A Quality of Patient Care Survey In a Community Hospital

by

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P.N.M.P.

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CHAPTER I

INTRODUCTION

> The lack of good nursing care is too apparent to need documentation. While more nurses are employed today than ever before in our history, the quality and quantity of nursing care patients receive declines rather than increases. In a day when accountability is on everyone's mind, the fact . . . that nursing falls far short of being adequate should give pause to nurse educators and nursing service administrators alike (Montag, 1974).

Montag's statement is only one of many addressing the issues and elements of quality of patient care (Donabedian, 1969; Abdellah, 1972; Phaneuf, 1972; Slee, 1972; Schlotfeldt, 1973; Gortner, 1974; Wandelt, 1974; Wandelt and Ager, 1974; Zimmer, 1974; Stevens, 1975; Wandelt and Phaneuf, 1976; Zimmer, 1976). Central to all the authors' arguments is the need for planned change. Zimmer not only summarizes that point well, but also includes the need for evaluation. Essentially she says, change must not only be planned but must be evaluated for effectiveness also. Documentation of effective change will lead to increased effectiveness and higher staff morale. Identification of ineffective change will also prevent continuation of practices that cause wasted resources, increased costs, and/or, lower quality of care (Zimmer, 1976).

In considering evaluation and planning for effective change, a question is raised: How does a hospital evaluate the current level of care in order to rationally plan for change that will increase the quality of patient care? This question was posed to the investigator by the Director of Nursing Services of a small community hospital in a predominately rural area in Oregon. In light of the emphasis given to the issues of quality assurance and accountability in the recent nursing literature, the question was considered legitimate for further study.

Review of the Literature

This review of literature will cover the following major points: the need for quality assurance, professional accountability, performance evaluation, the essential components of quality assurance programs, and the types of instruments available to measure the effectiveness of the quality assurance program. To answer the question posed in the present study, the literature on quality assurance was considered. From this review it was ascertained that deliberate and dynamic change appears as a central component in quality assurance. Most authors maintain that change must follow a problem-solving approach that begins with identification of the problem.

The Need for Quality Assurance

Abdellah, in a discussion of "Assumptions Regarding the

Professional Nurse of the 1970's" pointed out that ". . . in the modern world, adaptive change is required for survival and innovative change a condition for success" (Abdellah, 1972, p. 3). Quality assurance can be classified as both an adaptive change and as a planned change. It is considered an adaptive change in view of the legislative actions that mandate change. The Social Security Amendments of 1972 contain the incentives that if professionals and health delivery institutions/agencies/organizations do not organize and implement effective quality control methods and systems by 1976, the government may do so. It is considered a planned change in view of the fact that it is presently a voluntary action and entered into as a means to upgrade care.

Phaneuf in 1972 defined the quality of nursing care as "the essential character of nursing care, considered in the context of grade or merit" (Phaneuf, 1972, p. 5). Schlotfeldt, in 1973, saw the lack of clarity regarding nursing's central focus as being responsible for poor understanding of the nursing role and poor recognition and valuation of the consequences of "scientifically based, humane nursing practices" (Schlotfeldt, 1973, p. 766). She urged that philosophies and policies be established to guide practice and to make explicit the outcomes for which nurses would be held accountable. In addition, the American Nurses Association recognized the need to guarantee quality service to patients. Standards of practice

were developed by the Congress for Nursing Practice in 1973 to ". . . fulfill the profession's obligation to provide and improve (nursing) practice" (American Nurses' Association, 1973). In 1974, Gortner again reminded us that "accountability is an important issue in nursing today and inevitably the question follows: Accountability for what and to whom?" (Gortner, 1974, p. 764). Gortner went on to say that ". . . until scientific accountability becomes a part of our tradition . . . we cannot hope to improve the quality of nursing. Our services . . . will remain custodial and idiosyncratic" (Gortner, 1974, p. 765).

Gortner's comments give direction and purpose for professional accountability which cannot be achieved without evaluation of the individual and the collective practice of nursing. Evaluation is a fundamental part of professional accountability. Nurses are answerable to patients and families; to themselves as practitioners; to physicians and others who participate in the care of patients; to the institutions and agencies in which they practice; to the community and to the nursing profession which in turn is accountable to society. Evaluation of these facets of accountability requires careful problem identification so that the necessary, essential questions will be answered (Joint Commission on Accreditation of Hospitals, 1973).

Slee identifies three essential components of any quality assurance program: "standards, surveillance, and corrective action"

(1972, p. 38). According to Donabedian, the first step in structuring an evaluation system is the setting up of standards of criteria (1969). Agreeing with Donebedian, Stevens states that there are three types of standards: structure, process and outcome. Structure standards address themselves to the ways in which the organization is systematized and while they can be utilized to evaluate how the work is arranged, they do not address the issue of quality (Stevens, 1975).

> Process standards provide a second perspective on care delivery; they 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, but it is the individual rather than the standardized aspect of care . . . (Stevens, 1975, p. 148).

The outcome standard takes another perspective. "Outcome standards represent the ultimate goals of nursing measurement, for, if the patient outcome is satisfactory, it matters little what nursing process was used" (Stevens, 1975, p. 148). Outcome standards do not provide the information of how much of the patients' health outcome is due either directly or indirectly to nursing and how much is due to other factors. "Typically, the patients' health outcome is the

result of multiple interaction of multiple factors of which nursing is only one (Stevens, 1975). In order to actually determine what contributes to the care and how that care was delivered, it would be necessary to view the care as was being delivered, as is done with the process audit.

Many groups have developed criteria, guidelines and instruments for quality assurance. For example, the Joint Commission on Accreditation of Hospitals has developed guideline standards for both outcome and process audits. Each institution must develop audit criteria that fit each category of patients to be audited. This type of audit is directed toward looking at groups of patients which fall within specific disease categories. The Joint Commission requires patient care evaluation for voluntary accreditation. They point out a number of benefits to be gained from use of an audit procedure. The benefits derived from systematic patient care evaluation permit nursing staffs to:

1. Improve patient care.
2. Demonstrate deficiencies in hospital wide policies or procedures.
3. Encourage coordination of physician/nurse planning for patient care.
4. Improve communication with other hospital departments or services.

5. Provide better documentation of patient care.
6. Provide direction for education programs.
7. Point out where additional facilities, equipment, or personnel are needed.
8. Research particular aspects of patient care.
9. Provide methods of accountability to the governing body and to the public (Joint Commission on Accreditation of Hospitals, 1973).

A process instrument that looks at the nursing care as it is delivered is the Quality Patient Care Scale (Qualpacs). This instrument is "designed for use in any setting in which nurses interact with patients or intervene, directly or indirectly, to contribute to meeting a patient's nursing and health care needs" (Phaneuf, 1972). The Qualpacs looks at the quality of care delivered by the total nursing care staff in a given time frame without reference to any individual care giver. To evaluate an individual, it would be necessary to utilize an instrument such as the Slater Nursing Competencies Rating Scale which includes all of the 68 items which appear in the Qualpacs but has a grand total of 84 items. Since it deals with individual practice only, the Slater Scale is not useful if one is evaluating care provided by a total nursing staff (Phaneuf, 1972).

No matter what approach to quality assurance is chosen, be it structure, process, or outcome, the second essential component as

identified by Slee (1972) is surveillance. Evidence about the quality of care may be gathered either directly or indirectly, but a primary source, which gives the rater direct knowledge concerning the standard is desirable. However, where standards do not lend themselves to immediate observation techniques, an indirect or secondary source is employed. Examples of secondary sources are: charts, records, nursing care plans, rounds, patient interview, nurse interview, and interviews of other health personnel (Stevens, 1975, and Wandelt and Ager, 1974).

The Qualpacs meets the surveillance criterion of Slee in that it considers the total staff from the point of view of the quality of care received by the patients. It is administered by direct observations so it is known if the care was given and provides for use of secondary sources when questions in direct observation arise. With retrospective outcome audits, it is difficult to determine if items observed were done and simply not recorded. It is difficult also to determine many of the influencing factors in the care regimen. The direct observation process presents a definite advantage in these areas (Wandelt and Phaneuf, 1976, p. 229-237).

The third essential component of the quality assurance program as identified by Slee (1972) is that of corrective action. A quality control system is useless unless appropriate feedback is offered to the nursing units involved. If possible, the staff should be motivated

to view quality control as a challenge rather than a threat. From this viewpoint, the program has greater productivity potential. All the instruments reviewed incorporated this component (Joint Commission on Accreditation of Hospitals, 1973; Phaneuf, 1972; Wandelt and Ager, 1974; Wandelt and Phaneuf, 1976).

Quality assurance programs often result in change. It is recognized that effective change is accomplished through a problem-solving approach and that "the most important part of problem-solving is that of problem definition" (Stevens, 1975, p. 41). There are many available solutions to existing problems and with solutions pressing from all sides, it is not surprising that temptation exists to simply reach out and grab one. Later, when the results of that solution are found to wear off after a short period, the solution is condemned as ineffective. The fact is that the solutions are effective only when applied to the right problems (Stevens, 1975). The first essential principle in problem solving is knowing all the relevant facts before diagnosing any problem. The second principle for averting premature classification is that of recognizing that most problems are not problems of fact but of interpretation (Stevens, 1975). If these principles are adhered to, the problem will be identified before a solution is selected.

Statement of the Problem

The researcher was approached by the Director of Nursing

Service in the study hospital with the stated need for assistance in determining what changes were needed within the existing nursing care delivery system. Concern over the quality of care, particularly on the medical and the surgical units, was expressed by the Director of Nursing Service. In addition, the nursing staff, particularly on the day and the evening shifts, had expressed dissatisfaction over the level of staffing. Adding staff, however, had not eliminated the complaints. Periodic complaints from physicians specifically concerning the quality of care delivered to the patient, coupled with staffing concerns of the nursing staff, pointed to a need to identify the underlying problems, to systematically plan for change and finally to an evaluation of that change.

As a result of the fact-finding step, the problem was identified and the decision was made that a process instrument would be utilized to gather necessary information. It was also decided that a process instrument would be more useful in answering the questions pertaining to quality of care which involved the total nursing staff in the actual delivery of care.

Because the Quality Patient Care Scale (Qualpacs), incorporates the process standards of nursing care, it was selected (Wandelt and Ager, 1974). The scale utilizes both direct and indirect surveillance to document the level of quality of nursing care as a means to identify areas where change is indicated within the nursing care

delivery system. The information provided by the Qualpacs is then available for planning corrective action. Qualpacs also establishes a baseline prior to change so evaluation for the effectiveness of a change can later be accomplished using this same instrument.

Purpose of the Study

The purpose of this study was to evaluate the quality of nursing care in a given community hospital as the first step of a problem-solving process. The determination of the quality of nursing care provided will be used for decision making about needed direction for change.

To determine if differences in quality of care existed in the study hospital, four null hypotheses were tested. These were:

1. There will be no significant differences in Grand Mean scores on the Qualpacs between the medical and the surgical units.
2. There will be no significant differences in the Area Mean scores on the Qualpacs between the medical and the surgical units.
3. There will be no significant differences in Grand Mean scores on the Qualpacs during the day shift than during the evening shift.
4. There will be no significant differences in the Area Mean scores on the Qualpacs during the day shift than during the evening shift.

CHAPTER II

METHODOLOGY

Description of the Study

Using Abdellah's and Levine's definition, this study was applied research. It was done to evaluate the nursing care delivery system in a given community hospital as a means of problem identification in order to determine direction for needed change.

The study was done to determine the quality of patient care and to provide information for the type of change in patient care to be instituted. Once the changes are instituted, a reassessment of quality of patient care will be done in order to evaluate the change and the resulting level of care.

Setting of the Study

The setting for the study was a 100 bed rural, community hospital. The hospital had an average daily patient census of 52, with the following average census distribution:

Medical patients:	28.8
Surgical patients:	17.2
Pediatric patients:	3.0
Obstetric patients:	3.0
TOTAL	52.0

There were 37 physicians on the staff, approximately one-third of whom were in family practice. There were 109 employees involved in direct nursing care delivery. Fifty-two of these employees were registered nurses, 37 full-time and 20 part-time. In addition, there were twelve licensed practical nurses, eight full-time and four part-time. Finally, thirty-two nursing assistants and orderlies were employed, twenty-six full-time and six part-time.

The patient care areas evaluated included the medical, surgical, pediatric and intensive care areas. Obstetrics, Recovery Room, Operating Room, and Emergency Room care areas were not evaluated because each functioned as a separate unit, that is, they share a common Director of Nursing Services and shift supervisor with the rest of the nursing areas but do not rely on staff from other units to assist in delivery of patient care.

In most hospitals, pediatrics and intensive care areas have been recognized as completely independent care areas. However, in this community hospital, they had a wide census fluctuation and the staffing pattern varied with the census. Although the intensive care unit was a physically separate one, when there was a low census, the staff was used to meet patient care needs in other areas. The pediatric unit was physically part of the medical unit, consisting of a two room area designated as pediatrics and patient care was assigned along with adult patient rooms. No separate staffing was

utilized in this area. No differentiation was made between levels of care for adults and infants.

During the time of the study, the surgical unit had 13 rooms with a capacity of 22 patients. Census during the three-day observation period averaged 19 patients on the surgical unit. The medical unit, inclusive of intensive care and pediatrics, had 27 rooms with a total of 57 beds. During the three-day observation period, that census averaged 33.7 patients on the combined unit referred to as medical.

Data Gathering Instrument

The Qualpacs is a complex instrument designed for use in process evaluation. To avoid duplication and possible confusion, the procedures for use of the Qualpacs will be discussed along with the discussion of the instrument.

The Quality Patient Care Scale (see Appendix A, p. 64) was used to collect data. It is an instrument designed to evaluate the quality of nursing care received by patients, while 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 the 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 and Ager, 1974, p. xii).

The Qualpacs consists of 68 items, identified by item numbers, identified to be the elements composing n ursing care received by the patient. These 68 items are divided into six broad areas of care. The areas and the items within the area are not listed in any order or rank.

To aid the rater, each element is predesignated as to how the data will most commonly be obtained. This designation appears on the rating chart at the end of each item statement. 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 and Ager, 1974, p. 37).

Cue sheets (see Appendix B, p. 72) were utilized to enable the rater to more uniformly rate interactions. The cue sheets utilized were those developed to accompany Qualpacs. An example of one cue is as follows:

> Item 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.
>
> 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 (Wandelt and Ager, 1974, p. 15).

The standard of measurement for Qualpacs is the quality of care expected to be provided by a first-level staff nurse. An Individual Frame of Reference (see Appendix C, p. 93) was completed by each rater as the directions indicated. Each nurse rater completed a separate Individual Frame of Reference. Each of the raters wrote the name of the nurse that was felt would most typify a nurse in each of the five categories: Best Staff Nurse; Between; Average Staff Nurse; Between; Poorest Staff Nurse. Since each of the raters had different nursing experiences and backgrounds, these frames of reference were not alike but were held constant by each of the raters throughout the study. All observed care was reflected against and rated using this as the standard of measurement. These frames of reference were held constant throughout the pilot study and the actual study. This same frame of reference was applied regardless of the category of personnel delivering care. The rating of best staff on the Individual Frame of Reference coincides with the best care column on the Qualpacs and receives a rating of five. The poorest staff nurse on the Individual Frame of Reference coincides with the poorest care column on the Qualpacs and receives a score of one. The average staff nurse on the Individual Frame of Reference coincides with the average care column on the Qualpacs and receives the score of three.

Subjects and Sample Size

According to Wandelt and Ager (1974), a valid and reliable measurement may be secured by deriving a mean score from the scores of as few as five patients or fifteen percent of the patients, whichever is greater. Patients were randomly selected for observation through use of a table of random numbers. Criteria for inclusion in the study were:

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. Since there was interest in knowing quality of care in relation to staffing shifts and both 7 - 3 and 3 - 11 shifts were observed, patients observed on one shift were eligible to be reobserved on another shift but statistically count as separate patients.
4. Patients observed must be expected to remain within the patient care area during the observation period.
5. 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.

6. A reliable score is necessary for final inclusion of observed patients. Ratings of as few as 30 items will yield a reliable measurement of the quality of care received (Wandelt and Ager, p. 52).

The nurse-raters selected the patients for inclusion in the sample using the above criteria. The number of observation sessions included in the study, involved 17 patients over a three-day period. Nine of these observations were made on the 3 - 11 shift and eight observations were made on the 7 - 3 shift. These patients represented 30 percent of the total patient census on the Medical-Surgical units. Care was taken to include a proportionate number of subjects from the Medical and the Surgical unit. The two groups were selected from separate random assignments and were of a size equal to 30 percent of the population on the medical unit and the surgical unit. The surgical unit had an average census of 19 patients so six observations were made on that unit. The medical unit had an average census of 33.7 patients so 11 observations were made on that unit. Four of the patients observed on the 7 - 3 shift were reobserved on the 3 - 11 shift. The purpose of observing the same patient on

different shifts was to look at the effect of different staffing patterns on the quality of care.

Data Collection Procedures

Permission was sought and received from the Director of Nursing Services to conduct the study. Since the Nursing Care Committee was charged with the responsibility of determining the level or quality of nursing care and to recommend appropriate change, their permission was also sought. A Fact Sheet About Qualpacs (see Appendix D, p. 95) was distributed to members of the Nursing Care Committee, Supervisors, and the Director of Nursing Services, and to any other nurse who indicated interest in the project. The purpose of the fact sheet was to inform the staff about how the study would be conducted, what information would be needed, and what assistance would be needed from staff members. The dates for the pilot study and the actual study were also included on the fact sheets.

To use the Qualpacs, more than one rater is required. A pilot study was done to determine interrater reliability. The two nurse raters in the pilot study were the same ones who conducted the actual study. At the time of the pilot study, the census was 42 patients on the medical and surgical units. The pilot study included six patients, selected randomly and meeting the criteria for inclusion in the study. The total of six patients met the criteria for 15 percent of the

population being surveyed. Care was observed at times when it was expected that nurse-patient interaction would occur for all patients. Time periods selected were two hours in duration and on both 7 - 3 and 3 - 11 shifts.

All patients observed had at least four nurse-patient interactions and had at least 30 items rated on the Qualpacs. Of those observed, two patients were the single occupant in the room, two had roommates who also met the criteria for inclusion in the pilot study. All patients included in the pilot study were from the medical and the surgical units.

Prior to each observation the nurse-rater spent time learning about the patient, assessing nursing care needs and developing a nursing care plan. The nurse responsible for the patient's care introduced the nurse-raters to each patient and explained the purpose of the observation. The raters explained that interaction could not take place between the raters and the patient. Time was allowed after each observation session for discussion with the patient and with the staff, as well as time to gather supporting indirect data from the chart.

Time was allotted following each observation period to enable the raters to complete the ratings in retrospect. Both raters observed the same patients throughout the pilot study. After the first two observation periods, time was allowed to discuss how the

develop needed information on each subject.

In order to rate all nurse-patient interaction that occurred during the observation period, it was decided that notes on the interactions would be recorded and the rating done when time allowed. Each interaction was assigned a specific number and the category of worker who performed each interaction recorded to assist the rater in mentally reconstructing the interaction at the time of rating.

When particular nursing care and interventions considered to be part of the required care were not performed, these items were rated in the "poorest care" column. 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 the care had not been done.

Not all elements of the scale were expected to apply to any one patient. If the activity was expected but did not occur in the time frame observed, the notation was placed under the "Not Observed" column. If the item did not apply to that patient, the item was simply checked "Not Applicable." Care was taken to insure that essential care not observed was given. If it was not evidenced as given and was not observed, it was then classified as poorest care (Wandelt and Ager, 1974).

Analysis of Data

All interaction for each item was totaled by giving a score of five for each interaction rating ascribed to the "Best Care" column. All interaction being ascribed to the "Poorest Care" column received a score of one. In the three columns, "Between," "Average," and "Between," all interaction received four, three, or two points respectively. The total points for each item was divided by the number of interactions to determine the item mean score.

The Grand Mean score was the measure of quality of the nursing care received by the patient. The mean scores of all 68 items were added; this number was then divided by the number of items that had ratings. The final number was carried to one decimal point. Items "not observed" or "not applicable" did not count in the calculation of the total mean score. Area Mean scores were calculated in a manner similar to that used for the Grand Mean score. The mean scores of all items rated in the six areas were divided by the number of items rated. "Not observed" or not applicable" items were not counted in calculating Area Means (Wandelt and Ager, 1974).

From the data generated by the 17 patient observations, item means for each of the 68 items that had observed interaction were computed (see Appendix F, p. 101). In addition, the mean of each item, Area Means, and Grand Means were looked at in relation to

differences between the day shift and the evening shift (see Appendix G, p. 105) and for significant differences between the medical and the surgical units (see Appendix F, p. 101). The Mann-Whitney U test was used to determine if a significant difference existed between the day and the evening shifts and between the two patient care units (Siegel, 1956).

Because the study was done to provide information for a community hospital, the Director of Nursing Services, the Nursing Care Committee, and the investigator, jointly, decided on the levels of excellence and concern for the Qualpacs. The level of concern or need for remedial action was set at 2.7 on a scale of one to five where one represents the poorest care and five represents the best care. It was the decision of this group 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.

CHAPTER III

RESULTS

Overall Level of Care

The overall Area Means and the Grand Means for all observations fell within the level of acceptability (see Table 1). No significant strengths or weaknesses were detected from viewing the data in this manner.

Table 1

Overall Area Means and Grand Means

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

Differences became more apparent, however, when individual items were studied (see Appendix H, p.109 for item means). Items 12, 43, 44, and 59 received ratings at the level of excellence. Items 12, 43, and 44 involve allowing the patient to participate in the health care process; item 59 deals with staff participation in conferences concerning patient care. It should be mentioned that although observation of these conferences were made, no mention of them appeared on the care plan or in the patients' charts.

Eleven items received overall ratings in the level of concern. These items were 10, 15, 18, 19, 25, 34, 38, 49, 53, 57, and 58. Items 10, 15, and 49 deal with how the staff responded to the unskilled, debilitated, or difficult patient. Items 18 and 19 deal with meeting patients' needs as part of a group as when more than one patient occupies a room and have common needs. Items 25 and 34 deal with personal hygiene and medical asepsis such as handwashing of staff between patients and of the patient after use of a bedpan. Item 38 deals with using established techniques for safe administration of medications and parenteral fluids and item 53 deals with how the staff responded in observed emergency situations. In each of the two observed emergency situations. In each of the two observed emergency situations, medical orders indicated possible need for emergency measures, yet no evidence of nursing care plans were found to indicate awareness that patients might need suctioning or positioning for maintainance of airway. Item 57 deals with well developed written nursing care plans and as has already been noted, none were available for the individual patient. Written guidelines for care of patients with each of the observed health care problems were available on the units, but no evidence that these were being used was found. Item 58 deals with charting of pertinent incidents. An example of a charting omission was as follows: Although one patient was unable to swallow, had developed labored respirations,

and evidenced a change in condition, the nurses noted did not indicate that any new events had occurred. Other less dramatic but equally important omissions were noted such as omission of patient condition, discharge planning, patient teaching, and reasons for changing approaches to nursing care. Items 9, 17, 20, 21, 22, and 23 had no observed interaction.

Comparison of the Medical and the Surgical Units

The medical and the surgical units were divided for staff and for patient assignment purposes. For this reason, it was decided to compare the two units and determine if differences in the quality of care existed. Comparison of the Area and the Grand Means for the medical and the surgical units is illustrated in Table 2.

Table 2

Area and Grand Means for Medical and Surgical Units

	Area						Grand Mean
	I	II	III	IV	V	VI	
Medical Unit	2.8	1.2	2.5	2.8	2.4	2.6	2.6
Surgical Unit	4.3	5.0	4.2	4.4	4.4	4.6	4.3

It may be helpful to look at a more detailed description of each area and some of the item differences that existed. These are as follows:

Area I: Covers actions directed towards meeting the psychosocial needs of individual patients.

The Medical Unit received an acceptable rating of 2.8. None of the fifteen items in this area received ratings in the level of acceptability with items 1, 2, 5, 6, 7, and 10 receiving ratings in the level of concern. Items 1 and 2 deal with the patient receiving the nurses' full attention and being able to express his feelings. Items 5, 6, and 7 deal with action the nurse takes to relieve anxiety. Item 10 deals with how the rejecting or demanding patient is accepted.

The surgical unit received a rating of 4.3, at the level of excellence. Seven items in this area received scores at the level of excellence. These items were 3, 4, 5, 8, 11, 12, and 13. Four items rated at the level of acceptability and four items had no interactions. Items 5 and 6 rated in the level of excellence on the surgical unit while on the medical unit they rated within the level of concern. All the items that rated within the level of excellence on the surgical unit deal with how the nurse approaches the patient and assists him in coping with his illness and environment.

Area II: Covers actions directed toward meeting psychosocial

needs of patients as members of a group. Observed interaction in this area on the medical unit received a rating of 1.2, well within the level of concern. Only three of the eight items in this area had observed interaction and all three were rated at the level of concern. The surgical unit received a rating of 5.0, at the level of excellence, but this rating is misleading with only item 16 contributing to the Area score.

Area III: Covers actions directed toward meeting physical needs of patients. The medical unit received a rating of 2.5, within the level of concern. Six items received a rating at the level of acceptability with items 24, 25, 27, 28, 29, 30, 31, 34, and 38 receiving ratings within the level of concern. The surgical unit received a rating of 4.2, within the level of acceptability. Items 24, 27, 28, 29, 30, 31, and 36 received ratings within the level of excellence. Items 34 and 38 received ratings within the level of concern. The other six items in this area received ratings within the level of acceptability.

Item 34 deals with medical asepsis in relation to the patients' personal hygiene and rated at the level of concern for both units. Item 38 deals with safe administration of medication and also rated within the level of concern on both units. Items 24, 27, 28, 29, 30, and 31 rated within the level of concern on the medical unit while on the surgical unit these same items rated within the level of

excellence. These items all involve carrying out and adapting the medical plan for treatment to meet the physical needs of the individual patient.

Area IV: Covers actions that may be directed toward meeting either psychosocial or physical needs of the patient, or both at the same time. The medical unit received a rating of 2.8, within the level of acceptability. Items 43 and 44 involve allowing the patient to be active participants in problem-solving and activities of daily living as it relates to each individual. Both units received ratings at the level of excellence for these items. Item 48 deals with providing diversional or treatment activities to patients and 49 deals with encouraging the slow or unskilled performance of a patient. These items rated in the level of excellence on the surgical unit and in the level of concern on the medical unit. Items 51 and 53 also received ratings within the level of concern on the medical unit. Item 51 deals with the interaction being within the framework of the therapeutic plan and item 53 deals with appropriateness of response to patients in an emergency situation.

The surgical unit received a rating of 4.4, within the level of excellence. Items 40, 41, 43, 44, 45, 46, 47, 48, and 49 received ratings within the level of excellence. Five items received ratings within the level of acceptability and item 53 had no interaction.

Area V: Covers communications on behalf of the patient.

The medical unit received a rating of 2.4, within the level of concern. Three items received ratings within the level of acceptability and items 54, 55, 56, 57, 58, and 59 received ratings within the level of concern. The surgical unit received a rating of 4.4, within the level of excellence. Items 54, 55, 56, 57, and 59 received ratings within the level of excellence and the remaining three items received ratings within the level of acceptability.

Both units rated within the level of acceptability in communications with other disciplines as noted in items 60 and 61. The surgical unit rated well in other items also; however, the medical unit rated within the level of concern in the remaining items which included such things as communicating ideas, facts, and concepts about the patient in charting and intershift report and development of nursing care plans and utilizing them in making patient assignments.

Area VI: Covers care given to the patient reflecting initiative and responsibility indicative of professional expectations. The Medical Unit received a rating of 2.6, within the level of concern. One item received a rating within the level of acceptability and items 62, 63, 64, 65, 66, and 68 received ratings within the level of concern. The Surgical Unit received a rating of 4.6, within the level of excellence. Items 62, 64, 65, 66, 67, and 68 received ratings within the level of excellence. One item received a rating within the level of acceptability.

In this area, all the items rated substantially higher on the Surgical Unit than on the Medical Unit. Items in this area deal with the care components such as decision-making based on facts and reflecting good judgment, and evidence of insight into patient problems. Care given by well organized, informed staff who have a well developed plan of care for continuity of care is the central theme for the seven items which comprise this area.

Grand Mean: This total reflects the average of all item means. The Area Means are not totaled into this figure. The Medical Unit received a rating of 2.6, at the level of concern. Two items rated within the level of excellence, twenty-five items rated within the level of acceptability and thirty-four items rated within the level of concern. Seven items had no observed interaction. The Surgical Unit received a rating of 4.3, within the level of excellence. Thirty-five items received ratings within the level of excellence. Two items received ratings within the level of concern and eighteen items received a rating within the level of acceptability. A total of 13 items had no observed interaction.

Many of the items that received a rating within the level of excellence on the Surgical Unit received a substantially lower rating on the Medical Unit. Two items, 34 and 38, rated low for both units. These items deal with medical asepsis in relation to the patient's

personal hygiene and with the administration of medications and parenteral fluids.

From these results, some differences are then seen to exist. First, a difference does exist between the Medical and the Surgical Units in all areas. Second, the differences tends toward the quality of care ranging in the level of acceptability to the level of excellence on the Surgical Unit while the care on the Medical Unit ranges from the level of concern to the level of acceptability.

Comparison of the Day and the Evening Shifts

Staffing patterns differed on the day and the eveing shifts as well as different nursing care activities. It was decided to evaluate the quality of patient care on the day and the evening shifts. Results of this comparison are presented in Table 3.

Table 3

Area and Grand Means for Day and Evening Shifts

	Area						Grand Mean
	I	II	III	IV	V	VI	
Day Shift	2.9	1.2	2.8	2.9	2.6	2.6	2.8
Evening Shift	3.7	5.0	3.4	3.7	3.6	3.9	3.6

A more detailed description of each area and some of the item differences that existed are as follows:

Area I: This area deals with actions directed toward meeting the psycosocial needs of individual patients. Both the day shift and the evening shift received ratings within the level of acceptability. Both shifts had item 12 rated within the level of excellence. This item deals with utilization of the healthy aspect of the patient's personality. Items 3 and 14 also rated within the level of excellence on the evening shift. Both these items deal with how the nurse initiates interaction with a patient. Eight items rated within the level of acceptance on each of the two shifts. Item 15 received a rating within the level of concern on both shifts. This item deals with the manner in which care is given to the disoriented or unconscious patient. Other items that received ratings within the level of concern on the day shift were 5, 7, 8, and 14. Items 4 and 10 received ratings within the level of concern on the evening shift. Item 9 generated no observation on either shift.

Area II: Covers actions directed toward meeting psychosocial needs of patients as members of a group. Observed interaction in this area on the day shift rated 1.2, well within the level of concern. Only items 16, 18, and 19 had interaction. On the evening shift, the quality of care was rated at 5.0, within the level of excellence for

item 16. None of the other items in this area generated a rating on the evening shift.

Area III: Covers actions directed toward meeting physical needs of patients. Both the day and evening shifts received ratings within the level of acceptability. All items rated interaction on both shifts. The day shift had item 33 with interaction rated within the level of excellence. This item deals with how expectations of the patient varies after medication has been administered. Six items received ratings within the level of acceptability and items 24, 27, 28, 29, 30, 32, 34, and 38 generated ratings within the level of concern on the day shift. Items 24, 27, 28, 29, and 30 all involve carrying out and adapting the medical plan for treatment to meet the physical needs of the individual patient. Item 34 was also within the level of concern during the evening shift. This item deals with medical asepsis in relation to the patient's environment and personal hygiene. Item 38 deals with using established techniques for safe administration of medications and parenteral fluids. This item rated within the level of concern on the evening shift as well as on the day shift. Item 25 deals with meeting personal hygiene needs of the patient and this item received a rating within the level of concern on the evening shift. The main contributing factors here were the lack of handwashing before meals and after use of a bedpan. Item 37 deals with the use of safety measures to prevent harm to a patient.

This item received a rating within the level of concern on the evening shift also. The main contributing factor for this score was the absence of side rails on both sides of the bed on new post-operative patients. Items 30 and 32 received ratings within the level of excellence on the evening shift. The other nine items received ratings within the level of acceptability.

Area IV: Covers action that may be directed toward meeting either psychosocial or physical needs of the patient, or both at the same time. Both the day and evening shifts received ratings within the level of acceptability with a score of 2.9 and 3.7 respectively. All items had rated interaction on the evening shift, but item 43 generated no score on the day shift. On the day shift, item 44 rated within the level of excellence, eight items rated within the level of acceptability, and items 48, 49, 51, 52, and 53 rated within the level of concern. The evening shift had items 41, 43, 45, 46, and 47 rated within the level of excellence, eight items rated within the level of acceptability, and item 53 rated within the level of concern.

Item 48 deals with making diversional or treatment activities available to the patient as needed. It should be noted that this item received a rating within the level of excellence on the evening shift while the rating on the day shift fell within the level of concern. Both shifts received ratings within the level of concern for item 53, which deals with making appropriate responses to patients in emergency

situations. Items 49, 51, and 52, which received ratings within the level of concern on the day shift, deal with encouraging patients with slow or unskilled performance, interacting within the framework of the therapeutic plan, and making close observation of the patient with minimal disturbances.

Area V: Covers communications on behalf of the patient. The day shift received a rating of 2.6, within the level of concern. The evening shift received a rating of 3.9, within the level of acceptability. All items received ratings on the day shift and item 66 had no interaction on the evening shift. The day shift had four items rated within the level of acceptability and five items received this rating on the evening shift. Items 54, 56, 57, and 58 rated within the level of concern on the day shift. Item 58 also received a rating within the level of concern on the evening shift, this item deals with reporting of pertinent incidents of the patient's behavior. The main contributing factor for this low rating in this item was charting omissions of observed pertinent interactions. Item 56 specifically deals with charting and received a rating within the level of concern on the day shift as did items 54 and 57 which deal with developing nursing care plans and communicating ideas, facts, and feelings about the patient to the entire patient-care team.

Area VI: Covers care given to the patient reflecting initiative and responsibility indicative of professional expectations. The day

shift received a rating of 2.6, within the level of concern. The evening shift received a rating of 3.9, within the level of acceptability. All items had rated interaction on both shifts. The day shift had one item rated within the level of acceptability. Items 62, 63, 64, 65, 67, and 68 rated within the level of concern. Item 67 rated within the level of excellence on the evening shift and the other six items rated within the level of acceptance.

Item 67 deals with how care given the patient reflects flexibility in rules and regulations as indicated by individual patient needs. It is noted that this item generated a score within the level of excellence on the evening shift and within the level of concern on the day shift. The other items which rated within the level of concern on the day shift deal with the care components such as decision making being based on facts and reflecting good judgment, and evidence of insight into patient problems, and care given by well organized, informed staff members who have a well developed care plan for continuity of care.

Grand Mean: Both the day and the evening shift received ratings within the level of acceptability with a score of 2.8 and 3.6 respectively. The day shift had three items within the level of excellence and 27 items within the level of acceptability. Thirty-one items rated within the level of concern and seven items generated no score. The evening shift had fifteen items rated within the level of

excellence and thirty-five items rated within the level of acceptability. Seven items rated within the level of concern and nine items generated no score.

Using the criteria set for the levels of concern and excellence, the following results are noted: First, the quality of care on the day shift and the evening shift is within the level of acceptability in Areas I, III, IV, and the Grand Mean; second, the quality of care on the day shift is within the level of concern, while the quality of care on the evening shift is within the level of excellence in II and within the level of acceptability in Areas V and VI.

Analysis of Statistical Differences

It was hypothesized that no significant differences would be found in the Area Means and the Grand Means on the Qualpacs on either the medical or surgical units or between the day and the evening shifts. Results of the Mann-Whitney U test of differences are presented in Table 4. With the level of significance at .05, a U was also computed for the 68 Qualpacs items on both the day and evening shifts and for the medical and surgical units (see Appendix I, p. 112).

The first hypothesis states: There will be no significant differences in Grand Mean Scores on the Qualpacs between the medical and the surgical units. The Grand Means yielded a U which demonstrated a significant difference at the .02 level, therefore the first hypothesis is rejected.

Table 4

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

Units		Mann-Whitney U Area I	II	III	IV	V	VI	Grand Mean
Med/Surg	N_1	6	2	6	6	6	6	6
	N_2	11	2	11	11	11	11	11
	U	10	ID*	5	7.5	4	3.5	5
	p	.05		.002	.02	.002	.002	.02
Day/ Evening	N_1	8	2	8	8	8	8	8
	N_2	9	2	9	9	9	9	9
	U	19	ID*	27	28.5	18	15	19.5
	p	NS**		NS**	NS**	.10	.05	NS**

* Insufficient data to compute U.

** Nonsignificant U with no specific numerical value available.

The second hypothesis states: There will be no significant differences in the Area Mean scores on the Qualpacs between the medical and the surgical units. Areas I, III, IV, V, and VI yielded a U which demonstrated a significant difference existed. The level of significance for each was as follows: Area I: .05; Area III: .002; Area IV: .02; Area V: .002; and Area VI: .002. Since the data in

Area II was insufficient to compute a U, no analysis was done. There was a statistical difference between Area Means I, III, IV, V, and VI for the medical and the surgical units, therefore, the second hypothesis is rejected.

In comparison of the individual item means for the medical and surgical units (see Appendix I, p. 112),it was found that 28 items yielded a significant U value. Nineteen items had insufficient data to compute a value for U and the remaining 21 items yielded a non-significant U value. Items which generated a significant U were 1, 2, 3, 5, 6, 7, 11, 13, 24, 27, 29, 30, 31, 36, 41, 47, 50, 51, 54, 55, 56, 57, 62, 63, 64, 65, 66, and 68. Items 1, 2, 3, 5, 6, 7, 11, and 13 deal with care components of attitude which the nurse exhibits toward the patient and the amount and quality of psychological support given. Items 24, 27, 29, 30, 36, 47, 50, 51, and 62 deal with care components which provide for support, adaptation, and implementation of the therapeutic plan of care and insure that physical well being is maintained and promoted for each individual patient. Communications with the total patient care team and the family, verbally, as well as through clear and accurate charting are components incorporated in items 54, 55, and 56. Development of nursing care plans, and nursing actions that evidence insight into patients' problems are included in items 57, 63, and 64. Items 65, 66, and 68 deal with patient oriented organization and management by a well informed

nursing care team. Item 41 deals with maintaining the patient's right to privacy. The preceeding items were those where significant differences existed between the medical and the surgical units.

The third hypothesis stated: There will be no significant differences in Grand Mean scores on the Qualpacs during the day shift than during the evening shift. The Grand Mean yielded a U which demonstrated that no significant differences existed between the day and the evening shift, therefore, the hypothesis was accepted.

The fourth hypothesis stated: There will be no significant differences in the Area Mean scores on the Qualpacs during the day shift than during the evening shift. Area VI yielded a U which demonstrated a significant difference at the .05 level. No other area yielded a statistically significant U. Area II did not yield enough data to compute a U, therefore, no statistical significance could be established. The fourth hypothesis is rejected on the basis of the data yielded in Area VI. It can be stated that a significant statistical difference does exist between the day and the evening shift.

In comparison of individual item means for the day and the evening shifts (see Appendix I, p. 112), it was found that a significant difference existed between 13 of the item means. Items which generated a significant U were 1, 3, 7, 14, 29, 30, 41, 46, 49, 51, 63, 64, and 65. Eighteen items had insufficient data to compute a U and the remaining 32 items yielded a nonsignificant U value.

Items 1, 3, 7, and 14 deal with care components of the attitude which the nurse exhibits toward the patient and the amount and quality of psychological support given. Items 29, 30, 46, and 51 deal with care components which provide for support, adaptation, and implementation of the therapeutic plan of care and for insurance that physical well being is maintained and promoted for each individual patient. Evaluation of the patient's status to gain insight to be used in developing and revising the nursing care plan and its implementation are the care components in items 63 and 64. Item 41 deals with protecting the patient's right to privacy and item 49 deals with how the nurse responds to a patient's slow or unskilled performance. How the staff follows through with their responsibility for patient care is the care component dealt with in item 65.

CHAPTER IV

DISCUSSION

The quality of care being given on the medical and the surgical units in the study hospital was established. Results of the study indicated that there was a significant difference in the quality of care provided on the medical and the surgical units. There was, however, no difference in the Grand Means for the day and the evening shifts. For Area VI there was a significant difference between the day and the evening shift, therefore, hypothesis four was rejected.

When the overall item means were examined, it was found that four individual items received an overall rating within the level of excellence (see Appendix H, p. 109). Because of the high overall rating, these items will be explored more fully on an individual basis. These items are as follows:

Item 12: The healthy aspects of the patient's personality are utilized. The mean score for all observations for this item was 4.5 (see Appendix H, p. 109 for item scores and means and the overall mean). The day, evening and surgical ratings were all in the level of excellence for this item and the medical score was within the level of acceptability.

Item 43: Resources within the mileu are utilized to provide the patient with opportunities for problem-solving. No interaction was

noted which would apply to this item on the day shift. All observed interaction rated within the level of excellence for this item.

Item 44: Patient is given freedom of choice in activities of daily living whenever possible and within patient's ability to make the choice. Both the medical and the surgical units and the day shift rated within the level of excellence. The evening shift rated within the level of acceptability.

Item 59: Staff participates in conferences concerning patient care. This item had an overall rating of 4.3 but a wide variation of quality was noted when the subgroups were looked at. Both the evening shift and the surgical unit received ratings within the level of excellence. The day shift received a rating within the level of acceptance and the medical unit rated within the level of concern. The differences were primarily due to the different methods used by the staff to exchange report. The nursing assistants and the nurses on the surgical unit received report together and briefly planned care and discussed needs of the patients prior to beginning care. Staff seldom participated in conferences concerning patient care other than at report time. On the medical unit, nursing assistants were not included in the initial shift report. They were observed delivering patient care for a full hour prior to receiving a report on the care that was needed for the patients on their assignment sheet. All they knew about their patients for that first hour was what the nursing

assistant on the off going shift reported, what could be gathered from charts if time allowed, and from instructions on the bed cards above the patient beds. Bed cards above the patient beds were not always updated in these instances and made delivery of quality care very difficult. These assistants were given a report in greater detail one hour after the shift had begun, but this report did not include many of the details included in the report from the offgoing shift nor did it become a time when the team discussed what care would be best for the patient.

It was noted for the overall mean of individual items, that 11 items received ratings in the level of concern. Because of the low overall rating, these items will be explored more fully on an individual basis. These items are as follows:

Item 10: The rejecting or demanding patient continues to receive acceptance. Examples of observed interaction for this item were: A patient who turned a call light on frequently was reprimanded. A crying child was not comforted, nor were attempts made to divert his attention. The day shift received a rating of 2.8, which was within the level of acceptability. The scores that rated within the level of concern were generated during the evening shift on the medical unit. No applicable observations were made for this item on the surgical unit.

Item 15: The unconscious or nonoriented patient is care for with the same respectful manner as the conscious patient. Four of the two-hour observation periods involved patients in this category. No observations for this item were made on the surgical unit. Observations on both the day and the evening shifts on the medical unit generated ratings within the level of concern. Examples of observed interactions were: Two nurses entered a room where there were two non-responsive patients. Each nurse proceeded to turn one of the patients. While they performed this task, they discussed the degree of difficulty encountered and how it would be easier to be moving full sacks of potatoes. At no time during this episode was the patient addressed as a person or informed of what was to take place. When family members did the same task later, both patients were able to assist at least minimally, by holding a siderail when his hand was placed on it.

Item 18: Patient received encouragement to participate in or to plan for the group's daily activities. (See discussion under Item 19.)

Item 19: The member of the group is provided with the opportunity to assume responsibility according to his capability. These items deal with common care components and the applicable observed interactions were identical. Interaction for these items was observed on only the medical unit during the day shift. Three patients in the same room were observed to share common needs. When one

patient offered assistance and information to the nurse regarding the other, she not only did not acknowledge the patient offering the information but she turned her back on the patient. This did not stop the patient, however, he persisted by repeating his offer of information and this second time the nurse effectively blocked further communications on a group basis by drawing the privacy curtain to prevent further interaction.

Items 25: Patient's daily hygiene needs for cleanliness and acceptable appearance are met. The surgical unit and the day shift generated ratings within the level of acceptability. The medical unit and the evening shift, however generated scores within the level of concern and the overall item mean also fell within the level of concern. Failure to provide handwashing for the patient after use of a bedpan and omission of handwashing prior to the evening meal were the primary contributing factors.

Item 34: Medical asepsis is carried out in relation to the patient's personal hygiene and immediate environment. All means for this item scored within the level of concern. Failure to offer handwashing facilities to the patient reduced this item score and that of item 25 as well. Another factor contributing to the low score for this item was the failure of the staff to wash their hands between patients.

Item 38: Established techniques for safe administration of medications and parenteral fluids are carried out. All means for this item scored within the level of concern. At no time did the observer see the medication procedure followed completely. Often the medication card was not brought into the patient's room and in no instance was the patient identification band checked. On one occasion, the observed noted that an intravenous push medication was given into an incompatible primary solution. This error was confirmed after the observation period and brought to the attention of the nursing staff. Patients requesting pain medication were given what was requested promptly in each observed instance. No inquiry was made in any instance as to the nature or intensity of the pain, even though for several patients more than one pain medication had been ordered, and one was to be selected depending on the type and intensity of the pain. Questioning of the patient revealed that none of the patients who had more than one analgesic ordered were aware that more than one type of medication was available. Three of these patients indicated, during the interview with the observer, that a different pain medication would be requested when needed the next time.

Item 49: Patient with slow or unskilled performance is accepted and encouraged. This item received a score within the level of excellence on the surgical unit and a score within the level of concern during the day on the medical unit. The evening shift rated within the

level of acceptability. Examples of observed interaction for this item were: For one semi-comatose patient, passive range of motion was ordered twice a day. The nursing staff discussed the hopelessness of the situation while at the bedside and decided not to carry out this treatment. In another observation, an essentially disabled patient was being turned. Although he was able to assist only by holding on weakly to the rail with one hand, the nurse completed the turning task without assistance, all the while talking to the nurse at the bedside of the other patient in the room. Their discussion centered around the inability of the two patients to assist and how much work patients of this kind are. As has been previously noted, the level of excellence was achieved on this item for the surgical unit during the evening shift. Patients were observed ambulating for the first time postoperatively and were also seen being encouraged to do so.

Item 53: Response to the patient is appropriate in emergency situations. No interaction was observed for this item on the surgical unit. Ratings within the level of concern were observed on both the day and the evening shifts on the medical units. Two instances were observed, both dealt with the same problem for the same patient but on different shifts. Medical orders read: suction whenever necessary, the patient was semi-comatose, and had a partial paralysis of the throat muscles which impaired swallowing. No suction was available in the room during either observation. The observer intervened

and sought suction equipment after the second observation period. The observer had brought need for suction equipment and the lack of it to the attention of the nursing staff following the first observation period. When the observer actively sought the suction equipment, it took twenty minutes to locate an operable portable suction unit. Wall suction was available at the patient's bedside but no wall unit could be located to install.

Item 57: Well-developed nursing care plans are established and incorporated into nursing assignments. This item received a rating within the level of excellence on the surgical unit and within the level of acceptability during the evening shift. The rating within the level of concern was achieved for both the medical unit and the day shift as well as the overall item mean. No written nursing care plans were found for individual patients other than recording of allergies and direct physician orders. Written guidelines for care of patients with each of the observed health care processes was available on the unit, but no evidence was found that these were being used. The differences in the quality observed in the care plans that were used for assignments seemed to be primarily due to the differences in receiving report which has already been discussed on page 43 under Item 59.

Item 58: Pertinent incidents of the patient's behavior during interaction with staff are accurately reported. The evening shift received a rating within the level of excellence and the surgical unit

received a rating within the level of acceptability. The medical unit and the day shift as well as the overall mean were within the level of concern. Examples of observed interaction included omission of pertinent observations in the patient's record. Although one patient was unable to swallow, had developed labored respirations, and evidenced a change in condition, nurses' notes gave no indication of these symptoms. One paralyzed patient had attempted to speak on two occasions and moved one hand as directed while the observer was present. These were new occurrences yet no mention of this was made in the record. Nurses' notes on the evening shift were found to contain a general assessment of the status of the patient at the beginning of the shift and to mention briefly any changes that occurred during the shift. The day shift tended to use summary charting at the end of the shift and did not generally state the condition of the patient.

Differences in Staffing Levels

It is possible that the differences in staffing level had a direct relationship to the quality of care for the patients. Staff assignment records for the period covered in the study were utilized to provide the information on the level of staffing. Table 5 graphically illustrates that the medical unit on days had the lowest level of professional staff. On both shifts the medical unit had less staff time per patient than was allotted for the surgical unit.

Table 5

Nursing Care Hours per Patient per Shift

	Nurse Time (min)	Nonprofessional Time (including Ward clerk) (min)	Total Staff Time (min)
Medical-Days	38	100	138
Surgical-Days	51	115	166
Medical-Evenings	52	61	113
Surgical-Evenings	55	65	120

On the medical unit, a total of 138 minutes were allotted per patient on the day shift and 113 minutes of staff time were allotted on the evening shift. On the surgical unit, a total of 116 minutes were allotted on the day shift and 120 minutes per patient on the evening shift. The patient care policy in the study hospital states that the bath must, if at all possible, be given during the day shift. Two meals must be served also during that shift as opposed to serving one meal during the evening shift. The allotted time differences between the day and the evening shifts provides for 25 minutes to bathe the patient and to serve this extra meal on the medical unit and 39 minutes to provide this service on the surgical unit. It would be necessary to have a task analysis for the two shifts to determine if these

two tasks are the only major differences that exist on these two shifts.

The total amount of staff time per patient shows a 28-minute difference between the medical and the surgical unit on the day shift and a minimal difference of seven minutes on the evening shift. Again it would be necessary to determine if this staffing difference is justified through task analysis and by some method to systematically determine the level of care required by each patient. It would then be possible to determine if lighter care patients are assigned to the medical unit. If lighter care patients are assigned to the medical unit, this would account for the staffing ratio and rule out inequitable staffing as a factor in the differences in quality of care.

In addition to differences in the amount of total staffing per patient on the medical and surgical units, a difference in the type of staffing exists which may have been an influencing factor on the quality of care. The percentage of professional nurse staffing on the evening shift is 46 percent of the total staffing for both units, while on the day shift 27 percent of the total staff on the medical unit was composed of professional nurses and on the surgical unit 31 percent of the staff was professional nurses.

In rating the care on the Qualpacs, no distinction is made for the type of preparation of the care giver. All care is evaluated against the quality set in the Individual Frame of Reference (see Appendix C, p. 93). All care givers are referred to as nurses

regardless of positions or background. It is possible then, with this fact in mind, to consider that the amount of professional nurse staffing did affect the quality of care. This possibility receives strong support when looking at the one area mean that showed a statistically significant difference. Area VI deals with professional implications with the care given to the patient reflecting initiative and responsibility of professional expectations (Wandelt and Ager, 1974).

Areas of strengths and weakness were also found and are referred to area in the results chapter and by item in Appendix I. Items without observations yielded no data, therefore, no conclusions of strength or weakness could be drawn. Item 9: Patient receives attention for his spiritual needs; was an item with no observed interaction. This may simply mean that no opportunity arose where this interaction was appropriate or it may indicate it is an area that is not receiving attention. Despite the fact that the patient care kardex has a place to list the patient's religion, it was not used for any of the patient's included in the study and no evidence of referral to the hospital chaplain was found in the nurses' notes. Two of the seventeen patients in the study had a poor prognosis and were probably terminal, yet no notation was made regarding their spiritual needs.

Area II had minimal observations (a total of eight interactions rated). Five of the eight items in this area received no ratings at

all. The area deals with actions directed toward meeting the psychosocial needs of patients as members of a group. Areas where group nurse-patient interaction is considered useful is for teaching and motivation. This is considered to be a more efficient use of time than for the nurse to attempt to teach and/or motivate each patient on an individual basis. Besides increasing the efficiency of the nursing time, the patient is provided with the opportunity to gain from interaction with others. In the interest of expediency, it would seem more effective to teach six or eight preoperative patients about the basic breathing and leg exercises, rather than teaching each of them individually. Group work saves precious time that the nurse can easily use for some other purpose (Bower, 1972).

Effective group interaction was observed on the surgical unit during the evening shift. Three postoperative patients were ambulated during the same time frame. Each was assisted to begin ambulation, individually, beginning with the most active patient first. The patient who needed the most assistance from the nurse and the shortest ambulation, was brought into the hall last to join the group. The patients offered reassurance and encouragement to each other as well as sharing briefly of their experiences. The nurse acted as the group facilitator by introducing the third patient to the other two who had obviously met during a previous ambulation. The nurse was able to observe and assess the activity of all three patients and to offer

general comments of encouragement that applied to all three. Each patient appeared to interact readily and to benefit from this approach.

Ineffective use of possible group interaction was observed on the Medical unit during the day. As the nurse made her assessment rounds in a four-bed ward, the patients attempted to discuss common needs and assist in setting a schedule for when care would be given. The nurse turned her back on the patients offering input and focused on the individual closest to her. When the other patients continued to talk with the nurse and the patient she was assessing, the privacy curtain was drawn to insure meeting the individual patient's needs. It should be noted here that each of the three patients in this room did have an individual assessment and individually planned their activity with this nurse over a period of 45 minutes. So in time, this nurse did focus on their needs.

The philosophy of the study hospital is to meet the needs of each individual patient. The individual receives much emphasis. It would seem that this philosophy needs to be examined and determination made to see if it would be possible or practical to meet the needs of the individual patients on a group basis in some instances.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

> The lack of good nursing care is too apparent to need documentation. While more nurses are employed today than ever before in our history, the quality and quantity of nursing care patients receive declines rather than increases. In a day when accountability is on everyone's mind, the fact . . . that nursing falls far short of being adequate should give pause to nurse educators and nursing service administrators alike (Montag, 1974).

Echoing Montag's statement, this study points to the need for an improved quality of specific components of nursing care. Concern for delivery of quality care led to this study. It was done to determine the quality of care being given and to identify strengths and weaknesses within the existing care system of a small community hospital. By identifying the strengths and weaknesses and establishing the quality level of patient care it is planned that the survey will provide the first step in making effective change within the existing system. The Nursing Care Committee and the Director of Nursing Services jointly authorized this study as a means of beginning planned change and to provide baseline data that could be used for evaluation of the effectiveness of any changes that were made.

A pilot study was conducted to establish interrater reliability and to familiarize both the staff and the raters with the instrument.

The study consisted of seventeen, two-hour periods of direct observations of nurse-patient interaction over a three-day period by two nurse observers. Following each observation period, the interactions were rated for quality using the Quality Patient Care Scale as an instrument. Subjects were randomly selected and were proportionate from the medical and the surgical units. Observations were made on both the day and the evening shifts.

There were four hypotheses made prior to the survey. The first hypothesis: There will be no significant differences in Grand mean scores on the Qualpacs between the medical and the surgical units, was not accepted. The second hypothesis: There will be no significant differences in the Area Mean scores on the Qualpacs between the medical and the surgical units, was rejected. The third hypothesis: There will be no significant differences in Grand Mean scores on the Qualpacs during the day shift than during the evening shift, was accepted. The fourth hypothesis: There will be no significant differences in the Area Mean scores on the Qualpacs during the day shift than during the evening shift, was rejected.

The conclusions to be drawn from this research were that the quality of care did vary between the medical and the surgical units and also between the day shift and the evening shift. But besides pointing out where differences in the quality of care existed, the study points to components of care where excellence existed and

also to care components where the quality was within the level of concern. Since problem identification is the first step in effective change, the results of this study can now be utilized to plan for needed improvements in quality of patient care.

The following recommendations for future research are suggested:

(1) Replication of this study using a large enough sample from each shift, including nights to provide a 24-hour assessment of the quality of patient care.

(2) Cross validation of this study using an outcome nursing audit to determine if the quality of the nurse-patient interaction does affect the outcome of patient care.

(3) A task analysis of differences between the day and the evening shifts to determine adequate levels of staffing.

(4) Replication of the study after change has been instituted to determine effectiveness of the change.

(5) Replication of the study using special groups of patients such as obstetrical patients, psychiatric patients or avoided patients.

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APPENDICES

APPENDIX A

THE QUALITY PATIENT CARE SCALE

WAYNE STATE UNIVERSITY

College of Nursing

Date

QUALITY PATIENT CARE SCALE*

Qualpacs

Patient (name or No.):

Rater (name or No.):

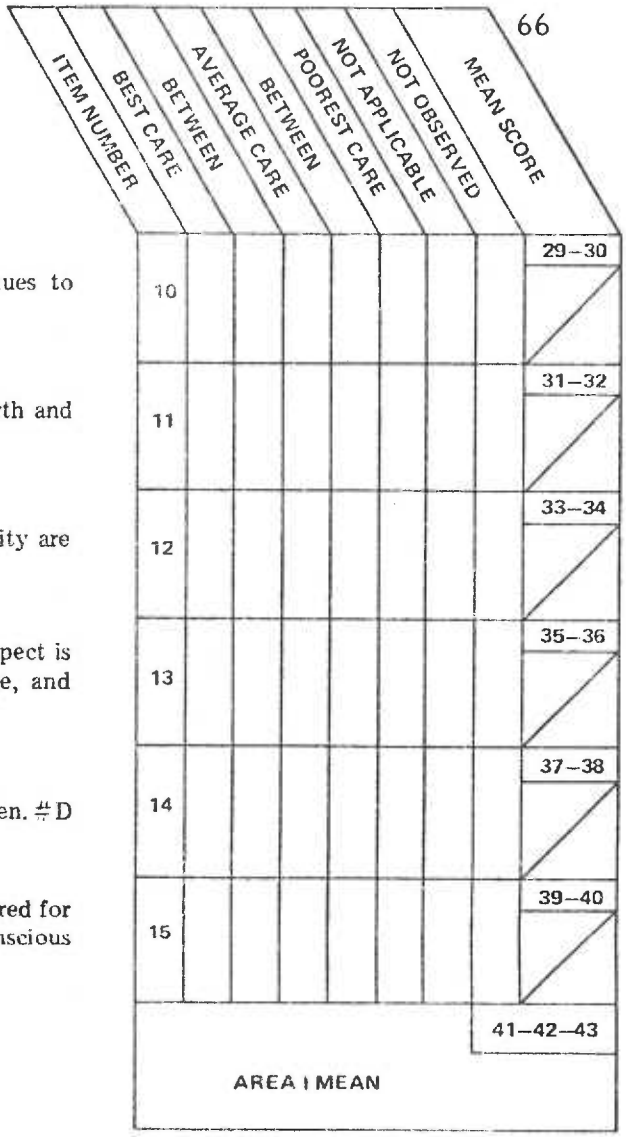
INTERACTIONS RECORD: AM/PM

No.:
Time:

PSYCHOSOCIAL: INDIVIDUAL

Actions directed toward meeting psychosocial needs of individual patients.

ITEM NUMBER	BEST CARE	BETWEEN	AVERAGE CARE	BETWEEN	POOREST CARE	NOT APPLICABLE	NOT OBSERVED	MEAN SCORE
1. Patient receives nurse's full attention. # D	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



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

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

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

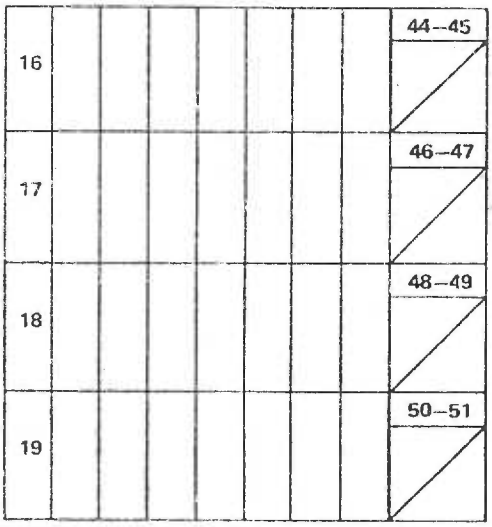
13. An atmosphere of trust, acceptance, and respect is created rather than one of power, prestige, and authority. # D

14. Appropriate topics for conversation are chosen. # D

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

PSYCHOSOCIAL: GROUP

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

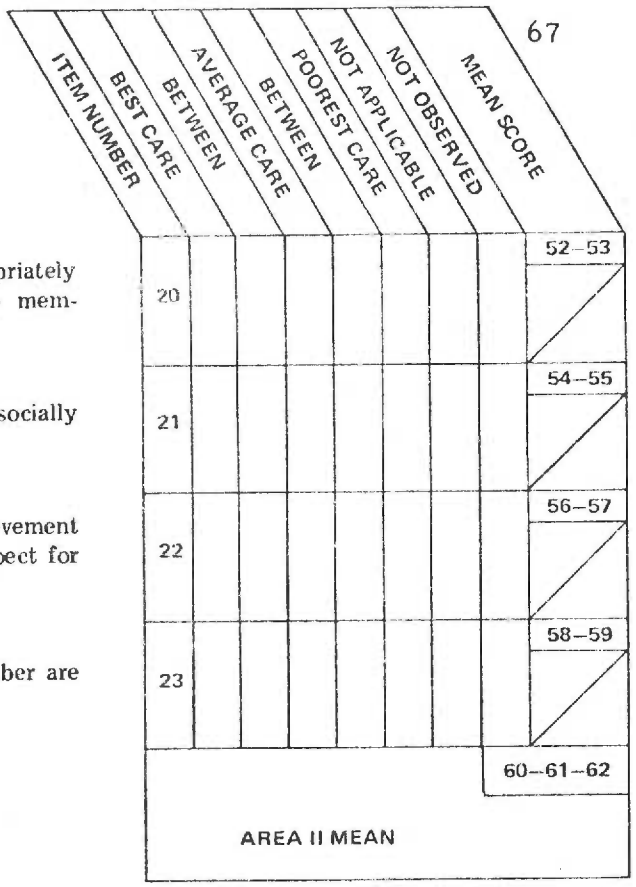


16. Patient as a member of a group receives warmth, interest, and attention from the staff. # D

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

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

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



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

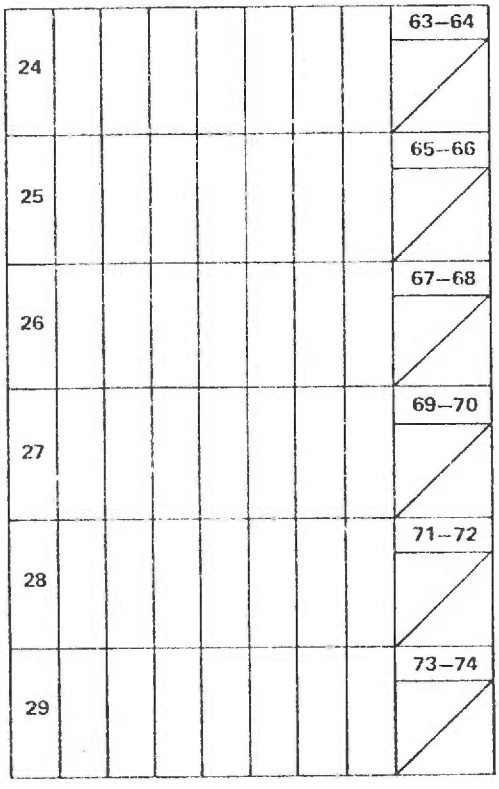
21. Patient is helped to vent his emotions in a socially acceptable way within the group. # D

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

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

PHYSICAL

Actions directed toward meeting physical needs of patients.



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

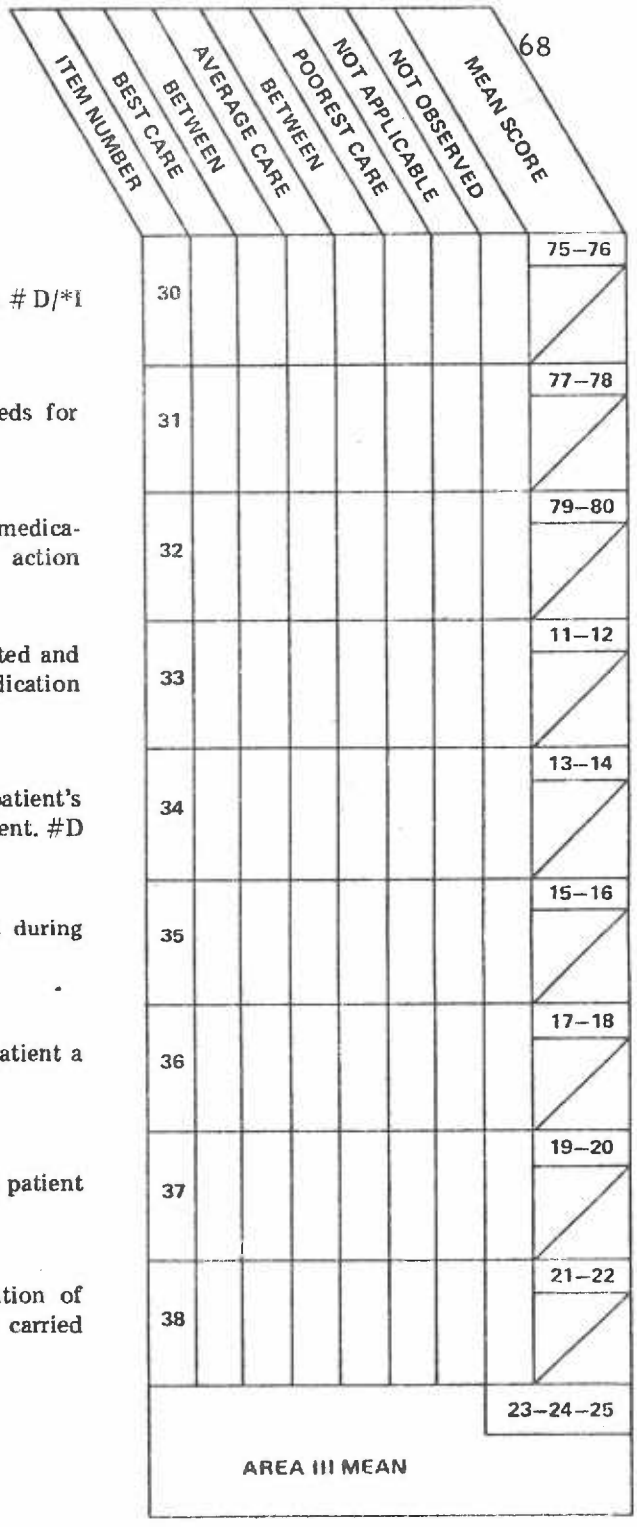
25. Patient's daily hygiene needs for cleanliness and acceptable appearance are met. # D

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

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

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

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



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

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

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

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

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

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

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

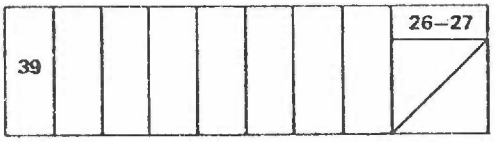
37. Safety measures are carried out to prevent patient from harming himself or others. # D

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

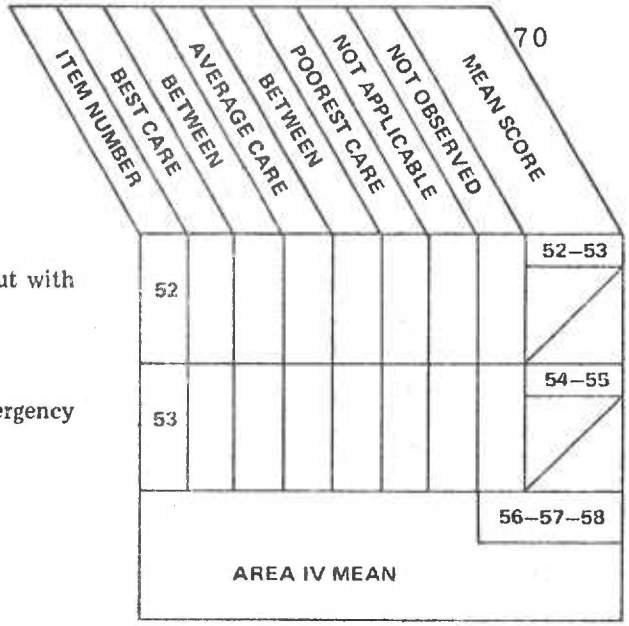
GENERAL

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

39. Patient receives instruction as necessary. # D



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

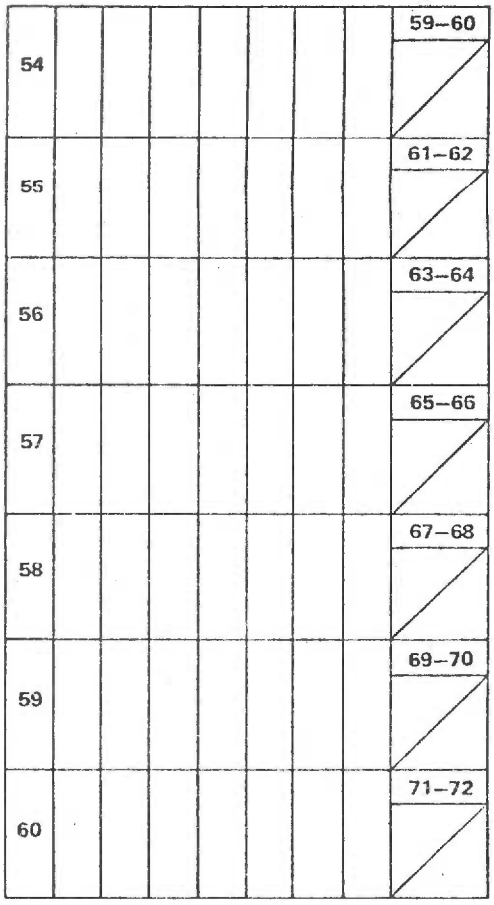


52. Close observation of the patient is carried out with minimal disturbance. # D

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

COMMUNICATION

Communication on behalf of the patient.



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

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

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

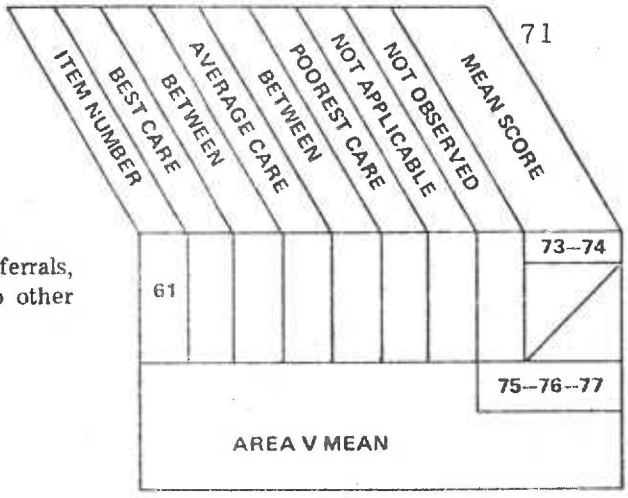
57. Well-developed nursing care plans are established and incorporated into nursing assignments. *I

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

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

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

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



PROFESSIONAL IMPLICATIONS

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

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

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

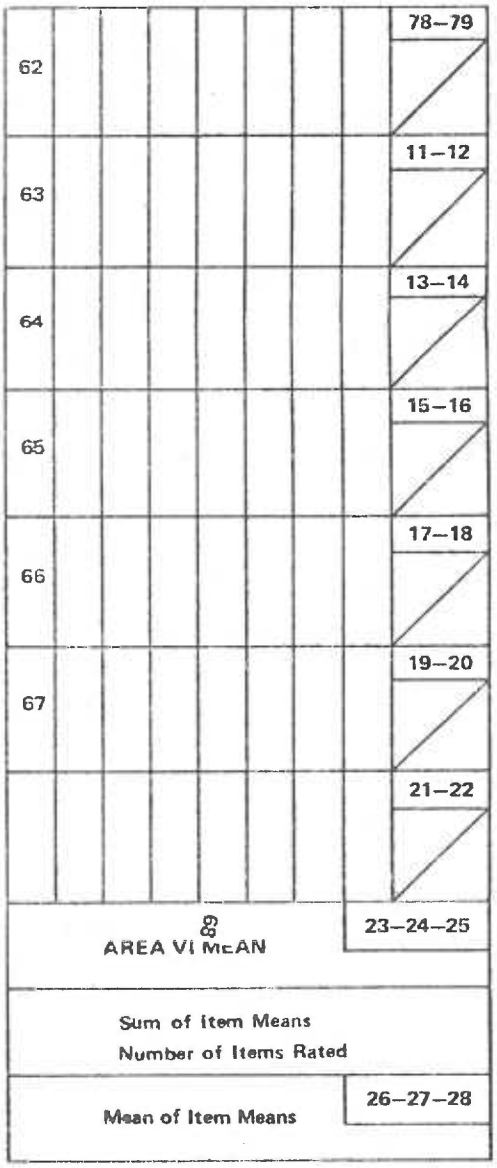
64. Changes in care and care plans reflect continuous evaluation of results of nursing care. # D/*I

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

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

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

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



APPENDIX B

CUE SHEETS

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 C

INDIVIDUAL FRAME OF REFERENCE

INDIVIDUAL FRAME OF REFERENCE

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

Slater Nursing Performance Rating Scale Rater _____

INDIVIDUAL FRAME OF REFERENCE CARD

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

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

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

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

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

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

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

APPENDIX D

A FACT SHEET ABOUT QUALPACS

QUALITY PATIENT CARE SCALE

A FACT SHEET ABOUT QUALPACS*

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

What

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

Conducted by the Department of Nursing

When

Date to *Date*

Why

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

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

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

How Will the Study Be Conducted?

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

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

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

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

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

**Developed by Kathlene F. Monahan*

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

Patient Information

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

What Help is Needed from Head Nurses?

A. Help in Identification and Selection of Patients

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

B. Introduction to Staff

Briefly explain that:

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

C. Introduction to Patients

A nurse who knows the patient should:

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

Schedule for Observation

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

APPENDIX E

THE INFORMATION FACE SHEET

and

THE RATER'S NOTES FOR ASSESSMENT AND PLANNING CARE

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 100

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 F

MEDICAL-SURGICAL QUALPACS ITEM MEANS

APPENDIX F

QUALITY PATIENT CARE SURVEY MEDICAL-SURGICAL QUALPACS ITEM MEANS

Qualpacs Item Number	Patient Identification Number																
	Medical Unit											Surgical Unit					
	50M	49M	48M	26M[1]	25M[1]	32M	10M	12M	13M	25M[2]	26M[2]	1S[1]	2S[1]	1S[2]	2S[2]	06S	22S
1	2.5	3.2	3.3	1.5	1.3	2.0	4.2	4.5	4.5	2.0	1.0	4.6	4.1	4.6	4.2	3.8	4.0
2	3.0	3.0	3.0	.0	1.0	.0	3.5	5.0	4.0	1.0	1.0	4.6	3.5	4.2	4.2	4.0	4.5
3	3.2	4.0	3.2	1.5	1.0	2.8	4.8	4.7	4.6	2.0	.0	5.0	4.4	5.0	4.6	4.3	4.3
4	.0	.0	4.0	.0	.0	.0	2.7	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
5	3.5	4.0	2.0	1.0	1.0	1.8	3.3	4.6	5.0	1.0	1.0	4.0	4.1	5.0	4.2	4.7	.0
6	4.0	3.0	3.0	1.0	1.0	2.2	2.8	4.5	4.4	1.3	1.0	5.0	3.4	5.0	4.0	4.5	5.0
7	2.5	3.3	3.8	1.0	1.3	2.0	3.7	4.7	4.6	2.3	1.0	3.8	3.6	5.0	4.6	3.8	3.9
8	3.5	.0	.0	2.0	.0	2.0	4.5	5.0	4.5	3.0	1.0	.0	.0	4.0	5.0	4.5	.0
9	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
10	.0	.0	4.0	.0	.0	1.6	2.3	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
11	4.0	3.7	3.2	1.0	1.0	2.0	3.8	4.5	4.4	2.0	1.0	4.2	3.9	4.6	5.0	3.4	4.0
12	.0	.0	.0	.0	.0	.0	4.0	.0	.0	.0	1.0	.0	4.7	5.0	4.2	4.3	5.0
13	4.0	2.5	3.3	.0	.0	2.0	3.7	4.5	4.8	.0	1.0	4.6	3.8	5.0	5.0	4.5	4.1
14	3.5	3.0	2.0	1.0	1.0	2.2	5.0	4.8	4.4	.0	.0	4.7	3.0	3.0	4.6	4.3	4.0
15	.0	.0	.0	1.0	1.0	.0	.0	.0	.0	2.8	1.0	.0	.0	.0	.0	.0	.0
Area Mean I	3.4	3.3	3.2	1.2	1.2	2.1	3.7	4.7	4.5	1.9	1.0	4.5	3.9	4.6	4.5	4.2	4.3
16	2.0	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	5.0	5.0	.0	.0
17	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
18	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
19	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
20	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
21	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
22	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0

APPENDIX F (continued)

Qualpacs Item Number	Patient Identification Number																
	Medical Unit												Surgical Unit				
	50M	49M	48M	26M[1]	25M[1]	32M	10M	12M	13M	25M[2]	26M[2]	1S[1]	2S[1]	1S[2]	2S[2]	06S	22S
23	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Area Mean II	1.3	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	5.0	5.0	.0	.0
24	5.0	.0	1.0	1.0	1.0	2.0	3.0	5.0	3.0	2.0	1.0	4.2	4.0	3.8	5.0	4.0	5.0
25	5.0	1.0	1.5	1.0	1.0	4.0	3.5	.0	1.3	2.0	1.0	5.0	5.0	.0	.0	3.2	1.0
26	3.0	2.2	4.0	1.0	1.3	4.0	3.0	4.7	4.6	1.3	.0	5.0	3.6	4.2	4.2	3.6	3.2
27	4.0	4.0	1.0	1.0	1.0	3.0	2.8	5.0	4.0	1.0	1.0	5.0	.0	5.0	5.0	5.0	4.1
28	.0	.0	.0	1.0	1.0	2.0	4.0	5.0	5.0	1.0	.0	5.0	.0	5.0	.0	5.0	4.2
29	3.0	4.0	1.0	1.0	1.5	1.0	4.0	5.0	.0	1.0	1.0	4.3	4.3	5.0	5.0	4.8	4.7
30	2.7	2.0	3.0	1.0	1.0	2.0	3.0	5.0	5.0	.0	.0	5.0	4.3	3.7	4.0	4.5	5.0
31	2.0	.0	2.5	1.0	1.0	5.0	2.0	5.0	3.0	3.0	1.0	5.0	4.0	4.0	5.0	4.0	4.5
32	.0	2.0	.0	1.0	.0	.0	3.3	5.0	5.0	.0	.0	3.5	.0	5.0	.0	4.0	.0
33	.0	.0	.0	.0	.0	.0	4.0	.0	.0	.0	.0	4.5	.0	5.0	.0	3.0	.0
34	1.0	.0	.0	1.0	1.0	4.0	3.5	2.0	1.0	3.0	1.0	3.5	3.0	3.0	2.6	2.0	1.0
35	.0	.0	.0	1.0	.0	.0	5.0	.0	.0	.0	.0	.0	5.0	.0	.0	2.0	.0
36	4.0	3.0	3.0	2.0	1.0	5.0	4.3	3.0	3.2	1.0	.0	5.0	3.8	3.0	5.0	5.0	5.0
37	4.0	3.0	2.5	3.0	.0	5.0	.0	2.0	1.2	.0	.0	5.0	3.5	.0	.0	2.0	5.0
38	.0	4.0	.0	1.0	1.0	.0	2.7	5.0	3.5	1.0	1.0	2.0	3.0	.0	.0	.0	.0
Area Mean III	3.4	2.8	2.2	1.2	1.1	3.4	3.4	4.3	3.3	1.6	1.0	4.4	4.0	4.3	4.5	3.7	3.9
39	4.0	3.5	4.0	4.0	.0	.0	2.5	4.8	4.5	.0	.0	4.5	4.3	5.0	4.0	3.3	.0
40	.0	.0	.0	4.0	.0	2.0	2.8	5.0	.0	3.5	.0	.0	.0	.0	.0	5.0	.0
41	3.0	.0	3.0	1.5	3.0	3.0	.0	4.6	4.0	.0	.0	4.6	.0	5.0	5.0	3.5	4.7
42	4.0	3.5	3.0	.0	1.0	.0	2.0	4.7	4.3	.0	3.0	3.8	3.1	4.0	4.8	4.3	5.0
43	.0	.0	.0	.0	.0	.0	.0	4.5	.0	.0	.0	.0	.0	.0	.0	5.0	.0
44	.0	.0	4.0	.0	.0	.0	.0	4.6	.0	.0	.0	5.0	5.0	.0	.0	3.0	.0
45	3.0	.0	2.0	.0	.0	.0	4.0	.0	.0	.0	.0	5.0	.0	5.0	5.0	3.5	.0

APPENDIX F (continued)

Qualpacs Item Number	Patient Identification Number																
	Medical Unit											Surgical Unit					
	50M	49M	48M	26M[1]	25M[1]	32M	10M	12M	13M	25M[2]	26M[2]	1S[1]	2S[1]	1S[2]	2S[2]	06S	22S
46	3.0	4.0	2.0	.0	2.0	3.0	4.0	.0	4.6	.0	.0	.0	.0	.0	5.0	.0	4.0
47	4.0	3.0	.0	.0	1.0	3.0	3.0	5.0	.0	.0	.0	5.0	5.0	.0	.0	5.0	.0
48	.0	.0	1.0	.0	.0	1.2	.0	4.5	.0	.0	.0	.0	.0	.0	.0	5.0	5.0
49	2.0	.0	2.0	1.0	1.0	1.0	.0	.0	4.3	2.0	.0	.0	.0	.0	.0	4.0	5.0
50	3.0	3.5	2.5	1.8	1.0	3.0	3.7	4.5	4.6	1.7	1.0	3.2	4.2	4.0	5.0	3.2	5.0
51	3.0	3.0	2.5	1.2	1.0	1.5	3.7	4.4	3.2	1.3	1.0	3.2	4.0	3.2	3.2	3.8	4.3
52	.0	2.0	.0	1.5	2.0	1.6	4.3	4.6	4.5	2.3	1.0	4.0	4.3	.0	.0	3.0	5.0
53	.0	.0	.0	.0	1.0	.0	.0	.0	.0	2.0	.0	.0	.0	.0	.0	.0	.0
Area Mean IV	3.2	3.2	2.6	2.1	1.4	2.2	3.3	4.7	4.3	2.1	1.5	4.3	4.3	4.4	4.6	4.0	4.7
54	1.0	.0	.0	.0	.0	1.5	3.0	4.6	4.0	.0	1.0	3.6	3.6	5.0	5.0	5.0	5.0
55	.0	.0	.0	4.0	.0	2.0	2.8	.0	3.0	3.5	1.0	.0	.0	4.0	5.0	4.0	.0
56	2.0	1.0	2.0	1.0	2.0	2.0	3.0	4.5	3.5	1.0	1.0	4.3	3.6	5.0	5.0	.0	5.0
57	1.0	1.0	1.0	1.0	1.0	2.0	1.0	4.5	4.3	2.0	1.0	4.5	4.0	4.0	4.0	1.0	4.0
58	1.0	.0	2.0	2.0	1.0	.0	.0	.0	.0	5.0	.0	.0	.0	.0	5.0	3.0	.0
59	.0	.0	.0	.0	.0	2.0	3.0	.0	.0	.0	.0	4.5	5.0	5.0	5.0	5.0	5.0
60	.0	4.0	.0	4.0	.0	3.0	4.0	4.5	.0	.0	4.0	.0	.0	.0	5.0	3.0	.0
61	.0	4.0	.0	4.0	.0	4.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Area Mean V	1.3	2.5	1.7	2.7	1.3	2.4	2.8	4.5	3.7	2.4	1.4	4.1	4.1	4.6	4.9	3.5	4.7
62	3.0	3.5	3.0	1.0	1.0	1.3	3.0	5.0	4.3	3.2	1.0	4.0	4.5	5.0	5.0	3.3	3.8
63	3.0	3.0	2.0	1.0	1.0	1.0	2.5	5.0	4.0	3.7	.0	3.0	4.5	5.0	5.0	3.0	4.6
64	2.3	3.0	1.0	1.0	1.0	2.0	3.0	5.0	.0	3.3	1.0	4.0	4.0	5.0	5.0	3.7	5.0
65	2.3	2.8	2.6	1.0	1.0	1.7	4.0	5.0	4.5	2.8	1.0	4.3	5.0	5.0	5.0	4.3	4.5
66	1.5	3.0	2.5	2.0	1.3	2.0	4.3	4.0	3.0	2.3	1.0	5.0	5.0	5.0	5.0	4.0	5.0
67	.0	.0	4.0	3.0	.0	1.0	4.5	.0	.0	5.0	4.0	.0	.0	.0	5.0	5.0	.0
68	3.0	2.0	2.0	1.0	1.0	2.0	3.0	4.0	2.0	4.3	1.0	4.7	5.0	5.0	5.0	5.0	5.0
Area Mean VI	2.5	2.9	2.3	1.4	1.1	1.8	3.5	4.7	3.6	3.5	1.5	4.2	4.7	5.0	5.0	4.0	4.6
Grand Mean	2.9	3.0	2.5	1.6	1.1	2.4	3.4	4.6	3.9	2.2	1.2	4.4	4.1	4.6	4.7	3.9	4.4

APPENDIX G

DAY-EVENING QUALPACS ITEM MEANS

APPENDIX G

QUALITY PATIENT CARE SURVEY DAY-EVENING QUALPACS ITEM MEANS

Qualpacs Item Number	Patient Identification Number																
	Day Shift								Evening Shift								
	50M	49M	48M	26M	25M[1]	32M	1S[1]	2S[1]	1S[2]	2S[2]	06S	22S	10M	12M	13M	25M[2]	26M[2]
1	2.5	3.2	3.3	1.5	1.3	2.0	4.6	4.1	4.6	4.2	3.8	4.0	4.2	4.5	4.6	2.0	1.0
2	3.0	3.0	3.0	.0	1.0	.0	4.6	3.5	4.2	4.2	4.0	4.5	3.5	5.0	4.0	1.0	1.0
3	3.2	4.0	3.2	1.5	1.0	2.8	5.0	4.4	5.0	4.6	4.3	4.3	4.8	4.7	4.6	2.0	.0
4	.0	.0	4.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	2.7	.0	.0	.0	.0
5	3.5	4.0	2.0	1.0	1.0	1.8	4.0	4.1	5.0	4.2	4.7	.0	3.3	4.6	5.0	1.0	1.0
6	4.0	3.0	3.0	1.0	1.0	2.2	5.0	3.4	5.0	4.0	4.5	5.0	2.8	4.5	4.4	1.3	1.0
7	2.5	3.3	3.8	1.0	1.3	2.0	3.8	3.6	5.0	4.6	3.8	3.9	3.7	4.7	4.6	2.3	1.0
8	3.5	.0	.0	2.0	.0	2.0	.0	.0	4.0	5.0	4.5	.0	4.5	5.0	4.5	3.0	1.0
9	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
10	.0	.0	4.0	.0	.0	1.6	.0	.0	.0	.0	.0	.0	2.3	.0	.0	.0	.0
11	4.0	3.7	3.2	1.0	1.0	2.0	4.2	3.9	4.6	5.0	3.4	4.0	3.8	4.5	4.4	2.0	1.0
12	.0	.0	.0	.0	.0	.0	.0	4.7	5.0	4.2	4.3	5.0	4.0	.0	.0	.0	.0
13	4.0	2.5	3.3	.0	.0	2.0	4.6	3.8	5.0	5.0	4.5	4.1	3.7	4.5	4.8	.0	1.0
14	3.5	3.0	2.0	1.0	1.0	2.2	4.7	3.0	3.0	4.6	4.3	4.0	5.0	4.8	4.4	.0	.0
15	.0	.0	.0	1.0	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	2.8	1.0
Area Mean I	3.4	3.3	3.2	1.2	1.1	2.6	4.5	3.9	4.6	4.5	4.2	4.3	3.7	4.7	4.5	1.9	1.0
16	2.0	1.0	.0	.0	.0	.0	.0	.0	5.0	5.0	.0	.0	.0	.0	.0	.0	.0
17	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
18	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
19	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
20	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
21	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
22	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
23	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0

APPENDIX G (continued)

Qualpacs Item Number	Patient Identification Number																
	Day Shift								Evening Shift								
	50M	49M	48M	26M	25M[1]	32M	1S[1]	2S[1]	1S[2]	2S[2]	06S	22S	10M	12M	13M	25M[2]	26M[2]
Area Mean II	1.3	1.0	.0	.0	.0	.0	.0	.0	5.0	5.0	.0	.0	.0	.0	.0	.0	.0
24	5.0	.0	1.0	1.0	1.0	2.0	4.2	4.0	3.8	5.0	4.0	5.0	3.0	5.0	3.0	2.0	1.0
25	5.0	1.0	1.5	1.0	1.0	4.0	5.0	5.0	.0	.0	3.2	1.0	3.5	.0	1.3	2.0	1.0
26	3.0	2.2	4.0	1.0	1.3	4.0	5.0	3.6	4.2	4.2	3.6	3.2	3.0	4.7	4.6	1.3	.0
27	4.0	4.0	1.0	1.0	1.0	3.0	5.0	.0	5.0	5.0	5.0	4.1	2.8	5.0	4.0	1.0	1.0
28	.0	.0	.0	1.0	1.0	2.0	5.0	.0	5.0	.0	5.0	4.2	4.0	5.0	5.0	1.0	.0
29	3.0	4.0	1.0	1.0	1.5	1.0	4.3	4.3	5.0	5.0	4.8	4.7	4.0	5.0	.0	1.0	1.0
30	2.7	2.0	3.0	1.0	1.0	2.0	5.0	4.3	3.7	4.0	4.5	5.0	3.0	5.0	5.0	.0	.0
31	2.0	.0	2.5	1.0	1.0	5.0	5.0	4.0	4.0	5.0	4.0	4.5	2.0	5.0	3.0	3.0	1.0
32	.0	2.0	.0	1.0	.0	.0	3.5	.0	5.0	.0	4.0	.0	3.3	5.0	5.0	.0	.0
33	.0	.0	.0	.0	.0	.0	4.5	.0	5.0	.0	3.0	.0	4.0	.0	.0	.0	.0
34	1.0	.0	.0	1.0	1.0	4.0	3.5	3.0	3.0	2.6	2.0	1.0	3.5	2.0	1.0	3.0	1.0
35	.0	.0	.0	1.0	.0	.0	.0	5.0	.0	.0	2.0	.0	5.0	.0	.0	.0	.0
36	4.0	3.0	3.0	2.0	1.0	5.0	5.0	3.8	3.0	5.0	5.0	5.0	4.3	3.0	3.2	1.0	.0
37	4.0	3.0	2.5	3.0	.0	5.0	5.0	3.5	.0	.0	2.0	5.0	.0	2.0	1.2	.0	.0
38	.0	4.0	.0	1.0	1.0	.0	2.0	3.0	.0	.0	.0	.0	2.7	5.0	3.5	1.0	1.0
Area Mean III	3.4	2.8	2.2	1.2	1.1	3.4	4.4	4.0	4.3	4.5	3.7	3.9	3.4	4.3	3.3	1.6	1.0
39	4.0	3.5	4.0	4.0	.0	.0	4.5	4.3	5.0	4.0	3.3	.0	2.5	4.8	4.5	.0	.0
40	.0	.0	.0	4.0	.0	2.0	.0	.0	.0	.0	5.0	.0	2.8	5.0	.0	3.5	.0
41	3.0	.0	3.0	1.5	3.0	3.0	4.6	.0	5.0	5.0	3.5	4.7	.0	4.6	4.0	.0	.0
42	4.0	3.5	3.0	.0	1.0	.0	3.8	3.1	4.0	4.8	4.3	5.0	2.0	4.7	4.3	.0	3.0
43	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	5.0	.0	.0	4.5	.0	.0	.0
44	.0	.0	4.0	.0	.0	.0	5.0	5.0	.0	.0	3.0	.0	.0	4.6	.0	.0	.0
45	3.0	.0	2.0	.0	.0	.0	5.0	.0	5.0	5.0	3.5	.0	4.0	.0	.0	.0	.0
46	3.0	4.0	2.0	.0	2.0	3.0	.0	.0	.0	5.0	.0	4.0	4.0	.0	4.6	.0	.0

APPENDIX G (continued)

Qualpacs Item Number	Patient Identification Number																
	Day Shift								Evening Shift								
	50M	49M	48M	26M	25M[1]	32M	1S[1]	2S[1]	1S[2]	2S[2]	06S	22S	10M	12M	13M	25M[2]	26M[2]
47	4.0	3.0	.0	.0	1.0	3.0	5.0	5.0	.0	.0	5.0	.0	3.0	5.0	.0	.0	.0
48	.0	.0	1.0	.0	.0	1.2	.0	.0	.0	.0	5.0	5.0	.0	4.5	.0	.0	.0
49	2.0	.0	2.0	1.0	1.0	1.0	.0	.0	.0	.0	4.0	5.0	.0	.0	4.3	2.0	.0
50	3.0	3.5	2.5	1.8	1.0	3.0	3.2	4.2	.0	5.0	3.2	5.0	3.7	4.5	4.6	1.7	1.0
51	3.0	3.0	2.5	1.2	1.0	1.5	3.2	4.0	4.0	3.2	3.8	4.3	3.7	4.4	3.2	1.3	1.0
52	.0	2.0	.0	1.5	2.0	1.6	4.0	4.3	3.2	.0	3.0	5.0	4.3	4.6	4.5	2.3	1.0
53	.0	.0	.0	.0	1.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	2.0	1.0
Area Mean IV	3.2	3.2	2.6	2.1	1.4	2.2	4.3	4.3	4.4	4.6	4.0	4.7	3.3	4.7	4.3	2.1	1.5
54	1.0	.0	.0	.0	.0	1.5	3.6	3.6	5.0	5.0	5.0	5.0	3.0	4.6	4.0	.0	1.0
55	.0	.0	.0	4.0	.0	2.0	.0	.0	4.0	5.0	4.0	.0	2.8	.0	3.0	3.5	1.0
56	2.0	1.0	2.0	1.0	2.0	2.0	4.3	3.6	5.0	5.0	.0	5.0	3.0	4.5	3.5	1.0	1.0
57	1.0	1.0	1.0	1.0	1.0	2.0	4.5	4.0	4.0	4.0	1.0	4.0	1.0	4.5	4.3	2.0	1.0
58	1.0	.0	2.0	2.0	1.0	.0	.0	.0	.0	5.0	3.0	.0	.0	.0	.0	5.0	.0
59	.0	.0	.0	.0	.0	2.0	4.5	5.0	5.0	5.0	5.0	5.0	3.0	.0	.0	.0	.0
60	.0	4.0	.0	4.0	.0	3.0	.0	.0	.0	5.0	3.0	.0	4.0	4.5	.0	.0	4.0
61	.0	4.0	.0	4.0	.0	4.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Area Mean V	1.3	2.5	1.7	2.7	1.3	2.4	4.4	4.1	4.6	4.9	3.5	4.7	2.8	4.5	3.7	2.4	1.4
62	3.0	3.5	3.0	1.0	1.0	1.3	4.0	4.5	5.0	5.0	3.3	3.8	3.0	5.0	4.3	3.2	1.0
63	3.0	3.0	2.0	1.0	1.0	1.0	3.0	4.5	5.0	5.0	3.0	4.6	2.5	5.0	4.0	3.7	.0
64	2.3	3.0	1.0	1.0	1.0	2.0	4.0	4.0	5.0	5.0	3.7	5.0	3.0	5.0	.0	3.3	1.0
65	2.3	2.8	2.6	1.0	1.0	1.7	4.3	5.0	5.0	5.0	4.3	4.5	4.0	5.0	4.5	2.8	1.0
66	1.5	3.0	2.5	2.0	1.3	2.0	5.0	5.0	5.0	5.0	4.0	5.0	4.3	4.0	3.0	2.3	1.0
67	.0	.0	4.0	3.0	.0	1.0	.0	.0	.0	5.0	5.0	.0	4.5	.0	.0	5.0	4.0
68	3.0	2.0	2.0	1.0	1.0	2.0	4.7	5.0	5.0	5.0	5.0	5.0	3.0	4.0	2.0	4.3	1.0
Area Mean VI	2.5	2.9	2.3	1.4	1.1	1.8	4.2	4.7	5.0	5.0	4.0	4.6	3.5	4.7	3.6	3.5	1.5
Grand Mean	2.9	3.0	2.5	1.6	1.1	2.4	4.4	4.1	4.6	4.7	3.9	3.8	3.4	4.6	3.9	2.2	1.2

APPENDIX H

COMPOSITE MEANS OF ITEM MEANS

APPENDIX H

QUALITY PATIENT CARE SURVEY
COMPOSITE MEAN OF ITEM MEANS

Qualpacs Item Number	Day Shift	Evening Shift	Medical Unit	Surgical Unit	All Observations
1	2.8	3.7	2.7	4.2	3.3
2	3.0	3.5	2.7	4.2	3.3
3	3.1	4.3	3.2	4.6	3.7
4	4.0	2.7	3.4	.0	3.4
5	2.7	3.6	2.6	4.4	3.1
6	2.8	3.6	2.6	4.5	3.2
7	2.7	3.7	2.7	4.1	3.2
8	2.5	3.9	3.2	4.5	3.5
9	.0	.0	.0	.0	.0
10	2.8	2.3	2.6	.0	2.6
11	2.9	3.6	2.8	4.8	3.3
12	4.7	4.5	4.0	4.7	4.5
13	3.7	4.1	3.2	4.5	3.8
14	2.6	4.3	3.0	3.9	3.4
15	1.0	1.9	1.5	.0	1.5
16	1.5	5.0	1.5	5.0	3.5
17	.0	.0	.0	.0	.0
18	1.0	.0	1.0	.0	1.0
19	1.0	.0	1.0	.0	1.0
20	.0	.0	.0	.0	.0
21	.0	.0	.0	.0	.0
22	.0	.0	.0	.0	.0
23	.0	.0	.0	.0	.0
24	2.6	3.5	2.4	4.3	3.1
25	2.9	2.0	2.1	3.6	2.5
26	3.0	3.6	2.9	4.0	3.3
27	2.7	3.7	2.5	4.8	3.2
28	2.3	4.2	2.7	4.9	3.5
29	2.5	3.8	2.2	4.7	3.2
30	2.6	4.3	2.7	4.4	3.4
31	2.9	3.5	2.6	4.4	3.3
32	2.2	4.6	3.3	4.2	3.6
33	4.5	4.0	4.0	4.2	4.1
34	2.3	2.1	1.9	2.5	2.2
35	3.0	3.5	3.0	3.5	3.3

APPENDIX H (continued)

Qualpacs Item Number	Day Shift	Evening Shift	Medical Unit	Surgical Unit	All Observations
36	3.4	3.7	3.0	4.5	3.5
37	3.3	2.6	2.9	3.9	3.3
38	2.2	2.6	2.4	2.5	2.4
39	4.1	3.5	3.9	4.2	4.0
40	3.0	4.1	2.9	5.0	3.7
41	3.0	4.5	3.2	4.6	3.7
42	3.1	4.0	2.9	4.2	3.6
43	.0	4.8	4.5	5.0	4.8
44	4.7	3.8	4.3	4.3	4.3
45	3.3	4.4	3.0	4.6	3.9
46	2.8	4.4	3.2	4.5	3.5
47	3.5	4.3	3.2	5.0	3.8
48	1.1	4.8	2.2	5.0	3.3
49	1.4	3.8	1.9	4.5	2.5
50	2.8	3.6	2.8	4.1	3.2
51	2.4	3.1	2.3	3.6	2.8
52	2.6	3.5	2.6	4.1	3.1
53	1.0	2.0	1.5	.0	1.5
54	2.4	4.1	2.5	4.5	3.5
55	3.0	3.3	2.7	4.3	3.3
56	2.2	3.5	2.1	4.6	2.9
57	1.9	2.9	1.8	4.3	2.4
58	1.5	4.3	2.2	4.0	2.7
59	3.8	4.6	2.5	4.9	4.3
60	3.7	4.2	3.9	4.0	3.9
61	4.0	.0	4.0	.0	4.0
62	2.7	3.7	2.7	4.3	3.2
63	2.3	4.1	2.6	4.2	3.2
64	2.3	3.9	2.3	4.5	3.1
65	2.3	4.0	2.6	4.7	4.7
66	2.8	3.7	2.4	4.8	3.3
67	2.7	4.7	3.6	5.0	3.9
68	2.6	3.8	2.3	4.9	3.2

APPENDIX I

CRITICAL VALUES OF U IN THE MANN-WHITNEY TEST OF DIFFERENCES FOR QUALPACS ITEMS

APPENDIX I

QUALITY PATIENT CARE SURVEY

CRITICAL VALUES OF U IN THE MANN-WHITNEY TEST OF DIFFERENCES FOR QUALPACS ITEMS

Qualpacs Item No.	Med/Surg Units				Day/Evening Shift			
	N_1	N_2	U	p	N_1	N_2	U	p
1	6	11	13	.02	8	9	10.5	.05
2	6	9	8	.02	6	9	22	.10
3	6	10	12	.05	8	8	13.5	.05
4	0	2	ID*		1	1	ID*	
5	5	11	8	.05	8	8	19.5	.20
6	6	11	5.5	.02	8	9	23.5	NS**
7	6	11	12.5	.05	8	9	15	.05
8	3	8	5.5	.27	3	8	4	.134
9	0	0	ID*		0	0	ID*	
10	0	3	ID*		1	2	ID*	
11	6	11	7	.02	8	9	20.5	.10
12	1	5	6	NS**	1	5	2	NS**
13	6	8	8	.042	6	8	12	.14
14	6	9	23	NS**	7	8	7	.014
15	0	4	ID*		2	2	ID*	
16	2	2	ID*		2	2	ID*	
17	0	0	ID*		0	0	ID*	
18	0	1	ID*		0	1	ID*	
19	0	1	ID*		0	1	ID*	
20	0	0	ID*		0	0	ID*	
21	0	0	ID*		0	0	ID*	
22	0	0	ID*		0	0	ID*	
23	0	0	ID*		0	0	ID*	
24	6	10	9	.05	7	9	23.5	NS**
25	4	10	11.5	NS**	6	8	8.5	.128
26	6	10	16	NS**	8	8	15.5	.104
27	5	11	2	.002	7	9	20	NS**
28	4	7	5	.11	4	7	7	.15
29	6	10	5	.02	8	8	13.5	.05
30	6	9	10	.05	7	8	10.5	.05
31	6	10	10	.05	7	9	26	NS**
32	3	5	5	.57	3	5	1	.072
33	1	3	ID*		1	3	ID*	
34	6	9	19	NS**	6	9	25.5	NS**

APPENDIX I (continued)

Qualpacs Item No.	Med/Surg Units N_1	N_2	U	p	Day/Evening Shift N_1	N_2	U	p
35	2	2	ID*		2	2	ID*	
36	6	10	11	.05	8	8	28.5	NS**
37	4	7	8.5	.41	4	7	8	.31
38	2	8	7	NS**	5	5	13.5	NS**
39	5	7	13	NS**	6	6	16	NS**
40	2	4	ID*		1	5	2	.53
41	5	7	2.5	.018	6	6	2.5	.016
42	6	8	11.5	.142	6	8	10	.082
43	1	1	ID*		0	2	ID*	
44	2	3	ID*		2	3	ID*	
45	3	4	1	.114	3	4	8	NS**
46	2	7	1	.11	4	5	1	.032
47	3	6	1.5	.048	3	6	6	NS**
48	2	3	0	.20	2	3	0	.20
49	2	7	1	.11	4	5	1	.032
50	6	11	12	.05	8	9	9.5	NS**
51	6	11	10.5	.05	8	9	11	.02
52	4	9	8.5	NS**	6	7	10.5	.18
53	0	2	ID*		1	1	ID*	
54	6	6	4	.026	4	8	5	.11
55	3	6	1	.048	2	7	4	NS**
56	5	11	2	.002	8	8	18	.16
57	6	11	16	.05	8	9	25	NS**
58	2	5	1.5	.38	3	4	0	.056
59	2	6	0	.072	3	5	4	.19
60	2	6	5.5	NS**	3	5	5.5	NS**
61	0	3	ID*		0	3	ID*	
62	6	11	9	.02	8	9	20	NS**
63	6	10	11	.05	8	8	8.5	.014
64	6	10	5	.02	8	8	13	.05
65	6	11	6	.02	8	9	15	.05
66	6	11	1.5	.002	8	9	23.5	NS**
67	2	6	1	.142	3	5	0.5	.072
68	6	11	0	.002	8	9	20	NS**

* Insufficient data to obtain a critical value for U.

** Nonsignificant U with no specific numerical value available.

APPENDIX J

QUALITY OF PATIENT CARE SURVEY
COMPARATIVE STAFFING LEVELS FOR THE MEDICAL AND THE SURGICAL UNITS ON THE EVENING SHIFT

APPENDIX J

QUALITY PATIENT CARE SURVEY

COMPARATIVE STAFFING LEVELS FOR THE MEDICAL AND THE SURGICAL UNITS ON EVENING SHIFT

	Day of Survey									
	Medical Unit					Surgical Unit				
	1	2	3	Total of 3 Days	Average During Survey	1	2	3	Total of 3 Days	Average During Survey
Patient Census	31	33	31	95	31.66	21	18	16	55	18.33
Total Staff	7.6	7.6	7.3	22.5	7.5	5.2	4.8	3.8	13.8	4.6
RN Staff	3.6	3.7	3.0	10.3	3.43	2.2	2.1	2.0	6.3	2.1
Other Staff	4.0	3.9	4.3	12.2	4.06	3.0	2.7	1.8	7.5	2.5
Pts/staff Members	4.07	4.34	4.24	12.65	4.21	4.3	3.75	4.21	12.26	4.08
Staff time/pt. (hrs)	1.96	1.84	1.88	5.68	1.89	1.86	2.13	1.90	5.89	1.96
Pts/RN	8.61	8.91	10.33	27.85	9.28	9.54	8.57	8.0	26.11	8.7
RN time/pt. (hrs)	.92	.89	.77	2.58	.86	.83	.93	1.0	2.76	.92
Pt./Other	7.75	8.46	7.20	23.41	7.8	7.0	6.66	8.88	22.54	7.51
Other time/pt (hrs)	1.03	.94	1.11	3.08	1.02	1.14	1.2	.90	3.24	1.08

APPENDIX K

QUALITY PATIENT CARE SURVEY
COMPARATIVE STAFFING LEVELS FOR
THE MEDICAL AND THE SURGICAL UNITS ON DAY SHIFT

APPENDIX K

QUALITY PATIENT CARE SURVEY

COMPARATIVE STAFFING LEVELS FOR THE MEDICAL AND THE SURGICAL UNITS ON DAY SHIFT

	Day of Survey									
	Medical Unit					Surgical Unit				
	1	2	3	Total of 3 Days	Average During Survey	1	2	3	Total of 3 Days	Average During Survey
Patient Census	31	33	31	95	31.66	21	18	16	55	18.33
Total Staff	9.4	9.5	8.4	27.3	9.1	6.8	6.3	5.9	19	6.33
RN Staff	3.0	2.5	2.0	7.5	2.5	1.4	2.3	2	5.7	1.9
Other Staff	6.4	7.0	6.4	19.8	6.6	5.4	4.0	3.9	13.3	4.43
Pts/Staff Member	3.29	3.47	3.69	10.45	3.48	3.08	2.85	2.71	8.7	2.9
Staff time/Pt. (hrs)	2.43	2.3	2.16	6.89	2.29	2.59	2.8	2.95	8.34	2.78
Pts/RN	10.33	13.2	15.5	39.03	13.01	15	7.82	8	30.82	10.27
RN time/Pt. (hrs)	.77	.60	.51	1.88	.62	.53	1.02	1	2.55	.85
Pt./Other	4.84	4.71	4.84	14.39	4.79	3.88	4.5	4.1	12.48	4.16
Other time/Pt. (hrs)	1.65	1.69	1.65	4.99	1.66	2.06	1.77	1.95	5.78	1.92

AN ABSTRACT OF THE FIELD STUDY OF

Peggy N.M. Preston

For the MASTER OF NURSING

Date of receiving this degree: June 10, 1976

Title: SURVEY OF THE QUALITY OF PATIENT CARE IN A COMMUNITY HOSPITAL

Approved [redacted]
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The purpose of this evaluative study was to investigate the quality of patient care in a community hospital in order to determine areas of strengths and weakness in the patient care delivery system as the first step of a problem solving process. The determination of the quality of nursing care will be used for decision making about needed direction for change. It was an additional purpose of this investigation to provide a baseline for evaluation of subsequent changes.

The two nurse raters conducted a pilot study to establish the interrater reliability. The survey sample involved 17 two-hour observation periods over a three day period. Nine of these observations were made on the 3-11 shift and eight observations were made on the 7-3 shift. Patients to be observed were randomly chosen. The data collecting instrument was Wandelt's and Ager's Quality Patient Care Scale (1974). The 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 the best care.

There were four hypotheses made prior to the survey. The first hypothesis: There will be no significant differences in Grand mean scores on the Qualpacs between the medical and the surgical units, was not accepted. The second hypothesis: There will be no significant differences in the Area Mean scores on the Qualpacs between the medical and the surgical units, was rejected. The third hypothesis: There will be no significant differences in Grand Mean scores on the Qualpacs during the day shift than during the evening shift, was accepted. The fourth hypothesis: There will be no significant differences in the Area Mean scores on the Qualpacs during the day shift than during the evening shift, was rejected.

The conclusions to be drawn from this research were that the quality of care did vary between the medical and the surgical units and also between the day shift and the evening shift. But besides pointing out where differences in the quality of care existed, the study points to components of care where excellence existed and also to care components where the quality was withing the level of concern.