NURSE AND RESIDENT CONGRUENCY ON NURSING ACTIVITIES AND THE RELATIONSHIP OF CONGRUENCY TO RESIDENT MORALE

by

Beverley M. Wilden

submitted in partial fulfillment
of the Master's of Nursing Degree

Thesis Committee

Christina Gow
Associate Professor, School of Nursing,
University of Manitoba

Cynthia Cameron
Associate Professor, School of Nursing
University fo Manitoba

Dr. Neena Chappell
Director, Centre on Aging
University of Manitoba

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A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

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ABSTRACT

This study served two purposes: first, to determine whether the nurses and residents in a long term care facility are congruent in their perspectives on the importance of common nursing activities; second, to examine whether congruent or incongruent expectations on caregiving had any relationship to the morale of residents. Examining the importance nurses and residents attach to the caregiving activities carried out in a geriatric facility was believed to constitute a step toward identifying what characterizes quality of care in these facilities. Morale was conceptualized as a positive outcome of congruence.

The design of the study is analytical, ex post facto and cross-sectional. The White (1972) Nursing Activities Checklist was answered by a randomly selected sample of nurses and residents to determine congruence on nursing activities. The Philadelphia Geriatric Morale Scale (Lawton, 1975) and the Delightful/Terrible Scale (Michalos, 1980) were used with the resident sample to determine morale.

The results did demonstrate a significant difference in the ratings nurses and residents gave to caregiving activities, with nurses rating all components of caregiving higher. Morale was found to be low for the P.G.C.M. subscale Attitude to Own Aging and the items on

the Delightful/Terrible Scale. The ability to correlate the level of incongruence on nursing activities with resident morale was limited by the inability to use individual matches of nurses and residents. A regression analysis was done using the resident scores on morale and on the subscales of the activities checklist. No significant correlation was found. Based on the findings from this study, a number of avenues for nursing practice and research have been suggested.

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CONTENTS

TABLES

FIGURES

Chapter I

Introduction

Statement of the Problem

The care of the elderly in Western society has been depicted as discriminatory, rejecting and negative. The role of nursing staff working with the elderly in long term care facilities (L.T.C.) has been described as custodial and dependency fostering rather than therapeutic and rehabilitative (Armstrong-Esther, Sandilands & Brown, 1985; Baum, 1977; Valdeck, 1980). Nurses, in turn, have often viewed working with the elderly in institutions as being less desirable (Ingham & Fielding, 1985), depressing, unrewarding and requiring less skill (Campbell, 1971; Armstrong-Esther et al 1985; Mercadante, 1983) than working with other age groups.

The Canadian population is aging and Manitoba is no exception. The provincial Fact Book on Aging (1985) notes the number of persons in Manitoba sixty-five years of age and over has grown consistantly from approximately 5,000 in 1901 to over 100,000 in 1981. The rate of growth for this group is much greater than that of the total population. The population over eighty has experienced an even greater growth, increasing from 1,000 in 1901 to 25,000 in 1981. Projections for 1991 and 2001 indicate there will be almost twice as many individuals over age eighty as there were in 1981 (Provincial Fact

Book on Aging, 1985). It has been estimated that one-fifth to one-quarter of elderly people can expect to spend time in a long term care facility and the focus of the health care system continues to be on institutional care rather than community services (Chappell, Strain, Blanford, 1986). Given these facts, it is relevant to address the issue of the quality of care for the institutionalized elderly. Although receiving little attention to date, developing methods to ensure quality of care for the elderly in long term care falls within the purview of gerontological nursing.

The need for assurance of quality care has come to the forefront of nursing practice in the last decade. Lang and Clinton (1984) postulate four reasons for this occurrence: (1) the public's concern about the quality and cost of health care; (2) nursing's commitment and accountability to the public; (3) nursing's evolution as a scientific discipline; (4) nurses' increasing involvement in shaping public and individual health agency policies.

Traditionally, the accountability of the nursing profession has been viewed as being directly and explicitly to institutions and to physicians. This model of accountability has come under increasing criticism. It has been argued that the accountability of nursing should include accountability to the public (Luke &

Modrow, 1982) which incorporates accountability to clients. Yet few studies directly address the accountability of nurses to the consumer of their services.

Methods devised to measure the quality of nursing care in acute care facilities are not readily transferable to long term care settings (Kane, 1982). The focus of acute care entails the diagnosing of illness, treatment and restoration of health, or rehabilitation. Discharge to home or community is an expected norm. In long term care, problems are chronic, patients are life time residents. Quality of care is inextricably linked to quality of life. Individuals enter long term care facilities accompanied by numerous losses, for example, home, health and community ties. Brook and Williams (1975) suggest that the quality of health care in chronic illness is the sum of the technical care provided, the art of care provided, and the interaction between the two.

Research on effective nursing interventions in long term care institutions has been extremely limited. The studies that have been done accentuate the absence of research on nurses' orientation to health maintenance, health promotion or prevention of further disability/illness (Adams, 1986). The studies provide no basis for evaluating the quality of care in long term care. Yet, "the traditions of nursing lie closer to the

nurturing requirements of long term care, emphasizing health promotion and supportive activities over diagnostic emphasis" (Kane & Kane, 1978, p.917).

Examining the values relating to practice and the interventions in caregiving could be of benefit to nurses working in long term care. Both are components to be considered in developing methods to identify quality nursing care for the elderly. Nurses' increasing accountability to the public includes identification of the elderly individuals' perceptions of their nursing care. Neither quality of care nor quality of life can be achieved without incorporating the viewpoint of the recipients of nursing care.

Purpose of the Study

The purpose of this study is twofold. The first purpose is to identify what characterizes quality of care for nurses and residents in a long term facility. Specifically, are their perspectives on and importance ratings of selected nursing activities congruent? The second purpose is to examine whether the congruent or incongruent expectations of care have a relationship to the morale of an institutionalized elderly population.

The majority of studies that have examined nurse/client ratings of nursing care activities differ on the importance given to physical care activities (treatments, bathing), as opposed to psychosocial (talking, listening) or educational (teaching, explaining) activities (Caron, 1984; Elbeik, 1986; Hinshaw & Oakes, 1977; Smith, Buck, Colligan, Kerndt, and Sollie, 1980; White, 1972). Most of the studies have been done in the acute care setting. The two exceptions are Caron (1984) and Smith et al. (1980). Too frequently the elderly are viewed, as are psychiatric patients, as unreliable or unable to contribute information on their needs. Therefore the elderly residents constitute a relatively untapped source of knowledge in identifying the nursing activities that represent, for them, quality care.

Criticism of long term care, particularly in terms of the psycho-social components, is widespread. Institutional environments need to maintain autonomy and social interaction for their residents if they wish to provide accomodations satisfactory for well-being (Penning & Chappell, 1980). Residents' view of what is important in their care and whether it meets their needs can affect their attitude towards care and the value derived from it.

The ability of the residents to function as autonomous persons could be reduced by a lack of involvement, to the extent of their capacity, in caregiving activities. This lack may well reduce the residents' morale, morale being defined as a sense of satisfaction with oneself, a feeling of syntony between self and the environment, and an ability to continue to strive appropriately (Lawton, 1972). The term syntony, as used above, comes from psychiatry and denotes the state or condition characterized by normal emotional responsiveness to the environment (Stein, 1967).

Relevance of the Study

Although the literature is replete with numerous accounts on how to achieve quality of care, there has been little research aimed towards assessing whether the nurses concept of quality of care has meaning for the care recipient. Based on Erickson's (1984) findings, caution may be advisable in equating a high quality of nursing with patient satisfaction. The above study was completed in an acute care facility. The very nature of long term care means deficiencies related to physical comfort and ability to maintain a satisfactory life style create permanent, not temporary hardships (Kane, 1982).

Research on what constitutes quality of care in long term care facilities for the elderly is almost non existent. The process activities in acute care, frequently based on the medical model and aimed at curing or rehabilitation, may foster dependency in a long term care setting. Outcome measures that are relevant to the institutionalized elderly have not yet been identified.

One of the components of quality care is values identification. Values identification includes the need to clarify the perspectives of the caregiver, care-recipient and the society or institution. Seeking a concensus on values among all interested parties is

essential in setting criteria to judge quality (Sliefort, 1985). In part, satisfaction with nursing care may depend on how well nurses and patients agree on what needs are most important (Williamson, 1978). The complex physical, cultural and psychosocial elements involved in aging are not likely to be decreased if an individual enters an institution.

The majority of nurses have no experience in living with a chronic illness, be it physical or mental. Valuable as it is, all the knowledge on appropriate nursing care activities does not ensure one will know what life is like for that individual having a chronic condition and living in an institution. Therefore, the need exists to validate the relevance of the beliefs of nurses and evaluate if congruency exists between the nurses valuation of caregiving activities and the valuation of the care-recipient. Involving the clients in identifying which interventions are viewed as important represents a beginning to identifying the clients' perceptions of needs.

Research is needed to develop and expand nursing practice knowledge in the areas of preventing, reducing and possibly reversing the documented negative effects of institutionalization. Accumulating knowledge in these domains of practice can only enhance care of the

elderly. Knowledge of the nursing interventions/activities residents perceive as important should facilitate satisfaction with care. Satisfaction with care has the potential to lead to satisfaction with institutional living. The combination of the two may help in avoiding the negative effects of institutionalization.

Although registered nurses are a minority in long term care and not the 'hands-on' care givers, their mandate includes on-going assessment of the resident, development of the care plan, including goal setting, and evaluation of the care. Incongruencies in the rating of care activities by nurses and residents could demonstrate unclear goals and expectations on the part of both residents and care-givers. Expectations of the importance of care activities can have a relationship to the perceptions of staff and residents as to what constitutes quality of care. These perceptions, in turn, have the potential to effect the psychosocial environment of the institution.

Literature Review

Introduction

Current literature will be explored in terms of the theoretical considerations for this study, derivation of common indicators or tools to measure quality of care, nurse/resident (or patient) congruence in expectations of care, nurses' attitudes towards the institutionalized elderly, and morale as a component of satisfaction with current life situations. In discussing these concepts, a diversity of results and claims based on the research will be noted. This diversity points to the state of the art in nursing research in general and gerontological nursing research in particular. The exploration of the available studies can also serve to illustrate the multifaceted nature of any attempt to identify the components in quality of care.

Theoretical Consideration

The Effect of the Medical Model

With few exceptions, health care professionals have viewed patients as passive recipients of care. Professional concern has focused on the extent to which patients accept 'expert', i.e. physician, advice and treatment (Chang, 1980). This view follows the medical model of helping and coping wherein people cannot be

expected to solve their problems. The help recipient is viewed as sick and expected to seek and use expert help to get well (Cronwett, 1983). Health care has been used as synonymous with medical care and the delivery of services by physicians in and around acute care hospitals (van Maanen, 1984). Thus the medical model has been the prevailing focus for health care delivery. The organizational context in which care is delivered within acute settings tends to be routinized, ritualized and fragmented (van Maanen, 1979). It is this prevailing type of model that has been transposed to long term care facilities.

Recently, the inappropriateness of the transference of a medical model to long term care has come to the forefront. Long term care of the elderly is complex and addresses problems of physical, mental and social dimensions. The quality of long term care is a continuing issue despite efforts to regulate and monitor the provision of care (Kane & Kane, 1982). Factors in long term institutions that were noted as having an affect on resident well-being include; a routine or environment that does not stimulate residents or encourage growth, loss of continuing ties with others, loss of personal space and belongings, loss of privacy and loss of control over decision making (Baum, 1977;

Driver, 1979; Miller & Russell, 1980; Powers & Williamson, 1982). Harel and Nagpaul (1979) found the relative importance of the above items varies from person to person, thus the nursing home that is flexible, tolerant and accomodating has the potential to provide a high quality of care.

As care for the institutionalized elderly has followed the medical model, the recipient of care is expected to be passive and compliant with health care goals. Rarely is the resident included or has input into planning or policy making (Gubrium, 1980; Wells, Singer & Polgar, 1985). The setting and clarification of goals has been the job of the staff. The resident's job is to adjust. Residents have often accepted the roles assigned to them.

State of Nursing Theory

Current nursing models have four basic components; person, environment, nursing and health (Fitzpatrick & Whall, 1983; Torres, 1985). However, the primary emphasis of the components can vary. Helping as a concept is implicit in almost every definition of nursing but has not been acknowledged as a central issue (Cronenwett, 1983).

Cronwett (1983) further notes that half the nursing models contained statements that implied a medical model approach to helping by having the nurse define the problem and act as an external regulatory force. This type of approach, if prevalently used, has implications for nursing in long term care. A resident's perceived locus of control as internal or external may affect morale (Chang, 1978; Chang, 1979; Ryden, 1984). Dependency may be fostered by use of a medical model approach. Miller (1985) found prolonged exposure to certain nursing activities, i.e. the traditional helping by 'doing for' the patient, resulted in increased patient dependency. She concluded that a considerable proportion of the dependency found in geriatric patients was iatrogenic, resulting from the type of nursing care given.

Nursing is still emerging as a profession. At this point in time, nursing lacks a strong theoretical basis for the conduct of research and continues to be involved in identifying and developing it's own unique knowledge base. Nurses have long subscribed to the concept of holistic and patient-centered care. Nursing as a humanistic science dates as far back as ancient Greece (van Maanen, 1984).

With the advent of hospitals and high technology, home care declined. Nursing followed medical trends and

became caregivers within the institutional setting. As a result, the majority of the nurses of today were trained in hospital settings and are employed to care for patients with acute illness.

Gerontological content in nursing curricula has been virtually non-existent until the last decade. Often, care efforts were aimed at curing and clinical experience in long term settings was minimal at best (Eliopoulos, 1981).

A holistic and client-centered approach is beginning to emerge within current nursing theories. For example, King's (1981), theory examines the process of nurse-client interactions that result in goal attainment (outcomes) and Orem's (Meleis, 1985), theory focuses on the self care practices clients initiate and perform on their own behalf.

Characteristics of Quality of Care Indicators

The medical profession's work in the area of quality of care has had an influence on the nursing profession's approach to and assessment of quality of care (Scherer, Farrell & Sinha, 1985). Nurses have been concerned with the assessment and assurance of the quality of nursing care since Florence Nightingale used a set of environmental standards to assess care provided during

the Crimean war (Lang & Clinton, 1984). However, the prevailing framework used is Donabedian's (1966) classic of structure, process and outcome. Structure is the essential supports or resources in the environment, for example, numbers of staff, policies, job descriptions. Process is the specific activities required to achieve client goals. Outcome is the end result of care.

Use of Donabedian's conceptualization of the areas of quality of care has provided a consistency in the approach to monitoring quality for both nursing and other disciplines. However, it is not surprising that similarity has occurred in the problems of the assessment and measurement of quality. Both the medical (Williams & Brook, 1978) and nursing (Bloch, 1980) professions have raised the issue of the relationship, or lack of a relationship, between quality assessment and scientific methodologies.

A comprehensive review of the literature by Scherer, Farrell and Sinha (1985) revealed that the theoretical framework of structure, process and outcome was supported by other studies but the major theoretical problem was deciding what attributes indicated quality and how these attributes should be defined. The common approach for assessment of quality care has been establishing list(s) of criteria. "Methodological problems thus include the establishment of criteria lists, the development of

instruments to measure the criteria and the examination of causal relationships among structure, process and outcome attributes" (Scherer et al, 1985, pg. 13).

A Critical Review of Current Care Evaluation Methods

The present common methods used to measure quality of nursing are generic instruments applied across patient populations. Currently there are five methods of globally evaluating quality of care (Jacquerye, 1984). These methods are; 1) the Phaneuf audit (Phaneuf, 1972, 1976), 2) the Quality Patient Care Scale (Qualpacs), Wandelt & Ager, 1974), 3) Rush Medicus, (Haussmann & Hegyvary, 1976; Hegyvary & Haussmann, 1976, a & b), 4) Horn and Swain as cited in Jacquerye (1984) and Scherer et al. (1985), 5) Methode d'Appreciation de la Qualite des Soins Infirmiers (MAQSI) (Jacquerye, 1984; Scherer et al. 1985). None of these methods has been specifically tested for long term care. The author of the MAQSI attempted to use her instrument with patients who had experienced a cerebral vascular accident and found it was not satisfactory (M. Chagnon, personal communication, May, 1986).

All the methods have disadvantages for long term care. Criticisms have been raised related to use of a retrospective chart audit such as the Phaneuf instrument. Retrospective audits are normally done after discharge,

thus quality of care is being measured after the fact (Scherer et al., 1985) and not amenable to change while the caregiving is occurring. Residents in long term care may remain for years, often until death, making a retrospective sample audit of charts neither random nor a representitive cross section of the population. Further, important nursing care that might not be recorded, especially in the domain of psychosocial care, cannot be accurately incorporated (Loveridge, 1983; Jacquerye, 1984).

Qualpacs and Rush Medicus are both concurrent audits. Qualpacs requires the direct observation of a patient (while receiving care) with a sixty eight item scale. Jacquerye (1984) raises the concern that only one third of the criteria are specific to nursing. This fact makes corrective actions difficult for nursing to apply. Rush Medicus is comprehensive and can use direct observations, records or interviews to collect data. However, in reality, the rater is directed towards a review of the last seven days of recorded care (Scherer et al., 1985). The Rush Medicus system requires a workload information system and a computer for analysis of the data.

The Horn and Swain and the MAQSI instruments focus on the outcomes of care. The Horn and Swain method has

not been applied in its entirety, making it difficult to know the global picture of the expected results and it is difficult to evaluate the specific part belonging to nursing (Jacquerye, 1984). The MAQSI method is currently available only in the French language making a general application problematic. As noted earlier, the MAQSI tool has been shown by the author to be ineffective in measuring quality for chronic care patients.

Common Components in Quality of Care

Common components are inherent in all methods and can be grouped according to the categories of physical (or technical) care needs, psychosocial care needs and education/learning needs. These, or similar categories, have been utilized in other studies on nursing activities and patient satisfaction. White (1972) devised four groupings; physical care, psychosocial aspects, preparing for discharge and activities involving reporting, observing and implementing medical care. Risser (1975) used the dimensions of technical/professional (including physical care and expertise), trusting relationship, and educational relationship. The components identified by Hinshaw and Oakes (1977) as defining quality in nursing care for patients were competency in technical skills, personalized care, information and professional demeanor

(i.e. attitude, mannerisms and appearance). Four additional components were identified for nurses; leadership abilities, co-operation with other personnel, professional creativity and knowledge. Elbeik (1986) utilized diagnosis/assessment, treatment, care/empathy and education/counselling to study clients, nurses' and physicians' perceptions of the quality of care in hospitals. The relative importance of and the specific indicators within each category still need more attention.

Congruency in Caregiving Expectations

Long Term Care Studies

The appropriate methods for the delivery of nursing care have been considered to be within the purview of the profession. However, nursing interventions may either help or hinder the geriatric client. Miller (1985) identified several nursing practices that were seen to be increasing patient dependency. A task allocation approach gave rise to increased dependency while individualized care plans encouraged independence. Interventions related to basic needs (food, hygiene) may be accomplished in a manner convenient for staff at the expense of independence for the resident. Therefore, the

importance nurses place on certain care practices may not be the most beneficial in terms of the outcome.

Caron (1984) modified the instrument developed by White (1972) to allow for its use in a long term care facility. Her results showed that nurses rated the psychosocial components of care higher than residents and residents the physical components higher than nurses. Both nurses and residents rated self care activities as least important. The low rating of self care activities may relate to the fact 90% of the subjects required assistance with three or more activities of daily living. The findings may also represent the perceptions and beliefs of nurses as to the involvement expected from individuals admitted to long term care. If the nurses believe the residents are dependent and do not wish to become involved, they will not encourage independence for or involvement from residents, leading to a self-fulfilling prophesy. The level of care required on admission is not known, nor was the type of nursing delivery system used (i.e. individualized or task oriented) a part of the study. These factors may have had an effect.

In another study (Smith, Colligan, Kerndt & Sollie, 1980), physical care was more highly rated by registered nurses/licensed practical nurses than by residents.

Although obtaining different results, Smith et al. (1980) also modified White's tool for their use. The sample of residents for their study were capable of self care, as opposed to the sample in Caron's study. This fact could account for these subjects rating psychosocial components higher than physical. What is not known is why the nursing staff rated physical care important with a population capable of self care. One possible explanation is that the nurses' general perceptions of residents and residents' needs influenced their choice.

As noted above, both Smith et al. (1980) and Caron (1984) modified White's (1972) instrument for their study. Specific information is not given as to the exact nature of the modifications in Caron's study but the scale was reduced to 40 items from the original 50, and items relating to discharge were not part of the analysis. Smith et al. (1980) dropped the three items relating to discharge referrals but retained the remainder of the items. The term nursing home was substituted for hospital.

Studies on Congruence of Expectations in Acute Care

In White's (1972) study, done in an acute care area, the patients rated physical care higher than did the nurses. However, the fact that one third of patients in the sample required only minimal physical care and none was acutely ill could have affected the nurses lower

rating on physical care. The nurses could have been comparing those patients in the sample to others in their experience who were acutely ill. The patients' lower rating for psychosocial aspects of care could reflect the fact that this hospitalization was of a short term duration and not, at this point in time, important in the general scheme of their lives.

Patients and physicians valued or expected personalized care from nurses in Hinshaw and Oakes (1977) study but personalized care was not valued by the nurses themselves. Competency in technical skills was valued by all three groups, patients, physicians and nurses. This fact is not unexpected given the study was done in the medical unit of an acute care facility. The findings are limited though in terms of the very small sample size, nine nurses, nine patients and nine physicians and the fact care was evaluated by having the three groups assess nursing care by viewing preselected photographs.

A study on perceptions of hospital care was conducted at four major New Brunswick institutions by Elbeik (1986). Only clients (patients) scored diagnosis/ treatment, care/empathy, and educational/counselling components in a similarly high fashion. Nurses rated diagnosis/treatment the highest, education/counselling the lowest.

A decade earlier, Risser's (1975) study demonstrated that patient/nurse perceptions may not have changed over the years. Patients expressed the most dissatisfaction in care with the educational relationship (giving directions and explanations) and the greatest satisfaction was found with the professional/technical area (skillful and organized in procedures). Satisfaction with the trusting relationship (listening, talking) was in the middle. However, in a sample of thirty-six hospitalized patients, Erickson (1984) found patient satisfaction lower on a unit where there was good physical care and health maintenance was taught yet higher on units where patients were oriented to the environment and extended courtesy.

Patients in oncology were found to perceive the nursing activities of knowledgeable monitoring, organization, competency with medications and knowing when to call the physician as important (Larson, 1984). Nurses in the study valued listening, touching and acknowledgement of patient's individuality as important. Not stated in the available report was the status of the oncology patient, i.e. newly diagnosed, undergoing treatment, inpatient/outpatient, or at the palliative care stage. These factors could potentially affect the rated importance of the nursing activities.

The only general conclusion that can be drawn from

these studies is that nurse/patient or resident incongruencies in rating the importance of care activities do appear to exist. Obvious problems are the fact the studies were conducted in multiple types of environments with different patient groups and multiple forms of measurement were utilized by the researchers. The partial exception was Caron's (1984) and Smith et al.'s (1980) use of White's (1972) instrument in a long term care setting. However, modifications to the instrument were made by each researcher to increase it's appropriateness for long term care. There were also differences in the self care abilities of the two samples. Not enough information was provided to assess whether the modifications were identical.

Nurse and Resident Interactions

The findings on potential congruency/incongruency in ratings of care activities point to a need to examine the communication interactions between nurses and residents. Communication skills are part of all nursing programs. However, there have been surprisingly few studies on nurse-patient communication (Adams, 1986; Armstrong-Esther, Sandilands & Brown, 1985). The studies that are available would tend to support the existence of inadequate or inappropriate communication techniques.

Barton, Baltes and Orzech (1980) examined the effect

of staff/resident interactions on the dependent or independent behaviours of residents. They found that while elderly residents of a nursing home exhibited a higher level of independent behaviour than dependent behaviour, staff showed more support for dependent behaviours. Dependency supportive behaviour on the part of the staff consisted of assisting a resident in personal maintenance, praise for a resident's acceptance of assistance, or discouragement of a resident's attempts to do personal maintenance tasks without help.

An extension of the above study (Baltes, Honn, Barton, Orzech & Lago, 1983) examined interactions related to the dependency/interdependency behaviour of residents with visitors and volunteers as well as staff. The findings corroborated the earlier study, i.e. dependent behaviours were reinforced. Only a single new category of independence, constructively engaged behaviour, received support.

Encouragement of dependent behaviours may be a function of the nature of communications between residents and nurses. Lipman, Slater and Harris (1979) found that the predominant quality of interactions between staff and residents was of an instrumental nature, i.e. focuses on the fundamental and service tasks, rather than on affective conversation with residents. Affective conversation incorporated the

acceptive quality of interactions (the emotional support) as opposed to the interactions related to physical tasks. A study on the institutionalized elderly's perception of spoken communication showed that they perceived themselves as talking with staff almost exclusively about health and medications. Other patient/staff topics included social amenities and "anything" (Lubinski, Morrison & Rigrodski, 1981).

The results of this research tend to indicate that caregivers and care-recipients may not be clearly identifying nor communicating their goals and expectations on caregiving activities to each other. As communication is an integral part of the art of care, the value nurses and residents place on the supportive/acceptive (psychosocial) elements of communication is worthy of further identification.

The Concept of Morale

Social environments can have considerable impact on an individual's way of life and feelings about him/herself. The person - environment fit model suggests that psychological and social problems can arise when people find themselves in an environment where the values, standards and lifestyles of the dominant culture make it difficult for minority persons to meet their needs (Zautra & Goodhart, 1979). The elderly in an

institution do not constitute a minority population in numbers but they do constitute a minority in terms of input into the organizational power base, whether it be at the level of the Board of Directors, middle management or the ward. The environment-fit model is tangential to this study and will not be dealt with in any detail. However, the model does have some relevence for its potential effect on the morale of the institutionalized elderly. Morale and life satisfaction can be viewed as having environmental contingencies and both have the potential to be affected by the expectations of others. The expectations of the nursing staff in relation to the residents and their care could be incorporated under the term expectations of others.

The term morale has been defined as subjective life satisfaction (Graney, 1974) and a measure of an inner state of harmony rather than a stable trait (Chang, 1978). Lawton (1972) believed morale to be a multidimensional concept involving a basic sense of satisfaction and a place in the environment for oneself, acceptance for what can not be changed, freedom from distressing symptoms and striving appropriately.

The individual's subjective perception of situational control was found to have a significant relationship to morale of residents (Chang, 1978, 1979; Pohl & Fuller, 1980; Ryden, 1984). Residents who

perceived themselves to be in control of their immediate environment had higher morale scores regardless of their personality orientations (Chang, 1978) and situational control of or self-determination in daily activities emerged as an important contributor to morale (Chang, 1979). A high functional dependency in residents was found to lead to less sense of control and a lower morale (Ryden, 1984). This fact has important implications in relation to the previously quoted studies on the tendency to reinforce dependent behaviour in residents and the task-oriented approach to caregiving. However, Pohl and Fuller (1980) found social interaction to be equal to choice in having a positive relationship to morale. They suggested a further need to look for factors influencing residents' perceptions of their control over their environment.

In 1985, Ryden reported on another phase of her study on the relationship between perceived control and morale. Administrative staff and caregivers were found to perceive themselves as the predominant decision makers and did not emphasize choices or options for residents. The large percentage difference in perceived control between staff and residents could relate to the fact caregivers often view the residents as having limited capability for decision-making. The rationale for this view could be a tendency on the part of staff to

generalize, based on working with a population comprised of some individuals who have a measure of incompetence in decision-making, that all residents are incapable of making any decisions on aspects of their life.

Chang's (1978, 1979) studies were limited by the small non-random sample size, thirty individuals from a total of four institutions, but Pohl and Fuller (1980) used a systematic sampling procedure to obtain fifty subjects and Ryden (1984) obtained a random sample of one hundred and thirteen residents from four nursing homes. Overall, these studies suggest that morale could be improved by using interventions, both physical and interactional, that allow for an actual or perceived increase in the elderly's sense of control.

To date, little work has been done on identifying the importance residents and nurses give to the caregiving activities that allow for either an actual or a perceived sense of control. Congruency on the importance of these activities could contribute to a real or perceived sense of choices and thus to an increased sense of control. However, there is the potential for nurses and residents to agree on the importance of activities that foster dependency. In this case, congruency need not lead to an increased sense of morale.

Should nurses and residents be incongruent in their expectations of care activities, regardless of whether it

is the nurses or residents who see the activities related to dependency and a lack of choices as important, the potential exists for a conflict situation to arise. This situation may reduce residents' morale. If, as Ryden (1985) suggests, caregivers perceive of themselves as the predominant decision makers, it is feasible that residents would not feel a sense of control or choices should incongruency exist.

Identifying a relationship between congruence and morale has implications for nursing practice. Conceiving of morale as a component of mental health, assisting individuals to maintain or improve their morale comprises a part of nursing practice, specifically in the areas of health promotion and health maintenance.

Although the issue of congruence and morale is complex and may not be easily resolved, the possibility exists that having to identify residents choices in caregiving activities could increase communication and social interaction between nurses and residents. At the same time, nurses may increase their awareness of the potential for incongruence or congruence on dependent activities to affect the residents in their care. Communicating a belief in the individuals right to make choices whenever possible, be self-directing and be a part of the decision-making process could contibute to the morale of care-recipients.

Attitudinal Issues

Nursing exists within the context of our society. The biases and negative attitudes current in our society are bound to have an effect on the values and attitudes of nursing. Ingham and Fielding (1985) have done an extensive review of the published research in Britain and America in the area of nurses' attitudes towards old people. They conclude that few studies pay sufficient attention to the linkage between attitudes and aims. Further, they noted the aims and goals of an institutional setting have the potential to affect nurses' attitudes. It could be possible that a nurse has negative attitudes and yet behave positively towards the elderly. Conversely, an individual could have positive attitudes yet strong pressure to conform to institutional norms results in negative behaviour. For example, a staff nurse may believe residents have the right to choices in their activities of daily living but the structure and policies of the institution negate the choices by setting a rigid schedule for activities. The nurse can be pressured to conform to the schedule. A case study documenting the pressures experienced by a middle management nurse when attempting to allow choices in the residents daily routine emphasizes this point (Baker, 1983).

However, whether attitudes are translated into

behaviors towards residents remains unknown. The data are still inconclusive. Caron (1984) found that residents and nurses at the aggregate level reached a statistically significant level of congruence on the positive items of the attitudinal scale. However, when the nurses and residents were paired, based on each nurse's responsibility (as a team leader) for care of one of the elderly residents, the congruence of the pairs on the items in the attitudinal scale was low. This finding appears to support a belief that nurses, as a group, may score more positively on an attitudinal scale than a nurse/resident pair, where the nurse is responsible for the care of the resident.

Nursing attitudes have been found to vary depending on the location of the care-recipient, whether the geriatric client is in a day hospital or on a long term care ward (Fielding, 1979). The scores of the nurses' concept of patients on the three factors of evaluation, affect and activity/potency showed a significant difference depending on whether the patient was located in a day hospital, assessment, rehabilitation or continuing care unit. Patients in long term care were rated lowest, those in day hospital were rated highest, across all categories. The patients themselves did not think that there would be any difference in the way nurses viewed them as a function of institutionalization.

A study on attitudes of nurses and the typification of nursing home residents into 'good' and 'bad' categories found that the sterotype of the old, poor, chronically ill individual being labelled as 'bad' did not exist (Gilliland & Brunton, 1984). Yet a subset of these attitudes was found to exist. Long term care residents were categorized as favorites and non-favorites or adjusted and non-adjusted. The categories cut across the usual good - bad criteria, i.e. a favorite may be responsive and appreciative (good) yet be deemed untrustworthy with periods of aggression (bad).

Although various studies have focused on nurses' attitudes to and conceptions of the institutionalized elderly, attitudes may or may not be translated into behaviours toward residents. The potential for attitudes to be predictive of behaviour would be of great concern to the nursing profession. However, as pointed out by Fielding (1979), any attempt to predict a cause and effect between attitudes and behaviours would be simplistic. The type of behaviour rewarded by the environment, attitudes of other nurses and position in the hierarchy can affect the behaviour of nurses.

The individual resident's perceptions of and expectations from the nurse are also important. These may be reflected in the residents' behaviour and/or attitude relative to the caregiving situation or the

environment. Identifying expectations in caregiving has the potential to increase nurses' awareness of residents as individuals and increase the awareness of the presence of attitudes or beliefs, whether personal or environmental, which may have an affect on the care given.

Summary

With population demographics pointing to a rise in the relative percentage of people over the age of sixty five, nurses will be increasingly involved in providing health care to the elderly. Nursing research is just beginning to examine the health care services it provides to this group. Little is known as to which processes of care will contribute to positive health practices among an institutionalized population. For example, does an increased sense of choice, perceived control or autonomy contribute to positive mental health among residents? Less is known about the appropriate outcomes of care. The elderly are not commonly involved in their care or program planning nor have their preferences often been identified.

Nursing has been described as an assistive process. Traditionally nursing has translated this assistance into 'doing for ' the patient. Today's nursing practitioners need to be aware that this simplistic approach will not

promote quality of care, particularly for the institutionalized elderly. There are complex dynamics involved in caring for residents in long term care. These dynamics include the values and attitudes of care-givers towards the elderly and the feelings related to providing care to someone whose condition is unlikely to change and can, in fact, deteriorate.

Conceptual Framework

Determining quality of care in any area of nursing is a multifaceted process with many confounding variables. What is quality? Who determines quality? What is the role of the professional, the consumer and society in determining the components of quality? As part of her doctoral thesis, Lang (1974) developed a model to provide a framework from which to examine or study quality assurance. The first component, formation of values is appropriate to this study.

"If a substantive definition (of quality) is to be achieved, then those aspects of patient care about which a statement of value, good or bad, is to be made must be specified. Endless detailed specifications must then define what constitutes goodness or badness" (Lang, 1974, p.66).

In defining values, Lang (1974, pg.78) cited King's (1962) definition that values are the principles by which priorities and hierarchies of importance among needs, demands and goals are established. To examine the potential elements involved in value formation, King's (1981) proposed theory of goal attainment provides appropriate guidelines.

Perceptions, interactions and communications between nurses in the caregiving environment are related to the component of values formation or identification of

importance among needs. These factors are themes presented in this study and are congruent with King's (1981) theory of goal attainment. Further, King's model represents a blended helping model that falls on a continuum between the medical model and the compensatory model (where clients initate contacts, define the problems, and identify solutions). King assumed both client and nurse were responsible for mutual goal setting including defining the problem and agreeing on the means to a solution (Cronwett, 1983). Mutual goal setting can be perceived as agreement on the goals that constitute components of quality care.

King's theory is derived from an open systems conceptual framework with three major components. The three components are personal systems, interpersonal systems and social systems. These components can be compared to the individual (resident or nurse), the actions between individuals and the work system. All of the three are important ingredients in congruence between nurses and residents on the importance or value of nursing interventions and all may have a potential effect on resident morale. Morale has been reported as being positively effected by perceptions of situational control of daily activities (Chang, 1978; Pohl & Fuller, 1980), the degree of social interaction (Pohl & Fuller,

1980), and environmental support for autonomy within an institutional setting (Ryden, 1985).

The major concepts within the three framework components are perceptions, self (personal systems); interactions, transactions, communications, role, stress (interpersonal systems); power, status, decision making (social systems). Perceptions are defined as "each person's representation of reality" (King, 1981, p.146). Perceptual accuracy is important in nurse/client interactions and a first step toward mutual goal setting. King (1981) identified two facets of perceptions that have the potential to influence behaviours, 'stereotyping' and the 'halo' effect. In long term care facilities, the potential for these facets to occur is possibly increased due to the length of the caregiving experience. Identification of the client/nurse ratings of the importance of nursing activities is an inherent component of mutual goal setting and should increase perceptual accuracy.

Purposeful interactions that should lead to goal attainment are called transactions. Transactions can offer a dynamic area for the study of expectations and performance of both nurse and client. "One approach to the study of transactions in nurse/patient interactions would be to search for: (1) concordance-discordance; (2) satisfaction-dissatisfaction; (3) congruence-

incongruence; and (4) accurate perceptions-inaccurate perceptions" (King, 1981, p.88). Searching for congruence-incongruence in nurse-resident interactions is relevent to identification of the priorities given to selected aspects of nursing care and, ultimately, to identification of congruence of nurse/resident values.

A long term care facility constitutes a social system. The concepts of authority, power, status and decision making were noted by King (1981) as part of a social system. Authority is viewed by King (1981) as a transactional process characterized by reciprocal relationships. The involvement of care recipients (residents) and nurses in identifying activities important to them involves the concept of authority sharing.

A feeling of having little or no status or power in the social system/organization has the potential to effect perceptions of self, control over decision making and personal status. Nurses who perceive a lack of power or status in the organization may have difficulty with mutual goal setting. Residents perceiving little or no involvement in decisions or control over their care may have decreased morale. In neither case will true quality of care be likely to exist.

The theory of goal attainment was derived from the conceptual framework by King (1981) described above.

The basis of the theory is that nurses and residents share information, set mutual goals and then work to obtain those goals. Three of the assumptions in her theory are particularly appropriate to this study. First, the perceptions, goals, needs and values of nurse and client influence the interaction process. Second, the goals of care-givers and recipients of care may be incongruent and third, individuals have a right to participate in decisions that influence their life and health. King (1981) hypothesized that congruence in role expectations and role performance increases transactions in nurse-patient interactions. This hypothesis is conceptually related to this study. Resident morale could be conceptualized as a positive transaction (or outcome) of the nurse/resident congruence on caregiving activities, in particular, activities that allow for a sense of control and choice.

In summary, the first component of Lang's (1974) model for quality assurance, formation of values, forms the background of the conceptual framework for this study. An examination of values in nursing care is the first step to establishing criteria or indicators of quality nursing care. In examining values, both the perceptions of the nurse and the resident need to be identified. To accomplish the above, King's (1981) theory, developed from an open systems framework,

provides an appropriate model. The theory deals with the nature and process of interactions between nurses and clients. The assumptions of her theory speak to the significance of patient involvement in the decision making and care processes, the importance of collaboration, and the humanity of the nurse/patient encounter (Meleis, 1985). The theory has the potential to predict the effectiveness or outcome of nursing/client interactions.

Chapter IV

Methodology

Overview

The major purpose of the study was twofold. The first purpose was to identify the importance nurses and residents placed on specific caregiving activities and the second, to explore the congruency or incongruency of their expectations in relation to the morale of the residents. The theoretical basis for hypothesizing that congruency or incongruency between nurses and residents may have the potential to relate to the concept of morale comes from King's (1981) theory of goal attainment. The theory assumes that the perceptions of nurse and client influence the interaction process and the goals of health professionals and recipients of care may be incongruent. Congruency in the goals of the nurse and client is considered to be a critical element in mutual goal setting. With incongruency, conflict and stress may occur for both. Given that residents remain in the institutional environment over an extended period of time conflict may well affect their morale. The concept of morale as used here was defined in the literature review.

Design

This study is a pilot project. The basic design is analytical and falls within the category of ex post facto (Wilson, 1985). In the first step, two groups of

subjects, nurses and residents, were compared as to the importance each ascribes, (on a scale of one to five ranging from no importance to extreme importance) to selected nursing activities. The second step involves identifying the congruence between the two group ratings of the activities. Thirdly, the congruence or non-congruence in the ratings of nursing activities will be examined to assess the extent to which this variable may affect the morale of the residents.

Theoretical and Operational Definitions

The following definitions are given for terms used in this study.

Theoretical definitions:

Morale: a multidimensional concept involving freedom from distressing symptoms, satisfaction with self, a fit between personal needs and what the environment has to offer and an ability to accept what cannot be changed. (Lawton, 1972).

Nursing: a process occurring in a nurse/client situation whereby information is shared about their perceptions in the nursing situation; goals, problems or concerns are identified and the means to achieve goals are explored. This process involves action, reaction and interaction. (King, 1981).

Congruence: the state or quality of being in agreement or having reached concensus on a point of agreement; being accordant or in harmony on ideas, beliefs and/or values.

Operational definitions:

Morale: operationally defined as a score obtained by residents, using the revised Philadelphia Geriatric Center Morale scale (Lawton, 1975). (See Appendix A).

Selected Nursing Activities: specific nursing actions, as modified from White's (1972) instrument, in four areas of resident care: 1) physical, 2) psychosocial, 3) medical/diagnostic, 4) educational/counselling. (See Appendix A).

Importance Rating: the level of importance given to a nursing activity as measured on a scale of one to five, ranging from no importance to extreme importance.

Congruency: The degree of agreement between nurses and residents on the importance of selected nursing activities as determined by White's modified instrument. There are two potential categories of congruence:

1) positive congruence; agreement that the activities which allow for a sense of control and decision making by residents are important.

2) negative congruence; agreement that activities which allow for a sense of control and decision making are not important.

Hypotheses

Two hypotheses were formulated for this study:

1. the importance rating of selected nursing activities by residents in a long term care facility will differ from the importance ratings of the same activities by registered nurses currently working in the same long term care facility.

2. the congruency in ratings between nurses and residents on the importance of nursing activities will have a direct relationship with the degree of the morale of the residents (as measured by the Philadelphia Geriatric Morale scale). The higher the congruency in ratings the higher the morale of the residents and conversely, the lower the congruency, the lower the morale.

Research Instruments

1. Nursing Activities Checklist

The White (1972) instrument consists of fifty statements describing nursing activities. The statements are scored on a Likert type scale ranging from extreme importance to no importance with a 'does not apply' category also on the scale. The fifty activities are divided into four categories; physical care (21 items), psychological aspects of care (15 items), medical care (7 items) and preparing for discharge (7 items).

The instrument was designed to determine the relative importance of the nursing activities. The checklist can be self-administered and requires little or no specific provisions or skills for completion beyond an introductory paragraph to provide a frame of reference and directions preceding the actual checklist. Content validity has been established (Ward & Lindeman, 1979) but no information directly dealing with reliability was found.

White (1972) developed the instrument for patients and nurses in an acute care setting. Modification of the tool is necessary to adapt it for a long term care setting. In particular, the fourth area of preparing for discharge needed to be altered to reflect teaching and counselling of residents. Item 41 and 50 pertaining to care at home and public health nurse visits were dropped from the tool. The elimination of these items would follow the approach of Smith et al. (1980). (See Appendix A for the complete instrument).

The limitations of this instrument are obvious. An advantage is the fact it is worded simply and devised to allow nurses and patients to rate nursing care activities specifically. The activities are not combined with caregiving activities performed by other health care professionals, therefore making it an appropriate tool to isolate the importance ratings of the nursing component

of caregiving. The scale has also been used twice previously with individuals in long term care facilities. The modified tool was reviewed for content relevance and clarity by expert professionals in the field of gerontology.

2. Philadelphia Geriatric Center (P.G.C.) Morale Scale

The P.G.C. Morale Scale was developed for an institutionalized geriatric population and designed to measure morale among the very old (Lawton, 1972). The term 'very old' means the mean sample age in two facilities was 77.9 and 78.8 respectively. The mean age of subjects for the revised instrument was 72.6. The scale is fairly short, thus reducing the fatigue factor for the elderly. The original scale consisted of 22 items representing six components; surgency (optimistic ideology, freedom from depression), attitude toward own aging, acceptance of status quo, agitation, easygoing optimism, and lonely dissatisfaction. The responses to the items are in a dichotomous format, i.e. yes, no; good, not so good; better, worse. Scoring is based on each 'correct' response. The mean morale scale judged to be above average in morale was 16.45 (standard deviation +4.02) and those deemed to be below average in morale obtained a mean score of 12.75 (standard deviation +4.64) (Lawton, 1972).

The original 22 item scale was retested and modified by Morris and Sherwood (1975) and Lawton (1975). Morris and Sherwood (1975) reduced the scale to 17 items, suggesting that 5 items appeared to be peripheral to the concept of morale. As the procedures they used resulted in replication of only three of the original six items, the suggestion was made that the items in the three components could be reduced to two longer factor scales, tranquility and satisfaction with life progression.

Lawton (1975) also reduced the scale to 17 items based on his retesting procedures but suggested that there were three consistently reproduced factors; agitation, attitude toward own aging and lonely dissatisfaction. These three factors were found to have a high degree of internal consistency with a Cronbach's alpha of .85,.81 and .85 respectively. This revision of the original scale constitutes the Revised P.G.C. Morale Scale.

Of the three versions of the scale presented here, the revised P.G.C. morale scale is being used. There is no overlap of identical items in the Lawton (1975) revision which is not true of the Morris-Sherwood scales (Morris & Sherwood, 1975). The other items from the original scale were not consistently reproduced in either of the two revisions (Lawton, 1975).

Correlations of life satisfaction, morale and adjustment measures have been reported (Lohmann, 1977). The results indicated that there is a high level of correlation among the several measures and this fact has been interpreted as meaning many of the measures are directed toward a common underlying construct. However, caution is issued by Sauer and Warland (1982) that since the scale was not developed from a theoretical base it, may be unclear whether the domain of morale has been adequately measured.

Other concerns have been raised regarding the measurement of morale (Kane & Kane, 1981). Inclusion of items on health and frequency of contact with relatives may confound the measure of morale. Morale should only be used with caution as an indicator of program effectiveness. There is the possibility of a positive-set response to items on a morale scale and there has, to date, been little involvement of the elderly themselves in identifying the components of the concept of morale. The potential may exist for subjects to form impressions about the state of their morale from the questions asked. These concerns have yet to be completely resolved.

Lawton (cited in Kane & Kane, 1981) recommended that the P.G.C. scale be used when there is interest in the separate dimensions of morale and with normally

responsive, marginally comprehending subjects. These criteria fit this study. There is evidence of reliability and validity from several samples. Given the current state of the art in the measurement of morale and the fact the P.G.C. scale was specifically devised for institutionalized residents, it has been selected for this study.

The Delightful-Terrible Scale (D-T Scale)

This scale, developed by Andrews and Whithey (1976) and modified by Michalos (1980) uses key words to identify various domains of people's lives. Individuals are asked to rate the words on a 7 point Likert scale. Test-retest validity and the alpha coefficient for the global scale of well-being were found to be .66 (Larsen, Diener & Emmons, 1985).

The scale has been used with many populations, including one with the rural elderly in Ontario (Michalos, 1982). A number of the domains, while very appropriate to individuals living independently or with support in the community, may not be appropriate to the type of institutionalized subjects in this study, for example, paid employment, housing, transportation and living partner. Health and finances, as defined, also raise some concerns. The definition of health includes being relatively free of common and chronic illnesses and

the category of finances includes income, assets, property, investments. Both of these definitions could create problems in subjects' responses to items. The potential exists for all the above mentioned items to be skewed to the negative side. Losses in these domains may have contributed to the process of institutionalization.

After deleting the inappropriate items and redefining health, the remaining items include; family relations, friendships, recreation/activity, religion and self esteem (See Appendix A). These, plus the two global questions on life satisfaction and happiness were used in conjunction with the P.G.C. morale scale. The added amount of time for subjects would not be more than 5 minutes.

Using the two scales could tap two different components of morale or well-being. The P.G.C. scale has a subjective (internal), affective oriented focus. The D-T scale, as adapted, has the potential to identify the external, cognitive and global factors perceived by respondents to be a part of life satisfaction and well-being. The number of items being deleted from the D-T scale and the lack of research on its' use with an institutionalized population make the investigator reluctant to use this measure alone.

In conclusion, Stones & Kozma (1985) have given

support to a hierarchial model of relationships among happiness/satisfaction scales. They suggest that scales with the highest internal consistency, such as the P.G.C. scale remain appropriate for gerontology. However, using two scales with slightly different domains has the potential to increase knowledge on the components of morale for the institutionalized elderly.

Subjects and Sampling

The sample was drawn from a 277 bed long term care facility in Winnipeg. This facility was chosen as it has a high population of residents and nurses from which to draw a sample. As well, it is a provincial facility and as such, does not have a specific ethnic or religious affiliation that could present an intervening variable. The facility is composed of both personal care and extended care units. The main difference between the two units lies in the number of nursing hours required to care for residents, extended care ostensibly having higher care requirements.

Data was collected by structured interview with the residents and questionnaires for the nurses. All participation in the study was on a voluntary basis. A resident, when approached by the investigator to explain the study and determine if he/she wished to participate, was offered the option of completing the questionnaire on his/her own without the investigator present. This decision would have been supported and questionnaires supplied in large print to facilitate those who might have had some visual losses. However, all residents expressed a wish to be interviewed by the investigator. The residents completed the modified White (1972) instrument rating the importance of selected nursing

activities, the revised P.G.C. morale scale (Lawton, 1975) and the adapted D-T scale (Michalos, 1980). Residents also completed a demographic data sheet. An interview would have been divided into two sessions if a subject resident found completing the data at one sitting too fatiguing but this was not necessary. Nurses were asked to fill out the demographic data form and the nursing activity checklist.

Resident Subject Selection

Criteria for selection of resident subjects included: a) age over 60; b) residing in a long term care facility on a permanent basis (as opposed to intermittent or respite admissions); c) admitted to the facility within the last four years (the facility was designated as a geriatric facility in 1983); d) ability to understand and speak English; e) oriented in three spheres (person, time and place).

The co-ordinator of each unit reviewed the kardex and generated a list of residents who met the criteria. From the 72 residents screened as being appropriate for the study, a random sample of thirty was chosen by the researcher Of the initial 30 subjects drawn, only four did not participate. One became too ill, one died and two did not wish to take part. Four other subjects were then randomly selected from the initial list to replace those not participating.

Nurse Subject Selection

Criteria for the nurse subjects included: a) current active registration with the Manitoba Association of Registered Nurses; b) currently working in a full or part time position in the long term care facility; c)working day or evening shifts. The last criterion was established to obtain nurses who will be most directly involved in caregiving activities and the goal setting component of the care plan. Nurses working permanently on the night shift have, by the nature of their hours of work, less interaction with residents than the other two shifts.

Registered nurses were selected for the study sample as they are the group with the overall responsibility for the care planning. They are in the leadership position on the long term care units, assign staff to residents and identify the nursing activities to be completed. They are also responsible to ensure activities are carried out as identified in the plan of care and for the evaluation of resident care.

The staffing clerk for the nursing department generated a list of nurses who met the identified criteria. There were 54 potential nurse subjects from which 30 names were drawn. From this initial group, only 13 consent forms were returned to the investigator. Reminder letters were sent out and another 17 subjects sent consent forms as well. In all, the

investigator was only able to obtain 28 consents from the nurses. Of these 28 subjects, 27 returned the completed questionnaires and data forms.

Other variables, deemed as having potential implications for the study, were collected on the demographic sheet (See Appendix B). The use of individualized care plans, involvement of residents in their plan of care, the level of care and type of nursing delivery system were previously identified as variables in studies on dependency and morale (Miller, 1985; Ryden, 1984; Ryden, 1985). The age of nurses, their educational background, total years experience in nursing and their experience in gerontology have the potential to affect their perceptions of residents, beliefs about nursing and the knowledge base from which they derive their practice (Chang, 1980; Cronwett, 1983; Eliopoulos, 1981).

Protection of the Rights of Subjects

The thirty resident subjects randomly selected for the study were first approached by the co-ordinator of their unit to determine their interest in speaking to the investigator regarding possible participation in her study. The researcher then contacted those subjects expressing an interest in participating. Subjects were assured that their participation was voluntary, they could withdraw at any time and/or refuse to answer

any questions without affecting the services provided to them. Assurance was given that all data collected would be confidential.

A letter of explanation and a consent form was sent to each nurse randomly selected from the list generated by the staffing clerk. This measure was done to avoid any feeling of coercion that might accompany being asked in person, either by the investigator or a supervisor. If the nurse wished to participate in the study, she/he returned the signed consent form. Then the investigator would send the nurse subject the questionnaire and demographic sheet. Anonymity was guaranteed by including an envelope, pre-addressed to the investigator, with the questionnaires. The nurses were assured that their names would not appear on the questionnaire or demographic sheet. Therefore, they could return their responses without the investigator being aware of their identity. Assurance was also given that all data would be confidential.

To ensure protection of subjects' rights, the study was approved by the Ethical Review Committee, School of Nursing, University of Manitoba (Appendix C).

Accessing Subjects

Since the subjects for the study were either residing or employed within the long term care facility, the administration of the facility was contacted

requesting approval for the study. Following verbal contact with administration, a written proposal was submitted. The proposal contained a written explanation of the study, criteria for subject selection, expected time requirements and the measures for confidentiality and anonymity (See Appendix D). A copy of the completed thesis was offered to the facility. A summarized final report was offered to the subjects upon request.

Data Analysis Procedures

The level of measurement is nominal and ordinal. To determine if the sample followed a normal distribution, the Shapiro-Wilk statistic, W, was computed. This statistic is reported to be the best with sample sizes of less than 51 (SAS User's Guide, 1985). Frequency tables, means, medians, modes, standard deviations and quartiles were calculated on the variables identified for both subject groups.

A percentile rank of the item scores from the White (1972) scale, the P.G.M. scale and the D.T.S. were found for both sets of subjects. The percentile rank was necessary to compare the scores from multiple scales that have different scoring measures. The Nursing Checklist has a 5 point Likert response, the D.T.S. a 7 point Likert response and the P.G.M.S. is a yes/no forced choice response.

As the sample was determined to not have a normal distribution and the level of measurement was within and between groups, the nonparametric statistical measure used to test for the first hypothesis (that residents and nurses would differ in rating nursing activities) was the Wilcoxon rank sum. Scatter diagrams were also done to obtain a visual presentation of the relationship between nurses and residents scores on the Nursing Activities Checklist (White, 1972).

Scatter plots were also used initially to identify any correlation between the independent variables identified as having a potential effect on the dependent variable, resident morale. These variables included age, marital status, length of time in the facility, the frequency of visits, and the resident scores on the nursing checklist.

Due to the nursing system in current practice, individual matches between nurses and residents to determine any correlation beteween congruence and morale could not be done. Therefore, a stepwise regression procedure was done with the resident data to determine if any relationship existed between the potential correlates of morale. Knowing the two groups' ratings of the subscales of the nursing checklist, it is possible to determine (by regression analysis) if the residents, whose score on the items of the physical or

psychosocial subscales differed from the nursing group score, had lower morale and vice versa. Other variables used in the regression analysis were age and frequency of visits. In doing the regression analysis, it was recognized that the sample size was too small to allow for many variables to be analyzed. The ideal would be 1:15 (1 variable to 15 subjects/per predictor) but 1:10 is acceptable (Stevens, 1986).

To further determine if there was a relationship between identified variables and morale, particularly with categorical variables, the Kendall Tau correlation procedure was used. The variables included length of time in the facility, education level, marital status, assistance with care, morale subscales, and the physical and psychosocial subscales from the nursing checklist.

Spearman correlation coefficients were done to determine if there was any association between the resident scores on: 1) the subscales of the nursing checklist and the total scores on the P.G.M. scale; 2) the subscales of the P.G.M.S. and the D.T. scale; 3) the eight items of the D.T. scale. The Spearman rho was chosen as it is a nonparametric technique that uses rank-order data.

Factor analysis had been considered, however the sample size was not large enough to warrent this test. The results could not be determined with any confidence.

Given the results of the rank order correlations on the morale scale, in particular the D.T. scale, and because there is little information available on the White (1972) scale, a reliability analysis, including alpha coefficients, was done on all three scales.

Reliability of Instruments: Current Study

From the data analysis the following information on the instruments used in this study was obtained.

Nursing Activities Checklist

As noted in the review of White's instrument on nursing activities, little information was found on reliability. For this study Alpha coefficients were calculated for both the total activities checklist and the four subscales for the two sample groups. These are as follows: for the nurses, the total scale .96, subscales; physical .93, psychosocial .91, education .80, medical .71; for the residents, complete scale .90, physical .85, psychosocial .76, education .65, medical .41. As can be seen, the Alpha coefficient for the medical subscale is lower for both groups, although especially for the residents. From this finding, it would appear that there is no internal consistency for the 6 items of this subscale for residents.

No alpha co-efficients were found for the original scale (White, 1972), therefore a comparison is not possible. Two items were changed from the original medical subscale for this study; one was deleted and one modified so the intent of the item reflected the category educational. This modification may have affected this subscale co-efficient. However, the subscale educational was modified to a greater degree. Four items relating to

discharge were inappropriate to an institutionalized population thus deleted or changed. Yet the internal consistency is higher for this subscale than for the medical subscale.

Inter-item correlations and correlation matrix from the reliability analysis found some redundancy in questions on the scale. Question 1 on temperature and pulse showed very little correlation with any other items and the two questions on religion (28 & 29) were highly correlated with each other for both groups.

D.T. Scale

Given that the D.T. scale has not been used extensively with the institutionalized elderly, a Spearman correlation coefficient was computed for all domain items (items 1-6) on the scale and the two global questions. The results showed no correlation between domain items. For the global questions, only the domain item self esteem correlated with satisfaction ($r=.5$, $p=0.005$), while health and self esteem correlated with happiness ($r=.43$, $p=0.02$ and $r=.57$, $p=0.001$ respectively). As the finding of no relationship between any of the domain items was unexpected, reliability analyses were done for the six items. An alpha coefficient of .04 was determined. From this finding, it was assumed that each domain item in the scale was acting independently for this sample

population. This finding could be related to the small sample size or different population characteristics.

P.G.C.M. Scale

Alpha coefficients were also computed for the P.G.C.M total scale and subscales. The reliablity coefficient for the total scale of 17 items was .85. The coefficients for the subscales were as follows: agitation, .84; lonely dissatisfaction, .63; attitude to own aging, .68. The coefficient for agitation is similar to Lawton's (1975) finding of .85. The other two correlation figures are lower than Lawton's figures of .85 and .81 respectively but close to Pohl and Fuller's (1980) findings of .73 for lonely dissatisfaction and .66 for attitude to own aging. Again, any differences may be due to different population characteristics or sample size.

Characteristics of the Sample

Nurses

An analysis of the responses from the 27 nurses who returned the demographic questionnaire revealed the following information. As might be expected given the current female orientation of the nursing profession, females were in predominence with 26 females and 1 male responding to the study. The mean age of the sample was 46.8 years, ranging from 37 to 63 years. The sample was older than might have been expected and it could be queried whether the older age range is true for nurses in other geriatric facilities. The Smith et al (1980) study, done in a geriatric facility, reported a mean age for nurses of 39.7 years. Published accounts of other studies (Caron, 1984; Fielding, 1974; Smith, 1986) have not reported the mean age of the nurse sample.

The high mean age is reflected in the mean number of years, 18.1 (SD 8.55 yrs.), spent working in nursing. No one had worked less than 4 years, with a range from 4 to 41 years. The mean number of years reported for working with the elderly and working at Deer Lodge Centre were almost identical, 8.81 (SD 5.31) for elderly and 8.88 (SD 5.26) for the Centre. It would appear from this finding that the relevant experience in working with the elderly was primarily gained while working within the

facility.

More than half the sample (51.9%) worked day shift. One third (33.3%) worked full time and the majority (81.5%) worked more than 2 days a week. These findings are similar to those reported by Ryden (1985).

In terms of education, 26 subjects (96.3%) held a diploma in nursing; 23 subjects were from 3 year hospital diploma programs, 3 from 2 year diploma programs. One respondent held a degree in nursing. Although diploma programs of 2 years duration are the norm currently, the number of subjects from 3 year programs could be expected given the age of respondents and the number of years spent in nursing. The assumption could also be made that the focus of the curricula content would be on the medical model, with little emphasis on aging per se.

Continuing education was limited. Forty eight percent (13 respondents) listed no certificates or degrees, 7 held certificates in gerontology, 7 more had certificates in administration. For this study, continuing education consisted of giving a list of options (see Nursing Demographic Sheet, Appendix B) for education. The education content need not have been specifically in the nursing field, however some measure of learning or standardization of course content was desired (by the investigator) for this variable. Thus course content should be recognized by an educational

centre or the professional association. The measure of recognition was obtaining a certificate for the course(s). Therefore, individual facility inservice education, unless it led to a certificate, was not included. The criterion of obtaining a certificate or degree as a measure of continuing education is also used by the Manitoba Association of Registered Nurses.

The nursing system most frequently reported as being practiced was team (55.6% or 15 subjects) followed by functional (40.7% or 11 subjects). One subject reported a primary system of nursing. As there was no unit with only one nurse responding, this response was probably an error on the part of the nurse.

All nurse subjects reported that individualized care planning was carried out (100%). In regards to resident involvement in the care planning, nurses who reported resident involvement were asked to describe the nature of the involvement. The responses were categorized as none, minimal, moderate or complete. The categories of minimal, moderate and complete were devised according to King's (1981) conceptual model.

The minimal category involved some form of interaction between nurses and residents. Goals were not mentioned by the nurses but it was acknowledged that residents had choice in some aspects of daily living such as choice of clothing, morning bath, or activities. All

of these items had the caveat 'according to their ability' applied by the nurses.

Moderate involvement would incorporate nurses' involvement of residents, to some degree, in goals pertaining to their care. An example of this type of involvement, as collected from the data, was a review of goals with residents or residents being consulted on goals related to certain aspects of care, such as their desire for a conservative approach to further treatment should they become ill. Complete involvement would meet the requirements for the theory of goal attainment and include nurses and residents as mutual participants in identifying desired goals and agreeing on the measures to achieve the goals.

For this study, 29.6% (8 nurses) reported no resident involvement in care planning. Another 59.3 (16) nurses reported minimal involvement and 11% (3) reported a moderate level of involvement. No one reached the category of complete resident involvement. The possibilty of a relationship between the type of nursing system and the amount of resident involvement in the care plan was explored by using a CHI-Square statistic. However, as the results showed that greater than 20% of the cells had an expected frequency of less than 5, this measure could not be considered valid.

Overall, the nurse subjects were similar to

those in the Smith et al (1980) study in terms of education, but were older and had worked in the facility longer. The deployment of nursing staff (numbers, shift schedules, nursing system) is similar to that found in the Smith (1986) study and raises the same implications for continuity of care and resident involvement in care.

Residents

The following information was derived from the analysis of the 30 resident respondents to the demographic portion of the study. The mean age of the resident subjects was 75.5 years (SD 9.45), with a range from 64 to 98 years. These findings are similiar to findings in other studies (Chang,1979; Ryden, 1984; Smith, 1980;) but slightly lower than the reported average of 84.3 years for residents of personal care homes in Manitoba (Havens, 1987).

The sample is unique in regards to sex, with 23 male respondents (76.7%) and 7 females (23.3%), when compared to other studies on long term care where females predominate. This fact reflects the 'Veteran' population and arises from the agreement to maintain 155 beds in the Centre for this group when the facility passed from the federal to provincial government. In this regard, the sample is closer to the study done by Epstein (1981) on the Veteran's Administrations health care system in the United States.

Forty percent (12) of the sample were widowed and 10 (33.3%) were married. The married category is slightly higher than reported in other studies (Linn & Linn, 1984; Epstein, 1981; Seelback & Hansen, 1980). The remaining 8 subjects were single, separated or divorced. As might be expected, the living status prior to

admission reflects the findings on marital status. Fourteen (46.7%) of residents lived alone prior to admission and 8 (26.7%) lived with a spouse. The latter figure is lower than the number of married subjects but is probably reflective of the few residents who were married yet had wives who received care elsewhere.

The reported frequency of visits tends to support the belief that residents are not abandoned by family and friends. As Shanas (1979) noted, it is a social myth that the elderly are alienated from their families. Visits either daily or two to three times a week were reported by 43.3% of the sample. Another 40% reported having visits as least weekly.

In regards to education, 14 (46.7%) had grade school or less. Combining the categories, high school (or less) and grade school, accounted for 63.3% of the sample. This finding is also similiar to other studies (Ferraro, 1980; Linn & Linn, 1984). As might be expected from the education findings, 80% of the sample were employed in manual or technical/clerical work.

Fifty percent of the resident sample had entered the Centre from another facility, either acute care or rehabilitiation. Forty percent entered from a private home (or apartment) and the remaining 10% from a senior housing facility, rooming house or another personal care home.

For this study, the length of time subjects had spent in the Centre was partially controlled by the criteria that eliminated any residents admitted less than 2 months prior to the study or who had lived in the Centre for 5 years or more. As a result, 70% of the sample had lived in the facility less than 3 years and 36.7% (11 subjects) had lived in the facility less than 1 year.

In terms of the level of care required, the Manitoba Health Services Commission categories were used. These categories range from 1-4, with the higher the level the higher the care needs. Care needs are based on the number of nursing hours required. The major emphasis is on physical care needs. The category for the resident subjects was either found on the kardex or reported by the nurses. Twenty-four (80%) of the subjects were listed as level 2; 6 subjects (20%) were level 3. The sample is representative of individuals who have lower physical care needs.

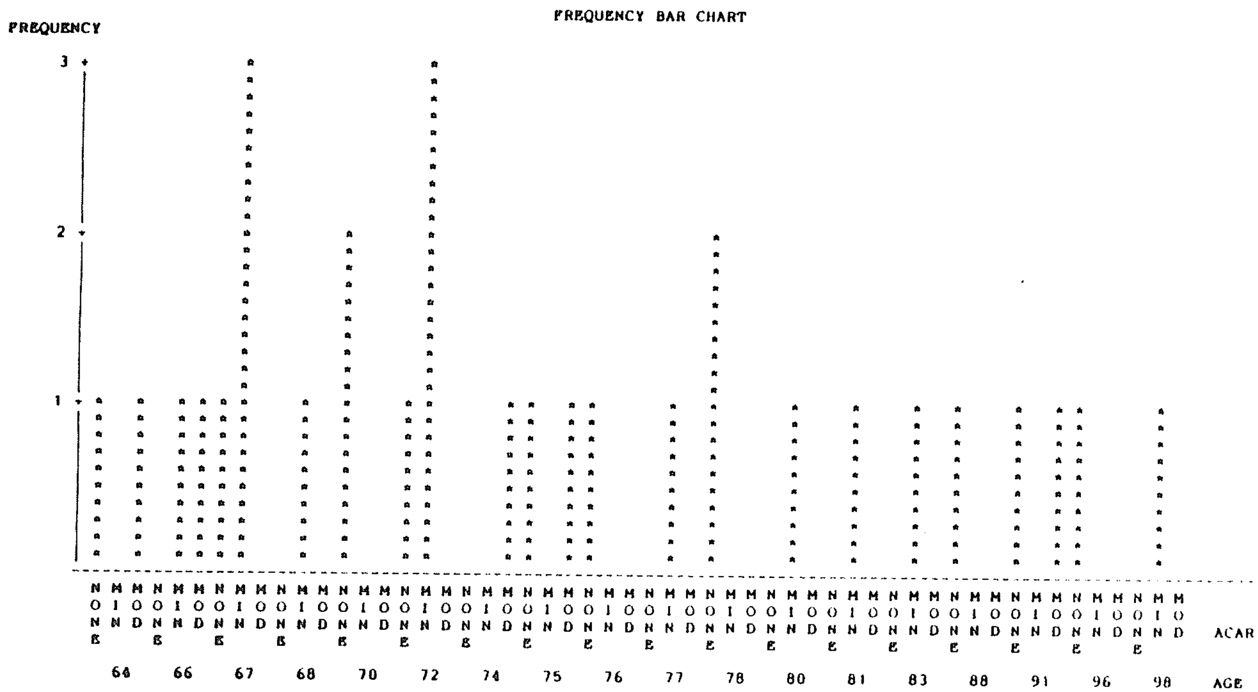
These findings are reflected in the results from the 'assistance required with care ' category. No resident reported requiring complete assistance with care. Eighty-three percent stated they required minimal or no assistance. The four categories for assistance were: 1) hygiene; 2) eating; 3) dressing; 4) mobility. To rate a response of no assistance, a subject would require no

assistance in any of the four categories (except perhaps wanting company off the ward). The minimal category meant assistance was required with one or two of the above categories (eg. cutting food, helping in or out of bathtub). Moderate assistance would include help in 2 or 3 of the above categories, while complete assistance meant help was required in all four categories.

The subjects rated themselves as to the amount of assistance required in each of the four categories. On the rare occasion where the investigator had a query related to the self rating, the nursing kardex was used to verify the information. In all cases the resident subject had been accurate in his/her appraisal of the assistance required with care. A CHI Square did substantiate that level of care was related to assistance with care. However as more than 20% of cells had a frequency count of less than 5, the test can not be considered valid.

A frequency bar chart was also done to examine any potential relationship between age and needing assistance with care. The question was whether older subjects needed more assistance with care. The results showed that increasing age was not a factor in this study (see Figure 1). In fact, more younger residents (4 in the 64-75 age range) needed moderate assistance, whereas only 1 resident in the 76-98 range needed moderate assistance.

FIGURE 1 AGE AND ASSISTANCE WITH CARE



However, this finding is also tempered by the fact there were 18 residents in the younger category and 12 in the the older category.

As noted in the description of the facility, it was designated as a long term care centre in 1983. Prior to this date, it was a veterans' hospital. However 6 units out of 9 (at the time of the study) remained for the veteran population. Therefore, the majority of subjects reflected this population. By random selection, 21/30 of the subjects were veterans. This factor has likely influenced some of the findings. It is definitely reflected in the number of males.

Other influences may have been present that were not identified in the study. Epstein's (1981) study on Veteran nursing home facilities in the United States found that, compared with a national sample, veterans "were less senile, and much less arthritic, although they had more mental illness and more heart disease" (pg. 62). They were slightly younger than the average. Epstein (1981) also found these veterans were single, poor men. This study had a higher than average rate of married subjects. Information on income was not directly collected but some subjects volunteered that they were "comfortably well-off". Some of the variables mentioned by Epstein (1981) may have been partly controlled for here by not including subjects admitted prior to the transfer of the facility.

Analysis of Hypotheses

The first hypothesis for this study stated that nurses and residents would differ in their ratings on the importance of nursing care activities. To determine if this occurred, the responses of the fifty-seven subjects (30 residents and 27 nurses) to the Nursing Activities Check List (White, 1971) and to the four subscale components (physical, psychosocial, medical and educational) were analyzed. A continuity correction of 0.5 was applied with the Wilcoxon test to adjust for the difference in the two sample sizes.

The mean score for the nurses on the total Nursing Activities scale was 193.81 (SD 18.73), with a low score of 161 and a high score of 224. The resident sample scored a mean of 161.83 (SD 22.99) on the scale with a low score of 116 and a high of 198. The median score of the nurses (at 198) was equal to the highest score of the residents. Using the Wilcoxon (Rank Sums) test to measure the significance of the differences in scores, the sum of scores was found to be 1074 (nurses) and 579 (residents), $Z=4.6446$ and $p>|Z|=0.0000$. Thus, as a group, nurses rated all activities on the nursing checklist significantly higher in importance than residents.

The results from the subscale physical were similar to the total scale. The mean score of the nurses was

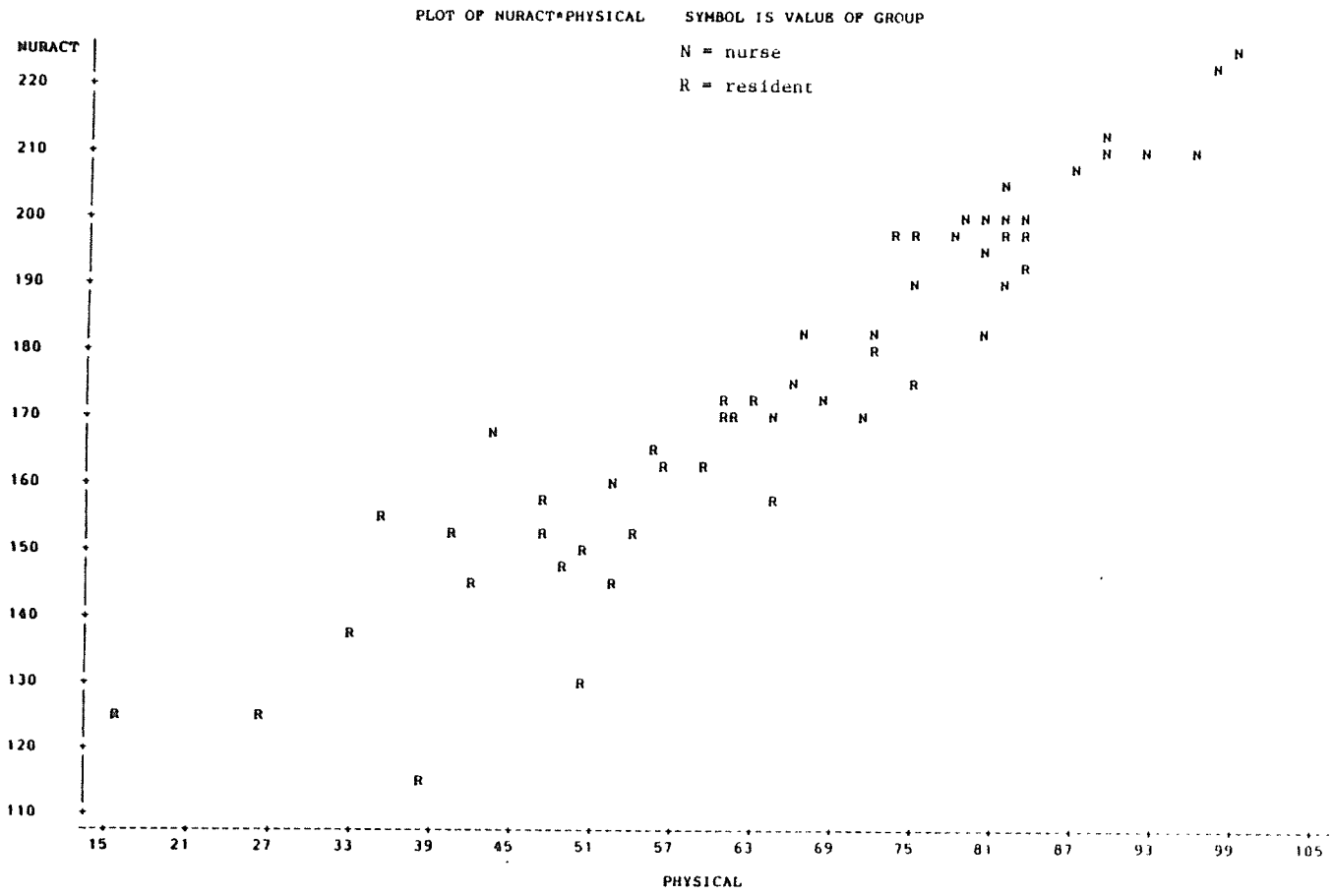
78.66 (SD 13.35) and the mean score of the residents was 56.05 (SD 17.08). Again, the median score of the nurses (80.2) was nearly equivalent to the highest score of the residents (82.9). Using the Wilcoxon test, the sum of scores was 1063.5 (nurses) and 589.50 (residents), $Z=4.4777$ and $p>|Z| =0.0000$. As before, the results depict a significant difference between nurse and resident subjects, with the nurse subjects rating the physical care activities higher in importance. (See Figure 2)

The scores from the subscale psychosocial offered corresponding results. The mean score for nurses was 84.08 (SD 11.1) and for residents 70.4 (SD 12.8). From the Wilcoxon, the sum of scores was 1018 (nurses), 634.50 (residents) with $Z=3.7595$, $p>|Z|=0.0002$. (See Figure 3)

Similar results were found for the remaining two sub scales. For the education subscale, the mean scores were 88.42 (SD 11.33) (nurses) and 72.08 (SD 19.68) (residents) with a Wilcoxon score of $Z=3.3594$, $p>|Z|=0.0008$. The medical subscale had mean scores of 87.8086 (SD 9.73) (nurses) and 73.6111 (SD 12.68) (residents) with a Wilcoxon score of $Z=4.0003$, $p>|Z| =0.0001$. Overall, on all four subscales, the nurses rated the associated activities higher in importance than did the residents. In examining the Standard deviation scores, nurses also showed less variability in responses. This finding is particularily true for the education,

FIGURE 2

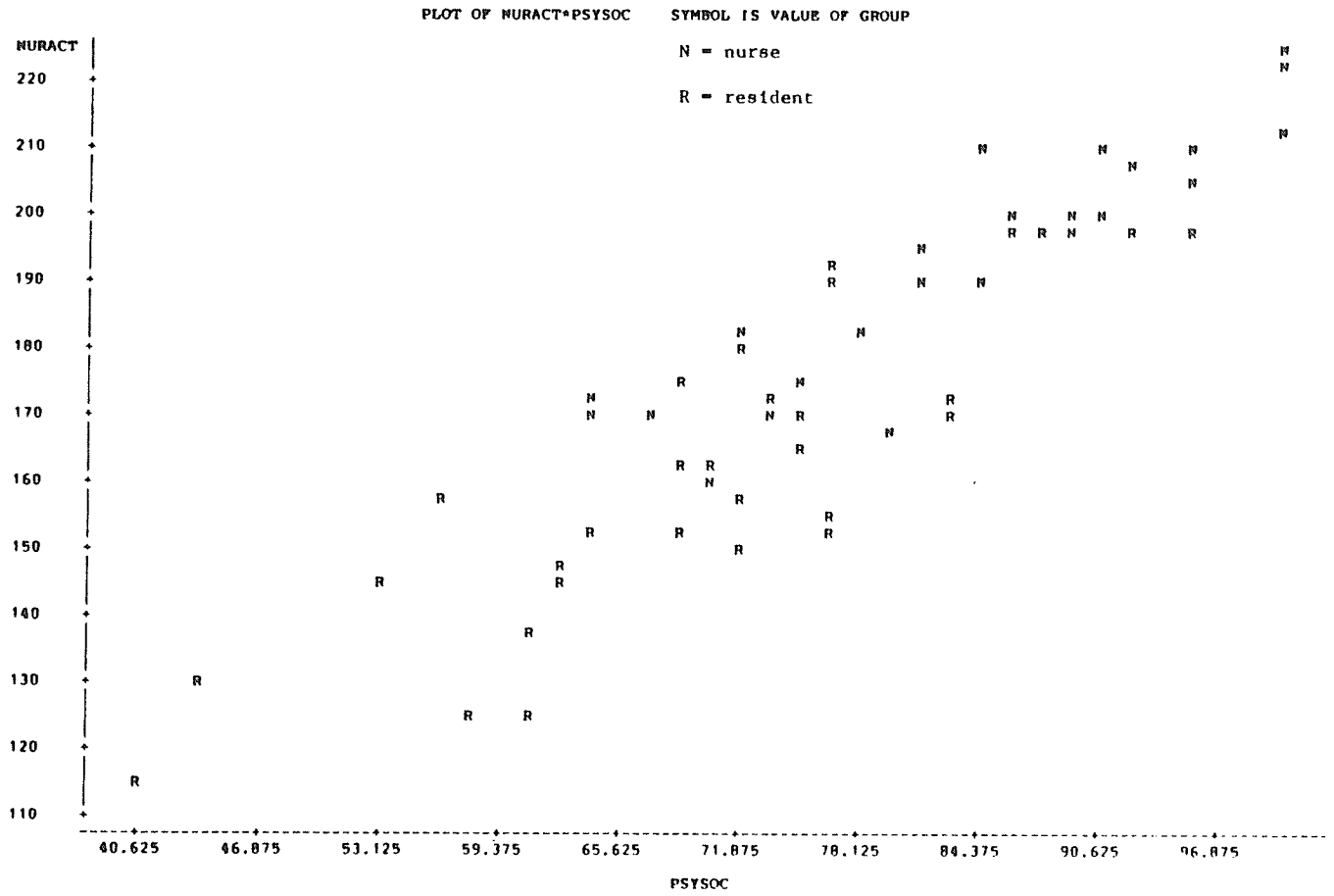
NURSE AND RESIDENT RATINGS OF SUBSCALE PHYSICAL WITH NURSING ACTIVITIES SCALE



Percentages

FIGURE 3

NURSE AND RESIDENT RATINGS OF SUBSCALE PSYCHOSOCIAL WITH NURSING ACTIVITIES SCALE



Percentages

medical and physical subscales.

Another measure of congruence/incongruence is the specific types of activities rated highest and lowest by the two subject groups. The five highest and lowest rated items for the two groups are listed in Table 1.

Of the five activities rated highest by nurses and residents, two items appeared in both sets but were given different ranks. Privacy was rated highest by the residents and in third place by the nurses. Caring and concern was rated second by the residents and tied for fifth place with the nurse group. Items were considered to be tied if there was no difference in the mean, standard deviation, standard error of mean and variance between the two. All five of the important items for residents were from the category of psychosocial; for nurses, two were from the medical category, one from the physical and three from the psychosocial category.

The five activities rated least important were also different for nurse and resident subjects. However, each group had three in the physical category and two in the psychosocial category. Both psychosocial items in the resident category pertained to religion.

The ratings of specific activities as high or low differs from the ratings found for the overall subscale categories. The rating of the psychosocial category as third for the resident group was surprising given that

Table 1 Ratings of Nursing Care Activities

Highest Rated Activities

Nurses		Residents	
Activity	Mean	Activity	Mean
1 notice pain	4.85	1 privacy	4.63
2 skin care	4.78	2 caring & concern	4.40
3 privacy	4.74	3 talk to resident	4.40
4 allow decisions	4.74	4 encourage self care	4.33
5 notice changes	4.70	5 take time to listen	4.30
caring & concern	4.70		

Lowest Rated Activities *

Nurses		Residents	
Activity	Mean	Activity	Mean
1 take temp/pulse	3.1	1 assist with meals	1.86
2 assist with bath	3.55	2 assist with mouth & teeth	1.96
3 copy of menu	3.59	3 arrange for visit by clergy	2.30
4 keep bedside tidy & clean	3.67	4 help in & out of bed	2.57
5 assist in getting to & from places	3.93	5 assist to attend religious services	2.60

* 1=lowest rated item, 2=2nd lowest in rating, etc.

the five top ratings of activities were in this category. As the two psychosocial items on religion were both found in the lowest ratings for the resident group, the subscale psychosocial was rerun with these items deleted. The results of both subject groups' ratings of the subscale components can be found in Table 2. Item means were determined from a reliablility analysis to obtain Alpha coefficients. As can be seen, the nurses rated Education highest, while the residents rated Medical as highest. However, within each group, the two categories are nearly equal. Both groups rated Psychosocial and Physical third and fourth, although the residents rated the Physical component far lower than the other three subscales. By deleting the two items on religion in the

Table 2 Ratings of Subscale Components from Highest to Lowest

Nurses			Residents		
Subscale	Mean%	Item Means	Subscale	Mean%	Item Means
Education	88.4	4.54	Medical	73.6%	3.90
Medical	87.8	4.52	Education	72.08	3.88
Psychosocial	84.1	4.36	* Psychosocial	70.4	3.81
Physical	78.7	4.16	Physical	56.05	3.24
			* Psychosocial (minus 2 items)	72.02	4.0

resident subscale Psychosocial, the item mean is now highest, the mean % is equivalent to Education.

By examining the reliabilty analysis data, differences were found for the two groups. For the nurses, questions on bowel functioning (17), helping in and out of bed (18) and assist with meals (30) correlated with all other items. The residents had a number of negative correlations for items, such as the question on allowing decisions (10). Items on talking to residents and taking time to listen were highly correlated for resident subjects but not for nurses. The question on observing the effects of treatments (15) showed a poor and negative correlation for the resident subject group.

Given the findings as presented here, the first hypothesis, that nurses and residents would be incongruent in their ratings of nursing activities, is accepted to the extent that the instrument used can capture incongruence. The primary area of incongruence was in the degree of importance given to activities i.e. the nurses rated items from both the total nursing activities scale and the subscales as higher in importance than did the residents. Incongruence was also found in the ratings given to specific items and subscale categories.

Hypothesis 2

The second hypothesis for this study is related to resident morale. It was conjectured that, if there was incongruence between nurses and residents on the importance given to nursing activities, residents' morale could be affected. To determine morale, the scores from both the P.G.C.M. scale and the D.T. scale were analyzed. For both scales, the higher the score, the higher the morale. It should be noted that the subscales in the P.G.C.M. are named for the low score, e.g. a low score for agitation means there are more characteristics of this component present and a high score means fewer characteristics.

P.G.C. Morale Scale

The mean score for the total P.G.C.M. scale was 64.1%. The scores, as noted under data analysis, were converted to percentages to allow for comparison between scales with different scoring measures. In numbers, the score would be 10.9 out of a potential total of 17. However, the total score does not give a complete picture of morale. Considerable variation was found between the subscales in terms of morale.

The score of the subscale agitation, which includes the symptoms of anxiety and dysphoric mood elements (Lawton, 1972) scored a mean of 68.06% (11.57). The subscale lonely dissatisfaction, which has a relevance to social relationships with a positive direction likely

to be consistent with satisfaction with relationships, had the highest mean rating at 72.5% (12.34). The high score here may be reflective of the frequent number of visits described previously under analysis of demographic data.

The greatest variation within the P.G.C.M. scale was found for the subscale, attitude to own aging. This component is noted as being "related to self perceived change or lack of change as one ages, evaluation of the quality of change and to some extent, stereotypic attitudes" (Lawton, 1972, pg.154). The mean score for this subscale was 49.3% (8.38). These findings suggest that subscale components yield more information than a total mean score.

The question that still begs to be answered is whether these scores constitute low morale. Lawton (1972),in his original development of the scale, stated the mean morale score of subjects from both samples judged to be above average in morale was 75% (16.54 out of a possible 22). The subjects judged to be below average in morale obtained a mean score of 58% (12.75). Other studies (Chang, 1978; Ryden, 1984) using morale as the dependent variable have only reported on the change or lack of change from manipulating the independent variables. Whether the morale was high or low for the sample was not discussed. However, the

reported mean scores for morale in other studies using institutionalized elderly subjects have been similar to the findings in this study. Ryden (1984) reported a total sample score of 11.01 (64.8%), while Pohl and Fuller (1980) found the mean score to be 10.98 (64.58%).

Using the criteria as established by Lawton (1972) for high and low morale, only one subscale, lonely dissatisfaction, could be interpreted as being high in morale. The agitation subscale could be considered to fall in an 'average' range while the subscale attitude to own aging was decidedly below average in morale. As the total P.G.C.M. score represents the range found in the subscales, any interpretation of this score becomes less meaningful than interpreting the subscale components for this study.

D.T. Scale

The mean score for the D.T. scale (domain items health, family relationships, friendships, recreation, religion, self-esteem, excluding the 2 global questions) was 63.24% (4.43 out of a potential of 7). The mean score for the global question on life satisfaction was 4.30 and for the global question on happiness, the mean score was 4.966. Given these results, neither domain or global questions reached the mean of 5.18 for domain items, 5.19 for satisfaction and 5.31 for happiness as cited by Michalos (1982). This study is more appropriate

for comparison than similar studies on the scale as it was done with an elderly population, albeit non-institutionalized. To date, little work has been done using the D.T. scale with an institutionalized population.

To identify any relationship between the P.G.C. morale scale, the D.T. scale and the global questions on satisfaction and happiness, Spearman correlation coefficients were computed (See Table 3). The highest correlation is found between the P.G.C.M. scale total score and the D.T. scale score (r=.57, p=0.0010). A

Table 3 Spearman Correlation Coefficients for P.G.C.M. and D.T. Scales N=30

	1.	2.	3.	4.
1. P.G.C.M.	1.000	0.571	0.338	0.367
	0.000@	0.001	0.067	0.046
2. D.T.S.		1.000	0.377	0.486
		0.000	0.039	0.006
3. D.T.7*			1.000	0.348
			0.000	0.059
4 D.T.8*				1.000
				0.000

@= p values

* D.T.7=satisfaction question; D.T.8=happiness question

correlation, although lower, was found between the P.G.C.M. scale and the global question on happiness (r=.37, p=0.05) but no correlation was found between the P.G.C.M scale and the global question on satisfaction (r=.34, p=0.07). Of interest was the finding that the correlation between the two global question did not reach significance (r=.35, p=0.06).

Further correlations were done between the subscale components of the P.G.C.M. scale and the D.T. scale (Table 4). The correlation for the subscales attitude to own aging and agitation did not reach statistical significance (r=.32, p=0.09). The subscale 'lonely' showed a correlation with both the other subscales. All the subscales of the P.G.C.M. scale were significantly correlated with the D.T. total score.

The subscales of the P.G.C.M.scale were also examined for their relationship to the two D.T. global questions, satisfaction and happiness. Neither agitation nor lonely dissatisfaction showed a correlation with the global satisfaction questions. Attitude to own aging had a weak correlation with satisfaction (r=.36, p=0.05). For the global question on happiness, the subscale agitation again showed no correlation but both lonely dissatisfaction and attitude to own aging did reach a statistically significant correlation with happiness (r=.38, p=0.04 and r=.45, p=0.01 respectively). It

Table 4 Spearman Correlation Coefficients for P.G.C.M. Subscales and D.T.Scale

	1	2	3	4	5	6
1.Agitation	1.000	0.440	0.319	0.364	0.154	0.249
	0.000@	0.015	0.085	0.048	0.415	0.183
2.Lonely		1.000	0.451	0.457	0.263	0.375
		0.000	0.012	0.011	0.159	0.041
3.Attitude			1.000	0.494	0.361	0.446
			0.000	0.005	0.050	0.013
4.D.T.Total				1.000	0.377	0.486
				0.000	0.039	0.006
5.D.T.7*					1.000	0.348
					0.000	0.059
6.D.T.8*						1.000
						0.000

@ = p values

* D.T.7=satisfaction question; D.T.8=happiness question

would appear from the findings that attitude to own aging is the factor from the subscales most highly correlated with the D.T.scale, including the two global questions on satisfaction and happiness.

The procedure used to identify any relationship between incongruence and morale was the stepwise regression analysis. As noted previously, individual matching to measure congruence/incongruence and its relationship to resident morale was not possible. Therefore, the strategy used was to identify any potential relationship between resident scores on the morale scale and the way they scored the two major subscales of the nursing activities checklist (physical and psychosocial). If a resident rated the subscale items as low in importance, given that the nurse group rated these items high, incongruence could be assumed and the resident's morale would be low. Conversely, if the resident agreed the nursing items were important, there would be congruence with the nurse group, and morale should be higher. The resident scores on the P.G.C.M. scale were used as the dependent variable and the subscales physical and psychosocial, age and frequency of visits as independent variables. However, no variables met the .15 significance level necessary to run the regression model.

A Kendall Tau correlation was also done using the physical and psychosocial subscale categories (from the nursing checklist), the length of time in the facility, education level, marital status, and assistance with care with the P.G.C.M. subscales. The variable assistance with care was used as one measure of health status, to

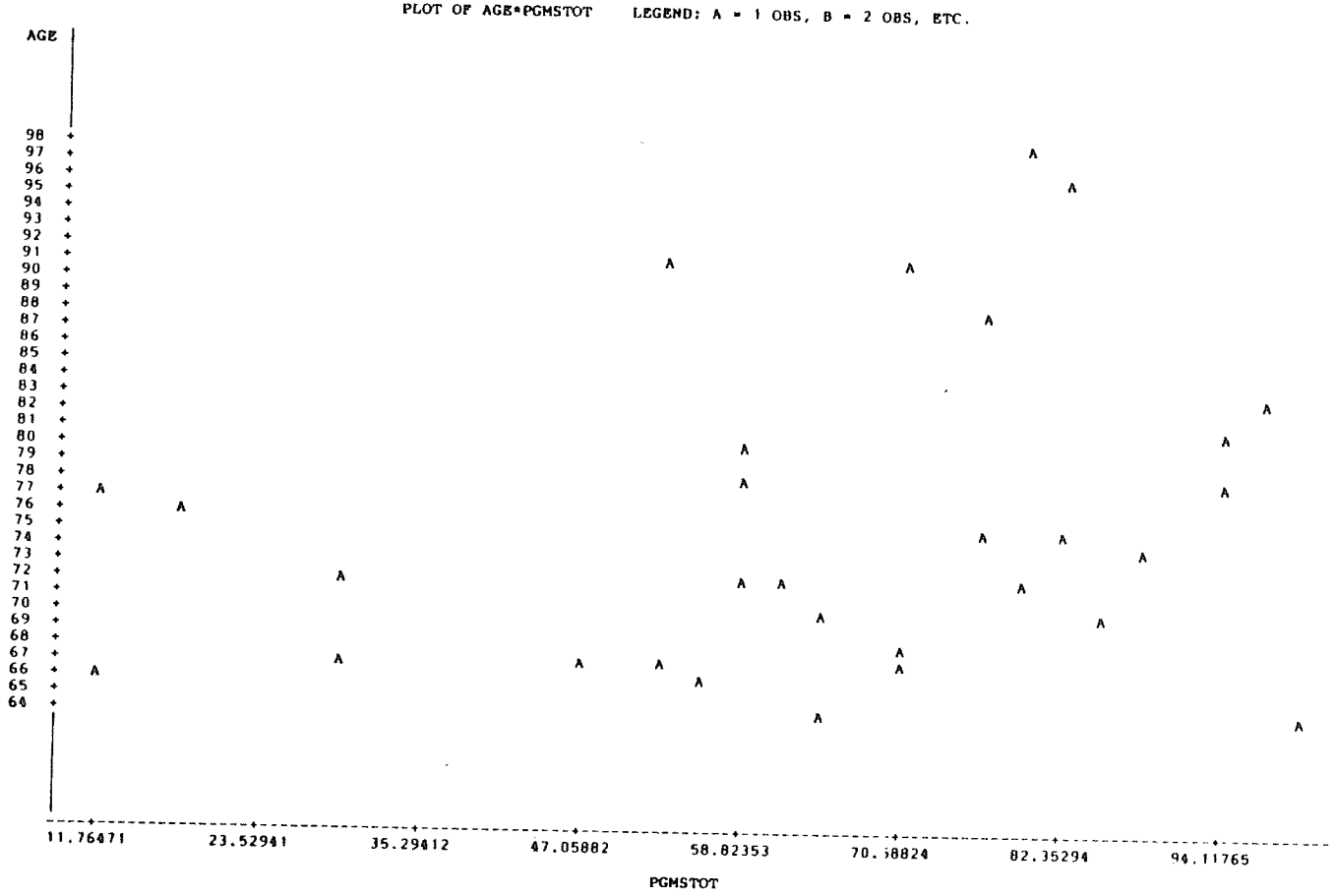
determine if physical health could have a relationship with morale. Again no correlation was found between the above variables and morale scores. The only relationship found was between the variable, assistance with care and the subscale physical ($r=.42$, $p=0.005$).

Other measures were used to examine the variables that were thought to have the capacity to affect morale. An examination of the means and scatter diagrams for the variables age, length of time, frequency of visits, and marital status showed no relationship with morale (see Figures 4, 5, 6, 7). The P.G.C.M. scores were again used as a measure of morale.

The lack of a relationship between morale, age, and length of time in the facility are similar to the findings of other studies (Chang, 1978; Pohl & Fuller, 1980; Ryden, 1984). The lack of a relationship between frequency of visits and morale is somewhat surprising as it is this factor that might be expected to account for the higher morale score found in the subscale lonely dissatisfaction.

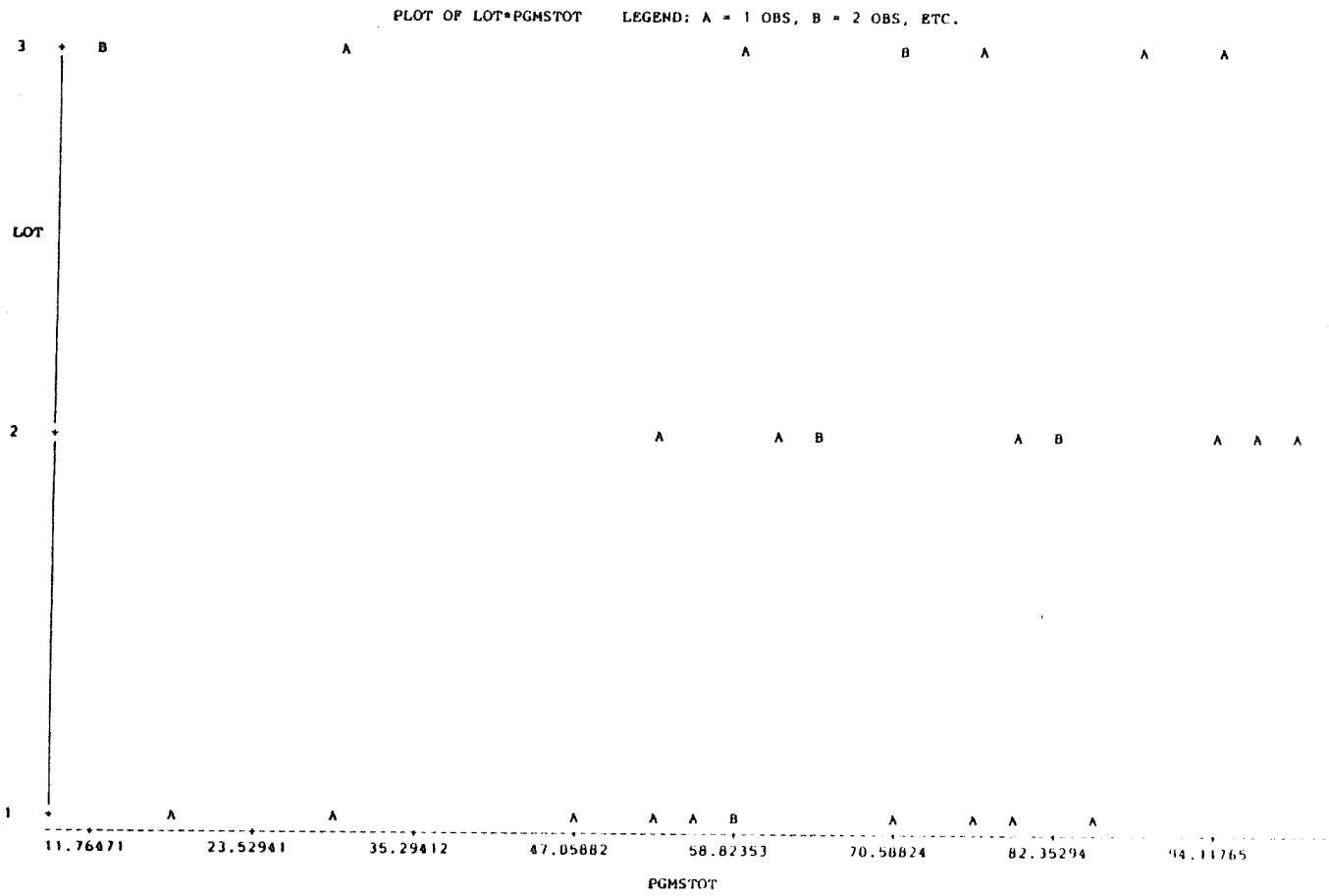
The Spearman correlation coefficients showed no relationship between P.G.C. morale scale and the importance residents gave to any of the items on the subscales of the nursing activities checklist. However, it was obvious the four subscales of the nursing activities checklist correlated with each other except

FIGURE 4 AGE AND PHILADELPHIA GERIATRIC MORALE SCALE



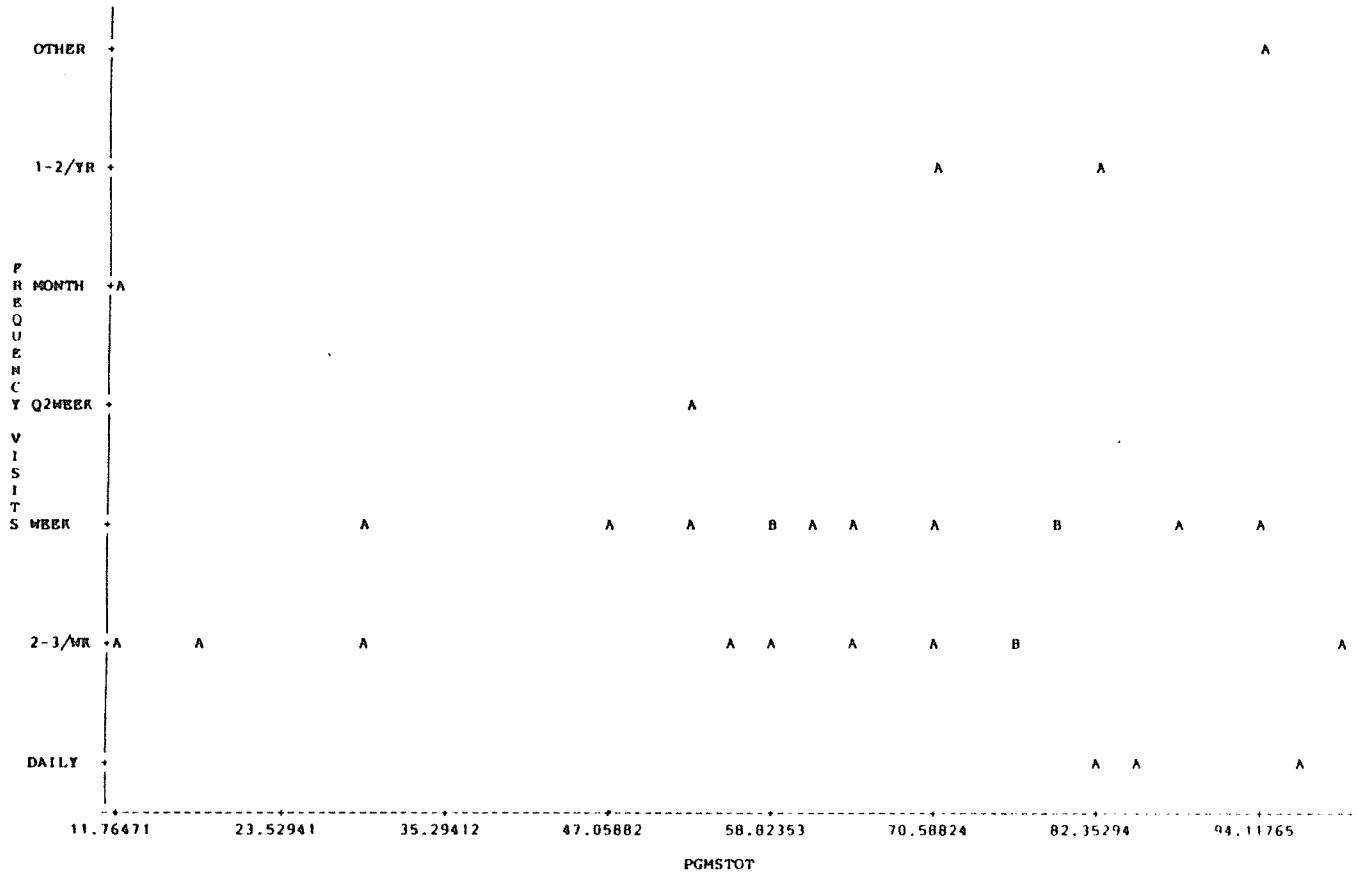
Scores in percentages

FIGURE 5 LENGTH OF TIME IN FACILITY AND PHILADELPHIA GERIATRIC MORALE SCALE



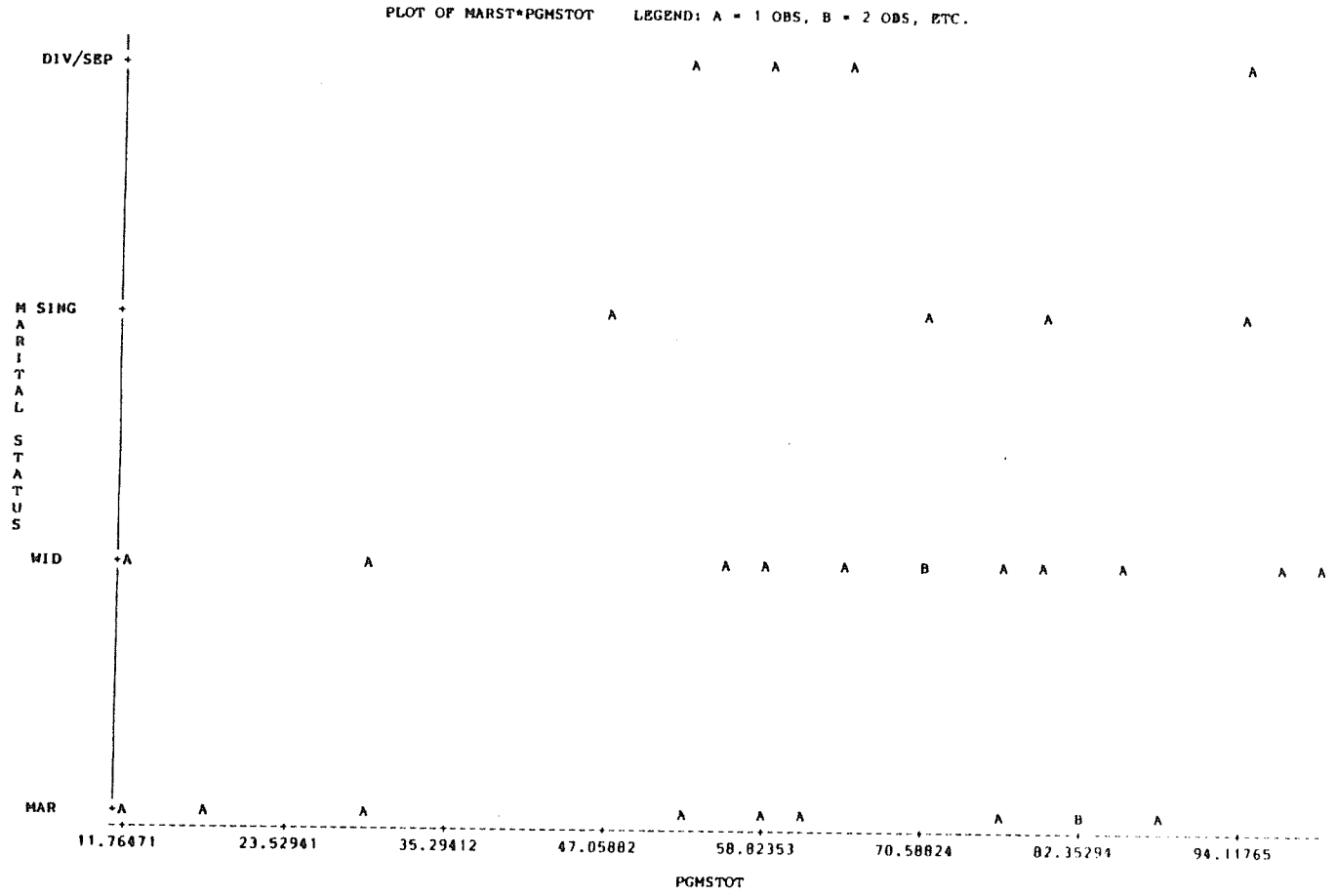
Scores in percentages

FIGURE 6 FREQUENCY OF VISITS AND MORALE SCORES



Scores in percentages

FIGURE 7 MARITAL STATUS AND PHILADELPHIA GERIATRIC MORALE SCALE



Scores in percentages

for the subscale education and physical (see Table 5).

The lack of a correlation between the subscales education and physical occurred only with the resident sample, N=30. Correlations were also done with the sample subjects combined (N=57) for the total nursing activities scale and the subscales. With the nurse subjects added, all subscales were highly correlated.

The second hypothesis, that resident morale would be related to the congruence/incongruence between nurses and residents, cannot be accepted given the evidence provided in this study. Although there was incongruence between the ratings of nurses and residents, no direct relationship was found between the scores on the nursing activities checklist and resident morale. Multicollinearity was guarded against by examining the correlation co-efficients of the variables prior running the regression analysis. It may be that this relationship does not exist, the sample size was too small to find an effect or there is a component within the measure of incongruence or morale that this study is not measuring with the instruments selected.

Morale was found to be low for some categories. The morale subscale component attitude to own aging, and the D.T. scale were low. The total P.G.C. morale score fell slightly below the figure reported in other studies. However, the component of morale represented by the subscale lonely dissatisfaction was not found to be low.

Table 5 Spearman Correlation Coefficients for P.G.C.M. Scale and Nursing Activities Subscales N=30

	1	2	3	4	5
1.Physical	1.000	0.595	0.317	0.713	-0.087
	0.000@	0.0005	0.088	0.0001	0.648
2.Psychosocial		1.000	0.589	0.643	0.115
		0.000	0.0006	0.0001	0.547
3.Educational			1.000	0.370	0.278
			0.000	0.044	0.137
4.Medical				1.000	-0.086
				0.000	0.650
5.P.G.C.M.					1.000
					0.000

@ = p values

Chapter VI Discussion and Implications

Findings on Incongruence

The findings obtained from the analysis of the responses of the two subject groups, nurses and residents, suggest that incongruence does exist between the two groups on the importance of selected nursing activities. The finding of incongruence is similar to other reported studies (Caron, 1984; Smith et al, 1980). For this study however, the major incongruency was in the level of importance given to all items and categories, as depicted by the subscales, more than in the ordering of subscale categories. It would appear that nurses, as a group, see all the activities they perform as more important than do residents as a group.

Caron (1984) reported that nurses tended to rate all activities higher than residents but the actual figures were not given. Smith et al (1980) found their subject samples rated specific categories differently but, with the exception of physical care, the range of reported scores between staff and residents was much closer. Differences in the rating of categories were also found in this study, but it was apparent that the nurses scores for all categories were higher. The lowest rated category for nurses was still higher than the highest rated category for residents.

Differences are also apparent in the ratings of individual items and the ratings of categories from the Nursing Activities Checklist. Medical care was the highest rated category for the residents, closely followed by education, yet all five individual items rated highest were from the psychosocial category. This fact is probably partially accounted for by the two items on religion, which rated among the lowest in importance and the limited number of items in the two top rated subscale categories (education, 4 items and medical, 6). The smaller the number of items, the smaller the range will be.

Similarly, although nurses rated the education component the highest, no item from this subscale appeared in the five top rated items. However, two of the highest rated items, notice pain and notice changes in condition, do fall in the medical category which was rated second highest by the nurses. Again, the limited number of items in these two categories may be having an effect.

It is also possible that, in actual fact, only two subscales exist, physical and psychosocial. The other subscales are components of these two in long term nursing care of the elderly. The preliminary effort to examine this factor by doing a reliability analysis did demonstrate an overlap in some items. A

factor analysis would be necessary to determine the specific categories, however the sample size in this study was too small to permit a valid analysis.

The correlation matrix and Alpha coefficients did suggest differences in nurses and residents responses. The low alpha found for the medical subscale and the number of negative correlations within the resident sample responses may be showing that nurses and residents do not use the same frame of reference for nursing activities i.e. that some items have different meanings for the two groups other than the rating of importance. As the resident group was interviewed, the investigator scored the items according to their responses and was available to give explanations. Therefore, the fault is not likely to be a misinterpretation of the item or an accidental circling of the wrong numbers.

This finding raises a number of issues. Nurses, as a group, are taught a terminology related to care-giving that provides a specific frame of reference. This frame of reference or meaning ascribed to care-giving activities may not be the same for residents as it is for nurses. If true, the difference in the frame of reference could be related to the setting (previously acute care) or due to the lower level of care required by the resident sample. Yet, this finding could have relevence for communicating in a

manner that is both meaningful to and understood by the two groups.

The discrepancies in the ratings of all items on the checklist could be attributed to a number of factors. The majority of residents interviewed did not have heavy physical care needs thus rated the physical component low, while the nurses responses were based on a generalization of needs, incorporating the number of residents who require more care. In other words, were the nurses responses based on their global perceptions of physical care needs?

Should a generalization of care needs be occurring in the nurse group, it is worth noting that seventy-four resident names were generated from which the investigator drew the random sample. Given the other subjects who were capable of responding but were eliminated due to length of time in the facility or because they were on the assessment/rehabilition unit, this number represents approximately one-third of all residents in the facility. What effect may a high rating of physical needs have for this group? Some possibilities from other studies could include an increased dependency of residents, particularly when combined with a functional type of nursing system (Miller, 1985), loss of autonomy (Ryden, 1985) and a loss of perceived control (Chang, 1979).

If a generalization of physical care need is

occurring with the nurse subject group, the nursing care system may be a factor. Individualized nursing (i.e. a primary care system) was not in practice. The alternatives, functional or team, both tend to have a task focus versus an individualized approach to caregiving. Completion of the tasks assigned (usually physical care items eg. bathing) becomes the important focus of care rather than the more holistic approach to individual care needs.

It is also possible that nurses were responding based on what they believed was the socially desirable answer, thus giving a positive set response (Wilson, 1985) to the questionnaire. Prior to the data collection phase, this possibilty had been suggested by the clinical nurse specialist who reviewed the items. To attempt to avoid this possibility, the instructions for the instrument were made more specific by asking respondents to reply based on individual nurse beliefs on the importance of items in this particular long term care facility. However, these instructions do not preclude a positive set response occurring.

The factor of perceived social desirability when responding to the items did not appear to be identified in other studies on nursing activities although nurses were noted as rating physical care items high with a population capable of self-care (Smith et al, 1980).

Therefore, if this is occurring, it could be due to factors or combination of factors within this sample. For example, the older mean age of the group, the type of nursing system (as noted by Miller, 1985), the educational background in nursing and/or educational preparation for working with the elderly could all be contributing variables. Given the age range, it is not surprising the majority of nurse subjects were from a three year diploma nursing program. However, it is also likely the program was hospital based with a focus on acute care. The educational preparation of the time may not have explored a holistic concept of health or caregiving.

There might have been some denial or reluctance on the part of the nurse group to distinguish between the real and the ideal situation. This mechanism may serve to reduce dissonance between what is perceived as desirable and nursing as it is practiced. Therefore, rather than rating nursing activities as these are actually priorized in the work situation, the valued or ideal was presented.

This possibility is based on a number of occurrences during the study. The nurses gave the item, taking a temperature and pulse, the lowest rating yet the residents stated it is done on a regular basis. In fact, the residents tended to give this task a measure of

importance only because the nurses performed it. This one item took on almost a mystical property. "It must have some importance (for my health) or they (nurses) wouldn't do it" was the common resident response. Other examples include the high nurse rating on allowing residents to make decisions about their care when 89% reported the residents had none or minimal involvement in the care planning.

The psychosocial activities were rated high by nurses (as were all the subscales), however the residents reported that items such as taking time to talk, listening and encouraging independence were not being done. The residents excused the nurses on the basis "they (nurses) are just so busy they don't have time". The activities that were reported (by residents) to be keeping nurses busy including bathing and feeding. However, the activity assisting with a bath was one of the nurses lowest rated items. These findings are not dissimilar to those of Smith et al (1980).

It was suggested by Caron (1984) that residents may not view some of the activities listed in the nursing checklist as being within the purview of nursing. Specifically, it was believed some residents had a lack of confidence in nurses ability to carry out activities such as medical liaison or counselling families. This fact could contribute to the residents

lower rating of items but would not explain the low ratings of physical care items found in this study as these would fall within the purview of nursing. Only one resident expressed a belief that an item belonged to another department in the facility and that item involved recreation activities. The resident stated that when there was a recreation department, this area was not the responsibility of nurses.

Many of the residents who rated certain activities low, expressed a desire to have control over these areas themselves. For example, some residents stated they were both capable and desirous of talking with the physician themselves or reporting pain to the nurse as opposed to the more passive approach of the nurse noticing and reporting pain. Residents sometimes felt they did not have enough time with the physician when he/she did visit and seemed to feel they were being removed from the decision making process. This factor may also account for the residents not choosing the item 'allowing decisions in care' important while the nurses rated it highly. It may be the connotations associated with the word 'allow' as compared to other words used in the scale, such as assist or encourage.

Similarly, in relation to items on nurses talking to family members, the feeling of being excluded came up again. Residents who rated these items low gave reasons

that fell into two general categories. First, a feeling that they were capable of talking to family members themselves to explain their condition and second, there was a feeling that any meetings/discussions held with family members should include the resident. One resident expressed reservations about family members' "right" to know everything about his (resident) condition. At no time was concern expressed about the nurses ability to perform these functions.

The statements and opinions of residents recorded in the above paragraphs were not solicited by the investigator during the interviews. There appeared to be a desire on the part of residents to explain the ratings they were giving to certain activities. In general, it appeared important to them that the investigator understand that the ratings they gave were not a reflection on the nurses and the facility. They were reassured by the investigator that she understood their responses were personal, not a reflection on the nurses or the facility, and their answers would remain confidential. Usually, but not entirely, the explanations would follow from giving an activity a low rating. The fact these exchanges occurred does suggest that residents might view themselves as vulnerable within the system and/or do not wish to be seen as opposing the dominant values or standards of the

environment.

Overall, the results support King's (1981) assumption that the goals of caregivers and care recipients can be incongruent. The perceptions of the residents, as a group, regarding their capabilities differ from the perceptions held by nurses (as a group) about residents. This finding was particularly true for the physical care category and some aspects of medical care. The finding of incongruence (by using the modified White (1972) scale) and the resident desire to explain ratings may have implications for perceptions of situational control.

Morale and Findings on Incongruence

In this study, incongruence in the ratings of nursing care activities was found between the nurse sample and the resident sample. Morale was also found to be low for the P.G.M. subscale of attitude to own aging and average for the subscale agitation. Only lonely dissatisfaction reached a score of above average. In this study, no relationship could be established between the variables morale and incongruence. As noted before, a direct measure of the congruence/incongruence using matched pairs of nurses and residents was not possible. An alternative method of measuring the relationship was a regression analysis using the resident scores on the two nursing checklist subscales and their morale scores

from the P.G.C.M. scale. However, it is possible that this alternative method was not as sensitive as having an actual numerical measure of congruence/incongruence between nurse and resident subjects for the analysis.

The designation of morale status as high or low was based on Lawton's (1972) original work in developing the scale. Using the D.T. scale, only the global question on happiness (4.966) could be said to reach the level of happy (5). All others fell in the mixed range and lower than the 5-7 category designated by Michalos (1980) as representing positive feelings.

What also remains problematic for studies is the point at which morale is deemed to be below an acceptable norm. At noted before, morale in the institutionalized elderly is often the dependent variable with changes reported when the independent variable is introduced. The findings on morale in this study are very similiar to others (Pohl & Fuller, 1980; Ryden, 1984). The scores for attitude appear to be significantly lower than the other subscales in the P.G.C.M. scale but as this was not the focus of these studies, it was not discussed.

This finding raises the question of whether attitude to own aging is the area of morale most affected for the institutionalized elderly. These findings are not be inconsistent with the findings for the D.T. scale. Only the domain of self esteem showed any relationship to

the two global questions on satisfaction and happiness. Self esteem could be construed as an element of or resulting from the attitude to one's aging.

Given the high correlation between the revised D.T. scale and the P.G.C.M. scale, it may be that, for the institutionalized elderly, the two scales are not tapping two different components of wellbeing; i.e. the P.G.C.M. scale tapping the more subjective or affective component, while the D.T. scale reflects the cognitive component of well-being. As suggested by Andrews and McKennell (1980) the components of cognition and affect may overlap and perhaps this overlap occurs to a greater degree with the institutionalized elderly. However, it is equally, or perhaps more possible, that this factor may be due to the exclusion of domain items such as housing, finances and employment, in this study, thus leaving the more subjective domains.

The belief that satisfaction has a higher cognitive than affective component and is tied to the comparisons of expectations and standards of current circumstances (McKennell & Andrews, 1980; Michalos, 1980) would correspond with the findings that satisfaction does not correlate with the total P.G.C.M. scale. This finding is similar to that of Lohmann (1977), who suggested that there may not be a relationship between the conceptual area measured by one question and other multi-item

measures. Yet satisfaction is correlated, albeit weakly, with the subscale, attitude to own aging, as is the global question happiness. It may be that the items in attitude to aging have both a cognitive and an affective factor and share a conceptual area for the subjects in this study.

The fact a relationship was not found between the domain items of the D.T. scale and there was a low Alpha coefficient may mean that, for this study population, each item was seen as something independent of or unrelated to their current life situation. Perhaps the domains of families, friendships, activities and religion are seen as less reflective of satisfaction and happiness in the current environment and other factors predominate. Michalos (1982) has suggested, based on his research, that the constituent elements, particularly for satisfaction, may vary for groups under 74 and those over 75 years of age.

Relationships Between Morale and Other Variables

The finding that the frequency of visits did not have any relationship to the scores on the P.G.C.M. scale is similar to the findings of Gibson (1986), where amount or quantity of interaction was not related to overall measures of wellbeing. It may well be that the quality of interactions with family or friends was the positive factor that contributed to the higher score on the

subscale lonely dissatisfaction. If so, a subject could be as satisfied with visits once every two weeks as another subject would be with more frequent visits. Data on the quality of interactions was not specifically gathered for this study but in the D.T. scale the highest rated item and the only one to average a score above 5 was in the family domain.

Even though the score for the family domain was higher than the other items on the D.T. scale, there was no relationship betwen this score and the global questions on satisfaction and happiness. This finding is different from Michalos' (1980) belief that family life relationships would be the major determinant of life satisfaction as a whole. Again, this finding may be reflective of this population. Family relationships are disrupted by institutionalization. The factor of institutionalization may account for the finding that marital status had no relationship to morale. Even if married, the relationship will likely be different to that experienced prior to admission or perhaps even prior to the events leading to being admitted to long term care.

The finding that neither age nor length of time one had lived in the facility had a relationship to morale are similar to the findings of Lawton (1972), Pohl and Fuller, (1980) and Ryden (1984). In this study, length

of time spent in the facility was partially controlled by the criteria for subject selection. The limits for resident subjects was a stay of more than two months and less than five years duration.

Other Findings

During the interviews with resident subjects, one area was identified by 29 of the 30 subjects as causing distress and reducing the quality of their life in the institution. This concern related to the mixing of cognitively impaired residents with the cognitively well. The residents' feelings in this area were not solicited by the investigator but were volunteered during the interview. The stimulus to discuss this concern varied. Sometimes it was prompted by a question on privacy, other times when describing other residents needs or the lack of someone with whom to talk. One study subject was very distressed as the situation in the unit was reminiscent of similar difficulties with family members.

Summary

The lack of a correlation between the residents scores on the Nursing Activities Checklist and their scores on the P.G.C.M. scale would support the belief that the ratings given to care activities per se are not related to morale. If the ratings of items were related to morale, some form of linear relationship, either positive or negative, would be expected (eg. residents who rated subscales low would be incongruent

with nurses, thus have low morale).

Incongruence between nurses and residents on the importance of nursing care activities was established but no relationship to morale was found. It may be that incongruence per se is not related to morale. However, the study of incongruence can assist in identifying the factors that are considered important for quality of care from the perspective of the care-recipient. Another area to be explored is whether a resident's locus of control, internal or external, is an intervening variable in nursing care activities being rated as important to care. The knowledge that incongruence exists points out the need for increased communication between nurses and residents to determine what is important to residents if quality in care-giving is desired by nurses.

Although all the P.G.C.M. subscale items were not low, the subscale on attitude to own aging was markedly low. Factors have been identified in this study, such as the discrepency between the ideal and real in nursing practice, the limited involvement of residents in aspects of daily activities, the potential for fostering dependency and the type of nursing delivery system, that suggest incongruence between nurses and residents could be a factor in lowered morale, specifically the area of attitude to own aging. Further research in this area would be warranted.

Limitations

Limitations were identified throughout this study, such the small sample size, the use of only registered nurses, the lack of individual matches between nurses and residents and the use of only one institution for subject selection. Although not necessarily a limitation, privacy was an issue in the study. Privacy was not assured when interviewing residents. There was no specific room available for residents to use that would provide for complete privacy. Staff wandered in and out of the room, sometimes to attend to other residents but sometimes with no ascertainable reason. When this occurred, it often inhibited the conversation between the resident and investigator for the time period the staff person was present. Whether the presence of staff had any effect on resident responses is not known but it proved to be distracting. However, even though the environment may not have been ideal it was realistic.

Implications Arising from this Study

Implications for Nursing Practice

The intent of the study was to examine nurses' and residents' congruency in rating nursing care activities and attempt to determine if congruence/incongruence might be a potential factor in the morale of residents. From the results obtained, a number of implications for nursing have emerged and are presented here for consideration.

There is a need to evaluate the discrepancies (or dissonance) between the real and the ideal functions as practiced by nurses. The nurses higher ratings of all activities was not only incongruent with residents' ratings but incongruent with what was reported (by residents) as actually occurring. To be desirous of providing a psychosocial and educational focus to care yet concentrating on physical tasks (rated lowest) could potentially lower job satisfaction and increase frustration. For residents, the incongruency identified, the focus on physical tasks and the lack of involvement in goal setting has the potential to be detrimental by increasing resident dependency (Cooke, 1987; Smith 1986), promoting learned helplessness (Slimmer, Lopez, LeSage & Ellor, 1987) and decreasing the person-environment congruence (Nehrke et al, 1984). Any or all of the above occurrences for residents could, in turn, increase the

nurses' work load leaving even less time for the educational/psychosocial tasks purportedly desired. While acknowledging that registered nurses, who constituted the subject population, do not deliver all the care, this group is responsible for the care plan and the method of care delivery.

The type of nursing delivery system could be examined as a factor in enhancing or inhibiting communication and mutual goal setting between nurses and residents. If the system is inhibitory, then incongruence is more likely to exist. In this study, the two prominent systems for delivery of care were functional and team. Both of these delivery systems have a task oriented approach to care. Neither system has the individualized approach to care (by long term assignment of a nurse to specific residents) that is found with a primary system.

A review, by nurses, of the meaning they ascribe to care-related terminology could be beneficial. This suggestion arises from the 100% agreement, among the nurses, that there were individualized care plans in effect while a significant number of residents were not involved in their care planning. Given that all the residents in the study were capable of participating in their plan of care and the fact there were definite inconsistencies in the importance of care items as rated

by nurses and residents, what constitutes the definition of individualized care might be a question for nurses to ask. This area could be expanded to include an examination of the values nurses hold relating to their practice.

The five items rated highest by residents were all in the psychsocial category. By far the lowest rated category was physical care. Although this sample of residents does reflect those with lower physical care needs, it would seem that an emphasis and enhancement of the psychosocial care needs might be warranted. The low rating in the morale category of attitude to own aging might be improved by nurses utilization of care activities that encourage a sense of independence and self worth. An improvement in these areas may be more likely to occur with a focus on the psychosocial components of care.

Implications for Nursing Research

A number of implications and possible directions for future research have arisen from this study. First is the need for further refinement of nursing scales that are used to rate nursing activities. Reliability and validity testing not only with nurses but also with other subjects, specifically the care-recipient group, would enhance the use of these scales in research. Scales devised for populations other than the elderly in long

term care facilities could be improved by being validated for use with this group.

More studies exploring the components of morale for residents in long term care could be beneficial. Longitudinal studies instituted prior to an individual being panelled for long term care would yield information on whether morale does change with institutionalization or remains relatively stable. At the same time, more research on which domains of satisfaction and happiness are deemed important by long term residents could be of benefit to care-givers. These domains may not be the same as those identified by the elderly living in the community or it may be that the domains are similar but need redefining to reflect the realities of institutionalization. For example, the domain housing might be defined to include elements of privacy, adequacy of environmental surroundings and ability or freedom to come and go independently rather than being eliminated as it was for this study.

Research exploring a potential relationship between the nursing delivery system(s) and long term care client needs could yield valuable information for nurses providing care in this field. The type or focus of care is different in this field and the staffing patterns vary from acute care, suggesting innovative approaches, backed by research, may lead the way to enhancing the quality of

care for residents. Following from the above, using a conceptual framework or nursing model (for example King, 1981) as the basis for research on the delivery system for care could provide a more client-centered focus for caregiving.

Studies exploring and/or identifying the nursing activities that could enhance the sense of well-being for residents may provide a positive contribution to nursing care of the institutionalized elderly. Specific activities that might have a relationship to well-being include the type and content of communication occurring in care-giving, the effects of nurse/resident mutual goalsetting, and the inclusion of residents in conferences related to their care. As well, studies that explore the relationship between the perceptions and values nurses hold, the meanings they ascribe to care-giving activities and the level of congruency between nurses and residents on the importance of care activities may well offer information for evaluating care or enhancing the quality of the care provided.

Replication of this study, with an enlargement and some modifications may yield further useful information for nursing. A larger sample size of both nurses and residents would increase the representativeness of the sample. Included in an enlargement of the sample could be other levels of staff, eg. nursing aides and

orderlies. Including these care-givers could assist in determining if there are differences in the level of congruence between subgroups. As well, increasing the sample may allow for an examination of the level of congruence between matched pairs of residents/care-givers rather than solely by group analysis. This method would provide more information on any effects of incongruence than was possible with this study.

Another expansion of the study would be to incorporate a qualitative component by interviewing both nurses and residents. Open ended questions with probes would allow for subjects to elaborate on the reasons for their responses to items on scales or questions relating to care provision. This method could provide insights into the perceptions and values of each set of subjects in relation to long term care-giving. Knowing what each group values would be helpful in finding measures to increase congruency between the two groups, thus hopefully leading to a higher quality of care.

Nursing Theory

The Theory of Goal Attainment (King, 1981) provided the conceptual basis for the development and implementation of this clinical research study on long term care nursing. The theory assumes that the goals, needs, values and perceptions of clients and nurses

influence the interaction process and individuals have the right to participate in decisions that have an influence on their life or health. According to the theory, if these elements are ignored in the nurse/client relationship, the goals (outcomes) of care are difficult to achieve.

The incongruency found between the nurses and residents ratings of the importance of nursing care activities has implications relevant to the information sharing that occurs between the two groups, whether there is the perceptual accuracy or the purposeful communication necessary to identify needs, concerns or goals. According to King's (1981) theory, goal attainment is the desired outcome of the process of nursing but is most likely to occur when there is shared information and mutually set goals. As found in this study, residents were not involved in mutual goal setting. Drawing upon King's (1981) open systems framework, the nurses and residents in this study were not sharing perceptions and judgements within the interpersonal system. Therefore their actions and reactions were not leading to mutual goal setting or attainment.

King proposed that effective nursing care occurs and satisfaction for nurse and resident results when the goals of care are attained. An underlying theme of this

study has been the quality of nursing care, specifically in long term care. Quality of care assumes nursing care that has been both effective and provided a measure of satisfaction. One potential outcome of quality of care for residents in long term care is a sense of well being, operationally defined as morale for this study. Morale was found to be low in the area of attitude to own aging. By utilizing King's (1981) theory, whatever the antecedent cause of poor attitude to aging, nurses and residents could be interacting to identify mutually determined measures for arriving at an outcome of improved attitude. This outcome would denote the theory's relevance for clinical practice as well as research.

By using King's (1981) theory, a number of variables have been identified that could provide more knowledge on the constituents of good care from the perspective of nurses and clients. This study has tried to examine congruence and the potential effect on well-being for residents. It was not possible to correlate incongruence to morale nor to identify if nurse perceptions or attitudes had an influence on the incongruence found in the study. These areas can provide direction for further studies.

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Revised Philadelphia Geriatric Centre Morale Scale

Little things bother me more this year.	yes	no
I sometimes worry so much that i can't sleep.	yes	no
I am afraid of a lot of things.	yes	no
I get mad more than I used to.	yes	no
I take things hard.	yes	no
I get upset easily.	yes	no
Things keep getting worse as I get older.	yes	no
I have as much pep as I had last year.	yes	no
As you get older you are less useful.	yes	no
As I get older, things are better/worse than I thought they would be.	better	worse
I am as happy now as when I was younger.	yes	no
How much do you feel lonely?	a lot	not much
I see enough of my friends and relatives.	yes	no
I sometimes feel that life isn't worth living.	yes	no
How satisfied are you woth your life today?	satisfied	not satisfied
I have a lot to be sad about.	yes	no
Life is hard for me much of the time.	yes	no

Revised Delightful/Terrible Scale

On the left hand side of the page are a number of key words or phrases which people use to identify various parts of their lives. Please read the word and consider how you would rate your own life, right now, in terms of that word. To assist you, there is a scale which runs in seven steps from delightful to terrible. Please pick the number from the scale that comes closest to describing how you feel and circle it.
1 = Terrible (Ter); 2 = Very Dissatisfied (VD); 3 = Dissatisfied (Dis); 4 = Mixed (M); 5 = Satisfied (S); 6 = Very Satisfied (VS): 7 = Delightful (Del); 8 = No Opinion (N.O.).

	Ter	VD	Dis	M	Sat	VS	Del	N.O.
Health	1	2	3	4	5	6	7	8
Family Relations	1	2	3	4	5	6	7	8
Friendships	1	2	3	4	5	6	7	8
Recreation/ Activity	1	2	3	4	5	6	7	8
Religion	1	2	3	4	5	6	7	8
Self-Esteem	1	2	3	4	5	6	7	8

Using the same scale, how do you feel about your life as a whole right now? Is life generally satisfying, dissatisfying, etc.

Ter	VD	Dis	M	Sat	VS	Del	N.O.
1	2	3	4	5	6	7	8

Considering your life as a whole, would you describe it as: 1 = very unhappy, VU; 2 = unhappy, UH; 3 = unhappy, UH; 4 = mixed. M; 5 = happy, H; 6 = happy, H; 7 = very happy, VH; 8 = no opinion, N.O.

VU	UH	UH	M	H	H	VH	N.O.
1	2	3	4	5	6	7	8

DEFINITIONS for DELIGHTFUL/TERRIBLE SCALE

Health: Your rating of your general, overall health at this point in time. (Modified from the original by the researcher).

Family Relation: The kind and frequency of contact you have with your family members, including personal contact, phone calls and letters.

Friendships: The kind and frequency of contact you have with your friends, including personal contact, phone calls and letters.

Recreation/Activity: Personal recreation activities you engage in for pleasure, includes reading, crafts, exercises, trips.

Religion: Your spiritual fulfillment.

Self-Esteem: How you feel about yourself; your sense of self-respect.

Revised Nursing Activities Checklist

The statements below describe some activities nursing staff might perform for a resident. The activities may vary in importance depending on the type of facility but you are being asked to consider the importance based on this facility at this time. You are being asked to rate each statement according to its importance to you. Please read over the entire list. Indicate the importance of each item by putting a circle around the appropriate number.
Extremly important (5); Very important (4); Average importance (3); Slightly important (2); Not important (1).

Nursing Activities

1.	Taking temperature and pulse.	5	4	3	2	1
2.	Assist with a bath on a regular basis	5	4	3	2	1
3.	Assist with care of mouth and teeth.	5	4	3	2	1
4.	Provide a clean, comfortable bed.	5	4	3	2	1
5.	Help with grooming,for example care of hair, nails or shaving.	5	4	3	2	1
6.	Provide necessary equipment,for example towels, soap, blanket.	5	4	3	2	1
7.	Provide for privacy.	5	4	3	2	1
8.	Take special care of skin so it does not become sore.	5	4	3	2	1
9.	Keep the bedside area clean and tidy.	5	4	3	2	1
10.	Allow residents to make decisions about their daily routine or care.	5	4	3	2	1
11.	Assist in obtaining a comfortable or appropriate position.	5	4	3	2	1
12.	Notice when pain occurs and give medication or have it ordered.	5	4	3	2	1
13.	Assist residents in getting to and from places,for example, the cafeteria,ward dining room or activities.	5	4	3	2	1
14.	Consider personal preferences when giving care.	5	4	3	2	1
15.	Observe the effects of treatments.	5	4	3	2	1

Nursing Activities Checklist

16. See that a bed pan, commode or urinal is provided when needed.	5	4	3	2	1
17. Check on bowel functioning and help maintain or restore normal function.	5	4	3	2	1
18. Help residents in and out of bed.	5	4	3	2	1
19. Help residents to get the necessary exercise.	5	4	3	2	1
20. Discuss with residents the amount and type of activities for them.	5	4	3	2	1
21. Encourage residents to do as much care as they can for themselves.	5	4	3	2	1
22. Give medications on time.	5	4	3	2	1
23. Explain about the medications and/or any changes in medications.	5	4	3	2	1
24. Plan care to allow for rest periods.	5	4	3	2	1
25. Provide a comfortable, pleasant, environment, for example, free from unpleasant odor, noise.	5	4	3	2	1
26. Relieve anxiety by giving reasons for treatments or a change in condition.	5	4	3	2	1
27. Show caring for and concern about residents.	5	4	3	2	1
28. Arrange for a priest, minister or rabbi to visit.	5	4	3	2	1
29. Make it possible to attend religious services in the nursing home.	5	4	3	2	1
30. Assist with meals as necessary.	5	4	3	2	1
31. Provide fluids and/or food between meals.	5	4	3	2	1
32. See that food is served properly.	5	4	3	2	1
33. See that residents have food they can chew.	5	4	3	2	1

Nursing Activities Checklist

34. See that residents have a copy of the menu or meal plan.	5	4	3	2	1
35. Talk with residents about topics unrelated to illness or care, for example news, hobbies, interests.	5	4	3	2	1
36. Plan some diversion or recreation.	5	4	3	2	1
37. Take time to talk to family members and answer their questions.	5	4	3	2	1
38. Notice changes in residents'condition and report them.	5	4	3	2	1
39. Tell the doctor when residents are worried about their conditon.	5	4	3	2	1
40. Show understanding if residents may feel irritable and/or demanding.	5	4	3	2	1
41. Take time to listen to residents.	5	4	3	2	1
42. Carry out the doctors orders.	5	4	3	2	1
43. Explain about any tests (Xray, Lab.) ahead of time so resident will know what to expect.	5	4	3	2	1
44. Encourage residents in finding tasks or activities that give a feeling of accomplishment.	5	4	3	2	1
45. Talk to residents about their condition in order to help them understand the changes that have occurred.	5	4	3	2	1

Nurses Consent Form

You are invited to take part in a study designed to identify the importance of selected nursing activities from the perspective of both the caregivers (nurses) and care-recipients (residents). You were randomly selected for this study because you work here on a permanent basis, either full or part time, on a long term or extended care unit. Although there may be no immediate benefit, it is hoped that the information obtained from this study will help to identify what characterizes quality of nursing care in a long term care facility.

Participation in the study will involve completing a questionnaire that requires you to rate specific nursing activities on a scale of one to five. Your answers will be based on your experience, at this point in time, in this facility. You would also be asked for some information on your background, education and experience. The questionnaire on your experience and background would include such items as age, educational background, years of experience in nursing and the shift(s) most often worked. Your time involvement would be a maximum of 30 minutes.

Should you agree to participate, the two forms would be given to you to complete and return anonymously. Your name will not appear on either of the two questionnaires. To further facility anonymity, an envelope, preadressed to the investigator, will be provided with the questionnaires. Any information obtained will be confidential. Data will be kept in a locked drawer both during the study and when retained for future secondary analysis. All data will be coded and in no way will any individual be identified in a future analysis. All dta will be destroyed after analysis is complete.

Your decision on participating in the study will have no repercussions for you as a nursing professional. Your nursing supervisor(s) will not be informed of who participates in the study and who does not. If you do decide to participate in the study, you will be free to withdraw at any time. You do not have to answer all of the questions, only those you feel comfortable in answering.

The study is being conducted by Beverley Wilden R.N., B.N., a Masters of Nursing student at the University of Manitoba. Supervising the study are C. Gow, Associate Professor, School of Nursing, University of Manitoba (Committee Chairperson); C. Cameron, Associate Professor, School of Nursing, University of Manitoba; Dr. N. Chappell, Director, Centre on Aging, University of Manitoba.

If you have any concerns or questions which you would like answered before making a decision to participate, please ask. If you have additional questions later, you may reach the investigator, Beverley Wilden at 832-1017 (home) or 831-2181 (office).

You will be given a copy of this consent form to keep. The final results of the study will be forwarded to the administration of the facility. A summary of the completed study will also be made available to you upon request.

Your signature indicates that you have read the above written information and have decided to participate in this study. Your decision to participate is voluntary and you have the option to withdraw your participation at any time, should you choose to do so.

Date: _____ _____

Signature of Participant

Date: _____ _____

Signature of Investigator

Consent Form (Residents)

You are invited to take part in a study to identify how important certain nursing care activities are from both the residents and nurses point of view. You were selected because you are currently living in this facility. Your name was randomly picked from a variety of residents here who are capable of rating how important certain nursing activities are to them. If you do decide to participate, you will be free to withdraw at any time. You do not have to answer all of the questions, only those you feel comfortable in answering. Your participation is solely on a voluntary basis. Although there may be no benefits to the participants, this study may provide information on nursing activities that will help to improve care in the future.

Your part in this study would involve completing a questionnaire to rate nursing activities and two short questionnaires on morale. Your answers will be based on your experience, at this point in time, while living in this nursing home. You would also be asked for some information on your background, for example, age, past occupation and length of time you have been living in this facility. It will probably take an hour of your time to answer the questions.

Your decision on participating in this study will not affect your care in any way. All information will remain confidential and be stored in a locked drawer both during the study and when retained for possible future secondary analysis. All data will be coded and in no way will any individual be identified in any future analysis. Data will be destroyed after all analysis is completed.

If you decide to participate, I would set a time to interview you to obtain your answers to the items on the questionnaires. However, should you prefer to complete the questionnairies on your own without an interview, you are welcome to do so.

The study is being conducted by Beverley Wilden, R.N., B.N., a Masters of Nursing student at the University of Manitoba. Supervising the study are C. Gow, Associate Professor, School of Nursing, University of Manitoba (Committee Chairperson); C. Cameron, Associate Professor, School of Nursing, University of Manitoba; and Dr. N. Chappell, Director, Centre on Aging, University of Manitoba.

If you have any concerns or questions which you would like answered before making a decision to participate, please ask. If you have additional questions later, you may reach the investigator, Beverley Wilden, at 832-1017, (home) or 831-2181 (office).

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP. THE FINAL RESULTS OF THE STUDY WILL BE FORWARDED TO THE ADMINISTRATION OF THE FACILITY. A SUMMARY OF THE COMPLETED STUDY WILL BE MADE AVAILABLE TO YOU UPON REQUEST.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ THE ABOVE WRITTEN INFORMATION AND HAVE DECIDED TO PARTICIPATE IN THIS STUDY. YOUR DECISION TO PARTICIPATE IS VOLUNTARY AND YOU HAVE THE OPTION TO WITHDRAW YOUR PARTICIPATION AT ANY TIME YOU CHOOSE TO DO SO..

Date:——— _____

SIGNATURE OF PARTICIPANT

Date:——— _____

SIGNATURE OF INVESTIGATOR

DATA BASE RESIDENTS

1. Date of Birth

2. Sex (Please circle)
   male
   female

3. Educational level completed (please circle)

   Grade school
   High school
   Technical/vocational course
   University degree
   Post graduate university degree

4. Previous Occupation
   Please specify

5. How long have you been at Deer Lodge?

   Year(s) _____
   Month(s) _____

6. Where did you stay before coming to Deer Lodge ?
   (please circle)
   Apartment
   Single room
   House
   Senior citizen apartment/housing

7. What was your living status before coming here?
   (please circle)

   alone

   or with:
   spouse
   daughter
   son
   sister or brother
   friend
   other (please specify)

8. Are you currently (please circle)
   Married
   Widowed
   Single
   Divorced/separated

DATA BASE RESIDENTS (con't)

9. How frequently do your family/friends manage to visit?

   Daily
   2 - 3 times a week
   weekly
   every two weeks
   monthly
   once or twice a year
   other (please specify)

10. Did you come from another hospital/care facility?
   yes
   no

11. If the answer to the above question was yes, which best describes where you were? (please circle)

   acute care hospital
   rehabilitation hospital
   nursing home
   other (please specify)

12. Level of care (as noted on Kardex)

For the following ask resident and/or check Kardex:

13. Assistance required with hygiene? Describe.

14. Assistance required with eating? Describe?

15. Assistance required with dressing? Describe.

16. Assistance required in giong from place to place within and outside the nursing home? Describe.

DATA BASE STAFF

1. Age

2. Sex
   female
   male

3. Education leading to R.N.

   Diploma program
      2 year
      3 year
   Degree program

4. Further education

   Degree in nursing (following diploma)
   Degree in other than nursing (please specify)

   Masters degree in nursing
   Masters degree in other than nursing (please specify)

Certificate courses completed:

   Gerontology
   Administration
   Other (please specify)

5. Shift most often worked.
   Day
   Evening

6. Do you work part time or full time?

   Full time
   Part Time

7. If part time, approximately how many shifts do you work?

8. How long have you been employed at Deer Lodge Centre? (round off to the closest number)

DATA BASE STAFF (con't)

9. How long have you worked with the elderly? (employment only)

10. How long have you been employed in nursing? (in total)

11. What is the type of nursing delivery system currently in use on your unit?

1. Primary (continued assignment to the same residents)

_____

2. Team nursing

_____

3. Functional (assignment by rooms or tasks)

_____

12. Do you have individualized care plans on each resident?

yes
no

13. Are residents involved in developing their care plan?

no
yes

If the answer to the above was yes, please describe residents involvement.

Appendix C

858 Fairmont Rd.
Winnipeg, Man.
R3R-1B4
March 23, 1987

Ethical Review Committee
School of Nursing
University of Manitoba

Dear Member:

Ethical approval is being sought from the review committee for a Master's thesis proposal entitled "Nurse and Resident Congruency on Nursing Activities and the Relationship of Congruency to Resident Morale".

The research will be conducted by myself, a student in the Masters of Nursing program at the University of Manitoba. My thesis committee consists of: C. Gow, Associate Professor, School of Nursing; C. Cameron, Associate Professor, School of Nursing; Dr. N. Chappell, Director, Centre on Aging, University of Manitoba.

The research is planned to commence as soon as ethical approval is obtained, hopefully in April, 1987. Verbal approval has been given, by the Executive Director and Medical Director of Deer Lodge Centre, to conduct the research in that facility.

Thank you for your review of this proposal.

Sincerely

Beverley Wilden R.N. B.N.

The University of Manitoba

SCHOOL OF NURSING

ETHICAL REVIEW COMMITTEE

Proposal Number N87/32

Proposal Title: "Nurses' and Residents' Congruency on the Importance of Nursing Activities and the Relationship of Congruency to Morale for Residents in a Long Term Care Facility."

Name and Title of Researcher(s): Beverley Wilden
Master of Nursing Student
School of Nursing
University of Manitoba

Date of Review: April 6, 1987

Decision of Committee: Approved: Apr.20/87 Not Approved: _____

Approved upon receipt of the following changes: _____

Approved with the submitted changes April 20, 1987.

Date: April 20/87

Cynthia F. Cameron, R.N., M.S Chairperson (acting)

Associate Professor
School of Nursing Position
University of Manitoba

NOTE:

Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

Appendix D

Letter requesting access to Deer Lodge Centre to conduct study

Beverley M Wilden
858 Fairmont Rd.
Winnipeg, Manitoba
R3R-1B4
Phone: 832-1017
March 12, 1987.

Mr. R. Brown
Executive Director
Deer Lodge Centre

Dear Mr. Brown;

As a Masters' student in nursing at the University of Manitoba, I am conducting research in the area of long term extended care. Specifically, I hope to examine how nurses and residents rate specific nursing activities and the affect, if any, the ratings may have on resident morale. Attached please find a brief proposal which includes a further explanation of the study. The purpose of this letter is to request access to your facility for the selection of subjects, both residents and nurses.

The study is being supervised by a thesis committee consisting of C. Gow, Associate Professor, School of Nursing, (Committee Chairperson); C. Cameron, Associate Professor, School of Nursing; Dr. N. Chappell, Director, Centre on Aging. All of the above committee members are currently at the University of Manitoba. Ethical approval for the study will be sought from the Ethical Review Committee, School of Nursing in March, 1987. Evidence of approval by the Committee will be supplied to Deer Lodge Centre. If there is an internal ethical review procedure for your facility, please let me know and I'll be happy to meet the requirements.

The time requirements for the study subjects are outlined in the included proposal but should not be more than 1/2 hour for staff and 1 hour for residents. The data collection phase should be completed within a month. A final report on the study results will be submitted to the institution. A copy of the investigator's thesis will be given to the institution if desired.

I am requesting that you review the proposal and distribute it to the appropriate divisions of your institution. If you have any questions regarding the proposal, I would be pleased to meet with you or with any internal committee in the institution at your convenience. I look forward to hearing from you.

Sincerely

Beverley Wilden, B.N.

Nurse/Resident Congruency on Nursing Activities and the Relationship of Congruency to Resident Morale.

Design

The basic design is descriptive and analytical. In the first stage, two groups of subjects, nurses and residents, will be compared as to the importance each ascribes, (on a scale of one to five ranging from no importance to extreme importance) to selected nursing activities. The second step involves identifying the congruence between the two groups' ratings of the activities. Thirdly, the congruence or non-congruence in the ratings of nursing activities will be examined to assess the extent this variable may affect the morale of the residents.

Sampling

A random sampling plan will be used for this study. Thirty subjects for each of the two groups will be drawn for a total of sixty subjects. The first group will consist of thirty residents from the long term care facility, the second will be thirty registered nurses from the same facility. Subjects who meet the selection criteria would be collected from both the personal care and extended care wards.

Criteria for Subjects

Criteria for selection of the resident subjects includes: a) age over sixty; b) residing in a long term care facility on a permanent basis (as opposed to

intermittent or respite admissions); c) ability to understand and speak English; d) oriented in three spheres (person, time, place). Should subjects come from the veteran's units, an additional criteria would be e) has resided in the facility less than 4 years. This criteria is to control for those residents that have spent a number of years in the institution, prior to it becoming a long term care facility.

The nursing Kardexes will be utilized initially as a quick screening measure by a health professional within the institution. The screening process is to eliminate potential subjects who do not meet the selection criteria.

Criteria for nurse subjects includes: a) current active registration with the Manitoba Association of Registered Nurses; b) currently working in the long term care facility; c) working day or evening shifts. The last criteria was established to obtain nurses who will be most directly involved in caregiving activities and the goal setting component of the care plan. Registered nurses were selected for the study sample as they are the group with the overall responsibility for the care planning, assign staff to residents and identify the nursing activities to be completed. They are also responsible to ensure activities are carried out as identified in the plan of care and for the evaluation of resident care.

Protection of the Rights Of Subjects

Written consent will be obtained from all subjects. The subjects will be assured that their participation in the study is voluntary, they can withdraw at any time and refuse to answer any questions without affecting the services provided to them or, in the case of the nurses, affect their employment status in any way. Assurance will be given that all responses elicited will be anonymous and confidential. Names will not appear on any of the questionnaires. Nurses agreeing to participate in the study will be given pre-addressed envelopes to facilitate an anonymous return of their responses.

Data will be collected by structured interviews for the residents and questionnaires for the nurses. Those residents capable of and desiring to fill out the questionnaire on their own without an interveiwer present will be supported in doing so. The purpose of the interveiwer is to facilitate those individuals who may need assistance due to some sensory losses.