THE RELATIONSHIP BETWEEN THE QUALITY OF LEADERSHIP AND THE QUALITY OF CARE

by

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A THESIS

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I

INTRODUCTION

Can one style of leadership be more effective than another in determining the quality of patient care? This question, asked by a panel of 433 nursing leaders was reported by Carol Lindeman, Dean of the University of Oregon Health Sciences Center School of Nursing. In an article titled "Priorities in clinical nursing research" (1975), Lindeman reported on the findings of her nationwide survey. Out of 2000 "burning questions" originally identified by the panel, fifteen items were selected in terms of research areas having the greatest value for the profession.

Because the research question addresses the relationship between the type of leadership style and the quality of care, the review of the literature has been organized around these two variables.

Situational Leadership Theory

Situational Leadership Theory, the conceptual framework for the present study, states that leaders are characterized in one of four basic styles. The four styles, while clearly defined, are not fixed, so that an individual identified as one style of leader can operate in another style as the situation demands. A leader who is in tune with the environment and is able to identify the qualities and needs of followers is the more effective leader. These four styles will be discussed in greater detail in the review of the literature.

The theory is relatively new and has come about as a result of changes in concepts of leadership theories throughout the years. For the purpose

of the present study, quality of leadership was assessed by ascertaining leadership style and the relative effectiveness of the styles. In other words, the leadership style of selected nurse-leaders was correlated with the quality of care given by them and their subordinates.

To provide the context for the conceptual framework, the progression of thought which led to Situational Leadership Theory will be presented. This review of the literature will cover various theories of leadership prevalent in this century and will include discussion of leadership styles which lead into Situational Leadership Theory.

The literature review will also include information relevant to quality of care, including rational for the concept.

Review of the Literature

Theories of Leadership

> "The relationship [of leader to follower] is not of power, but of understanding which exists between the leader and the followers and is brought on by the needs that the latter has for the former and the concern of the former in serving the latter (Jennings, 1960, p 8).

Historically, there have been several theories of leadership which have dominated. Such theories as the "great man" theory, trait theory and group leader theory have all played a part in the progression of thoughts about leadership from one period to another. In many ways, these theories have reflected the period in which they originated; i.e., the "great man" theory being predominate in periods when women were not considered leaders and trait theory developed to explain the leadership of those men. Situational Leadership Theory is a theory which can be applied to people as individuals, with the sex of that individual not being a

factor.

Great Man Theory

Since earliest days, the "great man" theory of leadership was prevalent. Plato postulated that those who do need no thought or knowledge, whereas those who know do not have to do. In this way, he drew the line between thought and action. In other words, the "great man", or leader, held the knowledge, made the plans and gave direction. The follower, who didn't know better, would accept the leader's words and blindly follow directions. In greater or lesser degree this is still the image of the leader to many minds.

Machiavelli, whose rules have helped to lay the foundation of political science, as well as the basic model for executives in many fields, believed in the omnipotent great man. In a similar vein, Thomas Carlyle believed that there were individuals who were superior. He believed that, although their motives and morals might be suspect, great men were the most important factor in all history. The leader was seen by John Stewart Mill as one who would restore independence and originality to a society sinking to collective thinking. He saw that the people could be given an aptitude for critical, independent thought by use of the powers of persuasion of their leaders. William James went one step further in suggesting that one could determine his own destiny. He also suggested that many great men remained unknown because they somehow missed the moment or situation which would make their genius possible or necessary. He further saw the leader as a resolver of problems; an initiator who persuades others to execute (as cited in Jennings, 1960).

Trait Theory

The trait theory of leadership, the traditional approach in the United States during the early part of the century, postulated that individuals had inborn traits which made them leaders. This was in essence an attempt to look at the attributes that went into the "great man".

Stogdill (1948) surveyed 124 books and articles reported to study traits and characteristics of leaders and offered conclusions based on positive evidence from fifteen or more of the studies. According to Stogdill's findings, the average leader differs from the average group member in the following respects: a) intelligence, b) scholarship, c) dependability in exercising responsibilities, d) activity and social participation and e) socio-economic status. The qualities, characteristics and skills required in a leader are determined to a large extent by the demands of the situations in which he is to function as a leader, according to Stogdill.

In a summary of 72 books and articles on military leadership, Jenkens made observations that show an early leaning toward situational leadership:

> "Leadership is specific to the particular situation under investigation. Who becomes a leader of a particular group engaging in a particular activity and what the characteristics are in a given case are a function of the situation..." (1947, p 56).

An early study (Bird, 1940) at the University of Minnesota, reviewed seventy experimental investigations about leadership traits and found that only five percent of them appeared on four or more of the lists (Adair, 1973). So it can be seen that, even at that early date, there was a difference of opinion as to what traits constituted which types of leaders.

Group Leader

Leadership is shared by all members of a group and leaders emerge from the group to provide the needed or effective function at any given time, according to group leader theory. The theory states that no one leader is necessary and that appointed or designated leaders only act as a safety net if the group fails to direct itself. While in the traditional traits view the strong leader was often seen to be autocratic, group leadership was, at least on the surface, more democratic. This theory emerged in the early 1950's and, in part, satisfied the requirements for the democratic model of the American culture following World War II (Adair, 1973; Reitz, 1977).

Emergence of leaders within the group continued to be of interest, however. Beginning in the late 1950's, researchers at Michigan State and Ohio State began to look at leadership as being a "less-to-more" rather than an "either-or" concept. One of the best known models of this ilk is that proposed by Tannenbaum and Schmidt (1958). Their model depicts a broad range of leadership styles from authoritarian behavior at one end to democratic behavior at the other (Figure 1).

The area of freedom for subordinates increasing as that area decreases for leaders, illustrates the possibilities of the relationship of leader/follower. In this concept, we begin to see the importance of the leader being able to properly diagnose the environment. The leader who is locked into an intractable leadership style, is less likely to be effective than one who is able to perceive the specific needs of the followers and adapt accordingly (Argyris, 1962; Adair, 1973; Hersey & Blanchard, 1977; Reitz, 1977).

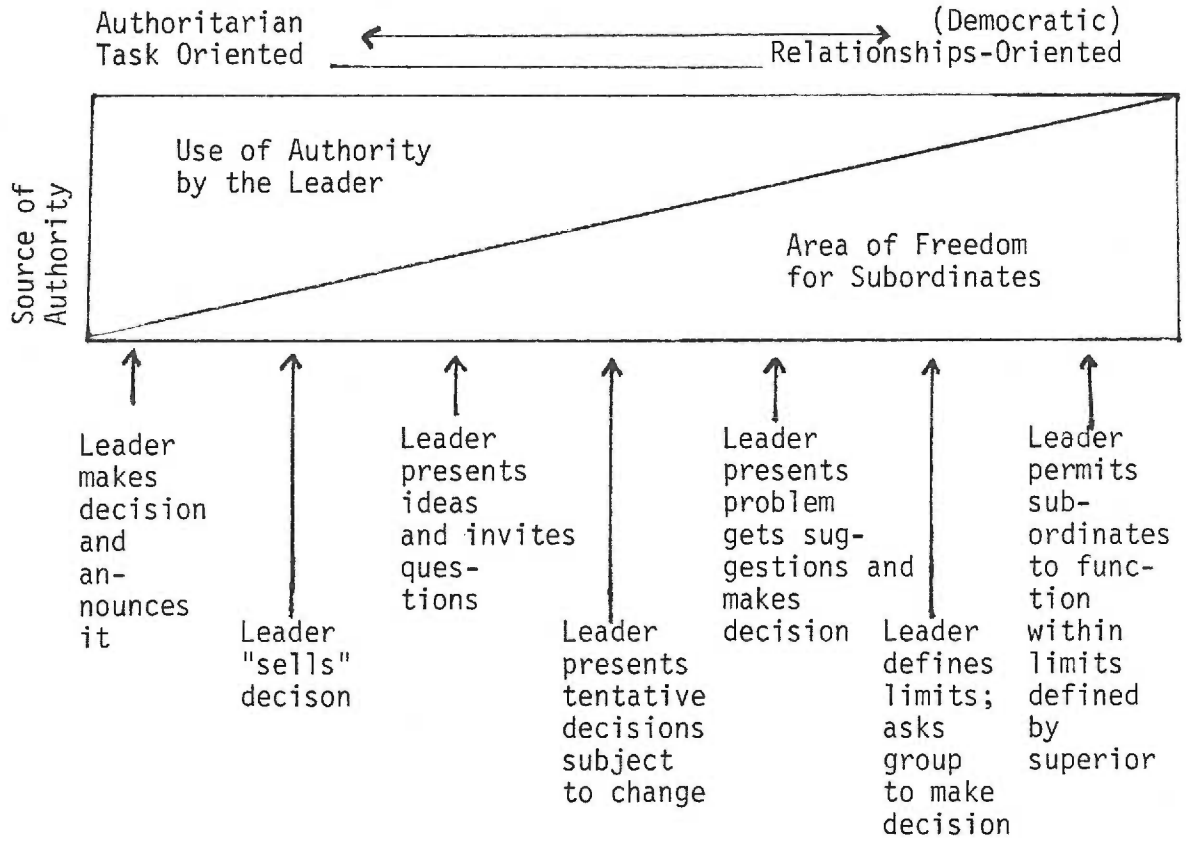

Figure 1. Continuum of leader behavior. (Tannenbaum & Schmidt, 1958, p. 96)

History of Management Thought

In the early 1900's Taylor initiated time and motion studies which emphasized production. The needs of the organization were put before the needs of the workers. The function of the leader under Scientific Management, as it was called, was to meet organization goals. Effectiveness was measured solely in terms of profit (as cited in Argyris, 1964).

The human relations movement, initiated by Elton Mayo and associates in the 1920's and 1930's, focused on human relations as the most important consideration for management.

> "The function of the leader under human relations theory was to facilitate cooperative goal attainment among followers while providing opportunities for their personal growth and development" (Hersey & Blanchard, 1977, p 91).

Thus we have one approach focusing on tasks and one on relationships. These two components have been identified in the studies at the University of Michigan, the Research Center for Group Dynamics and Ohio State University (Hersey & Blanchard, 1977). The similarities in their findings are shown in Table 1.

Table 1

Relationship/Task Similarities

	Michigan Leadership Studies	Group Dynamic Studies	Ohio State Studies
Relationship	Employee Orientation	Group Maintenance	Consideration
Task	Production Orientation	Goal Achievement	Initiating Structure

As is seen in Table 1, in earlier studies the emphasis was more on group and production orientation, whereas the later, Ohio State studies placed more emphasis on consideration and initiation structure.

The Ohio State researchers took the task-relationship model one step further by studying employee's perception of leader behavior. In so doing, they found that initiating behavior and consideration were neither mutually exclusive, nor "all or none" but that any leader could demonstrate various combinations of the two behaviors. Thus, for the first time, behavior was plotted on two axis/as shown in Figure 2 rather than on a continuum.

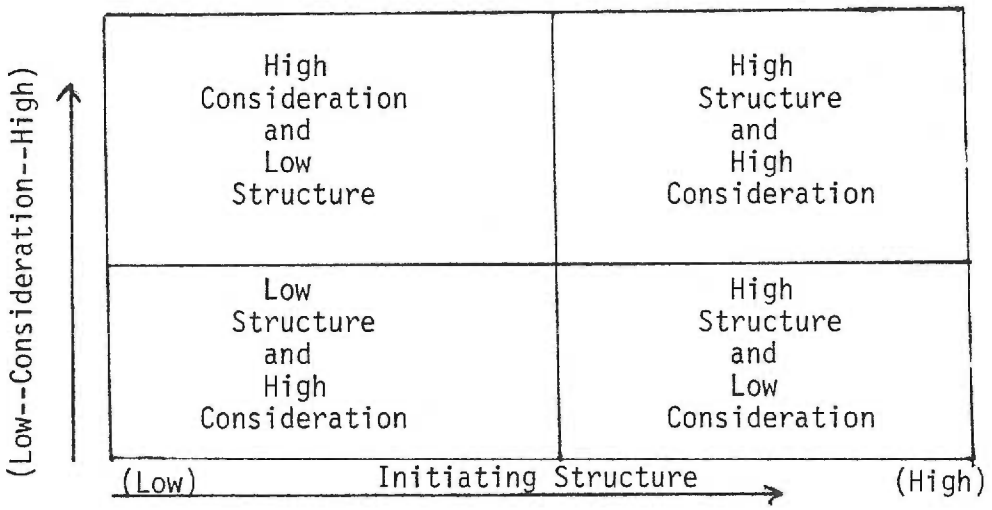

Figure 2. The Ohio State leadership quadrants.

Using this model a leader might operate under other different, or more expanded styles; that is, instead of being just a highly structured leader, one could be highly structured with either a high or low measure of consideration. Conversely, the leader might demonstrate a low amount of structure with a high or low measure of consideration.

The Ohio State model was developed as an indicator of how leader behaviors were perceived by others, and therefore is considered to be a behavioral model. Blake and Mouton (Hersey & Blanchard, 1977; Reitz, 1977) developed the Managerial Grid shown in Figure 3, using the same general format as the Ohio State model but focusing on attitudes of manager rather than on behaviors.

A manager's expressed emphasis on production and people placed the individual's predominate and backup leadership styles on the grid. Both the Ohio State and the Managerial Grid models imply that there is one best style of leadership (Hersey & Blanchard, 1977).

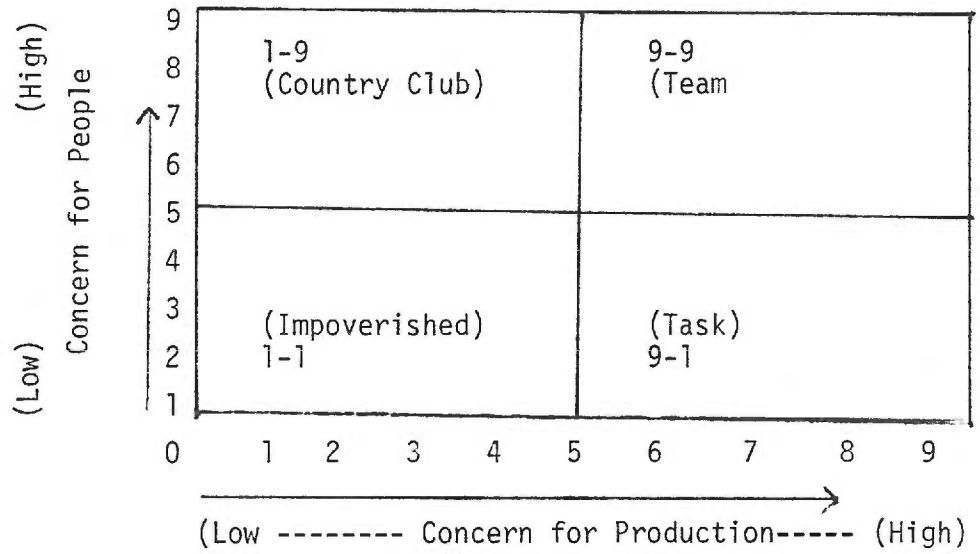

Figure 3. The Managerial Grid leadership styles. (As cited in Hersey & Blanchard, 1977).

On the other hand, Hersey & Blanchard (1977) and Adair (1973) state that there is no best leadership style; that is, one that is effective in virtually all situations. Leaders of any styles can be effective so long as adaptability to situations is liberally employed:

> "The more managers adapt their style of leader behavior to meet the particular situation and the needs of their followers, the more effective they will tend to be in reaching personal and organizational goals (Hersey & Blanchard, 1977, p 101).

Situational Leadership

Hersey and Blanchard expanded the idea of no one best leadership style and developed the Situational Leadership Theory. The major difference in their theory is the addition of the effectiveness dimension. The authors maintain that a leader's effectiveness is dependent upon the appropriateness of style to the maturity level of the followers. As can be seen in Figure 4, the grid, similar to Blake and Mouton's, is further

categorized into Q1, Q2, Q3 and Q4 styles.

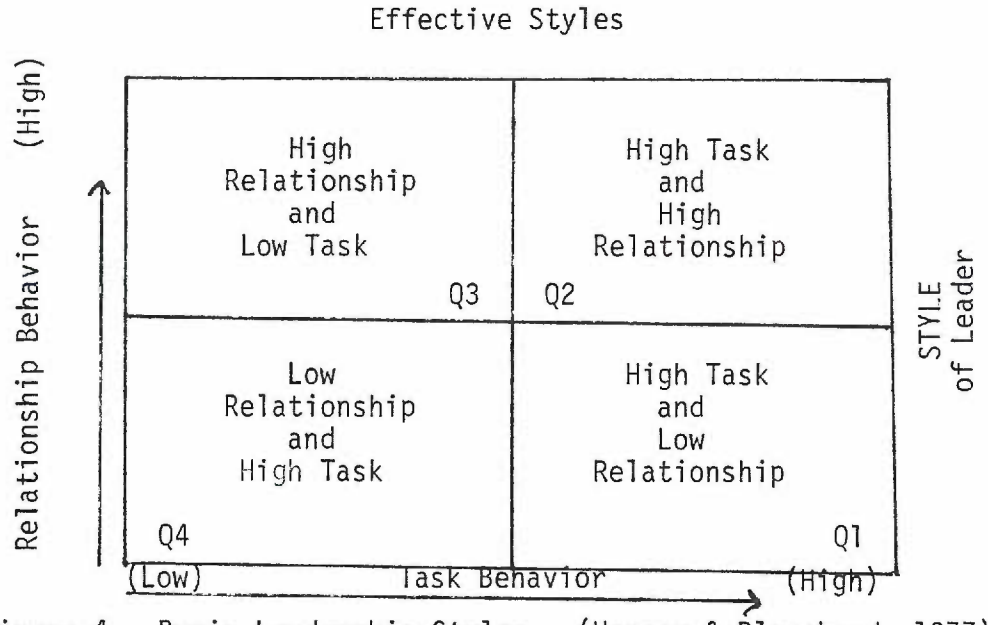

Figure 4. Basic Leadership Styles. (Hersey & Blanchard, 1977).

In Figure 5, further delineation can be seen in S1, S2, S3 and S4 styles of leadership and the maturity level of the followers.

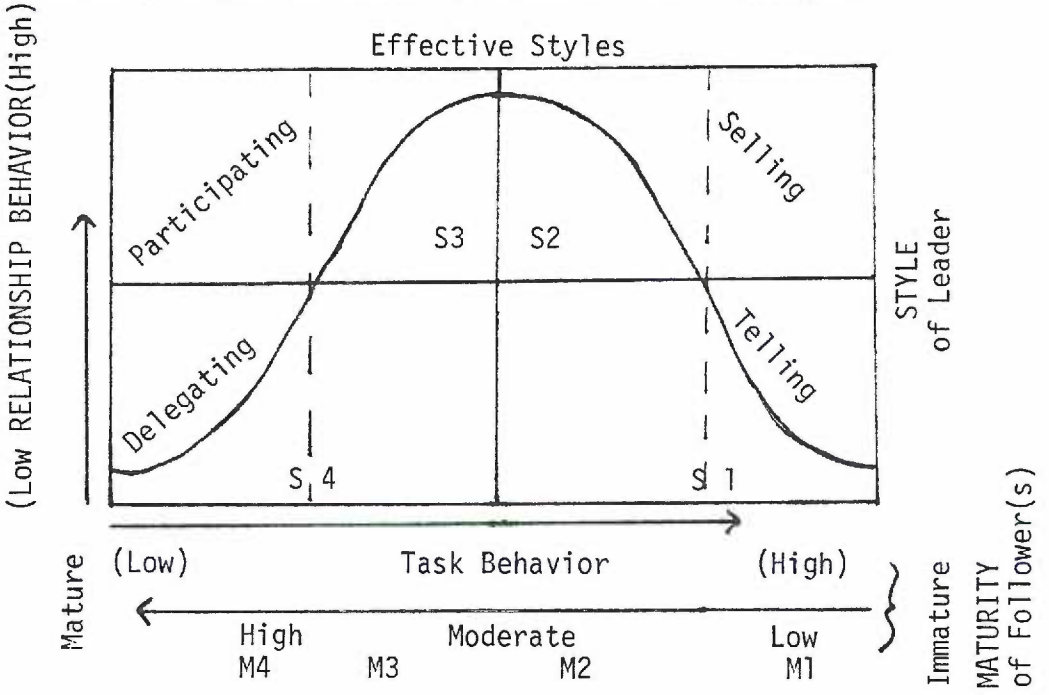

Figure 5. Description of Leader Behavior (Hersey & Blanchard, 1977)

Hersey and Blanchard maintain that a leader who is able to match leadership style to the maturity level of the followers will have a higher probability of effectiveness.

The curvilinear line on Figure 5 indicates the movement of the leader through the four basic leadership styles of behavior. These four basic styles are described as follows:

S-1 High task/low relationship leader behavior is referred to as "telling" because this style is characterized by one-way communication in which the leader defines the roles of followers and tells them what, how, when and where to do various tasks.

S-2 High task/high relationship behavior is referred to as "selling" because with this style most of the direction is still provided by the leader. He or she also attempts through two-way communication and environmental support to get the follower(s) psychologically to buy into decisions that have to be made.

S-3 High relationship/low task behavior is called "participating" because with this style the leader and follower(s) now share in decision-making through two-way communication and much facilitating behavior from the leader since the follower(s) have the ability and knowledge to do the task.

S-4 Low relationship/low task behavior is labelled "delegating" because the style involves letting follower(s) "run their own show" through delegation and general supervision since the follower(s) are high in both task and psychological maturity (Hersey & Blanchard, 1977, p 169-170).

Maturity, as described by Hersey and Blanchard, is a task specific concept. Follower's maturity, therefore, may vary from day to day or, from situation to situation. A follower may be exceptionally mature in one area, such as bedside care and interaction with patients, but immature in other areas, such as team leading or making nursing care plans. It is, therefore, most important that the leader be an expert diagnostician of the environment, knowing the position of each follower on the maturity scale and, to be most effective, which style of leadership to employ with each situation (Adair, 1973; Hersey & Blanchard, 1977).

As has been said, there is no best style of leadership. Any of the four styles is equally effective, depending on the situation the leader faces. The difference between effective and ineffective leadership, then, is the appropriateness of the leadership behavior, rather than the behavior itself.

Hersey and Blanchard have added an "effectiveness" dimension to their model to further demonstrate this concept. On this model, called the Tri-Dimensional Leader Effectiveness Model, appropriate leader style is termed "effective" and inappropriate style is termed "ineffective".

The effectiveness scale is divided into increments on both the effective and ineffective sides. The effectiveness dimension is co-labeled "environment", making it even more explicit that effectiveness is actually the appropriate adaptability of leadership styles within a given environment. In essence:

> "One might think of the leader's basic style as a particular stimulus, and it is the response to this stimulus that can be considered effective or ineffective. This is an important point because theorists and practitioners who argue that there is one best style of leadership are making value judgments about the stimulus, while those taking a situational approach to leadership are evaluating the response or the results rather than the stimulus" (Hersey & Blanchard, 1977, p 105).

But,does the style or the adaptability of leadership make a difference with the nurse leader? Given nursing leaders of the four different styles of leadership, how could their effectiveness dimension be measured? How can the response, or results of their effectiveness be measured? One way would be to measure the quality of care delivered by the nurse leaders and their respective followers.

Quality of Care

Turning to the measurement of quality of care, it is necessary to select a method by which the broadest possible look at care given can be seen and the quality of that care can be measured. Therefore, literature dealing with quality assurance was reviewed.

Standards, surveillance and corrective action (Slee, 1974, p 38) are the three essential components in any quality assurance program. Donabedian (1969) stresses setting criteria as the first step in structuring an evaluation system. He identifies three types of standards: structure, process and outcome. Structure standards do not address the issue of quality, as they focus on the ways in which the organization is systematized (Stevens, 1975). Since, in this study, we are looking at the quality of care given by nurse leaders and their followers in one institution, the systemization of the organization is not the issue here.

Another perspective is taken by the outcome standards. Stevens states that "it matters little what nursing process was used" (1975, p 148) if the patient outcome is satisfactory. However, outcome standards do not take into consideration other factors and are not a measure of how much of the patients' health outcome is due either directly or indirectly to nursing (Preston, 1977). "Typically, the patients' health outcome is the result of multiple interaction of multiple factors of which nursing is only one" (Stevens, 1975, p 149).

The third, or process standards, according to Stevens,

> "...measure aspects of the nursing process itself. Nursing process here refers to the activities of the individual nurse, i.e., those actual interactions between the nurse and the patient. Thus the nursing process takes place within the providing structure" (1975, p 148).

It would be necessary, therefore, to view the care as delivered, "in order to determine what contributes to the care and how that care was delivered. The process audit meets these criteria (Preston, 1977, p 6).

Surveillance is the second criteria identified by Slee (1972). A primary source, giving the rater direct knowledge concerning the standard is desirable, but evidence of quality of care can be gathered either directly or indirectly. Secondary sources could include charts, nursing care plans, rounds, patient interviews, nursing interviews and interviews with other health personnel (Stevens, 1975; Wandelt & Ager, 1974).

The third essential component of quality assurance is that of corrective action (Slee, 1972). Proper feedback offered to nursing units that adds a useful element to the quality control program and leads to a greater productivity potential. All the instruments reviewed by Preston (1977) incorporated this component: Joint Commission on Accreditation of Hospitals, 1973; Phaneuf, 1972; Wandelt & Ager, 1974 and Wandelt & Phaneuf, 1976. Since the purpose of this study is to determine the quality of care on units led by nurse leaders with different styles, no plan was developed for the researcher's involvement in any corrective action needed. The researcher will, however, conduct a one time seminar explaining Situational Leadership Theory and the individual head nurse's scores. Feedback will also be given to the Staff Development Director delineating generally strong and weak areas observed.

Meeting the three criteria identified by Slee (1972), is the Quality Patient Care Scale, which is used to measure quality of care. This instrument is "designed for use in any setting in which nurses interact with

patients or intervene, directly or indirectly, to contribute to meeting the patients' nursing and health care needs" (Phaneuf, 1972). Without singling out any care given, the Quality Patient Care Scale looks at care given in a specific time period by the total staff.

Statement of the Problem

What is the relationship between the effectiveness of the leader and the quality of care?

Purpose of the Study

The purpose of the present study is to evaluate the quality of care given under the direction of nurse leaders with different levels of leadership effectiveness.

Hypotheses

1. There will be a significant difference in the Grand Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders.

2. There will be a significant difference in the Area Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders.

Operational Definitions

Nurse Leader: For the purpose of this study, a nurse leader is one holding a position as a head nurse in a 465 bed teaching hospital in metropolitan Portland, Oregon. This nurse leader has 24 hour responsibility for a given unit, including staffing, supplies, establishing policies and overall supervision of employees.

Leadership Style: The style of leaders is the constant behavior patterns that they use when they are working with and through other people as perceived by those people. These patterns emerge in people as they begin to respond in the same fashion under similar conditions; they develop habits of action that become somewhat predictable to those who work with them (Hersey & Blanchard, 1977).

Quality of Care:

> "Quality:...the characteristics of excellence of the action or process" (Froebe & Bain, 1976, p 14).
>
> "Care of the whole patient is facilitated by a clear display of all important problems, data, assessments and plans to minimize errors of oversight. The nurse..., focused on one part of the patient, must be aware of the entire patient and his problems. Health records and crisis care records must be coordinated to facilitate preventative care, health maintenance and continuity of care" (Yarnall & Atwood, 1974, p 216).

Therefore, for the purpose of this study, quality of care will be the characteristics of excellence, or the lack of the same, observed while the overall care of the patient is underway.

CHAPTER II

METHODOLOGY

Design

The researcher expected to see a relationship between the quality of leadership of head nurses and the quality of care on their respective units. A Leadership Effectiveness Adaptability Description was given to a group of head nurses and, following that, the quality of care was measured on selected units using the Quality Patient Care Scale.

The design of the present study was correlational. This study is applied research, according to Abdella and Levine's definition. It is being done to evaluate the nursing care given by different styles of nurse leaders and to see if, indeed, different styles of nurse leaders produce different quality of care as an outcome.

Setting

The setting of the study was a 465 bed teaching hospital in metropolitan Portland, Oregon. There were 26 head nurses in the study setting and nursing units ranging from a five-bed pediatric intensive care unit, to a 36-bed surgical unit. The head nurses have 24 hour responsibility for their units and are accountable for staffing, evaluating and counseling of their employees; ordering supplies, recommending policies, and management of the unit. The head nurses supervise and direct registered nurses, licensed practical nurse, aides and one ward secretary.

Data Collecting Instruments

There were two data collecting instruments used in the present study:

the Leader Effectiveness and Adaptability Description (LEAD), (See Appendix A), and the Quality Patient Care Scale (QUALPACS), (See Appendix B).

Leader Effectiveness and Adaptability Description

LEAD consists of twelve situations, each delineating a problem which could be faced by a leader. Out of four possible solutions, the respondend is asked to choose one, taking a minimum amount of time to make the decision. A sample would be:

8. Group performance and interpersonal relations are good. You feel somewhat unsure about your lack of direction of the group.	A. Leave the group alone. B. Discuss the situation with the group and then you initiate necessary changes. C. Take steps to direct subordinates toward working in a well-defined manner. D. Be supportive in discussing the situation with the group but not too directive.

Out of the twelve situations, three involve groups of low maturity, three involve groups of low-to-moderate maturity, three of moderate-to-high maturity and three of high maturity. Each situation offers a choice among four alternative actions---one denoting "telling" behavior (S-1), one "selling" behavior (S-2), one "participating" behavior (S-3), and one "delegating" behavior (S-4).

Reliability and Validity of LEAD

The LEAD was selected primarily because of the effectiveness dimension. A telephone contact with the author (Paul Hersey) revealed that, since LEAD is an instructional and developmental management tool, studies to establish the reliability and validity have not been done. An instrument can be said to have face validity, however, to the degree to which it appears to an observer to be measuring the variable in question

(Lemon, 1973). In the case of the nurse leaders, they were observed by both raters to be the identified leaders on their units. Also, the answers of the LEAD are weighted in such a way that an answer placing the respondent in a predominate leadership style may show a weak score in effectiveness.

Each of the four possible alternatives is weighted, giving the choice with the highest probability a "score" of +2. The next highest probability choice would receive +1, the next -1, and the least -2. Therefore, if the respondent answered each of the twelve questions by selecting the high leader behavior or style, based on Situational Leadership Theory, the score on the effectiveness dimension would be +24 (Hersey & Blanchard, 1977).

The high probability responses include:

1. Three leadership style 1 choices appropriate for the three situations involving groups of low maturity (M-1).

2. Three leadership style 2 choices appropriate for the three situations involving groups of low-to-moderate maturity (M-2).

3. Three leadership style 3 choices appropriate for the three situations involving groups of moderate-to-high maturity (M-3).

4. Three leadership style 4 choices appropriate for the three situations involving groups of high maturity (M-4) (Hersey & Blanchard, 1977, p. 230-231).

The individual who answered in the most appropriate manner would have a score of "3" in each of the four quadrants, S1, S2, S3, and S4.

The scoring pattern would denote a leader with the widest possible range of behavior who could be comfortable in any of the four leadership styles and with the greatest flexibility in diagnosing the environment and responding to it appropriately. A score of "3" in each quadrant and a much lower score than +24 would indicate that the leader had the

flexibility of styles but was not able to perceive the need (maturity level) of the followers and act accordingly.

Subjects (Nurses)

Of the 26 head nurses in the facility, six had Associate Degrees in nursing, eight were Diploma graduates, ten had Baccalaureate Nursing Degrees and two were prepared at the Master's level. Both of the Master's prepared nurses had originally been Diploma graduates. They were the only two who had completed additional degrees. While nine were planning on seeking further degrees, only two were presently taking classes.

The head nurses had a wide range of age, with four being between 20 and 30, five between 30 and 40, ten between 40 and 50 and seven over 50. Time at the facility ranged from a few months to 24 years and all but one subject had held at least one other position at the facility before becoming head nurse.

A LEAD was given to each of the head nurses. The LEAD were scored and the results grouped according to the effectiveness dimension demonstrated (See Table 2).

TABLE 2

Head Nurse Effectiveness Scores

Effectiveness Scores	No. of Head Nurses in each Score
17	1
15	1
14	4
13	2
12	1
10	1
9	6
8	2
7	3
6	2
5	1
2	1
0	1

The nurse leaders all fell within the effectiveness range, with the lowest being 0 and the highest +17. The highest possible score is +24. Since the head nurse scoring +17 was from pediatrics she was rejected, as pediatrics had been pre-determined to be unacceptable for this study. One head nurse had a score of +15 and was chosen to represent one of the "more effective" leaders. Three had a score of +14 and it was determined to "draw from a hat" one to represent the second "more effective" unit. The first one to be drawn was rejected when it was noted that she had been the head nurse for only about a month. The second one drawn was accepted. The "less effective" nurse leaders were the ones with the two lowest scores, 0 and +2. The next lowest score that could be used was +6.

Of the 26 head nurses, seven were eliminated from the final sample because they were in specialty areas, i.e., the emergency room, the transportation service, and pediatrics. One head nurse refused to participate. The final sample was 19.

Quality Patient Care Scale

QUALPACS is designed to evaluate the quality of nursing care received by patients, while the care is in progress. It provides a quantitative measurement of the overall quality of nursing care patients receive on either individual nursing units or an entire nursing service program (Wandelt & Ager, 1974). The scale consists of 68 items arranged in six sub-sections: 1) psychosocial: individual; 2) psychosocial: group; 3) physical; 4) general; 5) communication and 6) professional implications (Lindeman, 1976). Procedures for use of QUALPACS will be discussed along with the discussion of the instrument to avoid possible confusion and duplication.

QUALPACS is designed to evaluate the quality of nursing care given to patients while that care is in progress.

> The Quality Patient Care Scale (QUALPACS) measures the quality of nursing care received by patients in any setting where nurse-patient interactions occur. Measurements are made of all nursing care provided a patient, regardless of the qualifications or job categories of personnel providing care. It provides a quantitative measurement of the overall quality of nursing care that patients receive on the individual nursing units or in an entire nursing service program. It identifies areas of program strengths and weaknesses, which can serve as basis for planning improvement (Wandelt & Ager, 1974, p xii).

Sixty-eight items make up the QUALPACS. These items are identified to be the elements composing nursing care and are divided into six broad areas of care. The rank is assigned to the areas or the items within the area.

The rater is aided by having predesignated symbols by each element, indicating how the data will most commonly be obtained. The symbols used are:

> #D: Observation that permits rating of the items will usually be a direct observation of an interaction.
>
> *I. Observation that permits rating will usually be indirect; e.g., a notation in the record or information from the nurses, patient or family.
>
> #D/*I: Observation may be either direct or indirect (Wandelt & Ager, 1974, p 37).

To enable the rater to more uniformly rate interactions, cue sheets developed to accompany the QUALPACS are used (Appendix C). Following is an example of one:

> Item 4. Patient's Inappropriate Behavior is responded to in a Therapeutic Manner. #D.
>
> a. Withdrawn patient is helped to consider various means for involvement or interactions with others.

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

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

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

e. Staff communicates, in an acceptable manner, dislike of abusive or provoking language or behavior (Wandelt & Ager, 1974, p 11-12).

The quality of care expected to be provided by a first level staff nurse is the standard of measurement for QUALPACS. Each rater completed a separate Individual Frame of Reference (See Appendix D) following directions on the form. For each of the five categories, Best Staff Nurse, Between, Average Staff Nurse, Between, and Poorest Staff Nurse, each rater wrote the name considered to typify the category. Regardless of the personnel delivering the care, the stated frame of reference was used. In other words, whether the care was done by a registered nurse, licensed practical nurse or nurses' aide, that care was judged by the care expected of a first level staff nurse. If it was the care expected of the "Best Staff Nurse" listed on the Individual Frame of Reference, it was judged as "Best". The care expected of the Average Staff Nurse listed was judged as "Average", and so on. The QUALPACS, likewise, has five columns which coincide with the five categories of first level staff nurse. The rating of the Best Staff Nurse coincides with the Best Care Column, and receives a rating of five. Conversely, the score of one coincides with the care given by the Poorest Staff Nurse. The Average Staff Nurse on the Individual Frame of Reference

coincides with the Average Care Column, receiving a score of three.

Subjects (Patients)

Wandelt and Ager (1974) state that a valid and reliable measurement may be secured by deriving a mean score from the scores of as few as five patients or 15% of the census, whichever is greater. Patients on the study units were selected by consultation with the head nurse and randomly selected from those meeting the criteria. Criteria for inclusion followed the criteria set by Preston (1977).

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

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

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

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

5. A reliable score is necessary for final inclusion of observed patients. Ratings of as few as 30 items will yield a reliable measurement of the quality of care received (p. 18-9).

The nurse raters set the criteria and selected the patients for inclusion in the sample using the above criteria. Patient care in units led by two nurse leaders from the "more effective" group and two from the "less effective" group were studied. Both raters observed patient care on a unit led by a "more effective" and a "less effective" nurse leader. Selecting a minimum of five patients from each of those units

necessitated at least 20 observations being done by the raters. Observations were done on the 7-3 shift only. One rater observed four pairs and two individual patients. The other rater observed four individual and three pairs of patients. Up to three patients can be observed during a single observation period, if they meet the criteria, so long as they are within viewing and hearing range (Wandelt & Ager, 1974).

Data Collecting Procedures

Permission was sought for the study through the Staff Development Department of the selected hsopital, utilizing the procedure for use of clinical facilities for research purposes provided by the facility. (See Appendix E, p. 90). Upon being contacted by the Staff Development Coordinator, the researcher submitted an abstract of the study and copies of the two instruments to be used. Arrangements were made to administer the LEAD to the 26 head nurses of the facility. After the LEAD was administered and scored, the results were grouped according to the effectiveness dimension demonstrated.

Pilot Study

Following selection of the head nurses whose units were to be used for QUALPACS observations, preparations were made to do the pilot study. A head nurse with a score of +9 was selected, the process was explained and a fact sheet about QUALPACS (See Appendix F, p. 92) was given to personnel. The fact sheet indicates how the study is conducted, what information is needed from staff members. Dates for the pilot study were set at this time.

At least two raters are required to use QUALPACS. Wandelt & Ager

state that "extensive testings...demonstrate that nurses competent to judge the quality of nursing care displayed in nurse-patient interactions hold common conceptions of care expected of a "first-level staff nurse". Therefore, the researcher felt comfortable in selecting a much younger nurse with different clinical background. To balance the differences, however, there was a shared philosophy in regard to what constitutes "good nursing care".

To determine interrelater reliability, a pilot study was done by the same raters who conducted the actual study. Subjects for the pilot study were selected in the random fashion chosen by the raters for the actual study, meeting the criteria for the study. The total number of patients for the pilot study was five, which was greater than the required 15% of the population being surveyed, which was 22. The pilot study was done on a unit not selected for the actual study. Times selected for the pilot study were when nurse-patient interactions were expected. If patients observed had at least four nurse-patient interactions and had at least 30 items rated on the QUALPACS, they qualified for the study.

The nurse raters spent time prior to observations learning about the patient, assessing nursing care needs and developing a nursing care plan. The raters were introduced to the patient by the nurse responsible for the patient's care and an explanation given to that patient that no interaction could take place between them. After the observation period, there was time allotted for discussion with staff and patient, and time to gather indirect data from the chart.

Both raters observed the same patients during the pilot study. After two observations, time was allotted to discuss how the interactions were

rated. The rest of the observations were jointly observed and QUALPACS completed before discussion took place.

The data generated by the two nurse raters during the pilot study were statistically compared to establish the interrater reliability. The Pearson-Product Moment Correlation was used for the correlation. The Pearson "r" for the final patient observed was .70.

During the study, the same procedure was used, except that each patient was observed by only one of the nurse raters. Separate observations were possible because interrater reliability had been established. Information needed on each subject was developed by utilizing the Rater's Notes for Assessment and Planning Care and the Information Face Sheet (See Appendix G). These tools used together formulated a care plan for each patient whose care was observed.

Items were rated in the "Poorest Care" column when particular nursing care and interventions considered to be part of required care were not done. Such ratings were given when omissions were noted during the observation period, when there was no record of the care having been given or when direct questioning confirmed that care had not been done.

Not all elements of the scale are expected to apply to any one patient. The notation was placed under the "Not Observed" column if the expected activity did not occur in the observation time. "Not Applicable" was checked if the item did not apply to a given patient.

Analysis of Data

A score of five was given for each interaction rating assigned to the "Best Care" column. Interactions appearing in the "Poorest Care" column

received a score of one. The "Between", "Average" and "Between" columns received four, three and two, respectively. The item mean score was determined by dividing the total points for each item by the number of interactions.

The measure of quality of the nursing care received by the patient is indicated by the Grand Mean Score. To determine this, the mean scores of all 68 items was added and this number divided by the number of the items having ratings. The final number was carried to one decimal point. "Not Observed" and "Not Applicable" items do not count when calculating the total mean score. The Area Mean scores, similarly, were determined by dividing the mean scores of all items rated by the number of items rated. Again, "Not Observed" and "Not Applicable" items were not used in the calculations (Wandelt & Ager, 1974).

Item means for each of the 68 observed interactions was computed (See Appendix H, p 98). Also, the overall mean of each item, Area Means and Grand Means were calculated (See Appendix I, p 103; J, p 105). The Area Means and Grand Means were used to calculate any differences between the "more effective" and "less effective" styles of leadership. Two factor Analysis of Variance was the method used to determine if a significant difference existed between the units led by the "more effective" and "Less effective" nurse leaders.

The levels of concern and excellence for QUALPACS were set as suggested by Preston in her 1977 study. The need for remedial action (level of concern) was set at 2.7 on a scale of one to five, where one represents poorest care and five represents best care. It was the decision of Preston that 2.7 was set low enough to allow for possible rater error but high enough to insure basic patient safety. The level of excellence was set at

4.3. Ratings between 2.8 and 4.2 were designated as the level of acceptability.

It must be noted that compiling data into means can sometimes obscure the facts. Examples are items 34 and 38, which will be discussed in detail later. Both shown an overall mean of 2.2, which is in the level of concern. By looking at the item means, however (Appendix H, p. 98), it can be seen that some of the patients received care within the level of acceptability on this item, while others received scores of 1.0, 1.2, 1.3, 1.5 and 2.0 which are clearly at dangerous levels. Item 38, likewise, shows shockingly low levels of 1.0, 1.7, and 2.0 in twelve out of eighteen observations, which are in the level of concern, according to Preston's criteria (1977). As we will see later, these two items deal with the basic skills of handwashing and administration of medications.

Conversely, discussion in terms of means also obscures excellence in care. On the unit led by "more effective" nurse leader B, patient number 5 had consistently good care, with 37 out of 56 observed items receiving higher than 4.3, or in the area of excellence. Because of the lower means scored on the other patients on that unit, however, no composite means were in the area of excellence (See Appendix J, p. 106).

CHAPTER III

RESULTS AND DISCUSSION

Overall Level of Care

The Overall Area Means and Grand Means for all observations fell within the level of acceptability (See Table 3).

Table 3

Overall Area Means and Grand Means

	Area						
	I	II	III	IV	V	VI	Grand
All Observations	3.3	3.2	3.1	3.2	3.1	3.3	3.2

The Area Means and Grand Means on all observations on the units led by the "more effective" and "less effective" nurse leaders also fell within the level of acceptability (See Table 4).

Table 4

Area Means and Grand Means

	Area						
	I	II	III	IV	V	VI	Grand
"More Effective"	3.5	3.3	3.1	3.3	3.2	3.4	3.3
"Less Effective"	3.1	3.0	3.0	3.1	3.0	3.1	3.1

The care on the floor led by the "more effective" leaders received ratings from 3.1 to 3.5 and care on the "less effective" units received ratings from 3.0 to 3.1. At a glance it can be seen that there is little difference between the two areas. It can also be seen that, although the Area Means and Grand Means are all within the level of acceptability, that the care was judged to be average, with no ratings in the level of excellence. Examination of the individual item means (Appendix H, p 98). reveals that on each of the four units studied there were items which fell within the area of excellence as well as some within the area of concern. The means of the individual items of the "more effective" and "less effective" units was also calculated (See Appendix J, p 105). Because of the lack of significant difference and for more clarity, the overall mean of each item, incorporating all 20 observations, will be used in the discussion (Appendix I, p. 103).

All observations had varying numbers of interactions in the Best Care, Between, Average Care, Between and Poorest Care categories. There were some observations, however, which were generally low in all units and may be responsible, in part, for the likeness on all units.

One of the similarities noted was that only two nurses were observed to use proper procedure when administering medication. Generally, the name band on the patient was not checked before medication was given. Thisgave an overall score of 2.2 for item 38, which states: "Established techniques for safe administration of medications and parenteral fluids are carried out".

Another area receiving a score of 2.2 was item 34, which states: "Medical asepsis is carried out in relation to patient's personal hygiene

and immediate environment". In all observations, few personnel were seen to wash their hands, even after emptying bedpans and other personal cares or before touching the patient, food trays, etc.

These two items were seen to be in the area of concern, or below 2.8, according to Preston (1977). It is interesting to note that Preston also found ratings of 2.2 for item 34 and 2.4 for item 38.

As has been said, the items "Not Observed" or "Not Applicable" were left out when the Area Means and Grand Means were figured. Two items which were "Not Observed" in any of the twenty patients were item 4, which states: "Patient's inappropriate behavior is responded to in a therapeutic manner", and item 9, which states: "Patient receives attention for his spiritual needs". These items were not observed in Preston's study (1977).

Two items were observed only twice each. Item 10, which states: "The rejecting or demanding patient continues to receive acceptance", and item 53, stating that "Response to the patient is appropriate in emergency situations". These items are very specific and would apply only to those patients who were demanding or in need of emergency help. They were appropriate for only 2% of the sample group.

Although QUALPACS is a tool which measures all cares given the patient and does not single out one nurse, there was one short interaction which drastically changed the outcome for that observation. The nurse brought in the breakfast tray, "plunked" it on the bedside table and said: "Hey, Jake (not the name), wake up!" "Can't I sleep a little longer?" responded the patient. "Nope", the nurse answered, "sleep time's over!" She abruptly left without arranging the tray, helping the

elderly patient to get comfortable or otherwise observably concerning herself with his welfare. This interaction received a score of one (Poorest Care) under a total of 34 items:

1. Patient receives nurse's full attention.
2. Patient is given an opportunity to explain his feelings.
3. Patient is approached in a kind, gentle and friendly manner.
5. Appropriate action is taken in response to anticipated or manifest patient anxiety or distress.
6. Patient receives explanation and verbal reassurance when needed.
7. Patient receives attention from nurse with neither becoming involved in a nontherapeutic way.
8. Patient is given consideration as a member of a family and society.
11. Patient receives care that communicates worth and dignity of man.
12. The healthy aspects of the patient's personality are utilized.
13. An atmosphere of trust, acceptance and respect is created rather than one of power, prestige and authority.
16. Patient as a member of a group receives warmth, interest and attention from the staff.
18. Patient receives encouragement to participate in or to plan for the group's daily activities.
19. The member of the group is provided with the opportunity to assume responsibility according to his capability.
20. Staff proposals for patient activities appropriately reflects interests and needs of the group members.
23. The rights and integrity of the group member are protected within the group structure.
24. Nursing procedures are adapted to meet needs of individual patient for treatment.
26. Nursing procedures are utilized as media for communication and interaction with patient.
29. Patient is encouraged to observe appropriate rest and exercise.
30. Patient is encouraged to take adequate diet.
41. Patient's sensitivities and right to privacy are protected.

42. Patient is helped to accept dependence/independence as appropriate to his condition.
43. Resources within the milieu are utilized to provide the patient with opportunities for problem solving.
44. Patient is given freedom of choice in activities of daily living whenever possible and within patient's ability to make the choice.
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.
46. Activities are adapted to physical and mental capabilities of patient.
47. Nursing care is adapted to patient's level and pace of development.
49. Patient with slow or unskilled performance is accepted and encouraged.
50. Nursing care goals are established and activities performed which recognize and support the therapist's plan of care.
51. Interaction with the patient is within framework of the therapeutic plan.
62. Decisions that are made by staff reflect knowledge of facts and good judgment.
62. Evidence (spoken, behavioral, recorded) is given by staff of insight into deeper problems and needs of the patient.
65. Staff are reliable: follow through with responsibilities for the patient's care.
67. Care given the patient reflects flexibility in rules and regulations as indicated by individual patient needs.
68. Organization and management of nursing activities reflect due consideration for patient needs.

Wandelt and Ager state that an interaction can be scored in as many items as is applicable (1974). Most interactions do not fit so many items. This one, an interaction of abrupt and negative nature, was scored in all areas because of both its commissions and omissions.

The Area and Grand Means for this patient were calculated with and without this interaction (Table 5).

Table 5

Means With and Without Interaction

	Area						
	I	II	III	IV	V	VI	Grand
With	2.7	2	2.5	2.1	2.8	2.5	2.4
Without	2.0	3	2.7	2.8	2.8	2.7	2.9

This illustrates the potential influence one strongly negative or strongly positive interaction can have, particularly if a patient has a limited number of interactions. This patient had nine interactions, however, which was only one less than the average number of interactions for the study. The difference in the Grand Mean with (2.4) and without (2.9) this interaction was 0.5 which is not overly large. The difference would, however, move the patient's score from the level of concern into the level of acceptability (2.8 to 4.2) if this interaction had not been observed.

Area Means--Area I

Area I covers actions directed toward meeting the psychosocial needs of the individual patient.

Item 1, which states: "Patient receives nurse's full attention", received slightly higher than average overall score of 3.4. Item 3, stating that the "patient is approached in a kind, gentle and friendly manner" also received an overall score of 3.4. These two items were observed on all 20 patients and substantiated the feelings of both raters that, in general, the personnel on all four units were concerned and attentive care givers.

Item 15, stating that "the unconscious or nonoriented patient is cared for with the same respectful manner as the conscious patient" received an overall score of 2.3, which is in the level of concern. This was principally because care givers tended to approach and care for the patients and even give injectable medications without speaking to the patients. There was a difference between the units of the nurse leaders in this item. The two patients observed on the unit led by one of the "more effective" leaders received a score of 2.8, which is acceptable care, and the two on the unit of one of the "less effective" leaders a score of 1.9, well below the level of concern.

Area II

Area II covers actions which are directed toward meeting the psycosocial needs of patients as members of a group. This area, as in Preston's study (1977), had the largest number of "Not Observed" and "Not Applicable" items; 62 out of a possible 160.

Only two items were observed on the majority of patients in Area II, item 16 on all 20 and item 23 on 19 observations. Item 16 states that the "patient as a member of a group receives warmth, interest and attention from the staff". That item received an overall score of 3.1. Preston found an overall mean of 3.5 for this item, but had a wide divergence in that the one unit studied scored 5.0 and the other 1.5. The divergence in the present study was not seen (See Appendix H, p 98).

An overall score of 3 on item 23 indicated that, in general, the care givers protected the rights and integrity of the group member within the group structure. Illustrating these two items is that care givers

tended to speak or smile upon coming into a room, regardless of with which patient they were directly interacting. Also, there were few instances when care was not taken to "pull curtains" and otherwise protect the privacy of the patient, except in the case of the unconscious patient.

Area III

Area III covers actions directed toward meeting physical needs of patients. Items 24, 25 and 26 were observed in the majority of patients (18, 15 and 20, respectively and received overall mean scores of 3.3, 3 and 3, respectively. These items look at whether "nursing procedures are adapted to meet the needs of individual patients for treatment", "patients daily hygiene needs for cleanliness and acceptable appearance are met", and whether "nursing procedures are utilized as media for communication and interaction with the patient".

As was mentioned earlier, few nurses used safe procedure when administering medications. Overall mean scores of 3.8 on items 32 and 33, however, indicate that the nurses did slightly above average on observing behaviors and physiological changes due to medications and taking appropriate action. It also indicates that "expectations of patient's behavior are adjusted and acted upon according to the effect the medication has on the patient". This result would indicate that, although nurses do not always follow procedures when administering medications, they are aware of what medications the patients are getting, what the side effects are and what actions are necessary should side effects occur.

Area IV

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

Items 39 and 50 were the only two items out of this group which were observed on all 20 patients and each received an overall Mean score of 3. This indicates that an average amount of care was taken in giving patients adequate instruction and that nursing care goals were established and activities performed recognizing and supporting the plan of care. An overall score of 3.9 for item 43 would indicate that resources within the milieu were utilized to provide the patients opportunities for problem solving. An example of this was a patient with two Jackson-Pratt suction bulbs dangling from an incision site. The nurse gave the patient every opportunity to problem solve a way to support those bulbs in such a way that she could ambulate with comfort. This item received the highest rating of any of the 68 items, but was still short of the 4.2 set for the level of excellence.

Item 53 also received an overall mean of 3. It refers to appropriate response to patient in emergency situations and the only two emergencies observed in the study where patients who needed suctioning. In each case, the nurse responded in what the rater considered to be an average fashion.

Area V

Area V covers communication on behalf of the patient. This includes charting, nursing care plans and staff conferences as well as communication to doctors, other disciplines and the community.

The item in this section receiving the lowest overall mean (2.8) was 57, which states that "well developed nursing care plans are established

and incorporated into nursing assignments". In general, nursing care plans were not found and, in one case, although a patient was a known diabetic and had insulin and fractional urines ordered and noted on the Kardex, there was no mention of the diabetes, precautions, health teaching or discharge planning. No mention of discharge planning was noted on any of the 20 observations. The mean of 2.8 places this item within the level of acceptability, based on the criteria.

The other items all received overall Means of 3 to 3.4, which indicates that communication on behalf of the patient was seen by the raters to be average.

Area VI

Area VI covers the care given to a patient which reflects initiative and responsibility indicative of professional expectations.

Such areas as decisions made with good judgment, evidence of staff awareness of patients' deeper problems and needs, changes in care and care plans, reliability of staff for follow through and flexibility, organization and management of nursing activities as they reflect patient needs are covered in this area. Some examples are a care giver who responded to a patient's request to wait an hour for a hair wash to give medicine given for pain a chance to take effect. The care giver returned to do the shampoo in exactly one hour. A nurse observed that an elderly patient was disturbed about the possibility of having to go to a nursing home. She stopped what she was doing, stood at the bedside and listened, offered to place a phone call for the patient and came back later with more information. A nurse caring for an elderly patient crippled with severe arthritis kept him informed of her whereabouts and timetable; he knew when he

could expect to get up and have a bath and when she would be back from lunch.

All seven items in this category received overall item means between 3.2 and 3.4, indicating that care within the level of acceptability was given in this area.

Analysis of Statistical Differences

It was hypothesized that a significant difference would be seen between the quality of care given on the units led by the "more effective" and "less effective" nurse leaders. Results of the Analysis of Variance (ANOVA) test for differences are presented in Table 6. (A summary of ANOVA Tables for Grand Means and Area Means can be seen in Appendix L, p 111).

Table 6

Analysis of Variance (ANOVA) Test for Differences

	Area						
	I	II	III	IV	V	VI	Grand
"F"	0.803	1.214	0.068	0.523	0.390	1.246	1.175
	An "F" of 4.49 is necessary for significance						

Because the "F" of 1.175 is so far from the 4.49 necessary for significance, the first hypothesis stating that: There will be a significant difference in the Grand Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders was rejected.

Although Area II and Area VI had slightly higher "F" ratings than the other Areas, 1.214 and 1.246 respectively, they still are far too low for

significance. The second hypothesis, therefore, stating that: There will be a significant difference in the Area Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders, was also rejected.

Discussion

The quality of care given on the sample units was established. By compiling the data, the quality of care given on the units led by "more effective" and "less effective" nurse leaders was also established. Cursory examination of the Area Means and Grand Means as well as statistical analysis reveals no significant difference in the quality of care in those two areas.

When the overall item Means were examined, it was found that none received a rating of excellence (See Appendix J, p105). Only one item, number 43, received a rating of 3.9. This item would indicate that resources within the milieu were utilized to provide the patients opportunities for problem solving. Results of Preston's study reveals that all observed interactions for this item rated within the level of excellence (1977).

In the present study, three items received overall ratings within the level of concern. They are: items 15, 34 and 38 which indicate care given to the unconscious or nonoriented patient is not as respectful as if the patient were conscious (2.3); asepsis is not carried out in relation to patient's personal hygiene (2.2); and safe techniques for administration of medication and parenteral fluids are not being carried out (2.2). These three items were also found to be in the level of concern in Preston's study. She also made similar observations in her discussion, i.e., that

nurses worked around the unconscious patients and performed procedures on them without speaking to them; that proper techniques for dispensing medications were not being observed; and that the staff didn't routinely wash their hands (1977).

Two of the items were not observed on any of the units. The remaining 62 items all fell within the level of acceptability according to the criteria that 2.8 to 4.2 are considered acceptable.

To summarize, it would seem that the quality of nursing leadership does not have a relationship to the quality of care. It would also seem that although most of the overall item ratings fell within the level considered acceptable, and the overall means ranged from 2.8 to 3.9, the patients received "poorest care" in some areas considered by the researcher to be unsafe care. Three outstanding areas are treatment of the uncounscious patient, delivery of medications and preventative asepses.

Let us turn, now, to the subject of leadership to see if a common ground for the "more effective" and "less effective" nurse leaders can be found.

In their book, Management of Organizational Behavior (1977), Hersey and Blanchard state that in a sample of over 20,000 middle managers in 14 cultures, the effectiveness scores of 83% of those taking the LEAD was between +6 and -6. The 26 nurse leaders in the present study scores between 0 and +17, with 21, or 81%, falling between +6 and +14 (see Table 7).

Eighty-one percent also scored higher than the +6 at the top of Hersey and Blanchard's sample, which would indicate that they are more effective leaders than most. It is reasonable, therefore, to expect all of the nurse leaders to produce at least adequate care and those with higher scores to produce excellent care. As we have seen, this did not happen.

Table 7

Head Nurse Effectiveness Scores

Effectiveness Scores	No. of Head Nurses in Each Score	
17	1	
15	1	
14	4	
13	2	81%
12	1	
10	1	
9	6	
8	2	
7	3	
6	2	
5	1	
2	1	
0	1	

81%

Turning again to Situational Leadership Theory, it is noted that the least significant data on the LEAD is the total effectiveness score, as that score has little or nothing to do with the individual's effectiveness in a present position. The reason for this is that actual job assignments have individuals dealing with one or two levels of maturity, and the instrument is designed to give opportunities to make decisions dealing with all four levels (Hersey & Blanchard, 1977). Looking at the staffs of the nurse leaders studied it was noted that there are considerably more registered nurses on each of the units than either licensed practical nurses or aides (see Table 8).

Table 8

Levels of Staffing

		RN	LPN	Aide
"More	A	12	6	6
Effective"	B	23	11	4
"Less	C	11	3	0
Effective	D	21	0	0

From that perspective, the conclusion could be made that the scores of the "least effective" reflect the fact that in their present position they have little opportunity to make decisions dealing with all levels of maturity. Looking at a table of all 26 nurse leaders, however, it can be seen that some with both high and low scores have low percentages of other than registered nurse personnel on their staff (See Table 9).

Table 9

Staffing With Percentages on All Units

Head Nurse	Effectiveness Score	RN	%	LPN	%	Aide	%	Total Staff	% of Mixed Maturity
1	17	60	94	2	3	2	3	64	6
2	15	12	50	6	25	6	25	24	50
3	14	12	63	4	21	3	16	19	37
4	14	9	64	4	21	1	5	14	26
5	14	23	60	11	29	4	11	38	22
6	14	8	38	4	19	9	43	21	62
7	13	8	62	2	15	3	23	13	48
8	13	14	78	2	11	2	11	18	22
9	12	15	94	0		1	6	16	6
10	10	12	55	4	18	6	27	22	45
11	9	8	47	0		9	53	17	53
12	9	14	67	3	14	4	19	21	33
13	9	10	67	4	27	1	6	15	33
14	9	16	67	3	13	5	20	24	33
15	9	16	67	3	13	4	20	23	33
16	9	22	100	0		0		22	0
17	8	15	94	0		1	6	16	6
18	8	22	85	0		4	15	26	15
19	7	21	75	0		7	25	28	25
20	7	0		0		25	100	25	0
21	7	11	76	1	9	2	15	14	24
22	6	13	72	2	11	3	17	18	28
23	6	9	90	0	0	1	10	10	10
24	5	24	75	7	22	1	3	32	25
25	2	11	78	3	22	0		14	22
26	0	21	100	0		0		21	0

Three trends appear when examining the information in this matter:

1. Of the top nine scores, 12, 13, 14, 15 and 17, five had 26% or more of staff with a mixed maturity level. In other words most of these nurse leaders had a staff composed of fairly balanced maturity levels to direct;
2. In contrast, seven of the nurse leaders with the bottom ten scores of 8, 7, 6, 5, 2 and 0 had a poor balance of different maturity levels to direct, less than 25% of their staffs being of mixed maturity levels; and
3. Finally, the middle seven scores of 9 and 10, only had one less than 33% of staff with mixed maturity levels.

Most of these nurse leaders in the middle range (the mean being 9.5) had a mixed maturity level of at least 1/3 and, therefore, a greater chance to direct different maturity levels.

Hersey and Blanchard point out that the effectiveness score is the least important in assessing overall effectiveness. They state that the way in which the questions on the LEAD were answered reflects areas in which the individual tends to be naturally effective or areas in which individuals should exercise more care in being able to effectively diagnose the environment and is therefore more important (1977).

Let us now look at the styles of leadership of the nurse leaders. To review, there are four basic styles of leadership, according to Situational Leadership Theory: "Telling" (S-1), "Selling" (S-2), "Participating" (S-3) and "Delegating" (S-4). Table 10 illustrates the distribution of the nurse leader's scores in the four basic areas.

Table 10

Predominating Styles of Leadership

S-3 Participating		S-2 Selling	
Score	# Answers	Score	# Answers
1	1		
2	2		
3	2	3	1
4	6	4	6
5	6	5	3
6	3	6	7
7	5	7	6
8	1	8	3
77%			**85%**
S-4 Delegating		**S-1 Telling**	
Score	# Answers	Score	# Answers
0	13	0	15
1	10	1	7
2	1	2	2
3	2	3	1
		4	1
88%			**85%**

It can be seen that the majority of answers in the sample are in the "selling" and "participating" areas with 85% scoring between +4 and +7 in "selling" and 77% scoring between +4 and +7 in "participating". The other two areas show 85% scoring 0 or +1 in "telling" and 88% scoring 0 or +1 in "delegating". The results indicate that all of the 26 nurse leaders are stronger in the two areas which demonstrate a high degree of relationship behavior. The two areas which demonstrate low relationship behavior show very low scores, indicating that the nurse leaders do not feel comfortable in either of the roles of "telling" or "delegating".

The four nurse leaders in the sample group were typical of the larger group in that they all had scores of from +4 to +7 in S-2 and S-3 and one only

had a score higher than +1 in either S-1 or S-1 (see Table 11).

Table 11

Effectiveness/Styles of Sample Group

Effectiveness Score		S-1 Telling	S-2 Selling	S-3 Participating	S-4 Delegating
A	15	0	6	5	1
B	14	2	6	4	0
C	2	0	7	4	1
D	0	0	5	7	0

Although the styles of the four nurse leaders are basically the same, with an emphasis on high relationship behavior, there is a significant difference in the effectiveness scores of nurse leaders A & B versus nurse leaders C & D. As has been shown, one reason for this could be that the "more effective" nurse leaders have a greater opportunity to make decisions concerning followers of a wider range of maturity. Conversely, the "less effective" nurse leaders, having a large majority of RN's on their staffs, (78% for nurse leader C and 100% for nurse leader D) have less opportunity.

Another reason for the difference in effectiveness scores could be that nurses A & B are more skilled in employing their basic leadership styles than are nurse leaders C & D. They also could, according to Situational Leadership Theory, be more aware of their weaker areas and more successfully apply techniques of "telling" and "delegating" when the situation demands (Hersey & Blanchard, 1977).

Whatever the reasons, however, it made little difference in the outcome. As has been shown, any differences in the cares given by the

followers of the "more effective" nurse leaders and the "less effective" nurse leaders were not significant.

One could be led to speculate what would happen if these nurse leaders were encouraged to develop a higher degree of S-1, or high task/ low relationship behavior. Could it be possible that the basic skills of attention paid to the unconscious patient, safe techniques in administering medications and adequate hand washing be done at a more acceptable level?

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

> Assess the relationship between the quality of nursing leadership and the quality of nursing practice in institutions (Lindeman, 1975, p 697).

This was one of fifteen items selected from 2000 "burning questions" (p 693) originally identified by a panel of 433 nursing leaders. Since the quality of care can be considered an outcome of nursing practice, it seemed appropriate to study the question: Does the professional nurse in a leadership role make a difference in the quality of care?

Situational Leadership Theory forms the conceptual framework for this study. This theory states that leaders are characterized in one of four basic styles. The four styles, while clearly defined, are not fixed, so that an individual identified as one style of leader can operate in another style as the situation demands. A leader who is in tune with the environment and is able to identify the qualities and needs of followers is the more effective leader (Hersey & Blanchard, 1977).

Nurse leaders were identified as head nurses of a 465 bed teaching hospital, who had 24 hour responsibility for their units, including staffing, evaluating and counseling their employees as well as for ordering supplies, making policies and overall supervision.

The basic leadership styles of those nurse leaders, as well as the effectiveness of those styles, were established by administering to them a Leadership Effectiveness and Adaptability Description (LEAD). This

placed them in the four basic styles of "telling", "selling", "participating" and "delegating" (Hersey & Blanchard, 1977). It also gave each an effectiveness rating from 0 to +17 out of a possible -24 to +24. Four of these nurse leaders were chosen as the sample group. The "more effective" leaders were those with scores of +15 and +14, the "less effective"; those with scores of +2 and 0.

The quality of care was measured by the use of the Quality Patient Care Scale (QUALPACS). QUALPACS is a complex instrument designed to evaluate the quality of nursing care received by patients, while care is in progress. It provides a quantitative measurement of the overall quality of nursing care that patients receive on individual nursing units or an entire nursing service program (Wandelt & Ager).

A pilot study was done to familiarize the raters with the instrument and to establish interrater reliability. The study consisted of 20, two hour observations over a three day period. Following each observation period, the interactions were rated for quality using the QUALPACS as an instrument. Five subjects were randomly selected on each of the four units.

Prior to the survey, two hypotheses were made. The first hypothesis: There will be a significant difference in the Grand Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders, was rejected. The second hypothesis: There will be a significant difference in the Area Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders, was also rejected.

Conclusions

The conclusions to be drawn from this research are that, at least from this study, no significant differences can be seen in the care given by followers of the nurse leaders identified as "more effective" and "less effective". It is evident, however, that the nurse leaders tested all fell into the two categories identified by Situational Leadership Theory as High Relationship/High Task (Selling) and High Relationship/Low Task (Participating). Both of those styles, by their names, display a large measure of relationship, or helping, or supporting behavior. Conversely, the nurse leaders displayed an extremely low propensity to the two remaining categories, which are High Task/Low Relationship (Telling) and Low Task/Low Relationship (Delegating). This indicates that these nurse leaders feel uncomfortable in the roles required to be both a directive leader who can "lay it on the line" and one who can step back and let the followers "go it alone".

Recommendations

The following recommendations for further study are suggested.

1. Using another, but similar facility, such as a private hospital which is not associated with a medical school.

2. A study designed to look at whether individuals of certain styles go into nursing or whether nursing promotes those styles.

3. A study designed to assess the relationship of leadership styles of nurses and other management groups who are also principally women.

4. A study designed to compare educational preparation to leadership effectiveness.

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APPENDICES

APPENDIX A

Leader Effectiveness and Adaptability Description

LEADER EFFECTIVENESS AND ADAPTABILITY DESCRIPTION

SITUATION	ALTERNATIVE ACTIONS
1. Your subordinates are not responding lately to your friendly conversation and obvious concern for their welfare. Their performance is declining rapidly.	A. Emphasize the use of uniform procedures and the necessity for task accomplishment. B. Make yourself available for discussion but don't push your involvement. C. Talk with subordinates and then set goals D. Intentionally do not intervene.
2. The observable performance of your group is increasing. You have been making sure that all members were aware of their responsibilities and expected standards of performance.	A. Engage in friendly interaction, but continue to make sure that all members are aware of their responsibilities and expected standards of performance. B. Take no definite action. C. Do what you can to make the group feel important and involved. D. Emphasize the importance of deadlines and tasks.
3. Members of your group are unable to solve a problem themselves. You have normally left them alone. Group performance and interpersonal relations have been good.	A. Work with the group and together engage in problem-solving. B. Let the group work it out. C. Act quickly and firmly to correct and redirect. D. Encourage group to work on problem and be supportive of their efforts.
4. You are considering a change. Your subordinates have a fine record of accomplishment. They respect the need for change.	A. Allow group involvement in developing the change, but don't be too directive. B. Announce changes and then implement with close supervision. C. Allow group to formulate its own direction. D. Incorporate group recommendations, but you direct the change.

SITUATION	ALTERNATIVE ACTIONS
5. The performance of your group has been dropping during the last few months. Members have been unconcerned with meeting objectives. Redefining roles and responsibilities has helped in the past. They have continually needed reminding to have their tasks done on time.	A. Allow group to formulate its own direction. B. Incorporate group recommendations, but see that objectives are met. C. Redefine roles and responsibilities and supervise carefully. D. Allow group involvement in determining roles and responsibilities but don't be too directive.
6. You stepped into an efficiently run organization. The previous administrator tightly controlled the situation. You want to maintain a productive situation, but would like to begin humanizing the environment.	A. Do what you can to make group feel important and involved. B. Emphasize the importance of deadlines and tasks. C. Intentionally do not intervene. D. Get group involved in decision-making, but see that objectives are met.
7. You are considering changing to a structure that will be new to your group. Members of the group have made suggestions about needed change. The group has been productive and demonstrated flexibility in its operation.	A. Define the change and supervise carefully. B. Participate with the group in developing the change but allow members to organize the implementation. C. Be willing to make changes as recommended, but maintain control of implementation. D. Avoid confrontation; leave things alone.
8. Group performance and interpersonal relations are good. You feel somewhat unsure about your lack of direction of the group.	A. Leave the group alone. B. Discuss the situation with the group and then you initiate necessary changes. C. Take steps to direct subordinates toward working in a well-defined manner. D. Be supportive in discussing the situation with the group but not too directive.

SITUATION	ALTERNATIVE ACTIONS
9. Your superior has appointed you to head a task force that is far overdue in making requested recommendations for change. The group is not clear on its goals. Attendance at sessions has been poor. Their meetings have turned into social gatherings. Potentially they have the talent necessary to help.	A. Let the group work out its problems. B. Incorporate group recommendations, but see that objectives are met. C. Redefine goals and supervise carefully. D. Allow group involvement in setting goals, but don't push.
10. Your subordinates, usually able to take responsibility, are not responding to your recent redefining of standards.	A. Allow group involvement in redefining standards, but don't take control. B. Redefine standards and supervise carefully. C. Avoid confrontation by not applying pressure; leave situation alone. D. Incorporate group recommendations, but see that new standards are met.
11. You have been promoted to a new position. The previous supervisor was uninvolved in the affairs of the group. The group has adequately handled its tasks and direction. Group interrelations are good.	A. Take steps to direct subordinates toward working in a well-defined manner. B. Involve subordinates in decision-making and reinforce good contributions. C. Discuss past performance with group and then you examine the need for new practices. D. Continue to leave group alone.
12. Recent information indicates some internal difficulties among subordinates. The group has a remarkable record of accomplishment. Members have effectively maintained long-range goals. They have worked in harmony for the past year. All are well qualified for the task.	A. Try out your solution with subordinates and examine the need for new practices. B. Allow group members to work it out themselves. C. Act quickly and firmly to correct and redirect. D. Participate in problem discussion while providing support for subordinates.

APPENDIX B

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	1							11–12
2. Patient is given an opportunity to explain his feelings. # D	2							13–14
3. Patient is approached in a kind, gentle, and friendly manner. # D	3							15–16
4. Patient's inappropriate behavior is responded to in a therapeutic manner. #D	4							17–18
5. Appropriate action is taken in response to anticipated or manifest patient anxiety or distress. # D/*I	5							19–20
6. Patient receives explanation and verbal reassurance when needed. # D	6							21–22
7. Patient receives attention from nurse with neither becoming involved in a nontherapeutic way. # D	7							23–24
8. Patient is given consideration as a member of a family and society. # D/*I	8							25–26
9. Patient receives attention for his spiritual needs. # D/*I	9							27–28

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

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

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

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

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

14. Appropriate topics for conversation are chosen. # D

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

PSYCHOSOCIAL: GROUP

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

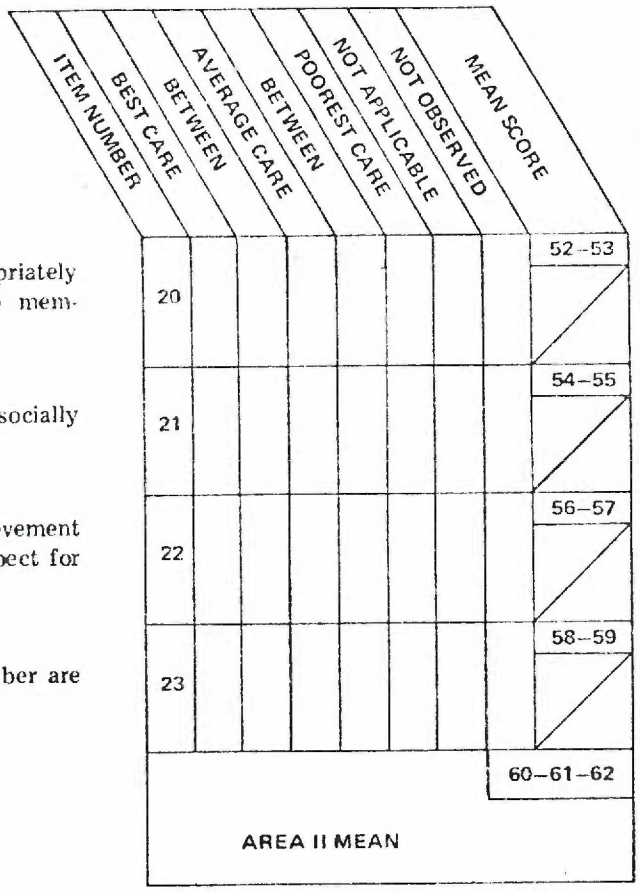
16								44–45
17								46–47
18								48–49
19								50–51

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

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

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

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



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

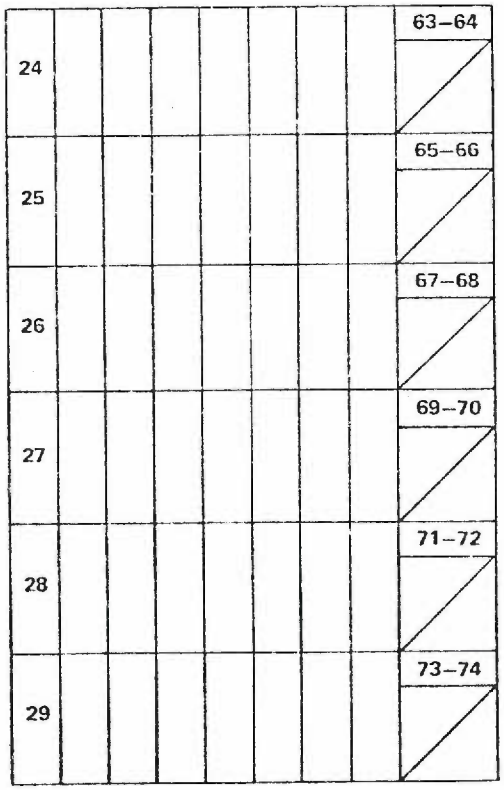
21. Patient is helped to vent his emotions in a socially acceptable way within the group. # D

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

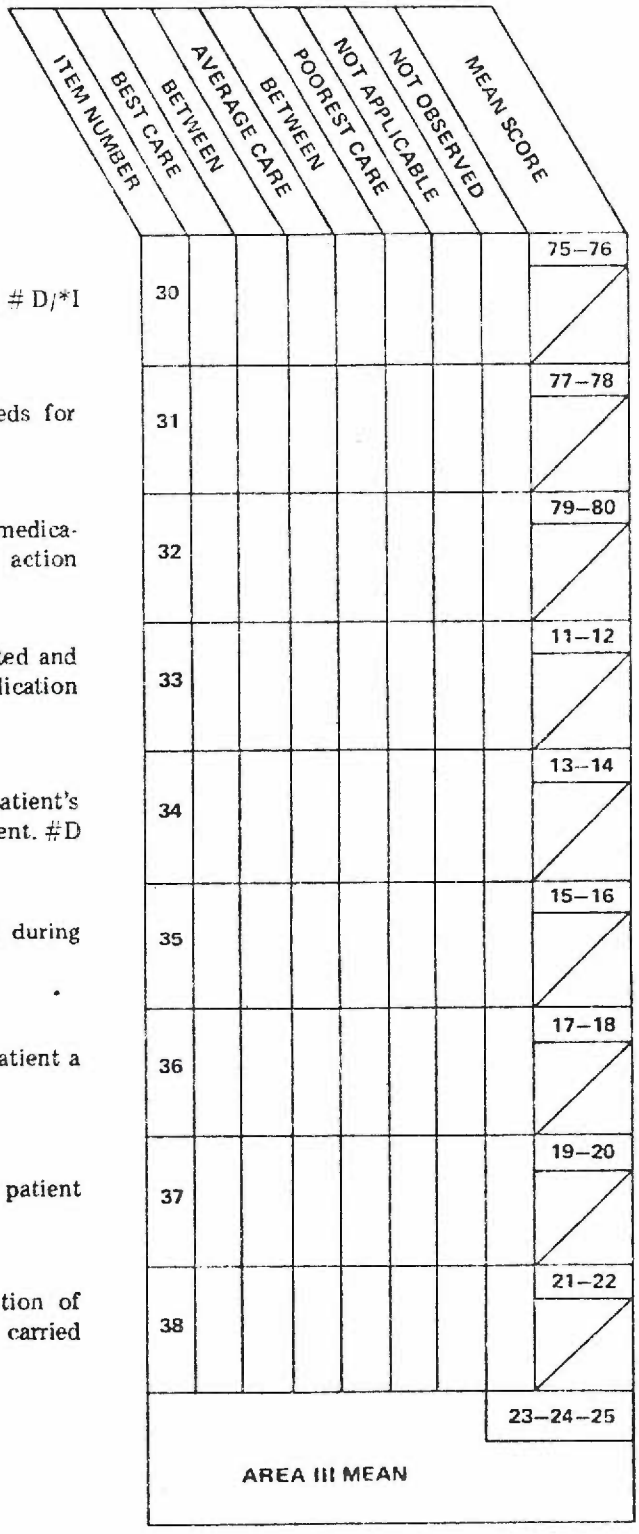
25. Patient's daily hygiene needs for cleanliness and acceptable appearance are met. # D

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

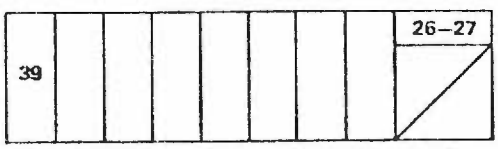
37. Safety measures are carried out to prevent patient from harming himself or others. # D

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

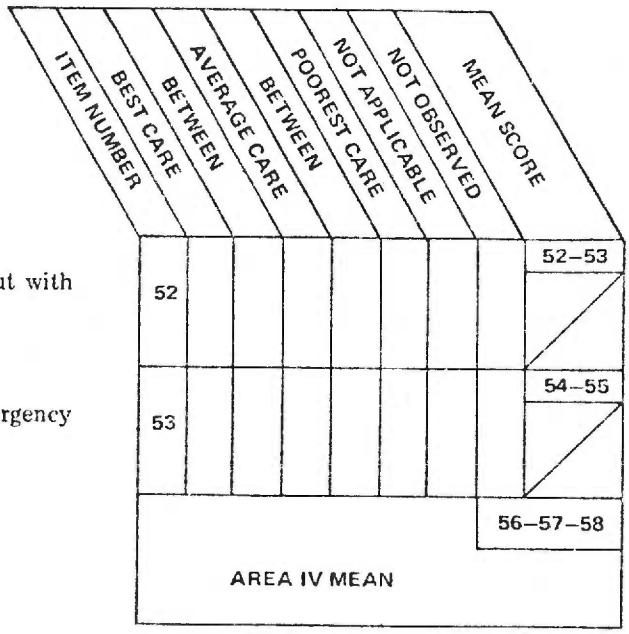
GENERAL

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

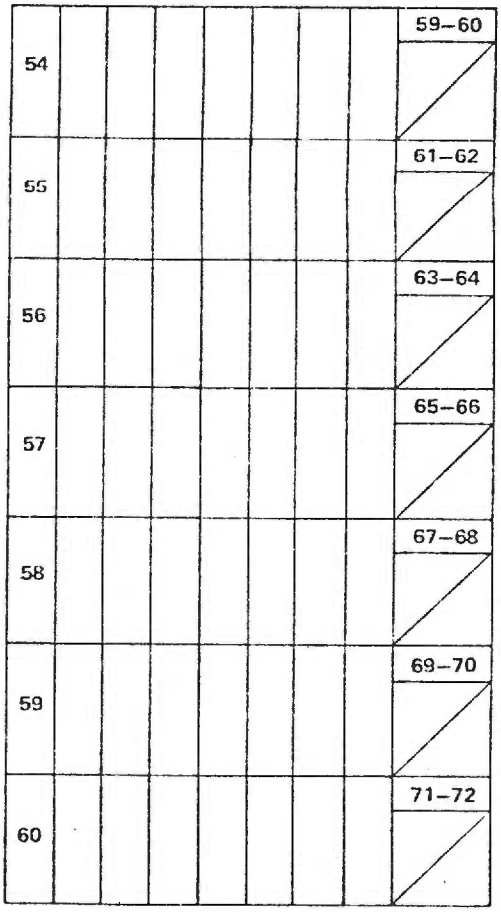


52. Close observation of the patient is carried out with minimal disturbance. # D

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

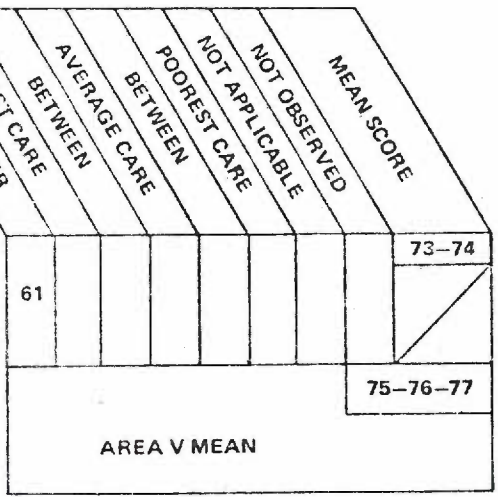
57. Well-developed nursing care plans are established and incorporated into nursing assignments. *I

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

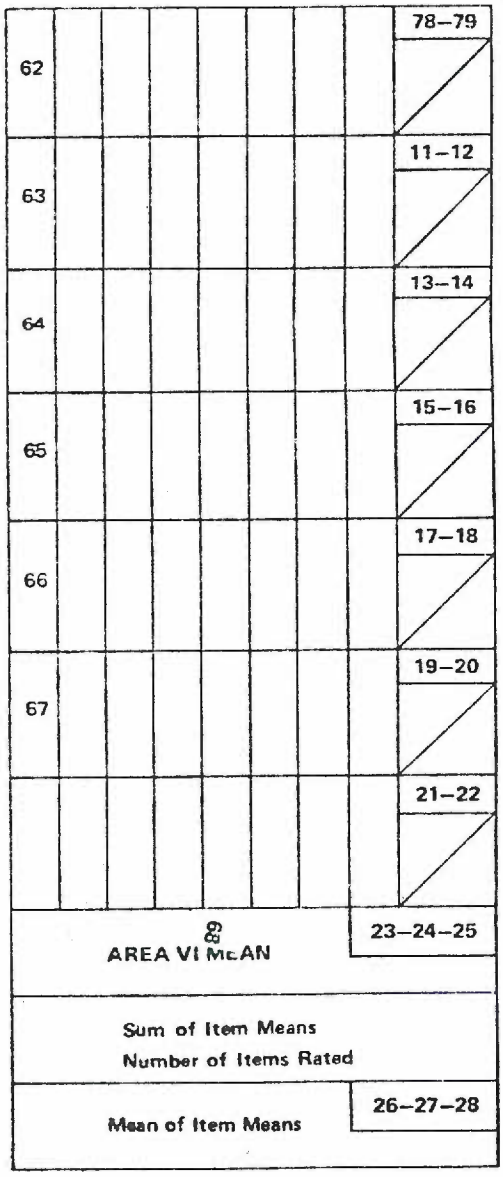
64. Changes in care and care plans reflect continuous evaluation of results of nursing care. # D/*I

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 C

Cues for QUALPACS

PSYCHOSOCIAL: INDIVIDUAL

Actions directed toward meeting psychosocial needs of individual patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PSYCHOSOCIAL: GROUP

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

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

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

18. Patient Receives Encouragement to Participate in or to Plan for the Group's Daily Activities. # D
    a. Patient is helped to plan activities and time schedules, such as bathroom privileges.
    b. Patient is encouraged to make plans helping others in the group; e. g., when to take the paralyzed patient to the sunporch in a wheelchair.
    c. Patient's suggestions and assistance are sought in making changes in physical setting—furniture arrangement, room assignments, etc.
    d. Patient is helped to make arrangements for some social activities; e. g., sharing 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 Interests and Needs of the Group Members. # D
    a. Involvement of each patient in group activities is noted and subtle modifications suggested to insure the appropriate involvement of all; e.g., proposing that the child with the injured knee keep score for the volleyball games.
    b. Ways of dividing group into small common-interest groups are suggested: checkers, pinochle, jig-saw puzzles, playing with dolls, building with blocks, etc.
    c. New diabetic is guided in discussing with others the disease and its meaning to them.
    d. New mother is encouraged to attend infant bath demonstrations.

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

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

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

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

PHYSICAL

Actions directed toward meeting physical needs of patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Site for injection of medication is cleansed properly prior to administration of drug.
c. Irrigations are 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 is noted; patient is 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. Patient's 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 Patient 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 indicates impulsiveness and confusion is protected by the continuous presence of staff or the appropriate use of equipment; e.g., 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.—so that he knows safe handling, capabilities, and dangers.

38. 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 psychosocial or physical needs of the patient, or both at the same time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMUNICATION

Communication on behalf of the patient.

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

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

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

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

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

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

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

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

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

PROFESSIONAL IMPLICATIONS

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

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

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

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

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

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

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

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

68. Organization and Management of Nursing Activities Reflect Due Consideration for Patient Needs. # D/*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 mealtimes.
    e. When patient is acutely ill, he receives care before patients with less acute needs.
    f. Staff assignment plans reflect consideration of patient's needs.

APPENDIX D

Individual Frame of Reference

INDIVIDUAL FRAME OF REFERENCE

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

Slater Nursing Performance Rating Scale Rater _____

INDIVIDUAL FRAME OF REFERENCE CARD

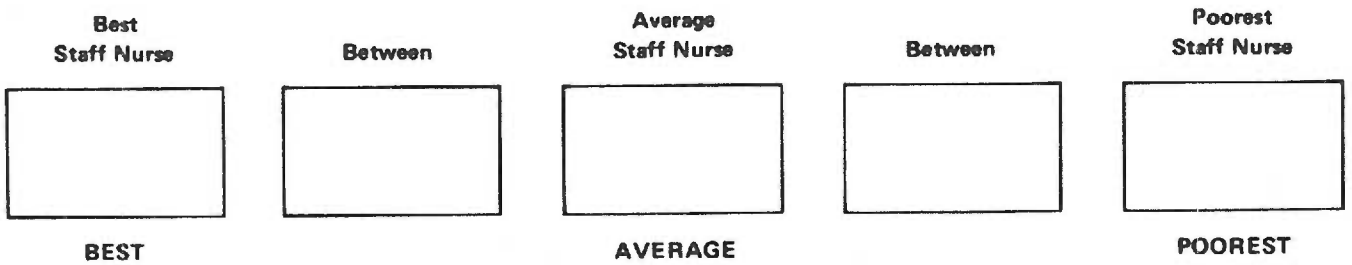
Write the names of staff nurses whom you know or have known in their respective boxes:

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

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

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

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



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

APPENDIX E

Procedure for Use of Clinical Facilities for Research Purposes

PROCEDURE FOR USE OF CLINICAL FACILITIES FOR RESEARCH PURPOSES

RESPONSIBILITY	ACTION
Investigator	Writes letter requesting permission, from Director of Nursing Service, to utilize clinical facilities.
Director of Nursing	Approves or disapproves research endeavor.
	Forwards letter of request to Staff Development Coordinator.
Staff Development Coordinator	Contacts investigator and arranges appointment for facilitating use of clinical facilities.
Investigator	Provides evidence that research proposal has been sanctioned by Human Subjects Committee.
	Submits copy of: Abstract Consent Form Tool
	Indicates methodology to be used, including: Type of subjects Number of subjects Method of administering tool
Staff Development Coordinator	Reviews research endeavor with investigator.
	Facilitates use of clinical facilities by discussing research proposal and obtaining permission (for appropriate individuals to participate in data-collecting process) from Patient Care Coordinator and Head Nurse of identified service.
Subject of Study	Participates in nursing research.
Investigator	Collects and analyzes data.
	Furnishes Staff Development Coordinator with abstract of research findings.
Staff Development Coordinator	Shares research findings with Patient Care Coordinator, Head Nurse and other nursing staff participating in research endeavor.

APPENDIX F

Fact Sheet About QUALPACS

A FACT SHEET ABOUT QUALPACS

WHAT:
A survey to evaluate the quality and conditions of delivery of nursing care to patients at UOHSC Hospital. Conducted by Maureen Whitman, R.N., graduate student, as part of a Thesis study looking at the different styles of nursing leadership and any relationship to quality of care.

WHY:

I. To examine the quality of care provided to patients on selected units at UOHSC Hospital.
II. To identify ward activities and conditions which might influence quality of care.
III. To provide information relevant to the quality of care given on units led by different styles of nurse leaders.

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.

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 give an efficiency rating.

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

WHAT HELP IS NEEDED FROM THE HEAD NURSE?

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

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

C. Introduction to Patients: A nurse who knows the patient should:
   1. Introduce the observer to all patients in the immediate study area.
   2. Explain briefly what the observer will be doing and why she is there.
   3. Explain that the observer will be "observing" and writing and will not be talking or working with patients.
   4. It is not necessary to state which patient is being observed.

SCHEDULE FOR OBSERVATION:

A. Observations for each unit will be scheduled on successive days, for the time needed (usually 2 to 3 days).
B. You will be notified the day before the observer plans to begin observations on your unit.
C. Please do not make any unusual modifications of your unit assignments.

APPENDIX G

Rater's Notes

Information Face Sheet

QUALITY PATIENT CARE SCALE

INFORMATION FACE SHEET

Patient

Name _____

Record # _____

Room # _____ Accommodations _____

Admission Date _____

Diagnosis:

Admission _____

_____

_____

Current _____

_____

_____

Condition of Patient _____

_____

_____

_____

Unit

Name _____ Type _____

Number of Rooms _____

Number of Beds _____

Census _____

LEVELS OF CARE (Number of patients in each)

A _____ C _____ E _____

B _____ D _____

PERSONNEL CODE AND CENSUS

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

OTHER PERTINENT DATA:

Date _____ Rater _____

Time of Day _____ AM/PM INTERACTIONS _____

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

Team _____ Total of Items Used _____

Other _____ Score (Mean of Means) _____

Additional notes or questions:

QUALITY PATIENT CARE SCALE

RATER'S NOTES

FOR

ASSESSMENT AND PLANNING CARE

PATIENT _____

ORDERS, NEEDS, NURSING ACTIONS

Diet (meals, fluids, nourishment)

Medications

Treatments (dressings, irrigations)

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

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

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

Activity (bedrest, ambulation, etc.)

Sensory deficit (blind, aphasic, deaf)

Safety

Teaching patient and family

Socialization and diversion

Multiple services (referrals, consultations)

Reporting and recording

Planning for continuity of care

Other

APPENDIX H

Item Means

ITEM MEANS

"MORE EFFECTIVE" NURSE LEADERS

Patient	A 1	A 2	A 3	A 4	A 5	B 1	B 2	B 3	B 4	B 5
Item										
1	3.6	3.5	2.2	3.4	2.5	3.	3.9	4.4	4.3	4.4
2	3.8	-	-	3.	2.6	2.8	3.8	3.5	5.	4.7
3	3.6	3.3	2.8	3.4	3.	2.5	3.8	4.3	4.4	5.
4	-	-	-	-	-	-	-	-	-	-
5	3.5	-	4.	3.	3.	2.3	2.	4.	4.3	5.
6	3.6	2.5	2.3	3.2	2.	2.3	3.	3.7	4.4	5.
7	3.	-	3.	2.8	3.	2.5	3.6	3.6	4.4	5.
8	3.	2.	2.	3.6	2.	2.8	3.8	4.1	4.6	5.
9	-	-	-	-	-	-	-	-	-	-
10	-	-	-	4.	-	-	-	-	-	-
11	3.4	3.	2.3	3.3	2.3	2.8	3.6	4.2	4.4	4.2
12	4.	-	-	3.	3.	2.8	3.9	3.9	4.4	5.
13	3.3	3.	2.6	3.3	3.	2.8	3.4	4.	4.5	5.
14	3.6	2.3	2.3	3.3	3.	-	3.6	4.	4.2	5.
15	-	3.1	2.4	-	-	-	-	-	-	-
16	3.	3.4	1.8	3.3	2.5	2.8	3.9	4.3	4.4	4.2
17	-	-	-	3.5	3.	-	-	4.	-	-
18	-	-	-	-	4.	1.	2.7	4.	3.6	-
19	3.	-	-	4.	-	1.	3.	3.3	3.9	5.
20	-	-	-	3.5	3.	1.	2.7	4.	3.9	5.
21	3.	-	-	3.5	-	3.	2.	-	3.8	4.
22	-	-	-	3.	-	-	5.	-	-	5.
23	3.	3.6	2.7	3.	3.	2.7	3.8	4.4	3.8	1.
24	3.	3.7	2.8	3.	-	2.5	2.8	4.	4.	3.
25	-	4.	3.	2.	-	2.	4.	3.	3.	4.
26	3.	2.	1.9	3.8	2.	2.5	3.7	3.3	4.4	4.7
27	3.	4.	3.5	-	3.	-	-	-	-	5.
28	2.	-	3.	3.	3.	3.	2.	-	5.	5.
29	-	3.3	3.	3.7	3.	2.	3.	3.8	3.3	4.
30	-	3.	2.5	3.5	3.	3.	3.	3.3	4.	5.
31	4.	4.	3.5	3.7	3.	2.5	3.	3.5	4.	3.
32	-	4.	4.	3.5	3.	-	-	-	-	-
33	-	4.	4.	-	4.	-	-	-	-	-
34	1.5	3.	2.7	2.	1.3	1.	2.	-	3.	4.5
35	1.5	2.	2.5	-	-	-	1.	-	4.	-
36	-	3.	3.1	3.5	3.	3.	3.	4.	3.5	5.
37	-	-	3.6	4.	-	3.	3.	3.	-	4.
38	1.	3.	2.	3.	1.	-	-	1.	2.5	1.
39	3.	3.	2.5	3.5	2.3	2.	3.	3.	4.	5.
40	-	4.	3.	3.5	-	-	1.7	-	-	5.
41	3.	-	2.4	3.	2.	2.6	2.5	4.	3.8	5.
42	-	-	-	3.3	-	2.3	2.8	4.	4.4	5.
43	-	-	-	-	-	1.5	3.5	-	3.7	5.
44	-	-	-	4.	3.	2.5	2.3	4.3	3.9	5.
45	3.	-	-	3.	-	2.6	3.5	4.2	4.	5.

Patient	A 1	A 2	A 3	A 4	A 5	B 1	B 2	B 3	B 4	B 5
Item										
46	2.	3.	3.	4.	-	1.	3.5	3.4	3.9	4.
47	-	3.	3.3	3.	-	1.	2.7	3.2	3.9	4.
48	3.	-	2.3	3.	3.	-	3.5	-	4.3	-
49	-	-	-	-	-	1.	3.	4.	3.3	5.
50	3.	3.	3.	3.	3.	2.8	3.	3.6	3.9	5.
51	3.2	-	2.1	3.2	2.5	2.7	3.4	3.6	4.3	5.
52	3.	3.	2.5	3.5	3.	3.	-	5.	-	-
53	-	-	-	-	-	-	-	-	-	-
54	-	3.7	2.7	3.	3.	-	-	-	-	4.
55	-	3.	3.	3.	-	-	-	-	-	4.
56	3.	3.	3.	4.	4.	2.	1.	-	3.	3.
57	4.	5.	5.	3.	2.	3.	2.	1.	1.	5.
58	3.	4.	4.	3.	3.	3.	1.	3.	2.	3.
59	-	4.	-	-	-	3.	3.	3.	3.	3.
60	3.	4.	-	3.5	3.	-	4.	-	-	4.
61	3.	3.	3.	3.	3.	-	4.	-	-	5.
62	3.3	3.7	2.9	3.	2.5	1.5	2.3	4.2	3.9	5.
63	3.	4.	2.	3.	2.3	2.6	3.5	4.3	4.4	4.2
64	-	4.	3.	3.	3.	3.	2.5	-	4.8	5.
65	3.	4.	3.	3.3	3.	2.3	2.8	3.7	4.	5.
66	-	3.8	3.	3.	-	3.	3.	4.3	4.	5.
67	-	4.	3.	3.5	3.	2.4	3.	4.5	4.	5.
68	3.3	4.	2.2	3.	3.	2.5	3.	4.3	4.	5.

ITEM MEANS

"LESS EFFECTIVE" NURSE LEADERS

Patient	C 1	C 2	C 3	C 4	C 5	D 1	D 2	D 3	D 4	D 5
Item										
1	4.	3.4	3.9	3.	3.5	2.7	3.4	2.4	3.4	2.7
2	3.8	3.3	4.	3.5	3.2	2.7	3.3	1.8	3.5	-
3	4.	3.4	3.3	3.2	3.5	2.9	3.2	2.6	3.4	2.6
4	-	-	-	-	-	-	-	-	-	-
5	3.7	-	4.5	3.2	4.	3.	3.6	1.5	3.5	1.5
6	3.9	4.	3.8	2.	3.5	3	3.6	1.4	3.7	2.
7	3.3	3.7	3.8	2.3	3.5	4.	4.	1.	4.	2.
8	3.8	3.5	4.	2.	3.5	3.	3.5	1.2	3.5	1.5
9	-	-	-	-	-	-	-	-	-	-
10	-	-	-	3.	-	-	-	-	-	-
11	3.5	3.4	3.8	2.8	3.2	2.8	3.4	1.9	3.2	1.8
12	3.5	3.	3.6	3.	-	3.	3.	3.	3.5	1.8
13	3.8	4.	4.	2.5	3.5	2.8	3.2	1.5	3.4	1.5
14	3.6	4.	3.8	2.8	4.	3.	4.	2.8	3.4	1.6
15	-	-	-	-	-	-	-	2.	-	1.7
16	3.4	3.	3.8	2.8	3.4	2.	3.5	2.	3.4	1.2
17	-	-	4.	-	-	-	-	-	3.4	-
18	-	-	4.	-	4.	-	3.	3.	3.	-
19	-	-	4.	-	-	3.	3.	2.	3.	-
20	-	3.	4.	-	-	3.	3.	3.	3.7	3.
21	3.	-	-	2.	-	-	3.	-	3.	-
22	-	-	3.	-	4.	-	-	1.	3.8	1.
23	3.3	3.7	3.3	2.	-	3.	3.3	2.	3.4	1.3
24	3.5	3.8	4.	3.	3.5	-	3.	3.	3.6	3.
25	-	3.	3.	-	-	2.3	2.	3.	3.1	3.
26	3.7	3.7	3.8	2.4	3.	2.	4.	1.8	3.4	1.4
27	3.5	-	4.	2.3	2.	-	3.	2.8	3.5	3.
28	2.	-	3.	2.	2.	-	3.	-	3.3	3.
29	4.	3.5	3.7	3.	3.	3.	3.	-	3.8	2.
30	3.3	4.	3.3	-	3.3	3.	4.	-	3.5	-
31	4.	4.	3.7	3.	3.	3.	3.5	3.	3.	3.
32	4.	-	5.	3.3	-	-	-	-	4.	3.
33	-	-	5.	3.3	-	3.	-	-	4.	3.
34	3.5	3.6	2.5	1.	1.	2.9	4.	1.	2.6	1.2
35	4.	3.	3.	2.	-	3.	3.	2.	3.	1.3
36	5.	3.	-	3.3	2.8	3.	3.	2.	3.	1.5
37	5.	-	-	-	3.5	3.	3.	3.	3.	2.5
38	5.	4.	4.	2.3	3.	1.	2.	1.7	1.	2.4
39	3.6	3.7	3.8	1.8	3.3	3.	3.	1.6	3.4	1.7
40	3.5	-	4.	2.6	4.	2.	3.	-	3.	-
41	3.3	3.7	3.	1.	2.3	3.	3.	1.	3.1	1.5
42	3.	3.	4.	2.	3.5	3.	3.3	2.	3.2	1.5
43	-	-	4.	-	-	-	3.	-	3.	-
44	4.	3.7	4.	3.	5.	2.	3.	2.	3.	-
45	4.	4.	3.5	-	3.	3.	3.	2.	3.	-

Patient	C 1	C 2	C 3	C 4	C 5	D 1	D 2	D 3	D 4	D 5
Item										
46	-	4.	3.	2.	3.7	3.	3.	3.	3.	2.4
47	3.	-	4.	-	3.	3.	3.	3.	3.5	3.
48	-	3.5	4.	2.	-	3.	3.	-	3.5	-
49	-	-	-	-	3.5	3.	-	-	3.	-
50	3.4	3.	4.	3.	2.	2.4	2.5	2.7	3.1	2.8
51	3.1	3.7	3.6	2.5	2.	3.	3.	2.5	3.	1.8
52	3.7	3.8	3.3	2.8	3.	3.	3.	3.	4.	3.
53	-	-	-	-	-	-	-	-	3.	3.
54	4.	-	4.	-	-	-	1.	2.6	2.7	2.8
55	2.	3.	4.	2.5	3.	-	3.	-	3.	-
56	4.	4.	3.	3.	4.	1.	2.	3.	3.	3.
57	4.	4.	3.	4.	4.	1.	1.	1.	1.	2.
58	3.	3.	3.	3.	3.5	4.	3.	4.	4.	3.
59	-	-	3.	3.	3.	2.	3.	2.5	3.	3.
60	3.7	3.	4.	2.	2.5	-	3.	3.	3.	3.
61	3.	3.	4.	3.	4.	3.	4.5	3.	3.	3.
62	3.6	4.	3.7	2.8	2.8	3.	3.6	3.	3.	2.1
63	4.	3.5	3.8	2.	3.	3.	4.	1.6	3.8	1.5
64	3.	3.	3.8	2.5	3.5	-	3.	3.	3.	2.
65	3.3	3.3	4.	3.3	2.8	3.	3.	2.6	3.2	2.8
66	4.	4.	3.8	1.7	-	3.	3.	2.9	3.3	3.
67	4.	4.	3.3	2.7	3.	2.3	3.5	3.	3.3	2.4
68	4.	3.3	3.6	3.	3.7	2.9	3.	2.5	3.4	2.3

APPENDIX I

Overall Mean of Each Item

OVERALL MEAN OF EACH ITEM

Area I		Area II		Area III	
1	3.4	16	3.1	24	3.3
2	3.4	17	3.6	25	3.0
3	3.4	18	3.2	26	3.0
4	0	19	3.2	27	3.3
5	3.3	20	3.3	28	3.0
6	3.1	21	3.2	29	3.2
7	3.3	22	3.2	30	3.4
8	3.1	23	3.0	31	3.4
9	0			32	3.8
10	3.5			33	3.8
11	3.2			34	2.2
12	3.4			35	3.2
13	3.3			36	3.2
14	3.2			37	3.3
15	2.3			38	2.2

Area IV		Area V		Area VI	
39	3.0	54	3.0	62	3.2
40	3.1	55	3.0	63	3.2
41	2.8	56	3.0	64	3.3
42	3.1	57	2.8	65	3.3
43	3.9	58	3.1	66	3.4
44	3.4	59	3.0	67	3.4
45	3.4	60	3.2	68	3.3
46	3.1	61	3.4		
47	3.1				
48	3.1				
49	3.2				
50	3.1				
51	3.1				
52	3.3				
53	3.0				

APPENDIX J

Composite Mean of Item Means

QUALITY PATIENT CARE SURVEY

Composite Mean of Item Means

QUALPACS ITEM NUMBER	"MORE EFFECTIVE" LEADERS' UNITS	"LESS EFFECTIVE" LEADERS' UNITS	OVERALL
1	3.5	3.2	3.4
2	3.7	3.2	3.4
3	3.6	3.2	3.4
4	0	0	0
5	3.5	3.2	3.3
6	3.2	3.1	3.1
7	3.4	3.2	3.3
8	3.3	3.0	3.1
9	0	0	0
10	4.0	3.0	3.5
11	3.4	3.0	3.2
12	3.8	3.0	3.4
13	3.5	3.0	3.3
14	3.5	3.3	3.2
15	2.8	1.9	2.3
16	3.4	2.9	3.1
17	3.5	3.7	3.6
18	3.1	3.4	3.2
19	3.3	3.0	3.2
20	3.3	3.2	3.2
21	3.2	2.8	3.2
22	4.3	2.6	3.2
23	3.1	2.8	3.0
24	3.2	3.4	3.3
25	3.1	2.8	3.0
26	3.1	3.0	3.0
27	3.7	3.0	3.3
28	3.3	2.6	3.0
29	3.2	3.2	3.2
30	3.4	3.5	3.4
31	3.4	3.3	3.4
32	3.6	3.9	3.8
33	4.0	3.7	3.8
34	2.3	2.3	2.2
35	2.2	2.7	2.5
36	3.5	3.0	3.2
37	3.8	3.3	3.3
38	1.8	2.6	2.2
39	3.1	2.9	3.0
40	3.4	3.2	3.1
41	3.1	2.5	2.8
42	3.6	2.9	3.1
43	3.4	3.3	3.9
44	3.6	3.3	3.4
45	3.6	3.3	3.4

QUALPACS ITEM NUMBER	"MORE EFFECTIVE" LEADERS' UNITS	"LESS EFFECTIVE" LEADERS' UNITS	OVERALL
46	3.1	3.0	3.1
47	3.0	3.2	3.1
48	3.2	3.2	3.1
49	3.3	3.2	3.2
50	3.3	2.9	3.1
51	3.3	2.8	3.1
52	3.3	3.3	3.3
53	0	3.0	3.0
54	3.3	2.9	3.0
55	3.3	3.0	3.0
56	2.9	3.0	3.0
57	3.1	2.5	2.8
58	3.0	3.4	3.1
59	3.2	2.8	3.0
60	3.6	3.0	3.2
61	3.4	3.4	3.4
62	3.2	3.2	3.2
63	3.3	3.0	3.2
64	3.5	3.0	3.3
65	3.4	3.1	3.3
66	3.6	3.2	3.4
67	3.6	3.2	3.4
68	3.4	3.2	3.3

APPENDIX K

Area Means and Grand Means

AREA MEANS

	1	2	3	4	5
		Area I			
A	3.5	2.9	2.6	3.3	2.6
B	2.7	3.5	4.0	4.4	4.8
C	3.8	3.6	3.9	2.8	3.5
D	3.0	3.6	2.0	3.5	1.8
		Area II			
A	3.0	3.5	2.3	3.4	3.4
B	2.0	3.3	4.0	3.9	4.0
C	3.2	3.2	3.7	2.3	3.8
D	2.8	3.1	2.2	3.3	4.6
		Area III			
A	2.4	3.3	3.0	3.2	2.7
B	2.5	2.9	3.2	3.7	4.0
C	3.9	3.6	3.7	2.6	2.7
D	2,7	3.1	2.3	3.2	2.4
		Area IV			
A	3.0	3.2	2.7	3.3	2.7
B	2.1	3.0	3.3	4.0	4.8
C	3.5	3.6	3.7	3.0	3.3
D	2.8	3.0	2.3	3.2	2.3
		Area V			
A	3.2	3.7	3.5	3.2	3.0
B	2.8	2.3	2.3	3.0	3.9
C	3.4	3.3	3.5	3.0	3.4
D	2.2	2.6	2.7	2.8	2.9
		Area VI			
A	3.2	4.0	2.7	3.1	2.8
B	2.5	2.9	4.2	4.0	4.9
C	3.7	3.6	3.7	2.6	3.4
D	2.8	3.3	2.7	3.3	2.3

GRAND MEANS

	1	2	3	4	5
A	3.0	3.4	2.8	3.3	2.8
B	2.4	3.0	3.7	4.0	4.4
C	3.6	3.5	3.7	2.7	3.2
D	2.7	3.1	2.3	3.2	2.3

APPENDIX L

ANOVA Table for Area Means and Grand Means

SUMMARY OF ANOVA TABLES FOR AREA MEANS

Source	D.F.	S.S.	M.S.	F.
		Area I		
A	1	0.338	0.338	0.803
B	1	0.050	0.050	0.118
AB	1	3.362	3.362	7.995
Error	16	6.728	0.420	
Total	19	10.478		
		Area II		
A	1	0.544	0.544	1.214
B	1	0.084	0.084	0.188
AB	1	1.300	1.300	2.899
Error	16	7.176	0.448	
Total	19	9.105		
		Area III		
A	1	0.018	0.018	0.068
B	1	0.072	0.072	0.274
AB	1	0.968	0.968	3.694
Error	16	4.192	0.262	
Total	19	5.250		
		Area IV		
A	1	0.180	0.180	0.523
B	1	0.024	0.024	0.071
AB	1	1.984	1.984	5.756
Error	16	5.516	0.344	
Total	19	7.705		
		Area V		
A	1	0.060	0.060	0.390
B	1	1.624	1.624	10.480
AB	1	0.060	0.060	0.390
Error	16	2.480	0.155	
Total	19	4.225		
		Area VI		
A	1	0.512	0.512	1.246
B	1	0.008	0.008	0.019
AB	1	1.250	0.410	3.048
Error	16	6.572	0.410	
Total	19	8.342		

SUMMARY OF ANOVA TABLES FOR GRAND MEANS

Source	D.F.	S.S.	M.S.	F.
		Grand Means		
A	1	0.312	0.312	1.175
B	1	0.040	0.040	0.152
AB	1	1.404	1.404	5.285
Error	16	4.252	0.265	
Total	19	6.009		

APPENDIX M

Agreement for Informed Consent

Demographic Information

AGREEMENT FOR INFORMED CONSENT

I,_____, herewith agree to
(First Name) (Middle Name) (Last Name)
serve as a subject in the investigation name, "What is the Relationship of Quality of Leadership to Quality of Care in Institutions?" by Maureen Whitman, R.N., B.S., graduate student, under the supervision of Marie Berger, R.N., M.N., faculty advisor.

I understand that I will be asked to take a Leadership Effectiveness and Adaptability Description which will describe my leadership style. This will take approximately 15 minutes. I also understand that if my name is chosen in random fashion, that I will be asked to cooperate with Ms.Whitman and/or another rater as they observe up to five patients on my unit while care is in progress. I understand that they will use the Quality Patient Care Scale, an instrument designed for this purpose. I understand that in no way will the raters interfere with care or become a part of the staff but will be merely observers.

I understand that all data collected will be coded and my anonymity preserved. Any information transmitted as a result of the study will be aggregated and the units studies will not be named. Additionally, my name will not appear in any report of the study.

I may benefit from these procedures by learning something of my leadership style, and if I wish, ways in which I can use that style to become a more effective leader.

Maureen Whitman has offered to answer any questions that I might have about my participation in this study. I understand that I am free to refuse to participate in the study at any time without effect on my relationship or employment.

I have read the foregoing.

_____ _____
(Date) (Subject's Signature)

_____
(Witness's Signature)

DEMOGRAPHIC INFORMATION ABOUT NURSE LEADERS

Age: 20-30 _____ 30-40 _____ 40-50 _____ 50-60 _____ Over 60 _____

Basic nursing preparation: Year graduated:
- Associate degree _____ _____
- Diploma _____ _____
- Baccalaureate _____ _____

Additional degrees: Year received:
- Baccalaureate _____ _____
- Masters _____ _____
- Other _____ _____

Do you plan to seek the next academic degree? Yes _____ No _____
If so, when? _____
What do you see as your terminal degree? _____

Special Certificates held: Year received:
- _____ _____
- _____ _____

How long at present hospital: _____ years

How long in other positions before becoming a head nurse:
- Staff nurse _____ _____ years
- Assistant head nurse _____ _____ years
- Other _____ _____ years

Did you work on your present unit before becoming the head nurse? _____

How long have you been the head nurse on your unit? _____

Type of your unit: _____

Total patient capacity: _____ Average number of patients: _____

Briefly, in no more than two sentences, describe your position as head nurse.

_____

_____

Number of personnel on your unit.
RN _____ LPN _____ Aide _____ Sec. _____ Other _____

Briefly, in no more than two sentences, describe the relationship you have with your staff.

_____

_____

How many days weekly do you expect to have float personnel on your unit?___

AN ABSTRACT OF THE THESIS OF

Maureen Whitman

For the MASTER OF NURSING

Date of Receiving this Degree:

Title: THE RELATIONSHIP OF THE QUALITY OF NURSING LEADERSHIP TO THE QUALITY OF CARE

Approved: [redacted]

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

The purpose of this study was to evaluate the quality of care given under the direction of nurse leaders with different levels of leadership effectiveness.

Situational Leadership Theory, stating that the way in which an individual uses leadership style is more important than the style, itself, is the Conceptual Framework for the study.

Twenty-six head nurses at a large teaching hospital were given a Leadership Effectiveness and Adaptability Description (LEAD) to establish their leadership styles and the effectiveness with which they utilize those styles. Four of those nurse leaders, representing the "more effective" and "less effective" leadership styles were chosen as the sample group.

To determine the quality of care on the four units, the Quality Patient Care Scale (QUALPACS) was used. QUALPACS is an instrument designed to evaluate the quality of care while that care is in progress. It was determined that the outcome of this evaluation would represent

the outcome of the "more effective" and "less effective" styles of nursing leadership.

Two nurse raters conducted a pilot study to establish the inter-rater reliability. Following that, the survey sample involved 20 two-hour observation periods over a three day period. The patients were randomly chosen. The QUALPACS scale requires the raters to rate the care observed on a scale of one to five, with one representing the "Poorest Care" and five representing "Best Care".

Prior to the survey, two hypotheses were proposed. The first: There will be a significant difference in the Grand Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders, was rejected. The second hypothesis: There will be a significant difference in the Area Mean scores on the QUALPACS between the units led by the "more effective" and "less effective" leadership styles of nurse leaders, was also rejected.

The conclusions are that no significant differences can be seen in the care given by the followers of nurse leaders identified as "more effective" and "less effective". All 26 of the nurse leaders, according to Situation Leadership Theory, were in the two categories of leadership identified as having high relationship characteristics. Conversely, the nurse leaders scored extremely low in the two styles displaying both high task and low task. In other words, all of the nurse leaders indicated comfort in roles needing helping or supporting behaviors, and discomfort in roles requiring them to be a directive leader who can "lay it on the line" and one who can step back and let the followers "go it alone".