A QUALITY OF PATIENT CARE STUDY IN A VETERANS ADMINISTRATION HOSPITAL

by

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CHAPTER I

INTRODUCTION

> There is a "social contract" between society and the professions. Under its terms, society grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of their own affairs. In return, the professions are expected to act responsibly, always mindful of the public trust. Self-regulation to assure quality in performance is at the heart of this relationship. It is the authentic hallmark of a mature profession. (Donabedian, 1971, p. viii).

Nursing has traditionally been concerned with fulfilling an obligation to the public trust. For many years, the practice of nursing has been carefully monitored by a strict hierarchy within institutional and agency settings. Both nursing activities and practice settings have been limited and stereotyped. Today nurses practice not only in diverse settings, but also in increasingly more complex roles. The expanding scope of nursing responsibilities reflects the confidence of patients and other health professionals in nursing. With these responsibilities, the individual nurse becomes more autonomous, and in one sense, free from direct supervision by the hierarchy within nursing. Because of the expanding scope of nursing responsibilities, accountability for quality of practice becomes a critical issue to the individual nurse and to the profession.

Within the professional community of nursing, it is appropriate that nurses evaluate their own practice. Evaluation, used to measure effectiveness of nursing interventions, is an integral part of the nursing process. The purpose of evaluating a program of nursing is to provide information for decisions aimed at improving the quality of care delivered.

Two nurse leaders, Wandelt and Phaneuf (1972) refer to this accountability for quality as "quality assurance." Quality is determined by identifying those observable characteristics of excellent care and examining variations from this standard. Assurance of quality is attained when systematic evaluations of care are followed by continuous efforts to improve. Other authors address the need for systematic assessment of practice (Zimmer, 1974; Lindeman, 1976). To honor our social contract and to provide standards for improving our practice, programs of quality assurance are essential.

There are three major approaches to evaluating the quality of care: the evaluation of structures within which care is given, the process of care, and its outcomes (Donabedian, 1969). Phaneuf (1972) recommends that all three components be measured within a system of quality assurance, and that the interaction between approaches be studied. It is apparent that to provide comprehensive measures of quality, all three components require evaluation, using methods individually appropriate.

Within the hospital selected for the present study, there are mechanisms for quality assurance having standards of structure and outcome as their primary focus. There is need for further study of the process of nursing within this setting. This study examining the quality of care in progress met this need.

Review of the Literature

This literature review will address four major areas; the need for quality assurance programs, accountability within the profession, the components of a system for quality assurance, and the monitoring instru-

ments and processes designed to measure the effectiveness of that program.

The Need for Quality Assurance

In addition to pressure from within the nursing profession to provide evidence of accountability for practice, there have been pressures from a concerned public (Mullane, 1975). Several factors that led to the consumer demand for quality in health care can be isolated (Ellis, 1975). Rising public awareness of health care standards combined with broader options in practitioners and settings has allowed the consumer to select among modalities. Changes in the process of payment for care have introduced a third party into the provider-client relationship: the health insurance carrier. Both voluntary and governmental programs of payment for care have become a strong influence in directing and monitoring health care services. As analyzed by Phaneuf, these programs hold values of economy and efficiency that are best met by large scale systems for care that tend to reduce the individualization of care (1976). She predicts that this conflict between individualized care and economy could be resolved by selecting as the priority value that one which serves the individual best, saying:

"On this basis, the challenge in health care is the provision of personalized care to large numbers of people combined with an efficiency that maximizes use of resources without sacrificing quality of care." (p. 1).

There is a demand for quality assurance by accrediting bodies and agencies of the government as well as by the consumer of care. These demands provide an impetus for the development of mechanisms for the achievement of quality health care. Professional Standards Review

Organizations (PSROs) have been mandated by the Social Security Amendment of 1972 by Public Law 92-603. While authorizing physicians to assume responsibility for reviewing quality of medical care, the amendment requires all health professionals to implement quality control methods or submit to governmental evaluation.

In response to societal pressures for accountability for the care delivered to the consumer, the American Hospital Association and the American Nurses' Association have developed mechanisms to assure quality of care. A 1972 manual produced by the American Hospital Association, Quality Assurance Programs for Medical Care in Hospitals, stated that "By law, society delegates to the hospital the authority and accountability for the organization and delivery of hospital services...to assure the public of optimal quality of all care delivery by all professionals within the institution." The manual contained a Patient's Bill of Rights, which stated that each patient had the right to expect a certain quality and continuity of care from the medical health team.

Accountability Within the Profession

It is evident that professional nursing organizations support the concept of quality assurance for nursing practice. The American Nurses' Association in 1973 developed standards of practice and criteria for measuring quality and effectiveness of care:

Standard II

"Nursing administration has the responsibility and authority for the quality of nursing practice within the organization."

The Association held as its first priority for the 1974-1976 biennial

convention "Improving the practice of nursing through assisting by implementation of standards of practice enunciated by ANA."

Phaneuf and Wandelt urged nurses to seize the opportunity to develop and utilize methods of quality control to improve nursing practice, saying "...any profession that does not monitor itself becomes a technology" (1974, p. 3280). Zimmer defines quality assurance as involving both evaluating and improving activities "...in order to fulfill the public trust that professionals continually search for means to secure more advantageous consumer health and resource cost outcomes" (1974, p. 71). Gortner (1974) stipulates that improving the quality of nursing relies on adopting as part of our tradition accountability for our practice. Phaneuf addresses the ethical and moral obligation as a justification for action, defining accountability as "...being responsible and answerable for use of resources in the provision of service with regard to quality, quantity and costs" (1972, p. 5).

Accountability has been defined as a measure of individual, group, or institutional efficiency and productivity judged against a standard by both agent and client (Froebe & Bain, 1974). Peplau (1971) points out that accountability carries the option of being called to account; to answer for what one has done. Hartnett (1971) shares this view, adding that accountability is a form of evaluation, or measure of goal attainment.

The legal and professional mandates for formal programs of quality assurance fulfill these definitions for accountability; that is, accepting the responsibility for ongoing measurement of care against a standard as a means of assuring adequacy of practice. Attesting to the profession's response to these mandates, nursing literature is replete with articles

concerning accountability for practice through programs of quality assurance (Lang, 1974; Zimmer, 1974; Lindeman, 1976).

The Components of a System of Quality Assurance

Lindeman (1976) names three major components of the nursing care system that relate to quality of care: the setting, the nursing process, and the patient outcome. Explaining that there is little research information available concerning the relationship of these components to each other, Lindeman states that it is as right to measure quality in terms of one component as the other. These components will be discussed in greater detail to clarify the characteristics of individual frameworks.

Structural Standards

Structural components refer to the way an organization is systematized, and include considerations of purpose and agency; authority; fiscal and organizational characteristics; qualifications of professionals and other employees; physical facilities; status of accreditation and certification (Phaneuf, 1976).

In reference to quality, Phaneuf points out that structural standards do not directly address the issue; assumption of a positive relationship is not a substitute for evaluation of the care patients actually receive (1976).

Process Standards

Stevens (1975) identifies process standards as measures of the activities of the nurse as an individual performer rather than the standardized aspect of care. Evaluation of the process of care can be approached in two ways: measuring the competencies of the nurse who delivers care, and measuring care received by the patient. Because of its focus on the

patient, the latter measurement is directly pertinent to the issue of patient care evaluation. Since the nursing process is controlled by nurses, evaluation of process quality is simplified. In contrast, the structures for care and the outcomes of care are not subject to nursing control (Phaneuf, 1976).

Outcome Standards

The evaluation of the outcomes of care is directed at the end result of care, defined by Shapiro: "The term 'end result' refers to some measurable aspect of health status which is influenced by a particular element or array...of elements..of care" (1967, p. 7). Investigators associated with Wisconsin Regional Medical Program have developed criteria for evaluating nursing care relative to specific disease states (Anderson, 1974; Hilger, 1974; Lang, 1974; Taylor, 1974; Zimmer, 1974). While Donabedian (1969) claims outcomes to be the ultimate validators of care, other factors influence outcome. The patient's health outcome is the complex result of many factors, of which nursing care is only one (Stevens, 1975).

There are claims that the process-related-to-outcome type measures should be the ultimate goal of nursing care evaluations because it relates actions of providers to changes in the recipient (Bloch, 1975; Diers, 1972). Berni and Readey (1974) have provided an alternative format combining record review of performance with audit of care as delivered. While Jacox (1975), Kramer (1975), and Verhonick (1961), studied aspects of the relationship between nursing process and patient outcomes, several investigators looked at provider-patient interactions in relation to patient outcomes (Felton, 1976; Johnson, 1972; Lindeman, 1972, 1973; Lindeman & VanAernam, 1971). Lindeman's pre-operative teaching and

Johnson's stress reaction studies have been well replicated and most clearly documented the contributions of the nursing process to patient outcomes. Other process-outcome studies have been done by Brook (1973), Hulka and Cassel (1975), Kessner, Kalk and Singer (1973), Sanazaro and Williamson (1968).

Even though nursing research has not yet identified relationships between components, the complexity of nursing care and the diversity of practice settings point to a need for programs of quality assurance that include evaluation of all three components; structure, process and outcome.

Monitoring Instruments and Processes

Assessing the quality of nursing care has long been hampered by a need for adequate measurement instruments. During the past decade, however, several assessment instruments have been developed and tested for reliability and validity.

One such measure is the nursing audit which is a fifty-item scale designed to measure the quality of nursing care delivered by retrospective chart review of a particular time cycle. It attempts to measure the extent to which the nursing process is utilized in practice and the extent to which nursing care measures up to the characteristics that are specified (Phaneuf, 1972).

In order to accurately determine what nursing measures contribute to care, and the way those measure are applied in practice, it is necessary to observe the care in process. Instruments designed to measure processes of care have been well defined in the literature; they are the Slater Scale (1975), which measures nurse competencies in the clinical setting,

the Nurse Performance Description Scale (Dyers, 1967), and Tate's (1969) Nursing Performance Evaluation Instrument. All of these instruments can be used to measure both the performance of individual nurses and the care received by patients.

A process methodology for monitoring quality of care within the framework of the nursing process was developed (Hegyvary & Hussman, 1975). The secondary aim of this evaluation instrument was to present a reasonable picture of the "state of the art" in the application of the nursing process.

The Quality Patient Care Scale (QualPaCS) was derived from the Slater Scale by changing the nurse-oriented items to patient-oriented items (Wandelt & Phaneuf, 1972). This instrument addresses specific items in nursing care as it is performed, and has been "...designed for use in any setting in which nurses interact with patients, or intervene, directly or indirectly, to contribute to meeting a patient's nursing and health care needs" (Phaneuf, 1972, p. 33). The lens of this instrument is focused on care as delivered to the patient by the total nursing staff. It is prepared to measure the quality of care from direct nurse-patient interventions or from interactions on behalf of the patient, and there is no reference to any individual care giver.

The design of a quality assurance program should be such that the resulting information is appropriate for both evidence of accountability and as a guide to programs for improvement, according to Phaneuf and Wandelt (1974). They say further that the purposes of evaluation are these:

1. To account for the level of care provided
2. To make comparisons (of settings, situations and times)
3. To provide bases for planning improvement.

The QualPaCS examines the quality of care as it is delivered by the staff and gives evidence about the quality from direct observations rather than from indirect or secondary sources, such as charts, care plans, or interviews (Stevens, 1975). Indirect and secondary sources are used, however, to supplement observations and to answer questions that arise during observation.

The second purpose of evaluation, to make comparisons, is possible using the direct observation method where sequences of events in the delivery of care and interactions between patients and nurse are recorded. Attention is directed to the way nursing competencies are related to patient needs. The direct observation process presents an advantage over outcome audits: errors or omissions in documentation do not influence the study; other factors that may influence care are isolated; there is consideration of the total staff effort toward the patient's care.

The third component identified by the authors of this tool is that of corrective action. The most important reason for evaluating nursing care is to use the data for planned improvement in delivery of care. The constant analysis of practice is the essence of accountability for a profession. The objectives for care have been translated into behavioral terms, providing for the measurement of desired outcomes; this becomes the standard for quality. Performance measured against these objectives permits a built-in system of evaluation which provides for feedback.

Appropriate feedback of information allows practicing nurses to use the findings of evaluation to improve their practice. The improvement of practice is the expected outcome of a quality assurance program. The first step in problem solving is defining the problem: evaluation of the process of nursing care using a valid tool can be the first step.

Statement of the Problem

Within the study hospital, there was a need to assess the quality of nursing care and to determine whether quality was consistent throughout the hospital. To meet this need, two units were randomly selected for study on both the day and the evening tour of duty.

An expressed short-term goal of the hospital for this year was to coordinate the Quality Assurance Program to reflect process as well as outcome audits of care. Process data was needed for comparison with outcome audits to focus staffing and documentation needs, as well as to establish the level of care. Observer measurements of the quality of care received provide an accurate evaluation of the total staff who are actually involved in that care.

Because the Quality Patient Care Scale (QualPaCS) utilizes process standards related to the patient's physical, psychological and social needs, (Wandelt & Ager, 1974), it was selected as the instrument to measure care. The scale utilizes direct and indirect observation to document the level of care; the level of care becomes the measure of the quality of care. Measurement of this quality was used to indicate areas of concern where change may be implemented. The data obtained will act as a base for planned improvement in the delivery of nursing care.

Purpose of the Study

This study was conducted to evaluate the quality of nursing care in a given Veterans Administration Hospital as part of a comprehensive Quality Assurance program. The process information provided by this study will supplement information recovered by outcome audits to define quality of care. Extending previous research, this study is built on Preston's 1977 clinical investigation in a small community hospital and follows her recommendation for replication in another setting.

Hypotheses

To determine whether quality of nursing care was consistent throughout this hospital, four hypotheses were tested. These were:

1. There will be a significant difference in Grand Mean scores on the QualPaCS between medical and surgical units.
2. There will be a significant difference in Area Mean scores on the QualPaCS between medical and surgical units.
3. There will be a significant difference in Grand Mean scores on the QualPaCS during the day tour as compared to the evening tour of duty.
4. There will be a significant difference in Area Mean scores on the QualPaCS during the day tour as compared to the evening tour of duty.

CHAPTER II

METHODOLOGY

Description of the Study

This study was designed as applied research; that is, the purpose was to find a solution to a practical problem (Polit & Hungler, 1978). The purpose was to evaluate nursing care in a Veterans' Hospital as a means for identifying strengths and weaknesses in care so that appropriate action for improvement can be taken. The instrument and methods of this study followed Preston's (1977) recommendation that her study be replicated in a larger setting.

Setting of the Study

The setting for this study was a 460 bed urban Veterans Administration Hospital. This teaching hospital has full university affiliation, and the physician staff is composed of permanent staff physicians as well as rotating residents, interns and medical students. The nursing service at the time of the study employed 329 persons: 148 staff nurses; 15 head nurses; 11 nurse specialists; 3 education specialists; 8.2 supervisory and administrative staff; 35.5 licensed practical nurses; and 108.9 nursing assistants. The hospital has separate surgical, medical, cardiac and renal intensive care areas. Other care areas are designated according to specialty:

IA: Eye, Ear, Nose and Throat and Surgical Neurology

IB: General Surgery

1C: Orthopedics and Urology

ID: Head and Neck Surgery and General Surgery

4A: Rehabilitation

5A: Psychiatry

25C: Cardiology and General Medicine

25D: Oncology

25E: Minimal Care Unit

25F: Medical Neurology and General Medicine

Special units were not evaluated in this study because their staffing density, autonomy and specially prepared staff are not representative of the hospital in general. Nurses from special units are infrequently expected to help on ward units.

The patient care areas for this study were selected by random draw from a pool of all the units except those special units: intensive care units, psychiatry, rehabilitations and minimal care. The medical unit chosen was 25D, a general medicine and oncology unit with a capacity for 49 patients. During the study, the average census was 45 patients. The surgical unit selected was ID, a unit of head and neck surgery patients and general surgery patients. The capacity of this unit was 29 beds, and the census averaged 25 patients during the two-day observation period.

Data Collecting Instrument

The QualPaCS was selected for this process evaluation study of nursing care. For clarity, the procedures for using this instrument will be included with description of the QualPaCS.

This instrument consists of 68 items selected as representative elements of nursing care (see Appendix A, p.67). The instrument is designed

to sum ratings of quality of care delivered to patients. It is designed for use in any setting where nurse-patient interactions occur. Ratings are made on nursing care provided to the patient, regardless of provider status or category. The objective of this instrument is to quantify the overall nursing care as received by the patient. The strengths and weaknesses of the care program can thus be identified and a rational plan for improvement based on these findings (Wandelt & Ager, 1974).

The QualPaCS items are arranged into six broad areas of care:

I. Psychosocial-Individual: actions directed toward meeting psychosocial needs of the individual patient.

II. Psychosocial-Group: care received reflects recognition of the patient's psychosocial needs as a member of a group.

III. Physical: actions directed toward meeting physical needs of the patient.

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

V. Communication: communication on behalf of the patient.

VI. Professional Implications: care given to patients reflects initiative and responsibility indicative of professional expectations.

The areas and the items within the areas are numerically consecutive without order or rank. Each item is followed by a symbol to reference instructions for observation of the item. Key for symbols and collection of data instructions are as follows:

#D: Observation that permits rating will usually be direct observation of an interaction.

#I: Observation that permits rating of the items will usually be indirect: e.g., a notation in the record or information from nurses, patient, or family.

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

The cue sheets that were designed to accompany QualPaCS (see Appendix B, p. 74) were used to increase interrater uniformity by furnishing quidelines in the form of several concrete examples of activities illustrative of each item.

The instrument was designed to be used by trained observer-raters, and the authors recommend that at least two nurses be used to rate any evaluation project. The authors stated:

> Observer-raters are usually comfortable and used the scale reliably after observing and rating four or five patients, or at the end of two days of tryouts and discussions (Wandelt & Ager, 1974).

The standard of measurement is the level of care that can be expected from an entry-level staff nurse who holds state licensure. Each rater completed an Individual Frame of Reference (see Appendix C, p.94) indicating by name the nurse from her experience who best typified practice in five levels: Best Staff Nurse; Between; Average Staff Nurse; Between; and Poorest Staff Nurse. Each rater used the Individual Frame of Reference she developed throughout the study, to serve as a standard of performance, regardless of the category of staff delivering care.

Each item was rated by placing a check in the appropriate space on the 5-point rating scale. Items were rated as frequently as observed during the observation period, and spaces marked to indicate "Not Applicable" and "Not Observed". When the nurse observer completed the observation and ratings, a score was calculated. The lowest rating of Poorest Staff Nurse on the Individual Frame of Reference compares to the Poorest Care column on the QualPaCS, and receives a rating of one. Between Poorest care and Average Care is given a value of two. The Average Staff Nurse on the Individual Frame of Reference corresponds to the Average Care column, and is rated three. Between Average and Best Staff Nurse is rated four, while the highest rating of Best Staff Nurse on the Individual Frame of Reference corresponds to the Best Care column on the QualPaCS and is given a score of five.

Subjects and Sample

The authors of this tool have stated that a valid and reliable measurement can be obtained from the mean of scores representing care to as few as five patients or fifteen percent of the patients, whichever is the greater number (Wandelt & Ager, 1974). Patients studied were randomly selected for observation by using a random number table. Five criteria were used to establish eligibility for inclusion in the study, as designed by Preston (1977):

1. Individual patient observations generating ratings on thirty items are eligible for inclusion. Ratings of thirty items are necessary to a reliable measurement of the quality of care received (Wandelt & Ager, 1974), p. 52).

2. Patients whose observation reveals less than four nurse interactions during the two-hour period of study will be excluded. A minimum of four interactions is necessary for inclusion, but each interaction may be rated on as many items as appropriate to the tool.
3. Patients must remain in the care area during the entire observation period.
4. The same patient may be observed on two tours of duty, entered as separate numbers.
5. When more than one eligible patient occupies the room of a selected patient, the rater may make up to three observations concurrently.

Raters used the five criteria to select patients for inclusion in the study. The study sample consisted of 24 subjects, 12 patients from each unit selected by separate random sampling. The medical unit had an average census of 45 patients on the two days of observation, while the surgical unit census averaged 25 during the two days of observation. The sample represented a population equal to 34 percent of the total patient census on the two units. Twelve observations were made on the day tour of duty and twelve were made on the evening tour.

Data Collection Procedures

Permission was requested and granted from the Hospital Administrator, the Chief, Nursing Service and the Quality Assurance Committee.

Orientation to the study was offered to administrative and head nurse staff by distribution of A Fact Sheet About QualPaCS (Monahan, 1975) which

summarizes information about conducting the QualPaCS (see Appendix D), indicating the assistance needed from nursing staff members. The purpose of the study, the process of data collection and procedures of the study were presented in detail to the members of the Quality Assurance Committee. Dates for the pilot study and the actual study were set with the cooperation of this group.

More than one rater is required in rating the QualPaCS to provide a mix of decisions concerning the quality of care. Three nurse raters became familiar with the instrument by viewing films, Preparing the Nurse Observer to Use the Quality Patient Care Scale (Buffalo Veterans Administration Hospital, 1978), and by reading the scale, guide and cue sheet.

Pilot Study

A pilot study was conducted to ensure interrater reliability. The three raters used in the pilot study conducted the actual study. The pilot study sample consisted of ten patients, selected at random and meeting inclusion criteria for the study. Patients included in the pilot study were selected from units not observed in the actual study. Time periods for observation were of two hours' duration and represented both tours of duty.

Prior to each observation period, the nurse-rater reviewed the patient's chart and developed a nursing care plan. Taped tour reports, nursing care plans, charts and assignment sheets were studied to learn about the patient and to assess care elements. The nurse team leader introduced the raters to each patient, briefly explaining the purpose of the observation, and that interaction could not take place between

the raters and the patient. The investigator and another nurse-rater observed five patients together following this joint procedure. Following each two-hour observation, time was spent in discussion with patient and staff. The chart was reviewed to gather supporting data, and the rating scale was completed. The investigator and one nurse-rater observed five patients together following this joint procedure. After each of the first two observation periods, the interactions were discussed during rating to clarify definitions and criteria. The remaining observations were performed jointly, but not discussed until rating of the QualPaCS was complete. This procedure for more than two raters was then carried out with the investigator and the third nurse-rater. Two observations were made jointly and discussed before rating, then three observations were made jointly and rated individually.

The data generated by the three nurse-raters during the pilot study were statistically compared to establish interrater reliability readings. The Pearson Product Moment Correlation Coefficient was used for the relation. The Pearson "r" for the final patient observed by the investigator and the other two raters was .80 and .85 respectively.

Study Procedure

The procedure for the actual study was the same as used for the pilot, except that each patient was observed by only one nurse-rater. Since interrater reliability had been established, separate observations were possible. Each rater contributed observations on each of the four subsets studied: medical-days, surgical-evenings, surgical-days, medical-evenings. In this manner, an adequate mix of opinions was assured.

Prior to each observation, time was spent in developing the Rater's Notes for Assessment and Planning Care and the Information Face Sheet (see Appendix E, p.97), to develop a data base and construct a nursing care plan.

Following Preston's (1977) example, complete notes were made during the observation period, recording time and category of worker involved in a consecutive list of interactions that could be reconstructed later for rating.

All elements of the scale did not apply to any one patient. "Not Applicable" was marked if the item did not apply to a given patient. "Not Observed" was noted when an expected activity was not performed during the observation period. However, care was taken to insure that care considered essential that was not observed had been given. If it was not observed, and no evidence was available that the care had been given, it was marked "Poorest Care".

Analysis of Data

After a rater had completed an observation and rating, the score was calculated. All interactions under each item were totaled: each check representing Best Care was given a value of five; Between Best Care and Average Care, a four; Average Care, three points; Between Average Care and Poorest Care, two points; Poorest Care, one point. The score for each item was the average computed from the ratings in all of the cells of the item. The mean score of all items in each of the six areas receiving ratings was divided by the number of items rated to yield an

Area Mean score. The mean score of all items was summed, and this sum divided by the number of items having assigned ratings; carried to one decimal place. This became the Grand Mean score, the measure of the quality of care received by the patient.

A composite mean of item means was computed from the 24 instruments scored (see Appendix F, p. 99). Item means were separated by unit and tour for further comparison (see Appendix G,p.101), and to prepare Area Mean and Grand Mean scores for the medical and the surgical unit and for each tour. The Mann-Whitney U test (Siegel, 1956) was applied to these scores to determine whether a significant difference existed in the quality of care between the medical and surgical unit and between the two tours. The analysis of variance, ANOVA, was used to test for differences between means of the four subsets of data, and to consider the effects of variables of area, unit and tour simultaneously. Hays (1965) described the statistical model for this approach.

Since the Quality Assurance Committee is charged with the responsibility for processes that evaluate quality of care in this hospital, they were asked to set the numerical levels for excellence and for concern on the QualPaCS. They designated 2.7 as the level of concern with the quality of care, and 4.2 as the level of excellence. Ratings between 2.8 and 4.1 were to be considered in the range of acceptability.

CHAPTER III

RESULTS

This chapter will present results from analysis of data generated by observations of care performed on twenty-four sample subjects rated on the QualPaCS instrument. There were four hypotheses tested by this study:

1. There will be a significant difference in grand mean scores on the QualPaCS instrument between medical and surgical units.
2. There will be a significant difference in area mean scores on the QualPaCS instrument between the medical and surgical units.
3. There will be a significant difference in grand mean scores on the QualPaCS during the day tour as compared to the evening tour of duty.
4. There will be a significant difference in area mean scores on the QualPaCS during the day tour as compared to the evening tour of duty.

Comparison of grand mean and area mean scores between units and between tours of duty will be made to test the four hypotheses. Results of statistical tests of difference will be used to describe data in relation to the hypotheses. Evidence of the overall level of care within the hospital will be examined, and item means compared to identify areas of strength and weakness.

Comparison of Grand Mean and Area Mean Scores Between Units

As a measure of consistency in nursing care throughout the hospital,

a medical unit and a surgical unit were selected randomly for comparison; the medical unit selected was 25D, the surgical unit was 1D. These units operate under different structural constraints imposed by staffing, environment, support and supply problems. In addition, they focus on different sets of nursing skills. Therefore, it was of interest to compare the quality of care provided in the two areas to note differences.

The first hypothesis predicted a difference in grand mean scores on the QualPaCS between medical and surgical units. Since the grand mean yielded a U below the .05 set for significance (see Table 1), the first hypothesis is accepted.

TABLE 1

Mann-Whitney U Test of Differences Between Units

Units		Critical Values of U Area						Grand Mean
		I	II	III	IV	V	VI	
Medical	N_1	12	ID*	12	12	12	12	12
Surgical	N_2	12	ID*	12	12	12	12	12
	U	29.9	ID*	36	30.5	22.5	36.5	22
	p	< .05		.05	.05	.05	.05	.05

*Insufficient Data to compute U.
U value of 27 significant at a = .01: Value of 37 significant at a = .05

Comparison of grand mean scores displayed in Table 2 shows that the surgical unit ratings yielded means within the range of acceptability for eleven of the twelve patients observed. The medical unit ratings

generated only four grand mean scores above the 2.7 level of concern.

TABLE 2

Grand Mean Scores by Unit

Medical Unit												
Patient #	4.1	4.2	4.3	4.4	4.5	4.6	4.7	3.1	3.2	3.3	3.4	3.5
Score	2.4*	2.6*	2.6*	2.6*	1.9*	2.8	2.7*	2.9	3.3	2.1*	2.9	2.5*
Surgical Unit												
Patient #	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5
Score	3.6	3.5	3.1	3.5	2.8	3.4	2.8	2.6*	2.8	3.0	3.0	2.9

*Level of Concern - 2.7

The second hypothesis stated that there would be a significant difference in area mean scores between the medical and the surgical units. There was a statistically significant difference between area means for the units on five of the six area means; therefore, the second hypothesis is accepted.

TABLE 3

Area Mean Scores by Unit

QualPaCS Area		Medical Unit n	Medical Unit Mean Score	Surgical Unit n	Surgical Unit Mean Score	Significance
I.	Psychosocial: Individual	12	2.8	12	3.3	*
II.	Psychosocial: Group	8	2.7	6	3.2	I.D.
III.	Physical	12	2.7	12	3.1	*
IV.	General	12	2.6	12	3.0	*
V.	Communications	12	2.3	12	2.9	**
VI.	Professional Implications	12	2.5	12	3.1	*
	Grand Mean	12	2.6	12	3.0	**

**p < .01 *p < .05 I.D. = Inadequate Data

While comparisons of area means for the two units in Table 3 show differences between the medical and surgical units across areas, an explanation of area content and discussion of item mean differences reveals specific areas of strength and weakness (for a complete description of each item, see Appendix A, p. 67).

Area I: This area of fifteen items concerns those actions directed toward meeting psychosocial needs of the patient as an individual. While Area I had the highest mean scores among areas, variances in individual scores ranged from one to five. All but one item mean fell in the range of acceptability for both medical and surgical units.

Eight ratings of excellence were earned by the surgical unit: Item I, regarding full attention given the patient, rated "Best Care" three times; Item 3, monitoring a kind approach, was scored 5 on three occasions. Receiving one excellent mark each were Item 2, allowing the patient to express his feelings; Item 6, relating to explanation and verbal reassurance; Item 7, therapeutic attention; Item 8, concerning consideration given as a family member; Item 13, dealing with creating an atmosphere of trust; and Item 19, relating to appropriate topics of conversation.

The medical unit rated "excellent" twice on Item 3 and once on Item 13.

There were 39 scores of "4" indicating ratings between "Average" and "Excellent" in Area I, showing that there was a general concern for giving attention, for a friendly approach, and for considering the patient as a member of a family group. Observations that rated "Poorest Care" were scattered in this area. There were thirteen entries for Item 10, which

deals with problem patients, and this suggests that handling problem patients may be a rather common concern. Five of these entries rated in the area of concern, however, earning a 2.7 mean for this item, the lowest in Area I.

Area II: Nursing actions that meet the psychosocial needs of the individual as a member of a group had few patient interactions in this eight-item area. The twenty-eight ratings made were on five items; Item 16, concerned with the patient receiving warmth as a group member earned two marks of concern on the surgical unit and four on the medical unit; Item 17, stating that help is given to limit behavior for group welfare, earned one mark of excellence on the surgical unit; Item 18, dealing with encouragement to participate or to plan group activities, rated one average mark on the surgical unit; Item 22, rating the giving of praise and recognition according to individual need with respect for group members, had two marks of concern on the surgical unit; Item 23, concerned with the rights and integrity of group members, rated average marks. It is of interest that other investigators (Preston, 1977; Whitman, 1979; Eichhorn & Frevert, 1979) also experienced difficulty with the evaluation of care under Area II items. Preston rated many items "Not Observed" or "Not Applicable" with a wide range in scores, while Whitman observed only two items on the majority of her subjects, Items 16 and 23. Although the post-primary scores on the study by Eichhorn and Frevert show a significant gain over pre-primary scores in Area II, the number of observations was less than one-third that for the other five areas.

Area III: Actions meeting physical needs of patients are rated in this fifteen-item section. The surgical unit received a mean rating of 3.1 for Area II, while the medical unit earned a rating of 2.7 at the designated level of concern. The surgical unit was high in environmental hygiene; patient rooms, utility and supply areas were clean and orderly, and except for housekeeping staff, the handwashing procedure was excellent. Overall, Item 25, rating hygiene and appearance of the patient earned only one mark below acceptability in twenty-four observations. Item 27, identifying physical changes, received one mark of excellence on the surgical unit; however, it was marked "Unobserved" in thirteen observations. This item could be rated only from direct observation, and not from chart review, therefore several record notations that revealed prompt identification of changes followed by appropriate action could not be rated in this section.

Item 33, concerned with medication effects, was the lowest mean in this area; the one mark of excellence was on the surgical unit. Item 34 and 35, both general and procedural asepsis earned marks of excellence on the surgical unit, but linen on the floor, soiled pads in wastebaskets and bedpans on the furniture waiting attention lowered marks on the medical unit. Although Item 36, providing for feelings of safety and security earned two scores of excellence, improper restraints, unattended smokers and out-of-reach call bells rated five unacceptable scores on related Item 37, ensuring patient safety.

Item 38, relating to medication administration, was unacceptable in four ratings, one on the surgical unit, three on the medical unit.

Of these, three were due to failure to properly identify the patient, and one because a patient was supplied antacids for self-administration without adequate instructions and supervision. This man drank from his bottle freely, and apparently no nurse noted his heavy use of the medicine.

Area IV: Entitled "General," this section of fifteen items covers actions that may be directed toward meeting either physical or psychosocial needs, or both. Both medical and surgical units received some ratings on individual items that were below acceptability. The medical unit mean was 2.6 and the surgical unit averaged 3.0. Item 39, patient instruction, was at the level of concern in five ratings. Involving the patient and family in the plan for care, Item 40, received eight unacceptable ratings overall. There were many ratings of "Unobserved" on three items; #43, actions that utilize resources within the milieu to help the patient problem solve; #48, making diversional or treatment activities available; and on #49, referring to accepting the unskilled or slow. In contrast, Preston (1977) found ratings at the level of excellence on both medical and surgical units studied for Item 43, and on the surgical unit for Items 48 and 49. Whitman (1979) cited Item 43 as yielding the highest item mean in her study.

Only two observations that could be classified as emergencies occurred during the twenty-four two-hour observation periods; one concerned a patient who choked while being fed, another referred to a patient with decreasing level of consciousness. Both on the medical unit, these interactions were rated in the area of concern on Item 53, evaluating

the nurse's response to emergencies.

The medical unit received five ratings of "Poorest Care" within Area IV, three of these dealing with involving the family in care, Item 40. This item received their one rating of excellent in Area IV.

The surgical unit rated five scores of excellence in this area: Item 39, relating to the giving of necessary instruction; Item 40, involving the family; Item 49, encouraging the slow; Item 51, concerned that interactions are within the framework of the therapeutic plan; and Item 52, relating to close observation without disturbance of the patient. Three scores of "Poorest Care" were given: one on Item 41, concerning protecting the patient's sensitivities and right to privacy; two on Item 50, which states that nursing care goals are established and activities performed which recognize and support the therapist's plan of care.

Area V: This section of eight items addresses communication on behalf of the patient, including charting and care plans. The surgical unit mean was 2.9, with "Poorest Care" entered for two items; #57 concerned with developing nursing care plans and then incorporating them into assignments, and #58, relating to the accurate reporting of patient behavior. Charting was largely incomplete in relating patient behavior. In one instance, no note explained a fall reported on an incident summary in the chart. By contrast, work sheets such as intake and output records and flow sheets for personal care seemed to be complete and accurate.

The mean for the medical unit was below the level of acceptability at 2.3, with Items, 54, 55, 56, and 57 of greatest concern; these measure oral and written communication and plans for implementing care.

Tour reports overall were complete, and dealt with priority issues, even though the taping procedure precluded two-way communication. On two occasions, however, questions were raised that led to a record search for more information than contained in the report; the record was also inadequate. Team conferences were not observed, but appeared to take place following tour report and then informally as needed. Weekly multi-disciplinary conferences were scheduled to take place on both units. While there were no ratings of excellence recorded in this area on either unit, there were many examples of excellent charting. When the patient's nursing notes were considered as a whole, however, the score was considerably weakened.

Care plans also varied in quality and character, with many indicating great care in outlining goals but no plan for implementing them; some plans had no goals and were not kept current; other plans seemed to be a replay of the physician's orders, that is, listing activities and treatments without identifying goals or specific nursing interventions.

Comparison of Area V findings with studies in other settings reveals similar weaknesses in planning and assigning care. In Preston's (1977) community hospital study, the surgical unit mean for this area was in the range of excellence, while the medical unit rated in the area for concern. The large hospital studied by Whitman (1979) yielded a mean of 3.1 for this area, lowest of her area mean scores reported. Both studies cited ratings of concern for items dealing with making nursing care plans and incorporating them in assignments. Wide differences in mean scores between items in the Communication Area in all three studies

indicate a need to study the variables influencing care planning, of which staffing is but one.

Area VI: This section of seven items evaluates initiative and responsibility of the nurse. The average for the medical unit was 2.5 for Area VI, with high scores rated on Item 65, which refers to good follow-through and reliability, and on Item 66, reflecting that staff keep informed of patient's condition and whereabouts.

Many items in this subsection were below acceptability for the medical unit, including four scores of concern on Item 62, which rates actions that reveal staff judgement. Insight for patient problems, Item 63, received seven poor scores. Item 64 earned nine scores in the area of concern, showing little attention to adapting care plans to patient needs or evaluating plans. There were six ratings of concern on Item 65, addressing responsibility issues, and four scores of concern on Item 67, marking flexibility in rule application. The organization and management of patient care, rating on Item 68, received seven of the twelve ratings in the area designated unacceptable.

The surgical unit mean was 3.1 for Area VI, with only four ratings of excellence: Items 65, 66, 67, and 68. Similar to the medical unit, low ratings for the surgical unit were more frequent in this area concerned with actions reflecting professional expectations. There were two poor entries on Item 63, four on Item 64, and one unacceptable mark each on 65, 55, 57, and 68. While there were far fewer ratings of concern on the surgical unit compared with the medical unit, the overall number of unacceptable marks makes this a special area for concern with

the quality of nursing care.

Comparison of Grand Mean and Area Mean Scores Between Tours

To further evaluate consistency in the quality of nursing care, twelve of the observations were made on the day tour and twelve on the evening tour of duty. Seven surgical unit observations were made on evenings, and five were made on days. On the medical unit, seven observations were made on the day tour and five on evenings. Table 4 displays the results of the Mann-Whitney U test of ranked differences in area mean and grand mean scores between the two tours. The third hypothesis stated that there would be a significant difference in grand mean scores on the QualPaCS during the day tour as compared to the evening tour of duty. The grand mean yielded a U which demonstrated a statistical difference between the day and the evening tours, therefore, the third hypothesis was accepted.

TABLE 4

Mann-Whitney U Test of Differences Between Tours

Units		Critical Values of U AREA						Grand Mean
		I	II	III	IV	V	VI	
Days	N_1	12	ID*	12	12	12	12	12
Evenings	N_2	12		12	12	12	12	12
	U	33	ID*	31.5	62	56.5	34	34
	p	$< .05$		.05	NS**	NS**	.05	.05

* Insufficient data to compute U.
**Nonsignificant U obtained with no specific numerical value available.

Comparison of grand mean scores between tours presented in Table 5 reveals that the evening tour had two grand mean scores in the level of concern while the day tour earned six grand means below the 2.7 level. One-half of the patients observed on the day tour did not meet the standard for acceptable care.

TABLE 5

Grand Mean Scores by Tour

Day Tour Patient #	4.1	4.2	4.3	4.4	4.5	4.6	4.7	2.1	2.2	2.3	2.4	2.5
Score	2.4*	2.6*	2.6*	2.6*	1.9*	2.8	2.7*	2.6*	2.8	3.0	3.0	2.9
Evening Tour Patient #	3.1	3.2	3.3	3.4	3.5	1.1	1.2	1.3	1.4	1.5	1.6	1.7
Score	2.9	3.3	2.1*	2.9	2.5*	3.6	3.5	3.1	3.5	3.8	3.4	2.8

*Level of Concern = 2.7

Area means were computed for the day and the evening tour and are presented in Table 6. As can be seen, area means were above the level of concern for the day tour on Area I. Areas III and IV were at the 2.7 level of concern, and Areas II, V, and VI were below the level set as acceptable. The evening tour area means fell in the area of acceptability except for Area V, which was at the 2.7 level of concern.

TABLE 6

Area and Grand Means for Day and Evening Tours

QualPaCS Area		Day Tour n	Day Tour Mean Score	Evening Tour n	Evening Tour Mean Score	Significance
I.	Psychosocial: Individual	12	2.8	12	3.3	*
II.	Psychosocial: Group	12	2.6	12	3.1	I.D.
III.	Physical	12	2.7	12	3.1	*
IV.	General	12	2.7	12	2.9	N.S.
V.	Communication	12	2.6	12	2.7	N.S.
VI.	Professional Implications	12	2.5	12	3.1	*
	Grand Mean		2.6		3.0	*

** $p < .01$ * $p < .05$ I.D. = Inadequate Data N.S. = Nonsignificant U

The fourth hypothesis predicted a significant difference in area mean scores on the QualPaCS during the day tour as compared to the evening tour of duty. Differences of statistical significance were demonstrated in Areas I, III, and VI, therefore, the fourth hypothesis is also accepted. The data from Area II was inadequate for a meaningful test difference, and Areas IV and V yielded nonsignificant tests of difference.

In order to better investigate the effects of interaction between unit, tour and area means, an Analysis of Variance (ANOVA) was also used to describe the findings. Table 7 is a summary of ANOVA showing the interaction of area, unit and tour. Unit means were significantly different in quality of care at a level less than .05. Tour was significantly related to care at the .02 level. Tour by area effect ($p < .02$) indicated that the tours responded differently along the six areas of the QualPaCS instrument.

TABLE 7

Summary of Analysis of Variance

Source of Variance	S.S.	df	M.S.	F	Probability
Between Subjects	23.14	19	1.21		
Units	8.41	1	8.41	13.0	0.002
Tour	3.86	1	3.86	5.9	Confounded
Units x Tour	.53	1	.53	.8	0.37
Subject Within Group (Error Between)	10.33	16	.64		
Within Subjects	9.55	80	.11		
Area Means	1.51	4	.37	3.7	Confounded
Units x Area	.25	4	.06	.6	0.64
Tour x Area	1.21	4	.30	2.9	0.02
Unit x Tour x Area	.04	4	.01	.11	0.97
Area x Subject Within Group (Error Within)	6.52	64	.10		

One factor influencing this interaction effect was the number of observations made on a unit during the evening tour, since both evening tours yielded higher means. The medical unit had five observations made on the evening tour, while the surgical unit was observed seven times on evenings. Examination of item means (see composite, Appendix G) by unit and tour shows that highest mean ratings were made by the surgical unit's evening tour, followed by surgical day tour; next highest were medical

unit's evening observations, and lowest were day tour observations on the medical unit. This distribution of scores suggests that the influence of tour was secondary to that of unit in relationship to quality of care. It can be said that observations between patient and registered nurse were more frequent during the evening tour, when smaller staffs were assigned, and that these observations yielded higher scores on the QualPaCS.

Notice that day tour and evening tour profiles shown in Figure 1 are similar, with greater score variances between tours seen in Areas I, II, and VI.

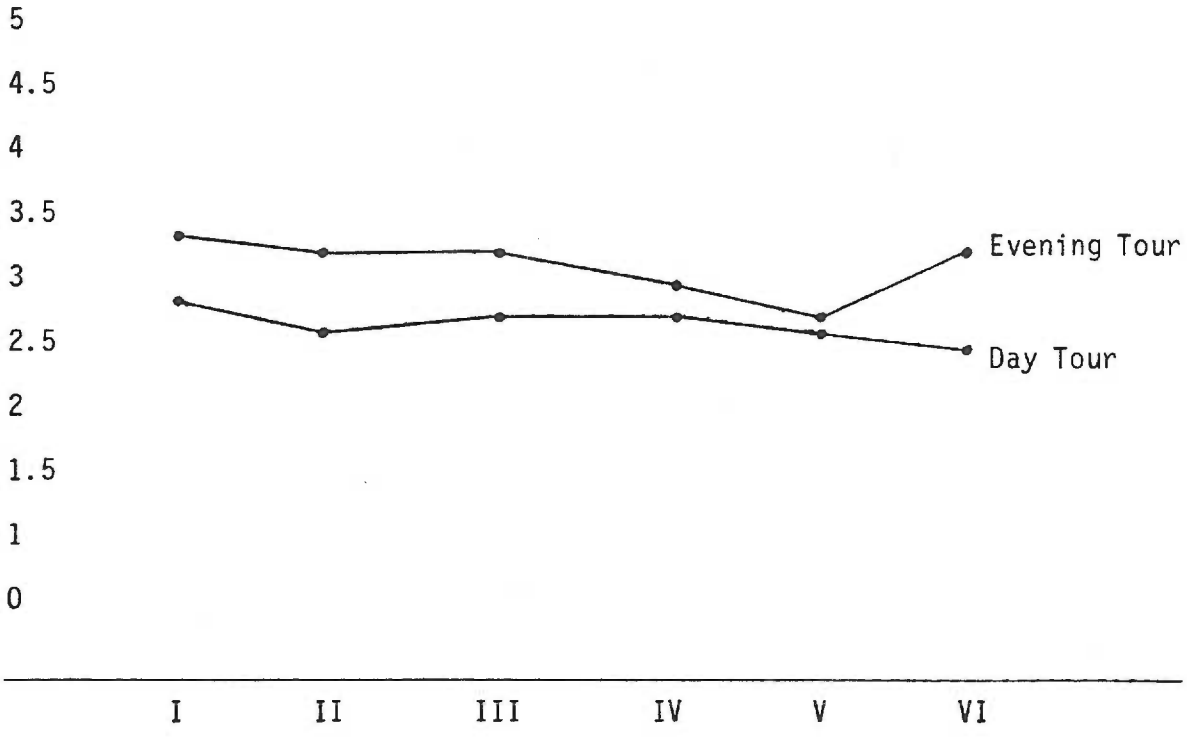


Figure I, Area Mean Scores by Tour

Results did not fall in the direction expected by the investigator, who anticipated that the larger staff assigned on the day tour would provide a higher quality of care, meriting higher scores on the QualPaCS.

A comparison of item means by area revealed specific areas of difference in the quality of care between the day tour and the evening tour.

Area I: Within this area relating to the psychosocial needs of the individual, the evening tour mean was 3.3, while the day tour averaged 2.8, both above the level for concern. Nine individual ratings of excellent were earned by the evening tour of duty on the following items: #2, rating care that allows the patient to express feelings; #3, concerned with a kind and friendly approach; #6, scoring explanation and reassurance; #7, involving therapeutic attention, #8, regarding consideration as a family member; #13, relating to an atmosphere of trust; #14, rating the use of appropriate topics for conversation. While the day tour rated excellent on Item 3 also, there were scores in the area for concern on Item 2, Item 5, dealing with patient anxiety, and Item 10, concerning acceptance for the demanding patient. There were two Items, #4, regarding response to inappropriate behavior, and #15, dealing with care to the unconscious patient, which received few ratings on either shift. The need for informed consent made it impossible to include confused or unconscious patients who had no family available to give consent, so observations on these items was limited.

Area II: While there were few observations in this area dealing with psychosocial interactions within a group, differences between tours were found. The day tour was rated on eleven observations, and earned scores

below acceptability on Item 16, relating to staff showing friendly attention to groups of patients, and Item 22, evaluating the giving of recognition and praise. Evenings also rated two marks of "Poorest Care" on Item 22, but earned one rating of excellent on Item 17, concerned with helping patients limit behavior.

Area III: Care reflecting actions to meet physical needs in this area averaged in the range of acceptability for the evening tour. There were six marks of excellence, all earned on the surgical unit. These were Item 26, utilizing time for communication; Item 27, identifying changes and taking action; Items 34 and 35, carrying out medical and surgical asepsis; Items 36 and 37, involving measures for safety and security. The evening tour earned twenty-five marks that were in the area of concern: Item 26, dealing with communication, rated four of these: Item 28, quick response to physical distress earned three; Item 29, encouragement to observe appropriate rest and exercise rated three; Item 31, actions to meet hydration and elimination needs scored two; Item 32, involving the effects of medication earned three; Item 33, handling behavioral expectations rated three. There was one score of concern for Item 35, medical and surgical asepsis; four marks, all on the medical unit, for Item 36, maintaining a safe and secure environment; Item 37, concerning preventing patient harm earned one mark; Item 38, involving safe medication administration rated one mark.

The day tour earned one mark in the range of excellence in Area III: Item 36 rated "5" on the medical unit, where four other observations of this item were of concern. Thirty-five scores were in the range of con-

cern for the day tour: Item 24, adapting nursing procedures for the individual rated four; Item 25, hygiene needs earned one; Item 26, three, Item 27, identifying physical changes, two; Item 28, three; Item 29, one; Item 30, encouraging the diet, two; Item 31, two; Item 32, six; Item 33, four; Item 34, three; Item 35, one; Item 36, one; and Item 38, two. Similarity in area of concern items between tours suggests a need for concern with overall performance of these activities relating to the physical care of the patient.

In Preston's (1977) community hospital study, hygiene needs were not met on the medical unit or on the evening shift, and all means for Item 34, medical asepsis related to personal and environmental hygiene, were in the range for concern. Both Preston and Whitman (1979) rated performance poor on Item 38, following established procedures for safe medication administration. Whitman, however, found higher scores on Items 32 and 33, indicating that while the nurses observed did not always follow procedure for medication administration, they knew what medications the patients received and their side effects.

Area IV: In this area concerned with meeting either physical or psychosocial needs or both at the same time, five marks of excellence were given, all on the surgical unit's evening tour. All the means for surgical evenings were above concern in Area IV, and four grand means rated scores of four, indicating above average care. Rating excellent were Items 39, regarding teaching; 40, involving the family in care; 49, dealing with acceptance; 51, concerning inappropriate interactions; 52, showing close observation. Thirty-four items rated below acceptability

for the evening tour. Of these, eleven were on Item 39; five on Item 40; two on Item 41, concerned with patient sensitivities and privacy; one on Item 42, rating help given to accept dependence; two on Item 43, relating to utilizing resources within the milieu to help the patient problem-solve, an item unrated on the medical unit; two on Item 44, evaluating the giving of choice in decision making whenever possible; three on Item 45, concerned with encouraging independence; two on 46, adapting activities; two on 47, adapting care to abilities; two on 48, relating to diversional activities; one on 49; four on 50, goals and activities that support the therapist's plan for care; three on Item 52, concerning close observation of the patient. The two ratings of concern on Item 53, involving emergency response, were entered on the medical unit.

The day tour shows many unmarked items in Area IV, and neither unit received scores of excellence on any item. Of concern on the day tour were thirty item ratings; these were more evenly distributed, but pointed concern at the same activities as the evening tour. There was one rating of concern each on Items 42 and 46; two on Items 39, 47 and 51; three on Items 40, 41, 43, 45, 47, 48, and 50; and four ratings of concern on Item 44, relating to patient choices.

Preston (1977) had similar findings in regard to emergency responses; rated once on each shift on the medical unit, the interactions scored in the area for concern. Nurses in Whitman's (1979) study responded to two emergency situations in an average fashion; however, Items 39 and 50 were the only two items in this area observed on all subjects.

Area V: Communication on behalf of the patient, rated in this area, earned no scores of excellence on either day or evening tour. Mean score for the day tour was 2.6, and for evenings 2.7, both in the range of concern. Several items rated marks in the area of concern. They were Item 54, relating to verbal communication, which rated two such marks on evenings and three on the day tour; Item 55, concerning communication with family, earned two on each tour; Item 56, involving charting, rated three on evenings and six on days; Item 57, rating care plans, scored five on evenings and seven on days; Item 58, dealing with accurate reporting of patient behavior, rated five on evenings and eight on day tour; Item 59, regarding patient care conferences, rated one on evenings; Item 60, evaluating communication and relationships with other disciplines for the patient's benefit, earned two on evenings and four on day tour. Item 61, which relates to the use of referrals to meet patient needs for care, rated one poor mark on the evening tour and three on the day tour.

Area VI: In scoring professional implications of care delivery in this area, the day tour received a rating of 2.5, within the level of concern, while the evening tour was rated 3.1, within the range of acceptability. Preston (1977) had similar findings for Area VI, with a day mean of 2.6 and an evening shift rating of 3.9.

Two item means were above the level of concern for the day tour; Item 62, stating that decisions made by staff reflect knowledge of facts and good judgement, and Item 65, regarding staff reliability and follow through. The remaining five item means in this area evidenced concern for care during the day tour related to insight into patient problems,

evaluation of care results, and knowledge of patient's condition and whereabouts, and management of care that is flexible, based on patient needs.

The evening tour rated in the area of concern on two item means in Area VI. Relating to insight into the deeper needs of the patient, Item 63 scored low marks for lack of communication with terminal patients as well as failure to address pre-operative concerns of the surgical patient. Item 64, reflecting that care plans show continuous evaluation of care results earned poor ratings for failure to update plans to provide for new needs.

A comparison of unit mean scores and tour means reveals a contrast of interest. As can be seen in Figure I, Area VI means showed a rise on both the medical and the surgical evening tour, and a decrease as compared to other means, on the day tour.

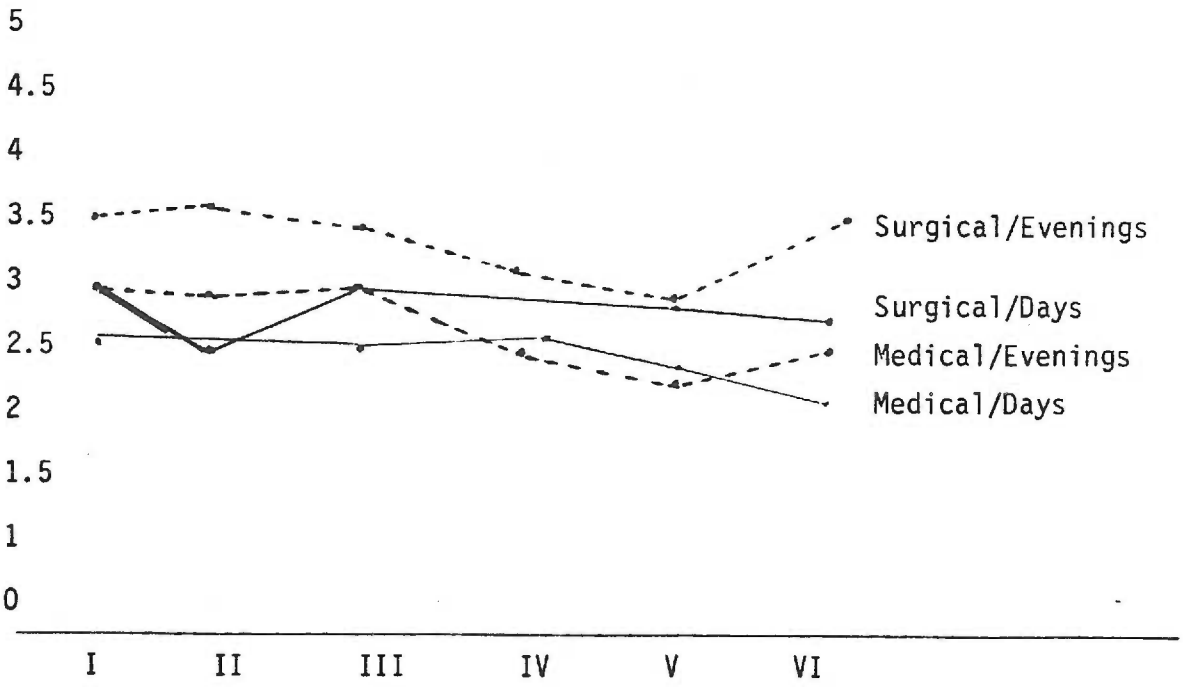


Figure II. Area Mean Scores by Unit and Tour

While each care-giver was rated as a first-level staff nurse, many observations on the day tour rated activities performed by non-professionals, such as baths and personal care. Although there were fewer nurse/patient interactions during the evening tour, many of these involved treatments, dressings, or medications administered by the professional nurse. The professional nurse interactions yielded higher scores in this area relating to sound judgement, knowledge, and decision-making ability.

Overall Level of Care

The overall area means and grand mean scores were computed and appear in Table 8. Area mean scores for observations within five of the six areas of the QualPaCS instrument rated above the level of concern set by the Quality Assurance Committee. The area mean score for Area V, Communication, was 2.6, below the level set as acceptable. The grand mean score for all observations was 2.8, in the range of acceptability.

TABLE 8

Overall Area Means and Grand Means

	I	II	III	IV	V	VI	Grand Mean
All Observations	3.0	2.9	2.9	2.8	2.6	2.8	2.8

Wide variances in ratings from poor to above average were seen in item mean scores (see Appendix G, p. 105). These scores reflect means on each of the 68 items from all observations. Fourteen item means were in

the area of concern. No item means were recorded at the level of excellence, designated by the Quality Assurance Committee at 4.2, and there were but ten item mean scores above the 3.0 rating for "Average".

Items in Area II, dealing with the psychosocial needs of the patient as a member of a group had few ratings, as shown in Table 9. Presumably few interactions observed could be rated under these items dealing with group behavior. Only 28 of a possible 192 ratings were made overall in Area II, which seems especially significant since twenty-three of the twenty-four patient observations were made while at least one other patient was in the room, and some interactions that indicated perception of the patient as a member of a group could have been expected. Mean scores in Area II ranged from a low of 1 to a high of 4.0 a range which is misleading since both reflected items with only two ratings from all observations.

TABLE 9

Area II Item Mean Scores

QualPaCS Item	Day Tour	Evening Tour	Medical Unit	Surgical Unit	Overall Mean
15	3.0	3.6	3.1	3.5	3.1
16	2.3	3.2	2.7	2.8	2.8
17	.0	3.5	3.0	4.0	3.4
18	.0	3.0	.0	3.0	3.0
19	3.0	.0	3.0	.0	3.0
20	.0	.0	.0	.0	.0
21	.0	.0	.0	.0	.0
22	2.0	.0	1.0	2.0	2.3
Grand Mean	2.6	3.3	2.6	3.0	2.9

A conclusion was drawn by the raters that interactions dealing with patients as members of a group were not seen as valuable nursing interventions on the two units observed.

An analysis of tour data by unit displays further differences in care delivery (see Table 10, p. 46). The medical unit day tour shows item mean scores ranging from 1.3 to 3 on a total of 335 rated items, with 58% falling into the acceptable range. The medical unit evening tour rated slightly higher, with an item mean range of 1 to 3.5, and 68% of the scores were above the level of concern. The surgical unit day tour item means ranged from a low of 2 to a high of 3.7, with 79% of scores in the range of acceptability. The evening tour on the surgical unit earned the highest item mean scores, with a range from acceptable to above average; 2.7 to 4. While 80% of the scores on 363 rated items were acceptable, there were 27 ratings in the range of excellence.

TABLE 10

Item Means Analysis by Unit and Tour

	Item Means of Excellence	Item Means of Concern	% Total	Item Means Acceptable	% Total	Unrated Items
Medical/Day	1	133	39	196	58	145
Medical/Evening	5	76	31	168	68	91
Surgical/Day	1	50	20	189	79	100
Surgical/Evening	27	43	11	293	80	113

The smaller evening staffs on both medical and surgical units were confined to the delivery of priority care, as has been pointed out, which led to a higher percentage of interactions involving the professional nurse with the patient, and this tended to raise ratings. Two other factors were noted that contributed to differences in care; they were related to the physical environment and to the orientation of staff members.

The larger medical unit consisted of two long wings, making care delivery difficult. Patient care seemed to be arranged by scheduled rounds to adjust for this inconvenience in access, limiting both the frequency of interactions and the ability to individualize care.

Another factor of influence in care quality may have been the experience of the staff, since two new nurses were team leaders and two new nursing assistants were team members on the medical service during observations there. While the surgical service sustained staff losses due to illness during the observation period, nursing staff were all familiar with the unit.

CHAPTER IV

DISCUSSION

Observation of care in progress recorded on the QualPaCS instrument established a measurement of the quality of care on the medical and surgical units in the study hospital. Analysis of the study results indicated that there was a significant difference in the quality of care delivered by the two units studied. Area means and grand mean scores for the surgical unit were within the range set as acceptable, while area means for the medical unit fell in the range of concern except in Area I, meeting psychosocial needs of the individual. There were differences in the quality of nursing care between tours, but not in the direction expected by the investigator. The evening tour scores were acceptable in all areas except Area V, concerning communication on behalf of the patient, while day tour area means were in the range for concern except for Area I, meeting psychosocial needs of the patient as an individual.

The purpose of this evaluative research was to define areas of strength and of weakness in order to appropriately guide efforts for corrective action. Examination of the overall mean for each item reveals several areas of general strength. While no item mean rated in the range of excellence (see Appendix F, p.103), 50 of the 61 item means having more than two observations fell in the acceptable range. This represented 81% of the total ratings made.

Falling at the 2.7 level or below were 15 item means, indicating that 24% of scores were of concern. Within Area I, only one item mean was at the level of concern, suggesting that psychosocial needs of the

individual are generally addressed in a therapeutic manner. Only two items within Area II received sufficient ratings for mean analysis, and while some items were in the range of acceptability, the lack of interactions in which the patient is recognized as a member of a group is of concern. Three of the Area III means were of concern in 15 questions concerning physical care. Five means of concern were in the Area IV designation of general care; four were in Area V, Communication, and two in Area VI, Professional Implications.

Item Examples

Items that generated means in the level of concern will be examined individually using examples from the raters' notes to illustrate specifics of care:

Item 10: The rejecting or demanding patient continues to receive acceptance. Although the surgical unit evening tour handled the demanding patient in an acceptable manner, and no observation of such behavior was noted on the medical unit's evening tour, the other two groups resorted to scolding or avoidance in five observations.

Item 28: Physical distress evidenced by the patient is responded to quickly and appropriately. Of concern were the means for the medical unit days, and both evening groups. Examples of interactions responsible for these low scores:

When a terminal patient began to moan during linen change, his caretaker completed the bedmaking silently and left the room. The medication nurse administered an analgesic, again without questioning the patient regarding his discomfort.

Another patient requested pain medication, and was told that he would have another when it was due. Less than fifteen minutes later, he

asked again, and the nurse crossly told him to put out his light, that his order was for every six hours and it was not time. When he rang again in six minutes, telling the now angry nurse that he wanted "a shot right away", she advised him to talk to the doctor in the morning about the frequency he had ordered.

An observed patient became restless and tachypneic. The nurse looked at him with obvious concern, but took action only when his roommate called her back to voice his concern for the man. She called the physician in without checking the vital signs or neurologic indicators.

Item 32: Behavioral and physiologic changes due to medications are observed and appropriate action taken. Of concern in ratings for both day tour groups, examples include:

The patient who is on both narcotics and antacids has not been offered his "as needed" laxative, and is offered only sympathy when he complains of distention.

A man on DES and chemotherapy had no nurse's note regarding the obvious side effects he suffered.

Item 33: Expectations of patient's behavior are adjusted and acted upon according to the effect medication has on the patient. Rated by both direct and indirect observation, this item was of concern on both surgical tours and on medical unit days.

A patient on bronchodilators known to stimulate restlessness complains of exhaustion and persistent insomnia, but his schedule is not adjusted nor is the physician informed.

The post-operative patient on frequent narcotics has become anxious and emotionally upset between doses for two days.

An elderly patient with peripheral vascular disease is on Haldol and Morphine. He is very agitated and restless, requiring restraint. His intravenous injection is running ahead of schedule, although his output is down.

Two administrations of analgesics were unaccompanied by exploration of need or explanation of expected result.

Item 40: Patient and family are involved in planning for care and treatment. Ratings of concern were made on the medical unit and on the surgical unit evening tour. Although some patients had no family or "significant other", several missed opportunities for involving family and patient in care were noted.

Hospitalized because he has become too forgetful to monitor his diabetes, the patient awaits nursing home placement. The woman who lives with him visits daily, expressing her loneliness and the hope that he can return home. No arrangements have been made to have her participate in his care or in planning for care.

When a working family member could come only in the evening, the day tour nurse left a note for her relief to discuss discharge plans with him. However, when the son came to visit, he questioned the nurse sharply about his father's intravenous site, and she left the room quickly without discussing the impending discharge.

No note, observation or referral indicated discussion of change in either diet or life style with the young ulcer patient and his wife.

One wife stayed in a motel to be able to visit her husband another time before returning to their distant home. She was dismayed to find that he would be off the ward most of the day for examination.

Although the family of the patient who is in alcoholic withdrawal look anxious and concerned as they view him in restraints, and actively hallucinating, the nurse does not speak to them.

Item 43: Resources within the milieu are utilized to provide the patient with opportunities for problem solving. Unrated on medical evenings, this item earned marks of concern in the other groups. Examples of poor utilization of available resources:

Sent to the bathroom to change his dressing because he had no mirror in his room, the patient used the community basin to clean and dress his surgical wound.

The paraplegic man had no trapeze to assist with turns and lifts.

Although the forgetful elderly patient is checked several times, he is not offered a urinal during the observation period. Eventually, he wet the bed.

Item 47: Nursing care is adapted to patient's level and pace of development. Five of twenty-four scores were of concern and twelve observations were marked "Unobserved" on this basic process. There was little evidence that care was adapted for individual patients:

The debilitated patient was exhausted when he returned from the shower, but his bed was unmade, so he had to sit up.

The elderly diabetic has returning orientation, but the nurse gives only a smile in answer to his questions about his insulin.

Item 48: Diversional and/or treatment activities are made available to the patient according to his capabilities and needs. Above concern on surgical evening scores, that staff provided one patient with a Bible and

a reading glass, another with a visit to a pal down the hall. Other groups had problems making activities available:

One gregarious patient spent his "up" period at his bedside, faced away from the television the others were watching.

The hyperthyroid patient paced with frustrated energy until another patient took him to the pool room.

Sent to physical therapy for crutch walking, the patient is unable to take part dressed in gown and slippers, carrying his urinary drainage bag.

Item 53: Response to the patient is appropriate in emergency situations. Rated by direct observation only, this item was marked on two records, both in the range for concern:

When one patient's level of consciousness fell dramatically, his nurse came into the room and looked at him frequently, but did not check vital signs or summon his physician until another patient became alarmed.

The weak patient choked while being fed, becoming cyanotic and agitated. His caretaker stood by patiently, instructing him to "cough it up" without raising his head or offering assistance. Although the patient was exhausted and shaky following the paroxysm, the team leader was not notified and his breath sounds were not assessed.

Dangerous practices were observed that could have precipitated emergencies:

Bedside rails were left down several times on an unresponsive patient.

Physicians drawing blood left equipment in the bed and on the stand after completing the task.

Although the physician was notified immediately of an elevated potassium, the patient was fed before a resin enema was administered. The possibility of delay leading to an arrythmia was not addressed.

Two nurses lifted a heavy patient from his wheelchair, and would have dropped him without the assistance of a nurse observer.

Item 54: Ideas, facts, feelings and concepts about the patient are communicated clearly in speech to medical and paramedical personnel. Rated in the area of concern in each group, this item pointed observations to several communication problems:

Evening nursing assistants who must answer lights often miss information at report.

One nurse's exchange was highly emotional and did not contribute to better understanding of the patient's problem by her team.

The hepatitis patient with severe weight loss continued to miss meals as tests are scheduled at mealtime. Discussed among the staff for several days, it finally came to the physician's attention.

Few questions were asked of nursing assistants that related to describing the patient's condition or to the plan for care. While each interaction was rated considering the care giver as a first-level staff nurse, as detailed by the design, many care givers were non-professionals. If effort was made to include them in communication describing the patient, it was not observed.

Item 57: Well-developed nursing care plans are established and incorporated into nursing assignments. While there were several examples of well-written care plans, few utilized the planning by incorporating them

into the care assignments, and fewer still evidenced evaluation of success and change in the initial admission plan. Written assignments were studied; most specified physical care, bed status and special concerns such as appointments. There was no reference to the objectives of the plan of care. One written assignment was room numbers only, unembellished by care or plan. No plan studied revealed information about the patient's likes or dislikes, although staff conversation with the patient and among themselves indicated a real interest in responding to needs the patient had identified.

Item 58: Pertinent incidents of the patient's behavior during interaction with the staff are accurately reported. This item generated means of concern on the surgical unit day tour and on both medical unit groups. Contributing to these scores were notes that failed to reflect changes in the patient's behavior. Few notes detailed clearly the response to nursing care given:

An angry patient who wanted to leave for two days had no entry recording either his feelings or his refusal to comply with his ordered regimen.

There was no nursing entry recording a fall outlined in an incident summary on the chart. Another record noted that a fall had occurred, but there was no incident summary on the chart.

The unusual behavior of the patient who is a study in perpetual motion, consuming six candy bars between meals and pestering for snacks is undocumented.

No notes for nearly a month appear on one patient, although he was on chemotherapy during this time, experiencing severe side effects.

Item 61: Patient's needs are met through the use of referrals, both to departments in the hospital and to other community agencies. Rated by both direct and indirect review, this item was in the level of concern on the medical unit. Average means were earned by the surgical unit. Although this facility's procedure calls for the physician to make most referrals, those responsibilities appropriate to nursing were seldom addressed. For example:

The patient noted to be a poor eater continued to sustain weight loss, but there was no diet consult ordered.

A young alcoholic is treated and discharged without referral to social service staff.

A chaplain was not called to visit the anxious pre-operative patient, although his plan listed a religious affiliation.

Item 63: Evidence is given by staff of insight into deeper problems and needs of patients. Spoken, behavioral and recorded evidence was considered by raters, and both surgical groups, day and evening tour, rated in the level of acceptability. Of concern were ratings on both tours on the medical unit studied, where lack of insight was apparent in these interactions:

A patient awaiting exploration of his coin lesion is placed in a room with a terminal cancer patient. When he openly expresses his fear of his own prognosis to the nurse, there is no reply.

The dying patient is avoided.

Problems of the young patient who has sustained a change in body image are not addressed.

Plans for nursing home placement are not revealed to the sometimes confused patient who has had a difficult time adjusting to the hospital environment.

Item 64: Changes in care and care plans reflect evaluation of results of nursing care. Low ratings on the medical unit contributed to the mean within the area for concern. For example:

The patient who developed a decubitus lacks an updated care plan changing his skin care and mobility schedule.

Two patients evidenced remarkable weight loss during hospitalization, and while a can of diet supplement was noted on each stand, no plan refers to diet changes.

A debilitated patient is still "up ad lib" even though he has had two falls. There is no plan to provide him with a walker or to assist him in ambulating.

Staffing

A major aim of nursing service administration is to predict and assign the number and kind of nursing staff to administer adequate care. To compare the care element with the structural element of staffing, the care hours for each unit and each tour were recorded and are illustrated in Table II (for a complete staffing analysis, see Appendix J, p. 115).

Differences in scheduled activities account for the wide divergences in staffing between tours of duty: most baths are given on the day tour, two meals are served, patients are sent to and received from examinations, therapy, and surgery. In addition, staff meetings, conferences and inservice presentations are scheduled during the day tour.

Table 11

Nursing Care Time Per Patient

	Nurse Time (Minutes)	% Total	Non-Professional Time (Minutes)	Total Staff Time (Minutes)
Medical-Days	52	71%	73	125
Surgical-Days	36	50%	71	107
Medical-Evenings	22	50%	44	66
Surgical-Evenings	24	57%	42	66

The medical unit day tour assigned 59 minutes more than their evening tour, while the surgical unit day tour shows a 41 minute difference over the evening tour. Although there was the same staff time allotted per patient between the two units on evenings, the surgical unit showed slightly more professional nurse time, and this may account in part for the higher ratings earned by that unit.

The medical unit assigned a total of 125 minutes of care time per patient on the day tour, and 66 minutes of staff time were allotted on the evening shift. The surgical unit day tour allowed 107 minutes per patient on the day tour, 66 on the evening tour. Differences that exist in the categories of patients making up the census account in part for the variance (see Appendix J, p.115). Staffing is but one factor among variables that influence the quality of care, and it is not within the scope of this study to define a relationship between staffing and the quality of care. However, it is of interest to note that the surgical

unit, displaying the smaller staff per patient ratio, achieved higher ratings.

Differences also exist in the type of personnel assigned: the medical unit day tour averaged 52 minutes of professional nurse care per patient, or 71% of the total staffing; the surgical unit averaged 36 minutes of nurse time, or 50% of total staff time. The percentage of professional nurse staffing on the evening tours was closer, at 50% for medical unit and 57% for the surgical unit. The results of this study did not reveal a direct relationship between the hours of care assigned to the professional nurse and the scores earned on the QualPaCS scale.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This evaluation study was done as part of the overall plan for Quality Assurance in this Veterans Hospital. The purpose was to provide information concerning the standard of care and to study the effect of unit and tour on the quality of care. Authorized by the Chief Nurse and with the cooperation of the Quality Assurance Committee, this survey will complement structure and outcome audits of care to provide comprehensive bases for planning improvements in nursing practice and better patient care.

The Quality Patient Care Scale (QualPaCS) was used to measure the quality of care. This instrument is designed to evaluate the quality of nursing care delivered to the patient while that care is in progress without regard for the category of personnel providing care. A pilot study was conducted to provide the three raters with instrument familiarity and to generate data to establish interrater reliability. The study consisted of twenty-four two hour periods of direct observation of patient care. Components of nurse-patient interactions were rated on the QualPaCS instrument. Subjects were selected by random process, with an equal number from the medical and the surgical unit studied on both the day and the evening tour of duty.

Four hypotheses were made prior to this study. The first hypothesis: There will be a significant difference in grand mean scores on the QualPaCS between medical and surgical units, was accepted. The second

hypothesis: There will be a significant difference in Area Mean scores between the medical and surgical units, was accepted. The third hypothesis: There will be a significant difference in grand mean scores on the QualPaCS during the day tour as compared to the evening tour, was accepted. The fourth hypothesis: There will be a significant difference in area mean scores on the QualPaCS during the day tour as compared to the evening tour, was also accepted.

Conclusion

The conclusion drawn from this study was that the quality of nursing care is not consistent throughout this hospital, but that significant difference exists between the medical unit and the surgical unit studied, as well as between the day tour and the evening tour of duty. The research also identifies specific areas of concern, acceptability and excellence in care, using the levels set by the Quality Assurance Committee. This measurement identifies areas of strength and weakness and can serve as a first step in planning corrective action.

Recommendations

It is suggested that the Quality Assurance Committee make recommendations for corrective action to improve the quality of nurse-patient interactions in those areas falling below the level of acceptability on the QualPaCS. It is also suggested that the results of this study be compared to findings from structure and outcome audits of care made by the Committee to cross validate findings. Echoing Preston's recommendation

for replication, the suggestion is offered to the Committee to duplicate this study after corrective action has taken place, in order to measure the effectiveness of the measures.

The outcomes of this study suggest several areas for future research:

1. Replication of this study using the same subjects over three tours of duty, to measure consistency in the quality of care over a 24-hour period.
2. A similar study designed to evaluate care in the Critical Care Units in this setting, for comparison with this study.
3. Measure the exercise of professional responsibilities by nurses in public and private settings, using QualPacs Area VI items.
4. Compare the educational preparation of the caregiver to the quality of nursing care provided, as measured by a QualPacs survey.

REFERENCES

REFERENCES

American Hospital Association. Quality assurance program for medical care in the hospital. Chicago: American Hospital Association, 1972.

American Nurses Association. Standards of Nursing Practice. Kansas City: American Nurses Association, 1973.

Anderson, M. I. Development of outcome criteria for the patient with congestive heart failure. Nursing Clinics of North America, 1974, 9 (2), 349-358.

Berni, R. & Readey, H. Problem-oriented medical record implementation: allied health peer review. St. Louis: The C. V. Mosby Co., 1974.

Bloch, D. Evaluation of nursing care in terms of process and outcome. Nursing Research, 1975, 24, 256-264.

Brook, R. H. Quality of care assessment: a comparison of five methods of peer review. No. 74-3100, Dept. of Health, Education and Welfare, Health Resources Administration, Washington, D. C., 1973, 57-59.

Donabedian, A. Some issues in evaluating the quality of nursing care. American Journal of Public Health, 1969, 59 (10), 1833.

Donabedian, A. Foreward in Phaneuf, M. C. The Nursing Audit. New York: Appleton-Century-Crofts, 1972.

Diers, D. The effect of nursing interaction on the patient in pain. Nursing Research, 1972, 21, 419-428.

Dyer, E. D. Nurse performance description: criteria, predictors, and correlates. Salt Lake City: University of Utah Press, 1967.

Eichhorn, M. L. & Frevert, E. Evaluation of a primary nursing system using the Quality Patient Care Scale. The Journal of Nursing Administration, 1979, 9 (12), 11-15.

Ellis, G. L. PSRO's background and perspective. AORN Journal, 1975, 22 (2), 169-178.

Felton, G. Preoperative nursing intervention with the patient for surgery: outcomes of three alternative approaches. International Journal of Nursing, 1976, 13 (2), 83-96.

Froebe, D. J. & Bain, R. J. Quality assurance programs and controls in nursing. St. Louis: The C. V. Mosby Co., 1976.

Gortner, S. R. Scientific accountability in nursing. Nursing Outlook, 1974, 22 (12), 764-768.

Hartnett, H. T. Accountability in higher education: a consideration of some of the problems of assessing college impacts. New York: College Entrance Examination Board, 1971.

Hays, W. L. Statistics for Psychologists. New York: Holt, Rhinehart & Winston, 1965.

Hegyvary, S. T. & Haussman, R. K. D. Monitoring nursing care quality. Journal of Nursing Administration, 1976, 6 (9), 3-27.

Hilger, E. E. Developing nursing outcome criteria. Nursing Clinics of North America, 1974, 9 (2), 323-330.

Hulka, B. & Cassel, J. The AAFP-UNC study of the organization, utilization and assessment of primary medical care. American Journal of Public Health, 1973, 63, 494-501.

Jacox, A. Pain alleviation through nursing intervention. (Report of unpublished nursing research, grant No. NU 00467), Bethesda, MD., Division of Health Manpower, U.S. Public Health Service, 1976.

Johnson, J. E. Effects of structuring patients' expectations of their reactions to threatening events. Nursing Research, 1972, 21, 499-504.

Kramer, M. Extra tactile stimulation of the premature infant. Nursing Research, 1975, 24, 324-334.

Kessner, D. M., et al. Assessing health quality - the case for tracers. New England Journal of Medicine, 1973, 288, 189-194.

Lang, N. B. A model for quality assurance in nursing. Unpublished doctoral dissertation, Marquette University, 1974.

Lindeman, C. A. Nursing intervention with the presurgical patient: effectiveness and efficiency of group and individual preoperative teaching - phase two. Nursing Research, 1972, 21, 196-209.

Lindeman, C. A. & VanAernam, B. Nursing intervention with the presurgical patient - the effect of structured and unstructured preoperative teaching. Nursing Research, 1971, 20, 319-332.

Lindeman, C. A. Measuring quality of nursing care. Journal of Nursing Administration, 1976, 6 (5), 7-9.

Mullane, M. K. Nursing care and the political arena. Nursing Outlook, 1975, 23 (11), 699-701.

Peplau, H. E. Responsibility, authority, evaluation and accountability of nursing in patient care. Michigan Nurse, 1971, 44, 5-7.

Phaneuf, M. C. The nursing audit: profit for excellence. New York: Appleton-Century-Crofts, 1972.

Phaneuf, M. C. The nursing audit: self-regulation in nursing practice. New York: Appleton-Century-Crofts, 1976.

Polit, D. & Hungler, B. Nursing research: principles and methods. New York: J. B. Lippincott Company, 1978.

Preston, P. N. M. A quality of patient care survey in a community hospital. Unpublished manuscript, University of Oregon Health Sciences Center, 1977.

Sanazaro, P. J. & Williamson, J. S. End results of patient care: a provisional classification based on reports by internists. Medical Care, 1968, 123-130.

Shapiro, S. End result measurement of quality of medical care. Milbank Memorial Fund Quarterly, 1967, 45, 7-30.

Siegels, S. Non-parametric statistics for the behavioral sciences. New York: McGraw-Hill Book Co., 1956.

Slater, D. The Slater nursing competencies scale. Detroit: Wayne State University Press, 1967.

Stevens, B. J. The nurse as executive. Wakefield, Mass.: Contemporary Publishing Company, 1975.

Tate, B. L. Test of a nursing performance evaluation instrument. New York: National League for Nursing, 1969.

Taylor, J. W. Measuring the outcomes of nursing care. Nursing Clinics of North America, 1974, 9 (2), 337-348.

U.S. Public Law 92-603, 92nd Congress, 2nd Session, 1972.

Verhronick, P. J. Decubitus ulcer observations measured objectively. Nursing Research, 1961, 10, 221-224.

Wandelt, M. A. &Ager, J. Quality patient care scale. New York: Appleton-Century-Crofts, 1974.

Wandelt, M.A. & Phaneuf, M.C. Three instruments for measuring the quality of nursing care. Hospital Topics, 1972, 50, 20-29.

Whitman, M. The relationship between the quality of leadership and the quality of care. Unpublished manuscript, University of Oregon Health Sciences Center, 1979.

Zimmer, M. J. Quality assurance for outcomes of patient care. Nursing Clinics of North America, 1974, 9 (2), 305-315.

APPENDICES

APPENDIX A

THE QUALITY PATIENT CARE SCALE

WAYNE STATE UNIVERSITY

College of Nursing Date

QUALITY PATIENT CARE SCALE*

Qualpacs

Patient (name or No.): Rater (name or No.):

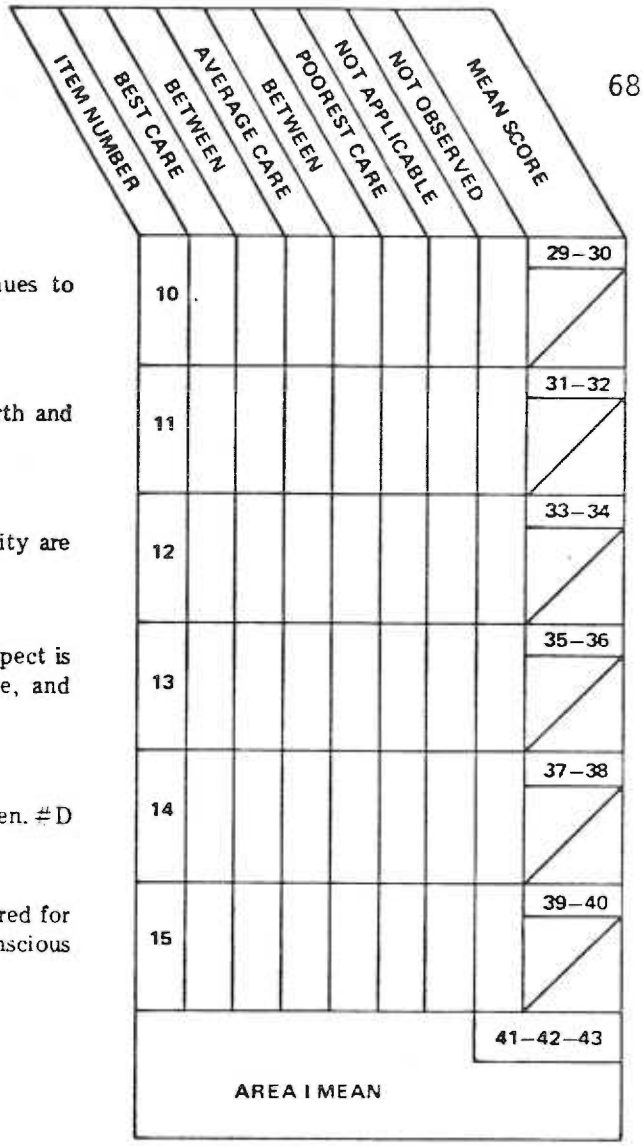
INTERACTIONS RECORD: AM/PM

No.:
Time:

PSYCHOSOCIAL: INDIVIDUAL

Actions directed toward meeting psychosocial needs of individual patients.

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



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

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

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

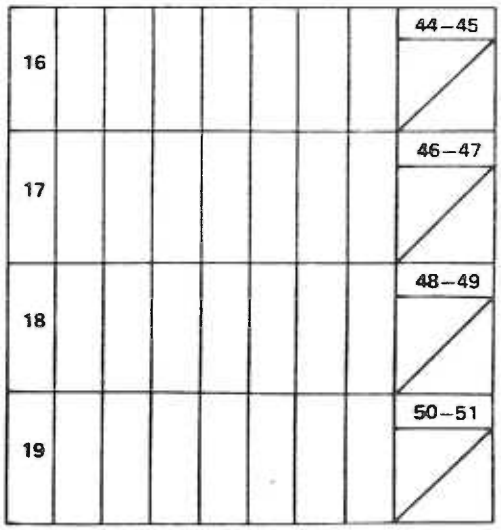
13. An atmosphere of trust, acceptance, and respect is created rather than one of power, prestige, and authority. # D

14. Appropriate topics for conversation are chosen. # D

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

PSYCHOSOCIAL: GROUP

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

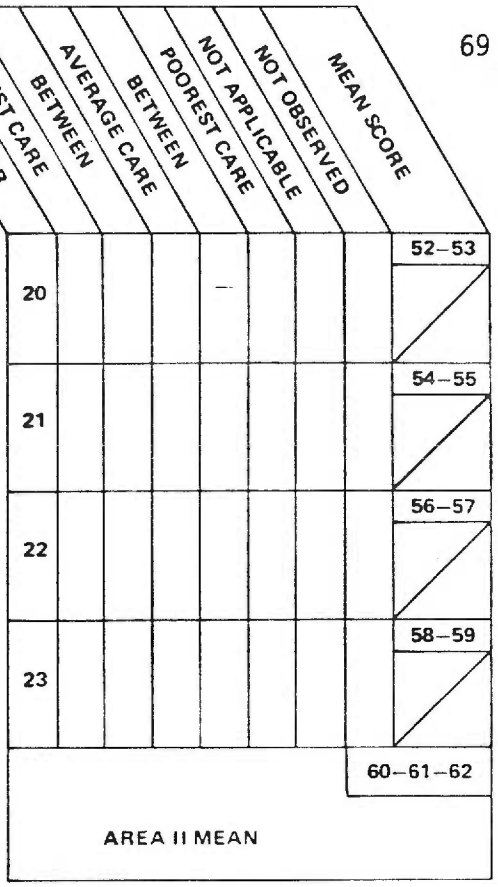


16. Patient as a member of a group receives warmth, interest, and attention from the staff. # D

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

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

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



20. Staff proposals for patient activities appropriately reflect interests and needs of the group members. # D

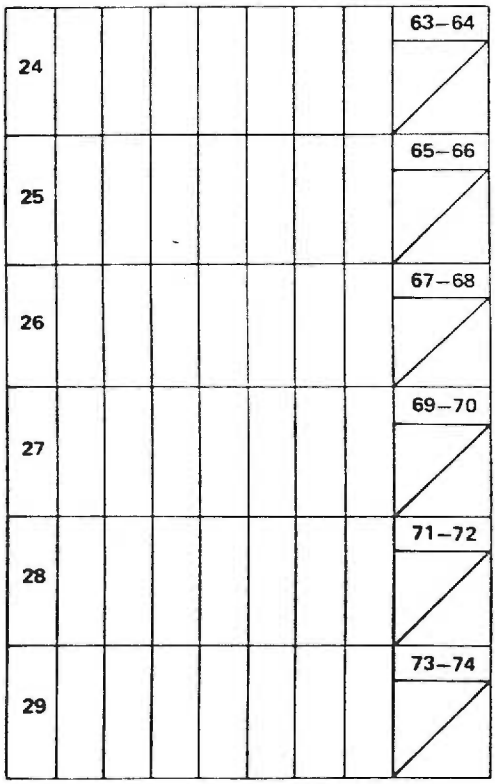
21. Patient is helped to vent his emotions in a socially acceptable way within the group. # D

22. Praise and recognition are given for achievement according to individual needs and with respect for others in the group. # D

23. The rights and integrity of the group member are protected within the group structure. ≠ D

PHYSICAL

Actions directed toward meeting physical needs of patients.



24. Nursing procedures are adapted to meet needs of individual patient for treatment. ≠ D

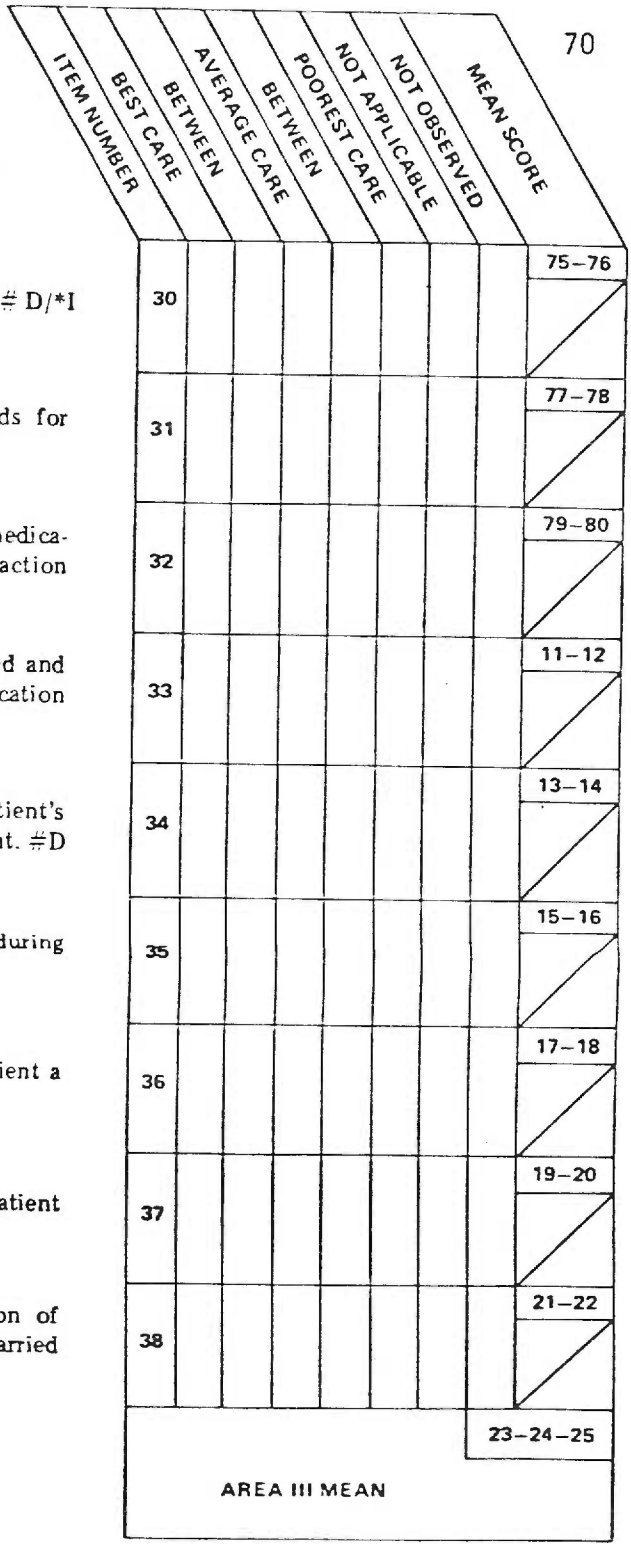
25. Patient's daily hygiene needs for cleanliness and acceptable appearance are met. # D

26. Nursing procedures are utilized as media for communication and interaction with patient. ≠ D

27. Physical symptoms and physical changes are identified and appropriate action taken. ≠ D

28. Physical distress evidenced by the patient is responded to quickly and appropriately. ≠ D

29. Patient is encouraged to observe appropriate rest and exercise. # D/*I



30. Patient is encouraged to take adequate diet. # D/*I

31. Action is taken to meet the patient's needs for adequate hydration and elimination. # D/*I

32. Behavioral and physiologic changes due to medications are observed and appropriate action taken. # D/*I

33. Expectations of patient's behavior are adjusted and acted upon according to the effect the medication has on the patient. # D/*I

34. Medical asepsis is carried out in relation to patient's personal hygiene and immediate environment. #D

35. Medical and surgical asepsis is carried out during treatments and special procedures. # D/*I

36. Environment is maintained that gives the patient a feeling of being safe and secure. # D

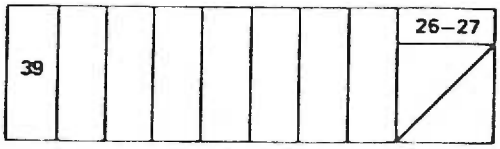
37. Safety measures are carried out to prevent patient from harming himself or others. # D

38. Established techniques for safe administration of medications and parenteral fluids are carried out. # D

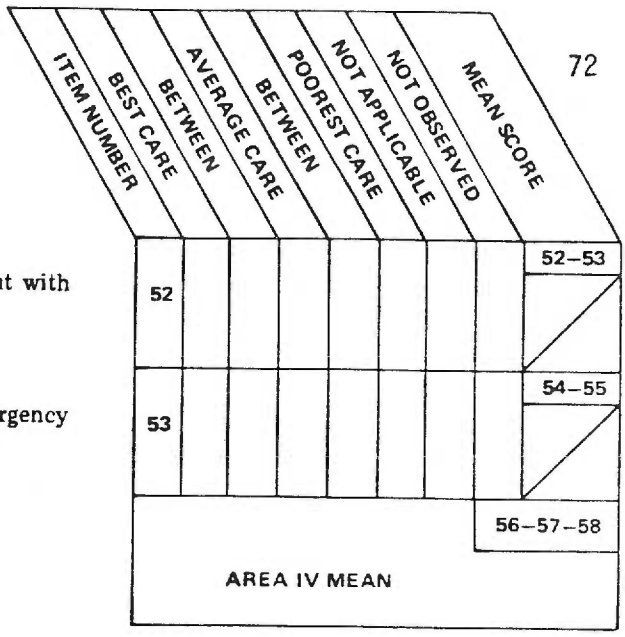
GENERAL

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

39. Patient receives instruction as necessary. # D



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

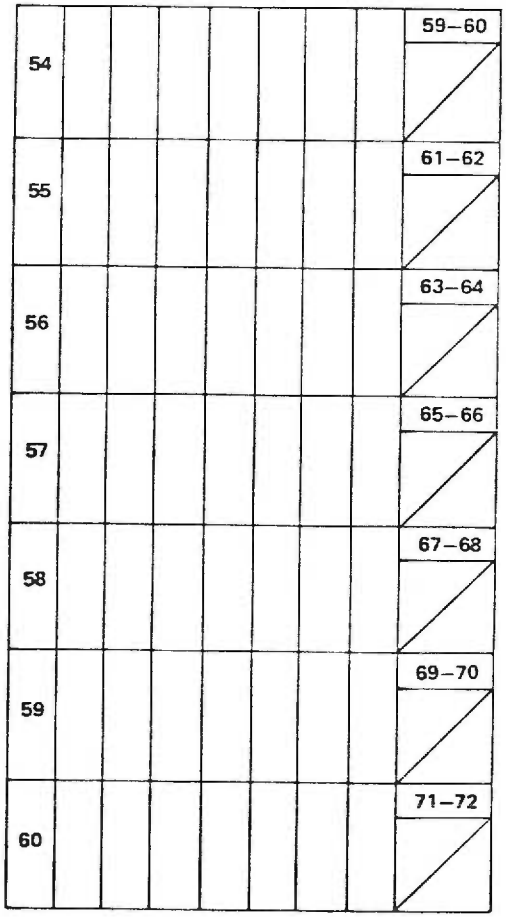


52. Close observation of the patient is carried out with minimal disturbance. # D

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

COMMUNICATION

Communication on behalf of the patient.



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

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

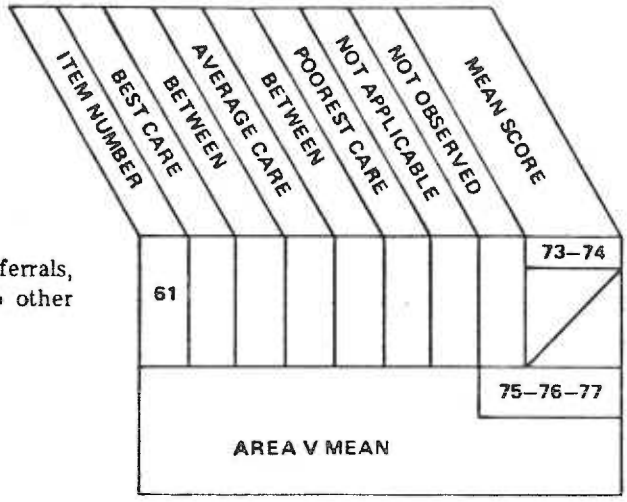
56. Ideas, facts, and concepts about the patient are clearly communicated in charting. *I

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

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

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

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



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

PROFESSIONAL IMPLICATIONS

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

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

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

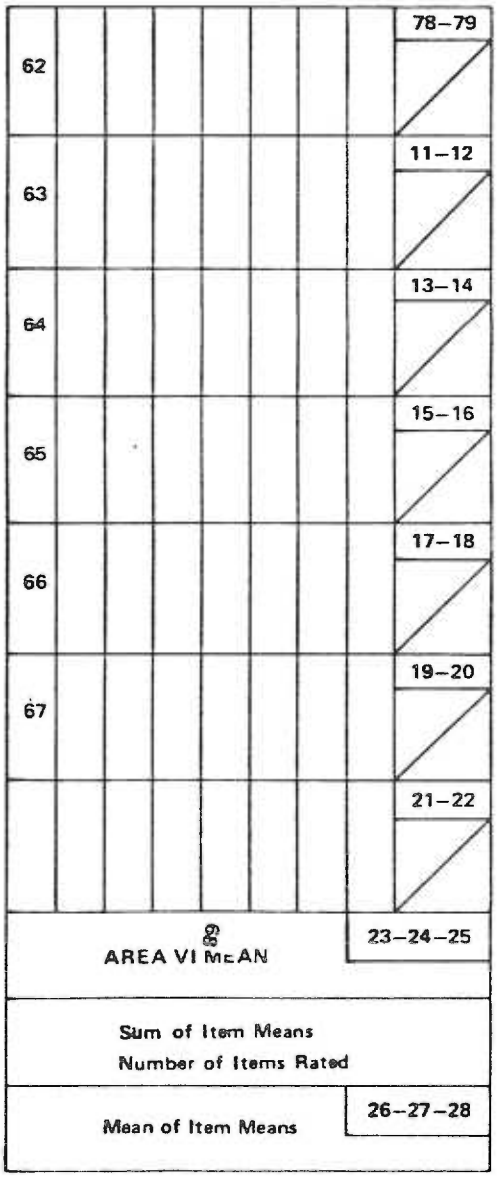
64. Changes in care and care plans reflect continuous evaluation of results of nursing care. # D/*I

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

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

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

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



APPENDIX B

CUE SHEETS FOR QualPaCS

PSYCHO-SOCIAL: INDIVIDUAL
Actions directed toward meeting psycho-social needs of individual patients.

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

2. PATIENT IS GIVEN AN OPPORTUNITY TO EXPLAIN HIS FEELINGS. #D
   a. Facial expression of staff indicates interest in and understanding of patient.
   b. Patient is given time to talk.
   c. Patient is allowed to complete sentence before staff speak or move away from patient.
   d. Conversation is encouraged by staff using brief comments or leading questions to let patient know they are listening and interested.
   e. Conversation is terminated in a manner that patient understands reason for termination, leaving patient with feeling of satisfaction about discussion. (patients facial expression indicates this satisfaction)

3. PATIENT IS APPROACHED IN A KIND, GENTLE, AND FRIENDLY MANNER. # D
   a. Staff speak clearly, with soft and pleasant tone of voice.
   b. Patient is called by name, and informed of name of nurse through distinct enunciation.
   c. Crying patients (all ages) are shown patience and understanding (verbally and nonverbally).

d. Patients are approached with a smile and encouraging word.

e. Patient is given opportunity to initiate verbalization of needs.

4. PATIENT'S INAPPROPRIATE BEHAVIOR IS RESPONDED TO IN A THERAPEUTIC MANNER. # D

a. Withdrawn patient is assisted to consider various means for involvement or interactions with others.

b. Attention of adolescent who is teasing others and interfering with activities of others is redirected.

c. Patient who refuses examination or treatment is helped to think through various facets and alternatives in the situation.

d. Expressions of hostility are accepted and changes that can be made are made, explanations of why some things cannot be changed are given, and indications are given to the patient that the nurse is interested in knowing the patient's feelings.

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

5. APPROPRIATE ACTION IS TAKEN IN RESPONSE TO ANTICIPATED OR MANIFEST PATIENT ANXIETY OR DISTRESS. # D/*I

a. Leading questions are asked to determine what the patient knows about pending therapy and to allow him to express fears.

b. The laboring mother is encouraged to express her thoughts and feeling about impending delivery, her own safety, and the health of her baby.

c. Time is spent with the patient or arrangements are made to have someone stay with anxious patient.

d. Physical indicators of anxiety and distress are noted, such as wringing of hands, disphoresis, withdrawal, etc.

e. Patient's repeated reference to a topic is noted, and he is encouraged to discuss it.

6. PATIENT RECEIVES EXPLANATION AND VERBAL REASSURANCE WHEN NEEDED. # D/*I

a. Components and purpose of treatments or nursing care action are explained as appropriate.

b. Attempts are made to describe kind of pain or discomfort patient may anticipate; including estimate of duration of discomfort and what will be done and what patient might do to alleviate pain or distress.

c. Patient is helped to explore and understand why he feels about or behaves as he does toward other persons, toward himself, or toward his illness.

d. Comments are made about patient's actions to remind and reassure him of signs of movement toward wellness.

e. Patient is informed of when staff will leave and when they will return.

7. PATIENT RECEIVES ATTENTION FROM NURSE WITH NEITHER BECOMING INVOLVED IN A NON-THERAPEUTIC WAY. # D

a. Nurse-patient relationship is maintained by focusing on patient's interests.

b. Child's needs for affection and closeness are provided for, but child is helped to remember parents and siblings.

c. Appropriate names of address are utilized by both nurse and patient rather than inappropriate endearing terms.

d. Monopoly of time of either patient or nurse is avoided.

e. Patient considering alternate actions is listened to and encouraged, but allowed to make own decision; staff is neither authoritarian nor patronizing.

8. THE PATIENT IS GIVEN CONSIDERATION AS A MEMBER OF FAMILY. # D/*I

a. Care and treatment activities are provided at times that will least interfere with visiting family or friends.

b. Family is encouraged to participate in care of patient, mother encouraged to feed child.

c. Patient is assisted to maintain communication with friends and colleagues — comfortable setting for visitors, assistance with telephoning, positioning and materials for letter writing, prompt mail delivery.

d. Rules are adjusted to meet special needs of patient or family e.g. underage child allowed to visit parent.

9. PATIENT RECEIVES ATTENTION FOR HIS SPIRITUAL NEEDS. # D/*I

a. Patient's religious beliefs and practices are respected.

b. Religious articles are handled with respect.

c. Pastor is promptly called when patient expresses desire to see him, or nurse volunteers to call pastor.

d. Assistance is offered and patient encouraged to attend services of his faith that are available to him (within the realm of his physical ability to go to them).

10. THE REJECTING OR DEMANDING PATIENT CONTINUES TO RECEIVE ACCEPTANCE. #D/*I
    a. Patient who refuses to talk is visited frequently by nurse who displays interested manner and gives assurance of "being there."
    b. Willingness to understand patient's point of view is displayed in relation to refused activity or treatment.
    c. Patient who turns away or shouts, "Go away," is remained with, spoken to quietly and reassuringly, and helped with resolution of need to reject attention offered.
    d. Attempts are made to help patient clarify his understanding of rationale for nurse actions or for treatments she proposes.
    e. Call light is answered promptly and without hostility, despite frequency of demands.

11. PATIENT RECEIVES CARE THAT COMMUNICATES WORTH AND DIGNITY OF MAN. #D
    a. Patient is cared for with kindness and helpfulness.
    b. Patient is encouraged to make choices about daily care and allowed time to make decision and to respond.
    c. Requests and needs of hopelessly ill or dying patient are met with same display of interest as that shown other patients.
    d. Means and opportunities for communication are provided and utilized with patient with communication limitations--speech loss or defect, deafness, limited language skills.
    e. Physical movement of patient is handled so that minimal strain is inflicted on patient.
    f. Patient with permanent body defect is cared for the same as other patients.

12. THE HEALTHY ASPECTS OF THE PATIENT'S PERSONALITY ARE UTILIZED. #D/*I
    a. Patient receives guidance in resolving a problem to decrease frustration of indecision.
    b. Opportunities are provided for patient to receive satisfaction through contributing to others; e.g., having child in wheelchair take toy to child confined to bed.
    c. Patient's abilities are pointed out, while avoiding focus on his disabilities.
    d. Ways are provided and the patient encouraged to enlarge his knowledge in areas that are of interest to him.
    e. The patient's sense of humor is responded to in an appropriate manner.
    f. Conversation is directed into optimistic vein; dwelling on pessimistic outlook is subtly curbed.

13. AN ATMOSPHERE OF TRUST, ACCEPTANCE, AND RESPECT IS CREATED RATHER THAN ONE OF POWER, PRESTIGE, AND AUTHORITY. #D
    a. The patient is trusted in as many ways as possible; he is allowed to perform those care activities within his capacity.
    b. Patient is allowed to express his opinions, and respect for his opinions is reflected in plans and activities of care.
    c. Withholding ordered treatment or necessary care is not used to solicit patient cooperation.
    d. Patient's conversation or activities are not needlessly disrupted.
    e. Inappropriate comments or actions made by the patient are quietly and briefly pointed out to him.

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

15. THE UNCONSCIOUS OR NON-ORIENTED PATIENT IS CARED FOR WITH THE SAME RESPECTFUL MANNER AS THE CONSCIOUS PATIENT. #D
    (Note: Applies as well to lethargic, sedated, or non-verbal patient.)
    a. Assistance is sought in moving the patient and moving is performed in a safe, gentle manner.
    b. Conversation of staff is focused on matters about the patient and his immediate care; jocularity is avoided.
    c. Patient is referred to by name, is spoken to in a well-modulated tone, discussion of patient's condition or prognosis is avoided in patient's presence.
    d. Disoriented patients are informed about anticipated treatments, instructions are offered about what will be expected of him, an attitude of interest in helping the patient to understand is portrayed.
    e. For the patient anticipating anesthesia or other induced unconsciousness, anxiety regarding being unconscious is recognized and discussed. Patient is given support regarding confidentiality of his behavior and conversation during period of unconsciousness.

PSYCHO-SOCIAL: GROUP

Care received reflects recognition of the patient's psycho-social needs as a member of a group.

16. THE PATIENT AS A MEMBER OF A GROUP RECEIVES WARMTH, INTEREST, AND ATTENTION FROM THE STAFF. # D
    a. Conversation of group members are listened to and comments made that promote continuation of patient's interests.
    b. Each member of the group is recognized and acknowledged by the staff.
    c. Patients receive appropriate information about changes in group structure, e.g., one of the ward patients is to remain in I.C.U. overnight following surgery.
    d. New patients are introduced to the group by the staff.
    e. When more than one staff is working with patient, the patient is given recognition as a part of that group.

17. THE PATIENT RECEIVES THE HELP NECESSARY TO ACCEPT LIMITS ON HIS BEHAVIOR THAT ARE ESSENTIAL TO GROUP WELFARE. # D
    a. Reasons for limitations that relate to "regulations" are identified, i.e., no smoking with O_2 in the room.
    b. Group member receives the necessary explanation and guidance regarding group aims.
    c. Groups of adolescents are helped to plan games that permit participation of few with physical limitations, without placing undue attention on individuals with the limitations.
    d. Hostile expressions relating to limits are accepted, but staff remains firm and consistent in maintaining necessary limits.
    e. Reason for exclusion of an individual from a group is explained without embarrassment for either the individual or group.

18. THE PATIENT RECEIVES ENCOURAGEMENT TO PARTICIPATE IN OR TO PLAN FOR THE GROUP'S DAILY ACTIVITIES. # D
    a. Patients are assisted with planning activities and time schedules, such as bathroom privileges.
    b. Patients are assisted in planning to help others in the group, e.g., when to take the paralyzed patient to the sunporch in a wheelchair.
    c. Patients' suggestions and assistance are sought in making changes in physical setting — furniture arrangement, room assignments, etc.

d. Patients are assisted in making arrangements for some social activities, e.g., sharing of meals by three or four patients.

19. THE MEMBER OF THE GROUP IS PROVIDED WITH THE OPPORTUNITY TO ASSUME RESPONSIBILITY ACCORDING TO HIS CAPABILITY. # D

a. Mother with one or more children is given the opportunity to offer suggestions to "new mothers."

b. Aggressive patient is encouraged to serve as member of committee providing support to "chairman," but not "take over" chairman's duties.

c. Patient is provided with schedule for his examinations or treatment and it is suggested that he assume responsibility for being at the right place at the right time.

d. Patient is allowed to initiate preparations for meals, visits, or bedtime, without being reminded each time that it is time to do these things.

e. The ambulatory patient is permitted to feed other patients in the room.

20. STAFF PROPOSALS FOR PATIENT ACTIVITIES APPROPRIATELY REFLECT THE INTERESTS AND NEEDS OF THE GROUP MEMBERS. # D

a. Involvement of each patient in group activities is noted and subtle suggestions given of modifications to insure appropriate involvement of all, such as proposing that the child with the injured knee keep score for the volley ball games.

b. Ways of dividing group into small common-interest groups are suggested: checkers, pinochle, jig-saw puzzles, playing with dolls, building with blocks, etc.

c. New diabetic is guided in discussing with others, the disease and its meaning to them.

d. New mother is encouraged to attend infant bath demonstrations.

21. THE PATIENT IS HELPED TO VENT HIS EMOTIONS IN A SOCIALLY ACCEPTABLE WAY WITHIN THE GROUP. # D

a. Group is helped to establish guidelines and discussion of emotion-laden issues is encouraged, e.g., that children discuss experiences, and feelings about the school and teachers or that patients "debate" merits of various sides of political issues.

b. New-mother is given opportunity to discuss her fears and hopes with other mothers, staff, other parents.

c. Hostility is recognized and activities offered that demand physical strengths, energy and movement; e.g., a round or two with punching bag, volleyball, or dodgeball.

d. Group who is confined in the hospital for long periods of time (e.g. TB patients) are guided in discussing their feelings about isolation and restriction of physical activity, and helped to devise activities appropriate to the limits imposed, e.g., developing a patient-government.

e. Patients who have suffered a change in body image (amputation of lower limb, colostomy, mastectomy) are allowed to grieve without being forced to participate in activities before they are ready.

22. PRAISE AND RECOGNITION IS GIVEN FOR ACHIEVEMENT ACCORDING TO INDIVIDUAL NEEDS AND WITH RESPECT FOR OTHERS IN THE GROUP. # D

a. Staff moves quickly to next activity, when "braggart" has scored point — patient is helped to recognize his accomplishment in relation to his abilities and those of others; he is guided to recognize achievements of others.

b. Staff discuss and help patient recognize relationship of small accomplishment to potential for "next (more difficult) step;" e.g., patient able to hold self up off bed for 30 seconds in preparation for crutch walking, mastectomy patient able to raise affected arm above head.

c. Child is praised for his control during an examination.

23. THE RIGHTS AND INTEGRITY OF THE GROUP MEMBER ARE PROTECTED WITHIN THE GROUP STRUCTURE. # D

a. Conversations about death are changed by staff if one of the members is displaying anxiety.

b. The group members or patients are informed of the problems of the aphasic patient, e.g., he can understand conversation but cannot contribute verbally.

c. The patient who is unable to eat without drooling is given assistance with feeding.

d. Hesitant patients are encouraged to join activity; less apt patients are assisted without the performance actually being done for them.

e. Provision is made for maintaining confidentiality when personal matters of the patient are involved.

C. PHYSICAL: ACTIONS DIRECTED TOWARD MEETING PHYSICAL NEEDS OF PATIENTS.

24. NURSING PROCEDURES ARE ADAPTED TO MEET NEEDS OF INDIVIDUAL PATIENTS FOR TREATMENT. # D
    a. Sufficient time is allowed following patient's smoking, eating or drinking in taking an oral temperature.
    b. Equipment and materials are arranged on side of bed and in convenient position for left-handed patients to do his own tracheal suction.
    c. General morning care of arthritic patient is left until last so no one will feel pressure of time and movements can be made slowly.
    d. Colostomy irrigation is done at the time the patient states would be most convenient for him at home.

25. PATIENT'S DAILY HYGIENE NEEDS FOR CLEANLINESS AND ACCEPTABLE APPEARANCE ARE MET. # D
    a. Staff offer to comb hair of patient unable to do so for physical or mental reasons; e.g., cardiac patient, patient with upper extremity injury, patient in state of emotional shock following loss of loved ones, regressed mental patient.
    b. Disturbed patient is helped to shower, shave, and select clean clothing or items of attire that go together.
    c. Bedside environment is made neat and orderly, soiled gowns changed P.R.N.
    d. Assistance is offered with oral hygiene; e.g., brush is prepared and basin held for patient with upper extremity cast; dentures brushed under running water for patient unable to do this himself; child is taught proper brushing technique.
    e. Body, dressing, and air deodorizers are provided as indicated.

26. NURSING PROCEDURES ARE UTILIZED AS MEDIA FOR COMMUNICATION AND INTERACTION WITH PATIENTS. # D
    a. Withdrawn patient is encouraged to talk of self, interests, and family, while receiving direct nursing care.
    b. During each contact, staff encourage and allow time for the patient unable to speak (aphasic, tracheotomized, etc.) to write some message; they take time to respond to each message in an unhurried manner.
    c. The periplegic patient is encouraged to discuss his progress in Physiotherapy while the nurse makes his unoccupied bed.
    d. Mother is helped to listen to heartbeat of her unborn child and encouraged to talk about the baby and its meaning to her.
    e. Patient is encouraged to assist, even in a small way, with particularly painful treatment, e.g., burn dressing, repeated intramuscular injection, etc.

27. PHYSICAL SYMPTOMS AND PHYSICAL CHANGES ARE IDENTIFIED AND APPROPRIATE ACTION TAKEN. # D

a. Cyanosis is noted — staff checks for bleeding, oxygen flow, position in relation to breathing.

b. Motley tissues over bony prominence are noted; frequency of turning patient is increased and ways provided to keep pressure from area.

c. Languor and shallow breathing of small child is noted and appropriate action taken.

d. Undesirable weight loss is noted in elderly clinic patient; patient is questioned about changes in eating habits, living conditions, appetite.

e. The fundus of the uterus is massaged to evaluate the possibility of postpartum hemorrhage.

28. PHYSICAL DISTRESS EVIDENCED BY THE PATIENT IS RESPONDED TO QUICKLY AND APPROPRIATELY. # D

a. Patient is moved up in bed and pillows adjusted to provide a comfortable position and good body alignment.

b. Patient's complaint of pain or burning at site of infusion prompts investigation for infiltration and possible removal of the needle.

c. Signs of pain are noted — restlessness, perspiration, facial contortion — action is taken to alleviate pain: position changed, medication, fresh dressing.

d. Excoriated buttocks of baby noted and diapers changed frequently to keep baby clean and dry, and soothing protective ointment or powder applied.

e. Patient with respiratory tract secretions either is assisted to deep breathe and cough, or is suctioned.

29. PATIENT IS ENCOURAGED TO OBSERVE APPROPRIATE REST AND EXERCISE. # D/*I

a. Patient is helped to understand role of rest in his treatment — cardiac, thrombophlebitis, hepatitis, chorea.

b. Patient is helped to understand role of exercise in treatment of his illness — post-surgical, paralysis, traction or cast immobilization.

c. Elderly patient is assisted out of bed; patient is encouraged to stand and to help self. Patient is given time to do for himself, but necessary assistance and protection is offered.

d. Patient is helped to plan ways to save movement and steps in accomplishing tasks of daily care.

e. New activities are suggested to patient; reading or light handcrafts for rest; playing pool or ping pong for exercise.

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

31. ACTION IS TAKEN TO MEET THE PATIENT'S NEED FOR ADEQUATE HYDRATION AND ELIMINATION. # D/*I
    a. Elimination patterns are identified and steps taken to promote adequate elimination, e.g., laxatives, proper diet, exercise.
    b. Patient overanxious about elimination is given opportunities to discuss concerns and is provided information to enhance understanding.
    c. Fluids are encouraged in the dehydrated patient or the patient losing large amounts of fluid, e.g., diaphoresis with elevated temp.
    d. Intake and output is measured accurately, e.g., N/G drainage, Foley catheter, wound drains, postpartal bleeding.
    e. Diarrhea in the infant is reported promptly and measures taken to alleviate the problem.
    f. Measures are initiated to prevent elimination problems or problems of limited intake whenever there is psychomotor retardation as in the depressed patient.

32. BEHAVIORAL AND PHYSIOLOGICAL CHANGES DUE TO MEDICATIONS ARE OBSERVED AND APPROPRIATE ACTION TAKEN. # D/*I
    a. Skin reactions of patients are reported and drug is withheld as necessary.
    b. Disturbances in orientation are recorded and reported.
    c. Anorexia is noted and reported in a patient on a digitalic preparation.

d. Relaxation and amount of sleep obtained in response to sedative is noted and reported.

e. The effect of a mucolytic agent administered during an I.P.P.B. treatment is noted: expectoration, productivity quality of cough.

33. EXPECTATIONS OF PATIENT'S BEHAVIOR ARE ADJUSTED AND ACTED UPON ACCORDING TO THE EFFECT THE MEDICATIONS HAS ON THE PATIENT. # D/*I

a. Drowsiness and retarded psychomotor activity is accepted by supporting the patient when he points out that he is unable to participate in active discussions or sports.

b. For the tremulous patient, projects are selected that require little coordination.

c. Patient who has postural hypotension as a result of drug therapy is allowed to ambulate slowly without pressure to hurry; notation is made in nursing care Kardex.

d. Allows tranquilized or sedated patients ample time to respond to questions.

e. Photo-sensitivity is observed and patient is not expected to participate in outside activities for extended periods of time.

34. MEDICAL ASEPSIS IS CARRIED OUT IN RELATION TO PATIENT'S PERSONAL HYGIENE AND IMMEDIATE ENVIRONMENT. # D

a. Staff wash hands as necessary, e.g., on completing care of one patient and before moving to another, before beginning "clean" procedure, following any obvious contamination, etc.

b. Floor is recognized as grossly contaminated area; e.g., items picked up from floor are cleaned or replaced; hands are washed after picking up something from floor; staff avoid placing supplies or equipment on the floor.

c. In giving a bath, motion proceeds from the clean to the unclean areas.

d. All equipment used by or for patient is clean: tub, sitz bath, I.P.P.B. etc, used by more than one patient are cleansed well between uses; wheelchair, Hoyer lift, and carts for transporting supplies and equipment to patient are clean.

e. Soiled linen and dressings are changed promptly to prevent infection or skin breakdown to the patient.

35. MEDICAL AND SURGICAL ASEPSIS IS CARRIED OUT DURING TREATMENTS AND SPECIAL PROCEDURES. # D/*I

a. Dressings are handled so that surface that will cover wound and surrounding area remains sterile.

b. Site for injection of medication is cleansed properly prior to administration of drug.

c. Irrigations done without contamination.

d. Cross contamination is avoided, e.g., gloves are changed between dressings for each stump of the patient with a bilateral amputation.

e. Breaks in technique are recognized and steps taken to correct them, e.g., contaminated catheter is replaced by sterile catheter, gloves are changed if tear occurs.

f. Staff make appropriate judgment as to when medical or surgical asepsis is called for in Rx.

36. ENVIRONMENT IS MAINTAINED THAT GIVES THE PATIENT A FEELING OF BEING SAFE AND SECURE. # D

a. Assistance of a sufficient number of persons is obtained when a patient is to be lifted.

b. Siderails are provided per request by patient; the necessity for siderails is explained.

c. Placement of various cords and tubing are noted; patients are informed of their presence and, as necessary, instructed about movement.

d. Reasons for "no smoking" signs in presence of oxygen administration are discussed with patient and visitors.

e. Patients' allergies are known and measures taken to prevent exposure to allergies, e.g., feathers, eggs, bleach.

f. Patient is properly secured when on Stryker frame, circle bed, or some type of similar equipment.

37. SAFETY MEASURES ARE CARRIED OUT TO PREVENT PARIENT FROM HARMING HIMSELF OR OTHERS. # D

a. Threats made by patient to harm himself or others are reported and precautions taken as indicated.

b. Patient whose behavior indicated impulsiveness and confusion is protected by the continuous presence of staff or the appropriate use of equipment (siderails and body restraints).

c. Staff ask for assistance when needed to provide safety for the patient himself and/or personnel.

d. Patient is given adequate instructions in use of self-operated particularly powered, equipment (wheelchair, hi-low bed, water temperature controls, etc.) as that he knows safe handling, capabilities and dangers.

38. THE ESTABLISHED TECHNIQUES FOR SAFE ADMINISTRATION OF MEDICATIONS AND PARENTERAL FLUIDS ARE CARRIED OUT. # D

a. IV and tube feedings with medications added are labeled appropriately.

b. Those medications left at bedside are properly labeled; they are left only when it is advisable and feasible for the patient to administer to himself and only following adequate instructions to the patient.

c. Patient is addressed by name or asked to state name, or the identaband or bed tag is checked, before medication is given. Nurse remains with patient until medication is taken.

d. Medication tray is not left unattended where it could be a danger to one or more patients.

e. IV flowrate and site are checked to assure appropriate administration.

GENERAL

Actions that may be directed toward meeting either psycho-social or physical needs of patients, or both at once.

39. PATIENT RECEIVES INSTRUCTION WHEN NECESSARY. # D

a. Mother is guided as she picks up baby, staff demonstrates and has mother demonstrate holding baby for burping and bathing.

b. Uses of signal cord and intercom are demonstrated to newly admitted patient.

c. Medications patient will be taking at home are discussed; nurse insures that he knows identity of each, purpose for which it is being prescribed, dosage and schedule for taking each, and expected effects of medication.

d. Cardiac patient is given examples of how to conserve energy at home, e.g., arrangements of cooking utensils in the kitchen.

e. Pre and post-operative instruction is provided.

40. THE PATIENT AND FAMILY ARE INVOLVED IN PLANNING FOR CARE AND TREATMENT. *I/# D

a. When giving instructions to patient, nurse involves family member if he is visiting — not only allowing him to remain in his room, but actually including him in discussion.

b. Arrangements are made to have family member participate in treatments, eventually doing entire treatment, if it is one patient will not be able to do for himself at home.

c. Plans are made with patient and family members to do care procedures at time when family member can participate; details of care needed at home are planned with patient and family members.

d. Patient is helped to communicate with family about needs for items and procedures of care after discharge — wife to know diet, husband to know of work-saving methods and devices, parents to anticipate teasing of child by other children and ways to help child cope.

41. THE PATIENT'S SENSITIVITIES AND RIGHT TO PRIVACY ARE PROTECTED. # D

a. Sheets or towels are used as drapes to avoid unnecessary exposure of body.

b. Curtain is drawn around bed for procedures of physical care.

c. Arrangements are made to have patient taken to room where interview (social worker, psychologist, homemaker) can be conducted in private.

d. Sensitivities of maturing child and teenager are protected.

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

42. PATIENT IS HELPED TO ACCEPT DEPENDENCE/INDEPENDENCE AS APPROPRIATE TO HIS CONDITION. # D

a. Role of rest in treatment of disease is discussed, patient is reassured of gradual progress toward resumption of responsibility of doing for himself.

b. Patient having surgery is helped to understand the purpose of early ambulation and exercises in the post-operative period, e.g., out-of-bed to bathroom instead of urinal or bedpan.

c. Mother encouraged to hold infant and offer bottle feeding during early postpartal period.

d. Patient with disability of musculoskeletal system is helped to understand disease process, rationale for treatments, and probable outcome.

e. For a patient wishing to continue dependence, the rationale for increasing independence is explained; the staff display empathy and provide support and encouragement as the patient performs required activities for movement toward independence. E.g., a patient (any age), with an upper extremity or chest injury, is supported and encouraged to wash his face, brush his teeth, do his hair, and feed himself.

43. RESOURCES WITHIN THE MILIEU ARE UTILIZED TO PROVIDE THE PATIENT WITH OPPORTUNITIES FOR PROBLEM SOLVING. # D

a. Patient is encouraged to suggest ways to accomplish "routine" tasks despite limitation due to incapacitated or absent body feature. He is helped to plan placement of articles as he will use them in hospital and at home or work.

b. Patient is helped to consider alternatives in relation to choice of diversional activity.

c. Child is helped to select the most appropriate toy for the situation — kind of toy that can be used in bed, one that allows for solitary play, or one that allows others to join in play, etc.

d. Patients are asked to propose furniture arrangement that will provide for best use of day and artificial lighting and for least distressful light glares.

44. PATIENT IS GIVEN FREEDOM OF CHOICE IN ACTIVITIES OF DAILY LIVING WHENEVER POSSIBLE AND WITHIN PATIENT'S ABILITY TO MAKE THE CHOICE. # D

a. Determination is made of whether patient is "early" or "late" riser, plans are made with him about timing for needed care.

b. Patient is allowed morning or evening shower or bath — depending on custom and preference.

c. Patient is assisted to arrange for type of clothing he prefers to wear, as long as it does not interfere with the therapy.

d. Requests are granted involving changes in daily routines that can be made without major disruptions in ward plans.

45. PATIENT IS ENCOURAGED TO TAKE PART IN ACTIVITIES OF DAILY LIVING THAT WILL STIMULATE HIM FOR POSITIVE PSYCHOSOCIAL GROWTH AND MOVEMENT TOWARD PHYSICAL INDEPENDENCE. # D/*I

a. "Early" riser is encouraged to assist with serving morning coffee, where a.m. coffee is a practice.

b. Stroke patient is encouraged to shave himself — electric razor is provided if indicated.

c. Patient is invited to assist with caring for flowers — his own and those of others.

d. Child is helped and encouraged to brush his teeth regularly.

e. Patient's efforts and successes are recognized.

46. ACTIVITIES ARE ADAPTED TO PHYSICAL AND MENTAL CAPABILITIES OF PATIENT. #D/*I

a. Hard of hearing patient is provided with an earphone to facilitate listening to his radio or T.V.

b. Confused patient is guided through steps of preparation for visit to therapist: reminds patients, one step at a time about washing face and hands, brushing teeth, combing hair, dressing, storing night clothing, etc.

c. Time is allowed for small child, or slow or hesitant patient, to do things for himself, so that he may develop confidence and independence.

d. Assistance is provided to patient before he reaches point of frustration at inability to perform task.

e. Long term diabetic patient allowed to administer own insulin while hospitalized.

47. NURSING CARE IS ADAPTED TO PATIENT'S LEVEL AND PACE OF DEVELOPMENT. #D

a. Child is allowed to perform task of which he is capable; is provided with challenging tasks within his ability to learn and perform them.

b. "Contests" related to learning new tasks are avoided when patients would experience frustration and feelings of inadequacy.

c. Instructions and performances of tasks to be learned are repeated as often as necessary.

d. Patient is assisted to rethink a problem and decide whether to pursue a path different from one selected earlier.

e. A doll is used to illustrate the care a child scheduled for surgery will receive.

48. DIVERSIONAL AND/OR TREATMENT ACTIVITIES ARE MADE AVAILABLE TO PATIENT ACCORDING TO HIS CAPABILITIES AND NEEDS. #D

a. Stories are read to a small child.

b. Rubber ball is provided for stroke patient for hand exercise.

c. Older patient is taken to dayroom and time spent with him, he is encouraged to visit or share activity--needlework, cards, program on TV.

49. PATIENTS WITH SLOW OR UNSKILLED PERFORMANCE ARE ACCEPTED AND ENCOURAGED. #D

a. Gentle persuasion is used to keep regressed patient moving in process of morning toilet and dressing.

b. Time is provided for the aphasic patient to speak.

c. A child with cerebral palsy is encouraged to learn to feed himself.

d. A dyspneic patient is provided time "to catch his breath" when moving in bed or ambulating.

50. NURSING CARE GOALS ARE ESTABLISHED AND ACTIVITIES PERFORMED WHICH RECOGNIZE AND SUPPORT THE THERAPIST'S PLAN OF CARE. #D/*I

a. The arthritic patient received encouragement and direction from the nursing personnel in doing ordered hand exercises.

b. New mother is assisted with breast feeding, e.g., proper cleansing of breast prior to feeding, proper positioning, etc.

c. Child's tray is removed after thirty minutes, regardless of amount of food eaten (when purpose is to assist child to establish good eating habits, and to not play with food).

d. Toileting schedule is planned with paraplegic patient, with view to achieving independence from indwelling catheter.

e. A patient with a decubitus ulcer is helped to plan a menu high in protein and encouraged to eat.

51. INTERACTION WITH PATIENT IS WITHIN FRAMEWORK OF THE THERAPEUTIC PLAN. #D

a. A disoriented patient is helped to reorient himself by having reality pointed out to him when confused.

b. Patient with myocardial infarction is reassured that it is not too much bother to feed him.

c. A patient learning to use crutches is reassured that the nurse will remain near and will support him if needed, but is encouraged to walk with support of crutches.

52. CLOSE OBSERVATION OF PATIENT IS CARRIED OUT WITH MINIMAL DISTURBANCE. #D

a. Quiet is maintained as staff move into and out of room for frequent checking: IV, O_2 flow, urine output, etc.

b. Bed clothing is arranged so that it can easily be lifted to check on extremity.

c. Staff approach and stand quietly beside group engaged in game or conversation, without interrupting or distracting attention or members of group.

d. Room of patient with suicidal tendencies is checked during daily cleaning for harmful objects.

53. RESPONSE TO PATIENT IS APPROPRIATE IN EMERGENCY SITUATIONS. # D

a. Staff wait until help is available to move patient who has fallen from bed.

b. Patient who has assumed posture to suit his words of threatening to strike nurse is spoken to quietly.

c. Staff remain with child having asthmatic attack and summon available help.

d. Staff stay with a convulsing patient for observation and to provide protection from injury.

e. Intravenous glucose is immediately prepared for the diabetic patient in severe insulin shock.

COMMUNICATION

Communication on behalf of patients.

54. IDEAS, FACTS, FEELINGS, AND CONCEPTS ABOUT THE PATIENT ARE COMMUNICATED CLEARLY IN SPEECH TO MEDICAL AND PARAMEDICAL PERSONNEL. # D

a. Feelings and thoughts expressed are neither mumbled nor highly emotional.

b. Complete description of patient's behavior is given without excessive repetition and using good sequence.

c. Reports of observations are factual and clearly stated leading to meaningful conclusions.

d. Questions are used to help aides report and describe patient's condition, and to ascertain that aides have understood plan for care.

55. THE FAMILY IS PROVIDED WITH THE OPPORTUNITY FOR RECIPROCAL COMMUNICATION WITH THE NURSING STAFF. # D/*I

a. Explanations regarding the treatment and therapy that the patient is receiving are stated clearly and in understandable terms.

b. The fears and concerns of the family are responded to in a manner which promotes an understanding and acceptance of their role in meeting the patient's needs, e.g., Mother stays overnight in room with child who has had a tonsillectomy.

c. The family is kept informed of changes in the patient's condition, e.g., the expectant father is given frequent reports on his wife's progress during labor.

d. The family is used as a resource for additional information about the patient to develop a relevant plan of care, e.g., daily activities, occupation, habit patterns, etc.

56. IDEAS, FACTS, AND CONCEPTS ABOUT THE PATIENT ARE CLEARLY COMMUNICATED IN CHARTING. *I
    a. Precise and specific observations are recorded; few generalizing cliches are used (i.e., comatose, disoriented).
    b. Possible interpretation of reasons for patient's behavior is recorded.
    c. Sentence structure is clear and grammatically correct; excessive use of abbreviations is avoided.
    d. All pertinent facts or observations in a situation are included in charting.
    e. Written communication is legible, legal abbreviations only used.

57. WELL DEVELOPED NURSING CARE PLANS ARE ESTABLISHED AND INCORPORATED INTO NURSING ASSIGNMENTS. *I
    a. Immediate and long-range objectives of care are included; changed as patient needs change, also dated.
    b. Information is included about patient's likes and dislikes.
    c. Suggestions for modification of procedures that make care easier or more effective for patient are included.
    d. Plan for implementation of progressive care is included relating to anticipated future needs of patients, e.g., "plan to teach colon irrigation beginning tomorrow."
    e. Written assignments or worksheets reflect the objectives of the plan of care.

58. PERTINENT INCIDENTS OF PATIENT'S BEHAVIOR DURING INTERACTION WITH STAFF ARE ACCURATELY REPORTED. # D/*I
    a. Nurse reports that patient refused to take IM injection, with claim she hurt him last time she gave it.
    b. Nurse reports patient refusal to sit up in chair because patient states he was left up too long yesterday.
    c. Patient's response during or after the interaction with the staff, e.g., Patient withdrew from group discussion after being reprimanded in front of group by nurse for telling a vulgar story.
    d. After instruction for giving self injection, nurse charts patient's response to his initial self injection.

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

60. EFFECTIVE COMMUNICATION AND GOOD RELATIONSHIPS WITH OTHER DISCIPLINES WITHIN THE HOSPITAL ARE ESTABLISHED FOR THE PATIENT'S BENEFIT. *I/# D
    a. Physical therapist is consulted to seek suggestions of what nursing staff might do to enhance patient's treatment.
    b. Social worker is called for a patient who might benefit from help, e.g., payment of rent while in hospital, care of children during hospital stay.
    c. X-ray or lab is notified promptly to clarify orders for preparation of patient or when patient will be delayed or unable to keep appointment.
    d. Physician is notified of all pertinent information about patient — verbal reports, printed notes on front of chart, paging or telephoning.
    e. Occupational therapy consultation is requested for patient with severly injured hand.

61. PATIENT'S NEEDS ARE MET THROUGH THE USE OF REFERRALS, BOTH TO DEPARTMENTS IN THE HOSPITAL AND TO OTHER COMMUNITY AGENCIES. *I/# D
    a. VNA referral is made for new mother with first baby who is new to city and has no family or friends who can assist with teaching care of new baby.
    b. Social worker is consulted about referral to visiting housekeeper for elderly patient who lives alone.
    c. Local school system is called to arrange for home teaching for adolescent patient.
    d. Adequate information regarding post-discharge clinic appointments is given to the patient, e.g., location of clinic within hospital, time and date of appointment.

F. PROFESSIONAL IMPLICATIONS

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

62. DECISIONS THAT ARE MADE BY STAFF REFLECT KNOWLEDGE OF FACTS AND GOOD JUDGMENT. # D/*I

a. Room assignment of patient whose baby died during delivery is changed to avoid placing her in room with mother with day-old baby.

b. PRN analgesic and PRN hypnotic are administered at bedtime to second day post-operative patient with spinal fusion.

c. IV fluid is promptly slowed when post-operative patient manifests increased difficulty and rate of breathing.

d. Emphysema patient is served six small feedings a day.

e. Joking references made by patient about "jumping out of window" are responded to with increased periods of observation and by obtaining available information (doctor, chart, etc.) for adequate evaluation of behavior.

f. Nurse aide seeks help when in doubt.

63. EVIDENCE (SPOKEN, BEHAVIORAL, RECORDED) IS GIVEN BY STAFF OF INSIGHT INTO DEEPER PROBLEMS AND NEEDS OF PATIENTS. # D/*I

a. Patient who lost first two children at birth is not left alone any more than necessary, and nurses share her experience with her.

b. Staff attempt to help adolescent with severe acne to recognize and utilize assets and abilities to contribute to interest and happiness of others, thereby gaining confidence and satisfaction in his own worth.

c. Staff provides support to the dying patient by listening to his fears and by avoiding unrealistic cliches as "you'll be up and around in no time."

d. Staff discuss possible approaches to be used with patient who has just sustained a change in body image, i.e., hysterectomy, mastectomy, amputation, spinal cord transection, hemiplegia.

64. CHANGES IN CARE AND CARE PLANS REFLECT CONTINUOUS EVALUATION OF RESULTS OF NURSING CARE. *I/# D

a. Suggestion is made that wound be dressed after wife's visit since changing the patient's dressing before her visit focus's his attention on the wound to the extent that he discusses little else.

b. Referrals for home visits are made for the amputee patient when it is discovered that his recent return to dependency upon the staff is the result of his fears about his adequacy in the home situation.

c. Passive exercises to the paralyzed hand of the C.V.A. patient have resulted in prevention of contractures and plans are made to continue them.

d. Suggestions or criticisms made by the patient and family are utilized constructively in planning and evaluating care.

e. Change is suggested in types of foods, since patient is not eating present diet and complains that it is "baby" food.

65. STAFF ARE RELIABLE: FOLLOW THROUGH WITH RESPONSIBILITIES FOR PATIENT'S CARE. # D/*I

a. Staff ask for help in doubtful situations, rather than making errors.

b. Staff report when work is not completed.

c. Nurse views situation herself, rather than depending on reports alone; e.g., visits patient on report of bleeding, checks conditions of very ill patients in preparation for change-of-shift report.

d. Assignments and work accomplished are periodically reviewed to replan, establish priorities, and fulfill responsibilities.

e. Staff follows through on commitments they have made; e.g., return to patient's room at time stated, perform treatment when scheduled.

66. ASSIGNED STAFF KEEP INFORMED OF PATIENT'S CONDITION AND WHEREABOUTS. # D

a. All assigned patients are visited to ascertain their condition before day's tasks are begun.

b. Patient's whereabouts are known along with reason for his being off the unit or away from bedside unit, and when he is expected to return.

c. Current condition of patient is known as well as changes in past 24 hours, and plans of care are reported to staff of succeeding tour of duty.

d. If indicated, patient is accompanied by staff when leaving unit for tests or conferences.

67. CARE GIVEN PATIENT REFLECTS FLEXIBILITY IN RULES AND REGULATIONS AS INDICATED BY INDIVIDUAL PATIENT NEEDS. # D/*I

a. Adjustments in visiting hours are made in accord with the patient's condition and the special needs of his family.

b. Room change is provided as soon as possible for non-ambulatory patient who smokes when he is assigned to room where O_2 is in use.

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

d. Patient who has worked on the midnight shift for years and is not able to sleep is allowed to watch late TV or listen to the radio when it will not disturb other patients.

68. ORGANIZATION AND MANAGEMENT OF NURSING ACTIVITIES REFLECT DUE CONSIDERATION FOR PATIENT NEEDS. # D/*I

a. Treatments are performed at times that will not interfere with visiting hours.

b. One member of staff directs ambulation of patient when several are involved in task.

c. Necessary supplies and equipment are assembled and prepared prior to initiation of treatment.

d. Provision is made so that patient receives adequate and prompt assistance at mealtime.

e. When patient is acutely ill, he receives care before patients with less acute needs.

f. Staff assignment plans reflect consideration of patient's needs.

APPENDIX C

INDIVIDUAL FRAME OF REFERENCE

APPENDIX C

INDIVIDUAL FRAME OF REFERENCE

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

Slater Nursing Performance Rating Scale Rater _____

INDIVIDUAL FRAME OF REFERENCE CARD

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

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

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

3. Think of a nurse whom you consider to be a typical or average staff nurse, neither noticeably good or noticeably poor; write her name in the middle box, labeled "Average Staff Nurse."

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

Best Staff Nurse	Between	Average Staff Nurse	Between	Poorest Staff Nurse
BEST		AVERAGE		POOREST

---

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

APPENDIX D

A FACT SHEET ABOUT QualPaCS

QUALITY PATIENT CARE SCALE

A FACT SHEET ABOUT QUALPACS*

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

What

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

Conducted by the Department of Nursing

When

Date to Date

Why

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

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

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

How Will the Study Be Conducted:

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

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

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

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

*Developed by Kathlene F. Monahan

The study is not an efficiency rating of personnel. Names of personnel are not recorded. The study is concerned with what nursing care the selected patient receives regardless of who does it. From the records the Nurse Observer keeps it would not be possible to retrieve a person's name and given an efficiency rating.

Patient Information

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

What Help is Needed from Head Nurses?

A. Help in Identification of Selection of Patients

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

B. Introduction to Staff

Briefly explain that:

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

C. Introduction to Patients

A nurse who knows the patient should:

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

APPENDIX E

RATER'S NOTES FOR ASSESSMENT AND PLANNING CARE

INFORMATION FACE SHEET

RATER'S NOTES

FOR

ASSESSMENT AND PLANNING CARE

PATIENT _____

ORDERS, NEEDS, NURSING ACTIONS

Diet (meals, fluids, nourishment)

Medications

Treatments (dressings, irrigations)

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

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

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

Activity (bedrest, ambulation, etc.)

Sensory deficit (blind, aphasic, deaf)

Safety

Teaching patient and family

Socialization and diversion

Multiple services (referrals, consultations)

Reporting and recording

Planning for continuity of care

Other

QUALITY PATIENT CARE SCALE

INFORMATION FACE SHEET

Patient

Name _____

Record # _____

Room # _____ Accommodations _____

Admission Date _____

Diagnosis:

Admission _____

_____

_____

Current _____

_____

_____

Condition of Patient _____

_____

_____

_____

Unit

Name _____ Type _____

Number of Rooms _____

Number of Beds _____

Census _____

LEVELS OF CARE (Number of patients in each)

A _____ C _____ E _____

B _____ D _____

PERSONNEL CODE AND CENSUS

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

OTHER PERTINENT DATA:

Date _____

Time of Day _____ AM/PM

REPORTS: Change of Shift _____

Team _____

Other _____

Rater _____

INTERACTIONS _____

OUTCOMES: Total Item Mean Score _____

Total of Items Used _____

Score (Mean of Means) _____

Additional notes or questions:

APPENDIX F

COMPOSITE MEAN OF ITEM MEANS

APPENDIX F

COMPOSITE MEAN OF ITEM MEANS

QualPaCS Item Number	Day Tour	Evening Tour	Medical Unit	Surgical Unit	All Observations
1	2.9	3.3	2.7	3.5	3.1
2	2.6	3.2	2.7	3.1	2.9
3	3.3	3.7	3.2	3.8	3.5
4	2.9	3.2	3.1	3.0	3.0
5	2.4	3.2	2.6	3.0	2.8
6	2.9	3.1	2.8	3.2	3.0
7	2.8	3.2	2.7	3.2	3.0
8	2.8	3.2	2.6	3.4	2.9
9	2.9	3.0	3.0	3.0	3.0
10	2.1	3.2	2.0	3.2	2.7
11	2.9	3.3	3.0	3.7	3.1
12	3.0	3.2	2.8	3.4	3.0
13	2.8	3.3	2.9	3.3	3.0
14	2.8	3.1	2.6	3.3	3.0
15	3.0	3.6	3.1	3.5	3.1
16	2.3	3.2	2.7	2.8	2.8
17	.0	3.5	3.0	4.0	3.4
18	.0	3.0	.0	3.0	3.0
19	3.0	.0	3.0	.0	3.0
20	.0	.0	.0	.0	.0
21	.0	.0	.0	.0	.0
22	2.0	.0	1.0	2.0	2.3
23	3.5	.0	.0	3.5	3.3
24	2.5	3.0	2.6	2.9	2.8
25	2.9	3.1	3.0	3.1	3.0
26	2.8	2.9	2.5	3.2	3.0
27	2.3	3.5	2.9	3.5	3.2
28	2.2	2.8	2.4	2.6	2.6
29	3.1	3.0	2.9	3.2	3.0
30	2.9	3.5	3.1	3.2	3.1
31	2.9	3.0	3.0	3.0	3.0
32	1.9	2.8	2.3	2.4	2.3
33	2.3	2.8	2.7	2.4	2.6
34	2.7	3.3	2.7	3.3	3.0
35	2.9	3.2	2.9	3.1	3.2
36	2.9	2.9	2.5	3.2	3.0

APPENDIX F

COMPOSITE MEAN OF ITEM MEANS
(continued)

QualPaCS Item Number	Day Tour	Evening Tour	Medical Unit	Surgical Unit	All Observations
37	3.0	3.3	3.2	3.1	3.1
38	2.3	3.2	2.5	2.9	3.0
39	2.8	2.9	2.7	3.1	2.9
40	2.5	2.5	1.9	3.0	2.5
41	2.7	2.8	2.6	2.9	2.8
42	2.5	3.0	2.7	2.9	2.7
43	2.6	2.7	2.6	2.6	2.6
44	2.9	2.8	2.7	2.7	2.8
45	2.8	2.9	2.6	3.0	2.8
46	2.4	2.8	2.6	3.0	2.8
47	2.7	2.8	2.6	2.5	2.7
48	2.7	2.9	2.6	2.9	2.7
49	3.0	3.2	3.0	3.2	3.1
50	2.9	2.7	2.7	2.9	2.8
51	2.8	3.3	2.8	3.3	3.0
52	2.9	3.3	3.0	3.3	3.1
53	2.0	1.9	1.9	.0	1.9
54	2.8	2.7	2.3	2.6	2.6
55	3.0	2.7	2.4	3.2	2.8
56	2.4	3.0	2.7	3.2	2.8
57	2.1	2.7	2.4	2.6	2.5
58	2.9	2.6	2.0	2.9	2.2
59	3.0	2.8	2.8	3.0	2.9
60	2.8	2.8	2.6	3.0	2.7
61	2.4	2.7	2.4	3.0	2.6
62	3.0	2.9	2.6	2.9	2.9
63	2.4	2.7	2.2	3.1	2.5
64	2.1	2.6	2.0	2.8	2.2
65	2.7	3.5	2.7	3.3	3.0
66	2.8	3.5	2.7	3.5	3.2
67	2.7	3.3	2.8	3.2	3.1
68	2.7	3.1	2.5	3.3	3.0

APPENDIX G

QualPaCS ITEM MEANS BY UNIT AND TOUR

APPENDIX G

QualPaCS ITEM MEANS FOR MEDICAL UNIT

QualPaCS Item Number	Day Tour Patient Identification Number							Evening Tour Patient Identification Number				
	4.1	4.2	4.3	4.4	4.5	4.6	4.7	3.1	3.2	3.3	3.4	3.5
1	2.7	2.2	1.0	3.0	3.0	3.0	4.0	3.6	3.0	1.5	3.0	2.2
2	2.3	2.5	3.0	3.0	2.0	2.0	2.0	3.0	3.0	3.0	3.0	3.0
3	3.3	3.0	3.0	3.0	2.0	3.0	3.0	5.0	5.0	1.5	3.0	2.3
4	3.0	.0	3.0	.0	3.0	.0	2.0	4.0	3.0	3.0	.0	3.5
5	1.0	.0	3.0	.0	3.0	.0	1.0	3.0	4.0	2.0	4.0	3.0
6	3.0	2.0	3.0	.0	2.0	4.0	2.0	3.0	.0	3.0	3.0	2.3
7	2.1	3.0	.0	3.0	.0	3.0	.0	3.0	3.0	1.0	3.0	3.0
8	3.0	3.5	1.0	3.0	3.0	2.0	2.0	3.0	2.0	3.0	3.0	2.0
9	3.0	3.0	3.0	3.0	3.0	3.0	2.0	3.0	3.0	3.0	3.0	3.0
10	.0	.0	1.0	.0	1.5	.0	.0	3.0	4.0	2.0	3.0	2.0
11	3.0	3.0	3.0	.0	2.0	4.0	3.0	4.0	3.0	2.0	.0	3.0
12	1.0	3.0	3.0	3.0	3.0	3.0	2.0	3.0	3.0	2.5	3.0	.0
13	2.2	3.0	3.0	.0	1.5	3.0	3.0	4.0	5.0	1.5	3.0	2.0
14	2.0	3.0	2.0	3.0	2.0	3.0	.0	3.0	3.0	1.5	3.0	.0
15	.0	.0	3.0	.0	.0	.0	3.0	3.2	4.0	.0	.0	2.5
Area I Mean	2.4	2.8	2.5	3.0	2.4	3.0	2.4	3.4	3.4	2.2	3.1	2.6
16	.0	3.0	2.0	3.0	2.0	.0	.0	3.0	4.0	2.0	.0	2.0
17	.0	.0	.0	.0	.0	.0	.0	3.0	3.0	3.0	.0	3.0
18	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
19	.0	3.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
20	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
21	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
22	.0	.0	.0	.0	.0	.0	.0	.0	.0	1.0	.0	.0
23	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Area II Mean	.0	3.0	2.0	3.0	2.0	3.0	.0	3.0	3.5	2.0	.0	2.5

APPENDIX G

QualPaCS ITEM MEANS FOR MEDICAL UNIT
(continued)

QualPaCS Item Number	Day Tour		Patient Identification Number					Evening Tour				
	4.1	4.2	4.3	4.4	4.5	4.6	4.7	3.1	3.2	3.3	3.4	3.5
24	1.0	3.0	.0	.0	2.0	2.0	3.0	2.7	3.0	3.0	.0	.0
25	2.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	.0	.0
26	2.5	2.0	2.0	.0	.0	3.0	3.0	3.0	3.0	1.0	.0	3.0
27	2.0	2.0	.0	.0	.0	.0	3.0	3.0	4.0	.0	.0	.0
28	2.0	.0	.0	.0	1.0	3.0	3.0	.0	3.0	.0	.0	1.7
29	3.0	1.0	3.0	3.0	3.0	3.0	3.0	3.0	.0	3.0	4.0	2.0
30	3.0	3.0	3.0	3.0	2.0	3.0	2.0	3.5	4.0	3.0	4.0	3.0
31	3.0	3.0	3.0	3.0	2.0	4.0	3.0	3.0	4.0	3.0	1.5	3.0
32	1.0	2.0	2.0	2.0	.0	2.0	.0	2.0	2.0	.0	4.0	3.0
33	.0	2.0	2.0	2.0	.0	.0	4.0	3.0	2.0	.0	4.0	2.5
34	1.0	2.0	.0	.0	.0	2.0	4.0	3.0	3.0	.0	.0	.0
35	.0	.0	1.0	.0	.0	3.0	4.0	3.0	.0	.0	.0	3.0
36	3.0	3.0	3.0	.0	2.0	3.0	5.0	2.0	3.0	2.0	2.0	2.3
37	3.0	3.0	.0	2.0	3.0	3.0	.0	3.0	3.0	.0	.0	4.0
38	2.0	.0	.0	.0	.0	.0	2.0	3.0	3.0	2.0	3.0	4.0
Area III Mean	2.2	2.4	2.5	2.7	2.3	2.9	3.3	2.9	3.0	2.5	3.2	2.9
39	3.0	3.0	3.0	.0	1.5	2.0	3.0	3.0	3.0	2.0	.0	.0
40	.0	3.0	1.0	1.0	.0	2.0	3.0	2.0	1.0	.0	2.0	.0
41	2.0	3.0	3.0	3.0	2.0	3.0	.0	2.0	3.0	.0	3.0	2.0
42	2.0	2.0	2.0	3.0	2.0	3.0	.0	3.0	3.0	.0	.0	.0
43	.0	3.0	.0	2.0	2.0	3.0	3.0	.0	.0	.0	.0	.0
44	4.0	3.0	2.0	3.0	1.0	4.0	2.0	3.0	3.0	2.0	.0	.0
45	2.5	.0	1.0	3.0	2.5	3.0	3.0	2.7	3.0	2.0	3.0	.0
46	.0	3.0	3.0	3.0	1.5	3.0	.0	2.0	3.0	.0	3.0	2.0
47	2.0	.0	3.0	3.0	.0	.0	.0	2.5	3.0	2.0	.0	.0
48	2.0	.0	3.0	3.0	1.0	3.0	.0	2.0	3.0	.0	3.0	.0

APPENDIX G

QualPaCS ITEM MEANS FOR MEDICAL UNIT
(continued)

QualPaCS Item Number	Day Tour		Patient Identification Number					Evening Tour				
	4.1	4.2	4.3	4.4	4.5	4.6	4.7	3.1	3.2	3.3	3.4	3.5
49	3.0	3.0	.0	.0	.0	.0	.0	3.0	3.0	.0	.0	3.0
50	3.0	3.0	4.0	2.0	2.0	3.0	2.0	2.3	3.0	3.0	3.0	3.0
51	2.8	3.0	3.0	2.0	1.0	3.0	3.0	3.0	4.0	.0	.0	2.0
52	3.0	3.0	3.0	3.0	3.0	3.0	2.0	4.0	4.0	3.0	3.0	2.0
53	.0	.0	.0	.0	.0	.0	.0	2.0	.0	.0	.0	1.7
Area IV Mean	2.7	2.9	2.6	2.6	1.8	2.9	2.5	2.6	3.0	2.3	2.9	2.2

APPENDIX G

QualPaCS ITEM MEANS FOR MEDICAL UNIT
(continued)

QualPaCS Item Number	Day Tour		Patient Identification Number					Evening Tour				
	4.1	4.2	4.3	4.4	4.5	4.6	4.7	3.1	3.2	3.3	3.4	3.5
54	.0	2.0	.0	.0	1.0	3.0	3.0	3.0	3.0	.0	.0	2.0
55	3.0	3.0	.0	3.0	1.0	2.0	3.0	2.0	2.0	.0	3.0	3.0
56	1.0	2.0	2.0	4.0	3.0	2.0	2.0	2.0	4.0	3.0	4.0	2.0
57	2.0	2.0	3.0	2.0	2.0	3.0	1.0	1.0	3.0	2.0	3.0	2.0
58	1.0	2.0	1.0	1.0	1.5	3.0	3.0	2.0	3.0	2.0	1.0	2.0
59	3.0	3.0	.0	.0	.0	3.0	3.0	3.0	.0	.0	.0	2.0
60	3.0	3.0	2.0	2.0	2.0	3.0	3.0	3.0	3.0	2.0	2.0	3.0
61	3.0	3.0	3.0	1.0	1.0	3.0	3.0	3.0	3.0	.0	1.0	.0
Area V Mean	2.3	2.5	2.2	2.2	1.6	2.8	2.6	2.7	3.0	2.3	2.3	2.3
62	1.8	3.0	3.0	4.0	1.0	3.0	3.0	3.0	3.0	1.0	4.0	1.7
63	2.0	1.0	3.0	3.0	1.0	2.0	2.0	3.0	3.0	1.0	3.0	2.0
64	1.0	1.0	3.0	2.0	1.0	2.0	1.0	3.0	3.0	1.0	3.0	2.0
65	3.0	3.0	2.0	2.0	1.0	3.0	3.0	5.0	4.0	1.0	2.0	2.5
66	3.0	3.0	.0	.0	1.0	3.0	3.0	5.0	4.0	1.0	.0	2.0
67	.0	3.0	2.0	2.0	2.0	3.0	.0	3.0	4.0	2.0	3.0	.0
68	2.5	2.5	2.0	2.0	2.0	2.0	3.0	3.0	4.0	1.0	3.0	3.0
Area VI Mean	2.2	2.4	2.5	2.5	1.3	2.6	2.5	3.6	3.6	1.1	3.0	2.2
Grand Mean	2.4	2.6	2.6	2.6	1.9	2.8	2.7	2.9	3.3	2.1	2.9	2.5

APPENDIX G

QualPaCS ITEM MEANS SURGICAL UNIT
(continued)

QualPaCS Item Number	Evening Tour Patient Identification Number 1.1	1.2	1.3	1.4	1.5	1.6	1.7	Day Tour 2.1	2.2	2.3	2.4	2.5
1	3.8	4.6	4.3	4.5	2.5	4.0	4.0	3.3	2.7	3.5	2.5	3.0
2	3.3	5.0	3.0	4.0	2.3	3.0	3.0	3.0	3.0	2.0	3.0	2.8
3	4.0	5.0	3.4	4.0	3.0	4.0	4.0	4.0	4.8	3.0	3.0	3.7
4	.0	4.0	2.0	3.0	.0	.0	.0	.0	3.0	.0	.0	3.0
5	.0	4.0	2.6	.0	.0	3.0	3.0	.0	2.5	3.0	.0	2.8
6	5.0	4.0	2.7	4.0	2.3	3.0	3.0	3.0	3.0	3.0	3.0	3.0
7	4.0	4.0	3.5	4.0	3.0	3.0	4.5	3.0	2.0	.0	3.0	2.7
8	5.0	4.0	3.0	3.0	.0	4.0	.0	.0	3.0	3.0	3.0	3.0
9	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
10	.0	.0	3.0	4.0	.0	.0	.0	.0	1.7	3.0	3.0	2.9
11	4.0	4.0	3.7	4.0	3.0	3.0	3.0	3.0	2.0	2.0	4.0	2.8
12	4.0	3.0	3.3	3.0	2.0	.0	3.5	3.0	3.0	3.5	4.0	3.4
13	5.0	4.0	3.0	3.0	3.0	3.3	3.5	3.0	3.0	3.0	3.0	3.0
14	5.0	3.0	3.0	4.0	3.0	3.0	4.0	3.0	3.0	.0	3.0	3.0
15	.0	4.0	.0	.0	.0	.0	.0	.0	3.0	3.0	3.0	3.0
Area I Mean	4.1	4.2	3.1	3.3	2.7	3.3	3.5	3.1	2.8	3.0	3.0	3.0
16	3.0	3.0	4.0	4.0	.0	.0	.0	.0	.0	2.0	.0	2.0
17	.0	4.0	3.0	5.0	.0	.0	.0	.0	.0	.0	.0	.0
18	.0	.0	3.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
19	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
20	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
21	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
22	.0	.0	.0	.0	.0	.0	.0	.0	.0	2.0	.0	2.0
23	.0	.0	.0	.0	.0	.0	.0	.0	.0	3.5	.0	3.5
Area II Mean	3.0	3.5	3.3	4.5	.0	.0	.0	.0	.0	2.5	.0	2.5

APPENDIX G

QualPaCS ITEM MEANS SURGICAL UNIT
(continued)

QualPaCS Item Number	Evening Tour		Patient Identification Number					Day Tour				
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5
24	3.5	4.0	3.0	4.0	.0	3.7	3.0	3.0	.0	3.0	2.0	2.7
25	3.0	3.0	3.0	3.0	3.0	4.0	3.0	3.0	3.0	3.0	3.0	3.0
26	4.0	3.0	3.5	5.0	2.3	3.7	2.5	3.0	3.0	3.0	.0	3.0
27	3.7	5.0	3.0	3.0	.0	.0	3.0	.0	.0	.0	.0	.0
28	4.0	3.0	2.6	3.0	.0	3.0	.0	.0	1.3	3.0	.0	2.1
29	4.0	3.0	3.5	3.0	2.0	3.0	2.0	4.0	3.0	3.0	4.0	3.5
30	4.0	3.0	3.0	4.0	3.0	4.0	3.0	3.0	3.0	3.0	3.0	3.0
31	3.0	3.0	3.0	4.0	2.0	4.0	3.0	1.0	3.0	3.0	4.0	2.8
32	3.0	.0	2.0	3.0	.0	3.0	.0	.0	2.0	.0	.0	2.0
33	3.0	.0	2.0	2.0	.0	.0	.0	.0	2.0	.0	.0	2.0
34	3.0	3.0	4.0	4.0	3.0	5.0	3.0	3.0	3.0	.0	.0	3.0
35	4.0	3.5	4.0	.0	3.5	5.0	2.5	3.0	3.0	.0	.0	3.0
36	3.0	3.0	4.0	3.0	3.0	5.0	3.0	3.0	3.0	3.0	3.0	3.0
37	3.0	3.0	3.0	3.0	3.0	5.0	2.5	3.0	3.0	3.0	3.0	3.0
38	3.1	4.0	3.0	.0	3.0	.0	3.0	.0	2.5	.0	.0	2.5
Area III Mean	3.4	3.1	3.1	3.5	2.8	4.0	2.8	2.9	2.7	3.0	3.1	2.8
39	4.5	4.0	3.0	3.0	2.5	3.0	2.0	3.0	.0	.0	3.0	3.0
40	3.0	3.0	2.0	3.0	.0	5.0	2.0	.0	.0	3.0	3.0	3.0
41	3.0	3.0	3.0	3.0	3.0	3.0	3.0	1.0	4.0	3.0	.0	2.7
42	3.0	3.0	3.0	4.0	2.6	3.0	3.0	2.0	.0	3.0	3.0	2.7
43	2.0	3.0	3.0	3.0	2.0	.0	3.0	2.0	.0	.0	3.0	2.5
44	3.0	3.0	3.5	3.0	2.0	3.0	.0	2.0	.0	.0	3.0	2.5
45	4.0	3.0	3.0	4.0	2.0	3.0	2.0	3.0	.0	3.0	3.0	3.0
46	3.0	3.0	3.0	3.0	.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
47	3.0	3.0	3.0	3.0	.0	.0	.0	2.0	.0	.0	.0	2.0
48	.0	3.0	4.0	2.0	3.0	3.0	3.0	3.0	.0	3.0	3.0	3.7

APPENDIX G

QualPaCS ITEM MEANS SURGICAL UNIT
(continued)

QualPaCS Item Number	Evening Tour Patient Identification Number 1.1	1.2	1.3	1.4	1.5	1.6	1.7	Day Tour 2.1	2.2	2.3	2.4	2.5
49	.0	3.0	.0	5.0	2.0	.0	.0	3.0	3.0	3.0	.0	3.0
50	4.0	4.0	2.0	3.0	1.0	4.0	1.0	3.0	3.0	3.0	3.0	3.0
51	4.0	4.0	3.3	5.0	2.0	4.0	2.0	3.0	3.0	.0	3.0	3.0
52	4.0	4.0	3.0	5.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
53	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Area IV Mean	3.4	3.3	2.9	3.5	2.3	3.4	2.5	2.5	3.2	3.0	3.0	2.9

APPENDIX G

QualPaCS ITEM MEANS SURGICAL UNIT
(continued)

QualPaCS Item Number	Evening Tour Patient Identification Number 1.1	1.2	1.3	1.4	1.5	1.6	1.7	Day Tour 2.1	2.2	2.3	2.4	2.5
54	4.0	3.0	3.0	3.0	2.7	3.0	.0	2.0	.0	.0	.0	2.0
55	3.0	3.0	3.0	4.0	.0	4.0	2.0	3.0	.0	3.0	4.0	3.3
56	3.0	3.0	3.0	3.0	3.0	3.0	2.0	2.5	3.0	4.0	4.0	3.4
57	3.0	4.0	2.0	3.0	2.0	3.0	2.0	1.0	2.0	4.0	3.0	2.5
58	3.0	3.0	3.0	3.0	2.5	3.0	.0	1.0	2.0	.0	3.0	2.0
59	3.0	.0	.0	3.0	3.0	3.0	.0	3.0	.0	.0	.0	3.0
60	3.0	3.0	.0	3.0	3.0	.0	3.0	2.0	3.0	4.0	3.0	3.0
61	3.0	3.0	3.0	3.0	.0	3.0	3.0	2.0	3.0	4.0	3.0	3.0
Area V Mean	3.1	3.1	2.8	3.1	2.7	3.1	2.4	2.0	2.6	3.8	3.3	2.7
62	4.0	5.0	3.0	3.0	3.0	3.0	3.0	2.3	2.0	3.0	.0	2.4
63	3.0	3.0	2.0	4.0	2.0	3.0	3.0	3.5	.0	3.0	3.0	3.2
64	3.0	3.0	2.0	3.0	1.0	3.0	2.0	2.0	.0	3.0	3.0	2.7
65	4.0	5.0	4.0	5.0	3.0	4.0	3.0	3.5	1.0	3.0	3.0	2.6
66	4.0	5.0	5.0	5.0	3.0	3.0	3.0	2.0	.0	3.0	4.0	3.0
67	.0	3.0	3.0	5.0	.0	4.0	2.0	2.0	.0	3.0	4.0	3.0
68	4.0	4.0	3.0	4.0	3.0	4.0	3.0	2.3	3.0	3.0	4.0	3.0
Area VI Mean	3.7	4.0	3.1	4.1	2.5	3.4	2.7	2.5	2.0	3.0	3.5	2.8
Grand Mean	3.6	3.5	3.1	3.5	2.8	3.4	2.8	2.6	2.8	3.0	3.0	2.9

APPENDIX H

COMPOSITE OF AREA MEANS AND GRAND MEANS

APPENDIX H

COMPOSITE OF AREA MEANS AND GRAND MEANS

	QualPaCS Area						Grand Mean
	I	II	III	IV	V	VI	
Medical Unit	2.8	2.7	2.7	2.6	2.3	2.5	2.6
Surgical Unit	3.3	3.2	3.1	3.0	2.9	3.1	3.0
Day Tour	2.8	2.6	2.7	2.7	2.6	2.5	2.6
Evening Tour	3.3	3.1	3.1	2.9	2.7	3.1	3.0
Overall	3.0	2.9	2.9	2.8	2.6	2.8	2.8

APPENDIX I

OVERALL MEAN FOR EACH ITEM

APPENDIX I

OVERALL MEAN FOR EACH ITEM

Area I		Area II		Area III	
1	3.1	16	2.8	24	2.8
2	2.9	17	3.4	25	3.0
3	3.5	18	3.0	26	3.0
4	3.0	19	3.0	27	3.1
5	2.9	20	1.0	28	2.6
6	3.0	21	.0	29	3.0
7	3.0	22	2.3	30	3.1
8	2.9	23	3.3	31	3.0
9	3.0			32	2.3
10	2.7			33	2.6
11	3.1			34	3.0
12	3.0			35	3.2
13	3.0			36	3.0
14	3.0			37	3.0
15	3.1			38	3.0

Area IV		Area V		Area VI	
39	2.9	54	2.6	62	2.9
40	2.8	55	2.8	63	2.5
41	2.7	56	2.8	64	2.2
42	2.7	57	2.5	65	3.0
43	2.6	58	2.2	66	3.2
44	2.8	59	2.9	67	3.1
45	2.8	60	2.7	68	3.0
46	2.8	61	2.6		
47	2.7				
48	2.7				
49	3.0				
50	2.8				
51	3.0				
52	3.1				
53	1.9				

APPENDIX J

COMPARATIVE STAFFING LEVELS

APPENDIX J

COMPARATIVE STAFFING LEVELS FOR THE MEDICAL UNIT AND THE SURGICAL UNIT

Day Tour	Pt. Census by Category I	II	III	IV	Total Census	R.N. Staff	Other Staff	Patient/ Staff	Care/ Patient (Hours)	Patient/ R.N.	R.N. Care/ Patient (Hours)
Medical Unit											
Day 1	8	22	12	2	44	5	7	3.7	2.04	8.8	.99
Day 2	16	10	18	2	46	5	7	3.8	1.9	9.2	.86
Surgical Unit											
Day 1	3	13	9	2	27	2	4	4.5	1.8	13.5	.59
Day 2	3	14	9	1	27	2	4	4.5	1.8	13.5	.59
Evening Tour											
Medical Unit	14	14	13	3	44	2	4	7.3	1.09	22	.36
Surgical Unit	2	7	9	2	20	1	1.7	7.4	1.08	20	.40

APPENDIX K

AGREEMENT FOR INFORMED CONSENT

CONSENT FORM FOR HUMAN RESEARCH

APPENDIX K

UNIVERSITY OF OREGON HEALTH SCIENCES

AGREEMENT FOR INFORMED CONSENT

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

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

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

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

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

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

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

_____ _____
(Date) (Subject's Signature)

CONSENT FORM FOR HUMAN RESEARCH

I, _____, herewith agree to
(First Name) (Initial) (Last Name)

serve as a subject for the study named "A Quality of Patient Care Study in a Veterans Administration Hospital", by Rosemary Peterson, R.N.,B.S.N., under the supervision of Marie Berger, R.N.,M.S. This study explores elements of nursing care to patients. My participation in the study requires that I allow a nurse observer to be at my bedside for a two-hour period to observe care and to study my hospital record. I may benefit by participating as evaluation of care may lead to improvement.

I understand that participation in this study will involve no risk for me: however, it will reduce the privacy of my interactions with the nursing staff for the observation period. The information obtained will be kept confidential. My name will not appear on any project records and anonymity will be maintained by the use of code numbers. I understand that I have the right to refuse to participate in this study. This study has been discussed with me and I have had the opportunity to ask questions.

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

_____ _____
(Date) (Participant Signature)

_____
(Witness Signature)

APPENDIX L

ABSTRACT

APPENDIX L

AN ABSTRACT OF THE THESIS OF

Rosemary Peterson

For the MASTER OF NURSING

Date of receiving this Degree:

Title: A QUALITY OF PATIENT CARE STUDY IN A VETERANS ADMINISTRATION HOSPITA[redacted]

Approved: _____
Marie Berger, R.N.,M.S., Thesis Advisor

The purpose of this study was to evaluate the quality of nursing care provided patients within the study hospital as part of an ongoing program for Quality Assurance. Evaluation theory states that the function of evaluation is to guide decision making. This assessment of the quality of patient care will be used to provide information for decisions about changes in the delivery of care by nursing staff. In addition, it will serve as a comparison instrument in validating information from structure and outcome audits of care.

This study was designed to establish the level of care and to investigate differences in care between a medical unit and a surgical unit and between the day tour and the evening tour of duty. The units for study and the twelve patient subjects from each unit were selected by random process. Following a pilot study by the three nurse-raters to establish interrater reliability, each subject was observed by a rater for a two-hour period. Twelve observations were made on the day tour and twelve on the evening tour of duty. Ratings were recorded on the Wandelt and Ager Quality Patient Care Scale (1974), an instrument designed

to measure care in progress. Scores were recorded on the one to five scale, with one representing poorest care and five representing best care.

To determine whether the quality of care was consistent throughout the hospital, four hypotheses were tested. The first hypothesis: There will be a significant difference in grand mean scores on the QualPaCS between medical and surgical units, was accepted. The second hypothesis: There will be a significant difference in area mean scores between the medical and surgical units, was accepted. The third hypothesis: There will be a significant difference in grand mean scores on the QualPaCS during the day tour as compared to the evening tour, was accepted. The fourth hypothesis: There will be a significant difference in area mean scores on the QualPaCS during the day tour as compared to the evening tour, was also accepted.

The conclusions drawn from this research were that variances in the quality of care did exist between the medical unit and the surgical unit as well as between the day tour and the evening tour. This study also established the level of care provided, identifying those specific care components that earned marks of excellence, acceptability, or concern.