance the quality of foster care given to elderly residents.

Recommendations for Future Research

Replication of this study is recommended using the suggestions put forth in the section on limitations of the study. Refinements for the instrument are suggested along with some changes in the procedure for accessing the population.

In addition to the transfer of information, social and health care professionals are interested in the characteristics of foster care providers and the level of care required by elderly residents who are placed in foster care homes. Additional areas that need to be researched include the placement of residents in foster homes, the adjustment of the resident in the foster home, the matching of foster care provider and resident, and the resident's evaluation of the foster care. Further, the population of unlicensed foster care homes needs to be studied in a systematic way. Research about adult foster care for the elderly is just beginning and further research is strongly recommended.

Summary

The number of foster care homes for the elderly has been increasing in recent years. The number of adult

foster care homes, in the area sampled for this study, has more than doubled in the last three years (personal communication, R. Davison, December, 8, 1987). Adult foster care is gaining acceptance as an alternative level of care for impaired elderly (Newcomer & Stone, 1985; Steinhauer, 1982). Those who provide foster care are being challenged by the diversity of the care needs of the resident. In order to evaluate these care needs, the providers need adequate and accurate information about the residents they care for, as well as a fundamental knowledge of how to meet the caregiving needs of the resident.

In this study, the receipt of information about the new foster home resident, by foster care providers was explored. This area of research has not been previously addressed in the literature. Therefore, a conceptual framework for information transfer was presented.

Family members of the new resident were the major source of information for the foster care providers. The new resident gave information about himself/herself in less than one-third of the placements. Most foster care providers received information about their new resident in person and from more than one referral source. In addition, nearly half of the providers received some information about the new resident 3 to 7 days before the resident was placed.

Providers were given information about the new resident's physical health problems. For example, in 80% of the cases providers reported that their new

resident had chronic health problems. Of these cases, 18% were not told about these problems. Providers were also given information about the new resident's mental and functional health, personal preferences and interests, and family members.

In general, 80% of the providers perceived the information that they received about the new resident to be adequate. However, 47% of the providers qualified their response by indicating that the information they received lacked specific, helpful information about the resident for determining the level of care the resident needed and setting fees.

The majority of the foster care providers in the sample were women, had completed a high school education, and were the average age of 46 years. Approximately 56% of the providers had job experience related to the health care field and 40% had experience related to nursing care. Providers had been foster care providers for a median of 3.9 years and were motivated to become providers because they had helped another person who was a foster care provider. Additionally, providers needed a source of income and wanted to provide care to the elderly in a nontraditional setting.

Adult foster care for the elderly has become a viable alternative in the United States. Nurses can and must become involved in issues that confront foster care providers, their residents, and families of the residents. The transfer of information at the time of placement is just one important issue on the continuum

of concerns that have been raised. This study provides a beginning picture of information transfer and the characteristics of adult foster care providers.

References

Allison-Cooke, S. (1982). Deinstitutionalizing nursing home patients: Potential vs. impediments. The Gerontologist, 22, 404-408.

Archbold, P., & Hoeffer, B. (1981). Utilization of institutional or community-based services by frail elderly in rural areas. Raw data. Oregon Health Sciences University & Institute on Aging, Portland State University.

Bradshaw, B.R., Vonderhaar, W., Keeney, V., Tyler, L.S., & Harris, S. (1976). Community based residential care for minimally impaired elderly: A survey analysis. Journal of American Geriatrics Society, 9, 423-429.

Chouinard, E. (1975). Family homes for adults. Social and Rehabilitation Record. 2, 10-15.

Deines, H. G., Bradshaw, B. R., & Blakely, E. (1976, October). Invisible institution: Adult foster care in the U.S.A. Paper presented at the 29th annual meeting of the Gerontological Society, New York, NY.

Dillman, D. A. (1978). Mail and telephone surveys: The total design method. NY: John Wiley & Sons.

Floyd, J., & Buckle, J. (1987). Nursing care of the elderly: The DRG influence. Journal of Gerontological Nursing, 13, 20-25.

Handy, I. A. (1968). Foster care as a therapeutic program for geriatric psychiatric patients. Journal of American Geriatrics Society, 16, 350-358.

Lawton, M. P. (1970). Assessment, integration, and environments for older people. The Gerontologist, 10, 38-45.

Linn, M. W., & Caffey, E. M. (1977). Foster care placement for the older psychiatric patient. Journal of Gerontology, 32, 340-345.

McNeel, B. H. (1964). Family care. American Journal of Psychiatry, 120, 685-687.

Miller, M. C. (1977). A program for adult foster care. Social Work, 22, 275-279.

Molholm, H. B., & Barton, W. E. (1941). Family care: A community resource in the rehabilitation of mental patients. American Journal of Psychiatry, 98, 33-41.

Newcomer, R., & Stone, R. (1985, Summer). Board and care housing: Expansion and improvement needed. Generations, 38-39.

Newman, E. S., & Sherman, S. R. (1977). A survey of caretakers in adult foster homes. The Gerontologist, 17, 436-439.

Newman, E. S., & Sherman, S. R. (1979). Community integration of the elderly in foster family care. Journal of Gerontological Social Work, 1, 175-185.

Newman, E. S., & Sherman, S. R. (1979-80). Foster-family care for the elderly: Surrogate family or mini-institution. International Journal of Aging and Human Development, 10, 165-176.

Pollock, H. M. (1945). A brief history of family care of mental patients in America. American Journal of Psychiatry, 102, 351-361.

Reiss, J. B. (1983). Conflicting policy goals of federal programs and proposals. Health and Welfare Planning Council. Philadelphia: Dechert, Price & Rhoads.

Risdorfer, E. N., Primanis, G. & Dozoretz, M. D. (1971) Family care as a useful alternative to the long-term hospital confinement of geropsychiatric patients. Journal of the American Geriatrics Society, 19, 150-158.

Sherman, S. R., & Newman, E. S. (1977). Foster family care for the elderly in New York state. The Gerontologist, 17, 513-522.

Steinhauer, M. B. (1982). Geriatric foster care: A prototype design and implementation issues. The Gerontologist, 22, 293-300.

Appendix A

Survey Instrument

Appendix A

Survey Instrument

1. OPERATOR IDENTIFICATION.....[ ][ ][ ] V1 _ V2 _ V3 _

2. INTERVIEW DATE....[ ][ ] [ ][ ] [ ][ ] V4__ V5__ V6__
   MO DAY YR

3. DATE OF ADMISSION
   TO FOSTER CARE....[ ][ ] [ ][ ] [ ][ ] V7__ V8__ V9__
   MO DAY YR

4. DATE OF DISCHARGE FROM
   FOSTER CARE....[ ][ ] [ ][ ] [ ][ ] V10__ V11__ V12__
   MO DAY YR

5. TYPE OF ADMISSION AGREEMENT.....

   COUNTY CONTRACT FOR PERMANENT RESIDENCE...1

   PRIVATE CONTRACT FOR PERMANENT RESIDENCE..2

   COUNTY CONTRACT FOR RESPITE ADMISSION.....3

   PRIVATE CONTRACT FOR RESPITE ADMISSION....4 V13 _

THIS INTERVIEW IS CONDUCTED IN THE HOME OF THE ADULT FOSTER CARE PROVIDER. INTRODUCE SELF TO THE PERSON WHO ANSWERS THE DOOR AND ASK FOR THE PROVIDER WHO TAKES CARE OF THE RESIDENTS IN THIS HOME AND WHO MADE THE APPOINTMENT FOR THIS INTERVIEW.

The following is a statement to be read to each potential subject before the interview.

My name is Judy Alleman. I am the nurse from Oregon Health Sciences University who called you recently. As you may recall, you agreed to allow me to ask some questions about the type of information you received about your new resident.

Your participation is voluntary. The information will be strictly confidential. You may decide to withdraw at any time. Your position as an adult foster care provider will not be affected in any way. Are you still willing to be interviewed by me?
(IF NO, TERMINATE THE INTERVIEW WITH: e.g. I am sorry that you've changed your mind. REASSURE THE RESPONDENT THAT THERE WILL BE NO CONSEQUENCE FOR WITHDRAWING FROM THE STUDY).
(IF YES, ASK THE PROVIDER IF S/HE HAS OBTAINED VERBAL PERMISSION FROM HIS/HER EMPLOYER. IF YES, PROCEED WITH THE INTERVIEW).
Do you have any questions? (ANSWER PROVIDER'S QUESTIONS). During the interview you may look at the new resident's records if it would be helpful.

INTERVIEW

[CODE ANSWERS AS FOLLOWS: NO, 0; YES, 1; REFUSES TO ANSWER, (-6); DOES NOT APPLY (DNA), (-7); NOT SURE (NS), (-8); MISSING DATA, (-9)].

Now I'd like to ask you some questions about your newest resident.

6. Who are the persons who told you information about your new resident? The card I've handed you has a list of people who might have given you information: the new resident him/herself, a family member, a social worker/case manager, a hospital discharge planner, staff person from private referral agency, nursing home staff member, nurse, other?

Hand the provider a card with a list of the responses. More than one response OK

	NO	YES	NS	
THE NEW RESIDENT HIMSELF/HERSELF	0	1	-8	V14 _
FAMILY MEMBER OF THE RESIDENT	0	1	-8	V15 _
FRIEND OF THE RESIDENT	0	1	-8	V16 _
SOCIAL WORKER OR CASE MANAGER	0	1	-8	V17 _
HOSPITAL DISCHARGE PLANNER	0	1	-8	V18 _
RESIDENT'S PHYSICIAN	0	1	-8	V19 _
STAFF PERSON FROM PRIVATE REFERRAL AGENCY	0	1	-8	V20 _
NURSING HOME STAFF MEMBER	0	1	-8	V21 _
NURSE	0	1	-8	V22 _
OPERATOR/OWNER OF FOSTER CARE	0	1	-8	V23 _
GUARDIAN	0	1	-8	V24 _
OTHER (SPECIFY)_____	0	1	-8	V25 _

7. How did you get the information about the resident? Did you receive it: (READ OPTIONS)

Hand provider a card with list of the responses. More than one response OK.

	NO	YES	NS	
IN WRITING	0	1	-8	V26 _
BY TELEPHONE	0	1	-8	V27 _
IN PERSON	0	1	-8	V28 _

8. When did you get the information about your new resident? Did you receive it: (READ OPTIONS)

Hand provider a card with list of the responses. More then one response OK.

3-7 DAYS BEFORE S/HE MOVED INTO THIS HOME	0	1	-8	V29 _
1-2 DAYS BEFORE S/HE MOVED INTO THIS HOME	0	1	-8	V30 _
THE DAY S/HE MOVED INTO THIS HOME	0	1	-8	V31 _
1-2 DAYS AFTER S/HE MOVED INTO THIS HOME	0	1	-8	V32 _
3-7 DAYS AFTER S/HE MOVED INTO THIS HOME	0	1	-8	V33 _
OTHER (SPECIFY)_____	0	1	-8	V34 _
COMMENTS_____	0	1	-8	V35 _

Now I would like to talk a little about your resident's move.

9a Can you tell me why your new resident moved into this home? Answer yes or no. (CIRCLE ANSWER)

NO.....0

YES.....1

NOT SURE.....-8 V36 _

IF YES, EXPLAIN_____

_____

_____

9b Before moving into your home, where did the new resident live: own home, home of a friend or relative, room and board facility, lodge/hotel, nursing home, another foster home, hospital, other, not sure? (READ OPTIONS)

|Hand provider a card with list of the responses. More than one response OK.|

OWN HOME.....1

HOME OF FRIEND OR RELATIVE.....2

ROOM AND BOARD FACILITY.....3

LODGE/HOTEL.....4

NURSING HOME.....5

ANOTHER FOSTER CARE HOME.....6

HOSPITAL.....7

OTHER (SPECIFY)_____8

NOT SURE_____-8 V37 _

If the respondent answers with response #7, ask ...9c.....

9c If the new resident came from the hospital, where did they live before being hospitalized? (READ OPTIONS AND USE CODE FROM 9b)

COMMENTS_____

NOT SURE_____-8 V38 _

9d Did any of the following medical records come with your new resident:

	NO	YES	DNA	NS	
HOSPITAL DISCHARGE SUMMARY	0	1	-7	-8	V39 _
PHYSICIAN'S ORDERS	0	1	-7	-8	V40 _
NURSING CARE PLAN	0	1	-7	-8	V41 _
OTHER	0	1	-7	-8	V42 _

Now I would like for you to share with me which of these things you knew about your new resident before s/he moved in? Just say yes, I knew; no, I didn't know, or does not apply to the new resident, or you are not sure (CIRCLE 0, no; 1, yes; -7, does not apply; and -8, not sure).

10a Does your new resident have:	NO	YES	NS	---> IF YES, WERE YOU TOLD? NO	YES	DNA	NS	
CHRONIC HEALTH PROBLEMS	0	1	-8					V43_
If yes, were you told?				0	1	-7	-8	V44_
ALLERGIES	0	1	-8					V45_
If yes, were you told?				0	1	-7	-8	V46_
SPECIAL EQUIPMENT/AIDES	0	1	-8					V47_
If yes, were you told?				0	1	-7	-8	V48_
A SPECIAL DIET, e.g. low NA, diabetic, low calorie.	0	1	-8					V49_
If yes, were you told?				0	1	-7	-8	V50_
SPECIAL TREATMENTS, e.g. foot soaks, dressing changes, breathing machine	0	1	-8					V51_
If yes, were you told?				0	1	-7	-8	V52_
OTHER (SPECIFY)	0	1	-8					V53_
				0	1	-7	-8	V54_

10b Is your new resident taking:

MEDICATIONS	0	1	-8					V55_
If yes, were you told:				0	1	-7	-8	V56_
names of the medications?				0	1	-7	-8	V57_
reason for giving?				0	1	-7	-8	V58_
dosages and times to give?				0	1	-7	-8	V59_

	NO	YES	NS	IF YES, WERE YOU TOLD? NO	YES	DNA	NS	
10c Did you notice that your new resident was:								
DEPRESSED	0	1	-8					V60_
If yes, were you told of this b/4 admission?				0	1	-7	-8	V61_
CONFUSED	0	1	-8					V62_
If yes, were you told of this b/4 admission?				0	1	-7	-8	V63_
10d Did you notice your new resident had:								
BEHAVIOR PROBLEMS	0	1	-8					V64_
If yes, were you told?				0	1	-7	-8	V65_
A TENDENCY TO WANDER	0	1	-8					V66_
If yes, were you told?				0	1	-7	-8	V67_
OTHER PROBLEMS (SPECIFY)	0	1	-8					V68_
				0	1	-7	-8	V69_
10e Does your new resident have problems:								
SEEING	0	1	-8					V70_
If yes, were you told?				0	1	-7	-8	V71_
HEARING	0	1	-8					V72_
If yes, were you told?				0	1	-7	-8	V73_
SPEAKING	0	1	-8					V74_
If yes, were you told?				0	1	-7	-8	V75_
WITH ACCIDENTS OF URINE	0	1	-8					V76_
If yes, were you told?				0	1	-7	-8	V77_
WITH CONTROLLING BOWELS	0	1	-8					V78_
If yes, were you told?				0	1	-7	-8	V79_
OTHER PROBLEMS (SPECIFY)	0	1	-8					V80_
				0	1	-7	-8	V81_

	NO	YES	NS	IF YES, WERE YOU TOLD? NO	YES	DNA	NS	
10f Is the new resident:								
TOTALLY BEDRIDDEN	0	1	-8					V82_
If yes, were you told?				0	1	-7	-8	V83_
PARTIALLY BEDRIDDEN	0	1	-8					V84_
If yes, were you told?				0	1	-7	-8	V85_
UNABLE TO GET IN/OUT OF BED/CHAIR WITHOUT ASSISTANCE	0	1	-8					V86_
If yes, were you told?				0	1	-7	-8	V87_
UNABLE TO GET OUT OF BATHTUB BY HIM/HERSELF	0	1	-8					V88_
If yes, were you told?				0	1	-7	-8	V89_
UNABLE TO WALK WITHOUT ASSISTANCE	0	1	-8					V90_
If yes, were you told?				0	1	-7	-8	V91_
OTHER (SPECIFY)	0	1	-8					V92_
				0	1	-7	-8	V93_
10g When the new resident was admitted, did s/he use:								
A WHEELCHAIR	0	1	-8					V94_
If yes, were you told?				0	1	-7	-8	V95_
A CANE/WALKER	0	1	-8					V96_
If yes, were you told?				0	1	-7	-8	V97_
A CATHETER	0	1	-8					V98_
If yes, were you told?				0	1	-7	-8	V99_
DIAPERS/PADS	0	1	-8					V100_
If yes, were you told?				0	1	-7	-8	V101_
LEG/ARM BRACES	0	1	-8					V102_
If yes, were you told?				0	1	-7	-8	V103_
OXYGEN/BREATHING MACHINE	0	1	-8					V104_
If yes, were you told?				0	1	-7	-8	V105_
EYE GLASSES	0	1	-8					V106_
If yes, were you told?				0	1	-7	-8	V107_
HEARING AID	0	1	-8					V108_
If yes, were you told?				0	1	-7	-8	V109_
DENTURES	0	1	-8					V110_
If yes, were you told?				0	1	-7	-8	V111_
OTHER (SPECIFY)	0	1	-8					V112_
				0	1	-7	-8	V113_

	NO	YES	NS	IF YES, WERE YOU TOLD? NO	YES	DNA	NS	
10h Did you know that the new resident:								
NEEDS HELP WITH BATHING	0	1	-8					V114_
If yes, were you told?				0	1	-7	-8	V115_
NEEDS HELP WITH GROOMING	0	1	-8					V116_
If yes, were you told?				0	1	-7	-8	V117_
NEEDS HELP WITH DRESSING	0	1	-8					V118_
If yes, were you told?				0	1	-7	-8	V119_
NEEDS HELP WITH EATING	0	1	-8					V120_
If yes, were you told?				0	1	-7	-8	V121_
NEEDS HELP WITH ALL OF THE ABOVE	0	1	-8					V122_
If yes, were you told?				0	1	-7	-8	V123_
OTHER (SPECIFY)	0	1	-8					V124_
				0	1	-7	-8	V125_

10i Were you told the name of the new resident's: physician, pharmacist, financial/legal advisor, next-of-kin, guardian, code status,person to be notified in an emergency? (READ OPTIONS ONE AT A TIME-CIRCLE ANSWER)

	NO	YES	DNA	NS	
PHYSICIAN	0	1	-7	-8	V126 _
PHARMACIST	0	1	-7	-8	V127 _
FINANCIAL/LEGAL ADVISOR	0	1	-7	-8	V128 _
NEXT-OF-KIN	0	1	-7	-8	V129 _
GUARDIAN	0	1	-7	-8	V130 _
PERSON NOTIFIED IN AN EMERGENCY	0	1	-7	-8	V131 _
CODE STATUS	0	1	-7	-8	V132 _
OTHER (SPECIFY)	0	1	-7	-8	V133 _

10j Were you told about the new resident's personal interests: hobbies, community activities, TV/radio, reading, gardening, socializing, other? (READ OPTIONS ONE AT A TIME AND CIRCLE ANSWER)

	NO	YES	DNA	NS	
HOBBIES	0	1	-7	-8	V134 _
COMMUNITY ACTIVITIES	0	1	-7	-8	V135 _
TV/RADIO	0	1	-7	-8	V136 _
READING	0	1	-7	-8	V137 _
GARDENING	0	1	-7	-8	V138 _
SOCIALIZING WITH OTHERS	0	1	-7	-8	V139 _
OTHER (SPECIFY)	0	1	-7	-8	V140 _

10k Were you told anything about your new resident's personal preferences: smoker/non-smoker, food likes/dislikes, likes/dislikes children, enjoys pets, enjoys visitors, attends religious services, prefers to be alone, sleep habits?

SMOKER/NONSMOKER	0	1	-7	-8	V141 _
FOOD LIKES/DISLIKES	0	1	-7	-8	V142 _
LIKE/DISLIKES CHILDREN	0	1	-7	-8	V143 _
ENJOYS PETS	0	1	-7	-8	V144 _
ENJOYS VISITORS	0	1	-7	-8	V145 _
ATTENDS RELIGIOUS SERVICES	0	1	-7	-8	V146 _
PREFERS TO BE ALONE	0	1	-7	-8	V147 _
SLEEP HABITS	0	1	-7	-8	V148 _
OTHER (SPECIFY)	0	1	-7	-8	V149 _

101 Were you told whether and how often your new resident expects visitors?

NO.....0

YES.....1

NOT SURE.....-8 V150 _

IF YES, ASK THE FOLLOWING QUESTIONS.....

EXPECTS VISITORS OFTEN.....1

EXPECTS VISITORS SOMETIMES.....2

EXPECTS NO VISITORS.....3

OTHER (SPECIFY).....5 V151 _

_____

11 Do you think you had enough information about your new resident before he/she moved in? Answer yes or no. (CIRCLE RESPONSE)

NO.....0

YES.....1

NOT SURE.....-8 V152 _

IF NO, EXPLAIN ANSWER_____

_____

12. Is there anything you were not told about the new resident before s/he came here that would have been helpful to you? Answer yes or no. (CIRCLE RESPONSE)

NO.....0

YES.....1 V153 _

IF YES, EXPLAIN ANSWER_____

_____

_____

For the next questions, I'm interested in knowing a little about you and your home.

13. Are you the owner/operator, resident manager or foster care provider/employee, or other? (CIRCLE RESPONSE).

OWNER/OPERATOR.....1

RESIDENT MANAGER.....2

PROVIDER/EMPLOYEE.....3

OTHER.....4 V154 _

14. How long have you been a foster care provider? (CIRCLE RESPONSE)

|Hand card with list of response to provider|

MORE THAN FIVE YEARS.....6

3 UP TO 5 YEARS.....5

1 UP TO 3 YEARS.....4

6 UP TO 12 MONTHS.....3

3 UP TO 6 MONTHS.....2

LESS THAN 3 MONTHS.....1

REFUSES TO ANSWER.....-6 V155 _

15. What were some of your reasons for becoming a foster care provider. You may list more than one reason. List the most important one first.

_____

_____

_____

REFUSES TO ANSWER.....-6 V156 _

16. Can you share what previous experiences helped you with being a foster care provider?

_____

_____

_____

REFUSES TO ANSWER.....-6 V157 _

17. How many residents are you caring for now in this home?

|Hand card with list of responses to provider?|

MORE THAN 5 RESIDENTS.....4

4-5 RESIDENTS.....3

2-3 RESIDENTS.....2

1 RESIDENT.....1

REFUSES TO ANSWER.....-6 V158 _

18. How many residents are men/ women?

NUMBER OF MEN.....[ ] V159 _

NUMBER OF WOMEN.....[ ] V160 _

REFUSES TO ANSWER.....-6

These are the last few questions I'd like to ask.

19. What is your birth date..[ ][ ] [ ][ ] [ ][ ] V161__ V162__ V163__
MO DAY YR

REFUSES TO ANSWER.....-6

20. What is your Ethnic background? (RECORD WITHOUT ASKING UNLESS NOT OBVIOUS)

WHITE (NON-HISPANIC).....1

BLACK.....2

HISPANIC.....3

ASIAN.....4

INDIAN OR OTHER AMERICAN NATIVE...5

OTHER (SPECIFY)_____6

REFUSES TO ANSWER.....-6 V164 _

21. What is the last grade you finished? (Circle response)

1..2..3..4..5..6..7..8..9..10..11..12..13..14..15..16

OTHER_____ V165 _

REFUSES TO ANSWER.....-6

22. What is your current marital status? I am only referring to your last spouse. (CIRCLE RESPONSE)

NEVER MARRIED.....1

MARRIED.....2

WIDOWED.....3

DIVORCED.....4

LEGALLY SEPARATED.....5

REFUSES TO ANSWER.....-6 V166 _

23. This concludes the interview. Is there anything you would like to add?

_____

_____

_____

Thank you very much. I appreciate the time you've spent with me answering all these questions. I hope we will be able to understand what information you receive on new residents and what areas we need to improve upon in order to help you in caring for your residents.

(COMPLETE THESE QUESTIONS AFTER INTERVIEW)

24. Gender (CIRCLE)_____

MALE.....1

FEMALE.....2 V167 _

25. Provider uses records for recall during interview..

NO.....0

YES.....1 V168 _

Appendix B

Conceptual Coding for Questions in the Survey Instrument for Resident Information

APPENDIX B

Conceptual Coding for Questions in the Survey Instrument for Resident Information

Concept/Variable	Question on Survey Instrument	
	Item #	Research Question
Administrative Data:		
1. Code number for the interview	1	
2. Date of the interview	2	
3. Date of resident's admission	3	
4. Date of resident's discharge (death) from foster care	4	
5. Type of admission agreement	5	
6. Recall vs. documentation	25	
Information--specific facts about a new resident told to a foster care provider about the resident:		
1. Referral source giving information	6	1
2. Mode of information transfer	7	2
3. Timing of information transfer	8	3
4. Type of information	9a-d, 10a-l	4
5. Adequacy of information	11, 12	5

(continues)

Concept/Variable	Question on Survey Instrument	
	Item #	Research Question
Characteristics of the Adult Foster Care Provider:		
1. Roles performed for the foster home in addition to providing direct care to the resident	13	6
2. Length of time providing care in a foster care home	14	6
3. Reasons for becoming a provider	15	6
4. Experience which prepared the the provider for caring for the residents	16	6
5. Age	19	6
6. Gender	24	6
7. Ethnic origin	20	6
8. Education	21	6
9. Marital Status	22	6
10. Information provider wishes to add	23	1, 2, 3, 4, 5, 6
Characteristics of the adult foster care home - specific facts about the size/composition of the home:		
1. Number of residents in the home	17	
2. Gender of residents in the home	18	

Appendix C

Research Protocol for the Adult Foster Care Programs

Appendix C

Research Protocol for the Adult Foster Care Programs

RESEARCH STUDY: A Survey of Information Communicated to Adult Foster Care Providers in Relationship to Newly Admitted Residents.

STUDY OBJECTIVES: The purpose of this study is to describe the information that is given in writing, by telephone or in person to adult foster care providers in relationship to newly admitted residents. An ex post facto survey design will be used. The researcher will contact and screen all licensed adult foster care homes for the elderly in two large counties. Foster care providers who give direct care to residents in these licensed homes, meet the study's criteria, and are willing to participate will be interviewed by the researcher. Face to face interviews will be conducted to obtain descriptive data regarding the nature of information received about new residents, as well as characteristics of adult foster care providers.

SUBJECTS' SELECTION CRITERIA: This study will include providers of care in licensed adult foster care homes in two large counties. The names of the homes appearing on an adult foster care home registry for a specific month will be obtained through the licensing agency of each county. Certain characteristics of the foster care homes and of the foster care providers formulate the criteria which will be used for inclusion in this study. The criteria for foster homes will be: (a) homes described as providing care for older persons, including

persons with Alzheimer's Disease, (b) homes which exclude residents placed by programs for the mentally/emotionally disturbed (MED), the mentally retarded/developmentally disabled (MRDD), the alcohol and/or drug dependent person, (c) homes which have admitted an older resident (aged 65 and over) during the 30 day period prior to the initial contact by the researcher.

The criteria for the foster care provider's participation in the study include: (a) providers (owner/operator, manager, or provider) who actually give direct care to the newly admitted resident, (b) providers who are able to read, speak and understand English, and are 21 years of age or over.

Procedure

The procedures that will be used to conduct this study are outlined in the discussion that follows. The researcher will obtain permission to conduct this study from the agencies that regulate adult foster care homes in each county. The researcher will give a copy of the Research Protocol and the Letter of Endorsement to the administrators of the adult foster care programs in each county. The names of adult foster care homes will be obtained from the adult foster care home registries maintained by each county. The researcher will sign a statement of intent, which will be provided by the counties, limiting the used of the registries to this study. The names of adult foster care homes and providers will not be associated with data collected in

this study. Information that could identify an individual, an adult foster care home, or the adult foster care home programs of the participating counties will not appear in the final documentation of this study.

A Letter of Endorsement will be mailed to the adult foster care homes. This letter will introduce the researcher, explain the study, encourage the provider's participation, and tell the provider that the researcher will be calling him/her soon.

A telephone call will be made to licensed adult foster care homes for the elderly. During this call, the researcher will ask the provider four screening questions determining eligibility and willingness to participate in the study. The screening questions will be: (a) do you actually give direct care to the residents of this home, (b) has a new resident moved into this home within the last 30 days, (c) are you at least 21 years old, and (d) do you understand and read English? If the provider/home does not meet the study's criteria, the researcher will thank the provider for his/her time and terminate the call. If the provider is eligible for the study, the researcher will obtain the verbal consent of the provider and make an appointment to visit the provider in the foster home of the newly admitted resident. If the provider is an employee of the adult foster care home operator, the provider will obtain verbal consent from his/her employer.

A telephone call will be made to the participating provider, on the day of the scheduled interview, to make sure that the time for the appointment is convenient. Subsequently, the researcher will travel to the foster home and again obtain the verbal consent of the provider and conduct a 30 minute interview. Further, the survey instrument will be administered in the homes of foster care providers, as suggested by members of the an advisory committee of the adult foster care program of one of the participating counties, foster care program administrators, and colleagues, to minimize the refusal rate of potential participants.

The interviewer is a graduate nurse, who is sensitive to both signs of anxiety in the respondents and the needs of the residents. The interview will be discontinued or postponed if the clinical situation merits it. Finally, a summary of the significant findings of this study will be shared with the participating counties and/or providers at their request and by their consent.

DETAILS:

Researcher: Judith E. Alleman, R.N., B.S.N.,
Graduate Nursing Student

Research Advisor: Patricia G. Archbold, R. N., D.N.Sc.

Institution: Oregon Health Sciences University,
School of Nursing, Department of Family Nursing,
Aging Family.

Appendix D

Letter of Endorsement

Dear Foster Care Provider:

We are writing to encourage you to participate in a study entitled "A Survey of Information Communicated to Adult Foster Care Providers in Relationship to Newly Admitted Residents", which is designed to describe types of information that providers receive about new residents.

Judy Alleman, the researcher, is a graduate student and nurse at the School of Nursing, the Oregon Health Sciences University. Her interest in doing this study comes from being involved with adult foster care for the last several years.

Next week, Mrs. Alleman will be calling homes which are licensed to provide foster care to older adults. She will be asking to speak to the person who actually gives care to the residents of each home. (If you are not that person, will you please give this letter to the appropriate person). The purpose of the telephone call is to determine which providers are eligible and willing to participate in the study. To be in the study: (a) the provider must be giving care to residents, (b) a new resident must have been admitted to this home within the last 30 days, (c) the provider must be at least 21 years old and able to read and understand English.

If you agree to participate in this study, Mrs. Alleman will ask you questions about the <u>type</u> of information given to you regarding the newest resident. She will also ask you a few questions about your experience as a foster care provider. The interview will take about 30 minutes and all information will be kept confidential. Your name and the residents name will not appear on the interview.

The choice to participate is solely yours, and you may choose not to be in the study or you may withdraw at any time without affecting your relationship with our agency or the Oregon Health Sciences University. Mrs. Alleman will answer any questions you might have when she calls, or you may reach her by leaving a message at the Department of Family Nursing, Oregon Health Sciences University, 225-8297.

Your help is important to this study and to the Adult Foster Care Programs of our area. Mrs. Alleman is looking forward to contacting you and we appreciate you cooperation.

Sincerely,

Adult Foster Home Program Coordinator

This letter accompanied letter from researcher dated July 7, 1987

July 8, 1987

Dear Ms. Alleman,

I am writing to indicate my support for your graduate study project entitled "A Survey of Information Communicated to Adult foster Care Providers in Relationship to Newly Admitted Residents."

We have verified that you are a graduate student and nurse at the School of Nursing, The Oregon Health Sciences University, and are being supervised in this project by Pat Archbold.

I understand that next week you will be calling homes which are licensed to provide foster care to older adults, an asking to speak to the person who actually gives care to the residents of each home. The purpose of the telephone call is to determine which providers are eligible and willing to participate in the study. To be in the study: (a) the provider must be giving care to the residents, (b) a new resident has been admitted to this home within the last 30 days, (c) the provider is at least 21 years old and able to read and understand English.

If providers agree to participate in this study, you will as questions about the type of information given to providers regarding the newest residents, and about the provider's experience as a foster care provider. The interview will take about 30 minutes and all information will be kept confidential. Providers names and the residents names will not appear on the interview.

The choice to participate will be solely up to the provider, who may choose not to be in the study or who may withdraw at any time without affecting their relationship to the County Adult Housing Program or Long Term Care Program. I also understand you will answer any questions providers might have, and that you may be reached by leaving a message at the Department of Family Nursing, Oregon Health Sciences University, 255-8297.

Under these guidelines, we lend our support to your project and look forward to receiving a copy of your results, which we understand will include no provider identifiable information.

You may use this letter in contacting County Foster Care Providers.

Sincerely,

Program Services Manager

July 7, 1987

Dear Foster Care Provider:

I am writing to invite you to participate in a study entitled "A Survey of Information Communicated to Adult Foster Care Providers in Relationship to Newly Admitted Residents", which is designed to describe types of information that providers receive about new residents. I am enclosing a letter from County which describes my study.

My name is Judy Alleman and I am a graduate student and nurse at the School of Nursing, the Oregon Health Sciences University. My interest in doing this study comes from being involved with adult foster care for the last several years.

Next week, I will be calling homes which are licensed to provide foster care to older adults. I will be asking to speak to the person who actually gives care to the residents of each home. (If you are not that person, will you please give this letter to the appropriate person). The purpose of the telephone call is to determine which providers are eligible and willing to participate in the study.

The choice to participate is solely yours and you may choose not to be in the study or you may withdraw at any time without affecting your relationship to the Adult Foster Care Program of your County or the Oregon Health Sciences University. I will answer any questions you might have when I call, or you may reach me by leaving a message at the Department of Family Nursing, Oregon Health Sciences University, 225-8297.

Your help is important to this study and to the Adult Foster Care Programs of our area. I am looking forward to contacting you.

[redacted]

Appendix E

Telephone Interview

Appendix E

Telephone Interview

Hello. Is this the _____residence?
(last name)

(IF NO. The number I was calling is _____ and it was for _____residence.
(first and last name)

(IF WRONG NUMBER, TERMINATE WITH, E.G.: I am sorry to have bothered you.)

(IF YES. Proceed with the following introduction:)

This is Judy Alleman from The Oregon Health Sciences University. Recently, a letter was sent from your County's Adult Foster Care Program. Did you receive it? (IF NO. I'm sorry yours didn't reach you.)

This letter explained a little about the study I am doing about Adult Foster Care. Do you actually give give care to the residents of this foster home?

(IF NO. Thank you for your time. I'm sorry you won't be able to be in my study. Can you tell me when the provider (resident manager) might be available? Thank you I'll call back then.

(IF YES, CONTINUE WITH DIALOGUE.)
I am doing a study to find out the kinds of information adult foster care providers receive about their new residents. In order to do this, I can only talk with providers who have recently accepted a new resident. Have you admitted a new resident within the last 30 days? (IF NO. TERMINATE WITH, E.G.: I am sorry I won't be able to include you in my study since that is one thing that is necessary to be in the study. Thank you, that is all the questions I have to ask you).

(IF A RESIDENT HAS BEEN ADMITTED IN THE LAST 30 DAYS, CONTINUE WITH:
I would like to visit your home next week and ask you about the information you received on your new resident. I will be able to interview you if you are already 21 years old and can understand and read English. Are you at least 21? And do you understand and read English ? (IF NOT ABLE TO PARTICIPATE BECAUSE OF AGE OR LANGUAGE BARRIER:
I am sorry I won't be able to interview you. I'm sure I would have enjoyed a visit with you. Thank you for your time).

(IF RESPONDENT MEETS ALL FOUR CRITERIA, SET AN APPOINTMENT: Your new resident does not need to be a part of the interview. In fact, you will not be sharing your resident's name with me. The visit will take about 30 minutes. What would be a good time for you_____?

(IF NEXT WEEK IS NOT A GOOD TIME: When is a better time for you_____?)
TERMINATE WITH, E.G.: Thank you for being in my study. I'll be at your home on _____.
(repeat time)
I will call the day of the appointment and make sure you are available. Goodbye.

AN ABSTRACT OF THE THESIS OF
JUDITH E. ALLEMAN, R.N., B.S.N.

For the Master of Nursing

Title: A Survey of Information Communicated to Adult Foster Care Providers in Relationship to Newly Admitted Residents

This retrospective survey describes the information about a new resident that is given in writing, by telephone or in person to foster care providers by referral sources. Specifically, the source and mode of communication, timing, type of information, and the perceived adequacy of information given to foster care providers was measured using a structured interview guide. Selected characteristics of the foster care providers were also measured.

One foster care provider from each licensed adult foster care home for the elderly, in two large counties, was sent a letter introducing the study. Within a week of the mailing, the researcher telephoned each home, screened the providers for eligibility, and scheduled in-home interviews with willing providers (N=55). The resulting data was analyzed using descriptive statistics and content analysis.

Family members of the new resident were the major source of information for the foster care providers. The new resident gave information about himself/herself in less than one-third of the placements. Most foster care providers received resident information in person and from more that one source. In addition, nearly half of the providers received some information about the new resident 3 to 7 days before the resident was placed.

Providers were given information about the new resident's physical health. In 80% of the cases, providers reported that their new resident had chronic health problems. Of those, 18% were not told of these problems. Providers were also given information about the new resident's mental and functional health, personal interests and preferences, and family members.

In general, 80% of the providers perceived the information that they received to be adequate. However, 47% of those providers indicated they lacked specific information that would have facilitated the placement of the new resident.

The majority of the providers in the sample were women, had completed a high school education, and were the average age of 46 years. Approximately 56% of the providers had job experience in the health care field, and 40% had experience related to nursing care.