DIRECTORS OF NURSES ATTITUDE TOWARD OLD PEOPLE AND QUALITY OF CARE IN NURSING HOMES

by

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A Thesis

Presented to
The University of Oregon Health Sciences Center
School of Nursing
in partial fulfillment
of the requirements for the degree of
Master of Nursing

June, 1980

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ACKNOWLEDGEMENTS

The author wishes to express her sincere appreciation to the Army Nurse Corps for this educational opportunity. I would also like to express appreciation to all those individuals involved in the successful completion of this thesis. My thanks are extended to Linda Kaeser for her continued guidance and support throughout the many stages of development of this study, and to Dr. Julia Brown and Donna Schantz for their helpful suggestions. Special thanks are also in order to David Parker for his help in managing the computer and to Lynne Sells for her hours of hard work in typing this manuscript. I would also like to express my gratitude to Jan Smith for all her help throughout this master's program.

Finally, I would like to express my deepest appreciation to my husband, Ken, for his love and continued confidence in my ability, without which I could not have gotten through the rough spots.

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CHAPTER I

INTRODUCTION

The number of elderly Americans has increased substantially in the twentieth century. Currently there are more than 20 million people over age 65 and it is anticipated that these individuals will continue to live an additional 10 years. A parallel increase in the number of elderly requiring medical and nursing care can be expected. The nursing home is one type of service delivery system for the elderly. It is an important component both in terms of the amount of funding and the number of people who consume their services. Nine billion dollars were spent in nursing homes in 1975. One out of 20 persons over the age of 65 resides in a nursing home on a given day, and 1 in 5 can expect to spend some time in one during their lifetime (Winn & McCaffree, 1976).

The concern for quality of long-term care has been voiced by the consumer, professional groups and those governmental agencies financing health programs. Various approaches have been proposed to assess (Howard & Strong, 1977; Plant, 1977) and ensure (Goran, Crystal, Ford & Tebbutt, 1976) quality of care.

According to Kart and Manard (1976) researchers interested in the investigation of quality have generally taken one of three approaches. One method is to describe probable indicators of quality and study what types of facilities rate high according to these parameters. Examples of such characteristics thought to be important to the quality of nursing homes include: number of patients per room and

bathroom, number of staff hours per patient day, and therapeutic orientation of administration. One problem with this approach is that it does not measure what difference these characteristics actually make to the patient. The second approach is to study probable indicators such as crowding or staffing patterns in relation to outcome measures such as resident satisfaction and staff performance. The third approach examines institutional characteristics and their relation to quality. The most frequently examined characteristics are: (1) ownership (Anderson, Holmberg, Sneider & Stone, 1969; Beattie & Bulloch, 1964; Levey, Ruchlin, Stotsky, Kinloch & Oppenheim, 1973; and Townsend, 1963); (2) size (Greenwald & Linn, 1971; Winn & McCaffree, 1976); (3) socio-economic status of residents and staff including resources and price of care (Anderson et al., 1969; Kosberg, 1973; (4) social integration of residents (Bennett, 1963); and (5) professionalism. The profession-alism factor has been the least investigated of the five (Kart & Manrd, 1976).

There has been an increasing interest on the part of researchers to study the attitudes and perceptions of persons working in institutions for the aged and relating those results to quality of care (Kosberg & Gorman, 1975). Nurses are the single largest group of helath care professionals in the United States (Taylor & Harned, 1978) and nursing personnel under the direction of the professional nurse are the major providers of care to the elderly in nursing homes. It would seem appropriate to study the attitude of the professional nurse toward the elderly as it relates to quality of care. It is assumed that the Director of Nurses provides the professional leadership for

care in the nursing home (Laurice, 1978). It then follows that the attitude of the director is the key in setting the tone and creating the prevailing atmosphere for the care given to the residents (Coggenshall, 1973; Ornstein, 1976). How the Director of Nurses' attitude toward the elderly influences quality of care was the focus of this study.

Review of the Literature

The review of the literature will cover the relationship between attitudes and behavior, the attitude of nursing personnel toward the elderly, the role of the Director of Nurses in nursing homes, and evaluation of quality of care.

Relationship Between Attitude and Behavior

Rokeach (1968) defined attitude as an organization of beliefs. Each belief within the organization of an attitude has three components: affective, cognitive and behavioral. The affective component provides the motivational energy for behavior. The cognitive component sorts and collates the available information and prevailing beliefs about an object or person. The behavior component determines an individual's disposition to respond in a consistent way toward the object or person to whom the attitude is attributed (LaMonica, 1979).

The influence of attitudes in the nurse-patient encounter has been described by White (1977) as follows. Nursing personnel interact with patients within a health care environment. The encounter and subsequent nurse-patient behaviors are influenced by the quality of the environment

as well as factors within the patient and the nurse. Patient factors identified include goals, illness, self-care abilities, emotional status and social status. Factors within the nurse include goals, attitudes, knowledge and skills. Attitudes on the part of either are thought to trigger positive or negative responses when there is a stimulus from the person to whom the attitude is attributed. Behaviors associated with a nurse's attitude are, in turn, reinforced or not reinforced by factors in the environment.

Attitudes of Nursing Personnel Toward the Elderly

Studies of the attitudes of nursing personnel toward the elderly have been conducted in a variety of settings and with a wide range of personnel, although few studies have employed similar methods. The focus of investigation has been on those variables thought to influence attitudes such as age, level of education, experience with the elderly, and type of agency where one is employed. There is no consensus in the findings of the studies reviewed, however, as to the direction of influence of these variables.

Five of the studies reviewed addressed the relationship between age and attitude toward the elderly. Three of the studies (Taylor & Harned, 1978; Thorson, Whatley & Hancock, 1974; and Wolk & Wolk, 1971) indicated that younger nurses manifest more positive or favorable attitudes toward the elderly than do older nurses. Futtrell and Jones (1977) found the opposite -- older nurses manifest more positive attitudes than do younger ones. Gillis (1973) found no difference in attitude toward the elderly among nurses under and over 45 years of age.

The relationship between level of education and attitude toward the elderly was investigated in five of the studies reviewed. The findings have not been consistent. Campbell (1971) investigated attitudes among registered nurses, licensed practical nurses and aides and found that as the level of education increased stereotype acceptance decreased. Acceptance of stereotypes on the part of those with less education resulted in a negative or unfavorable attitude toward the elderly. Holtzman (1977) and Thorson et al. (1974) came to the same conclusion in their studies of professional and paraprofessional personnel working with the elderly. Futtrell and Jones (1977) on the other hand after studying the attitudes of physicians, nurses and social workers toward the elderly found no significant relationship between nurses' education and overall attitude toward the elderly. Gillis' (1973) study found that nurses with less education displayed significantly more positive attitudes than those with more education.

The relationship between length of time spent with the elderly and attitude has been investigated by Gillis (1973), Taylor and Harned (1978), Julian (1969) and Futtrell and Jones (1979). Gillis did not find any significant differences in attitude based on number of years that nurses were employed in nursing services for the elderly. Taylor and Harned, and Julian found that nurses with less experience in the care of the elderly exhibited more positive attitudes as measured by the Kogan Old People (OP) Scale. Futtrell and Jones, however, found that nurses with more experience in the care of the elderly expressed more positive attitudes. Again the findings have not been conclusive.

Two studies were found investigating the relationship between

nurses' attitudes toward the elderly and behavior in a nursing situation. Hatton (1977) studied seven nurses working in a long-term care facility and correlated their scores on the Kogan Old People Scale with their positive and negative interactions in response to patient needs. Although the findings were not statistically significant, those nurses with a more favorable attitude exhibited a higher percentage of positive interactions with patients. The results of the study have limited value due to the small sample size and nonsignificant findings but do generate questions for future research. The author recommended further research into the influence of attitudes on the nurse's interaction, and thereby on quality of care rendered. Julian's (1969) study of 166 Oregon registered nurses explored the relationship between expressed attitude toward the elderly and expressed nursing behavior in their care. In this study, attitude towards the elderly was measured by responses on the Kogan Old People Scale. Behavior toward the elderly was measured by what the individual said she would do in response to 15 nursing care situations. Results of the study indicated a significant positive relationship between expressed attitude toward the elderly and expressed nursing behavior in the care of the elderly. One of the conclusions drawn from this study was that "attitudes can and do affect behavior".

Only one study was found that investigated the relationship between a nurse's attitude toward the elderly and quality of nursing care. Quinlan (1978) conducted an "association testing study" with a sample of 30 nurses employed in three sites, namely, an acute care hospital, a nursing home, and a visiting nurse service. Attitude

toward the elderly was measured by a modified Tuckman-Lorge (1953) questionnaire and quality of nursing care was evaluated using a modified form of the Slater Nursing Competencies Rating Scale (Wandelt & Stewart, 1975). Results of the study indicated that nurses who expressed a more positive attitude toward the elderly provided a better quality of nursing care. The researcher concluded that attitude does indeed affect care.

That attitudes toward the elderly have a significant relationship with the quality of nursing care provided to the elderly has been supported by at least three of the studies reviewed. Several other studies have inferred that attitudes have an influence over the quality of care provided although they did not test this hypothesis.

Role of the Director of Nurses

According to Ornstein (1976) the attitude of the nursing director is especially important in setting the institutional tone and creating an atmosphere and spirit that will prevail in care given to nursing home residents. An examination of the role of a Director of Nurses is indicated to promote understanding of her influence on the institutional quality of care.

The Director of Nurses assumes the professional leadership for patient care in a nursing home and is responsible for the provision of nursing care and services on a 24-hour basis. The director as a member of a two-part nursing home management team, which includes the nursing home administrator, is the ranking health care professional with authority (Barney, 1974). By virtue of position, the Director of Nurses

is responsible for setting standards of care and ensuring staff compliance with these established standards. The administrator is not usually a health care professional and, thus, is only peripherally involved with nursing care standards. In addition, the nursing home, in contrast to other health care institutions has minimal back-up support from physicians in establishment and maintenance of standards. Thus, the Director of Nurses assumes almost exclusive responsibility for the quality of care provided.

The establishment of acceptable standards of care by the Director of Nurses is based on professional knowledge, experience, and philosophy. The Director of Nurses' philosophy is the very foundation of his/her nursing practice and is composed of attitudes, beliefs and values which govern decisions regarding the quantity and quality of nursing care that will be provided to each patient (Jennings, Nordstrom, & Shumake, 1972).

Quality of Care

Donabedian (1966) has identified three dimensions along which quality of care may be assessed: structure, process, and outcome. The dimension of structure is concerned with the characteristics of the setting in which the care is given. Structural variables include institutional size, physical facilities, equipment, personnel qualifications and experience, and organization of practice. The dimension of process is concerned with what actually happens in the provision of care. Included in process of care variables are definition of the problem, treatment plan, actual treatment and follow up care. Methods

employed to evaluate process are peer review, utilization studies, cost studies, nursing audits and medical audits or direct observation. The dimension of outcome is concerned with the end result of care. Outcome is usually measured in terms of mortality, morbidity, disability, social functioning and patient satisfaction. According to Donabedian, structure, process, and outcome are interrelated in determining the quality of care.

In this study, the quality of care instrument is based on the process dimension of care. Evaluation of quality is based on review of patient records and direct observation of residents and their immediate area.

Statement of the Problem

What are the relationships of age, years of nursing experience in nursing homes, and education and the Director of Nurses' attitude toward old people? What is the relationship between the Director of Nurses' attitude toward old people and the quality of nursing care in nursing homes?

Purpose of the Study

The purpose of this study is to investigate the relationship between Director of Nurses' attitude toward old people and the quality of nursing care provided under their direction. In addition, the effect of age, years of nursing experience in nursing homes, and level of education on attitude toward old people are examined.

Hypotheses

1. Younger Directors of Nurses will manifest more positive attitudes toward old people than older Directors of Nurses.

2. Directors of Nurses with a greater number of years of nursing experience in nursing homes will manifest more negative attitudes toward old people than those with a lesser number of years of experience in nursing homes.

3. Directors of Nurses who have achieved a Bachelor of Science Degree in Nursing will be more positive in attitude than directors who have attained an associate degree or diploma.

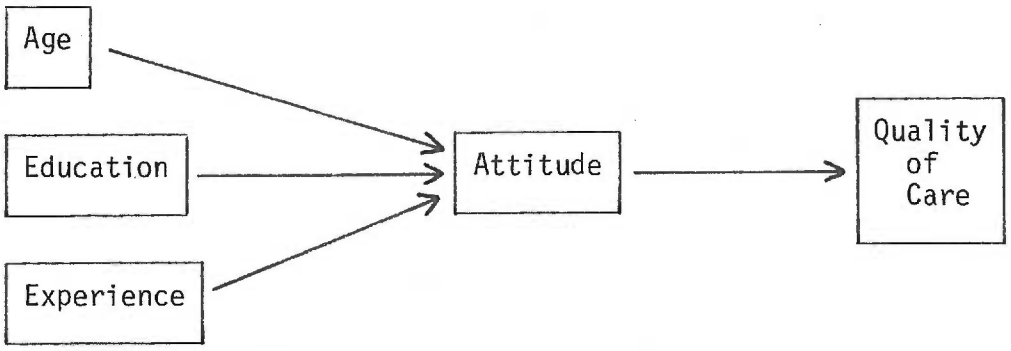
4. Those institutions in which the Director of Nurses demonstrates a positive attitude toward old people will rate higher in quality of care than those institutions in which the Director of Nurses demonstrates a negative attitude toward old people.

CHAPTER II

METHOD

Design

The design of this contextual study was correlational and is applied research according to Abdellah and Levine's (1965) definition. The major dependent variable is quality of care. The major independent variable is attitude toward old people. The major antecedent variables are age, years of nursing experience in nursing homes, and level of education. The design may be diagrammed as follows:



Subjects and Setting

Nursing homes and Directors of Nurses were selected for participation in this study based on the following four criteria: (1) classification of the institution by the Oregon State Health Division Licensing and Certification Section as an intermediate care facility (ICF) with certified Medicaid (Title XIX) beds; (2) the facility was reviewed by the Oregon Adult and Family Services (AFS) Resident Services Review Team during the period July 1, 1978 through July 30, 1979; (3) the

current designated Director of Nurses is the same as at the time of the review; (4) the facility had no designated skilled nursing care beds. The first three criteria were established because the quality of care measure to be used in this study was collected during the period July 1, 1978 through July 30, 1979. Those facilities with skilled nursing care beds were eliminated to control for the additional professional staff requirements necessitated by the presence of residents with skilled nursing care requirements.

Fifty-eight intermediate care facilities within the state of Oregon met the established criteria and comprised the universe and site for this study. This number comprised 41% of all intermediate care facilities (ICF) within the state. The fifty-eight DNS of the ICF comprised the universe of subjects for this study. These DNS according to Oregon Revised Statutes are registered nurses who are responsible for the provision of nursing care and services within a nursing home on a 24-hour basis.

Data Collecting Instruments

Two major sources of data were used. One of the sources was the reports of the State of Oregon Adult and Family Services (AFS) Resident Services Review Teams which was used as the quality of care measure. These data were collected by review teams during the period July 1, 1978 through July 30, 1979. The other data source was a mailed questionnaire containing the Kogan Attitude Toward Old People (OP) Scale and 6 questions designed to elicit demographic data (See Appendix B).

This questionnaire was mailed to the 58 Directors of Nurses who

qualified for inclusion in the study as per the established criteria. The questionnaire contained the 34 items of the Kogan OP Scale interspersed with 26 filler items, and the addition of 6 questions designed to elicit demographic data (see Appendix B). Accompanying the questionnaire was a cover letter (see Appendix C) explaining the purposes of the study; a self-addressed, stamped envelope for return; and an informed consent form (see Appendix D).

Measurement of Quality of Care

The reports of the Oregon Adult and Family Services (AFS) Resident Services Review (RSR) Teams were the source of quality deficiency data. These teams were composed of two registered nurses and one social worker. The teams were formed and have been functioning in response to federal rules and regulations promulgated by Medicaid to assure adherence to appropriate quality standards for Medicaid clients in nursing homes.

The RSR data collection instrument covers 38 areas against which quality of care to each Medicaid resident in the facility is assessed (see Appendix A for a copy of the instrument). This study focused only on those items which are designated as nursing. SRS nurses assessed quality deficiencies in nursing by examining patient records and visually examining residents and his/her bedside area. The registered nurse reviewer noted a deficiency in any nursing item by placing an X opposite the name of the individual resident to whom it applied. The absence of any mark indicated acceptable quality according to established standards.

The RSR instrument was reviewed by this researcher and 3 other registered nurses who had studied nursing home care to eliminate all items except those which fell clearly under the responsibility of the Director of Nurses. The items were then separated into two categories: (1) documented care, (2) observed care. Each category contained four subcategories. Since the 2 categories were not thought to be equally important, a weighting process was established. The observed subcategories were given heavier weighting because they directly measured outcomes of nursing care, whereas records only indirectly measured nursing care provided. The categories and their constituent items and weights are presented below.

Category 1 - Documented Care

1.1 Medication Management - Item #17
(10%) Medications recorded as ordered, given only with physician's order, signed, dated and reviewed monthly by the nurse.

1.2 Treatments and Diet - Items #18, 22, 25n, 25o.
(10%) Treatments recorded as ordered, given only with the physician's order, results documented and signed by the nurse. Diet provided as ordered by the physician. Adequate nutritional appearance; hydrated.

1.3 New developments/special incidents and restraints - Items #19, 21.
(10%) Documentation of action and follow up of new development or special incidents. Restraints used only with physician's order and their release every 2 hours documented.

1.4 Resident Care Plans - Items #1, 2, 20.
(10%) Adequate and updated nursing care plan signed and dated nursing notes. Adequate and updated rehabilitation plan.

Category 2 - Observed Care

2.1 (15%) Personal care management - Items #25a..l, q. Hygienic care of body, personal clothing, hair and scalp, eyes, ears, skin, fingernails, toenails, feet, odor, beard, decubiti, intubated orifices/ tubing.

2.2 (15%) Mobility status - Items #25p, r, s, t, 26f, g. Maximum mobility maintained, comfort/proper body alignment observed, evidence of turning/positioning and range of motion, absence of contractures.

2.3 (15%) Environmental management - Items #26i, j, k, 27. Adequately maintained linen, bed/mattress, bedside area, fresh water, presence of call bell, side rails or restraints, provision for privacy; personal care items adequate and in repair.

2.4 (15%) Supportive services - Items #26a, b, c, d, e, h. Need for or repair of visual exam/glasses, dental exam/dentures, audiogram/hearing aid, physical therapy, podiatry care and/or prosthetics.

Using the RSR evaluation form the number of deficiencies in each row (which, on the form represents one specific quality of care criterion) was totaled. This sum was divided by the number of residents evaluated and then expressed as the percentage of deficiencies per resident for that row. A mean score was calculated for all the rows within a given subcategory (i.e., medication management, treatments and diet, personal care management, etc.). The mean subcategory scores for each category was averaged to give a mean score for each of the two categories. According to the weighting system (40% documented care, 60% observed care) a "mean" score was calculated for the total number of items under the responsibility of the Director of Nurses. The potential range of scores was from 0 to 100. A lower percentage score indicated fewer deficiencies and, thus, a higher quality of care.

Measurement of Attitude Toward Old People

The attitude of Directors of Nurses toward old people was obtained through the use of the Kogan Old People (OP) Scale. The OP scale is a Likert scale consisting of 34 items constructed in the form of 17 positive and 17 negative statements about old people. The OP scale items focus on residential aspects of old people's lives, vague feelings of discomfort and tension experienced in the company of old people, qualities of old people, and interpersonal relations across generations. Clustering of items in the OP scale according to these categories are presented below.

I. Residential aspects of old people's lives

#1, 5, 12	Special reference to segregation of old people with regard to residential units, ability to maintain their home and characteristics of the neighborhood.

II. Feelings of discomfort and tension experienced in the company of old people

#2, 8	Reference to old people being different, hard to figure out; make one feel ill at ease.

III. Qualities of old people

#3, 6, 11, 13, 14, 15	Extent to which old people vary among one another with regard to cognitive style and capacity, in reference to irritating habits, and with respect to personal appearance and personality.

IV. Interpersonal relations across generations

#9, 10, 16, 4, 17, 7	Reference to old people talking about their past experiences, interfering in the affairs of others and giving advice, and complaining about the younger generation; dependence on their children for love and support; have powers in business and politics.

Each item is provided with six response categories: strongly disagree, disagree, slightly disagree, slightly agree, agree, strongly agree. Subjects check one alternative for each item. Response categories are scored 1, 2, 3, 5, 6, and 7 with 1 representing strongly disagree and 7 representing strongly agree. A score of 4 is assigned if the subject fails to respond to an item. The attitude score is obtained along two dimensions, positive or favorable attitude and negative or unfavorable attitude, by adding the scores of each scale taken separately. A total score of 17 - 119 is possible on each scale. A higher score on the OP+ scale indicates a more favorable (positive) attitude toward old people. Conversely, a higher score on the OP- scale indicates a more unfavorable (negative) attitude (Shaw & Wright, 1977). The mathematical difference between scores on the OP+ scale and OP- scale were not used by Kogan to measure attitude.

In the development of the original scale Kogan (1961) disguised the presence of logical opposites among the "old people" statements by interspersing them among 105 items from other attitude and personality scales. Shaw and Wright (1977) advise the use of filler items with the scale. For the purpose of this study only 26 filler items were used. Eighteen items were taken from the original Kogan study (1961) and 6 items were drawn from the attitude toward disabled people scale (Shaw & Wright, 1977). Filler items are marked with an asterisk in Appendix B. The instrument as administered by this researcher consisted of a total of 60 items. The sequence of items in the study instrument was determined by random draw (see Appendix B for the complete questionnaire). Scoring of the instrument was obtained based on the items of the OP scale exclusively and as previously described.

Reliability and Validity of Kogan Old People (OP) Scale

Kogan determined odd-even reliabilities on the OP+ and OP- scales for each of his three samples used in developing the scale. Correlated reliabilities were reported as .73 (N=128), .83 (N=186) and .76 (N=168) for the OP- scale. Corresponding reliability values for the OP+ scale were .66, .73 and .77 respectively.

The OP scales have reasonably good content validity (Shaw & Wright, 1977). In addition, Kogan tested construct validity by correlations between OP scores and attitude scales toward ethnic minorities and physically disabled groups. Scores on the OP scales correlated .08 to .46 with scores on Gilbert and Levinson's (1956) CMI scale of attitudes toward mental illness. Items measuring attitudes toward totally deaf and crippled persons were constructed or adapted from Cowen, Underberg, and Verillo's (1958) attitude-to-blindness scale. Scores on the OP scales correlated .21 to .50 with attitude toward deafness, and .21 to .53 with attitude toward cripples. A correlation of .14 is significant at the .05 level of confidence with the sample sizes used. Thereby, we can assume the scale to have construct validity. Kogan (1961) also derived a nurturant factor from a brief personality inventory of his subjects which may be taken as some evidence of validity.

Silverman (1966) conducted a study to determine whether the direct measurement of attitude by the Kogan Old People (OP) scale would be contaminated by the respondent's desire to select a socially acceptable answer. In his study the OP scale and the Ford Social Desirability Scale were administered to 67 male and 22 female students. The Ford instrument measured social desirability response-set bias. In addition,

the predictive validity of the OP scale was determined as a result of each student's ranking 10 groups of people according to their preference for interviewing each specific group. The category "retired people" was the criterion measure for association with old people. Results of the study indicated that despite the possibility of response-set bias the OP scale is capable of predicting the disposition to associate with the aged in a hypothetical behavioral situation (Silverman, 1966).

Kogan's Old People Scale was selected for administration to the participants of this study because it specifically measures attitude toward old people, is brief and easily scored. Its use in previous studies of professional nursing has been documented (Futrell & Jones, 1977; Julian, 1969; Hatton, 1977; Taylor & Harned, 1978; Thorson et al., 1976).

Demographic Data

Six items were added to the study instrument in order to elicit demographic data on the participants. Information desired included: year of birth, sex, total years of nursing experience, total years of nursing experience in nursing homes, highest level of education in nursing, and additional non-nursing degrees held. These variables have been identified in previous studies as variables which may be related to attitude toward old people.

Analysis of Data

A quality of care score was derived for each intermediate care facility based on the computation of quality deficiency data obtained

by the Oregon Adult and Family Services Resident Services Review Teams. The total number of deficiencies found under the items considered to be the responsibility of the Director of Nurses was tabulated and divided by the number of residents reviewed. A total mean score for nursing care was awarded to each institution. A lower mean score indicated the presence of fewer deficiencies and, therefore, higher quality of care.

An atitutde score for each of the Directors of Nurses was computed from the individual's answers to the Kogan Old People Scale. A high score on the OP+ Scale indicated a more positive attitude toward old people while a high score on the OP- Scale indicated a more negative attitude toward old people.

A matrix was constructed of the intercorrelations of scores on the Kogan Old People (OP) Scale and the quality of care rating, respondent's age, years of nursing experience in nursing homes, and education. Pearson's r was the statistical measure employed. In addition, one-way analyses of variance were carried out between level of education in nursing and scores on the OP+ and OP- Scales.

CHAPTER II

RESULTS AND DISCUSSION

Description of Subjects and Setting

Directors of Nurses

Forty-three Directors of Nurses returned the questionnaire at the end of the stipulated time limit, a 74% return rate. Of these 43 directors, 29 eligible Directors of Nurses agreed to participate. These 29 Directors of Nurses and their respective Intermediate Care Facility comprised the subjects and setting for this study. This number represents 50% of the universe for this study and 21% of all Intermediate Care Facilities (ICF) within the State of Oregon.

Of the 29 Directors of Nurses who agreed to participate in the study, eight had associate degrees in nursing, twelve were diploma graduates, four were diploma graduates with additional credits toward a Baccalaureate Degree in Nursing, and five had Baccalaureate Nursing degrees.

As may be seen from Table 1, the nurses exhibited a wide range of age. The youngest Director of Nurses was 28 and the oldest 66. The mean age was 47. Four were between 20 and 30, five between 30 and 40, seven between 40 and 50, ten between 50 and 60, and three between 60 and 70. Total length of nursing experience in nursing homes ranged from 1.5 to 28 years with a mean of 8 years and a standard deviation of 5.7. Total years of experience in nursing ranged from 5 to 39 years with a

Table 1

Director of Nurses' Characteristics

Characteristic	Value
Age	
Mean	47
S.D.	10.82
Range	28-66
Nursing Experience (years)	
Mean	21.26
S.D.	9.86
Range	6-39
Nursing Home Experience (years)	
Mean	8
S.D.	5.73
Range	1.5-28
Education	
A.A.	8
Diploma	12
Diploma+	4
B.S.N.	5

mean of 21.3 years (see Table 2).

There were no data available regarding the age, education, years of nursing experience in nursing home and total years of nursing experience for those Directors of Nurses who did not return the questionnaire. Therefore, how representative the respondents were of the total population of Directors of Nurses could not be determined.

Nursing Homes

The nursing homes included in this study varied in size from 23 to 107 beds; 9 of the Intermediate Care Facilities (ICF) were classified as small (under 40 beds), 5 were classified as medium (40 to 65 beds), and 15 were classified as large (over 65 beds). When compared with those nursing homes whose Directors of Nurses did not return the questionnaire, this number represents 50% of the eligible small Intermediate Care Facilities, 39% of the eligible medium Intermediate Care Facilities and 56% of the eligible large Intermediate Care Facilities (see Table 2). The mean institutional quality-of-care-score, 27.5%, for participating nursing homes was higher than the mean institutional score of 24.5% for homes whose Directors elected not to participate in this study. This finding indicated that those nursing homes who participated provided poorer quality of care than the homes that did not elect to participate in this study.

Table 2

Comparison by Size of Nursing Homes Included and Nursing Homes not Included in this Study

Size	Total	Included	Not Included	% Included
Small (under 40 beds)	18	9	9	50%
Medium (40-65 beds)	13	5	8	39%
Large (over 65 beds)	27	15	12	56%
Total	58	29	29	50%

Descriptive Findings of Major Variables

Quality of Care

Each of the nursing homes was assigned a mean quality of care rating following the computation of deficiencies found upon inspection by the Oregon Adult and Family Services (AFS) Resident Services Review Teams. Institutional quality of care scores ranged from 5% to 83% with the lower score indicating the higher quality of care; the mean score was 27.4 with a standard deviation of 18.06. As the possible range of scores on the quality of care instrument of 0% to 100%, the nursing homes exhibited few deficiencies and, thus, the sample is skewed in the direction of higher quality care.

Individual scores for Category 1, documented care, and Category 2, observed care, were also computed. The mean score for Category 1 was 16.4% with a standard deviation of 13.09, and a range of 1% to 54%. The mean score for Category 2 was 11.1% with a standard deviation of 7.06, and a range of 2% to 29% (see Table 3). These findings indicate that there were a greater number of deficiencies found in documented care than in observed care. Quality of care scores for individual nursing homes may be found in Appendix E.

A possible explanation for this finding is that charting in the patient's records was not given as high a priority by the individual Director of Nurses as the provision of direct care to the patient.

Attitude Toward Old People

Scores on the OP+ Scale ranged from 56 to 98 with a mean score of 81.6 and a standard deviation of 11.04. Scores on the OP- Scale

Table 3

Scores on Measures of Quality of Care and Attitude toward Old People: Means, Standard Deviations and Ranges

Measure	Mean	S.D.	Range
QOC Total	27.5	18.06	5-83
Category 1	16.4	13.09	1-54
Category 2	11.1	7.06	2-29
OP+ Scale	81.5	11.04	56-98
OP- Scale	39.8	10.86	20-70

ranged from 20 to 70 with a mean score of 39.8 and a standard deviation of 10.86. The possible range of scores on each scale is 17-119. All of the 29 Directors of Nurses who chose to participate in the study exhibited positive attitudes toward old people, i.e., the scores on the OP+ Scale were greater than on the OP- Scale (see Table 3). Individual attitude scores may be found in Appendix F. This finding of a higher positive score is consistnet with that of Julian (1969) who also found the attitudes of 166 registered nurses within the State of Oregon to be positive in nature. Both studies employed the same attitude scale and tested only registered nurses. However, Julian's study differed from the present one in that Julian investigated nurses employed in community health agencies and hospitals as well as nursing homes. The similarity in findings of the two studies may be due in part to their common use of the Kogan OP Scale and with registered nurses. In each study questionnaires were mailed to nurses who, in turn, elected to participate in the research. It could have been that only those nurses having positive attitudes toward the elderly agreed to participate.

Another explanation for the unanimously positive attitude of nurses in the present study could be that Directors of Nurses thought that it was more appropriate for individuals in their position to answer in a positive manner. This may also be an indication of the social desirability response-set identified by Silverman (1966) as a possible limitation in the use of this instrument.

A third explanation of the positive attitude finding is that Directors of Nurses who select to work in nursing homes and have worked in nursing homes over time do indeed have positive attitudes toward

old people. This may be the reason why they selected, and continue to work in the field.

Test of Hypotheses

Age and Attitude

The first hypothesis stated that younger Directors of Nurses would manifest more positive attitudes toward old people than older Directors of Nurses. Such a relationship would be indicated by a negative correlation between age and the score on the OP+ Scale, and indicated by a positive correlation between age and the score on the OP- Scale. The Pearson Product Moment Correlation (r) obtained was -.294 between age and the OP+, and .259 between age and the OP-. Both values are below that needed for significance at $p < .05$. The first hypothesis is, therefore, not accepted. (See Table 4.)

Directors of Nurses ranged in age from 28 to 66 with a mean age of 47. One possible explanation for this absence of correlation could be that there were not enough nurses in either extremes of age for a valid comparison. Twenty-one of the directors were within 1 standard deviation from the mean, 37 to 57 years. The previous studies of Gillis (1973), and Campbell (1971), had also found no correlation between age and attitude toward the elderly which in their studies operationalized as acceptance or rejection of stereotypes about the elderly. Campbell's sample consisted of 147 registered nurses, licensed practical nurses, and nursing assistants whose ages ranged from 20 to 65 years. The mean age of registered nurses, however, was 28.0 years as opposed to a mean age of 47 years for nurses in this study. Sr. Gillis studied 32

Table 4

Correlation Coefficients of Age and Nursing Home Experience of Directors of Nurses, with their Scores on Attitude toward Old People Scale (OP+ and OP-)

Characteristic	Scores of Directors of Nurses	
	OP+	OP-
Age	-.294	.259
NH Experience	-.285	.146

r = .368 is significant at $p < .05$

registered nurses, 28 licensed practical nurses and 26 nurses' aides and categorized them into two groups, over 45 years of age and under 45 years of age. Thorson et al. conducted a study with 59 professional and paraprofessionals who work with the elderly and found that younger subjects expressed more positive attitudes than older subjects. Taylor and Harned (1978) in their study of 71 registered nurses ranging in age from 20 to 70 years, found that younger nurses expressed more positive attitudes toward old people than did older nurses. Quinlan (1978) reported similar results in her study of 30 registered nurses ranging in age from 21 to 67 years. Futhrell and Jones (1977), on the other hand, in their study of 75 nurses ranging in age from 20 to 72 years, found that older nurses expressed more positive attitudes toward old people than did younger nurses.

Years of Nursing Home Experience and Attitude

The second hypothesis stated that Directors of Nurses who have experienced a greater number of years of nursing experience in nursing homes would exhibit a more negative attitude toward old people than directors with lesser years of experience. Such a relationship would be indicated by a negative correlation between nursing home experience and the score on the Kogan Old People (OP) Scale. The hypothesis was tested using Pearson's Product Moment Correlation. Results of the test revealed an r of -.285 between the OP+ score and years of nursing experience in nursing homes, and an r or .234 between the OP- score and years of experience (see Table 5). Although the results were in the expected direction, a value of r = .368 is necessary for significance

at $p < .05$. The second hypothesis, therefore, was not accepted.

The absence of a significant relationship between years of experience and attitude toward the elderly may be due to the limited contact between the Director of Nurses and the nursing home patients. Previous studies have indicated that frequency of contact with the elderly increases negative attitude toward them (Campbell, 1971). Thus, if the Director of Nurses is infrequently in contact with the elderly either due to the other requirements of the position or other factors, she would exhibit a less negative attitude toward old people. It is also possible that the lack of a stronger relationship between years of nursing experience in nursing homes and attitude is due to selective attrition, whereby nurses with greater unfavorable views may leave the nursing home field while those with more favorable views remain. Thus, their positive attitudes may be a reflection of their career goals of directing the care of the elderly in nursing homes. On the average, total years of nursing experience for Director of Nurses (see Table 1) was greater than her years of experience in nursing homes, thus presenting the possibility that additional experience in the care of the elderly could have been gained in a facility other than a nursing home. A comparison between total number of years of experience in the care of the elderly, whatever the setting, and attitude toward old people may have produced different findings. Studies of Campbell (1971), Taylor & Harned (1978), and Julian (1969) found that nurses with less experience in the care of the elderly exhibited more positive attitudes toward the aged while a study conducted by Futtrell & Jones (1977) found that nurses with more experience in the care of the elderly expressed more positive attitudes

toward old people.

Education and Attitude

In the third hypothesis it was predicted that Directors of Nurses who have achieved a Bachelor of Science Degree in Nursing would be more positive in attitude toward old people than directors who have attained associate degrees or diplomas. Mean scores by education level are presented in Table 5. The hypothesis was tested by one-way analysis of variance. The "F" value obtained for the OP+ Scale was .142, and the OP- Scale "F" value was .590. Because both "F" values were so far from the 2.98 needed for significance, the hypothesis was rejected.

The absence of any significant relationship between education level and attitude toward old people may be related to curriculum content of the various educational programs rather than years of education. If total years of nursing experience is related to year of completion of the educational program, 79% of the participants in this study completed their formal nursing education over ten years ago. Until recently, nursing curricula did not specifically include the study of geriatric nursing as a specialty area. Therefore, the effect of increased knowledge and understanding regarding the aging process and the nursing care of old people could not have been applicable to the participants of this study.

Previous nursing studies have resulted in mixed findings. Thorson et al. (1979), and Campbell (1971) in comparing the attitudes of registered nurses, licensed practical nurses and aides found that as the level of education increased the attitude toward old people was more

Table 5

Mean Score on Kogan OP Scale
According to Education for
Directors of Nurses in 29
Nursing Homes in Oregon

Education Level	Mean Scores on Kogan Attitude Scales	
	OP+	OP-
A.A. (n=8)	82.5	34.6
Diploma (n=12)	81.8	40.75
Diploma+ (n=4)	80.0	34.75
B.S.N. (n=5)	81.8	41.6

positive. Gillis (1973) compared the attitudes of baccalaureate, associate degree and diploma nurses and found that the associate degree and diploma nurses scored more positive attitudes than did baccalaureate nurses. Futtrell and Jones (1977) and Quinlan (1978) reported no significant relationship between level of education and attitude toward old people. The results of the present study were in accord with those of Futtrell & Jones and of Quinlan. All three of these studies employed the Kogan Old People (OP) Scale to measure attitude and compared only registered nurses rather than various levels of nursing personnel (nurses' aides, licensed practical nurses, registered nurses) as other studies had done. The consistency of this finding may indicate that for registered nurses the level of education does not significantly influence attitude toward old people.

Attitudes and Quality of Care

In the fourth hypothesis it was predicted that those institutions in which the Director of Nurses demonstrates a positive attitude toward old people would score a higher quality of care rating than those institutions in which the Director of Nurses demonstrates a negative attitude toward old people. This hypothesis was based on the assumption that there would be a number of directors who exhibited a positive attitude toward old people and a number who exhibited a negative attitude toward old people. The absence of Directors of Nurses exhibiting a negative attitude toward old people made a true test of the hypothesis impossible. In addition, the comparison of the degree of positive or negative attitude and quality of care was limited by the narrow range of scores

obtained on each attitude dimension. Those nursing homes studied were assigned relatively low quality of care scores, indicating that a high quality of care was being provided. Thus, a true comparison between those homes providing a poor quality of care with those providing a high quality of care could not be carried out.

With due consideration for the aforementioned limitations, an examination of the relationship between degree of positive and negative toward the elderly and overall quality of care score was conducted. As may be seen from Table 6, the Pearson Product Moment correlation obtained between overall rating of quality of care (QOC) and scores on the OP+ Scale was -.071, and on the OP- Scale was -.327. Neither relationship was significant at $p < .05$. Additional Pearson r correlations were calculated between scores of the two categories, documented care and observed care and the OP+ and OP- scores. The r between the OP+ Scale and Category 1 was -.071, and between OP+ and Category 2, $r = -.044$. The r between the OP- Scale and Category 1 was -.402, and between OP- and Category 2 was -.105.

One possible explanation for the significant negative relationship between quality of documented care and negative attitude may be the prioritizing of activities by the Director of Nurses. Although the documentation of care is stressed by licensing and accrediting bodies, it may be that in view of the limited time available and the requirement of other duties involved in the position, the director is unable to adequately perform charting functions. A further explanation can be provided in the context of staffing of the institution. Inadequate staffing both in terms of quality and quantity of personnel can increase

Table 6

Correlation Coefficients of Nursing Home Quality of Care Scores with Scores of Directors of Nurses on Attitude toward Old People Scale (OP+ and OP-)

Nursing Home QOC Score	Scores of Directors of Nurses	
	OP+	OP-
Total Care	-.071	-.327
Documented Care (Category 1)	-.071	-.402
Observed Care (Category 2)	-.044	-.105

r = .368 is significant at $p < .05$

the demand for the director to spend more time in those activities concerned with the orientation and training of personnel and assisting in the provision of direct care to patients. Another explanation for the poor documentation might be that it is a shared responsibility of all nursing personnel, and those members of the nursing staff who are not registered nurses are not as attuned to the necessity of adequate documentation and, therefore, do not give it as high a priority.

The absence of a significant relationship between Directors of Nurses' positive attitude toward old people and quality of care may indicate that within the nursing home there are other factors that more directly impact on the quality of care provided. Adequacy of staffing, proficiency of personnel, the influence of other registered nurses on the staff in maintaining standards of care may present barriers to the implementation of quality nursing care practices. It may also be possible that the attitude of those who give direct care to patients bears a greater relationship to the quality of care provided than does the attitude of the individual directing the care.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to investigate the relationship between Directors of Nurses' attitude toward old people and the quality of nursing care in the nursing homes under their direction. The relationships of the selected demographic variables of age, years of nursing experience in nursing homes, and level of education to attitude toward old people were also explored.

Fifty-eight intermediate care facilities (ICF) within the State of Oregon met the required criteria for inclusion in the study. Each of the nursing homes (ICF) was assigned a mean quality of care rating following the tabulation of deficiencies found upon inspection by the Oregon Adult and Family Services (AFS) Resident Services Review Team. The quality of care score was based on only nursing care items and was expressed as a percentage. A lower percent for the quality of care rating indicated a higher quality of care.

Directors of Nurses were mailed a 60-item questionnaire consisting of the 34-item Kogan Attitude Toward Old People (OP) Scale interspersed with 26 filler items. Additional information regarding the selected demographic data was also collected. Usable questionnaires were returned by 29 directors. These 29 directors and their respective ICFs became the subjects for the study.

Four hypotheses were formulated as follows: First, those institutions in which the Director of Nurses demonstrates a positive attitude toward old people will score a higher quality of care rating than those institutions in which the Director of Nurses demonstrates a negative attitude toward old people. Second, younger Directors of Nurses will manifest more positive attitudes toward old people than older Directors of Nurses. Third, Directors of Nurses who have experienced a greater number of years of nursing experience in nursing homes will exhibit a more negative attitude toward old people than those with lesser experiences in nursing homes. Fourth, Directors of Nurses who have achieved a Bachelor of Science Degree in Nursing will be more positive in attitude toward old people than directors who have attained an associate degree or diploma. None of the hypotheses were accepted.

Conclusions

The conclusions to be drawn from this research are that, at least for the study population, there is no relationship between the Director of Nurses attitude toward old people and the quality of nursing care provided under her direction. In addition, the selected demographic variables of age, years of nursing experience in nursing homes and level of education do not significantly affect attitude toward old people as had been noted in previous nursing studies.

Recommendations

The following recommendations for further study are suggested. First, that a study be conducted to measure the attitude toward old people of those nursing personnel who provide direct care of the patient. Although not supported by the findings of this study, previous studies have found a relationship between attitude and behavior in a nursing situation. Therefore, a study to investigate the relationship between a caregiver's attitude toward old people and the actual care being given as measured by a quality of care instrument, such as QUALPACS, or the Slater Nurse Competencies Scale would be a second recommendation. Third, a more expensive study to determine the attitude, positive or negative, of the Directors of Nurses of all intermediate care facilities within the State of Oregon. The final recommendation is that a similar study be conducted with a sample that includes a broader range of scores along the quality of care dimension and Directors of Nurses with both positive and negative attitudes toward old people.

Implications for Nursing Administration

The results of this research suggest that the attitude of the Director of Nurses toward the client population does not affect the quality of care provided under their direction. The primary implication of this finding for administration is the recognition that other factors, either within the Director of Nurses or within the institution, influence the quality of care provided, at least as quality of care is here operationalized. If nursing administration is responsible for the provision of quality care to the elderly in nursing homes, those factors which

influence the establishment and implementation of quality standards should be identified.

The higher incidence of deficiencies in the documented care category demonstrates the need for re-emphasis of the importance of keeping up-to-date records in order to validate the care being given. If all nursing personnel share the responsibility for ensuring that patient records are up-to-date and accurate, in-service programs can be designed to promote the proficiency of all individuals in proper charting technique.

Implications for Nursing

Few studies have been conducted investigating the influence of a nurse's attitude and the quality of care provided. There is evidence in the literature to support the idea that attitude and behavior are related in a nursing situation. The population of elderly in the United States is increasing with a parallel increase in the need for medical and nursing care. As nursing personnel play an important role in the provision of health care to the elderly, those factors that influence the quality of care provided should be identified. The major implication of this research for the nursing profession is that continued research is needed both in the study of attitudes and their influence on the nursing situations and in the identification of factors that influence quality of care in institutions.

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APPENDICES

APPENDIX A

Resident Services Review Instrument

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)

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 corrective action, 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. Follow-up action 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.

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

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)

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 2 hours

SEC. I 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

SEC. I RESIDENT ASSESSMENT (Cont)

C. DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

25. PERSONAL ATTENTION/OBSERVATION:

a. hair/scalp
b. eyes
c. ears
d. skin
e. oral hygiene/care of teeth
f. care of intubated orifices/tubing
g. overall cleanliness body/clothing
h. shaven
i. fingernails
j. feet
k. toenails
l. odor
m. edema
n. nutrition
o. hydration
p. contractures
q. decubiti care
r. turning/positioning -- ROM
s. comfort/body alignment
t. maximum mobility
u. behavioral management
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**		GENERAL: Facility Administrator/Staff cooperative with RSR personnel: _____yes _____no. If no, explain:
35. Humanitarian Concern Displayed		
36. Residents Satisfaction with Facility/Staff		
37. Management of Personal Funds		
(38.) Other		

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

**A - Acceptable
X - Corrective action indicated

APPENDIX B

Attitude Questionnaire

Please provide the following general information.

1. Year of birth: _____

2. Sex: M_____ F _____

3. Total years of nursing experience. _____

4. Total years of nursing experience in nursing homes. _____

5. What is your highest education level in nursing?

   a. Diploma _____

   b. Associate Degree _____

   c. Baccalaureate Degree _____

   d. Master's Degree _____

6. Do you hold a degree in a field other than nursing?
   If so, please give degree and major.

Instructions for completion of questionnaire

On the following pages you will find a number of statements expressing opinions with which you may or may not agree. Following each statement are six boxes labeled as follows:

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
☐	☐	☐	☐	☐	☐

You are to indicate the degree to which you agree or disagree with each statement by checking the appropriate box. Please consider each statement carefully, but do not spend too much time on any one statement. Do not skip any items. There are no "right" or "wrong" answers - the only correct responses are those that are true for you.

THIS INVENTORY IS BEING USED FOR RESEARCH ONLY AND IS COMPLETELY ANONYMOUS.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	
1. It would probably be better if most old people lived in residential units with people of their own age.	☐	☐	☐	☐	☐	☐	
2. There are things worse than being blind.	☐	☐	☐	☐	☐	☐	*
3. Most old people are cheerful, agreeable, and good humored.	☐	☐	☐	☐	☐	☐	
4. It is very difficult to make a deaf person change his mind once he has decided on something.	☐	☐	☐	☐	☐	☐	*
5. It would probably be better if most old people lived in residential units that also housed younger people.	☐	☐	☐	☐	☐	☐	
6. Crippled people do not have as much initiative as people who are not crippled.	☐	☐	☐	☐	☐	☐	*
7. Most old people are really no different than anybody else; they're as easy to understand as younger people.	☐	☐	☐	☐	☐	☐	
8. One can live in a competitive society without sight.	☐	☐	☐	☐	☐	☐	*
9. Most old people are constantly complaining about the behavior of the younger generation.	☐	☐	☐	☐	☐	☐	
10. Most disabled people do not feel sorry for themselves.	☐	☐	☐	☐	☐	☐	*
11. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.	☐	☐	☐	☐	☐	☐	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	
12. Most old people make excessive demands for love and reassurance.	☐	☐	☐	☐	☐	☐	
13. Most blind people feel that they are worthless.	☐	☐	☐	☐	☐	☐	*
14. Most deaf people are dissatisfied with themselves.	☐	☐	☐	☐	☐	☐	*
15. One seldom hears old people complaining about the behavior of the younger generation.	☐	☐	☐	☐	☐	☐	
16. A mental patient is in no position to make decisions about everyday problems.	☐	☐	☐	☐	☐	☐	
17. Blind people are more easily upset than sighted people.	☐	☐	☐	☐	☐	☐	*
18. Most old people tend to let their homes become shabby and unattractive.	☐	☐	☐	☐	☐	☐	
19. Old people have too little power in business and politics.	☐	☐	☐	☐	☐	☐	
20. One of the main causes of mental illness is lack of moral strength.	☐	☐	☐	☐	☐	☐	*
21. Most old people make one feel ill at ease.	☐	☐	☐	☐	☐	☐	
22. Disabled people are just as self-confident as other people.	☐	☐	☐	☐	☐	☐	*
23. It is evident that most old people are very different from one another.	☐	☐	☐	☐	☐	☐	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	
24. Most severely disabled people are just as ambitious as physically normal persons.	☐	☐	☐	☐	☐	☐	*
25. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.	☐	☐	☐	☐	☐	☐	
26. Disabled persons should not expect to lead normal lives.	☐	☐	☐	☐	☐	☐	*
27. Most old people respect others' privacy and give advice only when asked.	☐	☐	☐	☐	☐	☐	
28. If old people expect to be liked their first step is to try to get rid of their irritating faults.	☐	☐	☐	☐	☐	☐	
29. Most old people are very relaxing to be with.	☐	☐	☐	☐	☐	☐	
30. Deaf people are constantly worried about their future.	☐	☐	☐	☐	☐	☐	*
31. Old people have too much power in business and politics.	☐	☐	☐	☐	☐	☐	
32. I feel that blindness is as hard to bear as complete paralysis.	☐	☐	☐	☐	☐	☐	*
33. People grow wiser with the coming of old age.	☐	☐	☐	☐	☐	☐	
34. The way disabled people act is irritating.	☐	☐	☐	☐	☐	☐	*
35. When you think about it, old people have the same faults as anybody else.	☐	☐	☐	☐	☐	☐	

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	
36. Disabled people are usually sociable.	☐	☐	☐	☐	☐	☐	*
37. Most old people can generally be counted on to maintain a clean, attractive home.	☐	☐	☐	☐	☐	☐	
38. Most old people seem to be quite clean and neat in their personal appearance.	☐	☐	☐	☐	☐	☐	
39. A blind person is constantly worried about what might happen to him.	☐	☐	☐	☐	☐	☐	*
40. Most old people bore others by their insistence on talking about the "good old days".	☐	☐	☐	☐	☐	☐	
41. Most blind people think and act alike.	☐	☐	☐	☐	☐	☐	*
42. A crippled person can't afford to talk back to people.	☐	☐	☐	☐	☐	☐	*
43. Most old people are irritable, grouchy and unpleasant.	☐	☐	☐	☐	☐	☐	
44. Crippled people are used to failing in most of the things they do.	☐	☐	☐	☐	☐	☐	*
45. One of the most interesting qualities of old people is their accounts of their past experiences.	☐	☐	☐	☐	☐	☐	
46. There is something different about most old people; it's hard to figure out what makes them tick.	☐	☐	☐	☐	☐	☐	
47. A blind person should not have to meet the same standards as others.	☐	☐	☐	☐	☐	☐	*

		Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	
48.	There are a few exceptions, but in general most old people are pretty much alike.	☐	☐	☐	☐	☐	☐	
49.	Few, if any, mental patients are capable of real friendliness.	☐	☐	☐	☐	☐	☐	*
50.	Most old people would prefer to quit work as soon as pensions or their children can support them.	☐	☐	☐	☐	☐	☐	
51.	Most disabled people do not feel sorry for themselves.	☐	☐	☐	☐	☐	☐	*
52.	In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.	☐	☐	☐	☐	☐	☐	
53.	Most old people should be concerned with their personal appearance, they're too untidy.	☐	☐	☐	☐	☐	☐	
54.	Most old people are capable of new adjustments when the situation demands it.	☐	☐	☐	☐	☐	☐	
55.	Disabled persons are usually friendly.	☐	☐	☐	☐	☐	☐	*
56.	It is foolish to claim that wisdom comes with old age.	☐	☐	☐	☐	☐	☐	
57.	Mental illness is an illness like any other.	☐	☐	☐	☐	☐	☐	*
58.	Most old people get set in their ways and are unable to change.	☐	☐	☐	☐	☐	☐	
59.	Most old people need no more love and reassurance than anyone else.	☐	☐	☐	☐	☐	☐	
60.	Most old people spend too much time prying into the affairs of others and giving unsought advice.	☐	☐	☐	☐	☐	☐	

APPENDIX C

Letter of Introduction

GRADUATE STUDIES DEPARTMENT
SCHOOL OF NURSING

Area Code 503 225-7838

3181 S.W. Sam Jackson Park Road

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

Dear

In partial fulfillment of the requirements for a Master of Nursing Administration degree at the University of Oregon Health Sciences Center School of Nursing, I am undertaking a study concerning Directors of Nurses and their feelings about the elderly. You are invited to participate in the study. It will involve completing the enclosed questionnaire, which will take approximately fifteen minutes. A self-addressed, stamped envelope is enclosed for your convenience in returning the completed questionnaire. If you do not wish to participate, enclose the unanswered questionnaire in the envelope provided and return. I would appreciate a response before April 15, 1980. Naturally you can expect your reply to be held in absolute confidence.

Your assistance with this study is very much appreciated.

Very truly yours,

Elise M. Gates

APPENDIX D

Agreement for Informed Consent

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER
SCHOOL OF NURSING

AGREEMENT FOR INFORMED CONSENT

I, _____, herewith agree
(First Name) (Middle Name) (Last Name)
to serve as a subject in the investigation name, "What is the Relationship Between Director of Nurses Attitude Toward Old People and the Quality of Care in Nursing Homes?" by Elise M. Gates, R.N., B.S., graduate student, under the supervision of Linda A. Kaeser, R.N., M.S.W., faculty advisor.

I understand that I will be asked to complete a questionnaire that will take approximately 15 minutes. I understand that all information collected will be coded and my anonymity preserved. Any information transmitted as a result of the study will be aggregated so that individuals and institutions cannot be identified. Additionally, my name and any other identifying characteristics will not be identified.

The potential benefit from my participation in this study will be to increase my awareness of the opinions I hold about certain individuals.

Elise Gates has offered to answer any questions I might have regarding participation in this study. I understand that I may refuse to participate, or withdraw from this study without affecting my relationship with, or treatment at, the University of Oregon Health Sciences Center.

It is not the policy of the Department of Health, Education and Welfare, or any other agency funding the research project in whcih you are participating, to compensate or provide medical treatment for human subjects in the event the research results in physical injury. The University of Oregon Health Sciences Center, as an agency of the State, is covered by the State Liability Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the Center, its officers or employees. If you have further questions please call Dr. Michael Baird, M.D., at (503) 225-8014.

I have read the foregoing and agree to participate in this study.

_____ _____
(Date) (Subject's Signature)

_____
(Witness's Signature)

APPENDIX E

Quality of Care Scores - Nursing Homes

QUALITY OF CARE SCORES - NURSING HOMES

Nursing Homes	Overall QOC Score	QOC Category 1	QOC Category 2
1	32%	11%	21%
2	13%	7%	6%
3	6%	4%	2%
4	83%	54%	29%
5	39%	19%	20%
6	38%	27%	12%
7	20%	11%	9%
8	5%	3%	2%
9	6%	6%	0%
10	19%	16%	3%
11	37%	28%	9%
12	11%	6%	5%
13	34%	20%	14%
14	19%	10%	9%
15	12%	3%	9%
16	27%	14%	13%
17	14%	7%	7%
18	22%	17%	5%
19	18%	10%	8%
20	31%	16%	15%
21	28%	7%	21%
22	20%	5%	15%
23	15%	11%	4%
24	50%	30%	20%
25	9%	1%	8%
26	64%	50%	14%
27	35%	27%	8%
28	61%	36%	25%
29	16%	9%	7%

A lower percentage score indicates higher quality of care.

APPENDIX F

Kogan Old People (OP) Scale Scores

KOGAN OLD PEOPLE (OP) SCALE SCORES

Subject	OP+	OP-
1	81	34
2	79	45
3	91	39
4	64	36
5	98	33
6	98	21
7	56	51
8	88	46
9	78	45
10	68	32
11	80	39
12	82	52
13	83	42
14	67	30
15	89	70
16	95	36
17	97	30
18	82	47
19	82	40
20	74	28
21	88	41
22	73	62
23	77	35
24	66	50
25	92	51
26	92	32
27	90	20
28	90	40
29	75	41

A higher score on the OP+ indicates a positive attitude toward old people.
A higher score on the OP- indicates a negative attitude toward old people.

AN ABSTRACT OF THE THESIS OF

Elise M. Gates

For the MASTER OF NURSING

Title: DIRECTORS OF NURSES ATTITUDE TOWARD OLD PEOPLE AND QUALITY OF CARE IN NURSING HOMES

Approved: _____
Linda Kaeser, R.N., M.S.W., Thesis Advisor

The purpose of this study was to investigate the relationship between Director of Nurses attitude toward old people and the quality of nursing care in nursing homes under their direction, and the effect of age, years of nursing experience in nursing homes, and education on attitude toward old people.

Criteria for inclusion in the study were established. Twenty-nine of the 58 eligible Directors of Nurses agreed to participate in the study. These 29 directors and their respective nursing homes became the subjects and setting for the study.

To determine the quality of care, a mean score expressed as a percent for nursing care was awarded to each facility based on the computation of deficiency data collected by the Oregon Adult and Family Services Resident Services Review Team during the period July 1, 1978 through July 30, 1979. A lower percent score indicated a higher quality of care.

To determine attitude toward old people the Kogan Attitude Toward

Old People Scale was used. All of the directors scored higher on the positive scale than the negative scale and, thus, all were said to exhibit positive attitudes toward old people.

Additional demographic data were collected; age, years of nursing experience in nursing homes, level of education, in order to explore the relationship between each variable and attitude toward old people.

Four hypotheses were formulated as follows. First, those institutions in which the Director of Nurses demonstrates a positive attitude toward old people will score a higher quality of care rating than those institutions in which the Director of Nurses demonstrates a negative attitude toward old people. Second, younger Directors of Nurses will manifest more positive attitudes toward old people than older Directors of Nurses. Third, Directors of Nurses who have experienced a greater number of years of nursing experience in nursing homes will exhibit a more negative attitude toward old people than those with lesser experience in nursing homes. Fourth, Directors of Nurses who have achieved a Bachelor of Science Degree in Nursing will be more positive in attitude toward old people than directors who have attained an associate degree or diploma. None of the hypotheses was accepted.

The conclusions are that there is no relationship between the Director of Nurses' attitude toward old people and the quality of nursing care provided under her direction. In addition, there is no relationship between age, years of experience in nursing homes and level of education and attitudes of Directors of Nurses toward old people.