A Comparative Study of the Quality of Nursing Care in an Osteopathic versus an Allopathic Health Care Facility

by

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CHAPTER I

INTRODUCTION

> Our problem is not to find
> better values but to be
> faithful to those we profess
> ---to make them live in our
> institutions.
>
> John W. Gardner

A decade ago there was little public discussion of the quality of nursing care in American hospitals, except for occasional "best in the world" rhetoric. The subject of nursing care currently is highly popular because there is a need for nursing to be unified in the pursuit of quality nursing care to all who need it.

In view of this popular subject, the purpose of this proposed research is to evaluate current levels of nursing care patients actually receive in two differently accredited health care facilities.

Phaneuf, as late as 1976, defined the quality of nursing care as the "availability of and access to care, so that the right patient is in the right place at the right time, receiving the services necessary to his well-being" (p. 9). Today, assurance of that quality has become one of the central health policy issues of the 1970s. It is so controversial in fact, that no longer is it pursued solely by researchers, but instead is mandated by two professional bodies, the Joint Commission on Accreditation of Hospitals and the American Osteopathic Association of Hospitals.

In just a few years, the amount of money spent on quality assurance activities has grown tremendously. The issue at hand is whether this expenditure of funds will increase health levels by improving the quality of nursing care provided (Egdahl § Gertman, 1976). Today when quantity, quality and costs of health care are social as well as professional issues, the need for a uniform way of assessing the quality of care received by patients is apparent.

Many methods have been used to evaluate nursing care (Donabedian, 1969; Slee, 1972; Wandelt § Ager, 1974; Phaneuf, 1976; Zimmer, 1976; Strauss, 1978). Some have concerned themselves with identifying those elements in the setting which are thought to influence performance (Phaneuf, 1976). Others have measured the outcomes of care defined as states of health or well-being (Donabedian, 1969). Still others have examined the process of care itself in search for evidence that bears on professional judgment and performance (Zimmer, 1976). The debate over which of these approaches is more appropriate remains.

Central to all authors' arguments is the need for evaluation. Block summarizes that point well, stating that "evaluation of nursing practice is however of the utmost importance, because evaluation is the practitioner's way of ascertaining whether or not his work, to say it simply, is good" (1975, p. 256). Phaneuf (1976) examined the need for evaluation of nursing practice, but also felt evaluation of the institution's structure was important.

She points out that consideration of physical facilities, equipment and status with regard to accreditation certification, or approval by appropriate voluntary bodies should be addressed. Phaneuf further states "a positive relationship between good structural attributes and good care is ordinarily assumed." For example, it is expected that patients will receive better care in an accredited hospital than in an unaccredited one (1976, p. 5).

This assumption and expectation, however, is not an acceptable substitute for evaluation of quality assurance. To date no known studies addressing whether patients receive better care in an accredited hospital has been conducted. Therefore, in light of this assumption it is the purpose of this research to evaluate current levels of nursing care patients actually receive in two differently accredited health care facilities.

In order to fully become aware of this problem, a review of the literature will follow.

CHAPTER II

REVIEW OF THE LITERATURE

To gain a better understanding surrounding quality assurance, a comprehensive review of the supporting professional literature was done.

To answer the question posed in the present study, the literature on quality assurance in health care facilities was reviewed. From this review it was ascertained that standard setting, evaluation and corrective action was accepted by most authors as a basic framework in quality assurance. The literature maintains that continuous evaluation of nursing practice is necessary for increased effectiveness and higher staff morale.

This review of literature will cover the following major areas in order: the need for quality assurance, professional accountability, performance evaluation, and the essential components of quality assurance programs.

The Need for Quality Assurance

Phaneuf, in a discussion of quantity and quality of health care costs, points out that "...one of nursing's needs in practice is bringing about health-oriented organization of personal care services characterized by demonstrated quality, adequacy in quantity, and the lowest cost compatible with the quality and the quantity of health care" (1976, p. 4). In 1978, Strauss also addressed the issue of need for quality assurance by stating "there is a need for nursing to be unified in the pursuit of quality

nursing care to all who need it. Service agencies, practitioners and educational institutions share equally the responsibility for meeting a common goal -- delivering quality and relevant care to consumers" (p. 19).

The current increased awareness for quality assurance can be attributed to recent legislative actions which have been stimulated by inclusion of specific quality control requirements in the Social Security Amendment of 1972. There is also potential for similar requirements in the future by federal and state health care legislation. Registered nurses should be making the changes needed to respond to this priority. In nursing the need to initiate or adapt to change is a familiar experience (Zimmer, 1974).

Professional Accountability

The American Nurses Association recognized the need to guarantee quality service to patients. Standards of practice were developed by the Congress for Nursing Practice to ".....fulfill the profession's obligation to provide and improve nursing practice" (1973). Accountability is an important issue in nursing today. Slee (1972) also reminds us that a "social contract" between society and nursing professionals exists. Under its terms, society grants the nursing profession authority over functions vital to itself and permits considerable autonomy in the conduct of their own affairs. In return, nursing is expected to act responsibly and assure quality in performance (Slee, 1972). Gortner further adds that "...accountability for what and to whom must be addressed in terms of research, practice

and education, for these are the major dimensions of our profession" (1974, p. 764). In 1976, Phaneuf continued to address this issue by stating....."Accountability in nursing practice means being responsible with regard to quantity, quality and costs" (p. 9). Central to all authors is the need for nursing to make a habit of becoming continually accountable for those activities for which they have authority and capacity to influence.

Performance Evaluation

Professional self regulation cannot be accomplished without appropriate evaluation of nursing practice and of the individual involved with that practice. Attempts to evaluate nursing practice are not new.

Derryberry (1939) in a report of a study of nursing accomplishments, stated....."In the past evaluations of nursing services have been based upon volume and intensity of service. Evidence of the more elusive quality of service, as expressed by the changing state of the patient, has been sought in present analysis" (p. 25). Derryberry's interest in evaluating nursing practice was novel at the time, but today people feel that evaluation of nursing practice is a must.

Gortner's comments on performance evaluation emphasize that nurses must make a habit of continually evaluating their activities in a systematic and cumulative way. Gortner concludes by stating:

> "evaluation is a hallmark of expert practice and is also the craft of

> science. I urge that we discipline ourselves to continuous evaluation of the impact of our activities upon others" (1974, p. 768).

Evaluation is a fundamental part of professional accountability. Identification of each facet of accountability requires careful evaluation.

Essential components of quality assurance programs

Strauss (1978) identifies four essential components of any quality assurance program as, 1) making value statements called standards, which are viewed as goals to be met; 2) obtaining measurements; 3) ascertaining from the measurement data to what degree the standards are met in practice; and 4) introducing change, based upon decisions made from those measurements, which is designed to increase the probability of achievement of the specified goals.

According to Strauss, the first component in establishing an evaluation system is the setting up of standards or criteria. Agreeing with Strauss, Donebedian (1969), Slee (1972), Stevens (1975), Bloch (1975), Phaneuf (1976), all state that there are three types of standards: structure, process and outcome. Evaluation of structure standards include: consideration of the purpose of the institution, it's legal authority to carry out the organizational characteristics including physical facilities, equipment, decision-making processes and approval with regard to accreditation (Phaneuf, 1976).

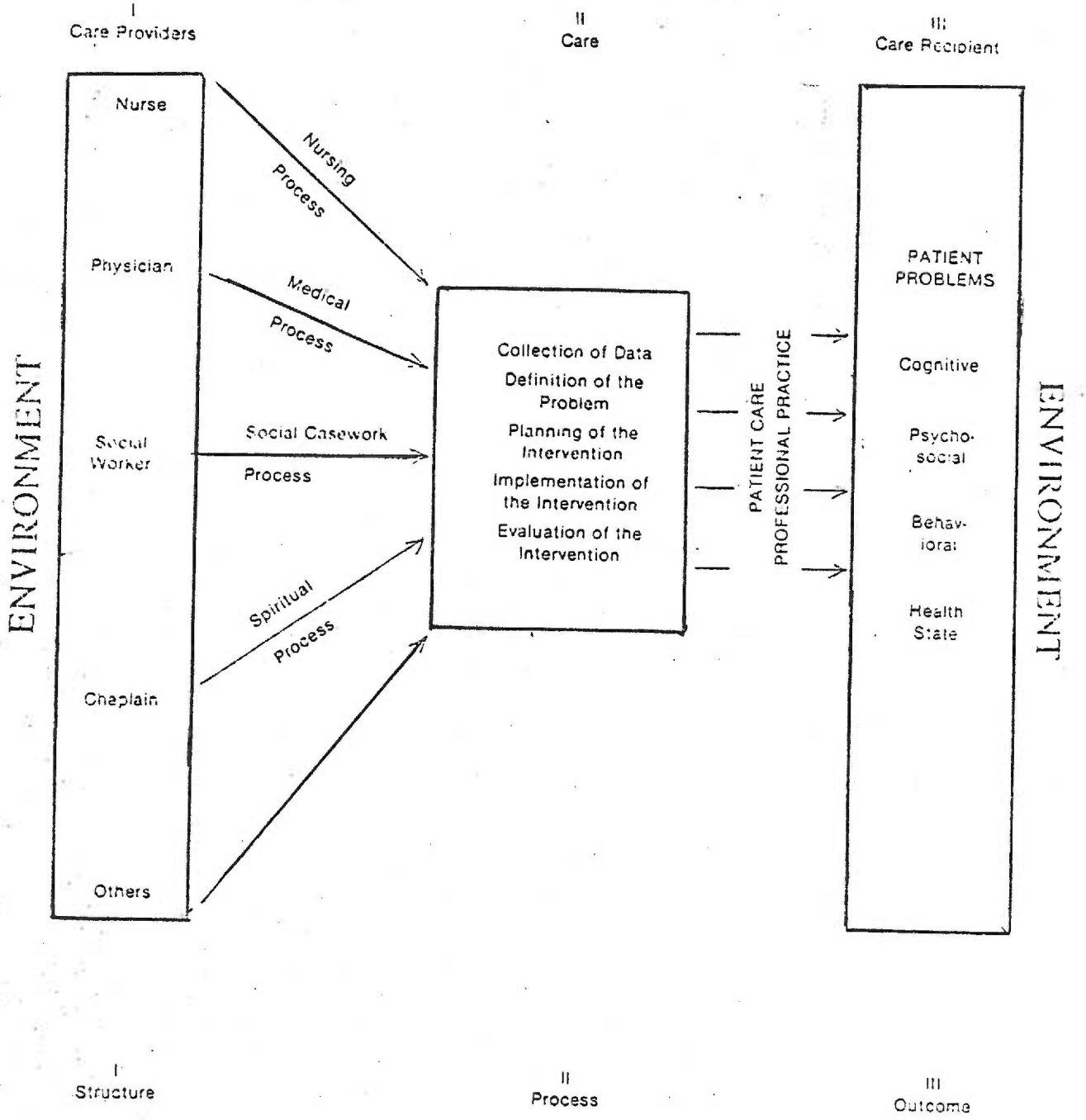
In 1975, Stevens wrote, "Process standards provide a

second perspective in care delivery; they measure aspects of the nursing process itself." The nursing process as defined by Stevens refers to the activities of the individual nurse and the patient. She concludes by noting, "Thus the nursing process takes place within the provided structure, but it is the individual rather than the standardized aspect of care..." (p. 148).

The outcome standards are derived from the problems or potential problems as defined by the practitioner, evaluator or researcher. Experts debate whether outcome evaluation should be process-focused or outcome-focused. Donabedian, 1969, spoke of "two camps: those who favor process and those who favor outcome" (p. 34). In process outcome evaluation, one examines and makes a judgment about what is done by the care provider. In outcome evaluation, one examines and makes a judgment about the achievement of patient-oriented objectives (Bloch, 1975).

To determine what contributes to patient care and how that care was delivered, one must become familiar with factors that affect patient care evaluation, and view the care as it was being delivered. The following model (See Figure 1) is representative of these factors affecting patient care in three areas: 1) the care providers; 2) the care given by the providers, and 3) the care recipient. These three aspects of evaluation translate into standards of criteria, structure, process and outcome (Bloch, 1975). To view care as it was being delivered, a process audit review would have to be conducted.

FIGURE 1. FACTORS BEARING ON EVALUATION OF NURSING CARE
(Adapted from Bloch, 1975, p. 259)



For example, the Joint Commission on Accreditation of Hospitals and the American Osteopathic Association have developed guideline standards for both outcome and process audits. The type of audit utilized is directed toward looking at groups of patients which fall within specific disease categories. The Joint Commission on Accreditation of Hospitals and the American Osteopathic Association require patient care evaluation for voluntary accreditation. Both point out benefits to be gained from the use of an audit procedure. Benefits derived from both process and outcome audit evaluations include:

1. Improve patient care;
2. Provide better documentation of patient care;
3. Provide direction for educational programs;
4. Demonstrate deficiencies in hospital wide policies or procedures;
5. Improve communication with other hospital departments or services;
6. Research particular aspects of patient care;
7. Provide methods of accountability to the governing body (Joint Commission on Accreditation of Hospitals, 1980).

"Quality Patient Care Scale (Qualpacs) is a process instrument that measures the quality of nursing care received by patients in a setting where nurse-patient interactions occur" (Wandelt & Ager, 1974, p. xii). Measurements are made of all nursing care provided a patient, regardless of the qualifications or job categories of personnel providing the care. Wandelt and Ager state that the scale "provides a quantitative measurement of the overall

quality of nursing care that patients receive on individual nursing units or in an entire nursing service program" (p. xii). Therefore, the scale is able to identify areas of program strengths and weaknesses, which can serve as bases for planning improvements.

To evaluate an individual care provider, it would be necessary to utilize an instrument such as the Slater Competency Rating Scale. The Slater Scale is not useful if one is evaluating care provided by a total nursing staff, since it deals only with individual practice (Phaneuf, 1976).

The second and third required components as identified by Strauss (1978) are; obtaining measurements, and ascertaining from the measurement data to what degree the standards are met in practice. Information regarding levels of quality care can be gathered directly or indirectly. Direct or primary sources give the investigator knowledge of actual practice as it occurs. Situations that do not lend themselves to direct observation require that an indirect or secondary method be employed. Examples of secondary sources are: nursing care plans, charts, records, rounds, patient interviews and the nurse interviewers (Stevens, 1975).

Since Qualpacs measure quality of care from the total staff's perspective, this instrument meets the second and third essential component of a quality assurance program as identified by Strauss (1978). The Scale may be used in any setting in which nurses administer, in behalf of patients, either direct nurse-patient observations or indirect observations. On the other hand, retrospective studies or

audits, if used to measure quality care make it difficult to determine many of the factors influencing patient care. This instrument is unable to determine if items observed were really done. The direct observation instrument appears to have definite advantages (Wandelt & Phaneuf, 1976).

Whether a process or an outcome instrument is utilized to obtain measurements, such measurements must be regular and continuous in monitoring patient care. It is a corporate responsibility to sound alarms when the care delivered does not conform to the standards which are expected. Data on the care given must be checked against the standards; not only must care given be reviewed, it must also be analyzed and evaluated. If the pattern of care given matches the pattern called for by the standards, the quality is evaluated as acceptable. If the two patterns do not match, then further investigation is required (Slee, 1972).

The fourth required component of the quality assurance program as identified by Strauss (1978) is introducing change. Most authors maintain that change must follow a problem-solving approach that begins with identification of the problem. To identify the problem, appropriate feedback is necessary in a quality control system. If possible, staff participation at all levels in the quality assurance program should be encouraged. All instruments reviewed incorporated this component (Wandelt & Ager, 1974; American Osteopathic Accreditation of Hospitals, 1977; Joint Commission on Accreditation of

Hospitals, 1980; Phaneuf, 1976; Wandelt & Phaneuf, 1976).

Quality assurance programs must identify that introducing change is an essential component. There must be objective and factual evidence that the practice does change toward the predetermined standards and that it does reach these standards within an appropriate time. Documentation of effective change will lead to increased effectiveness and higher staff morale. Identification of ineffective change will also prevent continuation of practices that cause wasted resources, increased costs, and/or lower quality of care (Zimmer, 1976).

Concern of nursing administrators to provide quality nursing care to all patients is apparent. According to the Joint Commission on Accreditation of Hospitals and the American Osteopathic Association, compliance with their established standards is important in promoting health care levels.

Before one can determine whether this voluntary accreditation does indeed promote health care levels, one must examine and understand the standards each accreditating agency enforces. The Joint Commission on Accreditation of Hospitals as late as 1980 defined standards as being:

> "valid, that is how they relate to the quality of care or services provided; they are optimal reflecting the highest state of art; they are achievable, meaning that compliance with them is measurable." p. 11).

Assurance of these standards as established by American Osteopathic Association and Joint Commission

on Accreditation of Hospitals, to ensure and promote quality nursing care is a standard shared by both accrediting agencies. American Osteopathic Association and Joint Commission of Hospitals both agree that each acute care facility applying for accreditation shall demonstrate a consistent optimal and attainable delivery of nursing care.

According to American Osteopathic Association, its accrediting requirements for ensuring this quality of nursing care includes:

1) Adequate nursing hours/patient day in all nursing service areas;
2) Analyzing patient services required and classifying patients according to nursing care needs;
3) Nursing care plans shall be written and developed for all patients;
4) Continuous audit evaluations (A.O.A., 1977).

The Joint Commission on Accreditation of Hospitals also states the effectiveness of a hospital quality assurance program should be emphasized in determining a hospital's accreditation. In order to meet their requirements, nursing service must demonstrate an ongoing quality assurance program that includes the following:

1) Identification of important or potential problems, or related concerns, in the care of patients.
2) Objective assessment of the cause and

scope of problems or concerns, including the determination of priorities for both investigating and resolving problems. Ordinarily, priorities shall be related to the degree of adverse impact on patient care that can be expected if the problem remains unresolved.

3) Implementation, by appropriate individuals or through designated mechanisms, of decisions or actions that are designed to eliminate, insofar as possible, identified problems.

4) Monitoring activities designed to assure that the desired result has been achieved and sustained.

5) Documentation that reasonably substantiates the effectiveness of the overall program to enhance patient care and to assure sound clinical performance (J.C.A.H., 1980).

This belief that voluntary accreditation of health care facilities will lead to increased quality assurance, led this researcher to identify a statement of the problem.

The Problem Statement

The problem is to ascertain if the quality of nursing care differs in institutions accredited by the Joint Commission on Accreditation of Hospitals versus institutions accredited by the American Osteopathic Association.

Purpose of the Study

The purpose of this study is to evaluate quality of nursing care given in a community hospital accredited by the Joint Commission on Accreditation of Hospitals and a community hospital accredited by the American Osteopathic Association. The levels of quality of nursing care determined in each facility will be used to decide whether the accrediting agency in each studied health care facility does/does not affect the levels of care.

Rationale for Study

Experience with past and present accrediting processes in both a Joint Commission on Accreditation of Hospitals accredited facility and an American Osteopathic Association accredited facility, led this researcher to the problem of attempting to identify inconsistencies between the two types of voluntary accrediting agencies. For example, one of the procedures for voluntary hospital accreditation appeared to be significantly more stringent than the other.

This, in addition to the periodical complaints at both a Joint Commission on Accreditation of Hospitals accredited facility and an American Osteopathic Association accredited facility from physicians and nursing staff regarding the quality of patient care delivered, pointed to a need to identify if whether the type of accrediting agency in each studied health care facility, does or does not affect the level of care delivered to patients.

Hypotheses

To determine if differences in the quality of care existed in two differently accredited studied hospitals; two null hypotheses were tested. These were:

1. There will be no significant differences in Grand Mean scores on the Qualpacs between a medical unit on day shift in a Joint Commission on Accreditation of Hospitals accredited facility and a medical unit on day shift in an American Osteopathic Association accredited facility.

2. There will be no significant differences in the Area Mean scores on the Qualpacs between a medical unit on day shift in a Joint Commission on Accreditation of Hospitals accredited facility and a medical unit on day shift in an American Osteopathic Association accredited facility.

CHAPTER III

METHOD

Design

Using Weiss' (1972) definition, this study was evaluation research conducted to evaluate the nursing care in two community hospitals. The study was done to determine if the voluntary accrediting agency represented in each studied facility does/does not affect the level of quality of nursing care being delivered.

Setting of the Study

The setting for the study was two 100 bed metropolitan community hospitals. The osteopathic hospital had an average daily census of 67, and an average census on the medical floor of 21. The allopathic hospital had an average daily census of 88, with the average census distribution on the medical floor being 15. There were 10 employees on the 7-3 shift during the study involved in direct nursing care delivery in the osteopathic hospital on the medical floor. Five of these employees were full-time registered nurses. In addition there was one part-time licensed practical nurse and four full-time nursing assistants.

In the allopathic facility there were five employees on the 7-3 shift during the study involved in direct nursing care delivery on the medical floor. Two of the employees were full-time registered nurses. There was one full-time licensed practical nurse and two full-time nursing

assistants.

During the time of the study, the medical unit in the osteopathic hospital had eight rooms with a capacity of 28 patients. The medical unit in the allopathic hospital had nine rooms with a capacity of 18 patients.

Census during the one day observation period on each medical unit in the two hospitals was, 30 in the osteopathic facility and 18 in the allopathic facility.

Data Gathering Instrument

A 68 item Likert-like scale (see Appendix A, p. 57) was used to assess the qualitiy of patient care. This scale is called the Qualpacs Scale for Quality of Patient Care, and was developed and validated by the College of Nursing at Wayne State University. Evidence leading to the validity of the Qualpac instrument is drawn from three studies, the most extensive of which was done at Harper Hospital, Detroit, by Dr. Wandelt and Dr. Ager.

In an investigation of the concurrent validity of Qualpacs, eight supervisors and directors at Harper Hospital were asked to rank-order the 21 wards at Harper in terms of the quality of care given on the ward. The rank-order average between the pairs of supervisors was .24. The reliability of the ward-ranked averages over the eight supervisors was estimated to be .56 when using the Spearman-Brown formula. Ward scores on Qualpacs were also obtained for the 21 wards using the continuous observation data. The rank-order correlation between ward ranks and Qualpacs became .44.

When the scores were corrected for attenuation, i.e., for unreliability of the average ward-ranks using .56 as estimated reliability, the correlation between ward-ranks and Qualpacs became .52. It would therefore appear that the Qualpacs instrument has a high degree of validity when used to discriminate among patient care units in terms of quality of care given.

One of the advantages of this instrument is its ability to investigate levels of nursing care utilizing both direct and indirect observations. The information provided by the Qualpacs enabled the researcher to determine actual levels of quality care in two differently accredited health care facilities.

The scale utilized six areas of assessment: 1) Psycho-Social (Individual); 2) Psycho-Social (Group); 3) Physical; 4) General (Meeting psycho-social and/or physical both at once); 5) Communication on Behalf of Patients; 6) Professional Implications (reflecting responsibility indicative of professional expectations).

As an added point of reference to accomodate the rater, symbols appear on the rating chart at the end of each item statement. The rater, as he/she scans items, can identify quickly which ratings may be ascribed in relation to any particular interaction/intervention. The symbols used are:

#D	Observation that permits rating of the items will usually be a direct observation of an interaction.
#I	Observation that permits rating will usually be indirect; e.g., a notation

in the record of information from the nurses, patient, or family.

#D/#I Observation may be either direct or indirect (Wandelt & Ager, 1974, p. 37).

The cue sheet (see Appendix B, p. 65) was utilized to contribute objectively to measurement of nursing interactions with, or interventions on behalf of, patients. It assisted the raters to consider observed behaviors rather than broad generalized behaviors. An example of one cue is as follows:

Item 25. Patient's Daily Hygiene Needs for Cleanliness and Acceptable Appearance are Met #D

a. Staff offer to comb hair of patient unable to do so for physical or mental reasons; e.g., cardiac patient, patient with upper extremity injury, patient in state of emotional shock following loss of loved ones, regressed mental patient.

b. Disturbed patient is helped to shower, shave, and select clean clothing or items of attire that go together.

c. Bedside environment is made neat and orderly, soiled gowns are changed P.R.N.

d. Assistance is offered with oral hygiene e.g., brush is prepared and basin held for patient with upper extremity case, dentures brushed under running water for patient unable to do this himself, child is taught proper brushing technique.

> e. Body, dressing, and air deodorizer are provided as indicated. (Wandelt & Ager, 1974, p. 17-18).

Standards of Measurement and the Ratings

The standard of measurement of the "quality of care expected to be provided by a first level staff nurse." According to Wandelt & Ager

> A first-level staff nurse is a nurse who, traditionally, is charged with responsibility for providing care that is both safe, adequate, therapeutic, and supportive for meeting nursing-care needs of patients.
>
> A first-level staff nurse is one who, purportedly, is prepared for her responsibilities by one of the programs of nursing education that prepare individuals for state licensure as registered nurses (1974, p. 45).

Individual Frame of Reference

Each rater completed an individual Frame of Reference Card (see Appendix C, p. 86) according to directions. The name of a nurse who best represented each level of nursing practice described in each of the five areas (Best Staff Nurse, Between, Average Staff Nurse, Between, and Poorest Staff Nurse) was entered by each rater in the appropriate space on the Frame of Reference form. Due to the differing backgrounds and previous education, the Frame of References were dissimilar. However, they were held constant by each rater throughout both the pilot study and the final research project.

Subjects and Sample Size

According to Wandelt and Ager (1974), a valid and

reliable measurement may be secured by deriving a mean score from the scores of as few as five patients or fifteen percent of the patients, whichever is greater. In the present study patients were randomly selected for observation through use of a table of random numbers. Criteria for inclusion in the study were those developed by Preston in her 1977 study. They are:

1. The patient was expected to receive a number of nurse interactions/interventions. A minimum of four interactions was necessary to include the observation in the study.

2. If more than one eligible patient occupied a room in which a patient selected randomly was being cared for, the nurse rater could rate up to three patients during a single observation period.

3. There was interest in knowing quality of care on the day shift only. Therefore, patients were observed between the hours of 7-3 p.m. during the week day period.

4. Patients observed must be expected to remain within the patient care area during the observation period.

5. Observed patients must have at least four nurse-patient interactions to provide ample observation for rating a sufficient number of items to provide a reliable score. A single interaction may be rated for as many items as the rater observes as being appropriate.

6. A reliable score is necessary for final inclusion of observed patients. Ratings of as few as 30 items will yield a reliable measurement of the quality of care received (p. 22).

The raters selected the patients for inclusion in the sample using the above criteria. The number of observation sessions included in the study involved nine patients over a two day period. All of these observations were made on the 7-3 shift. Care was taken to see that all subjects

were from the medical unit in each health care facility studied. The two groups were selected from separate random assignments and were of a size equal to the fifteen percent of the population on each medical unit observed.

Data Collection Procedures

The following procedure was used in gathering data for this study.

Orientation of the Rater-Observer to Use of Scale

It was determined that two individuals (clinical coordinator and the investigator) would do the rater-observations to provide a mix of reasoning and decisions concerning the quality of patient care. Each observer-rater became familiar with the scale by scanning the scale and accompanying cue sheet, reading the guide for use of the scale, and by pre-testing the scale in a setting typical of the one in which it would be used.

To accomodate the particular need of the study, three adjunct materials were used with the rating scale. These included the following:

1. The Information Face Sheet (see Appendix D, p. 88) was utilized to record adjunct data for analysis and interpretation of findings from the scale. Included were provisions for recording data that could influence the quality of care provided. The variables listed on the Face Sheet included: patient code, room, diagnosis, condition of the patient, unit, level of care, personnel code and census, interaction, reports and outcomes.

2. The Qualpac Raters Notes for Assessment and Planning of Care (see Appendix D, p. 88) included orders, needs, and nursing actions for each subject. The adjunct data was used to compare care delivered with actual needs.

3. A Fact Sheet About Qualpacs (see Appendix E, 91) was distributed to administrative nursing personnel, and to any other nurse interested in the project. The Face Sheet was utilized to inform the nursing personnel about how the research project would be performed and what assistance and information would be needed.

The goal of the scale and adjuncts was to provide a usable tool for receiving discriminating measurements of the quality of nursing care received by patients. The influence of different variables on the quality of care is a matter of other concern.

Pilot Study

The most critical reliability requirement for a rating instrument, such as the Qualpacs, is that of inter-rater agreement. To establish such agreement, a pilot study was conducted. In this pilot study, the two nurse raters were the same ones who conducted the actual study.

Instructions to Personnel

Prior to the study, time was spent obtaining signed consent forms from the administrative nursing personnel at both health care facilities studied (see Appendix H, p.104). Personnel were not informed as to the nature of the study, only that a study was being conducted. They were to proceed with their work as usual. It was felt that knowledge of

what was to be rated would introduce another variable.

Instructions to Subjects

Patient autonomy was considered by allowing patients selected for the study an opportunity to decline to participate in the study. A consent form (see Appendix H, p.104) was obtained from each patient, explaining the purpose of the observation, and that interaction could not take place between the raters and the patient. All were eager and willing to participate when told the information would be utilized to improve patient care.

Observations and Ratings; Multiple Ratings for Single Items

The observers recorded a rating for each item that appropriately measured the quality of nursing personnel's contribution to any interaction between the patient and members of the nursing staff. Cues for each item as listed in the guide served as reminders of observable interactions. A rating for each item was recorded each time it was appropriate to do so during a two hour observation period.

If two or more similar interactions occurred in rapid succession, a rating was ascribed for each interaction. The rationale for this lies in the influencing of the frequency of the ratings on the mean score of the item.

Observations and Ratings; Single Interactions or a Sequence of Interactions

Episodes of nurse-patient interactions were considered as single interactions, when the general train of the interaction portrayed a unity or oneness. Where there was an interruption, the episode was considered two interactions.

Observations and Ratings; Rapidly Occurring Interactions

When several interactions occurred in rapid succession hasty notes of the first episode were made to serve as reminders for later completion of items warranted by the episode.

Ratings in Retrospect

Most ratings were on the spot, but there were two instances in which retrospective ratings were done;

1) Where there was insufficient on-the-spot time to record ratings for all items.

2) If care was evident, but not performed during observation periods.

The majority of the ratings of items identifying elements of care received by the subjects were based on direct observations and recorded on the spot. Where observers did retrospective ratings, it was necessary to review items and clues. Sources of information, other than direct observation, included subjects: records, verbal reports or conversations of hospital personnel and the subject or his family, and questions posed by the observer to personnel or family.

Not Observed and Not Applicable Items

There was provision for recording that care was "not observed" or "not applicable" in rating the care received by the subjects. The rationale for this was that there may be situations in which certain of the actions would not be expected to occur. In this case, the "not applicable" columm could be utilized. If actions pertinent to the

patient care were not performed, the "not observed" column could be used.

Establishment of Interrater Reliability

After completion of the pilot study observations, the data generated by the two nurse-raters on the five Qualpacs was statistically compared to establish the interrater reliability. A Pearson product-moment correlation coefficient was computed for all items where care was observed. Eleven items did not have any observed care so no correlation coefficients were generated. The Pearson "r" for the final patient observation was .80.

Actual Study Procedure

In the actual study each patient was observed by only one nurse rater instead of joint observations as was done in the pilot study. The remaining data collection procedures enumerated in the pilot study were followed as described above. Four observations were contributed by one nurse-rater and the other nurse-rater contributed the remaining five.

Analysis of Data

The rating scales were processed in the following manner. Best care was equivalent to five; between best and average care was equivalent to four; average care was equivalent to three; between average care and poorest care was equivalent to two; and poorest care was equivalent to one. "Not applicable" and "Not observed" items were not processed. Single category mean scores were calculated by, adding the mean scores of all items rated in the category

and dividing by the number of items rated. "Not applicable" and "Not observed" items were not counted in calculating the category means. The total mean scores for each subject were calculated in a similar fashion to that of the item mean scores. The mean scores were summed and divided by the number of items to derive the mean of mean scores.

The Grand Mean score and the Area Mean scores were ascertained in the following manner: the mean scores of all 68 items were added separately for the osteopathic and allopathic facility studied; the number was then divided by the number of items that had received a rating (Wandelt & Ager, 1974).

From the data generated by the nine patient observations, item means for each of the 68 items that had interaction observed were computed (see Appendix F, p. 94). In addition, the mean of each item was computed (see Appendix G, p.100). Area Means and Grand Means were looked at in relation to significant differences between the medical unit on day shift in an American Osteopathic Association accredited osteopathic facility versus the medical unit of day shift in a Joint Commission on Accreditation of Hospitals accredited allopathic Health care facility. The Mann-Whitney U test was used to determine if a significant difference existed between the osteopathic and allopathic facilities (Phillips, 1978).

The levels of concern and excellence for Qualpacs were set as suggested by Preston (1977), and Whitman (1979). The need for remedial action (level of concern) was set at

2.7 on a scale of one to five, where one represents poorest care and five represents best care. It was the decision of both Preston and Whitman that 2.7 was low enough to allow for possible rater error but high enough to ensure basic patient safety. The level of excellence was set at 4.3. Ratings between 2.8 and 4.2 were designated as the level of acceptability.

As noted by Whitman (1979), consideration in this study, which will be discussed later, was allowed for the fact that compiling data obtained from the Qualpac instrument can sometimes obscure the facts, both in the area of concern as well as excellence.

CHAPTER IV

RESULTS

Overall Level of Care

The Overall Area Means and Grand Means for all observations at both the osteopathic and allopathic facility fell within the level of acceptability.

It can be seen that, although the Area Means and Grand Means are all within the level of acceptability, the care was judged to be average with no ratings in the level of excellence (see Appendix F, p. 94). Slight differences become more apparent at both the osteopathic and allopathic facility when individual item means were studied (See Appendix G, p. 100).

At the osteopathic facility, all observations had varying numbers of interactions in the Best Care, Between, Average Care, Between, and Poorest Care categories. Generally, the majority of the observations were seen in the Best Care category. However, there were two observed interactions which were categorized at the level of concern. These will be discussed and analyzed in the following paragraphs.

Item 39 was the only item to receive a rating at the level of excellence. Item 39 was involved with the patient receiving instructions as necessary. It was noted during the study, that patients received thorough information from

all nursing personnel about actions or procedures directed toward meeting either their psychosocial or physical needs. Items 33, 34, 35, 38, 57 and 59, received overall ratings in the level of concern. Items 33, 34, 35 and 38 deal with meeting the physical needs of the patient. Item 33 deals with expectations of the patient's behavior are adjusted and acted upon according to the effect the medication had on the patient. At the time of the study it was noted in a patient's chart, "appears very depressed". This patient was receiving Valium 10 mg. three times a day, and no nursing action in response to the effect this medication had on the patient was taken. Item 34 and 35 deal with medical asepsis, such as handwashing of staff between patients. Item 38 deals with using established technique for safe administration of medications and parenteral fluids. Item 57 deals with well developed, written nursing care plans. No care plans were seen available for the individual patients during the study. Item 59 deals with staff participation in conferences concerning patient care. Items 9, 17, 18, 19, 21, 22, 23, 32 and 53 had no observed interaction.

At the allopathic facility, all observations had varying numbers of interactions as were seen in the osteopathic facility. Again the majority of the observations were seen in the Best Care category.

Items 43 and 44 received ratings at the level of excellence. Items 43 and 44 involve allowing the patient to participate in the health care process. Five items received overall ratings in the level of concern. These items were

27, 28, 34, 35 and 63. Item 27 and 28 deal with meeting the physical needs of the patient, such as distress evidenced by the patient, is responded to quickly and appropriately. During the study it was noted that since a patient's head was poorly positioned, it was difficult for him to breathe. When the nurse made rounds she did not note this patient's labored breathing and respond appropriately. Items 34 and 35 deal with medical asepsis, such as handwashing of staff between patients and of the patient after use of a bedpan. Item 63 deals with care given to a patient reflecting initiative and responsibility indicative of professional expectations. Items 9, 15, 21, 32, 33, 59 and 61 had no observed interactions.

Comparison of the Osteopathic Versus Allopathic Health Care Facility

For the purpose of this study it was decided to see if differences in the quality of care existed in two differently accredited hospitals. Comparison of the Area Means and the Grand Means for the American Osteopathic Association accredited osteopathic hospital and the Joint Commission on Accreditation of Hospitals accredited allopathic health care facility is illustrated in Table 1.

Table 1

Area and Grand Means for the Osteopathic versus Allopathic Facilities

	Area						
	I	II	III	IV	V	VI	Grand Means
Osteopathic Facility	3.85	3.95	3.76	3.96	3.31	3.8	3.82
Allopathic Facility	3.99	4.0	3.74	3.88	3.7	3.57	3.81

A more indepth description of each area and some of the item differences follow:

Area I: Covers actions directed toward meeting the psychological needs of individual patients.

The osteopathic facility received an acceptable rating of 3.85. None of the fifteen items in this area received ratings in the level of excellence or concern. The allopathic facility received an acceptable rating of 3.9. None of the fifteen items in this area received ratings in the level of excellence or concern.

Area II: Covers actions directed toward meeting psychosocial needs of patients as members of a group.

Observed interaction in this area at both facilities received an acceptable rating of 3.9 at the osteopathic

facility and 4.0 at the allopathic facility. None of the eight items in this area received a rating in the level of excellence or concern at either facility studied.

Area III: Covers actions directed toward meeting the physical needs of patients.

The osteopathic facility received a rating of 3.76 within the level of acceptability. None of the items in this area received a rating at the level of excellence. Items 33, 34, 35 and 38 received a rating at the level of concern. The allopathic facility received a rating of 3.74 within the level of acceptability. None of the items in this area received a rating at the level of excellence. Items 27, 28, 34 and 35 received ratings within the level of concern. Items 27 and 28 deal with meeting the physical needs of the patient, such as "distress evidenced by the patient is responded to quickly and appropriately". These items rated at the level of concern only at the allopathic facility. Item 33 deals with expectation of the patient's behavior are adjusted and acted upon according to the effect the medication has on the patient, fell within the level of concern at the osteopathic facility only. Item 34 and 35 which deal with medical asepsis in relation to the patient's personal hygiene, rated at the level of concern for both hospitals studied. Item 38 which deals with safe administration of medication also rated within the level of concern only at the osteopathic facility. Items 27 and 28 rated

within the level of concern at the allopathic facility, while at the osteopathic facility these items rated well within the level of acceptability. Items 33 and 38 rated within the level of concern at the osteopathic facility but received .0 for item 33 and 4.0 for item 38 at the allopathic facility.

Area IV: Covers actions that may be directed toward meeting either psychosocial or physical needs of the patient, or both at the same time.

The osteopathic facility received a rating of 3.9 within the level of acceptability. Item 39 dealt with the patient receiving instructions as necessary. This item received a rating at the level of excellence. None of the fourteen items received a rating in the level of concern. The allopathic facility received a rating of 3.8 within the level of acceptability. Items 43 and 44 received ratings at the level of excellence. These items involve allowing the patients to be active participants in problem-solving and activities of daily living as it relates to each individual. None of the fourteen items received ratings in the level of concern. Item 39 rated within the level of excellence at the osteopathic facility, rated within the level of acceptability at the allopathic facility. Items 43 and 44 receiving a rating within the level of excellence at the allopathic facility received a rating of 3.6 for items 43 and 4.0 for item 44 at the osteopathic facility.

Area V: Covers communication on behalf of the patient.

The osteopathic facility received a rating of 3.3 within the level of acceptability. Two items received ratings within the level of concern. Item 57 and 59 deal with well developed nursing care plans and staff participation in patient care conferences. None of the eight items in this area received ratings in the area of excellence or concern, at the allopathic facility. Item 57 and 59 rated within the level of concern at the osteopathic facility received a rating of 3.0 for item 57 and .0 for item 59 at the allopathic facility.

Area VI: Covers care given to the patient reflecting initiative and responsibility indicative of professional expectations. The osteopathic facility received a rating of 3.8 within the level of acceptability. None of the seven items in this area received ratings in the area of excellence or concern. The allopathic facility received a rating of 3.5 within the level of acceptability. One item received a rating within the level of concern. Item 63 deals with evidence given by staff on insight into deeper problems and needs of the patient. None of the seven items received a rating in the level of excellence. Item 63 rated within the level of concern at the allopathic facility received a rating of 4.0 at the osteopathic facility.

As previously mentioned, "Not observed" and "Not

applicable" items were not computed when Area Means and Grand Means were figured. Yet it is interesting to note that at the osteopathic facility items 17, 18, 19, 22 and 23, relating with meeting the psychosocial needs of patients as members of a group had no observed interactions. At the allopathic facility these items rated well within the level of acceptability. During the study at the allopathic facility, both observers noted that patient care centered around two or more nurses at any given time. It is also of interest to note that item 9, dealing with meeting the spiritual needs for patients was not observed at either health care facilities. This item was not observed in Preston's (1977) or Whitman's (1979) study.

Grand Means: This total reflects the average of all item means. The Area Means are not totaled into this figure. The osteopathic facility received a rating of 3.82 within the level of acceptability. One item rated within the level of excellence. Fifty-one items rated within the level of acceptability and seven items rated within the level of concern. Nine items had no observed interaction. The allopathic facility received a rating of 3.81 within the level of acceptability. Two items received ratings within the level of excellence. Five items received ratings within the level of concern, and fifty-four items received a rating within the level of acceptability. A total of seven items had no observed interaction.

The items that received a rating within the level of concern at the osteopathic facility received a substantially higher rating at the allopathic facility. Conversely, items seen in the area of concern at the allopathic facility received higher ratings at the osteopathic facility. Two items, 34 and 35 rated low for both facilities. These items deal with medical asepsis in relation to the patient's personal hygiene.

From these results, it was found that all Area Means were well within the level of acceptability at both hospitals. In addition, only slight differences ranging from the level of concern to the level of acceptability between items was found. Therefore, it would appear that no differences exist in the quality of nursing care between the osteopathic or allopathic acute care facilities.

Analysis of Statistical Differences

It was hypothesized that no significant differences would be found in the Area Means and the Grand Means on the Qualpacs between a medical unit on the day shift in a Joint Commission on Accreditation of Hospitals accredited facility and one in an American Osteopathic Association accredited facility.

Results of the Mann-Whitney U test of differences are presented in Table 2. With the level of significance at .05, a U was computed for the Area Means and the Grand Means for both the osteopathic and allopathic facility.

Table 2

Critical Values of U in the Mann-Whitney Test of Differences

Mann-Whitney U

Hospital		Area I	II	III	IV	V	VI	Grand Mean
Osteopathic/ Allopathic								
	N_1	5	5	5	5	5	5	5
	N_2	4	4	4	4	4	4	4
	U	13	24	5	17	12	17	10
	P	.548	.548	.143	.548	.548	.548	.548

The first hypothesis states: There will be no significant differences in Grand Mean scores on the Qualpacs between a medical unit on day shift in a Joint Commission on Accreditation of Hospitals accredited facility and a medical unit in an American Osteopathic Association accredited facility. The Grand Means yielded a U which demonstrated that no significant differences existed between the American Osteopathic Association accredited osteopathic facility and the Joint Commission on Accreditation of Hospitals allopathic facility. Therefore, the first hypothesis was accepted.

The second hypothesis states: There will be no significant differences in the Area Mean scores on the Qualpacs between a medical unit on day shift in a Joint Commission on Accreditation of Hospitals accredited facility and a medical unit in an American Osteopathic Association accredited facility. Areas I, II, III, IV , V and VI yielded a U which demonstrated that no significant differences existed, therefore the second hypothesis was also accepted.

CHAPTER V

DISCUSSION

The quality of care being given on the medical unit in a Joint Commission on Accreditation of Hospitals accredited facility and a medical unit in an American Osteopathic Association accredited facility was established. Examination of the Area Means and Grand Means revealed that no significant difference existed in the quality of care in the osteopathic versus allopathic facility. Therefore both hypotheses were accepted. When the individual items were examined, it was found that three individual items received a rating within the level of excellence (see Appendix F, p. 94). Item 39 received a rating within the level of excellence at the osteopathic facility, while items 43 and 44 received a rating within the level of excellence at the allopathic facility.

Item 39: Patient receives instruction as necessary.

The mean score for observations for this item was 4.5 (see Appendix G, p.100 for item scores and the mean). The allopathic facility's rating was in the level of acceptability for this item.

Item 43: Resources within the mileu are utilized to provide the patient with opportunities for problem-solving.

Observed interaction for this item at the osteopathic facility fell within the level of acceptability, while at the allopathic facility this item fell within the level of

excellence.

Item 44: Patient is given freedom of choice in activities of daily living whenever possible, and within patient's ability to make the choice.

This item received an mean rating of 4.3. The osteopathic facility received a rating of 4.0 within the level of acceptability, while the allopathic facility received a rating within the level of excellence. An example of this item observed during the study at the allopathic facility was as follows: A nurse assigned to a patient with a hip prothesis informed this patient that ambulation three times a day was essential, yet allowed the patient to choose what time of the day he wanted to ambulate.

It is interesting to note that Preston (1977), also found ratings in the level of excellence for items 43 and 44 in her study of an allopathic community facility.

It was noted for the means of individual items, that 11 items received ratings in the level of concern. Items 33, 34, 35, 38, 57 and 59 received a rating within the level of concern at the osteopathic facility, while items 27, 28, 34, 35 and 63 received a rating within the level of concern at the allopathic facility.

Item 27: Physical symptoms and physical changes are identified and appropriate action taken.

The osteopathic facility received an item rating of 4.0 which was well within the level of acceptability.

This item generated a rating with the level of concern only at the allopathic facility. An example of the observed interaction at the allopathic facility to warrant an item rating of 2.3 was: A patient with a right hemiparesis was poorly positioned to the point the tissues over the bony prominence became mottled. The nursing personnel did not note these physical symptoms and intervene with appropriate nursing action.

Item 28: Physical distress evidenced by the patient is responded to quickly and appropriately.

This item which received a rating within the level of concern at the allopathic facility received an item rating of 4.0 at the osteopathic facility. An example of the observed interaction at the allopathic facility during the study to justify an item rating of 2.6 was: A semi-conscious patient's head was poorly positioned, so that it was very difficult for him to breathe. When the nurse entered the room she did not note this patient's physical distress of labored breathing, and respond appropriately.

Item 33: Expectations of patient's behavior are adjusted and acted upon according to the effect the medication has on the patient.

No applicable observations were made for this item at the allopathic facility. An example of the observed interaction at the osteopathic facility was noted in a patient's chart, "appears very depressed". This patient was receiving Valium 10mg. three times a day, and no

nursing action in response to the effect this medication had on the patient was taken.

Item 34: Medical asepsis is carried out in relation to the patient's personal hygiene and immediate environment.

This item scored within the level of concern at both facilities. Failure to offer handwashing facilities to the patient reduced this item score. Another factor contributing to the low score for this item was the failure of the staff to wash their hands between patients. It is interesting to note that Preston (1977) and Whitman (1979) also found a rating in the level of concern for item 34 in their Quality of Care Surveys.

Item 35: Medical and Surgical asepsis is carried out during treatments.

This item also scored within the level of concern at both facilities. (See discussion under Item 34).

Item 38: Established techniques for safe administration of medications and parenteral fluids are carried out.

This item received a rating of 4.0 at the allopathic facility, while receiving a rating within the level of concern at the osteopathic facility. During the observation period at the osteopathic facility, it was often noted that medications were administered, and in no instance was the patient's identification band checked. This item also fell within the area of concern in Preston's (1977) and Whitman's (1979) studies. Also noted by one of the

observers during the observation period was that on one occasion, the patient questioned the nurse about a pill he was to take, stating, "This isn't the same one I took last time". She proceeded to administer the medication anyway. The error was confirmed after the observation period and brought to the attention of the nursing staff.

Item 57: Well developed nursing care plans are established and incorporated into nursing assignments.

This item received a rating of 4.0 at the allopathic facility, well within the level of acceptability. It was noted earlier that during the study there was no evidence of any individualized nursing care plans seen at the osteopathic facility, while at the allopathic facility well defined care plans were seen for all patients observed.

Item 59: Staff participates in conferences concerning patient care.

No observations were made for this item at the allopathic facility, while at the osteopathic facility this item received a rating of 1.0. A wide variation of quality was seen during the study at the osteopathic facility. The differences were primarily due to the different methods used by the staff to exchange report. These different methods include that report between shift was done utilizing patient aides as well as the licensed personnel. Yet, when the floor had a team conference, patient aides were not in attendance.

Item 63: Evidence is given by staff of insight into deeper problems and needs of the patient.

This item received a rating of 4.0 within the level of acceptability at the osteopathic facility, while a rating of 2.0 within the level of concern was seen at the allopathic facility.

In summary, it would seem that no differences exist in the quality of nursing care between an American Osteopathic Association accredited facility and a Joint Commission on Accreditation of Hospitals accredited facility. It would also seem that although most of the item ratings fell within the level considered acceptable, item means ranged from 3.2 to 5.0. There were two areas of nursing care, considered by the researcher, to be unsafe. These two areas are delivery of medication and preventative asepsis.

As previously discussed in the review of the literature, the above problems identified in the delivery of nursing care, point to an essential first step in addressing the issue of the need for establishing a Quality Assurance program in both a Joint Commission on Accredition of Hospitals accredited facility and an American Osteopathic Association accredited facility.

Recognition by the nursing staff that there is a need to guarantee quality services to patients reminds the profession of its responsibility and accountability to those activities for which nurses have authority and capacity to influence.

Ensuring that the nursing profession remains accountable to patient care activities requires continuous performance evaluation in a systematic way.

Since identifying strengths and weaknesses is the beginning process in establishing an evaluation system for any Quality Assurance program, the results of this study can now be utilized to plan for needed improvement in patient care.

Although Phaneuf, in her publication, The Nursing Audit, states that patients will receive better care in an accredited hospital versus an unaccredited hospital, this study points out that no differences existed in the quality of care delivered to patients between two differently accredited facilities.

Implications to Nursing Practice

This discussion would not be complete without considering the implications of this study to the practice of nursing. To begin with, this study provides information regarding a valid method of determining the overall quality of patient care to nurses concerned with the care of patients at all levels.

Secondly, this valid measurement of care in two differently accredited hospitals can be used to identify areas of strengths and weaknesses, which can serve as a basis for implementing a Quality Assurance program, and planning for improvement in the level of patient care.

Thirdly, this research also provides feedback regard-

ing the effectiveness of a nursing service unit, which may be used as a basis for providing inservice education programs, supervisory assistance, modifications of programs, and improvements in equipment, facilities, and staff utilization.

Most importantly, this study serves as a resource in strengthening and communicating our responsibility of assuring quality of nursing care to clients. As nursing involves itself consciously in considering what we think we effect in client interactions, and what we actually effect, we can validate nursing's contribution to health care.

CHAPTER VI

SUMMARY, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

Reflecting back to Gardner's statement, at the beginning of Chapter I, this study indicates that both health care institutions appear to be faithful and accountable for those standards promoting Quality of Care. Concern that voluntary accreditation of health care facilities will lead to increased quality assurance led the researcher to this study. It was done to ascertain if the quality of nursing care differs in institutions accredited by the American Osteopathic Association versus institutions accredited by the Joint Commission on Accreditation of Hospitals.

A pilot study was done to familiarize the raters with the instrument and to establish interrater reliability. The study consisted of nine, two hour periods of direct observations of nurse-patient interactions. The Qualpacs as an instrument, rated the interactions for quality, following each observation period. Subjects were randomly selected on both medical units surveyed. All observations were made on the day shift.

Prior to the study, two hypotheses were made. The first hypothesis: There will be no significant differences in Grand Mean scores on the Qualpacs between a medical unit on day shift in a Joint Commission on Accreditation of Hospitals accredited facility and a medical unit

in an American Osteopathic Association accredited facility was accepted. The second hypothesis: There will be no significant differences in the Area Means scores on the Qualpacs between a medical unit on day shift in a Joint Commission on Accreditation of Hospitals accredited facility and a medical unit in an American Osteopathic Association accredited facility was also accepted.

Limitations of the Study

The scope of this study was confined to the information obtained by use of the Quality Patient Care Scale (see Appendix A, p. 57). The findings are dependent necessarily upon the subjectivity and interrater reliability of the nurse-raters utilizing the measuring instrument. Further limitations with regard to the sample population and setting were:

1. All observations were made on a medical unit.
2. Patients were observed only during day shift.
3. Willingness by subjects to be observed.
4. Willingness of nursing staff to participate in study.
5. The study included observations done over a two day period.
6. The study included two differently accredited health care facilities, of 100 beds in size, in the Portland Metropolitan Area.

No attempt was made to gain strict control over extraneous variables.

The conclusions to be drawn from this research are as follows: No significant difference can be seen in the quality of care between the Joint Commission on Accreditation of Hospitals accredited facility and the American Osteopathic Association accredited facility. Besides pointing out that no differences in the quality of care existed, more importantly, the study appears to point out that no relationship exists between the quality of nursing care and the institution's accrediting body enforcing their standards of care.

Despite the obvious importance of ensuring quality nursing care to hospitalized patients, developing a means of defining and evaluating the care given in any situation is a key step in achieving high quality care. Without such means, it is virtually impossible to ascertain needs and goal-directed activities to fulfill them. A continuous system of reporting on goals and activities of nursing care is desirable and the nursing professions have the responsibility of developing such a system.

The following recommendations for future research are suggested:

(1) Replication of this study utilizing an American Osteopathic Association accredited facility and a Joint Commission on Hospitals accredited facility of 250 beds.

(2) Replication of this study in another area of the United States, possibly the East Coast, to see if this study is representive of nursing care throughout the United States.

(3) Replication of the study involving not only the day shift, but also the evening and night shifts.

(4) Replication of the study using special groups of patients such as critical care, obstetrical, psychiatric and post-operative patients.

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APPENDICES

APPENDIX A

THE QUALITY PATIENT CARE SCALE

WAYNE STATE UNIVERSITY

College of Nursing

Date

QUALITY PATIENT CARE SCALE*

Qualpacs

Patient (name or No.):

Rater (name or No.):

INTERACTIONS RECORD: AM/PM

No.:
Time:

PSYCHOSOCIAL: INDIVIDUAL

Actions directed toward meeting psychosocial needs of individual patients.

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
1. Patient receives nurse's full attention. # D								11–12
2. Patient is given an opportunity to explain his feelings. # D								13–14
3. Patient is approached in a kind, gentle, and friendly manner. # D								15–16
4. Patient's inappropriate behavior is responded to in a therapeutic manner. #D								17–18
5. Appropriate action is taken in response to anticipated or manifest patient anxiety or distress. # D/*I								19–20
6. Patient receives explanation and verbal reassurance when needed. # D								21–22
7. Patient receives attention from nurse with neither becoming involved in a nontherapeutic way. # D								23–24
8. Patient is given consideration as a member of a family and society. # D/*I								25–26
9. Patient receives attention for his spiritual needs. # D/*I								27–28

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
10								29–30
11								31–32
12								33–34
13								35–36
14								37–38
15								39–40
								41–42–43
AREA I MEAN								

10. The rejecting or demanding patient continues to receive acceptance. # D/*I

11. Patient receives care that communicates worth and dignity of man. # D

12. The healthy aspects of the patient's personality are utilized. # D/*I

13. An atmosphere of trust, acceptance, and respect is created rather than one of power, prestige, and authority. # D

14. Appropriate topics for conversation are chosen. # D

15. The unconscious or nonoriented patient is cared for with the same respectful manner as the conscious patient. # D

PSYCHOSOCIAL: GROUP

Actions directed toward meeting psychosocial needs of patients as members of a group.

16								44–45
17								46–47
18								48–49
19								50–51

16. Patient as a member of a group receives warmth, interest, and attention from the staff. # D

17. Patient receives the help necessary to accept limits on his behavior that are essential to group welfare. # D

18. Patient receives encouragement to participate in or to plan for the group's daily activities. # D

19. The member of the group is provided with the opportunity to assume responsibility according to his capability. # D

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
20. Staff proposals for patient activities appropriately reflect interests and needs of the group members. # D								52–53
21. Patient is helped to vent his emotions in a socially acceptable way within the group. # D								54–55
22. Praise and recognition are given for achievement according to individual needs and with respect for others in the group. # D								56–57
23. The rights and integrity of the group member are protected within the group structure. # D								58–59
								60–61–62
								AREA II MEAN

PHYSICAL

Actions directed toward meeting physical needs of patients.

24. Nursing procedures are adapted to meet needs of individual patient for treatment. # D								63–64
25. Patient's daily hygiene needs for cleanliness and acceptable appearance are met. # D								65–66
26. Nursing procedures are utilized as media for communication and interaction with patient. # D								67–68
27. Physical symptoms and physical changes are identified and appropriate action taken. # D								69–70
28. Physical distress evidenced by the patient is responded to quickly and appropriately. # D								71–72
29. Patient is encouraged to observe appropriate rest and exercise. # D/*I								73–74

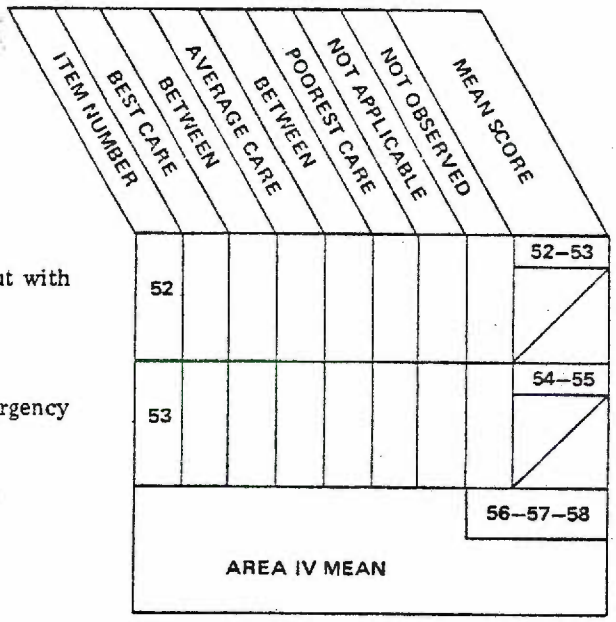
ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
30. Patient is encouraged to take adequate diet. # D/*I								75–76
31. Action is taken to meet the patient's needs for adequate hydration and elimination. # D/*I								77–78
32. Behavioral and physiologic changes due to medications are observed and appropriate action taken. # D/*I								79–80
33. Expectations of patient's behavior are adjusted and acted upon according to the effect the medication has on the patient. # D/*I								11–12
34. Medical asepsis is carried out in relation to patient's personal hygiene and immediate environment. #D								13–14
35. Medical and surgical asepsis is carried out during treatments and special procedures. # D/*I								15–16
36. Environment is maintained that gives the patient a feeling of being safe and secure. # D								17–18
37. Safety measures are carried out to prevent patient from harming himself or others. # D								19–20
38. Established techniques for safe administration of medications and parenteral fluids are carried out. # D								21–22
								23–24–25
								AREA III MEAN

GENERAL

Actions that may be directed toward meeting either psychosocial or physical needs of the patient or both at the same time.

39. Patient receives instruction as necessary. # D								26–27

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
40. Patient and family are involved in planning for care and treatment. # D/*I								28–29
41. Patient's sensitivities and right to privacy are protected. # D								30–31
42. Patient is helped to accept dependence/independence as appropriate to his condition. # D								32–33
43. Resources within the milieu are utilized to provide the patient with opportunities for problem solving. # D								34–35
44. Patient is given freedom of choice in activities of daily living whenever possible and within patient's ability to make the choice. # D								36–37
45. Patient is encouraged to take part in activities of daily living that will stimulate his potential for positive psychosocial growth and movement toward physical independence. # D/*I								38–39
46. Activities are adapted to physical and mental capabilities of patient. # D/*I								40–41
47. Nursing care is adapted to patient's level and pace of development. # D								42–43
48. Diversional and/or treatment activities are made available to the patient according to his capabilities and needs. # D								44–45
49. Patient with slow or unskilled performance is accepted and encouraged. # D								46–47
50. Nursing care goals are established and activities performed which recognize and support the therapist's plan of care. # D/*I								48–49
51. Interaction with the patient is within framework of the therapeutic plan. # D								50–51

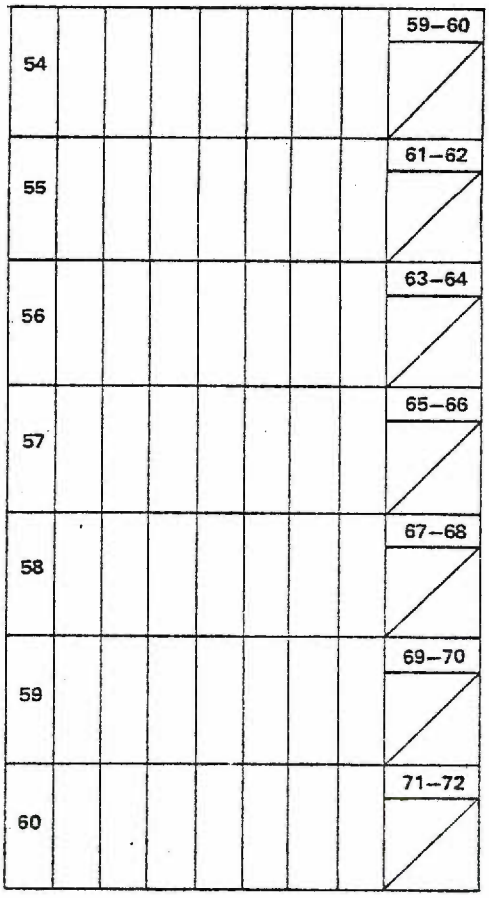


52. Close observation of the patient is carried out with minimal disturbance. # D

53. Response to the patient is appropriate in emergency situations. # D

COMMUNICATION

Communication on behalf of the patient.



54. Ideas, facts, feelings, and concepts about the patient are communicated clearly in speech to medical and paramedical personnel. # D

55. Family is provided with the opportunity for reciprocal communication with the nursing staff. # D/*I

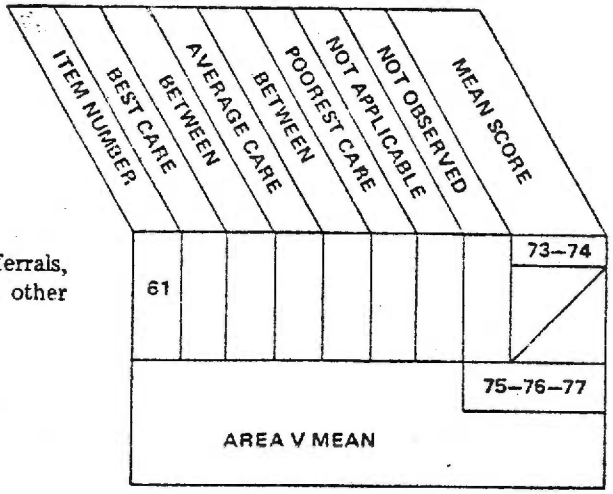
56. Ideas, facts, and concepts about the patient are clearly communicated in charting. *I

57. Well-developed nursing care plans are established and incorporated into nursing assignments. *I

58. Pertinent incidents of the patient's behavior during interaction with staff are accurately reported. # D/*I

59. Staff participate in conferences concerning patient care. # D

60. Effective communication and good relationships with other disciplines within the hospital are established for the patient's benefit. # D/*I



61. Patient's needs are met through the use of referrals, both to departments in the hospital and to other community agencies. # D/*I

PROFESSIONAL IMPLICATIONS

Care given to patient reflects initiative and responsibility indicative of professional expectations.

62. Decisions that are made by staff reflect knowledge of facts and good judgment. # D/*I

63. Evidence (spoken, behavioral, recorded) is given by staff of insight into deeper problems and needs of the patient. # D/*I

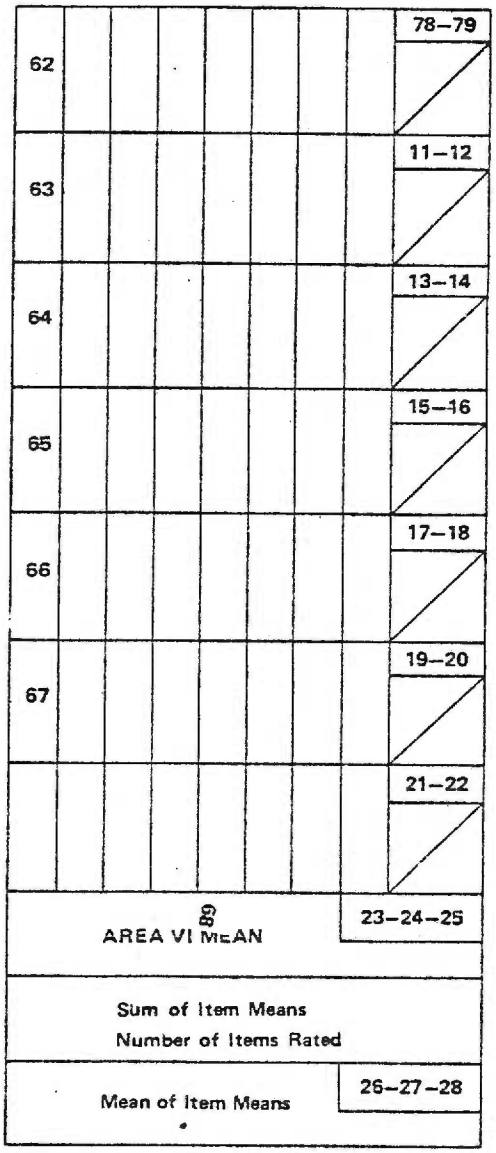
64. Changes in care and care plans reflect continuous evaluation of results of nursing care. # D/*I

65. Staff are reliable: follow through with responsibilities for the patient's care. # D/*I

66. Assigned staff keep informed of the patient's condition and whereabouts. # D

67. Care given the patient reflects flexibility in rules and regulations as indicated by individual patient needs. # D/*I

68. Organization and management of nursing activities reflect due consideration for patient needs. # D/*I



APPENDIX B

CUE SHEETS

PSYCHOSOCIAL: INDIVIDUAL

Actions directed toward meeting psychosocial needs of individual patients.

1. Patient Receives Nurse's Full Attention. # D
   a. Patient is appropriately responded to, verbally and nonverbally, without being asked to repeat phrases.
   b. Staff assumes positions that will aid in observation and communication with patient.
   c. Conversation of staff is restricted to patient who is receiving care.
   d. The infant is looked at and talked to as he receives a bottle feeding.
   e. Questions are posed which encourage patient to express feelings.
   f. Evidence is given by staff of anticipation of projected needs of patient.

2. Patient Is Given an Opportunity to Explain His Feelings. # D
   a. Facial expression of staff indicates interest in and understanding of patient.
   b. Patient is given time to talk.
   c. Patient is allowed to complete sentence before staff speak or move away from patient.
   d. Conversation is encouraged by staff using brief comments or leading questions to let patient know they are listening and interested.
   e. Conversation is terminated in such a manner that patient understands reason for termination, leaving patient with a feeling of satisfaction about discussion. (Patient's facial expression indicates this satisfaction.)

3. Patient Is Approached in a Kind, Gentle, and Friendly Manner. # D
   a. Staff speak clearly, in a soft and pleasant tone of voice.
   b. Patient is called by name, and informed of name of nurse through distinct enunciation.
   c. Crying patients (all ages) are shown patience and understanding (verbally and nonverbally).
   d. Patients are approached with a smile and encouraging word.
   e. Patient is given opportunity to initiate verbalization of needs.

4. Patient's Inappropriate Behavior Is Responded to in a Therapeutic Manner. # D
   a. Withdrawn patient is helped to consider various means for involvement or interactions with others.
   b. Attention of adolescent who is teasing others and interfering with activities of others is redirected.
   c. Patient who refuses examination or treatment is helped to think through various facets and alternatives in the situation.
   d. Expressions of hostility are accepted; changes that can be made are made, and explanations of why some things cannot be changed are

given; indications are given to the patient that the nurse is interested in knowing the patient's feelings.

e. Staff communicates, in acceptable manner, dislike of abusive or provoking language or behavior.

5. Appropriate Action Is Taken in Response to Anticipated or Manifest Patient Anxiety or Distress. # D/*I
   a. Leading questions are asked to determine what the patient knows about pending therapy and to allow him to express fears.
   b. The laboring mother is encouraged to express her thoughts and feelings about impending delivery, her own safety, and the health of her baby.
   c. Time is spent with the patient or arrangements are made to have someone else stay with anxious patient.
   d. Physical indicators of anxiety and distress are noted, such as wringing of hands, disphoresis, withdrawal, etc.
   e. Patient's repeated reference to a topic is noted, and he is encouraged to discuss it.

6. ient Receives Explanation and Verbal Reassurance When Needed. # D/*I
   Components and purpose of treatments or nursing-care action are explained as appropriate.
   b. Attempts are made to describe kind of pain or discomfort patient may anticipate, including estimate of duration of discomfort and what will be done, and what patient might do to alleviate pain or distress.
   c. Patient is helped to explore and understand why he feels about or behaves as he does toward other persons, toward himself, or toward his illness.
   d. Comments are made about patient's actions to remind and reassure him of signs of movement toward wellness.
   e. Patient is informed of when staff will leave and when they will return.

7. Patient Receives Attention from Nurse with Neither Becoming Involved in a Nontherapeutic Way. # D
   a. Nurse-patient relationship is maintained by focusing on patient's interests.
   b. Child's needs for affection and closeness are provided for, but child is helped to remember parents and siblings.
   c. Appropriate terms of address are utilized by both nurse and patient rather than inappropriate endearing terms.
   d. Monopoly of time of either patient or nurse is avoided.
   e. Patient considering alternative actions is listened to and encouraged, but allowed to make own decision; staff is neither authoritarian nor patronizing.

8. Patient Is Given Consideration as a Member of Family. # D/*I
   a. Care and treatment activities are provided at times that will least interfere with visiting family or friends.

b. Family is encouraged to participate in care of patient; mother is encouraged to feed child.
c. Patient is assisted to maintain communication with friends and colleagues—comfortable setting for visitors, assistance with telephoning, positioning and materials for letter writing, prompt mail delivery.
d. Rules are adjusted to meet special needs of patient or family; e.g., underage child allowed to visit parent.

9. Patient Receives Attention for His Spiritual Needs. # D/*I
   a. Patient's religious beliefs and practices are respected.
   b. Religious articles are handled with respect.
   c. Pastor is promptly called when patient expresses desire to see him, or nurse volunteers to call pastor.
   d. Assistance is offered and patient is encouraged to attend the services of his faith available to him (within the limits of his physical ability to do so).

10. The Rejecting or Demanding Patient Continues to Receive Acceptance. # D/*I
   a. Patient who refuses to talk is visited frequently by nurse who displays interest and gives assurance of "being there."
   b. Willingness to understand patient's point of view is conveyed in relation to refused activity or treatment.
   c. Patient who turns away or shouts, "Go away," is remained with, spoken to quietly and reassuringly, and helped with resolution of need to reject attention offered.
   d. Attempts are made to help patient clarify his understanding of the rationale for nurse actions or for treatments she proposes.
   e. Call light is answered promptly and without hostility, despite frequency of demands.

11. Patient Receives Care that Communicates Worth and Dignity of Man. # D
   a. Patient is cared for with kindness and helpfulness.
   b. Patient is encouraged to make choices about daily care and allowed time to make decisions and to respond.
   c. Requests and needs of hopelessly ill or dying patient are met with the same interest as that shown other patients.
   d. Means and opportunities for communication are provided and utilized within communication limitations of patient—speech loss or defect, deafness, limited language skills.
   e. Physical movement of patient is managed so that minimal strain is inflicted.
   f. Patient with permanent body defect is cared for in the same way as other patients.

12. The Healthy Aspects of the Patient's Personality Are Utilized. # D/*I
   a. Patient receives guidance in resolving a problem to decrease frustration of indecision.

b. Opportunities are provided for patient to receive satisfaction through contributing to others; e.g., having child in wheelchair take toy to child confined to bed.
c. Patient's abilities are pointed out, while focus on his disabilities is avoided.
d. Ways are provided and the patient is encouraged to enlarge his knowledge in areas that are of interest to him.
e. The patient's sense of humor is responded to in an appropriate manner.
f. Conversation is directed into optimistic vein; dwelling on pessimistic outlook is subtly curbed.

13. An Atmosphere of Trust, Acceptance, and Respect Is Created Rather than One of Power, Prestige, and Authority. # D
    a. Patient is trusted in as many ways as possible; he is allowed to perform those care activities within his capacity.
    b. Patient is allowed to express his opinions, and respect for his opinions is reflected in plans and activities of care.
    c. Withholding ordered treatment or necessary care is not used to solicit patient cooperation.
    d. Patient's conversation or activities are not needlessly disrupted.
    e. Inappropriate comments or actions made by the patient are quietly and briefly pointed out to him.

14. Appropriate Topics for Conversation Are Chosen. #D
    a. Topics of known interest to patient are introduced: particular sport, hobby, TV show, doll, or neighborhood activity.
    b. Patient is encouraged to talk about personal interests and concerns; e.g., children, family, what family is probably doing at home, etc.
    c. Conversation is guided to neutral or positive subject if argument develops or seems to be developing.
    d. Discussions realistic to plans for and feelings about the future are encouraged, whether expectation be complete recovery, living with limitations, or death.

15. The Unconscious or Nonoriented Patient Is Cared for With the Same Respectful Manner as the Conscious Patient.* # D
    a. Help is sought in moving the patient and moving is performed in a safe, gentle manner.
    b. Conversation of staff is focused on matters about the patient and his immediate care; jocularity is avoided.
    c. Patient is referred to by name and is spoken to in a well-modulated tone; discussion of patient's condition or prognosis is avoided in patient's presence.
    d. Disoriented patient is informed about anticipated treatments, instructions are offered about what will be expected of him, and interest in helping the patient to understand is evinced.

**Applies as well to lethargic, sedated, or non-verbal patient.*

e. For the patient anticipating anesthesia or other induced unconsciousness, anxiety regarding being unconscious is recognized and discussed. Patient is given support regarding confidentiality of his behavior and conversation during period of unconsciousness.

PSYCHOSOCIAL: GROUP

Care received reflects recognition of the patient's psychosocial needs as a member of a group.

16. Patient As Member of a Group Receives Warmth, Interest, and Attention from the Staff. # D
    a. Conversation of group members is listened to and comments are made that promote patient's continued interest.
    b. Each member of the group is recognized and acknowledged by the staff.
    c. Patients receive appropriate information about changes in group structure; e.g., one of the ward patients is to remain in I.C.U. overnight following surgery.
    d. New patients are introduced to the group by staff.
    e. When more than one staff member is working with patient, the patient is given recognition as a part of that group.

17. Patient Receives the Help Necessary to Accept Limits on His Behavior that Are Essential to Group Welfare. # D
    a. Reasons for limitations that relate to "regulations" are identified; e. g.; no smoking with O_2 in the room.
    b. Group member receives necessary explanation and guidance regarding group aims.
    c. Groups of adolescents are helped to plan games that include those with physical limitations, without placing undue attention on the latter.
    d. Hostile expressions relating to limitations are accepted, but staff remains firm and consistent in maintaining these when necessary.
    e. Reason for exclusion of an individual from a group is explained without embarrassment to either the individual or group.

18. Patient Receives Encouragement to Participate in or to Plan for the Group's Daily Activities. # D
    a. Patient is helped to plan activities and time schedules, such as bathroom privileges.
    b. Patient is encouraged to make plans helping others in the group; e. g., when to take the paralyzed patient to the sunporch in a wheelchair.
    c. Patient's suggestions and assistance are sought in making changes in physical setting—furniture arrangement, room assignments, etc.
    d. Patient is helped to make arrangements for some social activities; e. g., sharing meals by three or four patients.

19. The Member of the Group Is Provided with the Opportunity to Assume Responsibility According to His Capability. # D
    a. Mother with one or more children is given the opportunity to offer suggestions to "new" mothers.
    b. Aggressive patient is encouraged to serve as member of committee providing support to "chairman," but not take over chairman's duties.
    c. Patient is provided with schedule for his examinations or treatment and it is suggested that he assume responsibility for being at the right place at the right time.
    d. Patient is allowed to initiate preparations for meals, visits, or bedtime without being reminded each time that it is time to do these things.
    e. The ambulatory patient is permitted to feed other patients in the room.

20. Staff Proposals for Patient Activities Appropriately Reflect Interests and Needs of the Group Members. # D
    a. Involvement of each patient in group activities is noted and subtle modifications suggested to insure the appropriate involvement of all; e.g., proposing that the child with the injured knee keep score for the volleyball games.
    b. Ways of dividing group into small common-interest groups are suggested: checkers, pinochle, jig-saw puzzles, playing with dolls, building with blocks, etc.
    c. New diabetic is guided in discussing with others the disease and its meaning to them.
    d. New mother is encouraged to attend infant bath demonstrations.

21. Patient Is Helped to Vent His Emotions in a Socially Acceptable Way Within the Group. # D
    a. Group is helped to establish guidelines and discussion of emotion-laden issues is encouraged; e.g., children discuss experiences and feelings about schools and teachers or patients "debate" merits of various sides of political issues.
    b. New mother is given opportunity to discuss her fears and hopes with other mothers, staff, other parents, etc.
    c. Hostility is recognized and activities offered that demand physical strength, energy, and movement; e.g., a round or two with punching bag, volleyball, or dodgeball.
    d. Groups confined to the hospital for long periods of time (e.g., TB patients) are guided in discussing their feelings about isolation and restriction of physical activity and helped to devise activities appropriate to the limitations imposed; e.g., developing a patient government.
    e. Patients who have suffered a change in body image (amputation of lower limb, colostomy, mastectomy) are allowed to grieve without being forced to participate in activities before they are ready.

22. Praise and Recognition Are Given for Achievement According to Individual Needs and with Respect for Others in the Group. # D

a. Staff move quickly to next activity when "braggart" has scored point; patient is helped to recognize his accomplishment in relation to his abilities and those of others; he is guided to recognize achievements of others.
b. Staff discuss and help patient recognize relationship of small accomplishment to potential for "next—more difficult—step;" e.g., patient able to hold self up off bed for 30 seconds in preparation for crutch walking, mastectomy patient able to raise affected arm above head.
c. Child is praised for his self-control during an examination.

23. The Rights and Integrity of the Group Member Are Protected Within the Group Structure. # D
    a. Conversations about death are redirected by staff if one of the members is displaying anxiety.
    b. The group members or patients are informed of the problems of the aphasic patient; e.g., he can understand conversation but cannot contribute verbally.
    c. The patient who is unable to eat without drooling is given help with feeding.
    d. Hesitant patients are encouraged to join activities; less adept patients are assisted without the performance actually being done for them.
    e. Provision is made for maintaining confidentiality when personal matters of the patient are involved.

PHYSICAL

Actions directed toward meeting physical needs of patients.

24. Nursing Procedures are Adapted to Meet Needs of Individual Patients for Treatment. # D
    a. Sufficient time is allowed following patient's smoking, eating, or drinking when taking an oral temperature.
    b. Equipment and materials are arranged on the side of the bed and in a convenient position for left-handed patient to do his own tracheal suction.
    c. General morning care of arthritic patient is left until last so no one will feel pressure of time and movements can be made slowly.
    d. Colostomy irrigation is done at the time the patient states would be most convenient for him at home.

25. Patient's Daily Hygiene Needs for Cleanliness and Acceptable Appearance Are Met. #D
    a. Staff offer to comb hair of patient unable to do so for physical or mental reasons; e.g., cardiac patient, patient with upper extremity injury, patient in state of emotional shock following loss of loved ones, regressed mental patient.

b. Disturbed patient is helped to shower, shave, and select clean clothing or items of attire that go together.
c. Bedside environment is made neat and orderly, soiled gowns are changed P.R.N.
d. Assistance is offered with oral hygiene; e.g., brush is prepared and basin held for patient with upper extremity cast, dentures brushed under running water for patient unable to do this himself, child is taught proper brushing technique.
e. Body, dressing, and air deodorizers are provided as indicated.

26. Nursing Procedures Are Utilized as Media for Communication and Interaction with Patients. # D
    a. Withdrawn patient is encouraged to talk of self, interests, and family while receiving direct nursing care.
    b. During each contact, staff encourage and allow time for the patient unable to speak (aphasic, tracheotomized, etc.) to write some message; they allow time to respond to each message in an unhurried manner.
    c. Pariplegic patient is encouraged to discuss his progress in physiotherapy while nurse makes his unoccupied bed.
    d. Mother is helped to listen to heartbeat of her unborn child and encouraged to talk about the baby and its meaning to her.
    e. Patient is encouraged to assist, even in a small way, with particularly painful treatment; e.g., burn dressing, repeated intramuscular injection.

27. Physical Symptoms and Physical Changes Are Identified and Appropriate Action Taken. # D
    a. Cyanosis is noted; staff checks for bleeding, oxygen flow, position in relation to breathing.
    b. Mottled tissues over bony prominence are noted; frequency of turning patient is increased and ways provided to keep pressure from area.
    c. Languor and shallow breathing of small child is noted and appropriate action taken.
    d. Undesirable weight loss is noted in elderly clinic patient; patient is questioned about changes in eating habits, living conditions, appetite.
    e. The fundus of the uterus is massaged to evaluate the possibility of postpartum hemorrhage.

28. Physical Distress Evidenced by the Patient Is Responded to Quickly and Appropriately. # D
    a. Patient is moved up in bed and pillows are adjusted to provide a comfortable position and good body alignment.
    b. Patient's complaint of pain or burning at site of infusion prompts investigation for infiltration and possible removal of needle.
    c. Signs of pain—restlessness, perspiration, facial contortion—are noted and action is taken to alleviate it; e.g., change of position, medication, fresh dressing.

d. Excoriated buttocks of baby are noted and diapers changed frequently to keep baby clean and dry, and soothing protective ointment or powder applied.
e. Patient with respiratory tract secretions is either helped to deep breathe and cough or is suctioned.

29. Patient Is Encouraged to Observe Appropriate Rest and Exercise. # D/*I
    a. Patient is helped to understand role of rest in his treatment; e.g., cardiac, thrombophlebitis, hepatitis, chorea.
    b. Patient is helped to understand role of exercise in treatment of his illness; e.g., postsurgical, paralysis, traction or cast immobilization.
    c. Elderly patient is assisted out of bed; patient is encouraged to stand and to help self. Patient is given time to do for himself, but necessary assistance and protection is offered.
    d. Patient is helped to plan ways to save movement and steps in accomplishing tasks of daily care.
    e. New activities are suggested to patient; reading or light handicrafts for rest; playing pool or Ping-Pong for exercise.

30. Patient Is Encouraged to Take Adequate Diet. # D/*I
    a. Eating habits are discussed with patient to learn cultural and social habits as well as food likes and dislikes.
    b. Patient is helped to know what constitutes an adequate diet.
    c. Interest is displayed in attractiveness of patient's tray and in appropriateness of food served; assistance is promptly given in making dietary corrections.
    d. Pleasant atmosphere is provided for mealtime, company—other patients, volunteers, visitors—is provided wherever possible.
    e. Special dietary needs or increased requirements of certain dietary constituents are discussed, and appropriate foods on tray are pointed out to patient.

31. Action Is Taken to Meet the Patient's Needs for Adequate Hydration and Elimination. # D/*I
    a. Elimination patterns are identified and steps taken to promote adequate elimination; e.g., laxatives, proper diet, exercise.
    b. Patient overanxious about elimination is given opportunities to discuss concerns and is provided information to enhance understanding.
    c. Fluids are encouraged in the dehydrated patient or the patient losing large amounts of fluid; e.g., diaphoresis with elevated temperature.
    d. Intake and output is measured accurately; e.g., N/G drainage, Foley catheter, wound drains, postpartal bleeding.
    e. Diarrhea in the infant is reported promptly and measures taken to alleviate the problem.
    f. Measures are initiated to prevent elimination problems or problems of limited intake whenever there is psychomotor retardation, as in the depressed patient.

32. Behavioral and Physiologic Changes Due to Medications Are Observed and Appropriate Action Taken. # D/*I
    a. Skin reactions of patients are reported and drug is withheld as necessary.
    b. Disturbances in orientation are recorded and reported.
    c. Anorexia is noted and reported in a patient on a digitalic preparation.
    d. Relaxation and amount of sleep obtained in response to sedative is noted and reported.
    e. The effect of a mucolytic agent administered during an I.P.P.B. treatment is noted: expectoration, productivity quality of cough.

33. Expectations of Patient's Behavior Are Adjusted and Acted Upon According to the Effect the Medication Has on the Patient. # D/*I
    a. Drowsiness and retarded psychomotor activity is accepted by supporting the patient when he points out that he is unable to participate in active discussions or sports.
    b. For the tremulous patient, projects are selected that require little coordination.
    c. Patient who has postural hypotension as a result of drug therapy is allowed to ambulate slowly without pressure to hurry; notation is made in nursing care kardex.
    d. Staff allow tranquilized or sedated patient ample time to respond to questions.
    e. Photosensitivity is observed and patient is not expected to participate in outside activities for extended periods of time.

34. Medical Asepsis Is Carried Out in Relation to Patient's Personal Hygiene and Immediate Environment. # D
    a. Staff wash hands as necessary; e.g., on completing care of one patient and before moving to another, before beginning "clean" procedure, following any obvious contamination.
    b. Floor is recognized as grossly contaminated area; e.g., items picked up from floor are cleaned or replaced, hands are washed after picking up something from floor, staff avoid placing supplies or equipment on the floor.
    c. In giving a bath, motion proceeds from the clean to the unclean areas.
    d. All equipment used by or for patient is clean; tub, sitz bath, I.P.P.B. etc., used by more than one patient are cleansed well between uses; wheelchair, Hoyer lift, and carts for transporting supplies and equipment to patient are clean.
    e. Soiled linen and dressings are changed promptly to prevent infection or skin breakdown to the patient.

35. Medical and Surgical Asepsis Is Carried Out During Treatments and Special Procedures. # D/*I
    a. Dressings are handled so that surface that will cover wound and surrounding area remains sterile.

c. Patient is addressed by name or asked to state name, or the identaband or bed tag is checked, before medication is given. Nurse remains with patient until medication is taken.
d. Medication tray is not left unattended where it could be a danger to one or more patients.
e. IV flowrate and site are checked to assure appropriate administration.

GENERAL

Actions that may be directed toward meeting either psychosocial or physical needs of the patient, or both at the same time.

39. Patient Receives Instruction as Necessary. # D
    a. Mother is guided as she picks up baby, staff demonstrate and have mother demonstrate holding baby for burping and bathing.
    b. Uses of signal cord and intercom are demonstrated to newly admitted patient.
    c. Medications patient will be taking at home are discussed; nurse ensures that he knows identity of each, purpose for which it is being prescribed, dosage and schedule for taking each, and expected effects of medication.
    d. Cardiac patient is given examples of how to conserve energy at home; e.g., arrangement of cooking utensils in the kitchen.
    e. Pre- and postoperative instruction is provided.

40. Patient and Family Are Involved in Planning for Care and Treatment. *I/#D
    a. When giving instructions to patient, nurse involves family member if he is visiting, not only asking him to remain in room, but actually including him in discussion.
    b. Arrangements are made to have family member participate in treatment, eventually doing entire treatment if it is one patient will not be able to do for himself at home.
    c. Plans are made with patient and family members to do care procedures at time when family member can participate; details of care needed at home are planned with patient and family members.
    d. Patient is helped to communicate with family about needs for items and procedures of care after discharge; e.g., wife to know diet, husband to know of work-saving methods and devices, parents to anticipate teasing of child by other children and ways to help child cope.

41. Patient's Sensitivities and Right to Privacy Are Protected. #D
    a. Sheets or towels are used as drapes to avoid unnecessary exposure of body.
    b. Curtain is drawn around bed for procedures of physical care.
    c. Arrangements are made to have patient taken to room where interview (social worker, psychologist, homemaker) can be conducted in private.
    d. Sensitivities of maturing child and teenager are protected.

e. Dentures are promptly replaced after cleansing or after surgery for patient who is sensitive about being without them.

42. Patient Is Helped to Accept Dependence/Independence as Appropriate to His Condition. # D
    a. Role of rest in treatment of disease is discussed, patient is reassured of gradual progress toward resumption of responsibility of doing for himself.
    b. Patient undergoing surgery is helped to understand the purpose of early ambulation and exercises in the postoperative period; e.g., out-of-bed to bathroom instead of urinal or bedpan.
    c. Mother is encouraged to hold infant and offer bottle feeding during early postpartal period.
    d. Patient with disability of musculoskeletal system is helped to understand disease process, rationale for treatments, and probable outcome.
    e. For a patient wishing to continue dependence, the rationale for increasing independence is explained; the staff display empathy and provide support and encouragement as the patient performs required activities for movement toward independence; e.g., a patient (any age) with an upper extremity or chest injury is supported and encouraged to wash his face, brush his teeth, do his hair, and feed himself.

43. Resources Within the Milieu Are Utilized to Provide the Patient with Opportunities for Problem Solving. # D
    a. Patient is encouraged to suggest ways to accomplish "routine" tasks despite limitations due to incapacitated or absent body feature. He is helped to plan placement of articles as he will use them in hospital and at home or work.
    b. Patient is helped to consider alternatives in relation to choice of diversional activity.
    c. Child is helped to select the most appropriate toy for the situation; e.g., kind of toy that can be used in bed, one that allows for solitary play, or one that allows others to join in play.
    d. Patient is asked to propose furniture arrangement that will provide for best use of day and artificial lighting and for least distressful light glares.

44. Patient Is Given Freedom of Choice in Activities of Daily Living Whenever Possible and Within Patient's Ability to Make the Choice. # D
    a. Determination is made of whether patient is "early" or "late" riser, plans are made with him about timing for needed care.
    b. Patient is allowed morning or evening shower or bath, depending on custom and preference.
    c. Patient is assisted to arrange for type of clothing he prefers to wear.
    d. Requests are granted involving changes in daily routines that can be made without major disruptions in ward plans.

45. Patient Is Encouraged to Take Part in Activities of Daily Living That Will Stimulate Him for Positive Psychosocial Growth and Movement Toward Physical Independence. # D/*I
    a. "Early" riser is encouraged to assist with serving morning coffee, where A.M. coffee is a practice.
    b. Stroke patient is encouraged to shave himself; electric razor is provided if indicated.
    c. Patient is invited to help care for flowers—his own and those of others.
    d. Child is helped and encouraged to brush his teeth regularly.
    e. Patient's efforts and successes are recognized.

46. Activities Are Adapted to Physical and Mental Capabilities of Patient. #D/*I
    a. Hard of hearing patient is provided with an earphone to facilitate listening to his radio or TV.
    b. Confused patient is guided through steps of preparation for visit to therapist: reminds patients, one step at a time, about washing face and hands, brushing teeth, combing hair, dressing, storing night clothing, etc.
    c. Time is allowed for small child, or slow or hesitant patient, to do things for himself, so that he may develop confidence and independence.
    d. Assistance is provided to patient before he reaches point of frustration at inability to perform task.
    e. Long-term diabetic patient is allowed to administer own insulin while hospitalized.

47. Nursing Care Is Adapted to Patient's Level and Pace of Development. # D
    a. Child is allowed to perform tasks of which he is capable and is provided with challenging tasks within his ability to learn and perform them.
    b. "Contests" related to learning new tasks are avoided when patients would experience frustration and feelings of inadequacy.
    c. Instructions and performances of tasks to be learned are repeated as often as necessary.
    d. Patient is helped to rethink a problem and decide whether to pursue a path different from one selected earlier.
    e. A doll is used to illustrate the care a child scheduled for surgery will receive.

48. Diversional and/or Treatment Activities Are Made Available to the Patient According to His Capabilities and Needs. # D
    a. Stories are read to a small child.
    b. Rubber ball is provided for stroke patient for hand exercise.
    c. Older patient is taken to dayroom and time spent with him; he is encouraged to visit or share activity: needlework, cards, program on TV, etc.

49. Patient With Slow or Unskilled Performance Is Accepted and Encouraged. # D

a. Gentle persuasion is used to keep regressed patient moving in process of morning toilet and dressing.
b. Time is provided for the aphasic patient to speak.
c. A child with cerebral palsy is encouraged to learn to feed himself.
d. A dyspneic patient is allowed time "to catch his breath" when moving in bed or ambulating.

50. Nursing Care Goals Are Established and Activities Performed Which Recognize and Support the Therapist's Plan of Care. # D/*I
    a. Arthritic patient receives encouragement and direction from nursing personnel in doing ordered hand exercises.
    b. New mother is assisted with breast feeding; e.g., proper cleansing of breast prior to feeding, proper positioning, etc.
    c. Child's tray is removed after thirty minutes, regardless of amount of food eaten, when purpose is to assist child to establish good eating habits, and to not play with food.
    d. Toileting schedule is planned with paraplegic patient, with view to achieving independence from indwelling catheter.
    e. Patient with a decubitus ulcer is helped to plan a menu high in protein and encouraged to eat.

51. Interaction With the Patient Is Within Framework of the Therapeutic Plan. # D
    a. Disoriented patient is helped to reorient himself by having reality pointed out to him when confused.
    b. Patient with myocardial infarction is reassured that it is not too much bother to feed him.
    c. Patient learning to use crutches is reassured that the nurse will remain near and will support him if needed, but is encouraged to walk with support of crutches.

52. Close Observation of the Patient Is Carried Out With Minimal Disturbance. # D
    a. Quiet is maintained as staff move into and out of room for frequent checking: IV, O_2 flow, urine output, etc.
    b. Bed clothing is arranged so that it can easily be lifted to check on extremity.
    c. Staff approach and stand quietly beside group engaged in game or conversation without interrupting or distracting attention of members of group.
    d. Room of patient with suicidal tendencies is checked for harmful objects during daily cleaning.

53. Response to the Patient Is Appropriate in Emergency Situations. # D
    a. Staff wait until help is available to move patient who has fallen from bed.

b. Patient who has assumed posture to suit words of threatening to strike nurse is spoken to quietly.
c. Staff remain with child having asthmatic attack and summon available help.
d. Staff stay with a convulsing patient for observation and to provide protection from injury.
e. Intravenous glucose is immediately prepared for the diabetic patient in severe insulin shock.

COMMUNICATION

Communication on behalf of the patient.

54. Ideas, Facts, Feelings, and Concepts About the Patient Are Communicated Clearly in Speech to Medical and Paramedical Personnel. # D
    a. Feelings and thoughts expressed are neither mumbled nor highly emotional.
    b. Complete description of patient's behavior is given without excessive repetition and using good sequence.
    c. Reports of observations are factual and clearly stated leading to meaningful conclusions.
    d. Questions are used to help aides report and describe patient's condit and to ascertain that aides have understood plan for care.

55. Family Is Provided With the Opportunity for Reciprocal Communication With the Nursing Staff. # D/*I
    a. Explanations regarding treatment and therapy that the patient is receiving are stated clearly and in understandable terms.
    b. Fears and concerns of the family are responded to in a manner which promotes an understanding and acceptance of their role in meeting the patient's needs; e.g., mother stays overnight in room with child who has had a tonsillectomy.
    c. Family is kept informed of changes in patient's condition; e.g., the expectant father is given frequent reports on his wife's progress during labor.
    d. Family is used as a resource for additional information about the patient to develop a relevant plan of care; e.g., daily activities, occupation, habit patterns.

56. Ideas, Facts, and Concepts About the Patient Are Clearly Communicated in Charting. *I
    a. Precise and specific observations are recorded; few generalizing clichés are used; e.g., comatose, disoriented.
    b. Possible interpretation of reasons for patient's behavior is recorded.
    c. Sentence structure is clear and grammatically correct; excessive use of abbreviations is avoided.

d. All pertinent facts or observations in a situation are included.
e. Written communication is legible, legal abbreviations only used.

57. Well-Developed Nursing Care Plans Are Established and Incorporated into Nursing Assignments. *I
    a. Immediate and long-range objectives of care are included; changed as patient needs change, also dated.
    b. Information is included about patient's likes and dislikes.
    c. Suggestions for modification of procedures that make care easier or more effective for patient are included.
    d. Plan for implementation of progressive care is included relating to anticipated future needs of patient; e.g., "plan to teach colon irrigation beginning tomorrow."
    e. Written assignments or worksheets reflect the objectives of the plan of care.

58. Pertinent Incidents of the Patient's Behavior During Interaction With Staff Are Accurately Reported. #D/*I
    a. Nurse reports that patient refused to take IM injection, with claim she hurt him last time she gave it.
    b. Nurse reports patient's refusal to sit up in chair because patient states he was left up too long yesterday.
    c. Patient's response during or after interaction with staff; e.g., patient withdrew from group discussion after being reprimanded in front of group by nurse for telling a vulgar story.
    d. After instruction for giving self-injection, nurse charts patient's response to his initial self-injection.

59. Staff Participate in Conferences Concerning Patient Care. #D
    a. Staff volunteer observations they have made; e.g., in team reports.
    b. Pertinent information is given to the staff about a particular patient's disease condition and recommended treatment.
    c. Staff offer proposals of approaches to care of particular patient.
    d. Nurse asks questions that will elicit information or ideas from other workers.

60. Effective Communication and Good Relationships With Other Disciplines Within the Hospital Are Established for the Patient's Benefit. *I/#D
    a. Physical therapist is consulted to seek suggestions of what nursing staff might do to enhance patient's treatment.
    b. Social worker is called for a patient who might benefit from help; e.g., payment of rent while in hospital, care of children during hospital stay.
    c. X-ray or lab is notified promptly to clarify orders for preparation of patient or when patient will be delayed or unable to keep appointment.
    d. Physician is notified of all pertinent information about patient: verbal reports, printed notes on front of chart, paging or telephoning, etc.
    e. Occupational therapy consultation is requested for patient with severely injured hand.

61. Patient's Needs Are Met Through the Use of Referrals, Both to Departments in the Hospital and to Other Community Agencies. *I/# D
    a. VNA referral is made for new mother with first baby who is new to city and has no family or friends who can assist with teaching care of new baby.
    b. Social worker is consulted about referral to visiting housekeeper for elderly patient who lives alone.
    c. Local school system is called to arrange for home teaching for adolescent patient.
    d. Adequate information regarding postdischarge clinic appointments is given to the patient; e.g., location of clinic within hospital, time and date of appointment.

PROFESSIONAL IMPLICATIONS

Care given to patients reflects initiative and responsibility indicative of professional expectations.

62. Decisions that Are Made by Staff Reflect Knowledge of Facts and Good Judgment. # D/*I
    a. Room assignment of patient whose baby died during delivery is changed to avoid placing her in a room with mother with day-old baby.
    b. PRN analgesic and PRN hypnotic are administered at bedtime to second day postoperative patient with spinal fusion.
    c. IV fluid is promptly slowed when postoperative patient manifests increased difficulty and rate of breathing.
    d. Emphysema patient is served six small feedings a day.
    e. Joking references made by patient about "jumping out of window" are responded to with increased periods of observation and by obtaining available information—doctor, chart, etc.—for adequate evaluation of behavior.
    f. Nurse aide seeks help when in doubt.

63. Evidence (Spoken, Behavioral, Recorded) Is Given by Staff of Insight into Deeper Problems and Needs of the Patient. # D/*I
    a. Patient who lost first two children at birth is not left alone any more than necessary, and nurses share her experience with her.
    b. Staff attempt to help adolescent with severe acne to recognize and utilize assets and abilities to contribute to interest and happiness of others, thereby enhancing confidence and satisfaction in his own worth.
    c. Staff provide support to dying patient by listening to his fears and by avoiding unrealistic clichés such as "you'll be up and around in no time."
    d. Staff discuss possible approaches to be used with patient who has just sustained a change in body image; e.g., hysterectomy, mastectomy, amputation, spinal cord transection, hemiplegia.

64. Changes in Care and Care Plans Reflect Continuous Evaluation of Results of Nursing Care. *I/# D
    a. Suggestion is made that wound be dressed after wife's visit since changing the patient's dressing before her visit focuses his attention on the wound to the extent that he discusses little else.
    b. Referrals for home visits are made for the amputee patient when it is discovered that his recent return to dependency upon the staff is the result of his fears about his adequacy in the home situation.
    c. Passive exercises to the paralyzed hand of the C.V.A. patient have resulted in prevention of contractures and plans are made to continue them.
    d. Suggestions or criticisms made by patient and family are utilized constructively in planning and evaluating care.
    e. Change is suggested in types of foods since patient is not eating present diet and complains that it is "baby" food.

65. Staff Are Reliable: Follow Through with Responsibility for the Patient's Care. # D/*I
    a. Staff ask for help in doubtful situations, rather than making errors.
    b. Staff report when work is not completed.
    c. Nurse views situation herself rather than depending on reports alone; e.g., visits patient on report of bleeding, checks conditions of very ill patients in preparation for change-of-shift report.
    d. Assignments and work accomplished are periodically reviewed to replan, establish priorities, and fulfill responsibilities.
    e. Staff follows through on commitments they have made; e.g., return to patient's room at time stated, perform treatment when scheduled.

66. Assigned Staff Keep Informed of the Patient's Condition and Whereabouts. # D
    a. All assigned patients are visited to ascertain their condition before day's tasks are begun.
    b. Patient's whereabouts are known along with reason for his being off the unit or away from bedside unit and when he is expected to return.
    c. Current condition of patient is known as well as changes in past 24 hours, and plans of care are reported to staff of succeeding tour of duty.
    d. If indicated, patient is accompanied by staff when leaving unit for tests or conferences.

67. Care Given the Patient Reflects Flexibility in Rules and Regulations as Indicated by Individual Patient Needs. # D/*I
    a. Adjustments in visiting hours are made in accord with patient's condition and special needs of his family.
    b. Room change is provided as soon as possible for nonambulatory patient who smokes when he is assigned to room where O_2 is in use.
    c. Patient who is on a regular diet but not eating well is allowed to have family bring in favorite foods.

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    c. Patient who is on a regular diet but not eating well is allowed to have family bring in favorite foods.

d. Patient whose work, for years, has been during the midnight shift is not able to sleep at lights-out time; he is allowed to read, listen to radio, or watch late TV.

68. Organization and Management of Nursing Activities Reflect Due Consideration for Patient Needs. # D/*]
   a. Treatments are performed at times that will not interfere with visiting hours.
   b. One member of staff directs ambulation of patient when several are involved in task.
   c. Necessary supplies and equipment are assembled and prepared prior to initiation of treatment.
   d. Provision is made so that patient receives adequate and prompt assistance at mealtimes.
   e. When patient is acutely ill, he receives care before patients with less acute needs.
   f. Staff assignment plans reflect consideration of patient's needs.

APPENDIX C

INDIVIDUAL FRAME OF REFERENCE

INDIVIDUAL FRAME OF REFERENCE

Each rater completes her individual Frame of Reference Card according to the instructions on the card.* This framework may then be used for reference whenever she makes a judgment about the quality of any nurse actions performed in providing care for the patient. Should settings change markedly, such as from a geriatric hospital ward to a well-baby clinic, the rater may want to change the names of the staff nurses whom she recalls having worked in the particular specialized setting, but the general process of developing the frame of reference and applying the scale of the standard of measurement remains the same.

Slater Nursing Performance Rating Scale Rater _____

INDIVIDUAL FRAME OF REFERENCE CARD

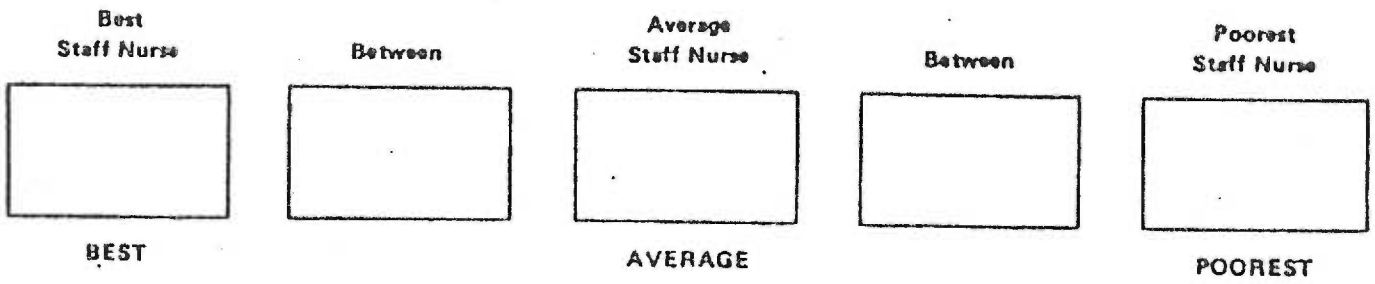
Write the names of staff nurses whom you know or have known in their respective boxes:

1. Write the name of the nurse whom you consider to be the best staff nurse you have known (the nurse you would like to have care for you if you were ill) in the box labeled "Best Staff Nurse."

2. Think of the nurse you consider to be the poorest staff nurse you have ever known; write her name in the box on the far right, labeled "Poorest Staff Nurse."

3. Think of a nurse whom you consider to be a typical or average staff nurse, neither noticeably good nor noticeably poor; write her name in the middle box, labeled "Average Staff Nurse."

4. Think of a nurse who falls between your "best" and your "average" nurse and one who falls between your "average" and your "poorest" nurse; write their names in the respective boxes.



Adopted from Slater Nursing Performance Rating Scale; Detroit: College of Nursing Wayne State University, 1967, p. 29.

APPENDIX D

THE INFORMATION FACE SHEET AND THE RATER'S NOTES

QUALITY PATIENT CARE SCALE

RATER'S NOTES

FOR

ASSESSMENT AND PLANNING CARE

PATIENT _____

ORDERS, NEEDS, NURSING ACTIONS

Diet (meals, fluids, nourishment)

Medications

Treatments (dressings, irrigations)

Special care:
- a. colostomy, trach., etc.
- b. skin-bath, lotion, etc.
- c. traction, cast
- d. decubiti

Observation of condition
- a. Direct
- b. Monitors (V.S., Pacemakers, etc.)

Diagnostic Tests
- a. On ward
- b. Off ward

Activity (bedrest, ambulation, etc.)

Sensory deficit (blind, aphasic, deaf)

Safety

Teaching patient and family

Socialization and diversion

Multiple services (referrals, consultations)

Reporting and recording

Planning for continuity of care

Other

QUALITY PATIENT CARE SCALE

INFORMATION FACE SHEET

Patient

Name _____

Record # _____

Room # _____ Accommodations _____

Admission Date _____

Diagnosis:

Admission _____

_____

_____

Current _____

_____

_____

Condition of Patient _____

_____

_____

_____

Unit

Name _____ Type _____

Number of Rooms _____

Number of Beds _____

Census _____

LEVELS OF CARE (Number of patients in each)

A _____ C _____ E _____

B _____ D _____

PERSONNEL CODE AND CENSUS

Registered Nurse	R _____
Practical Nurse	P _____
Nursing Student	SN _____
Practical Nursing Student	PN _____
Instructor	I _____
Head Nurse	H _____
Candy Striper	C _____
Supervisor	S _____
Orderly	O _____
Ward	W _____
Aide	A _____
Unknown Initiator	U _____

OTHER PERTINENT DATA:

Date _____ Rater _____

Time of Day _____ AM/PM INTERACTIONS _____

REPORTS: Change of Shift _____ OUTCOMES: Total Item Mean Score _____

Team _____ Total of Items Used _____

Other _____ Score (Mean of Means) _____

Additional notes or questions:

APPENDIX E

FACT SHEET ABOUT QUALPACS

QUALITY PATIENT CARE SCALE

A FACT SHEET ABOUT QUALPACS*

For distribution to and discussion with Head Nurses
and Ward Nursing Personnel

What

A Survey to Evaluate the Quality and Conditions of Delivery of Nursing Care to Patients at _____ Hospital

Conducted by the Department of Nursing

When

Date to *Date*

Why

I. To examine the quality of care provided to patients at _____ Hospital.

II. To identify ward activities and conditions which might influence quality of care (e.g., number of personnel, number of treatments, equipment, number of critical patients, etc.).

III. To provide information to Department of Nursing (supervisory and unit personnel) to serve as a base for planning for personnel assignment, inservice education, etc.

How Will the Study Be Conducted?

The Nurse Observer will spend a *two*-hour period observing the selected patient(s). Five to six patients will be observed on each unit. The observer will observe the care received by the patient(s) and ascribe ratings to pertinent items on the *Quality Patient Care Scale*.

The Nurse Observer will not participate or intervene in any nursing actions unless in her judgment not to do so would be dangerous for the patient.

The Nurse Observer will sit in the patient's unit during the observation period, in an area where it is possible to observe the patient and yet be as unobtrusive as possible.

She will be making recordings of her observations, therefore, she will be "turning pages," etc. Conversation with her by personnel and patients is to be discouraged during the observation periods. After she has finished her observation period discussion is permitted if the patient or personnel desire it.

The study is not an efficiency rating of personnel. Names of personnel are not recorded. The study is concerned with what nursing care the selected patient

**Developed by Kathlene F. Monahan*

receives regardless of who does it. From the records the Nurse Observer keeps it would not be possible to retrieve a person's name and give an efficiency rating.

Patient Information

The Nurse Observer will examine the patient's chart or kardex so that she has information concerning the needs of the patient whom she will be observing. In addition, she may need to supplement her information by spending a short time consulting with the head nurse or nurse who is providing care for the selected patient.

What Help is Needed from Head Nurses?

A. Help in Identification and Selection of Patients

1. The Nurse Observer will seek the charge nurse's assistance in identification of patients for the study.
2. The charge nurse will be contacted and consulted regarding the identification of patients who may be expected to receive a number of nursing interactions and interventions.
3. The observer has to observe patients for whom something is being done. If patients are scheduled for "off-ward" activities they should not be included in the study.

B. Introduction to Staff

Briefly explain that:

1. The study is to look at what activities nursing personnel do for patients.
2. The observer will be sitting in the patients' unit and will be "thumbing" papers.
3. *It is not an efficiency rating.*
4. Personnel are requested to continue their normal activities and disregard the presence of the observer.
5. The observer will wear a lab coat.

C. Introduction to Patients

A nurse who knows the patient should:

1. Introduce the observer to all patients in the immediate study area.
2. Explain briefly what the observer will be doing and why she is there.
3. Explain that the observer will be "observing" and writing and will not be talking or working with patients.
4. It is not necessary to state specifically *which* patient is being observed.

APPENDIX F

OSTEOPATHIC - ALLOPATHIC QUALPACS ITEM MEANS

APPENDIX F

QUALITY PATIENT CARE SURVEY OSTEOPATHIC-ALLOPATHIC QUALPACS ITEM MEANS

Qualpac Item Number	Patient Identification Number: Osteopathic Facility 1.0	2.0	3.0	4.0	5.0	Allopathic Facility 1A	2A	3A	4A
1	3.75	3.75	4.0	4.0	4.0	4.0	3.85	4.0	4.0
2	3.75	3.75	4.0	4.0	4.0	4.0	3.66	4.0	4.0
3	4.0	3.75	4.0	4.0	4.0	4.0	4.0	4.0	3.75
4	.0	.0	4.0	.0	4.0	4.0	.0	4.0	.0
5	4.0	.0	4.0	4.0	.0	4.0	4.0	4.0	4.0
6	4.0	3.33	4.0	4.0	4.0	4.0	4.0	4.0	4.0
7	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
8	3.75	4.0	4.0	4.0	.0	.0	4.0	.0	4.0
9	.0	.0	.0	.0	.0	.0	.0	.0	.0
10	.0	.0	4.0	.0	4.0	4.0	.0	.0	.0
11	3.75	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
12	3.75	4.0	4.0	4.0	4.0	4.0	4.0	4.0	.0
13	3.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
14	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
15	.0	.0	.0	4.0	4.0	.0	.0	.0	.0
Area Mean I	3.43	3.85	4.0	4.0	4.0	4.0	3.95	4.0	3.97

APPENDIX F (Continued)

QUALITY PATIENT CARE SURVEY OSTEOPATHIC-ALLOPATHIC QUALPACS ITEM MEANS

Qualpac Item Number	Patient Identification Number: Osteopathic Facility 1.0	2.0	3.0	4.0	5.0	Allopathic Facility 1A	2A	3A	4A
16	3.5	4.0	4.0	4.0	4.0	.0	4.0	4.0	4.0
17	.0	.0	.0	.0	.0	.0	4.0	.0	.0
18	.0	.0	.0	.0	.0	.0	4.0	.0	.0
19	.0	.0	.0	.0	.0	.0	4.0	.0	4.0
20	4.0	4.0	.0	.0	.0	.0	4.0	.0	.0
21	.0	.0	.0	.0	.0	.0	.0	.0	.0
22	.0	.0	.0	.0	.0	.0	4.0	.0	.0
23	.0	.0	.0	.0	.0	.0	4.0	.0	.0
Area Mean II	3.75	4.0	4.0	4.0	4.0	.0	4.0	4.0	4.0
24	4.0	4.0	4.0	4.0	4.0	4.0	3.0	4.0	.0
25	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
26	4.0	4.0	4.0	4.0	4.0	4.0	.0	4.0	4.0
27	4.0	.0	4.0	4.0	4.0	3.0	.0	4.0	1.0
28	4.0	.0	4.0	.0	4.0	3.0	.0	4.0	2.0
29	.0	4.0	4.0	4.0	.0	4.0	4.0	4.0	4.0
30	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	1.0

APPENDIX F (Continued)

QUALITY PATIENT CARE SURVEY OSTEOPATHIC-ALLOPATHIC QUALPACS ITEM MEANS

Qualpac Item Number	Patient Identification Number: Osteopathic Facility 1.0	2.0	3.0	4.0	5.0	Allopathic Facility 1A	2A	3A	4A
31	4.0	.0	4.0	4.0	4.0	3.0	4.0	4.0	4.0
32	.0	.0	.0	.0	.0	.0	.0	.0	.0
33	.0	.0	.0	.0	1.0	.0	.0	.0	.0
34	.0	.0	3.66	1.0	.0	1.0	2.4	2.0	4.0
35	1.0	.0	.0	.0	.0	1.0	.0	.0	.0
36	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
37	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
38	2.4	1.0	.0	.0	4.0	4.0	4.0	4.0	4.0
Area Mean III	3.58	3.62	3.96	3.7	3.7	4.15	3.71	3.83	3.27
39	5.0	4.0	5.0	5.0	4.0	4.0	4.0	4.0	4.0
40	.0	4.0	.0	.0	.0	4.0	.0	.0	.0
41	2.3	4.0	4.0	4.0	4.0	4.0	4.0	4.0	2.5
42	.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
43	.0	.0	4.0	3.0	4.0	5.0	.0	5.0	.0
44	4.0	4.0	4.0	4.0	4.0	5.0	4.0	5.0	.0

APPENDIX F (Continued)

QUALITY PATIENT CARE SURVEY OSTEOPATHIC-ALLOPATHIC QUALPACS ITEM MEANS

Qualpac Item Number	Patient Identification Number: Osteopathic Facility 1.0	2.0	3.0	4.0	5.0	Allopathic Facility 1A	2A	3A	4A
45	.0	.0	4.0	4.0	4.0	4.0	4.0	4.0	.0
46	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
47	.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	3.0
48	.0	.0	4.0	.0	.0	4.0	.0	.0	.0
49	.0	.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
50	4.0	3.0	4.0	4.0	.0	4.0	4.0	4.0	1.0
51	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	3.0
52	4.0	4.0	4.0	4.0	4.0	4.0	.0	4.0	4.0
53	.0	.0	.0	.0	.0	.0	.0	4.0	.0
Area Mean IV	3.9	3.9	4.07	4.0	4.0	4.13	4.0	4.15	3.27
54	4.0	.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
55	.0	.0	.0	4.0	.0	4.0	.0	4.0	.0
56	4.0	4.0	4.0	4.0	4.0	4.0	3.0	4.0	2.0
57	1.0	1.0	1.0	.0	1.0	4.0	4.0	4.0	1.0
58	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
59	.0	.0	.0	1.0	.0	.0	.0	.0	.0

APPENDIX F (Continued)

QUALITY PATIENT CARE SURVEY OSTEOPATHIC-ALLOPATHIC QUALPACS ITEM MEANS

Qualpac Item Number	Patient Identification Number: Osteopathic Facility 1.0	2.0	3.0	4.0	5.0	Allopathic Facility 1A	2A	3A	4A
60	4.0	4.0	.0	3.0	3.0	.0	4.0	4.0	4.0
61	.0	4.0	.0	.0	.0	.0	.0	.0	.0
Area Mean V	3.4	3.4	3.25	3.3	3.2	4.0	3.8	4.0	3.0
62	4.0	4.0	4.0	4.0	4.0	4.0	4.0	3.0	3.0
63	4.0	.0	4.0	4.0	4.0	2.0	.0	2.0	.0
64	4.0	4.0	3.0	4.0	1.0	4.0	4.0	4.0	2.0
65	4.0	4.0	2.66	4.0	4.0	4.0	4.0	4.0	3.5
66	4.0	4.0	.0	.0	4.0	3.0	4.0	4.0	4.0
67	4.0	4.0	.0	.0	.0	4.0	4.0	3.0	.0
68	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Area Mean VI	4.0	4.0	3.53	4.0	3.5	3.57	4.0	3.42	3.3
Grand Mean	3.56	3.79	3.99	3.93	3.86	3.82	3.91	3.92	3.44

APPENDIX G

COMPOSITE MEANS OF ITEM MEANS

APPENDIX G

QUALITY PATIENT CARE SURVEY

COMPOSITE MEAN OF ITEM MEANS

Qualpac Item Number	Osteopathic Facility	Allopathic Facility	All Observations
1	3.9	3.9	3.9
2	3.9	3.9	3.9
3	3.9	3.9	3.9
4	4.0	4.0	4.0
5	4.0	4.0	4.0
6	4.0	4.0	4.0
7	4.0	4.0	4.0
8	3.9	4.0	3.95
9	.0	.0	.0
10	4.0	4.0	4.0
11	4.0	4.0	4.0
12	4.0	4.0	4.0
13	3.8	4.0	3.9
14	4.0	4.0	4.0
15	4.0	.0	4.0
16	3.7	4.0	3.8
17	.0	4.0	4.0
18	.0	4.0	4.0
19	.0	4.0	4.0
20	4.0	4.0	4.0
21	.0	.0	.0
22	.0	4.0	4.0
23	.0	4.0	4.0

APPENDIX G (Continued)

QUALITY PATIENT CARE SURVEY

COMPOSITE MEANS OF ITEM MEANS

Qualpac Item Number	Osteopathic Facility	Allopathic Facility	All Observations
24	4.0	3.6	3.8
25	4.0	4.0	4.0
26	4.0	4.0	4.0
27	4.0	2.3	3.15
28	4.0	2.6	3.3
29	4.0	4.0	4.0
30	4.0	3.0	3.5
31	4.0	3.6	3.8
32	.0	.0	.0
33	1.0	.0	1.0
34	1.8	2.1	1.9
35	1.0	1.0	1.0
36	4.0	4.0	4.0
37	4.0	4.0	4.0
38	2.4	4.0	3.2
39	5.0	4.0	4.5
40	4.0	4.0	4.0
41	3.6	3.6	3.6
42	4.0	4.0	4.0
43	3.6	5.0	4.3
44	4.0	4.67	4.3
45	4.0	4.0	4.0
46	4.0	4.0	4.0

APPENDIX G (Continued)

QUALITY PATIENT CARE SURVEY

COMPOSITE MEAN OF ITEM MEANS

Qualpac Item Number	Osteopathic Facility	Allopathic Facility	All Observations
47	4.0	3.7	3.8
48	4.0	4.0	4.0
49	4.0	4.0	4.0
50	3.7	3.0	3.3
51	4.0	3.7	3.8
52	4.0	4.0	4.0
53	.0	4.0	4.0
54	4.0	4.0	4.0
55	4.0	4.0	4.0
56	3.8	3.0	3.4
57	1.0	3.0	2.0
58	3.8	4.0	3.9
59	1.0	.0	1.0
60	3.5	4.0	3.7
61	4.0	.0	4.0
62	4.0	3.5	3.7
63	4.0	2.0	3.0
64	3.2	3.5	3.3
65	3.7	3.8	3.7
66	4.0	3.7	3.8
67	4.0	3.6	3.8
68	4.0	4.0	4.0

APPENDIX H

INFORMED CONSENT

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER

AGREEMENT FOR INFORMED CONSENT

I, _____, herewith
(First name) (Middle name) (Last name)

consent to serve as a subject in the investigation called "A Quality of Patient Care Study in Eastmoreland General Hospital" by Gail Bond, R.N., B.S., graduate student, under the supervision of Marie Berger, R.N., M.S., faculty advisor.

I understand that I may be asked to cooperate with Ms. Bond and/or another rater as they observe care given to patients on my unit. I understand that the Quality Patient Care Scale will be used to evaluate care as it is in progress. I understand that the raters will function as observers only and will in no way interfere with care to patients.

I understand that names will not be recorded and that other data will be coded to preserve my anonymity. My name will not appear in any report of the study. The results of the study will reflect an aggregate of scores and the units under study will not be named in the report.

I understand that I have the right to refuse to participate in this study without jeopardizing my care.

I may benefit from this study by using the identification of nursing care strnegths and weaknesses to improve future care practices.

Gail Bond has offered to answer any questions that I might ask about this study and my participation in it. I understand that I am free to refuse to take part in the study at any time without effect to my relationships or to my employment.

"It is not the policy of the Department of Health, Education and Welfare, or any other agency funding the research project in which 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)

CONSENT FORM FOR HUMAN RESEARCH

I, _____
(First Name) (Middle Initial) (Last Name)

herewith agree to serve as a subject in the investigation named "Quality of Care in Willametter Falls Hospital", by Gail Bond, R.N., B.S.N. under the supervision of Marie Berger, R.N., M.S.

The investigation explores elements of nursing care delivered to patients. My participation in the study requires that I allow a nurse observer to remain at my bedside to observe my care for a two-hour period and to study my chart. I may benefit by participating as evaluation of care may lead to identification of areas needing improvement.

I understand that participation in this study will involve no risk for me; however, it will reduce the privacy of my interactions with the nursing staff for the observation period. The information obtained will be kept confidential. My name will not appear on any project records and anonymity will be maintained by the use of code numbers. I understand that I have the right to refuse to participate in this study and that the results of observations will remain anonymous.

This study has been discussed with me and I have an opportunity to ask questions.

"It is not the policy of the Department of Health, Education and Welfare, or any other agency funding the research project in which 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) (Participant's Signature)

_____
(Witness' Signature)

AN ABSTRACT OF THE THESIS OF

Gail Bond

For the MASTER OF NURSING

Date of Receiving this degree:

Title: A COMPARATIVE STUDY OF THE QUALITY OF NURSING CARE IN OST[redacted]IC HEALTH CARE FACILITY

Approved: _____

Marie Berger R.N., M.S., Thesis Advisor

The purpose of this study was to evaluate the quality of nursing care given in a community hospital accredited by the Joint Commission on Accreditation of Hospitals and a community hospital accredited by the American Osteopathic Association.

To determine the quality of care in both facilities, the Quality Patient Care Scale (Qualpacs) was used. Qualpacs is an instrument designed to evaluate the quality of nursing care received by patients, while care is in progress.

A total of nine patients were observed for the study. Five were observed in the Osteopathic facility and four in the Allopathic facility. Both direct and indirect observations were utilized in order to investigate the levels of nursing care being delivered at each hospital.

The information provided by the Qualpacs allowed the investigator to determine actual levels of quality care in two differently accredited health care facilities.

It was determined that the outcome of this evaluation would represent whether the accrediting agency in each studied health care facility does/does not affect the levels of care.