A STUDY OF THE ABILITIES OF SIXTY SEVEN PATIENTS AND OF THE REHABILITATIVE SERVICES PROVIDED IN TWENTY THREE NURSING HOMES IN OREGON AND WASHINGTON AS EXPRESSED BY TWENTY THREE REGISTERED NURSES

by

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INTRODUCTION

Introduction to the Problem

The aged in our population are becoming more of a concern to all individuals in these United States. The total population has doubled since 1900; the population of those over sixty five has nearly quadrupled.[34] The added years of life for an increased number of people has also increased the number of persons with chronic illness and its incidence is especially high among the aged.

This study is primarily concerned with the chronically ill aged patient in the nursing home. These patients have needs common to all humans and each individual seeks to satisfy these needs regardless of age. The individual seeks to do things on his own and to assume responsibility for his own action. It is with the need for independence that this study is centered. If a "self-care" philosophy exists in the care of the chronically ill, the possibility of caring for an increased number of persons is enhanced.

Nursing care that embraces rehabilitation recognizes the dignity and worth of man. Rehabilitation has the objective of providing services for the disabled individual that will help him to help himself to his fullest potentialities. It is an important means for increasing independence, dignity,

and self-respect, by providing help toward the restoration of capacity among the chronically ill aged patient.[39]

Statement of the Problem

Since the nursing home is a facility used to meet the needs of the aged patient, this study will seek to determine if the nursing home promotes the independence of the patient.

The specific purpose of this study is to ascertain from the registered nurse in the nursing home the following:

1. What are the abilities of the patient in relation to certain activities of daily living?

2. What rehabilitative services are used to improve the patient's level of ability?

Justification of the Study

This study is concerned with the improvement of the nursing home patient's abilities and the rehabilitative services used to promote the improvement of the patient's abilities. Florence Nightingale implied that the patient should be no worse for having been nursed.[29] This is equally true in 1963. The patient should be helped to "do as much as he can, as well as he can, as long as he can," according to Ruth Hubbard.[40]

The findings of this study may be of value to nurses caring for the nursing home patients and to other personnel working in cooperation with nurses in improving the abilities of those patients. This study may be helpful to those considering the improvement of nursing care for the nursing home patients.

Definition of Terms

For the purpose of clarification the following definitions will be used throughout this study:

1. Rehabilitation means the achievement and/or maintenance of the level of physical, mental, social, economic, and vocational functioning of which a person is reasonably capable following illness, injury, or conditions attendant with aging.[42] Simply, the promotion of self-help.

2. Rehabilitative services include all direct and definable indirect services of personnel, facilities and equipment which are provided to assist the patient toward rehabilitation.[42] These services promote self help and tend to improve the patient's level of ability toward independent living.

3. Nursing home means any home, place or institution, duly licensed, which operates and maintains facilities providing convalescent or chronic care, or both, for a period exceeding twenty four hours for two or more ill or infirm patients not related to the nursing home administrator or owner by blood or marriage.[35]

4. "Nursing in its broadest sense may be defined as an Art and a Science which involves the whole patient; promotes his spiritual, mental, and physical health by teaching and example; stresses health education and health preservation, as well as ministration to the sick; involves the care of the patient's environment--social and spiritual as well as the physical; and gives health service to the family and community as well as to the individual."[31]

5. Nursing care is the assistance provided a patient when for some reason he cannot provide for the satisfaction of his own needs: It is derived from a study of the patient's requirements for nursing care and is directed toward making the patient better able to help himself.[1]

6. The Registered Nurse in the nursing home refers to a duly licensed professional nurse who is responsible for directing the nursing care of the patients.

7. Chronic illness refers to a disease or injury which lasts over six weeks, which is apt to be progressive or not totally curable, and which makes real changes in the person's life pattern necessary.[17]

8. The level of patient ability relates to the degree of independence at which the patient functions or any improvement which enables the individual to function more effectively in his environment.[42]

9. The Promotion of self help implies the rehabilitative component in nursing care of the patient which encourages and promotes patient interest in simple tasks within the patient's ability to perform, which contribute to his psychological and emotional well being.[42]

Assumptions

For purposes of this study it was assumed that:

1. The patient in the nursing home can benefit from rehabilitation, specifically from those services that promote self help.

2. Rehabilitative services that tend to improve the patient's level of ability are inherent in the performance of nursing.

3. The registered nurses interviewed were capable of assessing the patient's abilities and objective in their discussion of the patient.

4. The interview guide was structured to elicit true responses from which reasonably accurate findings may result.

Limitations

1. This study was limited to information about abilities of, and rehabilitative services for sixty seven nursing home patients obtained by personally conducted structured interviews with registered nurses in twenty three nursing homes selected at random in Oregon and Washington located in Portland and it's proximity.

2. This study was limited to the abilities and services pertaining to three patients in each home; I. the most recent admission within a month, II. a patient who had been in the home from one month to a year, and III. a long term patient, preferably the patient who had been in the home the longest period of time.

3. This study was further limited because it did not attempt to investigate variables that influence why rehabilitative services were or were not used to improve the patient's level of ability as related to certain activities of daily living.

4. Further, no attempt was made to evaluate the effectiveness of the services offered.

Procedure for Solution of the Problem

The primary source of data consisted of responses expressed by twenty three registered nurses in twenty three nursing homes about sixty seven patients. The data were obtained during personally conducted structured interviews with registered nurses.

Proportional area sampling was chosen to facilitate the gathering of data. From a list of Oregon Nursing Homes prepared by the Oregon State Board of Health, homes in three counties, Columbia, Multnomah, and Washington were isolated to comprise the population from which the sample was chosen. The ten homes in the smaller populated counties, Columbia and Washington, were grouped together. Each of the homes was assigned a number with corresponding numbers placed in a container from which three numbers were drawn representing a portion of the sample. The thirty one homes located in Multnomah County and the twenty nine homes located within the city of Portland comprised two other groups from which twenty homes were selected by the same method described above. Additional homes were selected in like manner to obtain the desired sample in Clark County in Washington and others within the groups mentioned above.

A letter to explain the purpose of the study and a self addressed postcard which indicated whether or not the home would participate in the study, was sent to the registered nurse in each of the nursing homes selected for the study.

The registered nurse, who was interviewed in each of the

nursing homes, selected three patients according to these criteria: I, The most recent admission, within a month; II, A patient who had been in the home a month to a year; III, A long term patient, preferably the patient who had been in the home the longest period of time. This process of selecting patients considered the time element important in the rehabilitative process that carries through from onset of illness to independent living.[3 10]

The secondary sources of data were related studies, publications and periodicals of professional nursing and nursing home organizations, monographs and books written for medical and allied professions, and publications from the United States Department of Health, Education and Welfare.

Procedure for Collecting Data and Plan of Study

A pilot study was undertaken in the four nursing homes in the Longview-Kelso area in Washington to ascertain whether or not the interview guide was usable. The necessary changes were made to clarify and improve the interview guide with recognition that all comments did not necessarily indicate change in the tool.

The personal interview was selected as the means for gathering data to take advantage of the face to face situation in which apparent misunderstandings could be clarified promptly.[45] The literature was searched to discover the preferred and accepted rehabilitative services for nursing home patients. A structured interview guide was constructed

on the basis of the findings in the literature in accord with the established and defined purposes of the study. The same format was used for all the interviews. Questions were expressed as clearly as possible to avoid suggestiveness to the interviewee.

In the structured interview guide, patient levels of abilities were divided into five categories, ranging from complete independence to complete dependence. The nurses were questioned about the patient's level of ability in each of the selected activities of daily living. Opportunity was given for the nurse respondent to comment about the rehabilitation of each of the selected patients in each of the selected homes.

The date and time for the interview was made according to the location of the home. All participating homes were located on maps. Then interviews for each day were planned and scheduled for homes in close proximity of each other. Approximately forty five minutes were allowed for each of the three interviews scheduled for one day. Appointments were made beginning July 3, 1963 and continued through August third. Approximately fifteen days were involved in data gathering.

The collected data from the structured interviews were placed on unisort cards, then tabulated, tables drawn and analyzed. The findings were described, conlusions drawn, and recommendations for further studies made.

Preview of Subsequent Chapters

Chapter II is devoted to a review of the literature concerned with the rehabilitative aspects of nursing, rehabilitation in the nursing homes, and related studies. Chapter III describes the conduct of the study, findings and analysis of the results. The summary, conclusions and recommendations for further study make up Chapter IV.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The literature was searched for information relating to rehabilitation in the nursing home. It was found that the literature referred to the concept of rehabilitation in early records of nursing. Florence Nightingale implied that the patient should be no worse for having been nursed.[29] In 1901 Ruth Sherman cautioned her co-workers to guard against the danger of doing too much for the patient, remembering that the truest service is to restore his ability to wait on himself.[10]

The late Ruth Hubbard, former president of the former National Organization for Public Health Nursing, defined geriatric rehabilitation as the process of "helping the individual to do as much as he can, as well as he can, as long as he can."[40] Our nation's culture is based on the importance of the individual within the group and is permeated with the ideal of an increasingly good life for all. The satisfaction of human needs, basic to all individuals, is essential to his sense of well being as a person. Man strives for the satisfaction of these needs; 1. physical, 2. social, 3. intellectual, 4. emotional, 5. spiritual, and 6. self respect.[33]

The dignity and worth of man is recognized in the rehabilitative process. It strives to restore man to a sense of security in his own individuality. This is the keystone of rehabilitation.[43] Rehabilitation begins the day the patient becomes ill. It is a cooperative process, involving the patient and all the persons concerned with his welfare. This may include any number of individuals who represent a variety of special skills--a doctor, nurse, physical therapist, welfare worker, family, and most important of all, the patient himself. It is necessary that each patient accept his own responsibility for self help and self care.[43]

Illness often places a dependency on others which is unavoidable and often beneficial to the treatment of illness. The extent and length of dependency are related to a number of factors, namely the individual, the disease, the treatment, the skill of those directing and caring for the patient, and the attitude of society.[32] It is time to re-evaluate our traditional patterns of medical and nursing care of the chronically ill aged patient in consideration of these factors.[8 14 24 30 44]

Doctor Howard Rusk states that one of our great medical needs today is for the provision of total treatment of chronically ill aged patients in terms of the everyday problems of living which they face. Many such patients cannot be rehabilitated to the extent of employability, but a large percent can be rehabilitated to the point of sufficient self care so they live independently, requiring a minimum of aid from others.[36]

To function adequately within ability, to feel wanted, and to share interests under conditions which maintain personal esteem, are three basic needs shared by all people.

Rehabilitative Aspects of Nursing

The therapists in rehabilitation agree that one of the most important components of any program is the establishment of an integrated continuous process of rehabilitation that carries through from onset of illness to self-sufficient living.[3] The patient usually remains in the hospital during the acute phase of his illness and then as his condition requires long range treatment, he is apt to be transferred to the nursing home. In making the transfer the patient should not lose any of the newly acquired skills, but rather to improve them to the maximum benefit.

In rehabilitation, Terry points out, it is necessary for the nurse to revise her concept of nursing, that is to try to forget much she has been taught about doing everything for the patient and learn to teach him to do as much as possible for himself. The nurse's responsibility to the patient, quoting Terry, requires that she be able to:

1. Know and understand the techniques used in physical rehabilitation in order to:
   a. supply supportive measures which help prevent deformity.
   b. evaluate and develop physical activities within the patient's maximum capacities.
   c. maintain muscle tone and range of motion.
   d. carry out activity programs prescribed by the doctor. e.g. bed, sitting and ambulatory exercise, crutch walking, which compliment programs initiated by physical therapists, occupational therapists, and other members of the team.

2. Know and understand the needs for equipment in physical rehabilitation in order to:
   a. assist the patient to accept and use special devices and equipment aids as needed.
   b. assist the patient to accept braces, crutches, appliances, and protheses.
   c. evaluate the physical home environment to determine what changes, if any, are needed to provide for the patient's continued improvement and safety.[44]

Although a major share of the specific reconditioning exercises are assumed by functional re-conditional specialists, there is still a great deal in the prevention of deformity and in teaching and encouraging self help measures which nurses can do without infringing upon the work of the physical therapist or the occupational therapist.[14] According to Knocke, the nurse as a health teacher should apply certain hygienic measures in her daily work. These measures include:

1. Prevention of deformity and of other disability by proper bed position and frequent change of position to maintain normal range of motion in all affected joints.

2. Encouraging and teaching self help measures such as bathing, dressing, getting from bed to wheel chair or other chair; application and removal of appliances, toilet care, locomotion and travel.[14]

A basic precaution in the task of bed making is necessary to help prevent foot drop with a shortened heel cord by avoiding a tight upper sheet. The use of the foot board is taught in the schools of nursing but the value is not often recognized until caring for the chronically ill or disabled.[11]

The nurse in the nursing home has a challenging opportunity to use her skill and knowledge to safeguard the well being of

her patients. Usually she is the most highly skilled person on the nursing staff. She must consider every factor including housekeeping, nutrition, adequacy of and care of equipment, drug handling and techniques used by other personnel, community resources, recreation, rehabilitation, and public relations. Greater good can be accomplished for the patient if the nurse is aware of and understands the rehabilitative needs as well as physical needs of the patients. Dorothy Michlin states "her first and foremost responsibility is to saturate the atmosphere with hope for a healthier, happier future for the nursing home resident." It is her task to infuse the patients with the desire to utilize whatever capacities they possess at optimum levels amid pleasant and friendly surroundings. She adds a corollary to the slogan, "help the patient to help himself," and that is "help the patient to help others."[22] It is a great source of satisfaction to a patient once totally helpless, to learn to wash his own face again, to manipulate a wheelchair and to help his neighbor.

Geraldine Skinner further emphasizes the importance of rehabilitative aspects in nursing in reporting about her work: By the use of daily range of motion exercises and the maintenance of good body alignment, muscles and joints are protected. A patient with a paralyzed arm and hand is positioned with the arm in abduction and joint exercises are carried out conscientiously for adduction of the shoulder soon develops

and the patient cannot raise his arm.[37] She explains that every registered nurse, practical nurse, and nurse aide is taught how to give bed exercises, range of motion for normal joints, good bed positioning, methods of ambulation and body mechanics. Every patient with chronic disease is a potential cripple, especially the elderly, and the nurses must always be aware of this.

Rehabilitation in the Nursing Home

The nursing home has developed gradually and to a great extent is expediently growing out of complex social, medical and economic changes in our society. Since the nursing homes have been developing on the American scene only within the past twenty five years, and were not established as a specifically defined institutions, it is to be expected that they have yet to reach an ideal level of development. What the nursing home offers is not necessarily always the professionally appropriate answers to the problems it attempts to meet, according to Gerry Solon.[38] Those who administer nursing homes have not uniformly conceived the task and variations are broad and deep across the country as revealed in the 1956 report about nursing homes published by the United States Department of Health, Education and Welfare.[38]

State and local governments have established minimum requirements in interests of the patient and the public, these being hampered by the lack of broad information about existing nursing homes and uncertainty about what should constitute

proper requirements for approval.[23] [15] [35]

A study of State Licensing Requirements of Nursing Home Administrators undertaken by Mt. Angel College, Mt. Angel, Oregon, in 1960, indicated this wide range of variation.[23] As a part of a series of studies on aging, the Institute of Gerontology of Mt. Angel College undertook an examination of the nursing home license requirements in each of the states. The study revealed that interplay among numerous factors contribute to the operation of each establishment. These are as follows:

1. The interests and skills of the staff.
2. The demands and expectations of the residents and their families.
3. The attitudes in the surrounding community or the policies of the sponsoring agencies.
4. The pressures emanating from organization of professionals whose sphere of competence is involved.
5. The State licensing requirements.[23]

Information regarding rehabilitation of the aged patient in the nursing home was found in Nursing Homes, the official publication of The American Nursing Home Association. Early ambulation, exercises, skin care, and other rehabilitative measures have been stressed.[4] [9] [20] [21] William Cox, a physical therapy consultant, emphasizes activity because "psychologically inactive patients show a fairly typical decline in emotional stability and in responsiveness." They tend to become irritable, then may resist efforts of getting them up, preferring the dull lethargy of rest. The patient may become a semiconscious vegetable and lose contact with

reality.[5]

Geld is in agreement with the view previously stated. The enhancement of the dignity and worth and motivation for living of the aged person is achieved through purposeful activity and has meaning for the chronically ill patient.[6] Geld emphasizes that "a steadfast, programatic effort towards maximum rehabilitation be made which includes the establishment of goals, stages and methods by qualified technical personnel under medical supervision." The aged person should know the measures being taken and the reasons for them, the goal, the stages involved, and the prognosis.[6]

To plan to carry out rehabilitation of the patient in the nursing home, the qualified personnel or team may consist of the patient, the doctor, the nurse, the family, the social worker, the occupational therapist, and the physical therapist, or it may only consist of the patient, the doctor, and the nurse. The nurse then, may be playing "substitute" positions on the team. The nurse may have to learn to provide care for the patient which could best be performed by experts in other members of the health team, but the nurse may be the only one consistently available. Helen Anderson commented that "it is evidence of our evolving maturity that this overlapping, once frowned upon, is becoming accepted and considered good."[2]

Busse pointed out that apparently few physicians are capable of dealing with large numbers of chronically ill persons with sustained enthusiasm. The chronically ill patient

frequently indicates that he is dissatisfied with his treatment.[6] A nurse with insight to the situation can be helpful to the patient, the family and the doctor.

Information on the characteristics of nursing home patients is scattered and not always current. Combining results from various studies gives the appearance that the very elderly predominate among nursing home patients: the majority have some heart or circulatory difficulty, a sizeable proportion are unable to walk alone, the length of stay will exceed a year, and the services needed vary widely.

Related Studies

A demonstration of the value of rehabilitation nursing of the elderly patient was the object of a study conducted by the Minneapolis Health Department which extended over a one year period.[25] During that time intensive rehabilitative nursing was demonstrated in twelve nursing homes on selected patients with the authorization of the patient's own physicians. Seventy eight patients were used in the 1958-1959 program with seventy one patients in a control group. Patients with disabilities and limitations were chosen without regard to their prospects of benefiting from the techniques for both the study and control group. Patients were evaluated before the demonstration began, at the end of three months, and at the end of six months.

Public health nurses, under the direction of the nurse advisor, conducted teaching programs in the nursing homes

participating in the demonstration. The course included: muscle and joint movements, placement in bed, use of footboards, techniques of getting in and out of bed, use of wheelchairs, bowel and bladder training, patient motivation, and the like. The nursing home staff was expected to continue working with the selected patients throughout the six month period.

In the study, early in the educational program it was recognized that many defects and deficiencies in the nursing homes were being perpetuated because neither the staff nor the nursing home administrators knew how to do a better job. If nursing care were to improve, nurses' aides needed some training. Also the registered nurses needed better appreciation of their responsibilities for supervising aides, controlling medicines and treatments, contacting physicians about their patients, obtaining up to date orders, and keeping accurate and meaningful records. All this added up to an obvious need for training at all levels.[25]

The acceptance of the program was gratifying to the participants in the study. The nursing home personnel wanted to do a better job in caring for their patients and were only too anxious to learn how to accomplish it.[25]

The findings of the Minneapolis study were that of the seventy eight patients in the experimental group, twenty two were better, sixteen were markedly better; of the seventy one in the control group, eleven were better and only two were markedly better.[25]

Conclusions of the study showed some benefits not entirely foreseen. Getting people up during the day reduced the amount of laundry due to success in bowel and bladder training, practically eliminated bed sores and greatly reduced bed pan service. Other noteworthy conclusions were:

> 1. Experience showed that the acceptance of the principles of rehabilitation nursing and the enthusiasm of the nurse-in-charge were factors of primary importance.
>
> 2. Intelligent nurses' aides can carry out techniques after they have been given some grounding in basic nursing, an elementary description of each patient's physical and mental condition, and taught specifically what to do for each patient. The nurse aide should have ready access to a supervising nurse who has had special training in rehabilitation nursing.
>
> 3. Much can be accomplished in the preservation of function and restoration of activity within the framework of nursing techniques without infringing on the field of physical therapy.[25]

A selected group of 115 aged, infirm individuals in a New York county home were the basis for a study to determine the feasibility of a method of disability evaluation by Doctor Eugene Moskowitz. Patients were observed over a period of two years with the objective of developing a method of expressing the ability of an aged, infirm individual to perform routine physical activities within the limitations imposed by physical disorders.[28]

A continuous process of rehabilitation was shown to be necessary in those patients involving restoration, reactivation, and maintenance. There was a tendency for them to continue at the low level at which they were functioning when admitted.

Periodic reevaluation determined exactly what was happening to the patient. The physical rehabilitation program was then geared to the specific needs of the individual at that particular time. It has been recognized that the patient may undergo physical and mental deterioration without changes from the diagnostic point of view. Teaching the individual to walk to the bathroom can influence his dietary habits as well as his mental attitude and behavior. Contractures in the lower extremities are very prone to develop, from protracted sitting. The reevaluation immediately called attention to these changes and initiated the proper corrective measures according to the study.[28]

Moskowitz also conducted A Controlled Study of the Rehabilitation Potential of Nursing Home Patients beginning in 1957. During a period of eighteen months, 18 nursing homes and 163 patients were evaluated. After a lapse of one year, a follow up study of the same patients was conducted to gather data which might reflect the problems encountered by patients living in nursing homes.[27]

Analysis of the rehabilitation potential of the study group revealed that 17.2 percent had some possibility for improvement in their functional capacity. In assessing the rehabilitation potential, it became quite apparent that the major anticipated improvement would be primarily in the activities of daily living and could be achieved within the nursing home. While 82.8 percent of the study group did not have

any rehabilitation potential, it should be emphasized that they required supportive care. Many of these patients required a maintenance program to prevent further physical and mental deterioration.[27]

Some of the findings of the study revealed that some patients, transferred from hospitals, had had retention catheters which were removed just prior to their transfer. These patients developed "incontinence by habitation" and remained partially or completely incontinent unless a definite effort was made early to apply the technics of bladder training.[27]

To delay rehabilitation further, it was found that intercurrent illness or minor injury could initiate a decline in the condition of the patient who was permitted unnecessarily to remain in bed or in a wheelchair for a prolonged period of time without any attempt at reactivation. Some individuals were transferred from hospitals to nursing homes without any communication or understanding of the need for continued mobilization of the patient. Some patients were discharged from the hospital before any appreciable restoration program was initiated. It should be the responsibility of the attending physician and the nursing home personnel to activate these patients rather than to maintain them at the level at which they were admitted to the nursing home.[27]

The following is quoted from the summary of the study:

1, ----"The major rehabilitation needs of these patients were primarily to maintain or improve their

activities of daily living.

> 2. These needs could be met largely by simple nursing procedures. A comprehensive educational program directed not only at the professional but also at the attendant and nurses' aide level is vital"-----.[27]

Thomas Mahaffey's report on interviews with thirty five nursing home operators in Detroit in 1961 revealed some interesting opinions regarding rehabilitation.[18] Operators frequently mentioned that by the time most of the patients were put in a nursing home, they were too aged or ill to be rehabilitated. A few, however, voiced an opposing opinion. A registered nurse believed that much effort and intensive care must go into the rehabilitative program, but that even if the only accomplishment was to help the patient feed himself, it was effort well spent. Both of the doctor operators interviewed indicated that too few nursing home operators were well enough versed in the therapies that may be used to increase the number rehabilitated.[18]

The data concerning patient needs and services revealed that few nursing homes have attempted rehabilitation programs. The extent of rehabilitation practiced in any given nursing home varies with the knowledge and skill of the employees, and it seems that many who are so employed lack the necessary qualifications according to Mahaffey.[18]

The Rehabilitation Education Service Project sponsored by the Washington State Department of Health, The Division of Vocational Rehabilitation, and the State Department of

Public Assistance was conducted between January 1, 1959 and December 31, 1961 in twelve nursing homes in the State of Washington. The purpose of the project was to ascertain whether effective rehabilitation care would result in greater independence of patients, and if such care could be promoted and accomplished by a multi-disciplinary team spending a given length of time in each nursing home.[42]

The project staff consisted of a coordinator, three rehabilitation nurses, a physical therapist, an occupational therapist, a social worker, a vocational rehabilitation counselor, and a secretary all on a full time basis. The services of other consultants on a part time basis were a psychiatrist, a statistician, and a project design consultant. The services of consultants such as hearing and speech were available upon the recommendation of the psychiatrist and/or the prescription of the private physician.

This team approach to the patient's problems provided an opportunity for the private physician, the nursing staff and the project team to evaluate the patient's potential for self help and determine a tentative goal for the patient. It then became the responsibility of the project team to teach the nursing staff how to help the patient reach this goal.

In carrying out the objectives of the program, the Project team spent approximately two months in each nursing home, during which time the team conducted an organized educational and teaching program for the nursing staff. This

program included a general orientation to the broad aspects of rehabilitation, lectures, discussions, and demonstration of nursing techniques and procedures. Approximately twenty four hours of class instruction were included during the two month period with the remainder of the time spent with the nursing staff as they cared for patients. The nursing staff was assisted to put into practice that which they had been taught. Instruction was provided to personnel on all shifts.[42]

It was difficult to measure or evaluate gains in physical restoration but the case studies graphically described the mental and physical improvement of some patients from a state of total dependency to various degrees of independence in daily living. The conclusions of this study reaffirm statements that are found in rehabilitative literature on the care of the chronically ill and geriatric patient. These are that:

> 1. Lip service to rehabilitative care of the chronically ill and geriatric patient is not enough. There is a need for concerted effort to put present knowledge into everyday practice.
>
> 2. All disciplines, medicine, nursing, physical and occupational therapy, social work, and dietetics need to take more responsibility for leadership in the development of educational programs for individuals employed in the care of the chronically ill and geriatric patient.
>
> 3. In the educational programs of the medical disciplines there is need for increased emphasis on the rehabilitative care of the chronically ill and geriatric patient. The disciplines should be responsible in providing this education not only in the basic curriculum but provide continuation of the

education for individuals in active practice.

4. Continual education within an agency or institution providing rehabilitative care for the patient is needed to utilize and augment present knowledge.

5. To insure continuity of care there must be an effective method of communications among agencies, institutions and the community with a plan for active involvement of the patient and/or his family.[42]

The design of a study, An Experiment in the Rehabilitation of Nursing Home Patients, by Howard R. Kelman, employed matched samples of randomly assigned treated and untreated patients in which differences in self care status prior to and following one year of treatment were measured. The change criteria were levels of function in ambulation, dressing, feeding, toileting and transfer skills.[13]

The data suggested that there may be at least three quite different patient groups on the nursing home, each with different needs and requirements. These groups include: a. ambulatory patients with predominantly cardiovascular-renal conditions, b. patients with neuromuscular and musculoskeletal impairments, requiring some assistance in self care, and c. patients who have overwhelming medical problems or who are so severely incapacitated that they require maximum nursing care.

The initial findings and those at the end of one year pertaining to the comparison of differences in self care status indicated that rehabilitation treatment did not alter the function status of the patients in the treated study population. Similarly, comparing the treated and untreated patients,

levels of self care and ambulation were not favorably altered by treatment.[13]

It was concluded that activities designed to stimulate, motivate, and aid disabled nursing home patients in using their physical capacities for self care might be more appropriate than extensive clinical programs seeking to "restore," or improve physical function skills. Activity programs should also aim at maintaining the self care status of functionally independent patients.[13]

A study entitled The Nursing Home in Oregon, prepared as part of the Gerontological Studies sponsored by Mt. Angel College in Oregon, was completed in 1960. The primary objective was to study the nursing home organizational structure.[16]

The data showed that in general there is a high probability that the nursing home personnel will be inclined to over-react to the passive dependent nature of the nursing home patients. The authors further state that through the indulgent attitude of the nursing personnel, they characteristically elicit the helplessness on the part of the patient.[16]

A study to identify the individual nursing requirements of patients in nursing homes in Massachusetts was conducted between 1961 and 1963 at the Boston College School of Nursing.[12]

The study staff consisted of registered professional nurses with consultants from the fields of medicine, nursing, social science, and statistics who helped with the design of the project.

Data were collected from a random sample of nursing homes. One hundred and thirty six nursing homes participated in the survey visits to collect factual data and from this sample twenty five nursing homes were selected to participate in the patient study. The nurses on the project staff identified the nursing problems of six hundred and twelve patients residing in the twenty five selected homes, by structural interview with patient and nursing personnel. On the basis of the identified nursing problems, a plan of nursing care was developed for each patient, and estimations were made as to the amount and type of nursing service required.[12]

Most of the patients were found to be over seventy five years of age with ages ranging from twenty five to one hundred and five. Females were predominate with a three to one ratio. Most patients had multiple diagnoses and expected to remain in the nursing homes for the remainder of their lives. Long-term chronic illness was the primary reason for nursing home admission.

Of the patients studied, slightly over one third appeared to be mentally confused to some degree, more than one half were ambulatory, about forty five percent required assistance in toileting and about thirty percent were incontinent. The majority of patients required assistance and/or supervision with personal hygiene.

The patients expressed a variety of attitudes towards their nursing home stay, ranging from full acceptance to

complete inability to adjust to their present circumstances. The four hundred and thirty three patients who were interviewed spoke repeatedly of the importance of being treated as individuals. Data revealed that the patients' needs for physical care were readily identified by nursing service personnel and were generally adequately met. The psychosocial needs of patients were less often recognized by the personnel and, therefore, were frequently unmet.[12]

Data from the interviews with patients also revealed that most of them had worked hard during their lives and had little time to develop leisure activity. These appeared to be specific interests and abilities of the patients, although most of the nursing homes provided some leisure activity.

Findings related to services revealed that many nursing homes experienced difficulties in obtaining medical services for patients. There was little evidence of medical advisory services to the homes in the project. Communications were inadequate between physicians and nursing home personnel and other disciplines involved in the care of patients. Review of the nursing home records revealed a paucity of information relevant to plan effective nursing care.[12]

Recommendations based on the findings of the study stressed that nursing care be under the direction of a qualified registered professional nurse who is specifically prepared to assume a leadership role in the administration and supervision of patient care. Another recommendation stressed

the necessity for ongoing education for personnel in the nursing home to attend workshops and institutes related to longterm patient care.

As a result of the findings about patient care records, it was recommended that studies be instituted to develop a simple, concise, and accurate record system for nursing home patient care. Other studies recommended pertained to differences in the patient population and their requirements according to homes of various sizes, and studies to measure the progress of nursing home patients.[12]

Conclusions Drawn from the Literature

The literature consistently stresses activity designed to maintain physical function and to promote self care for the nursing home patient. If the nurse is to be effective in helping the patient to achieve his maximum rehabilitation potential, she must be cognizant of, and utilize rehabilitative measures.

CHAPTER III

REPORT OF THE STUDY

Procedure

This study was undertaken to determine the abilities of nursing home patients and what rehabilitative services are being used to improve the patients' level of ability.

The literature was reviewed to ascertain levels of patient ability and to identify rehabilitative services in the nursing home. A structured interview guide, based on the findings in the literature, was designed to achieve the purpose of the study.

A pilot study which necessitated minor changes in the interview guide was conducted in four homes in Washington. The changes were made to clarify the intent of the study.

The population from which the sample was selected included nursing homes in a metropolitan and adjoining area located in Multnomah County and Columbia County in Oregon and Clark County in Washington. The names and addresses of the nursing homes were obtained from a list of licensed nursing homes published annually by the respective State Departments of Health. The nursing homes involved in the study were selected by random proportional area sampling of which one third of the nursing homes in the area were chosen as described in Chapter I.

The participants in the study were twenty three registered nurses; information was elicited about sixty seven patients in twenty three nursing homes. Three patients in each home were selected according to length of stay in the home. They were categorized as: I. a recent admission, preferably the most recent admission within a month, II. a patient who had been in the home a month to a year, and III. a long term patient, preferably the patient who had resided in the home the longest period of time.

Since the capacity of the homes represented 1146 patients, the sample cannot be representative of the total population. Inferences can only be made about patients in three categories in the nursing homes in the selected areas. No inquiries were made concerning nurse preparedness or nursing home facilities, as no attempt to evaluate the basis for responses was to be made.

The data were collected with the aid of the interview guide and the interview guide key. (Apprendices B & C) The interview guide key was devised to facilitate the recording and reporting of information obtained about the patients. The key listed the patient categories: I. Most recent admission under a month, II. Over a month, under a year, III. Over a year, in the home the longest.

The interview key also listed the levels of patient ability as derived from the literature. The patient classification form used by the Washington Welfare Department was helpful

in determining levels of ability.[42] Levels of patient abilities ranged from A, completely independent to E, completely dependent as follows:

A. Requires no assistance, provides self care, continent, active participant in group, interested in community, mentally coherent.

B. Requires assistance with some details, occasionally incontinent, takes some initiative in group, interested in family, occasionally confused.

C. Requires frequent assistance, incontinent at night, joins group but watches, interested in self, confused at night.

D. Requires regular assistance, fed partially, no interest in group, personal interest slight, incontinent of urine, disoriented frequently.

E. Requires complete assistance, must be fed, incontinent of bowel and bladder, no social contacts, no self interest, mentally incoherent.

The services listed in the interview key were synthesized from the literature and served as a guide in classifying the services used to improve patient ability. Rehabilitative services for patients related to 1. preventive measures against deformities, 2. early activities of self care, 3. self help promotion, 4. referrals, and 5. diversional activities.

Each patient was rated as to level of ability in eleven activities of daily living; bathing, dressing, personal grooming, eating, eliminating, moving in bed, moving about

in wheel chair, standing-walking, mental and social interaction. The rating of the patient was placed in Column I of the interview guide.(Appendix C) If rehabilitative services were used to improve the patient's level of ability, the information was recorded in Column II of the interview guide. (Appendix C) General information, such as age, sex, diagnosis, and size of home, was also obtained and recorded on the interview as pertained to each of the patients in the study.

The data were placed on unisort analysis cards. (Appendix D) The cards facilitated the handling of the raw data which were then tabulated and analyzed.

Findings

The interview guide was constructed to elicit certain general information about the patient such as age, sex, and diagnosis. Table 1 shows the age distribution of the sixty seven patients in the study.

Table 1. Age Distribution of 67 Patients in 23 Nursing Homes in a Study of Patients' Abilities and Services to Improve Abilities

Age in Years	Number
below 50	2
50-59	3
60-69	15
70-79	22
80-89	18
90-99	6
100	1
Total	67

The average age of the sixty seven patients was 74.5 years. The average age in the three patient categories was as follows: Group I. 75.4, Group II. 70, and Group III. 77.9 years of age. The national average of the nursing home patient is eighty years of age. The sample population is somewhat below the national average age of the nursing home patient.

The sample population was composed of twenty three males and forty four females. National figures indicate two thirds of the nation's nursing home population are women.[38] The

sample population of this study was precisely two thirds women. Table 2 shows the distribution of the patients by sex in the three length of stay categories used in the study.

Table 2. Sex of 67 Nursing Home Patients in Three Length of Stay Categories Ranging from the Recent Admission to the Long Term Patient

Category	I	II	III	Total
Male	10	8	5	23
Female	11	15	18	44
Total	21[a]	23	23	67

a. two nursing homes did not have patients to meet criteria for Category I.

There was multiple diagnosis for 44.7 percent of the patients. Table 3 lists the primary diagnosis of the patients in the study.

Table 3. Rank order of Primary Diagnosis of 67 Nursing Home Patients

CVA	15
Fractured Hip	8
Arteriosclerosis	8
Senility	8
Cardiovascular	7
Chronic Brain Syndrome	4
Arthritis	3
Parkinson	2
Other	8
Total	67

Diagnoses grouped under "other" were diabetes, epilepsy, anemia, nervous disorder, paraplegia, old age, and alcholism. The finding that patients have a multiplicity of diagnoses substantiates the findings of several studies.[12] [46]

Of general interest was the facility in which the patient resided. Table 4 summarizes information about the size of the home. It is interesting to note that the majority of patients were found in the large nursing homes.

Table 4. Distribution of 67 Nursing Home Patients According to Size of Nursing Home.

	Bed Capacity of Nursing Home					
	small		medium		large	
	2-10	11-20	21-30	31-40	41-60	61-120
Number of Patients	3	7	12	9	9	27
Sub total	10		21		36	
Total	67					

The findings pertaining to the abilities of patients, based on the data obtained in Column I of the interview guide, (Appendix C), include information relative to eleven activities of daily living within five levels of patient ability ranging from A, most independent to E, complete dependence. (Appendix B) Table 5 shows these findings.

Table 5. 67 Nursing Home Patients Grouped According to Five Levels of Patient Ability in Relation to Eleven Daily Care Activities

Activity	Ability[a]					Number
	A	B	C	D	E	
Bathing	6	4	5	16	36	67
Dressing	9	1	10	13	34	67
Personal grooming	18	4	2	4	39	67
Eating	51	5	0	4	7	67
Eliminating	33	5	4	7	18	67
Moving in bed	37	5	5	4	16	67
Getting out of bed	23	1	3	21	13	61[b]
Moving about in wheel chair.	9	1	0	3	17	30[c]
Standing, walking	23	1	1	6	17	48[d]
Mental activity	15	19	7	13	13	67
Social interaction	12	19	15	7	14	67

a. Most independent category A, to most dependent category E
b. Six bed patients
c. " " " and 31 ambulatory and chair patients
d. " " " and 13 chair or wheel chair patients

It is interesting that a greater number of dependent patients were found in relation to certain activities. In the activity of bathing it was found that thirty six patients required complete assistance and sixteen patients required regular assistance. (refer to Columns D & E) Personal grooming and Dressing were other activities in which a predominance of dependent patients were found. In the activity of Eating, it was found that fifty one of the sixty seven patients were able to feed themselves. (refer to Column A)

To study the patient's abilities closer, the data in Table 5 were distributed in the three length of stay categories. The patients in Category II were shown to be more

independent in relation to most of the activities of daily living than the patients in Category I and III.

It can be speculated that because it was only in Category II that the interviewee could select a patient from the many who met the criteria of being in the home over a month and under a year, some differences could occur. The most recent admission was selected in Category I and the patient having the longest residence in the home was selected in Category III.

Tables 6, 7, and 8 distribute the findings pertaining to the abilities of patients according to the categories of I, recent admission, II, intermediate, and III, a long term patient.

Table 6. Number of Category I Patients Grouped in Five Levels of Ability as Related to Eleven Daily Care Activities

Activity	Ability[a]					Number
	A	B	C	D	E	
Bathing	0	1	3	4	13	21
Dressing	1	0	1	7	12	21
Personal grooming	4	3	0	0	14	21
Eating	15	1	0	1	4	21
Eliminating	10	1	1	1	8	21
Moving in bed	13	1	2	0	5	21
Getting out of bed	5	1	2	7	3	18[b]
Moving about in wheel chair	4	1	0	0	4	9[c]
Standing, walking	6	0	1	2	6	15[d]
Mental activity	3	8	2	6	2	21
Social interaction	3	5	5	2	6	21

a. Abilities range from A, independent to E, dependent
b. 3 bed patients
c. 3 bed and 9 ambulatory and chair patients
d. 3 bed patients, 3 patients unable to bear weight

Table 7. Number of Category II Patients Grouped in Five Levels of Ability as Related to Eleven Daily Care Activities

Activity	Ability[a]					Number
	A	B	C	D	E	
Bathing	4	3	2	6	8	23
Dressing	6	0	3	6	8	23
Personal grooming	10	1	1	2	9	23
Eating	19	0	0	2	2	23
Eliminating	14	3	0	2	4	23
Moving in bed	13	1	2	2	5	23
Getting out of bed	12	0	0	7	4	23
Moving about in wheel chair.	2	0	0	2	4	8[b]
Standing, walking	11	1	0	2	5	19[c]
Mental activity	8	2	3	4	6	23
Social interaction	3	8	7	1	4	23

a. abilities range from A, independent to E, dependent
b. 12 ambulatory and 3 chair patients
c. 4 patients unable to stand

Table 8. Number of Category III Patients Grouped in Five Levels of Ability as Related to Eleven Daily Care Activities

Activity	Ability[a]					Number
	A	B	C	D	E	
Bathing	2	0	0	6	15	23
Dressing	2	1	6	0	14	23
Personal grooming	4	0	1	2	16	23
Eating	17	4	0	1	1	23
Eliminating	9	1	3	4	6	23
Moving in bed	11	3	1	2	6	23
Getting out of bed	6	0	1	7	6	20[b]
Moving about in wheel chair.	3	0	0	5	8	16[c]
Standing, walking	6	0	0	2	6	14[d]
Mental activity	4	9	2	3	5	23
Social interaction	6	6	3	4	4	23

a. abilities range from A, independent to E, dependent
b. 3 patients are bed patients
c. 3 bed and 4 patients not using wheel chair
d. 9 patients unable to walk

To determine the services to be used to improve the recently admitted patient's level of ability, the following question was asked. "Do you believe this patient can be helped to improve his or her level of ability as related to certain activities of daily living?" If so, by what means? To determine the rehabilitative services used for the patients in Category II and III, this question was asked. "Has this patient's level of ability improved since admission as related to certain activities of daily living?" If so, by what means?

The percent of negative responses about patient improvement were 62.6. The "No" responses about improvement of level of ability according to patient categories were: Category I, 66.6 percent; Category II, 47.8 percent; and Category III, 73.9 percent. The lower rating of the patients in Category II is noteworthy.

The relationship of the length of stay of the patient to the nurse interviewee response of whether the patient's level of ability could be improved was tested statistically by the use of chi square. Table 9 shows the figures upon which the test was based.

Table 9. Relationship of Length of Stay as to "Yes"-"No" Nurse Opinion Regarding Improvement of Patient Ability

	Length of Stay Categories			
Response	I	II	III	Total number
Yes	6	13	6	25
No	15	10	17	42
Total	21	23	23	67

Using the formula for chi-square in which $x^2 = \sum \frac{(fo-fe)^2}{fe}$

chi-square = 4.96 df = 2

The test was not significant indicating that the length of stay has no relationship to nurse opinion regarding improvement of the patient's level of ability. This finding can be compared with but does not support Dr. Ferberger's study in which the degree of improvement of the patient was related to the time at which the rehabilitative measures were started.[7]

Mental status was considered as a possible factor in rehabilitation because of the increased number of "no" patients in the dependent (E) ability column, as related to the relatively few "yes" patients in the same dependent column. It was decided to test statistically whether or not a significant relationship existed. Table 10 shows the figures upon which the test was based.

Table 10. Relationship of Mental Status as to the "yes"-"no" Nurse Opinion Regarding Improvement of Level of Patient Ability

	Mental Status					
	A	B	C	D	E	Total
Yes	7	9	4	2	3	25
No	8	10	3	11	10	42
Total	15	19	7	13	13	67

Using the formula for chi-square in which

$$x^2 = \mathcal{E}\frac{(fo-fe)^2}{fe}$$

df = 4 chi-square = 7.06

The test was not significant indicating that the mental status of the patient has no relationship to nurse opinion regarding improvement of level of patient ability.

There was a statistical test to determine if there was a relationship between the age of the patient and whether or not improvement of the patient's level of ability was thought possible by the nurse. Table 11 shows the figures upon which this test was based.

Table 11. Relationship Between Age of Patient and the "Yes"-"No" Nurse Response Regarding Improvement of Patient Ability

	Age of Patient				
	31-65	66-75	76-85	86-100	Total
Yes	8	5	8	4	25
No	7	10	17	8	42
Total number of patients	15	15	25	12	67

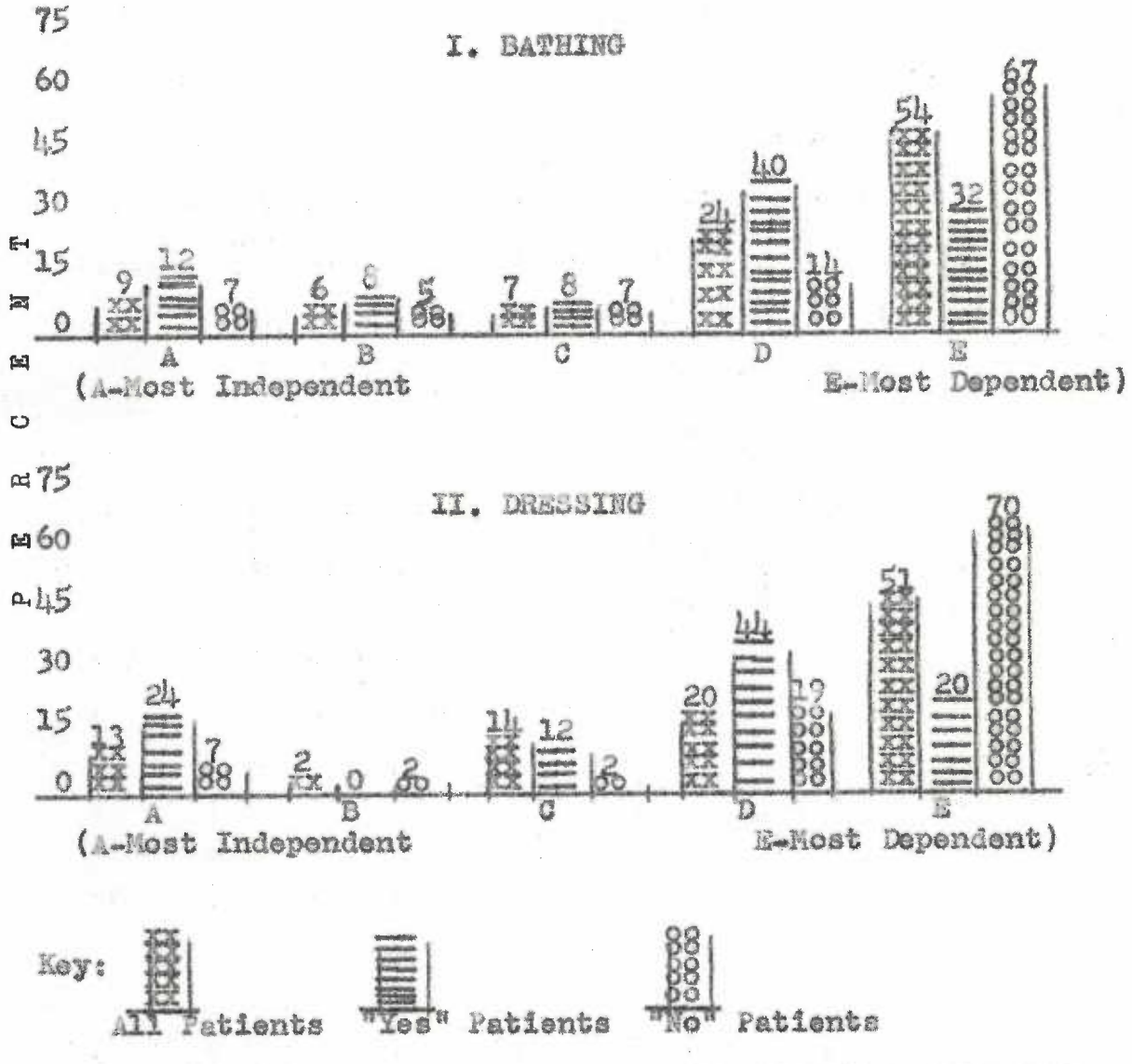
Using the formula in which $x^2 = \Sigma \frac{(fo-fe)^2}{fe}$

chi-square = 2.45 df = 3

The test was not significant indicating that the age of the patient has no relationship to the improvement of the patient's level of ability.

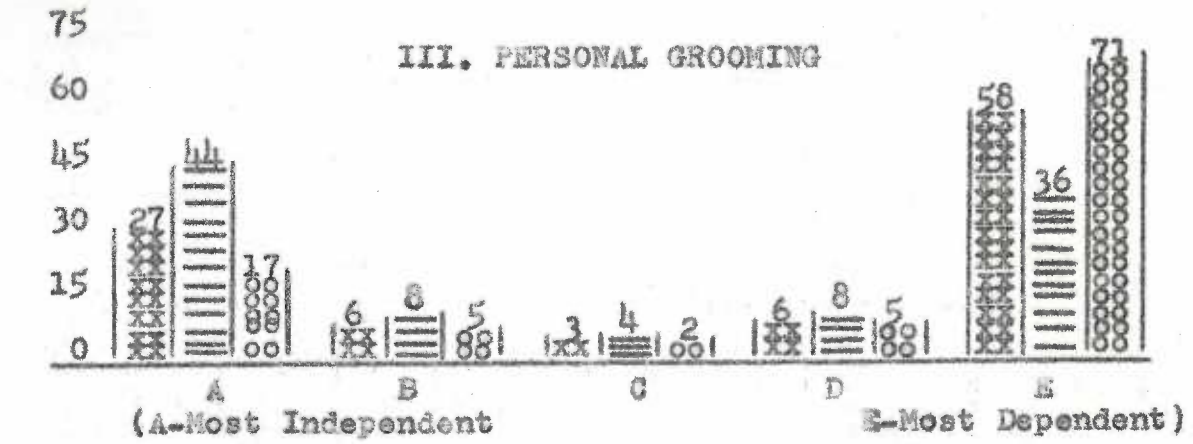
Figure 1. represents by histogram the percent of patients in each of the five categories of patient abilities and further identifies the percent of patients in the "yes" and "no" categories related to improvement of level of patient ability, all in relationship to each of the eleven activities of daily living.

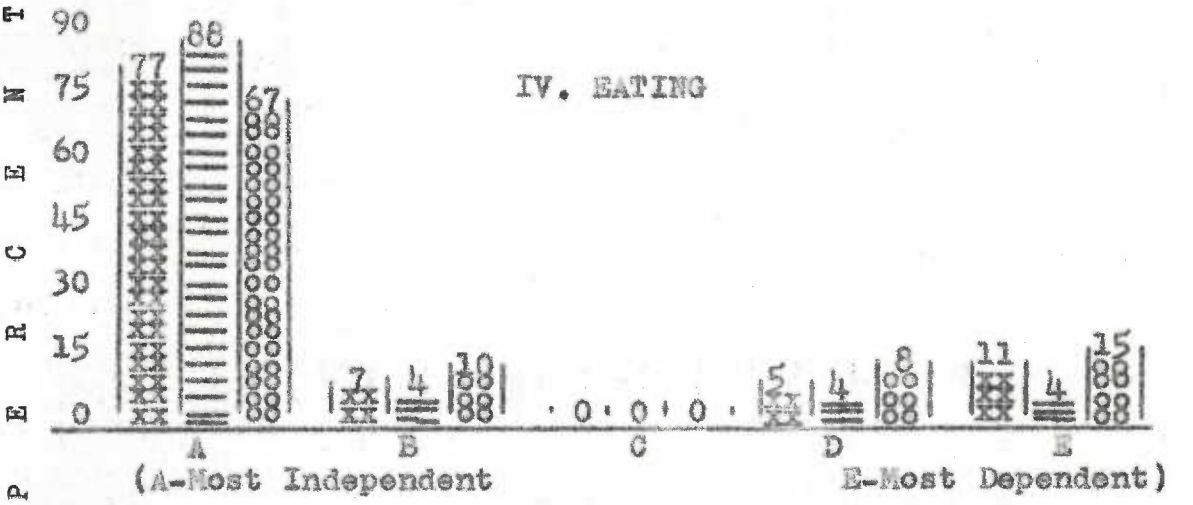
Figure 1. Distribution of 67 Patients by Percent in each of the Five Categories of Patient Ability, and further identifying the Percent of these Patients in the "Yes" and "No" Category of Nurse Opinion toward Improvement of Patient Ability, All in Relationship to each of the Eleven Activities of Daily Living.

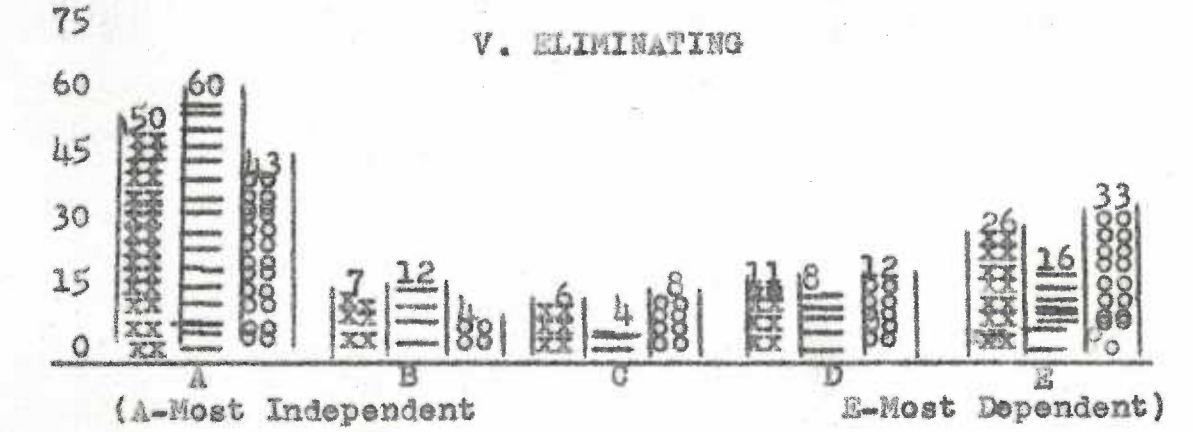


(Continued on page 47)

Figure 1. Continued



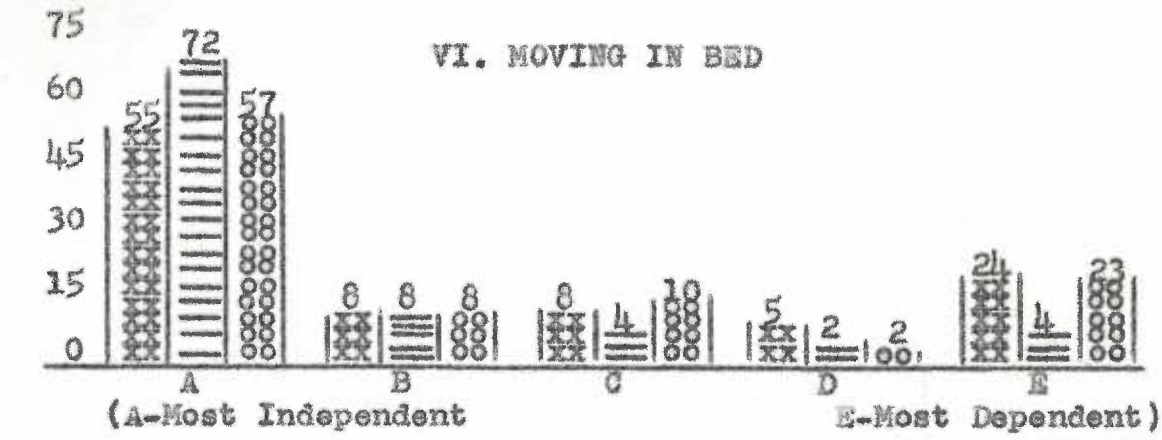


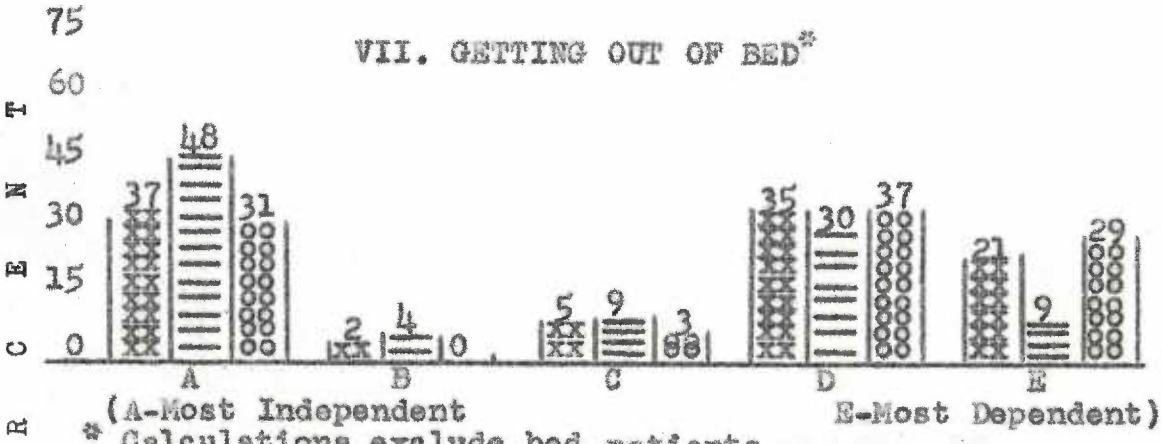


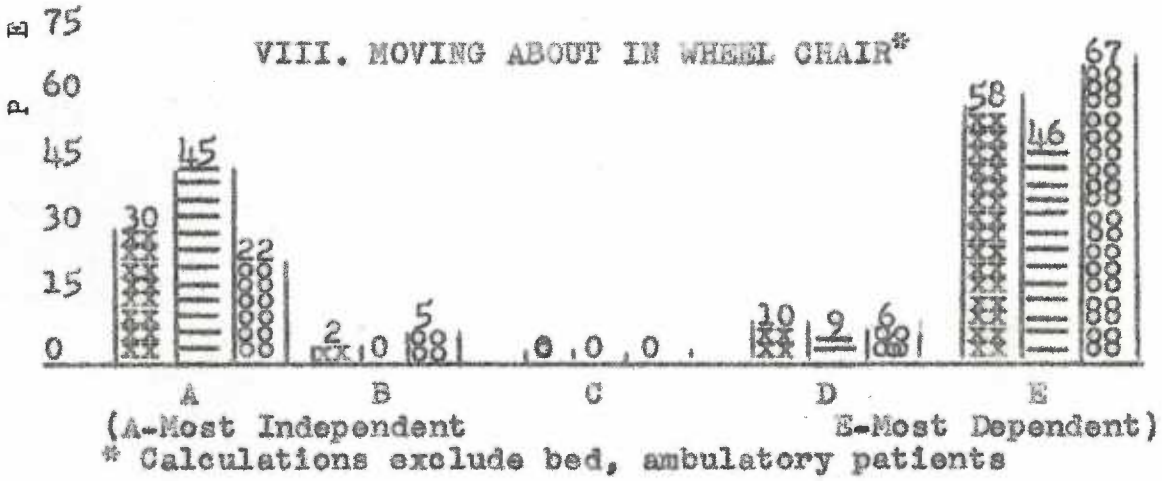
Key: All Patients "Yes" Patients "No" Patients

(continued on page 48)

Figure 1. Continued



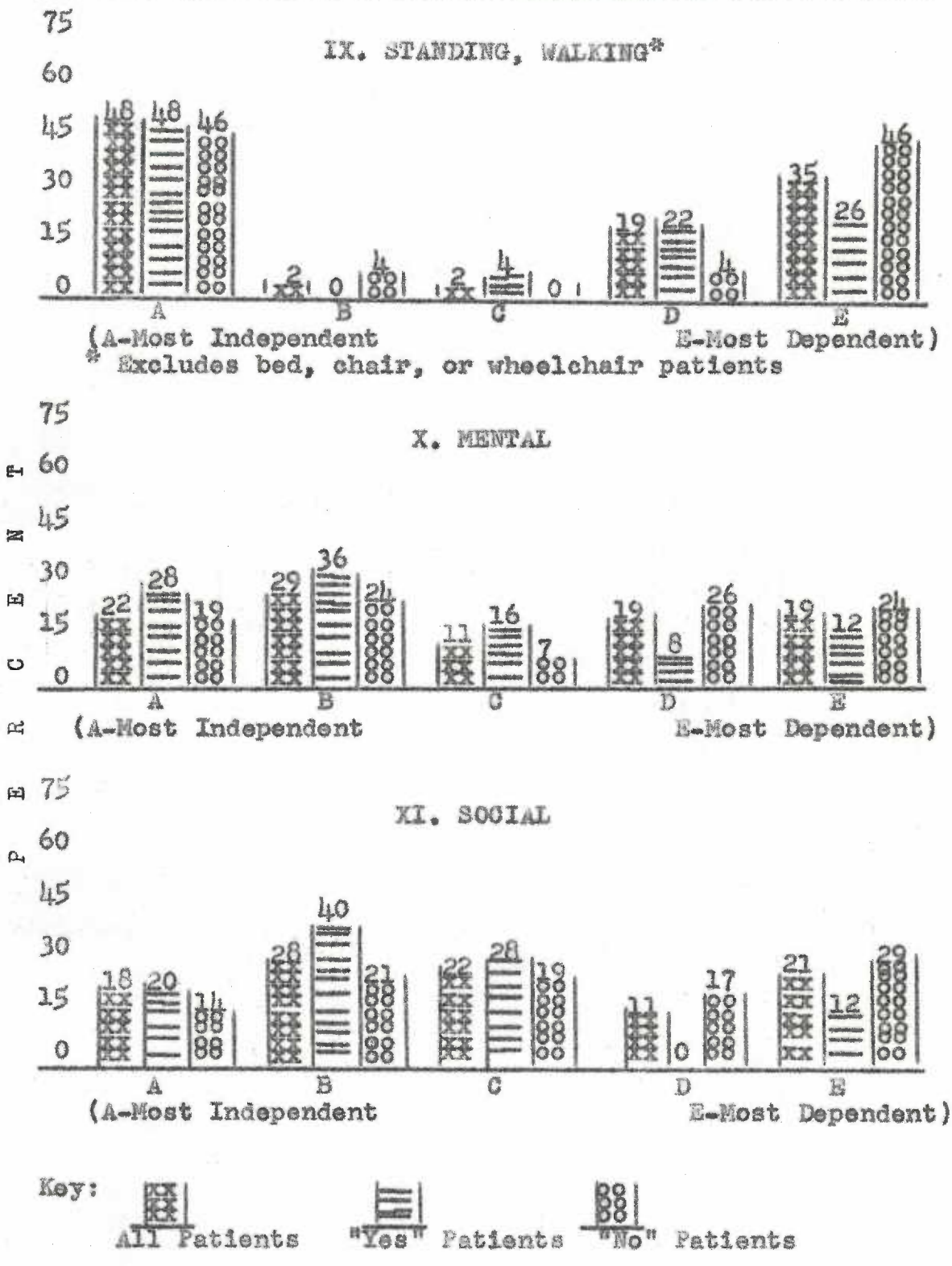




Key: All Patients "Yes" Patients "No" Patients

(concluded on page 49)

Figure 1. Concluded



The histogram shows that the increased percentage of patients who are dependent are in the "no" category. With an increased percentage of patients who are independent in the mental and social activities, and a correspondingly low percentage of independent patients in relation to bathing, dressing and personal grooming, it might be speculated that nurses continue to do for the patient instead of encouraging self care on the part of the patient.

This tends to support The Study of Nursing Homes in Oregon in which data implied that the nursing staff was inclined to be overprotective of the patient making that patient more dependent.[16]

The data obtained in Column II of the interview guide revealed information regarding services being used to improve levels of patient ability. Table 12 shows the frequency of distribution of these services under the headings of preventive measures, physical activities, promotional measures, referral to other agencies, and diversional activities.

Table 12. Frequency Distribution of Services Used to Improve Patients' Level of Ability[a]

Services	Number
1. Using preventive measures	
a. providing and teaching correct bed posture....	6
b. giving passive exercises.....	5
c. using foot board.....	2

(concluded on page 51)

Table 12. Concluded

Services	Number
2. Beginning physical activities of self care	
a. using trapeze	4
b. sitting in chair or wheel chair	9
c. bladder training	5
d. bowel training	2
3. Promoting self help	
a. encouraging and motivating patient	20
b. teaching and explaining to family	3
4. Referring to other professions and agencies	
a. obtaining eye glasses	1
5. Using diversional activities	
a. visiting other patients	4
b. encouraging individual projects	4
c. participating in activity programs	2
d. watching television	16
Total Services	83

a. Services were not used for 24 patients

If self help were promoted in all the listed activities of daily living, the sixty seven patients would have 737 services which could improve the patient's level of ability. The total of eighty three services represents only eleven percent of possible services for patients.

Twenty four of the sixty seven patients in the study did not have any services used which would improve the patient's level of ability. Of the services used for forty three patients, 62.6 percent of the services were for patients in the "yes" category which indicated that the nurse interviewee

thought this patient's level of ability could be improved.

Table 13 shows the distribution of rehabilitative services as related to the patient's level of ability in relation to the activities of daily living.

Table 13. Frequency Distribution of 83 Services in Relation to Activities of Daily Living and the Patient's Level of Ability

Service	Activity	Level of Ability				
		A	B	C	D	E
Promoting self help	Bathing				1	
Promoting self help	Dressing				3	
Promoting self help	Personal grooming	2			2	1
Teaching family					1	
Promoting self help	Eating				1	
Bowel training	Eliminating	1			1	
Bladder training		2		1	2	
Trapeze	Moving in Bed	1	1	1		1
Foot board					1	1
Passive exercises			1	1	1	2
Correct bed posture		1	1			4
Promoting self help		1			1	
Promoting self help	Getting out of Bed	2				
Starting early ambulation		1	1		1	1
Promoting self help	Moving in Wheel Chair	3			1	1
Learning standing balance	Standing, Walking				3	2
Promoting self help					1	1
Explaining to family	Mental				2	
Referral (glasses)			1			
Visiting		1	1	1		1
Individual projects		2	1	1		
Activity program			1	1		
Television		5	5	5	1	
sub total		22	13	12	19	17
Total				83		

Restorative services, such as preventive measures, physical activities, and the eye referral, accounted for forty one percent of the services offered to patients.

Services which were intended to promote self help, such as encouraging, motivating and teaching the patient and the family, accounted for 27.7 percent of the services. This relatively low percent substantiates the findings of the Massachusetts study which revealed the essential need for caring persons to bolster the patients' self esteem, to help them to maintain as much independence as possible, and to help them become interested and involved in suitable activities. The finding of this study that only 31.3 percent of the patients were given or sought diversional activities thus supports the Massachusetts study which reported extensive loneliness and anxiety of the nursing home patient.[12]

The combined findings related to restorative, diversional, and self help measures are in agreement with this statement of the Massachusetts study. "The patient's needs for physical care were readily identified and were generally adequately met; however, the psychosocial needs of the patients were less often recognized and, therefore, were frequently unmet."[12]

Comments

During the interviews, nurses were encouraged to comment freely about problems in relation to the daily care of the nursing home patient to aid in obtaining data relating to the abilities and rehabilitative services for these patients. The comments were categorized as those pertaining to knowledge of the patient, abilities of the patients, and services for the patient. The comments by the nurses were recorded as nearly verbatim as possible.

Pertaining to knowledge of the patient:

Several nurses commented that the patient came to the nursing home with little or no information. "Information has to be 'pried' from the hospital and repeated phone calls made to obtain necessary information for the nursing home record." Another nurse simply said, "We know little about our patients." Another nurse commented as she gave the listed diagnoses, Back Sprain, Disoriented, "This is really inadequate." She complained also of the lack of history stating that much time and effort must be spent in obtaining information about the patient from the hospital and the doctor. One nurse stated, "Hospitals will never tell you anything." In discussing an almost blind diabetic lady who was also deaf, the nurse commented that because she happened to know the supervisor of the hospital from which the patient was transferred, she was able to get helpful information regarding patients.

These comments by nurses support the study in Westchester County about the rehabilitative potential of nursing home patients.[27] This study revealed that the major anticipated improvement would be primarily in the activities of daily living and could be achieved in the nursing home. However, this study also revealed that some individuals were transferred from hospital to nursing home without any communication or understanding of the need for continued mobilization of the patient.[27]

Comments related to patient's abilities:

In discussing bathing of the patient, the nurse commented, "He could do more for himself but won't." Another nurse stated that all patients in nursing homes need assistance in bathing to be clean!

"Couldn't possibly improve." This was the nurse's comment about a patient in Category II on whom the exact age was not known and the diagnosis given was Cardio-vascular-accident, Senility, and Blind with cataracts. "The patient is gradually going downhill." "Condition is the same as on admission a year ago."

"This patient was completely incapacitated one and one-half years ago; may not improve, but has come a long way." "Patient may not improve; we hope to maintain her at this level." This comment was referring to a 100 year old lady who was up in the chair twice daily, could feed herself, but needed help with other daily care activities.

"Patient should improve, but it will depend on the patient." "This patient's independent nature has helped him to improve as he does not wish to be waited on." "Patient should be helped."--The nurse interviewed gave this information about a patient in Category II who had a stroke. No further information was obtained as to how this patient could be helped to improve her level of ability. The doctor's orders were non-directive. Preventive measures such as passive exercises were not given to this patient.

"This patient's state of senility will prevent the staff from helping the patient to improve." "Diagnosis will prevent her from improving; this will be her home for the rest of her life." This comment referred to an eighty year old lady with a diagnosis of heart block.

Comments pertaining to services:

One nurse stated the following about a long term patient, "This patient might have been helped had we known more about restorative measures. Now we give passive exercises such as range of motion regularly as our staff has been helped by the workshop promoted by the State Health Department." This comment supports the Minneapolis study which revealed nursing home personnel want to do a better job in caring for their patients.[25]

"The patient has improved and will improve with encouragement and the use of 'ultra sound' therapy." The nurse showed the interviewee a muscle-stimulating machine which was

used for a fifty-three year old female with the diagnosis of nerves, alcoholic, limb and back paralysis.

"We might be able to encourage activity if the language barrier is crossed." The patient spoke Italian.

"Rehabilitation has been kept up for this patient, (a paraplegic resulting from an accident forty years ago), as started in the Veterans Hospital." Many of his paintings hung on the nursing home walls.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This study was undertaken to determine from nurses the abilities of nursing home patients and what rehabilitative services are being used to improve the patients' level of ability.

A structured interview guide was designed to achieve the purposes of the study. A pilot study was made which necessitated minor changes in the interview guide to clarify the intent of the study. Letters explaining the purpose of the study were sent to the registered nurse in thirty nursing homes selected at random. Four nursing homes refused to participate and three homes were eliminated from the study. Interviews were conducted in twenty three nursing homes about sixty seven patients.

After the data from the interviews were tabulated, the findings revealed that:

1. Patients ranged from 31 to 100 years of age. Two-thirds of the sixty seven patients in the study were females. Approximately one half, or 44.7 percent, of the patients had multiple diagnoses, the primary ones listed were Cardio-vascular-accident, Fractured hip, Arteriosclerosis, and Senility.

2. Thirty six or 53.7 percent of the patients were in a

nursing home which had a bed capacity of forty one to one hundred and twenty beds. Twenty one patients were in medium sized homes with bed capacities of twenty one to forty. Only ten patients were in small homes of two to twenty beds.

3. In the five levels of patient ability as related to eleven daily care activities, patients were mostly dependent in relation to Bathing, Dressing and Personal grooming. Patients were primarily independent in relation to Eating and Moving in bed. Abilities related to Eliminating showed a slight majority as independent with few patients in the levels of ability between independence and dependence with more being dependent. Abilities relating to ambulation did not show trends but sizable proportions were both independent and dependent. The Mental and Social abilities showed an almost equal distribution of patients in the five levels of patient ability with a slight majority being more independent than dependent.

4. The answer to the question "How or will this patient's level of ability improve?" was NO for 62.6 percent of the patients. Patients in the NO category were generally more dependent than the patients in the YES category.

5. Eighty three or 11 percent of possible rehabilitative services were found to be used to improve levels of forty three patient's ability as related to eleven daily care activities. Twenty four patients were without such services. Restorative measures accounted for 49.1 percent, self help

promotion 27.6 percent, and diversional 31.3 percent of the rehabilitative services for patients.

6. Nurses frequently commented on the difficulties encountered in communicating with the hospitals from which the patients were transferred. Lack of information about the patient was another frequent comment.

Conclusions

The findings of this study have led to the following conclusions:

1. Rehabilitation measures were not being used to the optimum in the nursing homes visited.

2. The patient's length of stay, age, and mental status had no influence on the potential for improvement of the patient's ability according to the nurse interviewee's opinion.

3. Rehabilitative services pertaining to physical care were used more frequently than those pertaining to the social aspects of care, such as self help motivation and diversional activities.

4. The registered nurses in the nursing homes indicated a need for better communication between hospitals, doctors and nursing homes, but appear to need assistance in establishing the means of obtaining the desired information.

5. Although this study did not attempt to correlate opinion with practice or attitude, it could be conjectured that the nurse's opinion regarding the rehabilitation potential of the patient strongly influences the amount and extent of rehabilitation services for the patient.

Recommendations for Further Study

The following recommendations for further study are made after considerations of the data obtained from this study:

1. A study of how chronically ill and aged patients assess their nursing home care.

2. A study of nursing curricula to determine what is included specifically relating to the care of the chronically ill aged patient.

3. A study of how transfer processes of hospitals and health agencies are carried out to provide continuity in patient care.

4. Due to the increased age span and the prospect of increased population in nursing homes, the care of the chronically ill aged will in the future become a greater problem. Accordingly, it is recommended that health agencies, nursing organizations, and nursing home associations collaborate in promoting programs which will upgrade nursing home care and emphasize rehabilitation.

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APPENDIX A

INTRODUCTORY LETTER

June 28, 1963

_____

_____

_____

Dear Registered Nurse:

In partial fulfillment of requirements for a Master of Science degree at the University of Oregon School of Nursing, I am undertaking a study of abilities of nursing home patients and services being used to improve the patient's level of ability. You are invited to participate. It will involve a personal interview of approximately forty-five minutes. A self-addressed postcard is enclosed for your convenience in indicating your willingness to assist with the study. Since no nursing home will be identified in this study, your anonymity is assured.

I will be in your area on _____ at approximately ____ o'clock. I hope you will allow me to see you for a few minutes of your busy schedule. If this time is not satisfactory, indicate if another date and time could be arranged for the interview.

Upon completion of the study, copies of the report will be placed in the library at the University of Oregon Medical School.

Yours sincerely,

Evelyn M. Boyd

Mrs. Evelyn Boyd is a regularly enrolled graduate student at the University of Oregon School of Nursing. Any assistance you can offer Mrs. Boyd will be greatly appreciated.

Lucile Gregerson
Thesis Adviser

APPENDIX B

INTERVIEW GUIDE KEY

Interview Guide Key

PATIENT CATEGORY:
I. Most recent admission under a month
II. Over a month, under a year
III. Over a year, in the home the longest

LEVELS OF PATIENT ABILITY:
A. Requires no assistance, provides self care, continent, active participant in group, interested in community, mentally coherent.

B. Requires assistance with some details (buttons, zippers), occasionally incontinent, takes some initiative in group, interested in family, occasionally confused.

C. Requires frequent assistance (Putting on certain garments, etc.), incontinent at night, joins group but watches, interested in self, confused at night.

D. Requires regular assistance, fed partially, no interest in group, personal interest slight, confused, disoriented frequently, incontinent of urine.

E. Requires complete assistance, must be fed, incontinent of bowel and bladder, no social contacts, no self interest, mentally incoherent.

QUESTIONS:
I. Do you think this patient can be helped to improve his level of ability? If so, how?
II. & III. Has this patient's level of ability improved since admission? If so, how?

SERVICES FOR PATIENTS:
1. Using preventive measures against complications and deformities
   a. providing and teaching correct bed posture
   b. giving passive exercises
   c. using foot board

2. Starting early activities of self care
   a. sitting up in bed
   b. sitting in chair or wheel chair
   c. learning standing balance, walking
   d. using trapeze and other equipment
   e. using special eating utensils
   f. bladder training
   g. bowel training

3. Promoting self help
   a. encouraging and motivating patient in simple tasks
   b. teaching and explaining care to family

4. Referring to other professions and agencies
   a. Public Health Nurse
   b. Occupational Therapist
   c. Speech Therapist
   d. Psychological Services
   e. Social Service Counseling
   f. Vocational and Job Placement

5. Using Diversional Activities
   a. visiting in day room
   b. encouraging individual projects
   c. participating in volunteer activity programs
   d. participating in organized activity programs
   e. watching T.V.

APPENDIX C

INTERVIEW GUIDE

Age_____ Category I, II, III Size of Home_____

Sex_____ Diagnosis_____

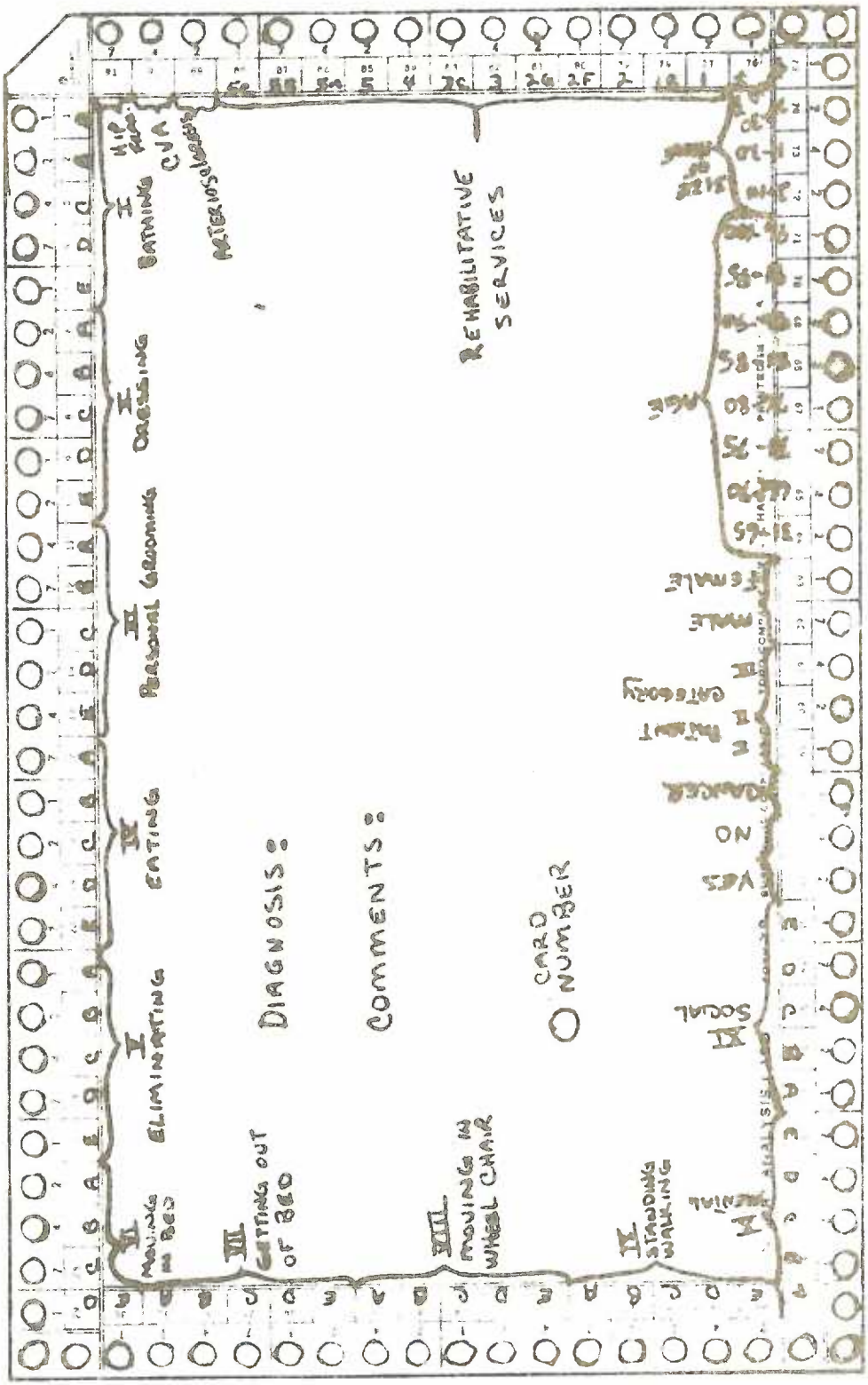
Activities	COLUMN I	COLUMN II
Bathing		
Dressing		
Personal grooming		
Eating		
Eliminating		
Moving in bed		
Getting out of bed		
Moving about in wheel chair		
Standing, walking		
Mental activity		
Social interaction		

Comments about rehabilitation of this patient:

APPENDIX D

SAMPLE UNISORT DATA CARD

Sample Uniform Card



Typed By

Pat A. Eaton