THE RELATIONSHIP BETWEEN THE EDUCATIONAL PREPARATION OF DIRECTORS OF NURSING IN NURSING HOMES AND QUALITY OF CARE

by

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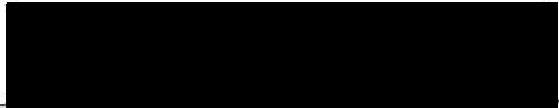

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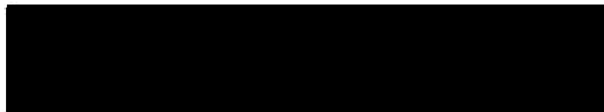

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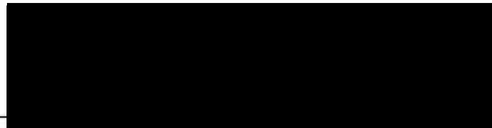

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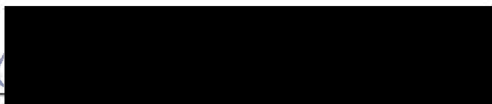

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CHAPTER I

INTRODUCTION

During the last two decades the United States has seen a considerable increase in numbers of long-term care facilities. This increase can be attributed in part to general growth in the numbers of elderly persons in the population. Persons over 65 years of age will comprise 12% of the population in the United States by the end of the century. One half of this group will be over 75 years of age (Kane, Solomon, Beck, Keeler & Kane, 1980). The changing status of members within the family unit and a growing mobility of Americans with fewer families now caring for aged members have also contributed to the growth of the nursing home industry.

Inflationary forces today make it economically difficult for an elderly person to maintain their own home. Equally important, there exists a general lack of alternatives for supportive care for those elderly who do wish to remain in their own residence. Today, long-term care in an institutional facility is seen as a real possibility by large numbers of elderly persons.

The elderly are heavy users of the health care system. Averaging 3.4 treatable problems per patient, 5% of the elderly in the United States are institutionalized at any one time. The institutionalized elderly spend three times as many days in acute care hospitals and 30 times as many days in nursing homes as people who are 45 to 65 years of age (Kane et al., 1980). In 1975 federal, state, and local

governments spent $5.7 to 5.8 billion on long-term care. Private costs were $5.9 to 7.7 billion. Total costs will increase in 1980 from $25.8 to 31.0 billion with the federal government spending $7.2 to 7.6 billion (Chow, 1980). In spite of this increase in spending, health care for the elderly has not measurably improved (Portnoi, 1979).

With the growth in numbers of nursing homes has come complexity in their structure and regulation. Medicare and Medicaid legislation have attempted to define levels of nursing home care and in so doing have set reimbursement levels. Extended Care Facilities, Intermediate Care Facilities, and Skilled Care Facilities each attempt to offer a level of care to the elderly that is consistent with each individual's abilities and needs. Currently, assessment of the quality of the care being offered to residents within these levels is primarily through regulation and review at the federal and state levels.

It is appropriate to address the quality of care in nursing homes given the large growth in numbers of such institutions and the inability of residents generally to monitor their own care. It is recognized that the quality of care provided within an institution can be affected by a number of variables. Included in these variables must be the care givers within the long-term care facility and the supervision that they receive.

The quality and quantity of nursing personnel and the direction given to them within a facility can be seen as a major factor affecting the quality of care that is offered to residents. Nursing homes have traditionally suffered from high turnover, low morale, high absenteeism, short staffing, and poor educational preparation

among personnel (Greenwald & Linn, 1971; Hickey, 1974; Williams, 1976). It is estimated that the total number of nursing personnel employed in nursing homes falls 50% below the need (Williams, 1976). In dealing with problems of this magnitude in nursing home staffs, the preparation of the nursing leader becomes significant.

Leadership in nursing homes for nursing personnel is provided by the Director of Nursing. The Director of Nursing within the nursing home is a position that has not been widely explored in the literature. Within acute care facilities the growth and direction of a nursing service is affected by the leadership provided by the Director of Nursing. Such positions are generally sought after by increasingly more educated and experienced nurses who have demonstrated excellence in their field. It is an expectation within many urban communities that nursing administrators of acute care facilities have completed advanced educational requirements. With the nursing profession as a whole currently addressing the issue of nursing education, the preparation of those assuming leadership positions in institutions becomes increasingly important. If the expectations of the educational preparation of nurse leaders in acute care facilities is increasing, what is occuring in long-term care facilities?

What is the educational preparation of Directors of Nursing in nursing homes? Does this educational preparation make a difference in the quality of care offered to nursing home residents? The focus of this study, then, is the relationship of the educational preparation of the Director of Nursing in Intermediate Care Facilities to the quality of care offered in these institutions.

Review of the Literature

This literature review will explore the role of the Director of Nursing within a nursing home, the relationship of nursing education to quality of care, and finally will discuss quality of care within nursing homes.

Directors of Nursing Within Nursing Homes

The Director of Nursing within a nursing home has the responsibility for the provision of nursing care and services to residents. She or he assumes professional leadership for the resident care provided by other registered nurses, licensed practical nurses or nursing assistants. The Director sets the standards of nursing care and is responsible for the meeting of these standards.

The Director of Nursing within nursing homes functions in a rather independent manner in areas of resident care. There is not the physician presence that occurs in acute care facilities and other professional staff usually serve the nursing home only on a part-time consultative basis (Kane & Kane, 1978). The Director of Nursing must directly deal with the shortage of professional nurses that exists in many nursing homes, and with those registered nurses and ancillary workers who are employed, recognize that in general these personnel are less well paid, less well trained, and less satisfied with their work than the rest of the health care system (Kane & Kane, 1978).

Within these described constraints, it is the Director of Nursing's responsibility to ensure that residents are being provided care that promotes well being. The literature points out that it is

the Director of Nursing within a nursing home who influences the milieu or environment of a facility (Schwartz, 1974) and that this environment or milieu was found to have more influence in positive changes in attitudes toward elderly than knowledge, experience or skill of staff (Ornstein, 1976; Solomon & Vickers, 1979). Thus through the setting of institutional tone or milieu, the Director can influence the care that is to be received by residents.

There has been little exploration in the literature regarding the Director of Nursing within nursing homes. The responsibility for resident care, the limited physician, as well as other professional support, and staff preparation and shortage issues leave the Director of Nursing as an almost single quality care agent and monitor. The issue of the Director's preparation becomes important in light of the responsibilities under which she or he functions. It is known that fewer than 20% of nursing service administrators (acute and long-term care) have master's degrees. Another 22% have baccalaureate degrees. These figures and the literature indicate an overall lack of formal educational preparation for the role (Duffy & Gold, 1980; Gaspard, 1971).

Relationship of Nursing Education to Quality of Care

A brief history of nursing education has importance in exploring a relationship between nursing education and quality of care.

The education of nurses extends back to Florence Nightingale's writings concerning the need for nurses to have formal education. Schools of nursing initially grew in close affiliation with hospitals and the education of nurses for the most part was apprenticeship

in nature (Pueschel, 1969). As nursing's body of knowledge grew and nursing research ensued, the belief that nursing education belonged in a university setting began to be expressed. Baccalaureate programs in nursing have been available since 1919. In the 1960's associate of arts programs in nursing were founded (Pueschel, 1969). The original purpose of the two year associate of arts program was to prepare a technical nurse while the professional nurse would be prepared at the baccalaureate degree level. Nursing's professional organization, the American Nurses' Association, in 1965 put in motion the "1985 plan" that proposed that all nursing education be done in the university setting. The components of this plan are as follows:

> The education for all those who are licensed to practice nursing should take place in institutions of higher education.
>
> Minimum preparation for beginning professional nursing practice at the present time should be baccalaureate degree education in nursing.
>
> Minimum preparation for beginning technical nursing practice at the present time should be associate degree education in nursing.
>
> Education for assistants in the health service occupations should be short, intensive pre-service programs in vocational education institutions rather than on the job training programs.
>
> (ANA's First Position on Education for Nursing, 1965)

Through the years the number of diploma schools has steadily decreased. At the present time the percentages of baccalaureate schools are 22%, associate of arts, 42%, and diploma, 36% (Hill, Gortner, and Scott, 1980).

The movement within nursing regarding nursing education is reflected in the amount of research over the last decade regarding

nursing education. While studies have addressed program structure, curriculum, and learners, few studies have addressed outcomes other than those of single institutions following up graduates (Hill et al., 1980). The ultimate test of educational outcomes is in performance on the job (Hill et al., 1980).

Outcome differences should occur in a profession that educates nurses in three different ways, one program lasting four or five years, one three years, and one two years. However, research has not consistently supported outcome differences.

Linn's 1976 study of associate degree, diploma, and baccalaureate degree students suggested that basic nursing preparation had no significant effect on subsequent ability to perform in the family practitioner role. However, differences have emerged in other studies. Improved performance in leadership skills, communication, planning, and consideration of patients' psychological/sociological needs have been found in baccalaureate degree prepared nurses (Gray, Roy, Murray, & Sawyer, 1977; Meleleis & Farrell, 1974; Reichow & Scott, 1976; Waters, Vivier, Chater, Urrea & Wilson, 1972). Schwirian (1976) found that baccalaureate graduates were rated significantly higher in areas of teaching collaboration and planning care. Performance in quality and quantity of patient care was found to be higher with increased levels of education, as well as increased utilization of actions requiring nursing knowledge and judgement without dependence upon direction from physicians or others (Davis, 1972; Davis, 1974). Relationships between educational preparation and patient care and nursing performance were found in an acute care setting by Dyer,

Cope, Monson, & VanDrimmelon (1972) and Dyer, Monson, & VanDrimmelon (1975). Highriter (1969), in her study within a public health setting, related formal education to job performance. Patient progress was selected as the measure of nursing performance. Results of comparisons of baccalaureate and diploma prepared nurses showed no statistically significant differences in any of the areas of nursing care. Of significance is Highriter's (1969) finding that nurses who had supervisors with a master of nursing degree and democratic leadership style had higher performance ratings than those with other supervisors.

In summary, nursing is experiencing movement and direction regarding education. It has been proposed that in 1985 nursing distinguish between the professional nurse educated at the baccalaureate level and the technical nurse educated at the associate degree level. While nursing research has not addressed outcomes in relation to education to a great extent, there have been a few relationships in settings other than nursing homes which have indicated that there may be outcome differences. Resident outcomes, or quality of care, as related to the preparation of the Director of Nursing within a nursing home, are of interest to this study.

Quality of Care

While it is accepted in the literature that evaluation of the quality of care offered within a nursing home is necessary and of importance, approaches to its measurement are diverse and findings frequently varied. Quality of care is difficult to measure and factors affecting variables are often difficult to control.

In approaching the evalution of quality of care, there are dimensions identified by Donabedian (1966). These include structure, process, and outcome. Structure is a dimension concerned with characteristics of the care setting and include size, physical facilities, equipment and training of staff. Outcome is a dimension concerned with the end result of care as measured by morbidity, mortality, functioning or satisfaction. Process is the dimension concerned with the actual process of care and can be measured using methods such as peer review, utilization studies, nursing audits or observations.

The quality of care instrument used in this study is based upon the process dimension. Patient records were reviewed and patients and their surroundings observed.

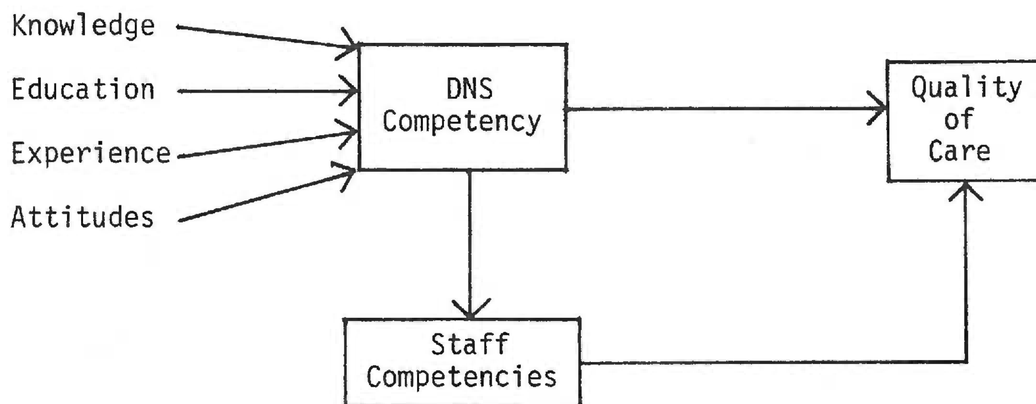
Description of Kaeser (1981) Study

In an unpublished study by Kaeser in 1981, expenditures and organizational variables of Oregon nursing homes were studied in relationship to quality of care scores as well as per patient day costs and revenues. Findings from this study indicated that increased registered nurse hours, a not-for-profit status, and an on site owner as administrator or Director of Nursing related with increased quality of care. Quality of care was measured by number of citations by the State of Oregon Resident Services Review survey.

If 22% of the variance in the Kaeser (1981) study could be explained by the above items, would the educational preparation of the Director of Nursing within these Intermediate Care Facilities explain any further variance?

Conceptual Framework

The conceptual framework for this study may be illustrated as follows:



In assuming the responsibilities for the resident care given within a facility, a Director of Nursing draws upon a knowledge base that includes, among other things, past work experience, attitudes, and education. These factors not only affect the competency level at which the Director of Nursing functions, but affect the functioning of the staff for whom she is responsible. By standard setting, teaching, disciplining, and interacting, the Director creates the milieu addressed earlier in the literature review (Ornstein, 1976; Solomon & Vickers, 1979).

This study, based upon the literature, sought to find the relationship between the educational preparation of the Director of Nursing and the quality of care given within the facility for which she or he is responsible. Recognized in this relationship

is the presence of other, many of which may be unknown, variables affecting the quality of care given with a facility.

Statement of the Problem

What is the relationship between the educational preparation of Directors of Nursing of nursing homes and quality of care offered in their respective facilities?

Hypothesis

The more advanced the nursing education preparation of a Director of Nursing, the higher will be the quality of care, as measured by number of citations, offered to residents within the nursing home.

CHAPTER II

METHODS

Design

The design for this study is a non-experimental descriptive correlational research design. The dependent variable is quality of care. The independent variable is educational preparation of Directors of Nursing of nursing homes.

Universe and Sample

The universe for the study was made up of 110 Intermediate Care Facilities in Oregon. A sample of 61 homes was used. To be included in the study the following criteria were required to have been met: (a) The facility must have served Intermediate Care level nursing home clients only during 1978-79, and (b) The facility must have accepted Medicaid clients during 1978-79. The first criterion was established to facilitate the focusing of the study on a homogenous population of elderly persons residing in a nursing home setting and to control for the additional professional staff required by state regulation for facilities including skilled beds. The second criterion was adopted to enable the utilization of all quality of care data collected by the Resident Services Review Teams.

Thirteen facilities were not included due to quality of care data which was incomplete. Four facilities were not included because they had either changed their names or closed, and therefore could

not be contacted. Thirty-two facilities had no information regarding the whereabouts of the Director of Nursing during 1978-79. Thus these 32 facilities were not a part of the sample.

Dependent Variable/Quality of Care

Reports of the State of Oregon Adult and Family Services Resident Services Review Teams analyzed by Kaeser (1981) comprised quality of care measurements. Collected between July 1, 1978 and June 30, 1979, this data was used as a measure of quality of care within the facility.

Federally mandated, the Resident Services Review provided annual assessment of every Intermediate Care Facility certified to house Medicaid clients. Its purpose was to ascertain that care being given within these facilities was appropriate and was meeting quality standards.

The Resident Service Review was accomplished by teams of social workers and registered nurses using an evaluation instrument itemizing aspects of care for assessment. The registered nurse review focused upon examination of documentation related to medical care, nursing care, and supportive services. Observation and assessment of the resident and his or her environment was also included. The social work review focused upon examination of records related to social service and activity plans of care. Interviews with selected patients as well as social service and activity staff were held. A deficiency was recorded by marking a "X" in the appropriate space. The absence of a "X" indicated the compliance of the facility to established quality standards. A copy of the instrument is displayed in the appendix.

Quality was inferred by few or no citations for poor care in four areas, documented care plans, documented physician care, documented and observed professional care (other than physician), and observed personal care. The documented care plan category included nursing care plans and notes as well as rehabilitation, social services, and recreation plans. Documented physician care includes diagnosis, medical history, laboratory and X-ray, transfer data, follow-up visits, medical treatment and telephone and verbal orders. Documented and observed professional care included giving and reviewing medications and treatments, responding immediately with appropriate follow-up for new developments or special incidents, and providing, when necessary, special professional services such as visual examinations and glasses. Observed personal care included alignment, assistance with mobility and evidence of adequate care for special conditions such as edema, dehydration, intubation and decubiti.

Since all quality of care indicators within and between categories were thought not to have the same importance, a panel of experts weighed the items. Each panelist rated the items and categories independently. There was no significant variance in response from the panel members. The panel included a nurse-reviewer of long-term care facilities, a gerontological nurse, a long-term care social worker, and a sociologist interested in patient responses to chronic illness. Weighing values within and between categories can be observed in Table 1.

Table 1

Quality of Care Weighing Values
Within and Between Categories

M.D. Care	Care Plans
(.15 wt.)	(.25 wt.)
Exam, history, transfer, and diagnosis (.38)	Nursing care plan and notes (.39)
Meds, Rx., diet, X-ray, lab and restraints (.39)	Social service (.23)
Follow-up visits and orders (.24)	Rehabilitation plan (.23)
	Activities plan (.15)
Professional Care	**Personal Care**
(.25 wt.)	(.35 wt.)
Med. Rx. and diet (.57)	Bedside environment (.28)
New development and special incident (.17)	Personal hygiene (.28)
Care for sensory needs, mobility and other special problems (.25)	Motion and mobility (.22)

Independent Variable/Educational Preparation of Directors of Nursing

Telephone interviews were utilized to determine the educational preparation of the Directors of Nursing as of June 30, 1979. Names of the Directors of Nursing were obtained from state survey reports. Educational preparation was identified as an associate degree in nursing, a diploma from a three year hospital affiliated school of nursing, a bachelor of science in nursing degree, or master of nursing degree. Determination was made, as well, of the presence of a degree in a field other than nursing at whatever level.

Control Variables

Kaeser's (1981) study, utilizing the same quality of care data, explained 22% of the variance in quality by expenditures for registered nurses, licensed practical nurses, nurses aides, and the demographic variables of profit status and on or off site ownership. The present study sought to explain further varience in quality by adding the variable of the Director of Nursing's educational preparation. Thus the control variables of registered nurse, licensed practical nurse, and nurse aide expenditures, profit status, and on or off site ownership were utilized.

Procedures

Ninty-three facilities were contacted via telephone by the researcher. The research participant's consent to participate in the telephone survey was obtained initially during the telephone conversation. Every telephone interview followed an exact format to assure informed consent, a copy of which is included in the appendix.

For the 61 facilities included in the sample, the researcher was able to either speak directly with the person who was the Director of Nursing during 1978-79 or be given a location where she could be reached. Follow-up telephone calls were then made to the suggested locations for data collection.

Data Analysis

Initially the data was organized by coding the sample according to educational preparation. A simple correlation was then used to test the hypothesis. In addition to known independent variables of registered nurse, licensed practical nurse and nurse aide expenditures, and on or off site ownership, the educational preparation of the Director of Nursing was regressed against the dependent variable quality of care.

CHAPTER III

RESULTS AND DISCUSSION

Characteristics of Sample

Turnover of Directors of Nursing

Fifty-six of the 93 facilities (60%) currently have different Directors of Nursing than they had during 1978-79. Of these, many reported during the telephone interview that the facility had, in fact, had several Directors of Nursing since 1978-79.

Educational Preparation of Directors of Nursing

Educational preparation of the Directors of Nursing varied. Of the 61, 17 Directors of Nursing, or 28%, were prepared at the associate degree level. Twenty-three, or 38%, were diploma prepared, and 19, or 31% were prepared at the baccalaureate degree level. Two, or 3%, had masters degrees in nursing with one of those having earned a master of nursing degree within a gerontology program. The educational preparation of Directors of Nursing included in the sample is illustrated in Table 2.

For the 32 Directors of Nursing who had left their facilities since 1978-79 and whose whereabouts could not be ascertained, there is no data regarding their educational preparation.

Test of Hypothesis

A correlational computation was done initially. This indicated that an educational preparation at the baccalareate level correlated with a reduced number of citations for poor care ($r=-.03314$).

Table 2

Educational Preparation of Directors
of Nursing Included in Sample

Educational Preparation	Total Number	Percentage of Sample
Associate Degree	17	28%
Diploma	23	38%
Bachelor of Science Degree in Nursing	19	31%
Master's Degree in Nursing	2	3%
Degree other than Nursing	0	0
Total Sample	61	100%

Educational preparation at the associate degree level was found to correlate with an increased number of citations for poor care (r=.00822). This correlation was in the expected direction but was not strong enough to support the hypothesis.

A regression analysis was then performed. Controlled in this equation was ownership and registered nurse, licensed practical nurse, and nurse aide hours in the institution. This was done because the previous findings of Kaeser (1981) indicated these variables had explained variance in quality of care.

When entered into a stepwise regression against the dependent variable, the baccalaureate degree of the Director of Nursing did not correlate significantly with reduced citations (r square change= .00385). The associate degree and diploma of the Director of Nursing also showed no significant relationships. Thus the hypothesis was rejected.

Discussion

Possible explanations for this hypothesis rejection include intervening factors for which there was no control. Length of time in the institution, experience, and age are all variables that may intervene into the relationship between education and quality of care. Intervening, as well, may be the significant variable of continuing education for Directors of Nursing. While formal education at an advanced level may not have been pursued, continuing education may have been utilized to a large extent by these nurses. Davis' 1972 study addresses the need for evaluation of practice and utilization of continuing education. Findings in that study indicated that while the quality and quantity of nursing care was affected

by education, it declined with increasing years of experience. This need for continuing education may be recognized and met by many Directors of Nursing of nursing homes.

Of interest is the finding of Gates (1980) in an unpublished study exploring attitudes of Directors of Nursing toward the elderly and its relationship to quality of care. The same quality of care data and universe as the present study was used, from which a sample of Directors of Nursing was drawn. No significant relationship was found between educational preparation of the Directors of Nursing and attitudes toward the elderly. This finding was consistent with the literature leading to the indication that for registered nurses the level of education may not significantly influence attitudes toward old people.

The findings of this study can be compared with literature that has indicated that for individual nurses in other settings, educational preparation has not related with nursing care (Highriter, 1969) or the ability to practice in another role (Linn, 1976). The correlation that was found initially between the baccalaureate degree prepared Director of Nursing and fewer number of deficiencies, although slight, may indicate that some relationship may exist. This finding can be compared with the findings of Dyer et al. (1975) where, in an acute care setting, education was positively related to patient care and performance scores. Davis' 1972 and 1974 studies indicated, as well, that advanced education made a difference in the quantity and quality of patient care provided by nurses. In comparing these studies with the present study, it must be kept in

mind that the Dyer et al. (1975) and Davis 1972 and 1974 studies measured the relationship of individual nurses' education and quality of care, not the relationship between educational preparation of a nurse leader and the quality of care given within a facility. Highriter (1969) did address this relationship somewhat in her study which found that nurses who had supervisors with a master of nursing degree and democratic leadership style had higher performance ratings than those with other supervisors. This study, however, was in a setting other than a nursing home.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to explore the relationship between the educational preparation of Directors of Nursing of Intermediate Care Facilities and the quality of care offered within their institutions. It was hypothesized that the more advanced the educational preparation of a Director of Nursing, the higher would be the quality of care given within the facility, as measured by number of citations given during a 1978-79 State of Oregon Adult and Family Services Resident Services Review survey. Telephone interviews ascertained the educational preparation of the Directors of Nursing as of 1978-79.

While a slight correlation was found between the baccalaureate degree prepared Director of Nursing and fewer number of citations, the hypothesis was not statistically significant.

Conclusions

In her 1981 study, Kaeser found that improved quality of care given in Intermediate Care Facilities correlated with increased wages and total hours of registered nurses, and decreased wages and hours for licensed practical nurses and nurse aides. She also found a positive relationship between profit status, presence of an on site administrator and better quality. The present study was unable to explain anymore than the 22% explained by Kaeser (1981)

with educational preparation of Directors of Nursing. Although a slight correlation was found between educational preparation at the baccalaureate degree level for Directors of Nursing and a fewer number of citations, no additional variance was explained.

Study Limitations

It is recognized that there are a number of intervening variables in the exploration of the relationship between quality of care and educational preparation of Directors of Nursing of long-term care facilities. These could include length of time within the facility, experience, age, continuing education, as well as numerous others. There was a recognized lack of control over the measurement of these intervening variables.

There was lack of control regarding the facilities included in the sample. Thirty-two Directors could not be contacted thus limiting the total number of participants and perhaps not accurately representing the educational preparation of Directors of Nursing within Oregon Intermediate Care Facilities.

There were limitations, as well, in the measurement of quality of care. The tool used in this study measured only certain aspects of patient care and may not have represented areas of care that would be of importance, particularly social and psychological aspects of long-term care. There were recognized weaknesses in interrater reliability in the use of the tool.

The results of the study cannot be assumed to apply to other populations. The study was done using 1978-79 data. Nursing education as well as expectations of the quality of care offered

to residents within a state can change rapidly. Caution must thus be used in generalizing the results.

Recommendations

The following recommendations for further study are suggested. It is suggested that the educational preparation of Directors of Nursing be measured in relationship to the quality of care given within their institutions, using tools that would allow for measurement that would reflect accurately the direct patient care given. It is recommended that the role of the Director of Nursing be further explored in an effort to ascertain what variables may or may not make the quality of care change within the facility. It is recommended that studies be done that compare and contrast differences in Directors of Nursings' roles and impacts in acute care and long-term care facilities.

The recommendation is made also that further research be done regarding the high percentage of turnover (60%) over a four year period in Directors of Nursing of Oregon Intermediate Care Facilities. This turnover may have an effect on the quality of care offered to residents.

References

American nurses' association's first position on education for nursing. American Journal of Nursing, 1965, 65, 106-111.

Chow, R. K. Quality of care; a present and future challenge for all nurses. Journal of Gerontological Nursing, 1980, 6, 255-259.

Davis, B. G. Clinical expertise as a function of educational preparation. Nursing Research, 1972, 21, 530-534.

Davis, B. G. Effect of levels of nursing education on patient care: a replication. Nursing Research, 1974, 23, 150-155.

Donobedian, A. Aspects of Medical Care Administration. Cambridge, Mass.: Harvard University Press, 1979.

Duffy, M. E., Gold, N. E. Education for nursing administration: what investment yields highest returns? Journal of Nursing Administration, 1980, 10, 31-38.

Dyer, E. D., Cope, M. J., Monson, M. A., VanDrimmelen, J. B. Can job performance be predicted from biographical personality, and administrative climate inventories? Nursing Research, 1972, 21, 294-304.

Dyer, E. D., Monson, M. A., VanDrimmelen, J. B. What are the relationships of quality patient care to nurses' performance, biographical, and personality variables? Psychological Reports, 1975, 36, 255-266.

Gaspard, N. J. Director of nursing in a comprehensive health center. Nursing Outlook, 1971, 19, 590-591.

Gates, E. M. Directors of nurses' attitude toward old people and quality of care in nursing homes. Unpublished Masters Thesis, Oregon Health Sciences University, School of Nursing, 1980.

Gray, J. E., Murray, B. L., Roy, J. F., Sawyer, J. R. Do graduates of technical and professional nursing programs differ in practice? Nursing Research, 1977, 26, 368-373.

Greenwald, S. R., Linn, M. W. Intercorrelation of data in nursing homes. The Gerontologist, 1971, 11, 337-340.

Hickey, T. Inservice Training in Gerontology; Toward the design of an effective educational process. The Gerontologist, 1974, 14, 57-64.

Hill, M. S., Gortner, S. R., Scott, J. M. Educational research in nursing: an overview. International Nursing Review, 1980, 27, 10-17.

Highriter, M. E. Nurse characteristics and patient progress. Nursing Research, 1969, 18, 484-501.

Kane, R. L., Kane, R. A. Care of the aged: old problems in need of new solutions. Science, 1978, 200, 913-919.

Kane, R. L., Solomon, D., Beck, J., Keeler, E., Kane, R. A. The future need for geriatric manpower in the united states. New England Journal of Medicine. 1980, 302, 1327-1332.

Kaeser, L. A. The relationship between patient care expenditures and quality of care in long-term care nursing homes. Unpublished Doctoral Dissertation, Cornell University, 1981.

Linn, L. S. Type of nursing education and the nurse practitioner experience. Nurse Practitioner, 1976, 1, 28-33.

Meleis, A. I., Farrell, K. M. Operation concern: a study of senior nursing students in three nursing programs. Nursing Research, 1974, 23, 461-468.

Ornstein, S. Establishing a therapeutic climate for geriatric care. Journal of Gerontological Nursing, 1976, 2, 30-36.

Portnoi, V. A. A health care system for the elderly. The New England Journal of Medicine, 1979, 300, 1387-1390.

Pueschell, S. J. A demographic analysis of the educational structure of american nursing. Nursing Research, 1969, 18, 211, 216.

Reichow, R. W., Scott, R. E. Study compares graduates of two, three, and four year programs. Hospitals, 1976, 50, 95-100.

Schwartz, A. N. Staff development and morale building in nursing homes. The Gerontologist, 1974, 14, 50-55.

Schwirian, P. M. Part I: A review of research related to prediction of nursing performance; Part II: admission practices, evaluation strategies and performance prediction among schools of nursing. Report of a study carried out under contract (NU 44127) with the Division of Nursing, HEW. As reported by Hill, M. S., Gortner, S. R., Scott, J. M. Educational research in nursing-an overview. International Nursing Review, 1980, 1, 10-16.

Soloman, D., Vickers, R. Attitudes of health workers toward old people. Journal of American Gerontology Society, 1979, 27, 186-191.

Waters, V. H., Vivier, M. L., Chater, S. S., Urrea, J. H., Wilson, H. S. Technical and professional nursing: an exploratory study. *Nursing Research*, 1972, *21*, 124-131.

Williams, T. F. Staffing problems in long-term care. *Medical Care*, 1976, *14*, 85-93.

APPENDICES

APPENDIX A

Resident Services Review Instrument
Quality of Care Reporting Form

P R E F A C E

The purpose of this report is to provide an evaluation of the quality of care - medical nursing, social services and activities - provided to the residents of a facility.

The report is divided into three sections. Section I contains a glossary of terms and interpretations, that is "keyed" to paragraph numbers in the report, and which is designed to outline expectations in the areas concerned. Section II contains items that are applicable to each resident's care and records, and to certain facility policies and programs. Section III contains comments clarifying or providing more detailed information, as needed, on items contained in Section II, and comments or suggestions of a general nature.

Although this review is based upon Federal requirements, certain elements are evaluated against State Health Division regulations and Adult and Family Services Division regulations and guides where they are either more stringent than the Federal requirements or are solely State requirements. Occasionally, comments or suggestions which are seen as good practice and in the resident's best interests will be included and should be considered on that basis. These comments or suggestions will be appropriately noted as such.

"X" marks on this report indicate that a discrepancy exists and that there is a need for <u>corrective action</u>, either by the facility on it's own part or by the facility contacting the appropriate attending physician, Adult and Family Services Division branch office or other responsible personnel or agencies. <u>Follow-up action</u> responsibility is indicated on the report as follows: If the number or letter for the item is circled, it will be the responsibility of the Adult and Family Services Division branch office; if it is underscored, it will be the responsibility of the State Health Division. In a few instances an item will be both circled and underscored, which means that both AFS and SHD will follow-up on that portion of the item that is of concern to them.

It is the intent of the Adult and Family Services Division that this report, besides fulfilling a Federal requirement, will serve as a useful management and training tool for the facility management and staff.

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES
ADULT & FAMILY SERVICES DIVISION

SNF-ICF RSR Report

To:
Health & Social Services Section

From: Resident Services Review
Utilization Control Unit, Health & Social Services Section
Adult & Family Services Division

The attached report represents an assessment of compliance by Skilled Nursing Facilities and Intermediate Care Facilities in accordance with Sections 1902(a)(26) and (31) of the Social Security Act and 45CFR 250.23 and 250.24.

Facility ________________ Date of Review ________

Address ________________

City ________________ Branch ________

Administrator ________________

Owner ________________

Director of Nursing Services ________________

Certified for: ______ Skilled beds; ______ ICF beds.

Title XIX Occupants: ______ Skilled; ______ ICF: ______ ICF-Home for Aged.

Title XIX Residents reviewed: ______ Skilled: ______ ICF: ______ ICF-Home for Aged.

Participants in this review:

Physician: ________________

Registered Nurses: ________________

________ ________

________ ________

________ ________

Social Workers: ________________

________ ________

Reviewed: ________________
SNF-ICF RSR Supervisor

____
Medical Review Physician, Utilization Control Unit

Approved: ________________
Health & Social Services Section

AFS 709 (Rev. 3/78)

GLOSSARY FOR SNF-ICF RSR REPORT

This glossary of terms and interpretations is designed to outline expectations and to provide clarification of certain items in Section I of the report. The items are "keyed" to paragraph numbers in the report.

Abbreviations: Every effort has been made to keep abbreviations to a minimum. The few that are used are as follows:

A	- Acceptable	ROM	- Range of Motion
AFS	- Adult & Family Services	RSR	- Resident Service Review
AC	- Alternate Care	S	- Skilled LOC
D	- Daily	SED	- Sedatives
H	- Home for the Aged LOC	SHD	- State Health Division
I	- Intermediate LOC	SNF	- Skilled Nursing Facility
ICF	- Intermediate Care Facility	ST	- Stabilized
L	- Less than daily	Tran	- Tranquilizer
LOC	- Level of Care	"X"	- Corrective Action Required
Narc	- Narcotic	(21)	- Follow-up by AFS Branch office (Circle)
		21	- Follow-up by State Health Division (Underscore)

Note: Wherever the term "other" is in the report, and whenever there is an "X" on that line, an explanation of the problem will be found in Section II and it will be "keyed" to the appropriate paragraph number.

RESIDENT ASSESSMENT

A. Documentation of Overall Plans of Care. There are four components of a resident's overall plan of care. They are: Health/Nursing Care; Rehabilitation; Social Components; and Activities Program. All must be adequately documented. If any component is thought to be not indicated, then that fact and the reasons therefore must be documented.

1. Health/Nursing Care Plan

a. assessment - nursing needs of resident based on available data from transfer form, history and physical, physician's orders, nursing assessment, interview of resident/family, etc.

b. goals (long and short term) - from available data, develop realistic long and short term achievable/measurable goals for the resident.

c. approaches to goals - individualized methods of achievement of goals.

d. reflect maximum potential - documentation and assessment should reflect resident's maximum mental and physical potential.

e. responsible service/services designated - services may include nursing, dietary, physical therapy, occupational therapy, etc., that are required to achieve the goals.

f. updated - reviewed every 30 days with date of review indicated.

2. Rehabilitation Plan. Same as above for the Health/Nursing Care Plan, except that the rehabilitation needs of the resident should be addressed. Areas to be considered could include physical therapy, Activities of Daily Living training, reality orientation, etc.

3. Social Components: Federal and State regulations in this area are relatively vague. While the three components are essential and required, their content is not clearly stated. Accordingly, we have endeavored in the following to outline what is considered to be "good practice", or what a responsible facility or staff member, who is sincerely concerned about the total welfare and care of a resident, would do.

   a. social history:

   The social history should contain enough information in the following areas to make an assessment of present or potential need for social services: living situation immediately prior to admission; reasons for admission; and alternatives explored; resident's feeling(s) about admission as demonstrated by his/her behavior and attitudes; significant relationships; previous and present vocation(s), interest(s), avocation(s), and skills; available resources, economic and other (see Social Assessment below); significant and relevant life-style factors.

   b. social assessment:

   The social assessment emerges from the social history. It should summarize the resident's resources and strengths as well as weaknesses and vulnerabilities. From this summary, present social service need(s) and prognosis should be identified. The areas of vulnerability will provide the basis for determining need for service, while the areas of strength will suggest possible approaches for corrective or preventative action in problem areas.

   c. social plan:

   The plan should be based on the social assessment and should include a statement of goals and prognosis for same. It should make specific recommendations for actions to achieve goals, and should designate who is responsible for what actions. Assets identified should be utilized to the fullest extent in the implementation of the plan. Plan must be signed and dated; goals, objectives, methods should be individualized, with anticipated date of accomplishment.

   Social Work reviewers will not accept statements such as, "no social needs observed at this time", because "social needs" are often found to refer only to prosthesis(es), dentures, clothing, finances, etc. Statements such as, "no planned contact by social service designee at this time", would be acceptable, only if there is additional documentation that no current social-emotional problems exist.

   (1) Incorporated in overall plan:

   Record should clearly document social plan of care and it should be congruent with overall plan of care.

(2) Implemented:

Record should document who is responsible, when each element of the plan is accomplished, and the results noted.

(3) Reviewed periodically:

There should be a clear periodic summary of goals accomplished, problems encountered if any, and changes which would result in modification of original goals. The altered goals should be stated clearly. "No change" or "continue plan" should be documented as to why.

4. Activities Programming:

a. Activities assessment:

The purpose of the activities assessment is to provide a basis for developing an individualized activity plan. At a minimum, it should describe the interests, activities and occupations which have been meaningful and part of the resident's life prior to nursing home admission. In addition it should include an evaluation of present impairment and an estimation of current potential.

b. Activities plan:

The individualized activity plan will be based on the assessment, in that it will reflect the interests and activities identified by the resident and/or family as meaningful. Its purpose is to restore and maintain the resident's mental and emotional functioning at an optimum level. It should reflect resident's participation in planning to the extent feasible.

1. Individualized goals:

The plan should contain short and long range goals that are individualized and measurable.

2. Appropriate approaches:

The plan should suggest specific and appropriate means and programs to be used to carry out the individualized goals, and should name personnel to be involved.

3. Incorporated in overall plan:

Chart should clearly document activities plan congruent with overall plan of care.

4. Implemented:

There should be clear documentation that the resident is appropriately involved in activities in accordance with the plan.

5. Reviewed quarterly:

The periodic (at least quarterly) review should include a summary of progress/regression in relation to goals. It should reflect resident's attitude toward the program and should summarize problems encountered in implementing the planning. When goals are revised, the reasons for change should be indicated.

B. Documentation of Physician's Services.

5. Transfer Data:

a. content - only necessary if transferred from another facility; name of transferring facility; identifying data; current diagnoses at time of transfer; physician's orders at time of transfer; condition of resident; pertinent data related to ongoing treatment (i.e. x-rays, lab work, etc.)

6. History/Medical Summary:

a. content - medical evaluation updated to time of admission.

7. Physical Examination:

a. content - medical evaluation based on physical exam. Admission physical exam must be done within 48 hours of admission, or within 5 days prior to admission.

8. Diagnoses:

a. content/updated - includes all diagnoses to support current orders and medical findings.

9. Medication Orders:

a. specific - to include name of medication, dosage, frequency, and route of administration. P.R.N. medications should include basis for administration.

10. Treatment Orders:

a. specific - to include type, area, duration, and frequency of treatment. P.R.N. treatments should include basis for administration.

11. Diet:

a. ordered by physician - all diets are to be ordered by the attending physician.

12. Restraint/Safety Measure Orders:

    a. specified - basis for use, type of restraint and duration to be used.

13. thru 15. - Self Explanatory.

16. Recertification of Need for Care - can be almost any type of an entry by a physician that indicates that continued care is required, e.g., a drug or treatment order, a change in a drug or treatment order, laboratory or X-ray order, a diet order, or a simple statement, "continue care" or "no change in care", etc.

    C. Documentation of Nursing and Supportive Services.

17. Medications:

    a. reviewed monthly - the review is by a Registered Nurse.

18. Self Explanatory.

19. Restraints/Safety Measures: includes all types of restraints, including being restrained in a Geri-chair or wheelchair.

20. Nursing Notes:

    a. reflect health-rehab. plan of care - pertinent entries reflecting assessment of progress or change in relation to resident's health-rehab. plan of care.

    b. summaries, as required - in SNF's reviewer will review for pertinent and current summaries in accordance with the policy of the facility for such summaries, e.g., every shift, once a day, etc.; in ICF's they are required weekly, as a minimum, by licensed nursing personnel. All entries should be dated and signed with identifying title, and reflect the resident's plan of care.

21. New Development/Special Incident: any marked deviation in resident's condition or unusual occurrence or incident, including accidents. A documentation in record should reflect action taken, emergency or otherwise, if applicable. Subsequent entries should reflect appropriate action taken to resolve the problem.

22. Diet

    All documentation of diet, in Nursing Care Plan, or nursing notes should reflect the current physician's order.

23. thru 27. - Self Explanatory.

28. RSR recommendation for Level of Care.

29. thru 30. - These are items for information only.

E. Social Services - Individual

31. Personal Fund Accounting:

a. AFS Form 713 - separate form for each resident whose funds are being handled by facility. Instructions for form 713 must be followed and current posting up to at least 30 days prior to RSR review. Review may go back to date of last review. Receipts for expenditures, if appropriate, must be available. Withdrawals by staff/resident/relative and purpose for withdrawal must be signed.

b. Appropriate charges - RSR reviewer reviews for compliance with Rule 461-17-140, 150, and 160 AFS Title XIX Long Term Care Facility Services Guide.

c. Quarterly accounting - evidence of quarterly accounting to resident or appropriate representative will be noted.

d. Delegation/Acceptance forms - required in those instances where someone other than the resident is handling the resident's personal incidental funds. An Adult Service Worker may not be the delegate.

e. Interest bearing accounts - required in those instances wherein the resident's personal incidental fund account balance reaches $75.00, or more.

32. Resident's Needs/Concerns Met - if a need or problem appears evident to reviewer through resident interview or chart review, and if no documentation exists that need/problem has been recognized, reviewer will indicate this by an "X", plus a brief explanation in Section II.

The following are examples of the kinds of problems that a resident may have which require action or intervention by the facility staff or other appropriate personnel:

a. feelings about placement/services
b. feelings about illness and aging
c. feelings about loneliness/isolation
d. financial problems
e. discharge or transfer
f. interpersonal problems with relatives/staff/residents
g. need for volunteer
h. need for other community resources

33. Residents' Rights Statement - statement should be clearly labeled with resident's name and date. If resident is unable to sign, the next acceptable signature is that of a relative/guardian or Adult Service Worker.

34. Discharge Plan (SKILLED ONLY) - Plan must include goals, person(s) responsible for effecting, alternative living arrangement, and should reflect a team approach. If alternative planning seems impossible, documentation should indicate reason.

35. Humanitarian Concern Displayed - all reviewers will be alert towards observing actions or conduct on the part of the facility staff that give evidence of a lack of compassion for, or consideration of, the residents, their needs, and their rights. This may vary from physical or verbal abuse to inattention or an act of omission.

36. Residents Satisfaction with Facility/Staff - all reviewers will be alert by both observation and interview to any complaints that residents may express to the reviewer.

NOTE: Items 37 and 38 are highly sensitive areas. Reviewers have been instructed to carefully evaluate any data they observe or hear on these items prior to reporting a discrepancy. Also, if a discrepancy is reported, complete details, including the name or names of the resident(s) or staff member(s) involved or registering a complaint, will be explained in Section II of the report. Exception to this policy may be made when a number of residents register the same complaint, e.g., not enough meat in diet, etc. In the latter case only the total number of residents complaining will be included.

37. Management of Personal Funds - Reviewer will ascertain that Personal Incidental Funds handled by the facility conform to the rules and regulations.

38. The item will be explained in the comment section of the report.

SNF-ICF
RSR Report

SECTION I

RESIDENT ASSESSMENT

Patient Number																									
A. DOCUMENTATION OF OVERALL PLANS OF CARE																									
1. HEALTH/NURSING CARE PLAN:																									
a. assessment																									
b. goals (long & short term)																									
c. approaches to goals																									
d. reflect maximum potential																									
e. responsible service/services																									
f. updated																									
2. REHABILITATION PLAN:																									
a. assessment																									
b. goals (long & short term)																									
c. approaches to goals																									
d. reflect maximum potential																									
e. responsible service/services																									
f. updated																									

SEC. I RESIDENT ASSESSMENT (Cont.)

A. DOCUMENTATION OF OVERALL PLANS OF CARE

3. SOCIAL COMPONENTS:
- a. social history ____
- b. social assessment ____
- c. social plan ____
  - (1) incorporated in overall plan ____
  - (2) implemented ____
  - (3) reviewed periodically ____

4. ACTIVITIES PROGRAMMING:
- a. activities assessment ____
- b. activities plan ____
  - (1) individualized goals ____
  - (2) appropriate approaches ____
  - (3) incorporated in overall plan ____
  - (4) implemented ____
  - (5) reviewed quarterly ____

SEC. I RESIDENT ASSESSMENT (Cont)

B. DOCUMENTATION OF PHYSICIAN'S SERVICES																									
5. TRANSFER DATA:																									
a. content																									
b. signed by physician																									
c. dated																									
6. HISTORY/MEDICAL SUMMARY:																									
a. content																									
b. signed by physician																									
c. dated																									
7. PHYSICAL EXAMINATION:																									
a. content																									
b. signed by physician																									
c. dated																									
8. DIAGNOSES:																									
a. content/updated																									
b. signed by admitting/attending physician																									
9. MEDICATION ORDERS:																									
a. signed on admission by attending physician																									
b. renewed/signed monthly by attending physician																									
c. dated																									
d. specific																									

SEC. I RESIDENT ASSESSMENT (Cont)

B. DOCUMENTATION OF PHYSICIAN'S SERVICES

10. TREATMENT ORDERS:
   - a. specific ______
   - b. signed by attending physician ______
   - c. dated ______

11. DIET:
   - a. ordered by physician ______

12. RESTRAINT/SAFETY MEASURE ORDERS:
   - a. specified ______

13. PHONE/VERBAL ORDERS:
   - a. signed by nurse ______
   - b. countersigned by physician ______
   - c. dated ______

14. PHYSICIAN'S VISITS:
   - a. recorded in required frequency* ______

15. PROGRESS NOTES:
   - a. in required frequency* ______
   - b. signed ______
   - c. dated ______

16. RECERTIFICATION OF NEED FOR CARE:

*Skilled - every 30 days, unless documented by physician for 60 days

*Intermediate Care Facility - every 60 days

SEC. I RESIDENT ASSESSMENT (Cont)

C. DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

17. MEDICATIONS:

a. reviewed monthly

b. recorded as ordered

c. signed

d. dated

e. given only with physician's order

f. other

18. TREATMENTS:

a. recorded as ordered

b. signed

c. dated

d. results documented

e. given only with physician's order

f. other

19. RESTRAINTS/SAFETY MEASURES:

a. used only with physician's order

b. documentation of release every [illegible]

Page ______ of ____

SEC. 1 RESIDENT ASSESSMENT (Cont)

C. DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

20. NURSING NOTES:
   - a. reflect health-rehab plan of care
   - b. summaries, as required
   - c. signed
   - d. dated

21. NEW DEVELOPMENT/SPECIAL INCIDENT:
   - a. action taken
   - b. follow-up

22. DIET:
   - a. provided as ordered

23. LABORATORY AND X-RAY:
   - a. physician's order
   - b. reports in chart

24. TUBERCULOSIS CONTROL REQUIREMENTS:
   - a. admission test, x-ray, or physician's statement
   - b. follow-up of positive skin test or positive x-ray

Page ______ of ____

SEC. I RESIDENT ASSESSMENT (Cont)

C. DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

25. PERSONAL ATTENTION/OBSERVATION:

a. hair/scalp personal
b. eyes
c. ears
d. skin
e. oral hygiene/care of teeth personal
f. care of intubated orifices/tubing professional
g. overall cleanliness body/clothing personal
h. shaven personal
i. fingernails personal
j. feet
k. toenails personal
l. odor personal
m. edema prof.
n. nutrition
o. hydration prof.
p. contractures "
q. decubiti care "
r. turning/positioning -- ROM prof.
s. comfort/body alignment prof.
t. maximum mobility prof.
u. behavioral management prof.
v. other

SEC. I RESIDENT ASSESSMENT (Cont)

C. DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

26. APPARENT NEED FOR OR REPAIR OF:
- a. visual exam/glasses
- b. dental exam/dentures
- c. audiogram/hearing aid
- d. podiatry care
- e. prosthetics
- f. walker/crutches
- g. wheelchair
- h. physical therapy
- i. clothing
- j. personal care items
- k. other

27. AVAILABILITY/CONDITION OF:
- a. linen
- b. bed/mattress
- c. bedside area
- d. fresh water
- e. call bell
- f. side rails or restraints
- g. provisions for privacy
- h. other

28. LEVEL OF CARE ASSESSMENT
- a. CURRENT AFS LEVEL OF CARE
- b. RSR RECOMMENDATION FOR LOC

E. SOCIAL SERVICES - Individual

29. RESIDENT NOT INTERVIEWED:*
30. PERSONAL FUNDS MANAGEMENT:*
    a. by resident
    b. by relative/other
    c. by facility

31. PERSONAL FUND ACCOUNTING:
    a. AFS Form 713
    b. Appropriate charges
    c. Quarterly accounting
    d. Delegation/Acceptance forms
    e. Interest bearing accounts
32. RESIDENT'S NEEDS/CONCERNS MET
33. RESIDENT RIGHT'S STATEMENT
34. DISCHARGE PLAN (SNF only)

F. SOCIAL SERVICES - Facility**
35. Humanitarian Concern Displayed
36. Residents Satisfaction with Facility/Staff
37. Management of Personal Funds
38. Other

GENERAL: Facility Administrator/Staff cooperative with RSR personnel: ____yes ____no. If no, explain:

*Information only - "✓" indicates status (No corrective action required)

**A - Acceptable
X - Corrective action indicated

SECTION II - COMMENTS, CONCLUSIONS, RECOMMENDATIONS:

APPENDIX B

Format for Telephone Survey to Assure Informed Consent

OREGON HEALTH SCIENCES UNIVERSITY

SCHOOL OF NURSING

To: Human Research Committee

From: Christine Samuelson Slusarenko

Subject: Format for Telephone Survey to Assure Informed Consent

It is proposed that Directors of Nursing of ninty-eight nursing homes in the state of Oregon be contacted by Christine Samuelson Slusarenko via telephone. Each telephone conversation will include every one of the following items:

(1) Identification of the institution, Oregon Health Sciences University, the researcher, Christine Samuelson Slusarenko, R.N., B.S.N., the thesis advisor, Linda Kaeser, R.N., Ph.D., and the thesis topic, The Relationship Between the Educational Preparation of Directors of Nursing in Nursing Homes and Quality of Care.

(2) Explanation that the purpose of the telephone conversation is to ascertain the Director of Nursing's educational preparation.

(3) Explanation that participation in the telephone conversation is voluntary.

(4) Explanation that the telephone conversation is confidential, that once recorded, results of the conversation will be coded, and when coded will be anonymous. Prior to coding, the results will be available only to the researcher and will be kept in a locked container. After coding, the original results will be destroyed.

(5) Explanation that participation in the telephone conversation will in no way affect the Director of Nursing's relationship with his or her employing institution.

(6) Explanation that the Director of Nursing may not benefit from the study but that participation in the study will increase knowledge about the relationship between the educational preparation of Directors of Nursing in nursing homes and quality of care.

(7) Explanation that the Christine Samuelson Slusarenko will answer any questions about what is required of the Director of Nursing during the telephone conversation.

(8) Explanation that the Director of Nursing may refuse to participate or withdraw from the conversation at any time and that doing so will not affect his or her relationship with, or treatment at, the Oregon Health Sciences University.

AN ABSTRACT OF THE THESIS OF

CHRISTINE SAMUELSON SLUSARENKO

For the MASTER OF NURSING

Date Receiving this Degree:

Title: The Relationship Between the Educational Preparation of Directors of Nursing in Nursing Homes and Quality of Care

Approved ______________________________

Linda Kaeser, Ph.D. Thesis Advisor

The purpose of this study was to investigate the relationship between the educational preparation of Directors of Nursing of nursing homes and the quality of care offered within their respective facilities. It was hypothesized that the more advanced the nursing education of a Director of Nursing, the higher would be the quality of care, as measured by number of citations, offered to residents within the nursing home.

Reports of the State of Oregon Adult and Family Services Resident Services Review Teams comprised quality of care measurements. Collected between July 1, 1978 and June 30, 1979, this data was used to measure quality of care within the facility.

Ninty-three Intermediate Care Facilities within the State of Oregon were contacted via telephone by the researcher and a sample of 61 was used. Educational preparation of the Directors of Nursing

as of June 30, 1979 was determined. Educational preparation was identified as an associate degree in nursing, a diploma from a three year hospital affiliated school of nursing, a bachelor of science in nursing degree, or a master of nursing degree. Determination was made, as well, of the presence of a degree in a field other than nursing at whatever level.

Stepwise regressional analysis was used to test the hypothesis. No significant relationship was found between the educational preparation of Directors of Nursing and quality of care as measured by number of citations. Recommendations for further study were made.