THE RELATIONSHIP BETWEEN QUALITY OF CARE AND NURSING HOME ADMINISTRATORS' ATTITUDES TOWARD COMMUNITY INVOLVEMENT

by

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C.N.C.

CHAPTER I

INTRODUCTION

There are formal and informal means of assuring high quality nursing care in nursing homes. No matter how thorough formal government mechanisms are, they prove inadequate to both evaluate and upgrade the quality of care. The informal mechanism of community involvement, on the other hand, is underutilized and could be of assistance in improving the quality of care. Whereas state nursing home inspectors may be hampered by a lack of enforcement powers (Kane, Jorgensen, Teteberg, & Kuwahara, 1976; Kart & Manard, 1976), friends and relatives of nursing home patients may be increasing their influence upon quality of care with each visit they make to the facility (Gottesman, 1974). Other authors (Barney, 1974; Kosberg, 1974; Glaser & Strauss, 1968) concur with Gottesman's findings that nursing home care is better in homes where visits from community members are frequent.

Anderson (1977) points out that a residential institution has a responsibility to the community. She indicates that the staff of a psychiatric hospital (one type of residential institution) is likely to create an environment which is hostile to a prime segment of the

community: the patient's family. On the contrary, she proposes that "family members should be made to feel welcome and relevant" (p. 699). Staff should involve the family in planning a patient's care, and hospital personnel should also attempt to meet emotional needs of the family.

The nursing home administrator is responsible for incorporating community involvement in the total patient care program. Kahl (1976) explains that the nursing home administrator sets the tone of the institution. He or she should therefore set an example for the staff by establishing warm ties with the community. Doing this involves a major commitment of time.

> Most of the administrator's time is spent on policy-making, program evaluation, budget planning, compliance with government regulations, and community relations. . . . Administrators personally interview families of prospective patients, . . .[and] spend a great deal of time in meetings. These include sessions with board members or trustees, speeches before civic groups, and meetings with community health and welfare agencies. (Kahl, p. 35).

Edward Brody (1977) the president of the American College of Nursing Home Administrators (ACNHA) in 1975, speaking on behalf of the association states,

> I believe that it is the administrator who sets the tone for the kind of service a facility delivers. I believe that the adequately educated and trained administrator will be in a position to do this effectively (p. 9).

The ACNHA advocates upgrading educational standards for administrators as a better means of improving quality of care than attempting to improve care by increasing

government regulation and enforcement efforts (Brody,1977). A nation-wide survey indicates that 45% of the nursing home administrators responding were college graduates, less than 37% had no more than a high school education, 12% had nursing diplomas and 7% had licensed practical nursing certificates (Burmeister,1977). Brody however, contends that even if an administrator is well educated he or she may be obstructed in attempts to provide quality care by an owner who is unwilling to allow adequate funding for care.

In the interest of improving quality of care in nursing homes it would be useful to study the relationship between nursing home administrators' attitudes toward community involvement and quality of care in their respective facilities. It should be remembered, however, that the administrator is responsible for implementing "policies established by the owner or board of trustees" (Kahl, p. 35), and that these policies may override the administrator's attitudes.

Review of the Literature

Theory Base for Quality Assurance Programs

Any system of assuring high quality nursing care whether it be formal or informal should be built upon an understanding of the patients' needs and potentials. A quality assurance program for nursing homes should be aligned with a theory of aging since most patients in these facilities are elderly. Theories of aging suggest descriptions, predictions and controls of problems and needs unique to geriatric patients. Some theories shed light upon potential for human development after old age is reached.

Theories of Aging

Behaviorists have proposed various theories upon which a nursing home quality assurance program could be based. One example is the often cited Disengagement Theory of Aging (Cumming & Henry, 1961). It proposes that growing old is accompanied by a universal expectation of death, the likelihood of decreased abilities, and psycholgical detachment from living. This theory may lead to the accentuation of patient weaknesses and decreased desire for social interaction and thus provide an excuse for the failure to provide activities for residents.

On the other hand, aging can be viewed as a

stage during which a person can achieve more positive changes in attitudes and behaviors (Edinberg, 1975). A quality assurance program grounded in such a developmental theory would be able to measure improvements as well as decrements in patient conditions.

The Activity Theory of Aging (Lemon, Bengston, & Peterson, 1972) which assumes that old age is a developmental period of life would make an excellent foundation for a nursing home quality assurance program.

> This theory suggests a positive relationship between social activity and life satisfaction in old age and further specifies that salient role loss is inversely related to life satisfaction (Lemon, et. al., 1972, p. 521).

The theory stresses the importance of maintaining one's self-concept and role-identity by being active. Lemon and his associates (1972) demonstrated by secondary analysis of data from a study done on 411 residents of a retirement village that informal activity with friends, relatives, and neighbors has a positive correlation with one's contentment with his or her general life situation. Further research on this theory (Conners, Powers, & Bultena, 1979) indicates that frequency of interactions with friends and relatives has a small positive correlation with life satisfaction and that there possibly exists a greater correlation between the intimacy or quality of interactions and life satisfaction.

Summarizing and interrelating these introductory remarks, the following conclusions can be reached. Quality assurance programs for nursing homes should assess the extent to which facilities meet patient needs and foster the development of patient potentials. The best way to accomplish this is to use a developmental theory such as the Activity Theory of Aging as a basis for the design of such quality assurance programs. Developmental theories point up the necessity of friendly social interaction for the maintenance or improvement of one's self-concept and life satisfaction. The administrator is responsible for setting the tone of the nursing homes and setting an example of being receptive to participation of community members in the overall program. Finally, community involvement in nursing homes can serve two functions. First, as mentioned earlier, community involvement in nursing homes can act as an adjunct to formal government efforts to assure quality of care. Second, the presence of friends and relatives from the community in the nursing home make possible the informal interaction that patients need for personal development.

The Need for Evaluations of Quality of Care in Nursing Homes

Books and the media repeatedly report cases of institutional mistreatment of the elderly. Nursing home operators have understaffed their facilities and posed licensed practical nurses as registered nurses to fool state inspectors. Disrespect has been shown for the unique characteristics of individual patients. Medical needs have been treated inappropriately. Patient safety needs have been disregarded as, for example, by failure to connect fire sprinkler systems to a water supply (Mendelson, 1974).

Not all nursing homes are guilty of gross negligence and abuse. There are some indications that quality of care in this state's (Oregon) nursing homes is quite good (Hoyt, 1979). In The Goldblatt Study (Goldblatt, 1977) all 50 nursing homes in Multnomah County, Oregon were reviewed by a team of surveyors. The report of the study indicates that "approximately one-third of the 50 homes demonstrated reasonably high to excellent levels of overall performance. The lower one-third of homes were considered to range from poor to adequate in their operations" (p. i). With regard to basic nursing care 58% of the homes occasionally neglected a few residents while providing fair to good care to the rest, and one home (2%) failed to maintain an acceptable standard of care (Goldblatt, p.43).

Even the best of nursing homes, however, subject patients to adverse conditions of institutionalization. Some factors of institutional life are: most activities occurring in one setting, lack of time to be alone, decreased responsibility for one's own affairs, and management of personal needs in a regimented fashion. These factors may reduce a patient's hope for the future, sense of self-worth, and potential for improving his or her ability to make wise judgments (Ainsworth, 1977; Tobin & Lieberman, 1976). Mendelson (1974) expresses grave concern over what she considers the most serious deprivation which institutionalized older people suffer: "the lack of active public concern" (p. xiii).

Quality of Care

It is generally accepted that quality of care in nursing homes is less than optimal; nevertheless, there is little agreement on the definition of "quality" (Kosberg, 1974). McLachlan (1976) cites four approaches to measuring quality of care each of which implies a different meaning to the term "quality". First, "structure" criteria such as characteristics of the physical plant or training of the staff may be measured. Second, one may evaluate the "process" or standards of care practiced in the facility. Third, a measure of "outcome" criteria may be made to determine the effects which therapies have on

patients. Last, "social acceptability" or patient satisfaction may be rated as an indicator of quality of care.

Researchers have shown the greatest interest in outcome measures of quality (Linn, Gurel & Linn, 1977; Anderson, 1974; Gottesman & Boureston, 1974; Linn, 1974; Levey, Ruchlin, Stotsky, Kinloch & Oppenheim, 1973). For example, Kahn, Hines, Woodson & Burkham-Armstrong (1977), noted changes in functional abilities of long term care facility residents. This was done by measuring their gains and losses in mobility, sensory abilities, behavioral patterns, and abilities to perform "Activities of Daily Living" at two different points in time.

Although Davis (1977) supports the use of outcome measures in nursing home quality assurance programs she asserts that criteria should be specific to the individuals of the institution. She claims that criteria standardized for the nation cannot do an adequate job of measuring the extent to which patients are improving in the local facility. She also warns that measurement of quality of care by outcome criteria may be anxiety producing and frustrating to the staff. Some research has focused on predictors of quality care in nursing homes. One study of 1,000 male nursing home patients indicated a significant positive correlation between outcome measures of quality of care and cost of care (Linn, et. al., 1977). This positive

correlation was also found in a study which used process criteria to measure quality (Gottesman, 1974) and in a study which used compliance with state regulations as a measure of quality (Levey et. al., 1973).

The predictive value of some structural factors have been demonstrated. Positive correlations have been found between quality of care and registered nurse hours per patient, quality of food service (Linn, et. al., 1977), and occupancy rates (Winn & Mc Caffree, 1976). High quality care can be anticipated in smaller (less than 100 beds), owner-operated facilities according to a study done by the Los Angeles County Health Department ("Quality Care Profitability "Correlate'", 1977). There is, however, no consensus on the predictive values of other structural criteria. For example, in their review of the literature Kart and Manard (1976) indicate that some researchers have found significant correlations between types of ownership and quality while others have not.

Formal Mechanisms for Controlling Quality of Care

Many types of quality assurance programs for nursing homes have been designed and implemented despite continued debates over the definition of "quality", the best way to measure quality, and predictors of quality. The

predominant formal mechanism for regulating the quality of nursing home care is the state inspection and licensure process. Government inspections of nursing homes are comprehensive in that they evaluate a wide variety of factors (e.g., design and safety of physical facility, patient care policies, patient records, patient appearance, and the services provided by the different departments within the organization) (Levy et al., 1973). The federal government tries to improve the quality of nursing home care by funding the cost of state nursing home inspections, providing financial assistance for the training of inspectors, and by promoting ombudsman programs (Callender, 1973).

There are, however, problems with government quality assurance programs. A frequently cited shortcoming of the state inspection process is that the many regulations are not adequately enforced. This may be due to insufficient enforcement powers being granted to regulatory agencies (Kane et al., 1976; Kart & Manard, 1976), inadequate numbers of inspectors (Bellin & Navaler, 1971), the unwillingness of government to protect the rights of patients (Mendelson, 1974) and/or the fact that if a nursing home is refused relicensure there may be no other place in the community to which the patients can be moved (Kane et al., 1976).

Professional Standards Review Organizations (PSRO's) which are supported to a large extent by government funds are still in developmental stages but their impact is increasing upon nursing home quality of care ("PSRO Role Still Limited", 1979; Kahn et al., 1977; Newmark, 1976). This system of peer review has scored considerable success in identifying trends of negative patient outcomes and then helping nursing homes to determine and eliminate the causes (Jessee, Ford & Pebbutt, 1976). Efforts of PSRO's to assure quality of care in nursing homes were only begun in 1972 and are not uniformly implemented throughout the nation (Goran, Crystal, Ford & Tebbutt, 1976).

The Joint Commission on Accreditation of Hospitals (J.C.A.H.) is a leader in quality assurance in hospitals but only minimally involved with nursing homes (Frank, 1972). For example, in the Greater Portland Area there is only one nursing home which has J.C.A.H. accreditation (Davenport, 1979).

An Informal Mechanism of Assuring High Quality Care: Community Involvement

In contrast to the above mentioned structured mechanisms for assuring quality care in nursing homes there are three informal means of maintaining or upgrading quality of care (Barney, 1974). The first is the business

incentive of providing a better product or service than competitors in order to increase market demand. The second informal approach is "professionalism" which implies that professionals employed by the institution will insist upon high standards of care. The last is community involvement.

Moos (1976), a pioneer in the field of milieu therapy, states that a person's moods, attitudes, behavior, health and sense of well-being are strongly influenced by the social environment in which he or she is situated. In turn, social environments try to alter the members of the environment.

> One can cogently argue that every institution in our society attempts to set up social environments to maximize certain directions of personal growth and development. Families, social groups, business organizations, secondary schools, colleges and universities, military companies, psychiatric treatment programs, correctional institutions, and communes all arrange social environmental conditions they hope will maximize "desirable" behaviors (and presumably minimize "undesirable" ones) (Moos, 1976, p. 320).

Social environments can be assessed along three sets of dimensions: (1) relationship dimensions, (2) personal development dimensions, and (3) system maintenance and system change dimensions. Relationship dimension of an environment include such characteristics as cohesion, involvement in group activities, emotional support between group members, commitment to group goals and the

expressiveness of group members. Personal development dimensions focus on the individual: how he or she changes over time and the directions which those changes take. Operations within the environment nurture personal growth. Emphasis placed on independence or intellectuality lead to changes in a person. The goals or philosophy of the environment have a great impact on the nature of change which the person undergoes. The system maintenance and system change dimensions relate to characteristics of the environment such as degree of order and organization, acceptance of innovation, the control mechanisms and the clarity of communication (Moos, 1976).

The dimension of social environment which relates most closely to the concept of community involvement is the relationship dimension which Moos (1976) refers to as "support." A supportive social environment emphasizes love, cohesiveness, "overriding concern of the inhabitants for their neighbors, mutual support, understanding, and unfailing sustenance in time of trouble" (Moos, 1976, p. 348). Interestingly, Moos demonstrates by citing various studies that the dimension of support is essential for the physical health and psycho-social well-being of individuals. For example, with a decrease in one's support dimension a person may

be more likely to develop heart disease and die at an earlier age. Moos claims that the nature of a work organization environment or a service organization environment (such as a nursing home) influences worker attitudes, productivity and efficiency. Also, in health care institutions, certain changes in the work environment have resulted in benefits to the clients being served. Moos states that all organizations are influenced by the external environments. "The organization, the people who comprise it, and the climate in which the personnel function are also affected by such external circumstances as economic, social, and political conditions" (Moos, 1976, p. 257). This statement lends support to this researcher's assumption that the quality of nursing home personnel services is affected by community involvement in a nursing home.

The importance of community involvement in the treatment of psychiatric patients is well established and may be thought of as a model for soliciting community involvement in nursing homes. C.M. Anderson (1977) emphasizes the need to treat both the psychiatric patient and the patient's family. It is pointed out that it is a family crisis when one member is institutionalized. Both family and patient should cooperate in negotiating the patient's treatment contract. Schaefer (1977)

identifies the need of emotionally disturbed children in residential treatment centers for parents who can help a child feel wanted and valued. He says that if the biological parents cannot fill this role that surrogate parents should be sought for the child. A study by Trop and Gold (1977) brought outpatients into direct contact with psychiatric inpatients. One positive benefit was improved communication between staff and distrustful patients. In another study (Gold, Davenport, Wehr & Goodwin, 1979) "normal" volunteers were admitted to a psychiatric unit for three months. The project helped patients deal with the stress of returning to life in the community.

> By admitting volunteers, we in effect brought the community to the hospital, which gave the patients an opportunity to deal with the difficulties involved in reintegration without having to deal with the complex issue of separation [from the institution] at the same time (p. 405).

A negative effect of the experiment was increased depression and a sense of failure when the patients compared themselves to the normal volunteers.

Gerontological literature points to the family as a "social support system in old age" (Shanas, 1979, p. 169), and as a care giving unit which can "provide substantial physical, emotional, social and economic support to. . . chronically ill elderly relatives" (Brody, Poulshock, Massiocchi, 1978, p. 557). The

family or guardian, and other "significant" persons may be involved in planning a nursing home patient's care (Snyder, Rupprecht, Ryrek, Brekhus & Moss, 1978, p. 279). Regarding an older person's need for interaction with family and friends Shanas (1979) says:

> It is not necessary for old people to have many visitors. What is important is that they have regular and concerned visitors (p. 197).

Nursing homes which incorporate people from the community in their overall programs are less inclined to allow mistreatment or abuse of patients (Kosberg, 1974). The involvement of community members may have a subtle but startling influence upon quality of care. Government regulatory controls cannot assess the nature of staff-patient relationships, neither are they able to design new and innovative approaches to providing care for the elderly since the energies of state inspectors are consumed in checking facilities for minimum standards of care. Conversely, members of the general public can assess and favorably influence subjectively discerned components of care like the levels of support and respect given patients by staff. In addition, friends and relatives of patients can offer creative ideas to nursing home management if they participate on nursing home advisory councils. The mere presence of community people in the nursing home can enhance staff morale and thus

improve the quality of the staff's work. The resultant higher quality of care is not just a show for the outsiders entering the building, but it is a natural response that any worker exhibits when another person takes interest in and appreciates his or her work (Barney, 1974).

Perhaps the most effective way for community members to influence quality of care is to pay friendly visits to individual nursing home patients. Gottesman and Bourestom (1974) studied the care provided to 1,144 residents of nursing homes. They found that patients who had had a visitor within the month prior to testing received more basic care, more nursing care, and engaged in more psychosocial activity. They assert that a patient's friend may be a stronger patient advocate than a state inspector. Administrators may prefer dealing with members of the general public than with state surveyors. In support of this assumption, administrators have rated civic groups, church groups, family and friends all as being more cooperative than representatives of the state licensing division (Goldblatt, 1977).

Community involvement in nursing homes can take many forms in addition to friendly visits. People living outside of a nursing home can volunteer time to write letters for patients whose hands are crippled with arthritis. They can teach classes, drive patients to church, repair clothing or bring merchandise to the

nursing home for patients to buy (Subcommittee on Long-Term Care of the Special Committee on Aging: United States Senate). Consumers of nursing home services or other concerned members of the general public can join "family and friends" councils established by the nursing home administration (Crandall, 1978, p. 30). They can monitor the activities of government regulatory agencies as by reading the reports of state nursing home evaluations and attending and voicing opinions at meetings of state boards (i.e., the boards of nursing, medicine, pharmacy, physical therapy, and nursing home administrators). Other possibilities include lobbying for more state staff to inspect nursing homes, and participating in consumer advocacy groups like the Gray Panthers (Crandall, 1978). Members of the community can also become involved in state nursing home ombudsman programs (Barney, 1974). Families of patients and patients can also register complaints of poor quality care with appropriate state agencies (Simler, 1977). In the same sense, the media can have a strong effect on quality of care not only by reporting poor quality care, but also by spotlighting homes that provide good care.

Deterrents to Community Involvement

Community involvement reportedly has a positive effect upon quality of care, but it is not a panacea for all the

ills of institutionalized care or every inconsiderate action of staff and administration. Nursing home operators can brush off a family's complaints of poor quality care by suggesting that the family take the elderly relative to another nursing home. This can be a threatening situation if all the nursing homes in the area provide substandard care (Mendelson, 1974).

The American socio-economic system presents some deep-rooted impediments to community involvement. Nursing home patients who are dependent upon public support are less likely to have families than private pay patients. These residents, therefore, have two limits to their power: (1) economic dependency, and (2) lack of family members to serve as patient advocates (Gottesman & Bourestom, 1974). A Canadian physician comments that North American Society highly values those who work, amass wealth, and achieve status. Old people who can no longer compete in these realms are left with nothing to do. Ultimately, elderly people can lose their abilities to care for themselves and are placed in institutions rather than being cared for at home by the family. Family ties and obligations are relatively weak compared with those of older societies (Wallace, 1973). After retirement, "one ceases to advance on his job, to be sought after for advice, to be reacted to as if sexually attractive, to be considered worthy of sharing

news with" (Lawton, 1974, p. 257). It is no wonder, therefore, that Gottesman and Bourestom (1974) when reporting their research findings speak of a paucity of visitors in some nursing homes.

Statement of the Problem

What is the relationship between nursing home administrators' attitudes toward community involvement and quality of care in their respective facilities?

Hypothesis

The more favorable an administrator's attitudes are toward community involvement in nursing homes, the better will be the quality of care in his or her nursing home.

CHAPTER II

METHODS

UNIVERSE AND SETTING

For the purposes of this study a universe of 32 nursing homes was selected. Inclusion in the universe was dependent on compliance with all 5 of the criteria listed below.

(1) The nursing home is located in Clackamas, Multnomah or Washington County in the State of Oregon.

(2) The nursing home is classified by the Oregon State Health Division Licensing and Certification Section as an intermediate care facility with beds certified for Medicaid (Title XIX).

(3) The nursing home was evaluated by an Oregon Adult and Family Services (AFS) Resident Services Review (RSR) Team at some time between the dates July 1, 1978 and July 30, 1979.

(4) The current nursing home administrator is the same one as at the time of the RSR Team evaluation.

(5) The nursing home does not have any beds classified by the Oregon State Health Division Licensing and Certification Section as being skilled nursing care beds.

The first criterion was established to focus on facilities in a predominantly urban area. This is because most nursing homes are located in small to large cities rather than in rural towns (i.e., 74% of Oregon's nursing homes are in cities with populations of 10,000 or greater. Another reason for choosing the urban focus was to broaden the researcher's knowledge of nursing home care in cities since he would like to become the administrator of an urban nursing home.

Convenience was also a reason for choosing this geographic region. The researcher lives in the Portland Metropolitan area and wished to personally administer his questionnaire so as to obtain a higher response rate than is common for mail questionnaires.

In reference to the urban nature of the area chosen, the Greater Metropolitan Portland area extends from Multnomah into Clackamas and Washington Counties. Population density figures derived from data in the Oregon Blue Book 1979-1980 (Lindly, 1979) may be compared as follows:

(1) Clackamas County, 116.2 people per square mile;

(2) Multnomah County, 1201.3 people per square mile; and

(3) Washington County, 300.3 people per square mile.

These population density figures reflect the basically urban nature of the tri-county area as compared to the state's overall population density of 25.5 people per square mile. All of the nursing homes in the study's universe are located in the City of Portland, in a suburb of Portland or in a nearby town.

Criteria #2, 3 and 4 were adopted in order to use Oregon ICF quality of care data collected by the RSR Teams during the period July 1, 1978 through June 30, 1979. Criterion #5 eliminated facilities with skilled nursing care beds because such facilities are required by state rules and regulations to staff for more hours of professional nursing personnel services per patient. Staffing for more registered nurse and licensed practical nurse hours may have a significant impact on the quality of care in the facility.

The group of 32 nursing homes that met the established criteria represents 51% of the ICF's in the tri-county area of Clackamas, Multnomah and Washington Counties.

DATA COLLECTION

For the purposes of this study two major sources of data were used. The first set of data was collected by the State of Oregon Residential Services Review Teams in the period July 1, 1978 through June 30, 1979. These data reflect the quality of care within each facility. The second set of data provide information about each nursing home administrator's attitudes toward community involvement in nursing homes. Letters of introduction (see appendix C) were sent to the administrators of the 32 homes. Follow-up phone calls were made in order to obtain appointments for one of the three following data collection days: April 24; April 25 or April 28, 1980. The researcher or one of two assistants administered the "Community Involvement in Nursing Homes" questionnaire to the 25 of the 32 administrators who agreed to participate.

Measurement of Nursing Home Quality of Care

Quality of Care deficiency data collected by Residential Services Review (RSR) Teams of the Oregon Adult and Family Services Division were used as the source of quality of care data. To comply with federal Medicaid rules and regulations the RSR Teams were formed and each was composed of two registered nurses and one social worker. During the period July 1, 1978 through

June 30, 1979 the RSR Teams assessed every Medicaid approved intermediate care facility (ICF) in Oregon with regard to quality of care.

The RSR Team in each facility evaluated the quality of care received by each Medicaid resident. The evaluation instrument itemizes 38 aspects of care for assessment. (See appendix A for a copy of the instrument.) The RSR Team instrument provided the teams with a means of assessing the quality of care being given in four areas: medical, nursing, social services and activities. The registered nurse members of each team focused on assessing the aspects of care related to medical care, nursing care, and supportive services (25 of the 38 aspects or items). The social worker assessed the remainder of the items relating to social services and activities plans.

For the purposes of this study 30 of the items were used for quality of care measurement (#1-15, 17-28). These are the items for which ICF quality of care deficiency data were collected on a resident-by-resident basis. Item #16 was omitted for another reason. No deficiencies were marked in this item for any of the homes. It appears that the surveyors may have simply chosen not to do any evaluations against criterion #16. For each Medicaid resident a deficiency in quality of care in any of these 30 aspects was recorded by marking an "X" in the appropriate box of a row (for specific criterion) and column (for

specific resident). Likewise, the absence of an "X" mark indicates that the RSR Team considered the quality of care in that instance to be adequate. Standards for measuring quality were established and are printed in the instrument.

In consultation with two other registered nurses the 30 items used in this study were placed into categories and subcategories. The two categories are: (1) observed care, and (2) documented care. Observed care items are those which the RSR Teams could evaluate by direct observation or in one case (item #32) by speaking with the resident. Documented care items are those which were evaluated by checking written records of care.

For scoring purposes, a weighting process was devised in consultation with two other registered nurses to reflect the unequal importance of the various items. Items falling within the "observed care" category were given greater weight in the quality of care analysis than "documented care" items because the outcomes of the care were actually observed by the RSR Team. Categories and subcategories are listed below along with brief descriptions of subcategories and their relative weights in the scoring system.

Category 1 - Documented Care

1.1 Physician Services - Items #5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15.

(10%) Adequate transfer data signed and dated. Adequate history/medical summary, physical exam signed and dated. Adequate diagnosis updated and signed. Visits and progress notes made in required frequency, signed and dated. Medicine and treatment orders made specific in writing, signed and dated. Nurse-signed verbal orders countersigned by physician. Diet ordered by physician.

1.2 Documented medication, treatment and diet management - Items #17, 18, 22, 23, 24.

(10%) Medications recorded as ordered, given only with physician's order, signed, dated, and reviewed monthly by nurse. Lab and X-ray completed as ordered and entered in patient record. Tuberculosis control measures taken. Treatments recorded as ordered, given only with the physician's order, results documented and signed by nurse. Diet provided as ordered by the physician.

1.3 Resident care plans and personal funds management - Items #1, 2, 3, 4, 20, 31.

(10%) Adequate and updated nursing care plan and signed and dated nursing notes. Adequate and updated plans for rehabilitation, social services and activities programming. Personal funds appropriately managed.

1.4 New developments/special incidents, restraints and residents' rights - Items #19, 21, 33.

(10%) Documentation of action and follow up of new developments or special incidents. Restraints used only with physician's order and their release every two hours documented. Resident's rights statement signed.

Category 2 - Observed Care

2.1 Personal care management - Item #25 . . . o, q, u, v.
(15%) Hygienic care of body, personal clothing, scalp, eyes, ears, skin, fingernails, toenails, feet, odor, beard, decubiti, intubated orifices/tubing, edema, nutrition, hydration, behavior.

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

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

2.4 Supportive services - Items #26 a, b, c, d, e, h; 32.
(15%) Need for or repair of visual exam/glasses, dental exam/ dentures, audiogram/hearing aid, physical therapy, podiatry care and/or prosthetics and provisions for psychosocial needs.

Using the RSR evaluation form, the number of deficiencies in each row (which, on the form, represents one specific quality of care criterion) were totaled. This sum was divided by the number of residents evaluated. The quotient was then expressed as a percentage score. A mean score was calculated for all the rows within a given subcategory (i.e., physician services; documented medication, treatment and diet management; etc.). The mean subcategory scores for each category were averaged to give a mean score for each of the two categories.

According to the weighting system (40% documented care, 60% observed care) a mean score was calculated for the entire quality scale for the facility. The potential range of percentage scores was 0% to 100% with 0% indicating the highest quality of care and 100% indicating the lowest quality of care. (See appendix B for a sample computation using hypothetical data.)

Measurement of Administrators' Attitudes Toward Community Involvement

For this study, administrators' attitudes toward community involvement in nursing homes were measured by means of the "Community Involvement in Nursing Homes" (CINH) questionnaire which was constructed by this researcher. (See appendix D for a copy of this instrument.) The items of the questionnaire are based upon information found in the literature. In addition, this researcher conducted an open-ended interview with six nursing home administrators and assistant administrators in the Seattle, Washington area. Their responses to questions about quality of care and community involvement gave direction to the construction of this instrument. Its development was also aided by the comments of other persons knowledgeable in the fields of gerontology, nursing and survey research.

The various items are designed to give indications of an administrator's attitudes toward input in nursing home activities and individual resident's activities by different classes of community members. The items of the questionnaire can be divided into three groups. The first group explores the administrator's attitude toward the effect of visitors and volunteers on residents, staff and nursing home finances (items #1, 2, 3 and 4). The second group is designed to give an indication of the administrator's attitude toward understanding of nursing home operations by families and friends of residents and of their capabilities of participating in the management of the facility (items #5, 6, 7 and 8). The last group deals with the administrator's valuation of maintaining relations with the community as a whole (items #9, 10 and 11).

The instrument consists of 11 items, each of which can be answered along a Likert-type scale. Five boxes are provided in a row between a negative response and a positive response to the question. Printed instructions on the questionnaire indicate that the subject is to place an "X" in the box which most closely approximates his or her opinion. Answers on the positive side of the scale (i.e., strong effect, positive effect, great importance, much interest, great value to nursing home/residents) were equated with a positive attitude toward community involvement. To deter social desirability acquiescence the

positive pole of the answer scale is sometimes on the left, and sometimes on the right side. For items #2, 3, 6, 7, 9 and 10 the positive answer is on the left side.

For each item the response boxes are rated from 1 to 5 points from negative response pole to positive response pole, and individual responses were scored accordingly. Any item left blank was assigned the value of the respondent's mean score on items completed. An administrator's scores for all items were totaled. The highest possible score on the instrument is 55. A score of 55 would indicate the most favorable possible attitude toward community involvement in nursing homes. The lowest possible score (indicating the most unfavorable attitude toward community involvement) is 11.

Demographic Data

Non-profit/for-profit business organization and an administrator's level of education may influence both the quality of care and the administrator's attitude toward community involvement. Therefore, as a control, state records were examined to determine which of the 25 nursing homes involved in the study are non-profit and which are for-profit businesses. Also to control for education, administrators were asked on the questionnaire if they are high school graduates. If the answer was negative, the number of high school level years of education was

asked; and if affirmative, the number of equivalent years of college level education was asked.

Reliability and validity of the Community Involvement in Nursing Home Questionnaire

A pretest was conducted on the original pool of 20 items in the CINH questionnaire. The instrument was administered to a convenience sample of 40 registered nurses. To determine item discrimination, a t-test was run on the responses to each of the 20 items. Those items with a t-value of less than 1.76 (0.05 level of significance) were dropped from the instrument. Using an odd-even split-half technique on the responses to the 11 remaining items a Pearsonian correlation of 0.57 was obtained. The split-half technique gives an indication of the instrument's internal consistency which is one attribute of reliability. A Pearsonian correlation of 0.70 is the generally acknowledged acceptable level for instrument reliability. Using the Spearman-Brown prophecy formula to take into account the instrument's limited number of items, the correlation increased from 0.57 to 0.73 which is slightly higher than the 0.70 acceptable level. No other instrument is available to be used to check for equivalence of measurement, another attribute of reliability.

The instrument's claim to validity is based on the concept of content validity. It samples the content area of "community involvement" discussed in the literature and by persons knowledgeable in the field. "Community involvement" is viewed primarily as persons entering a nursing home facility to be in direct contact with residents or spending time or money to benefit the facility's overall program. Excluded from the group considered "community" persons are the ICF's residents, owners, employees, business contacts, and agents of regulatory agencies.

Data Analysis

The quality of care percentage scores were derived from the RSR reports as previously described and as depicted in appendix B. Points on the Community Involvement in Nursing Homes questionnaire were totaled for each administrator. Pearsonian correlations were computed between total instrument and subcategory scores of instrument (dependent variable) and the attitude toward community involvement instrument (independent variable) to test the hypothesis.

To test for the effects of two extraneous variables the following tests were run. Mean scores for non-profit nursing home administrators were calculated for both variables and checked against mean scores for the for-profit home administrators. With only 3 non-profit homes

in the final sample it would not have been useful to run any tests for differences in correlations between the two groups. A partialling correlation technique was used to determine the significance of education as an extraneous variable.

CHAPTER III

RESULTS AND DISCUSSION

Description of the Subjects

Thirty-two nursing home administrators qualified to be included in the study according to the criteria detailed in the previous chapter. Twenty-five (78%) of these administrators cooperated in this study. Demographic data regarding the subjects are limited. Questions regarding educational background revealed that all subjects were high school graduates. The mean number of years of college education was 3.2 and the range was from 0 to 8 years. Three administrators operate non-profit nursing homes and the rest manage for-profit facilities. The average number of intermediate care patients for all the facilities was 34, the largest home having 115 intermediate care facility beds and the smallest having 10.

Scores on the Residential Services Review Team Instrument

Scores for the R.S.R. scale were drastically skewed to the left indicating a minimum of deficiencies. For example, the range of total scores was from 0.79 to 7.54, whereas, the potential range was 0 to 100. It should be taken into account that the instrument is based upon

minimum standards of care and that the actual range of scores would likely have been greater if care had been measured against optimal standards. Table 1 gives the mean, range and standard deviation for the facilities' total scores, category scores and subcategory scores.

Results indicated that facilities did more poorly in the documented care category than in the observed care category. The highest percentages of deficiencies were for the subcategories (I.3) "Documented residential care plans and personal funds management" and (I.4) "Documented new developments/special incidents, restraints and residents' rights." For subcategory I.4 most deficiencies were awarded for lack of evidence that residents or their legal representatives had seen and signed copies of the resident's bill of rights.

The data indicate that the 25 homes did better in maintaining mobility status (subcategory II.2) and in providing an adequate environment (subcategory II.3) than for any other grouping of items.

The R.S.R. team survey instrument has weaknesses. The authors of the instrument did not set standards whereby one could say care was either good or bad based on the number of deficiencies. The instrument was not tested for reliability or validity. Also, the creators of the instrument failed to build in a scoring system.

Table 1

Quality of Care Measure

(Residential Services Review Form):

Mean Scores, Ranges and Standard Deviations

As Used for the Evaluation of Care in 25 Nursing Homes

R.S.R. Form Category and Subcategory	Mean	Range	Standard Deviation
Total score	3.62	0.79- 7.54	1.67
Category I[a]	5.38	1.22-10.35	2.81
I.1	3.11	0 -12.89	2.91
I.2	3.08	0.14-14.53	3.18
I.3	8.61	0.30-21.38	5.69
I.4	6.68	0 -21.00	6.03
Category II[a]	2.41	0.51- 6.20	1.48
II.1	3.48	0.33-12.89	2.91
II.2	0.66	0 - 3.50	0.95
II.3	1.21	0 - 6.36	1.66
II.4	3.75	0 -12.00	2.66

[a]Category I refers to "documented care" and Category II refers to "observed care". See pp. 28-30.

Kart and Manard's (1976) criticism applies to this instrument. They state the opinion that government evaluations of quality of care in old age institutions focus primarily on improving institutional standards of safety and health care. Their concern is the inadequate assessment of quality and quantity of social interactions of residents.

This researcher can only conjecture why a grading scale was not established for this instrument. The instrument was designed to give results to be used to counsel administrators on the quality of care in their respective facilities. Apparently it was not the purpose to compare facilities. Frank (1972, p. 538) states that "nursing homes as a group have traditionally provided low quality care." Perhaps the surveyors agreed with this assumption and did not want to report gradations of poor care or falsely state that some facilities provide good or excellent care.

The fact that these nursing homes had a greater percentage of deficiencies for documented care items than for observed care items may be related to the frequently heard complaint of nursing home personnel that "there is too much paper work." The fact that a lower percentage of deficiencies was recorded for observed care items may

indicate that while documentation of care is neglected the actual care is at least adequate as demonstrated by the lower percentage of outcome deficiencies. One R.S.R. team survey had an explanatory note stating that individual resident activities plans were absent even though the facility had a good activities program with a high level of participation. Various authors (Kosberg, 1974; Linn, 1974; Levey, et.al., 1973) have expressed the opinion that evaluating nursing home care in terms of outcomes is more valid than process and structure evaluations. It is good, therefore, that the observed care category had better ratings than the documented care category.

The high frequency of deficiencies on the resident's bill of rights item is a serious problem. The sharing of this document with residents is mandated by federal regulations.

> Patient rights are the basis of the resident's ability to protect himself. Often dignity and self respect are denied the nursing home patient because s/he has not been given a chance to play an active role in his or her medical and/or social service care plan, or to participate in the usual freedom enjoyed by other citizens. The denial of patient rights by nursing homes resulted in development of the Patient Bill of Rights by the Federal government in 1974 and 1975 (Crandall, 1978, p. 15).

Crandall (1978) points out that even if the Patient's Bill of Rights is shared with and signed by a resident this documentation is not adequate. Unless the administrator takes a strong stand to uphold these rights they may, in effect, be "little more than written platitudes" (p. 16).

Scores on the Community Involvement in Nursing Homes Questionnaire

The mean of total scores for administrators on the C.I.N.H. questionnaire was 41 out of a possible 55 points. The scores were skewed to the positive side of the continuum. The range of total scores extended from 28 to 55 with a standard deviation of 5.98. Table 2 shows the mean, range and standard deviation for each item. As indicated earlier, the items fell into three groups. The first group (group A: items #1, 2, 3 and 4) explored the administrators' attitudes toward the effect of visitors and volunteers on residents, staff and nursing home finances. The second group (group B: items #5, 6, 7 and 8) was designed to give an indication of the administrators' attitudes toward the understanding of nursing home operations by family and friends of residents and of their capabilities of participating in the management of the facility. The third group (group C: items #9, 10 and 11) dealt with the administrators' valuations of

Table 2

Community Involvement in Nursing Homes Instrument:
Mean Scores, Ranges and Standard Deviations
As Administered to 25 Nursing Home Administrators

Items and groupings of items	Mean	Range	Standard Deviation
Total score[a]	40.72	28-55	5.98
Item[b] #1	4.00	2- 5	0.91
#2	4.20	3- 5	0.48
#3	3.32	1- 5	1.03
#4	4.44	1- 5	1.01
#5	3.04	1- 5	1.37
#6	3.24	1- 5	1.40
#7	2.80	1- 5	1.08
#8	2.84	1- 5	1.11
#9	3.92	2- 5	0.91
#10	3.88	1- 5	1.20
#11	4.84	2- 5	0.62
Group A[c] (#1, 2, 3 & 4)	15.96	10-20	2.24
Group B[d] (#5, 6, 7 & 8)	11.92	4-20	3.81
Group C[e] (#9, 10 & 11)	12.64	9-15	1.96

[a] possible range is 11-55.

[b] for each item possible range is 1-5.

[c] administrators' attitudes toward the effect of visitors and volunteers. possible range is 4-20.

[d] administrators' attitudes toward residents' families and friends' understanding of operations and capabilities of participating in management. possible range is 4-20.

[e] administrators' valuations of maintaining relations with the community as a whole. possible range is 3-15.

maintaining relations with the community as a whole. The mean, range and standard deviation for each of these groups also appears in table 2.

Item #11 of the CINH questionnaire yielded the highest mean score and the smallest standard deviation. Administrators, by their answers to item #11, indicated a strong positive attitude toward the value of groups of school children coming in contact with nursing home residents. Frequently the administrator would comment to the researcher that elderly people respond very well to children. Three or four referred to a specific facility which has maintained a very successful, on-going project in which grade school and pre-school children are regularly brought to the nursing home where they interact with residents. One administrator related an instance where the classroom behavior of 6th grade children seemed to improve after making visits to the nursing home. The teacher coordinating these visits had the objectives of exposing the students to a different life style and helping them become concerned about the needs of other people in their community. Administrator, residents, teacher and students all gained through these planned visits.

Question #7 regarding the effect of volunteers upon the facility's fiscal concerns received the lowest mean

score (2.80). The mode for that item was "3", an answer which a number of administrators checked while explaining that they thought volunteers have no effect upon finances. This question was based upon ideas for volunteer services suggested by the Subcommittee on Long-Term Care of the Special Committee on Aging: United States Senate (1975). Some of this committee's suggestions as repairing residents' clothing, feeding disabled residents, sponsoring field trips or helping in the activities department could have small but definite impact on facility finances. In the process of developing the CINH questionnaire, this researcher interviewed an administrator in Seattle who indicated that one community organization had donated a van to his nursing home for transporting residents. Such donations would have a substantial impact on the facility's budget.

Administrators verbalized particular concern over items #6 and 8 stating that they were personally responsible for the quality of care. They had misgivings about answering that friends and relatives would have a strong effect upon the quality of care since they thought that such an answer would also denote that there was a problem with the quality of care.

Another thing which concerned some participants was whether or not the responses "strong effect" and "much

effect in items #6, 7 and 8 were to be equated with "strong positive effect" and "much positive effect." A couple of administrators said that the questions regarding "Residents', Friends and Relatives Advisory Council" were inappropriate for them because they have a very small number of residents and their families already feel free to speak with the administrator on an informal basis at any time.

Subjects voiced more questions and concerns over the items dealing with family and friends participating in the governance of the facility (group B: items #5, 6, 7 and 8) than over any other group of questions. Subsequently, this group of questions (group B) had a lower mean score than either of the other two groups. For making such comparisons the group C mean may be adjusted to 16.85 to compensate for the fact that it contained one less item than either group A or B. As mentioned earlier, the small number of items in the scale was a weakness in the instrument. The apparent lack of clarity for items #5 through 8 was another weakness.

Test for Correlation Between Attitude Scale Scores and Quality of Care Scores

Pearsonian correlations were calculated for all combinations of total scores and subcategory scores for the attitude scale and the quality of care scale. Table 3 presents all of these correlations. Only 2 correlations attained a 0.05 level of significance. These two did not support the hypothesis. First, there was a significant direct relationship ($r = 0.484$) between positive attitudes toward maintaining relations with the community as a whole (items #9, 10 and 11 of C.I.N.H. scale) and poor scores on "documented medication, treatment and diet management" (subcategory I.2 of R.S.R. instrument). Second, there was a significant direct relationship ($r = 0.535$) between positive attitudes toward maintaining relations with the community as a whole (items #9, 10 and 11 of C.I.N.H. scale) and poor scores on "personal care management" (subcategory II.1 of R.S.R. instrument). These two positive correlations are not explainable in terms of the literature reviewed and may be due to chance.

The majority of correlation coefficients were not significant. This is likely explainable in terms of the weaknesses of the two instruments. Winn and McCaffree (1976, p. 415) for example, speak of appropriate measures of quality of care as continuing to be "elusive." The weaknesses of this researcher's Community Involvement in

Table 3

Product Moment Correlation Coefficient
Between Scores on Community Involvement
in Nursing Homes Instrument and
Quality of Care Measure
(Residential Services Review Form)

Quality of Care (R.S.R. Form) Category and Subcategory	Total C.I.N.H. Score	C.I.N.H. Group A (#1,2,3&4)	C.I.N.H. Group B (#5,6,7&8)	C.I.N.H. Group C (#9,10&11)
Total score	0.268	0.274	0.134	0.369
Category I	0.279	0.334	0.144	0.319
I.1	0.223	-0.047	0.279	0.276
I.2	0.163	0.296	-0.124	0.484*
I.3	0.376	0.349	0.255	0.298
I.4	-0.035	0.156	-0.047	0.077
Category II	0.197	0.118	0.090	0.368
II.1	0.337	0.329	0.115	0.535*
II.2	0.148	0.133	-0.008	0.391
II.3	-0.035	0.158	-0.286	0.236
II.4	-0.073	-0.167	0.093	-0.178

* $p < .05$

Nursing Homes instrument have already been discussed. Also, the value of this test of the hypothesis is in question because of the limited range of variables. Scores on both instruments clustered at the positive end of the continuum. If any confidence can be placed in these two instruments then one can conclude that in general there is no relationship between a nursing home administrator's attitudes toward community involvement and the quality of care in his or her intermediate care facility.

Differences Between Non-Profit and For-Profit Homes

Because only 3 nursing homes in this sample were non-profit businesses it would not have been meaningful to run correlations between scores on the two instruments.

Three nursing homes in this sample were non-profit facilities. The mean scores for the two instruments were a little lower in the non-profit home category than in the for-profit category. The mean scores on the attitude scale were 38.67 for non-profit and 41.00 for for-profit homes. Non-profit facilities had a mean of 2.85 on the quality of care scale, whereas, the for-profit facilities had a mean of 3.72. The differences in scores between the for-profit and non-profit homes appears insignificant when compared to the range of scores and when it is noted that the for-profit and non-profit means both fall within one standard deviation of the grand means. This coincides with other studies (Winn & McCaffree, 1976; Levey, 1973)

which indicate there is no difference in the quality of nursing home care depending on patterns of ownership.

Effect of Education

All subjects in this study were high school graduates. The administrators had from 0 to 8 years of college education. The mean number of college education years was 3.2. One standard deviation was 1.98. The Pearsonian correlation between years of college education and quality of care score is not quite significant at the 0.05 level (correlation = -0.386). There is a significant inverse correlation between administrators' attitudes toward community involvement and the number of years of college education they have had (r = -0.456).

These data do not lend support to the idea that nursing home administrators should have more college education. State licensing boards are leaning more toward requiring a bachelor's degree for applicants for the administrator's license (Kahl, 1976). In Oregon this is not a requirement. The statistical analysis of the data indicates that administrators with fewer years of education have more favorable attitudes toward community involvement. There was no reference in the literature to a relationship between one's receptiveness of community input and one's education. Perhaps those administrators with less education are more appreciative of less sophisticated approaches to maintaining quality care as

through volunteers, friends and family; while more highly educated administrators depend more heavily on specially trained nursing home personnel to make high quality care a reality.

A partialing correlation formula was used to partial out the effect of education in the relation between the two sets of total scores. The subsequent correlation coefficient of 0.112 was not significant at the 0.05 level.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Many literature sources report fair to poor quality care in some nursing homes. The literature also reveals problems with measuring quality of care and enforcing standards of care. The primary effort to regulate the quality of nursing home care is carried out by state licensure agencies with their teams of nursing home inspectors. This plan of maintaining standards of care may be inhibited by a lack of enforcement powers.

One means of improving the quality of nursing home care which is supported by the literature is to encourage community involvement. It has been speculated that the presence of family and friends in the facility has a positive effect upon the quality of work done by nursing home personnel. Volunteers can enrich a facility's activities program and community members can give valuable input into the affairs of a nursing home by serving on an advisory council or on a nursing home's board of directors.

The administrator is essentially the key figure in the nursing home. His or her attitudes tend to pervade

through all facility operations. The administrator's attitudes, specifically with regard to community involvement should have a strong influence over the nursing home's degree of receptivity toward community members.

Very little scientific study has been done in the area of community involvement in nursing homes. No research has been done to determine the relationship between nursing home administrators' attitudes toward community involvement and quality of care in their respective facilities. For the purposes of this study it was hypothesized that the more favorable an administrator's attitudes are toward community involvement in nursing homes, the better will be the quality of care in his or her nursing home.

Data used for this study came from two sources. Quality of care data were collected by state Residential Services Review Teams. The care received by residents of intermediate care facilities was evaluated on a resident-by-resident basis with deficiencies in quality of care recorded on the R.S.R. Form. This researcher and two other registered nurses collaborated in devising a categorized, weighted scoring system for this set of data.

The second set of data was obtained by the researcher and 2 assistants personally administering the Community Involvement in Nursing Homes questionnaire. Thirty-two nursing home administrators qualified according to pre-established criteria to be included in the study. Twenty-five of these agreed to participate. The Likert-type questionnaire was constructed by this researcher. It was based upon the review of the literature and upon information gathered in conversations with nursing home administrators and people who are knowledgeable in gerontology and survey research. It was pretested using a convenience sample of 40 registered nurses. As a result, 9 items with unacceptable t-values were dropped. This shortened questionnaire has only 11 items which is a notable weakness of the instrument.

A limited amount of demographic data was collected. It was determined whether or not each facility was a non-profit organization. Also, subjects were asked on the questionnaire if they were high school graduates. If the administrator's answer was "Yes", then the subject was asked how many years of college education he or she had completed. Similarly, if the administrator indicated that he or she was not a high school graduate, then the number of years of high school education was to be filled in on the questionnaire.

The Residential Services Review Team data revealed that the nursing homes received a lower percentage of

deficiencies for observed care measures than for documented care measures. Although low scores are not desirable, it is probably better to have deficiencies in documentation than in patient outcomes. From the Community Involvement in Nursing Homes questionnaire it was learned that administrators are more favorable toward resident - community member interaction than toward having community members participate in the governance of a facility.

Pearsonian product moment correlation coefficients calculated between these two major variables were of insufficient magnitude to support the hypothesis. Only 2 correlations were significant at the 0.05 level. One indicated that the less favorable an administrator's attitude toward community involvement, the higher the quality of care in his or her facility with regard to the documentation of medication, treatment and diet management. The other significant correlation pointed to poorer personal care management as the administrators' attitudes toward community involvement improved. It is believed that these results were due to chance.

It was also noted that for-profit homes may provide poorer quality care, but their administrators may have more favorable attitudes toward community involvement. Since there were only 3 non-profit homes in the study's population, and because actual differences in mean scores

for the two groups were minimal, it is impossible to draw hard conclusions from the data on these issues. Also, it was determined that the fewer the years of an administrator's college education, the better are his or her attitudes toward community involvement. Partialing out the effect of education does not yield a significant relationship between administrators' general attitudes toward community involvement and overall quality of care in their respective nursing homes.

This study has led the researcher to make five recommendations:

1. The Community Involvement in Nursing Homes instrument should be revised and expanded. Additional questions should be generated to focus on other ways in which community members can become involved in nursing home programs. All responses should indicate whether effects of community involvement would be positive or negative. This is because some subjects found it confusing to merely estimate the magnitude of effect of an activity.
2. Future studies should draw subjects from a broader population in order to have greater generalizability. This study, for example, only looked at administrators of intermediate care facilities.
3. More comprehensive tests of the hypothesis should control for additional extraneous variables. This

study only controlled for two commonly accepted variables which may influence quality of care: administrator education, and for-profit/non-profit status of the institution. Other variables which could be controlled include the administrator's length of experience as a nursing home administrator, his or her length of time as administrator in the facility, the administrator's age and sex, and various socio-economic factors relating to the residents of the nursing home and of the surrounding community.

4. The commonly accepted belief that contact with the community improves the quality of care in an institution should be formulated into a model with a theoretical base so as to be more useful in giving direction to future research. At present only an odd assortment of comments in the literature refer to this proposition.

5. Experimental design research is needed to more adequately test the hypothesis that community involvement has a positive effect upon the quality of care in a nursing home. The outcomes of community involvement interventions could be observed. This would eliminate the inherent weakness of survey research: subjects responding to items on the basis of what is socially acceptable.

In conclusion, the hypothesis was not upheld. Because of the weaknesses of the instruments and the limited range of the attitudinal and quality data, the hypothesis was not conclusively refuted. It still may be that the more favorable an administrator's attitudes are toward community involvement in nursing homes, the better will be the quality of care in his or her facility. What is needed are more highly refined instruments for the measurement of the attitudes and of quality of care.

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APPENDIX A

Residential Services Review

Team Evaluation Form

...T OF OREGON
...RTMENT OF HUMAN RESOURCES
...T & FAMILY SERVICES DIVISION

SNF-ICF RSR Report

Health & Social Services Section

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

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

acility_____ Date of Review_____

ddress_____

ity_____ Branch_____

dministrator_____

wner_____

...ector of Nursing Services_____

ertified for:_____Skilled beds;_____ICF beds.

itle XIX Occupants:_____Skilled;_____ICF:_____ICF-Home for Aged.

itle XIX Residents reviewed:_____Skilled:_____ICF:_____ICF-Home for Aged.

articipants in this review:

hysician:_____

egistered Nurses:_____ Reviewed:_____
SNF-ICF RSR Supervisor

_____ _____

_____ _____
Medical Review Physician, Utilization Control Unit

_____ _____ Approved:_____

ocial Workers:_____ _____ _____
Health & Social Services Section

...Page 1 o... ...09 (Rev. 3/78)

P R E F A C E

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

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

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

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

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

GLOSSARY FOR SNF-ICF RSR REPORT

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

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

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

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

RESIDENT ASSESSMENT

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

1. Health/Nursing Care Plan

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

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

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

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

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

f. updated - [illegible]

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

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

a. social history:

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

b. social assessment:

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

c. social plan:

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

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

(1) Incorporated in overall plan:

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

(2) Implemented:

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

(3) Reviewed periodically:

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

4. Activities Programming:

a. Activities assessment:

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

b. Activities plan:

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

1. Individualized goals:

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

2. Appropriate approaches:

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

3. Incorporated in overall plan:

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

4. Implemented:

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

5. Reviewed quarterly:

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

B. Documentation of Physician's Services.

Transfer Data:

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

History/Medical Summary:

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

Physical Examination:

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

Diagnoses:

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

Medication Orders:

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

Treatment Orders:

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

Diet:

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

Restraint/Safety Measure Orders:

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

thru 15. - Self Explanatory.

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

C. Documentation of Nursing and Supportive Services.

Medications:

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

Self Explanatory.

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

Nursing Notes:

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

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

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

Diet:

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

thru 27. - Self Explanatory.

28. RSR recommendation for Level of Care.

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

E. Social Services - Individual

31. Personal Fund Accounting:

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

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

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

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

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

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

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

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

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

CTION I

SIDENT ASSESSMENT

Patient Number

DOCUMENTATION OF OVERALL PLANS OF CARE

1. HEALTH/NURSING CARE PLAN:
   a. assessment
   b. goals (long & short term)
   c. approaches to goals
   d. reflect maximum potential
   e. responsible service/services
   f. updated

2. REHABILITATION PLAN:
   a. assessment
   b. goals (long & short term)
   c. approaches to goals
   d. reflect maximum potential
   e. responsible service/services
   f. updated

EC. I RESIDENT ASSESSMENT (Cont.)

DOCUMENTATION OF OVERALL PLANS OF CARE

3. SOCIAL COMPONENTS:
   a. social history
   b. social assessment
   c. social plan
      (1) incorporated in overall plan
      (2) implemented
      (3) reviewed periodically
4. ACTIVITIES PROGRAMMING:
   a. activities assessment
   b. activities plan
      (1) individualized goals
      (2) appropriate approaches
      (3) incorporated in overall plan
      (4) implemented
      (5) reviewed quarterly

. I RESIDENT ASSESSMENT (Cont)

DOCUMENTATION OF PHYSICIAN'S SERVICES

3. TRANSFER DATA:
   a. content
   b. signed by physician
   c. dated
2. HISTORY/MEDICAL SUMMARY:
   a. content
   b. signed by physician
   c. dated
. PHYSICAL EXAMINATION:
   a. content
   b. signed by physician
   c. dated
. DIAGNOSES:
   a. content/updated
   b. signed by admitting/attending physician
. MEDICATION ORDERS:
   a. signed on admission by attending physician
   b. renewed/signed monthly by attending physician
   c. dated
   d. specific

EC. I RESIDENT ASSESSMENT (Cont)

. DOCUMENTATION OF PHYSICIAN'S SERVICES

10. TREATMENT ORDERS:
   a. specific
   b. signed by attending physician
   c. dated
11. DIET:
   a. ordered by physician
12. RESTRAINT/SAFETY MEASURE ORDERS:
   a. specified
13. PHONE/VERBAL ORDERS:
   a. signed by nurse
   b. countersigned by physician
   c. dated
14. PHYSICIAN'S VISITS:
   a. recorded in required frequency*
15. PROGRESS NOTES:
   a. in required frequency*
   b. signed
   c. dated
16. RECERTIFICATION OF NEED FOR CARE:

killed - every 30 days, unless documented by physician for 60 days

ntermediate Care Facility - every 60 days

Appendix-A

I RESIDENT ASSESSMENT (Cont)

DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

7. MEDICATIONS:
   a. reviewed monthly
   b. recorded as ordered
   c. signed
   d. dated
   e. given only with physician's order
   f. other
8. TREATMENTS:
   a. recorded as ordered
   b. signed
   c. dated
   d. results documented
   e. given only with physician's order
   f. other
9. RESTRAINTS/SAFETY MEASURES:
   a. used only with physician's order
   b. documentation of release every 2 hours

SEC. I RESIDENT ASSESSMENT (Cont)

C. DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

20. NURSING NOTES:

a. reflect health-rehab plan of care

b. summaries, as required

c. signed

d. dated

21. NEW DEVELOPMENT/SPECIAL INCIDENT:

a. action taken

b. follow-up

22. DIET:

a. provided as ordered

23. LABORATORY AND X-RAY:

a. physician's order

b. reports in chart

24. TUBERCULOSIS CONTROL REQUIREMENTS:

a. admission test, x-ray, or physician's statement

b. follow-up of positive skin test or positive x-ray

SEC. I RESIDENT ASSESSMENT (Cont)

C. DOCUMENTATION OF NURSING AND SUPPORTIVE SERVICES

25. PERSONAL ATTENTION/OBSERVATION:

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

Appendix A

CIAL SERVICES - Individual																										
SIDENT NOT INTERVIEWED:*																										
RSONAL FUNDS MANAGEMENT:*																										
. by resident																										
. by relative/other																										
. by facility																										
RSONAL FUND ACCOUNTING:																										
. AFS Form 713																										
. Appropriate charges																										
. Quarterly accounting																										
. Delegation/Acceptance forms																										
. Interest bearing accounts																										
SIDENT'S NEEDS/CONCERNS MET																										
SIDENT RIGHT'S STATEMENT																										
SCHARGE PLAN (SNF only)																										

CIAL SERVICES - Facility**		GENERAL: Facility Administrator/Staff cooperative with PSR personnel: _____yes _____no. If no, explain:
manitarian Concern Displayed		
sidents Satisfaction with cility/Staff		
nagement of Personal Funds		
her		

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

ceptable

RESIDENT ASSESSMENT (Cont)

UMENTATION OF NURSING AND
PORTIVE SERVICES

APPARENT NEED FOR OR REPAIR OF:

- (c) visual exam/glasses
- (d) dental exam/dentures
- (e) audiogram/hearing aid
- (f) podiatry care
- (g) prosthetics
- f. walker/crutches
- (i) wheelchair
- (j) physical therapy
- (k) clothing
- (l) personal care items
- (m) other

AVAILABILITY/CONDITION OF:

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

) LEVEL OF CARE ASSESSMENT

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

APPENDIX B

Sample Computations

of RSR Form Data

In the same manner as for subcategory 1.1, the mean scores for the other seven subcategories will be calculated.

Category I

1.1 score = 3.31%
1.2 score = 6.02%
1.3 score = 7.70%
1.4 score = 4.16%
21.19

Mean score for Category I = 21.19% ÷ 4 = 5.30%

Category II

2.1 score =24.41%
2.2 score =17.02%
2.3 score = 4.30%
2.4 score = 2.81%
48.54

Mean score for Category II = 48.54% ÷ 4 = 12.14%

Total score for facility = (5.30% x .40) +
(12.14% x .60) = 9.40%

APPENDIX C

Letter of Introduction

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

GRADUATE STUDIES DEPARTMENT
SCHOOL OF NURSING

Area Code 503 225-7838

3181 S.W. Sam Jackson Park Road

Portland, Oregon 97201

My name is Carl Christensen. I am a registered nurse and a graduate student at the University of Oregon Health Sciences Center School of Nursing. I am writing my masters degree thesis on care of the aged.

In the next couple of days I will be calling your nursing home to ask for a brief appointment with you in order for me or a research assistant to bring you a copy of an 11 item questionnaire for you to fill out. The form should take 5 minutes or less to complete. Naturally, your name, the name of your facility and your responses on the questionnaire will be held in absolute confidence.

Your cooperation in making an appointment for me will be deeply appreciated since this project represents the culmination of a two year course of study.

Sincerely,

Carl Christensen

APPENDIX D

Community Involvement in Nursing Homes Questionnaire

Community Involvement in Nursing Homes

Answer each question by placing an "X" in the box which most closely approximates your opinion. There are no "right" or "wrong" answers to these questions. This form should take 5 minutes or less to complete. Please do not take too much time deliberating over any one question. Thank you.

1. To what extent do volunteers in a nursing home affect the self-image of the average resident?

   weak effect ☐ ☐ ☐ ☐ ☐ strong effect

2. What effect does the presence of visitors in a nursing home have upon the attitudes of nursing personnel toward their work?

   positive effect ☐ ☐ ☐ ☐ ☐ negative effect

3. What effect do volunteers in a nursing home have upon the nursing home's finances?

   generally positive effect ☐ ☐ ☐ ☐ ☐ generally negative effect

4. How important is it that a nursing home activities director have the ability to recruit and maintain volunteers in the activities program?

   little importance ☐ ☐ ☐ ☐ ☐ great importance

5. How much interest would there be among residents' relatives and friends with regard to forming a "Residents' Friends and Relatives Advisory Council" at this facility?

   little interest ☐ ☐ ☐ ☐ ☐ much interest

6. How much effect would a "Residents' Friends and Relatives Advisory Council" have upon patient care in this facility?

   strong effect ☐ ☐ ☐ ☐ ☐ weak effect

7. How much effect would a "Residents' Friends and Relatives Advisory Council" have upon fiscal concerns of this facility?

   strong effect ☐ ☐ ☐ ☐ ☐ weak effect

8. If one or two friends or relatives of residents were placed on the board of directors of any given nursing home, how much effect would they have on patient care?

much effect ☐ ☐ ☐ ☐ ☐ little effect

9. How much value is there to a nursing home to have the administrator speak on the subject of nursing home care provided at his/her facility to voluntary community organizations (i.e., Kiwanas, Rotary, Chamber of Commerce, special interst groups, Church, etc.)?

great value to nursing home ☐ ☐ ☐ ☐ ☐ little value to nursing home

10. How much value is there to a nursing home to have the administrator periodically make personal contact with clergy or lay representatives of the worship centers presently or formerly attended by the nursing home residents?

great value to nursing home ☐ ☐ ☐ ☐ ☐ little value to nursing home

11. How much value is there to nursing home residents to have small groups of school children visit in a nursing home?

little value to residents ☐ ☐ ☐ ☐ ☐ great value to residents

Educational background

Are you a high school graduate? Yes ☐ No ☐

If "Yes", approximate number of years of full-time college level education _____.

If "No", number of years of high school education _____.

APPENDIX E

Informed Consent Form

GRADUATE STUDIES DEPARTMENT
SCHOOL OF NURSING

Area Code 503 225-7838

3181 S.W. Sam Jackson Park Road

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

AGREEMENT FOR INFORMED CONSENT

I, _____, herewith
(First Name) (Last Name)

agree to serve as a subject in the investigation named, "The relationship between nursing home administrators' attitudes toward community involvement and quality of care" by Carl Christensen, R.N., B.S., graduate student, under the supervision of Linda Kaeser, R.N., M.S.W. faculty advisor.

I understand that I will be asked to complete a questionnaire that will take approximately 5 minutes to fill out. I understand that all information collected will be coded and my anonymity preserved. Any information transmitted as a result of the study will be aggregated and the institution studied will not be named. Additionally, my name will not appear in any report of the study.

The potential benefit from my participation in this study will be to increase my awareness of the opinions I hold about community involvement in nursing homes.

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

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

_____ _____
(Date) (Subject's Signature)

_____
(Witness's Signature)

AN ABSTRACT OF THE THESIS OF

CARL N. CHRISTENSEN

For the MASTER OF NURSING

Date Receiving this Degree:

Title: The Relationship Between Quality of Care and Nursing Home Administrators' Attitudes Toward Community Involvement

Approved: [redacted] Thesis Advisor

The literature indicates that in many cases the quality of care provided to nursing home residents is poor but that it might be improved if community members would become more involved in the life of the facility. It is also noted that the attitudes of the nursing home administrator set the tone for the operation of all aspects of the home. It can, therefore, be deduced that the quality of care in a nursing home may be positively correlated with the attitude of the administrator toward community involvement in the nursing home.

Quality of care data and community involvement attitudinal data were correlated for 25 Portland area intermediate care facilities and their administrators. The quality of care data were collected on site by State of Oregon Residential Services Review Teams. Deficiencies

in quality of care were recorded on a resident-by-resident basis. To assess administrators' attitudes toward community involvement this researcher constructed the Likert-type "Community Involvement in Nursing Homes" questionnaire. It was pretested and appropriately revised prior to administration to the 25 administrators. Pearsonian correlations computed using these two sets of data did not support the hypothesis. This may have been due to the weaknesses of the researcher's questionnaire.