Increasing Choice and Control: The Development, Implementation and Evaluation of a Program of Intervention at a Personal Care Home

By
Bonnie Griffiths

A Practicum Report

Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirement
For the Degree of

Master of Social Work

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

June 1990

ISBN 0-315-63239-9

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ABSTRACT

TITLE : Choice and Control: Development, Implementation and evaluation of a Program of Intervention at a Personal Care Home.

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The goal of the practicum was directed towards enhancing the quality of life and the emotional well-being of the residents of a personal care home. The objectives were to: (a) provide a method of ascertaining the specific areas of daily living activities over which residents wish to have more control and/or choice, (b) to identify the feasibility of and barriers to providing more choice and control to residents, and (c) to propose a rationale that supports the belief in personal autonomy for residents.

This report documents three interventions; the formation of a Choice and Control Committee, the designing of Residents' Preference Survey and the implementation of a field study. The student was able to implement the interventions in a manner that was beneficial to both residents and staff at the personal care home.

DEDICATION

- To Jodi and Derek Griffiths, who were my motivation for undertaking my M.S.W. program and who made the role of mother-student possible.

- To Bob Neil, for his unending support and belief that I would accomplish my goal.

- To Kim Clare, who for eight years walked the rocky road of frustration and elation with me.

- To the residents and staff at Taché, who participated in the final phase of my M.S.W. program and to Karen Mulgrew who provided assistance throughout the practicum study.

- To Joe Kuypers, Don Fuchs and Claire Pangman, whose flexibility and insistence of a well-developed proposal made this achievement possible.

- To Sally Yimsek, for her patience and ability to respond to my impossible deadlines.

- To Don Munsey for teaching me the meaning of the quality of life.

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INTRODUCTION: RATIONALE FOR SOCIAL WORK INTERVENTION

A. Development of graduate student's interest in practicum.

The graduate student (writer) was invited to conduct a workshop on elder abuse at Taché Nursing Centre (Taché) in May 1988, as part of the staff training and development program at Taché. The workshop was attended by thirty-five staff members representing a cross-section of the staffing component, including housekeeping, nursing, dietary, pastoral care, social services, physiotherapy, activities, and administration. The participants identified and discussed examples of physical, financial and psychological abuse within the community and within personal care homes.

In November 1988, the writer was asked to present a second workshop that was attended by fifty-one staff. The focus of this workshop was on passive psychological abuse within personal care homes. The workshop utilized video tapes on elder abuse (University of Massachusetts Centre on Aging.)

The video tape presentation suggested that the elderly persons' resistant attitude to personal care home placements is due to the process that creates a total abandonment of independence due to the loss of freedom to make choices about one's everyday life. It is having choice and control that gives a person dignity.

The writer proposed, at this workshop, that when an institution withholds choices and limits decision-making opportunities for residents the institution is engaging in a form of passive psychological abuse. The hypothesis, presented by the graduate student, was that by increasing the availability of decision-making opportunities that the life satisfaction level of the residents would concurrently increase, enriching the quality of life.

Prior to the workshop, the writer had discussed with Taché administration the focus of the workshop and the possible recommendations for change that may result from the workshop. The administration was both supportive of the workshop and indicated a willingness to explore any recommendations.

The workshop participants, working in groups of 7-8 members, engaged in a process of identifying the areas of daily living activities in which residents could be given greater choice and more responsibility for decision-making. The seven groups generated lists that contained ten to twenty-two items. The items were prioritized to indicate the most and least important items. Prioritization was achieved by group members voting on each item. The workshop allowed the participants to explore ways in which residents could exert greater control over their lives and thus enhance their independence. The evaluation of the workshop indicated an interest by the participants to further explore the findings of the group discussions. In order to facilitate this process the writer, as a graduate student in Social Work, discussed with the Staff Training and Development Department at Taché Nursing Centre the potential of fulfilling the requirements of her Social Work Practicum while simultaneously meeting the needs of the workshop participants. An agreement was reached in February 1989 that Taché Nursing Centre would become the site for the graduate student's practicum: the practicum to

involve the development, implementation and evaluation of a program of intervention designed to increase residents' personal autonomy.

It was also agreed that the graduate student would assist in the development of and act as a resource to a committee comprised of Taché staff members. The objective of the committee would be to further study the issues of psychological abuse that were raised in the previous workshops.

It was the graduate student's belief that the climate at Taché Nursing Centre was not highly conducive for abuse of residents. This contention was based on four observations by the graduate student:

1. There exists at Taché a staff training and development department consisting of three staff members. This department is responsible for the delivery of a well-designed nursing aide course that is mandatory for all new aides. As well, the department offers on-going program of professional training workshops, available to all staff.

2. A staff library and resource centre at Taché Nursing

Centre houses current journals, books and tapes pertaining to the field of gerontology is available to all staff members. Staff are made aware of new acquisitions and special days are made available for library displays.

3. An obvious commitment by Taché staff to the well-being of residents is indicated by the cheerfulness of the staff, the use of therapeutic touch, the positive and helpful attitudes of the staff, and the personal interaction between staff and residents.

4. Taché is a facility established by the Grey Nuns and it is dedicated to providing care for the disabled and elderly. Eric Cassell concluded in his 1989 study that for good care to be provided, there needs to be a sense of obligation on the part of the staff. He stated that the best care was given by religious-based homes because staff members are able to meet their obligations to God by serving the needy. The high quality of care advocated by Cassell is found at Taché Nursing Centre. The graduate student is of the persuasion that incidents of abuse of residents, particularly psychological

abuse, would be largely due to errors of omission rather than to errors of commission: errors made accidently or inadvertently rather than errors committed purposely or advertently. The workshops on elder abuse which were delivered at Taché were designed to raise awareness of elder abuse in institutions. By doing so the particular type of abuse caused by errors of omission would be reduced. Taché recognizes that psychological abuse and commitment to quality of life are not congruent.

The first committee meeting was held in May 1989 with staff representation from nursing, dietary, housekeeping, activities, and pastoral care. The committee was originally entitled the Elder Abuse Committee but at a subsequent meeting was changed to the Choice and Control Committee so as to better reflect the goals and direction of the committee.

B. Congruency between the philosophies of Social Work and Taché Nursing Centre.

Taché proposes twelve resident care beliefs (values) as forming a framework for their delivery of care.

(Appendix A). Of these twelve, three are cited as being particularly relevant to the discussion.

> #1. We believe that each resident is a unique individual who has worth and the right to live a life of dignity.
>
> #3. We believe in the protection of privacy and personal autonomy of each resident, and in the development of choice and control (self-determination) for the individual.
>
> #5. We believe that each resident has the responsibility and the right to participate in decisions affecting their care and lifestyle. (p.2).

The writer finds these beliefs to be in harmony with social work philosophy as outlined in the Canadian Association of Social Workers Code of Ethics (1983) (Appendix B). The Code of Ethics states as its philosophy:

> The profession of social work is founded on humanitarian and egalitarian ideals. Social workers believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination and respect of individuality. (p.2).

The Code of Ethics describes social workers as:

> engaged in planning, developing, implementing, evaluating and changing social policy, services, and programs that affect individuals, families, social groups, organizations, and communities. (p.2).

It is proposed that there is sufficient rationale for the practicum study, as the philosophy of Taché Centre and the philosophy of social work are congruent. As well, the role of the social worker, as outlined in the Code of Ethics, is consistent with the role of the graduate student in the proposed program of intervention.

CHAPTER 1. LITERATURE REVIEW

A. Elder Abuse:

It is appropriate to first examine the literature pertaining to elder abuse as it was from the concept of elder abuse that the practicum originated. An extensive body of literature exists that addresses abuse of the elderly living in their own homes and in the homes of relatives, but there is limited literature that focuses on elder abuse within personal care homes.

According to Cassell (1989) abuse occurs when a person, object or relationship is misused. When the conditions of the relationship have been breached, it is said that the person has been abused. "The elderly are abused when others in relationships to them use them to their advantage." (Cassell 1989, p.159)

The closer the relationship, the more likely the occurrence of abuse. The findings of Pillemer and Finkelhor (1988) indicated that elderly persons, living with others, particularly with spouse and one other and those in poor health are more likely to be abused. The authors describe three categories of elder abuse:

1. Physical Abuse means at least one act of physical violence against the respondent since he or she had turned 65.

2. Neglect is the deprivation of some assistance that the elderly person needs for important activities of daily living. If the neglect has occurred 10 or more times in the preceding year it is considered as abuse.

3. Psychological abuse is the elderly person being insulted, sworn at, or threatened at least 10 or more times in the preceding year. (p.53)

The issue of neglect, described by Pillemer and Finklehor is related to the issues of choice and control. It is the writer's belief that it is important not only that the institutionalized resident be provided assistance with daily living activities but also that the resident be allowed to exercise some degree of choice and control over the time and space for these activities. It would follow that the absence of an opportunity for such control would constitute neglect. The writer's assertion is supported by Betty Chang, (1978, B) who discussed residents' ability to influence their resources of time, space and assistance. The writer's belief is not supported by Paul Willging (1985) as indicated in his letter to Claude Pepper, the Chairman of the Federal Government's hearings pertaining to elder abuse in nursing homes in the USA. Willging cautioned against calling the lack

of choice and control abuse or crimes. He contended that the lack of choice of meals and bath times are simply the compromises required by institutional living.

The psychological abuse described by Pillemer and Finkelhor (1984) was also studied by Tarbox (1983). In his submission to the State Attorney General's Office on Texas nursing homes, Tarbox reported that incidents of physical, psychological, material and financial abuse are prevalent in many of the homes. The study revealed that physical abuse is least common while psychological abuse is most common. The following anecdotal report from the Texas Task Force survey reveals the importance of choice and control to the psychological well-being of residents.

> I would like warm food with some choice regarding size of portions. When I don't feel like eating, don't scold me. Don't force me as a child. When I lived at home, before I came to this nursing home, I made my choices, but now you want to take away all my decisions, all my opportunities to make decisions regarding what is done to my body, and that hurts.
>
> (Tarbox, 1983, p.43)

Other authors acknowledged the existence of abuse in personal care homes. (Cassell, 1989; Government of

Manitoba, 1989; Harrington, 1984; and Swartz, 1988). In Swartz's report on the Ontario Institute for Studies in Education Conference, she highlighted the presentation by Judith Walh, a panelist at the conference. Walh, a lawyer, stated that it is now mandatory to report all incidents of abuse to the administrator of the facility.

Harrington studied four nursing homes in the U.S. over a four year period. All four homes had a reputation for very high quality care. Although there were no reported cases of physical abuse, there were flagrant incidents of financial and psychological abuse in all four homes.

Cassell focused his discussion of elder abuse on the power of the caregivers, specifically nursing aides. His view of nursing aides is that generally they are powerless people in society and that their role as caregiver creates a climate that is conducive to abuse. "The abuse of sick old persons in nursing homes comes about through the actions of the relatively powerless against the completely powerless." (Cassell, 1989, p.160) The graduate student does not embrace Cassell's theory, rather choosing to suggest as casual

factors, lack of appropriate gerontological training for staff, coupled with low wages and poor working conditions. The existence of government standards can require that appropriate staff training take place and can influence working conditions in personal care homes although it is acknowledged that standards may not be able to control wages. It is through such standards, and through regular inspections of facilities, that the Government of Manitoba (1989) contends that the potential for institutional abuse is minimized.

B. Quality of Life:

It has been stated that Taché has, as its mandate, quality of life. The goal of this practicum is the increase in quality of life. It is fitting therefore to examine the quality of life literature.

In her 1988 study, Stryker compared the medical model and the residential-care model, with the latter being the appropriate model for nursing home facilities. Stryker described the major goal of the nursing home model as being that of quality of life.

The concept of quality of life is verified by Amrogi and Leonard (1988), and by Vallerand, O'Conner and

Blais (1989), as the combination of life satisfaction (morale) and autonomy.

The first determinant, that of life satisfaction, is influenced by the resident's perception of the situation. In her study Chang (1978 B) stated that "those who perceived situations to be self- determined scored higher in morale regardless of locus of control categories." (p.323) Chang's "locus of control" categories refers to inner-directed persons who perceive themselves as having control over and responsibility for personal life events and to outer-directed persons who perceive themselves as having little or no control over or responsibility for personal life events. Chang therefore suggested that by increasing decision-making opportunities regarding daily living activities, one then provides more control of the environment.

Ryden (1984) studied the relationship between morale and perceived control and found that residents who are self-determining had higher morale levels. The study suggested that interventions that increased situational control would positively influence morale. In a later study, Ryden (1985) suggested that one of the factors

that may inhibit greater situational control by residents is the use of the medical model of care. The medical model is based on a hierarchy of power with the resident at the bottom and the caregiver at the top of the hierarchy. Such a structure of power makes it difficult for the residents to exert power and to take control of decision-making in their lives.

As well as the factor of Ryden's situational control, Elias, Phillips & Wright (1980) studied the specific situations over which residents desired more control. Their findings showed that items of privacy, where to spend free time and situations that indicated relationships with others had the greatest value and that they were predictive of morale. The sample size in this study was relatively small (17) and the subjects were all female. These two factors may have affected the study results.

The second determinate of quality of life, that of autonomy, is addressed in a number of studies. Clark (1988) described personal autonomy as self-determination, independence, self-rule, decision-making and following one's own life plan. Lowy (1989) presented the issue of independence versus dependence as a

continuum that is not static, rather it fluctuates throughout the life span. Lowy stated that

> the need to reestablish a balance between independence and dependence, to maintain or gain a sense of mastery and autonomy is a significant part of acquiring self-confidence in dealing with the outside world when growing up; therefore when such self-confidence becomes threatened in the later years, means must be developed and methods designed to restore balance and achieve a reasonable socio-emotional equilibrium. (p.141)

The sense of mastery as required for self-confidence and well being, referred to by Lowy, is reiterated by Joyce Colling in her 1985 study. Colling found "that control [mastery] of daily living activities does influence well being." (p.3389). The author proposed that greater control and increased well-being of residents could be achieved by changing or adjusting environmental factors. It would appear that any adjustment of environmental factors that would decrease dependency would be advantageous. According to Birchell (1988) it is evidenced that dependency leads to a proneness for depression.

Both Clark (1988) and Cohen(1985) addressed the issue of autonomy in terms of a continuum. Cohen proposed that three issues need to be addressed so as to move towards the upper end of the autonomy continuum:

1. Residents need to experience an environment that is free from coercion and from undue restraint.

2. Residents need to have available to them all pertinent information so that they can make sound decisions.

3. Residents should be able to maintain a lifestyle that is reflective of their values and attitudes.

Maintenance of lifestyles and continuation of social roles were important factors in maximizing personal autonomy, according to Coons and Reichel (1988), who added an additional factor, that of flexible routines for bathing, meals and bedtimes.

The issue of flexibility of routines was paramount in the paper by Munley, Powers and Williamson (1982). The authors examined ways that the principles of hospice care could be adapted to nursing home care. The authors proposed a humanized environment as one method of addressing the loss of autonomy and alienation claimed to be experienced by so many nursing home residents. "Chief among the humanizing characteristics of the hospice model of care is the belief in the right of the individual patient to the prime decision-making position with respect to his or her care."(p.266) Munley, Powers and Williams concluded that this principle could be transferred to the nursing home

environment and would assist in creating a more humane environment that would be focused on the individuality of each resident. The promotion of individuality and 'normalization' was also advocated by Couchman and Ferris. (1987)

C. Choice and Control Philosophy:

The themes of control, decision-making and choice are evident in the previously cited literature regarding morale and personal autonomy. In the literature relevant to the issues of choice and control, definitions of choice and control are provided in the study by Moos. (1981) He defined control as participation in decision-making opportunities and choice as options in planning daily life activities.

Ruth Stryker (1988) concluded that as a person becomes less competent as a result of illness or disease there is a loss of control that results in greater need for support services. It is important that as a person adjusts to these realities that there not be a loss of self-esteem. Stryker believed that this could be accomplished by a residential model that provided for "client driven decision-making." (p.14) She suggested that staff needed to be aware of the importance of the

resident's sense of mastery. To do so "requires an understanding that reduced control creates a sense of anonymity, lowers self-esteem, and produces apathy, a sense of powerlessness and increased helplessness." (p.17)

Betty Wyckoff (1988) concurred with Stryker's viewpoint. Wyckoff, herself a resident, asserted that, due to failing health of residents, self-esteem and confidence are lowered, therefore personal care homes needed to provide opportunity for decision- making so as to increase independence. It is evidenced by the literature that a lack of control leads to behaviour characterized by withdrawal, passiveness and low self-esteem. (Moos, 1981; Stein, Linn & Stein, 1987)

The importance of decision-making as a factor affecting the life satisfaction level of residents was the focus of the studies by Banziger and Rousch (1983), Langer and Rodin (1976), Rodin (1986), and Roger (1988).

The study by Tim Booth, (1986) was designed to test the hypothesis that the more restrictive and controlling the climate of a personal care home, the poorer the functioning of the residents. The findings revealed

that the hypothesis was not supported and Booth concluded that

> the study suggests that the case for more liberal regimes and ways of working, in terms of the amount of control that residents have over their lives, should be argued on the bases of residents' rights instead of the assumption that they diminish the effects of institutionalization. (p.422)

Booth's study focused on the findings that clearly indicated that the amount of personal control (autonomy) afforded residents does not influence their functioning. Booth suggests, but does not elaborate on, a rational for the provision of greater personal control for residents. The rationale is simply stated as a question of the right of each resident to control his/her life. The issue of resident's rights will be addressed by the writer in Chapter 3 of this report.

Little agreement is to be found in the gerontology field as to the amount of control that should be provided for residents. Both Rodin (1986) and Moos (1981) cautioned that there are limits to the advantages created by increased control. They suggested that the frail elderly may react negatively to the stress created by undesired control. Clark (1988) took a much different approach to the issue of frailty. He called for practitioners to find ways of

enhancing personal control for the frail and low functioning cognitively impaired elderly. Clark suggested that some control could be provided by the introduction of simple choices regarding daily living activities. Clark's position is supported by the residents in the Institute of Medicine's study on Nursing Home Regulations (1986) who stated that "even such seemingly small choices as mealtimes, activities, clothing, or times to rise and retire, greatly enhance the sense of personal control that leads to a sense of well-being." (p.51)

Roper's 1988 study identified the need for choices regarding bed times and menus. He stated that a "facility must provide a range of meaningful choice." (p.17)

Tarbox (1983) pointed out that for many residents meals are the social event of the day and need to be treated with importance. In one paper, Shirley Power (1986) compared selective and non-selective menus. She conjectured that the true reasons behind non-selective menus is staff efficiency and cost. She does not believe that non-selective menus and a philosophy of residents' rights and freedoms are congruent.

The choice related literature stressed that coupled with the right to make choices is the right to refuse to participate in meaningless activity. (Munley, Powers & Williamson, 1982) Judith Rodin (1986) brought the choice-control issue full circle when she stated "the need for self-determination.... also calls for the opportunity to choose not to exercise control." (p.275)

D Choice and Control Interventions:

A number of studies presented and described choice control enhancing interventions. Muriel Ryden (1984) in her study on perceived control in institutionalized elderly, suggested that caregivers are themselves the intervention:

> caregivers who consistently communicate a clear belief in the right and responsibility of the resident to be self-directing, and who offer choices whenever possible, may alter not only the objective extent of control by residents but also the subjective perception of control. (p.134)

Rodin's (1986) study recommended the application of a program of coping skills to help reduce stress and to increase control over the environment.

Power (1986) put forth creative interventions designed

to incorporate the concept of "restaurant nights" complete with a maitre d', formal table cloths, and a menu selection. The intervention included the involvement of the residents in menu planning and decorating.

In a study by Katlan and Bergman (1988) the participation level of residents in old age homes in Israel was measured. The authors found that it was important to increase the ways in which the aged can participate in situations that require decision-making and problem solving skills so as to counteract the influence of declining health and decreasing networks. The intervention put forward by Katlan and Bergman was to involve more elderly residents in committee work. Committee work requires the use of problem-solving and decision-making skills, and the committee itself can create a network of support for the residents that can in some ways substitute for their former personal networks.

Autonomy can be increased for residents by the presence of a Residents' Council, a residents' Bill of Rights and a formalized grievance process. (Clark, 1988; Roper, 1988; and Ryden, 1985) These mechanisms can be

powerful tools in increasing choice and control for residents. To date these tools are not being fully utilized as they are often given lip service. (Clark, 1988) In conclusion, according to Stein, Linn and Stein (1987), "the social climate of an institution can promote health or it can serve to destroy initiative and independence. (p.45)

In reviewing the gerontology literature, it becomes apparent that there exists a powerful force exerting pressure on the personal care system to instigate measures that will maximize the personal autonomy of residents through enhanced control and choice. But it must simultaneously be recognized that many homes are structured on the medical model of care and are staffed by nurses who have been trained in this model of care. (Coons & Reichel, 1988; Milligan, 1987; and Munley, Powers, & Williamson, 1982). Milligan's (1987) paper describes an experimental unit which offers personalized accommodation for long-stay elderly. The senior nurse stated that it had a client-centered focus rather than a nurse-centered focus and had a non-traditional way of delivering service. Even though the nurses volunteered to work on the unit because of their commitment to the innovative philosophy, "many

years of working cannot be overturned immediately.... because they [nurses] are traditionally trained to be clinically-oriented, there were difficulties in changing for some of the nurses." (Milligan, 1987) According to the senior nurse some of the difficulty involves a perception of a loss of status by the nurses, even though the nurses were excited about working in a new way on a challenging project. It was the graduate student's experience, when working with the Choice and Control Committee at Taché that similar mixed feelings existed regarding the changes that may be made or recommended to be made as a result of the practicum interventions. The graduate student therefore operated from the premise that change would be gradual and could not be forced.

The gerontology literature, as described, connects the issues of psychological abuse and quality of life. The quality of life literature stresses the importance of choice and control as factors influencing the quality of life experienced by residents living in personal care homes. It was therefore imperative to review the literature in these fields so as to provide a framework for the practicum.

CHAPTER 2. THE PRACTICUM

A. Setting:

The practicum setting was Taché Nursing Centre, 185 Despins Avenue, St. Boniface. The facility houses disabled and elderly residents requiring nursing care. There are 318 beds and a staff component of 330 persons. The Centre was founded over 100 years ago by the Grey Nuns.

B. Graduate Student's Goals for the Practicum

The writer's goal for the original elder abuse workshops was to increase the quality of life of residents by decreasing the incidents of emotional abuse. The method for achieving this goal was to raise staff awareness of abusive situations and to create an environment in which staff could discuss and report incidents of abuse.

The goal for the practicum remained directed towards the quality of life and the emotional well-being of the residents. Gerontology studies support the view that morale and emotional well-being of residents are directly influenced by the degree of decision-making and

control of daily living activities. (Banziger & Roush, 1983; Langer & Rodin, 1976; Rodin, 1986; and Roper, 1988).

In his 1988 study, Clark stated

> Increased research linking positive health outcomes and a sense of personal control over one's life underscores the need for developing programs to enhance the autonomy of elderly persons. (p.279)

Holder and Frank (1988) reported the findings of a study on quality of life conducted by the National Citizens' Coalition for Nursing Home Reform (NCCNHR) that involved insights of over 450 residents. The residents described the condition and factors that were instrumental in maintaining a high quality of life as being "maintenance of the best possible physical condition with pain and discomfort being minimized;...self-determination, personal control, involvement in group efforts and group decision-making." (Holder & Frank, 1988, p.28).

To achieve the graduate student's goal of enhancing the quality of life of the residents the objectives of the program of intervention were selected to promote greater personal autonomy for the residents.

C. Objectives of the Program of Intervention

The Belief Statements of Taché Nursing Centre, cited on p. 7, address issues of human dignity and worth, personal autonomy, choice and control, decision-making and residents' rights. It was, therefore, imperative that the program of intervention provide a framework for operationalizing the Belief Statements. The following three objectives provide that framework.

Objective I To provide a method of ascertaining the specific areas of daily living activities over which residents wish to have more control and/or decision-making opportunities.

Objective II To provide a report with specific recommendations for changes in procedures, policies and environment required to facilitate greater control and decision-making opportunities for residents. The feasibility of such changes and the identification of barriers to change would be incorporated into the report.

Objective III To propose a rational that supports the belief in personal autonomy for residents living in personal care homes.

D. Beneficiaries of Intervention

There was a dual target population for the program of intervention as both the staff and the residents were potential beneficiaries. The staff populations targetted as beneficiaries were the Choice and Control Committee and specific staff departments, including dietary, activities and nursing.

The practicum was designed to directly benefit the specific residents who comprised the experimental group in the field study. As well, it was speculated that there would be long-term benefits for the general resident population at Taché.

E. Personnel

The graduate student was assisted in her work by Karen Mulgrew, instructor in the Staff Training Department at Taché. Karen initiated and organized the Elder Abuse Workshops and the Choice and Control Committee.

The 12 Choice and Control Committee members provided a network of support to the graduate student during the process of the practicum. A selected number of committee members administered the measurements dictated by the field study and are referred to in the evaluation of the study as "research assistants."

The field study required an additional six interviewers to administer the happiness, alertness and morale measurements. The Department of Volunteers at Taché provided the additional personnel required to complete this task. The volunteers were trained as interviewers (research assistants) by the graduate student.

F. Duration

The practicum commenced February 1989 with the approval of Taché Nursing Centre that the facility would be the practicum site for the graduate student. The completion date was May 1990.

G. Criteria for Evaluation

The criteria for the evaluation was two-fold. The

first criterion was that the practicum achieve the objectives of the program of intervention. The second criterion was that the practicum deliver the benefits to staff and residents.

CHAPTER 3. EVALUATION

A. Achievement of Objectives

The objectives of the program of intervention will be restated and analyzed individually to determine the degree to which they were achieved.

OBJECTIVES

Objective I: To provide a method of ascertaining the specific areas of daily living activities over which residents wish to have more control and/or decision-making opportunities.

Process: The graduate student designed a four page Residents' Preference Survey. The survey was designed using information and suggestions from four sources:

i] The elderly abuse workshop that produced lists of areas in which more choice and control could be given to residents.

ii] A Choice and Control Committee meeting that discussed the workshop findings and that identified the area over which committee members would want more choice if they were residents.

iii] A Resident Council Meeting, where council

members discussed, with Karen Mulgrew the types of choices and control that they desired.

iv] The choice and control literature.

The Residents' Preference Survey identified the specific areas of concern to individual residents and identified specific changes desired by each resident. (Appendix C). The survey incorporated questions pertaining to control of time, space and assistance that were identified by Chang (1978) as being related to life satisfaction and morale. The questions pertaining to time were phrased so as to first determine the exact time that the residents performed specific activities such as rising, retiring, bathing and eating. The residents were then asked what time they would prefer to perform these activities. The survey questions strove to identify existing differences between present schedules and preferred schedules, with differences being the indicator of a need for more flexible schedules. Coons and Reichel (1988) prescribed flexible routines for bathing, meals and bed times as being instrumental in fostering greater personal autonomy for residents. Munley, Powers and Williamson (1982), and Couchman and Ferris (1987) recognized that flexibility in care-giving

routines promote individuality. It is the retention of individuality that is critical to a sense of well-being and to self-esteem. (Stryker 1988)

Chang's control of space factor was incorporated into the survey through questions relating to the degree of privacy accorded each resident and to the desirability of the way in which the resident's room was arranged and decorated. The third factor identified by Chang, that of control of assistance, was addressed in the survey through questions that first determined the type of assistance required by each residence such as assistance in dressing, rising, grooming, bathing, eating, and ambulation.

The residents were then asked whether the manner in which the assistance was given was satisfactory and whether it demonstrated respect of and sensitivity to the resident.

The survey was tested with four members of the Residents' Council Executive and five questions were deleted due to their being either irrelevant and/or confusing. The decision to involve the Residents' Council in designing and testing the survey had two

rationales. The first rationale was to test the survey in terms of clarity and relevance. The second rationale was to provide a vehicle by which the Residents Council members could have impact into the field study. Katlan and Bergman (1988) found that resident involvement in decision-making and problem-solving situations, such as committee work, assisted in reducing the effects of declining health and smaller networks. The suggestions made by the council members were incorporated into the redesigned survey that was administered by the graduate student to the experimental group.

Resident involvement in the study was promoted and encouraged. One resident assisted with the literature computer search and with the design and production of the invitations to the Coffee Party sponsored by the Choice and Control Committee to thank the residents who formed the study population and the volunteers who conducted the interviews.

The Resident's Preference Survey produced the data required to determine the specific intervention for each resident. A summary of the findings are described in Table 1.

TABLE 1: Residents' Preference Survey Data: Requests for Change (23 respondents)*

ITEM	NO. OF REQUESTS
No intervention (change) required	6
Additional baths	6
Attendance at more activities	0
Rising/retiring times	2
Food related changes	11 (with 23 specific changes)
Disregard of lifestyle by staff	2
Change of seating in diningroom	1
Change in meal times	1
Increase/decrease in number of physiotherapy sessions	0
Manner in which physical assistance is given to those requiring assistance	0
Change in room decor	2
More Privacy	1
More opportunity to communicate with residents/staff	0

* A number of residents indicated more than one intervention.

The Resident's Survey findings indicate a strong desire for changes in food choices. These findings are congruent with the findings of Roger's (1988) study in which the need for choice of foods was the most important item. Tarbox (1983) also stressed that selective menus are a resident's right and should not be considered as a privilege.

The graduate student found the Dietary Department at Taché most cooperative in providing the food changes required for the interventions for the study. As well, the Dietary Department was very receptive to any feedback regarding choice of food that would enhance the well-being of individual residents.

The survey findings of food being the most important item and bathing being the second most important issue, are identical to the results of the Coon and Reichel study (1988). The data produced by the Taché study do not concur with the findings presented in the study by Elias, Phillips and Wright (1980). The authors found that the items of most value to the residents were privacy, where to spend free time and relationships with others. The graduate student speculates that the structural design of Taché Nursing Centre, that the majority of rooms being private rooms rather than shared accommodation has effectively met the need for privacy. Private rooms may also decrease the potential for interpersonal conflict between residents. Taché has a well staffed and effective Activity Department that offers a wide variety of activity. There is an activity worker assigned to each unit. This structure allows the workers to

develop supportive relationships with each resident and to provide encouragement for active involvement of each resident. This structure could account for the non-response in the survey to the questions relating to desire for additional free time activity.

A final revision of the Residents' Preference Survey was presented to the Choice and Control Committee for approval in May 1990. The revised survey reflected the items that had elicited the greatest response from the 23 residents in the original study pool. (Appendix D)

Objective II To provide a report with specific recommendations for changes in procedures, policies and environment required to facilitate greater control and decision-making opportunities for residents. The feasibility of such changes and the identification of barriers to change to be incorporated into the report.

Process: The graduate student presented to the Choice and Control Committee, in May 1990, a working paper that

i] outlined the potential areas for greater choice and control,

ii] described the staff relationship to changes in procedure and routines,

iii] discussed the ability of the facility to respond to identified barriers to greater choice and control, and

iv] listed recommendations for consideration.

The committee discussed the paper, made revisions, deleted and added recommendations. The Committee added a recommendation (#3.0 Appendix K) that focused on total staff responsibility for providing the dietary department with information as to residents' food preferences and choices.

The working paper recommended the dissolution of the Choice and Control Committee and the formation of a new committee, but the Committee did not agree with this recommendation. They recommended that the Choice and Control Committee continue to meet, develop new objectives, and restructure the membership. (Recommendations 0.0, 9.1, 9.2, 9.3, Appendix K) The final committee assessment report and recommendations are contained in Appendix E.

Objective III To propose a rationale that supports the belief in personal autonomy for residents living in personal care homes.

Process: The graduate student conducted a field study to explore the hypothesis that increased control over decision-making and increased availability of choices leads to an increase in morale, alertness, happiness, participation in activities and social interactions.

The study was to be comprised of 50 residents. The graduate student attended a Nurses' Practices Meeting to explain the history of her involvement at Taché, to outline the objectives of the study, and to request from the nursing staff a list of the names of residents who met the criteria (Appendix F) for the study and to seek confirmation from the nursing staff as to their willingness to conduct a Nurse's Rating evaluation of the selected residents at three different time periods. A total of 62 names of residents were submitted. The residents were randomly divided into two groups. One was the experimental group and the other was the control group. The random sampling was achieved by free draw of names with the first name drawn being in the control group, the second name in the experimental group and alternatively thereafter.

This process culminated with 31 residents in each of the two groups. The graduate student visited each of

the 62 residents in the study to explain the purpose of the study and to ask that they sign a consent form if they were willing to participate in the study. (Appendix G). Signatures of consent were obtained from 46 residents. At the termination of the study, 22 residents remained in the study.

The causes for the high attrition of the study pool are described in Table 2.

TABLE 2: CAUSES OF ATTRITION IN STUDY POOL: EXPERIMENTAL AND CONTROL GROUPS

CAUSE OF ATTRITION	EXPERIMENTAL GROUP	CONTROL GROUP
Original study pool	31	31
Refusal to participate in study	- 6	- 8
Balance	25	23
Ill or deceased	- 2	0
Balance	23	23
No intervention required by resident	- 6	- 6 *
Balance	17	17
Not possible to provide requested intervention	- 6	- 6 *
Balance	11	11

* Removal from study by researcher to balance experimental group.

FIELD STUDY

METHOD

Subjects

The study was conducted at Taché Nursing Centre, a personal care home that provides levels 1 - 4 nursing care with level 4 being the heaviest level of care available. The facility has one of the highest proportions of private (286) vs. shared (16) accommodation units and offers a high quality of nursing care, recreational activity and physio-therapy. The facility is large, modern in design, well maintained, with a beautifully landscaped outdoor patio/recreation area. The staff attitude appeared generally positive and enthusiastic. The resident population of Taché is 318 with 263 residents over the age of 60. Of these 263 residents, 71 were males and 192 were females, a ratio of approximately 3 females to 1 male. Residents who were cognitively impaired, or who were deemed by the nursing staff to be extremely frail and/or non-communicative were omitted from the sample. The male/female ratio of 1 to 3 found in the general population of over 60 year old

residents at Taché was maintained in the study population. Thus, 22 semi-ambulatory male and female personal care home residents, ranging in age from 60 - 94 constituted the total sample for the study.

Procedure

To introduce the resident-specific interventions that had been produced from the Residents' Preference Survey data (Table 2), the graduate student met with the staff member(s) directly responsible for the delivery of each intervention. As 10 or the 11 interventions involved a change in menu, the procedure was easily facilitated due to the positive and cooperative attitude of the dietary staff.

Dependent Variables

The measurements chosen for the study included:

i) The Philadelphia Geriatric Centre Morale Scale (Revised Lawton 1975). (Appendix H)
The inclusion of a morale scale was deemed appropriate based on the literature that indicates that morale is sensitive to change in control of

decision-making situations. (Chang, 1978; Ryden, 1984). It was the writer's belief that the specific interventions would increase the perceived sense of control of decision-making.

The choice of specific morale scale was made on the basis that the original Philadelphia Geriatric Centre Morale Scale was designed to assess morale of very elderly repondents. The revised scale by Lawton (1975) is relatively short (17 items), compared to the more lengthy versions of morale scales, and therefore is more suitable for administration to the frail elderly. The scale has split-half reliability of .79 and has predictive validity. The morale scale, because of its predictive validity, should therefore be a useful measurement in predicting morale.

ii) Self-rating Scales (7 pts) for Happiness and Activity levels. (Appendix I)

iii) Interviewer-rating Scale (7 pts) for Alertness (Appendix J)

iv) Activity Worker Rating Scales (7 pts) for Alertness, Happiness, Activity, and Grooming. (Appendix K)

The self-rating, interviewer rating, and staff-rating scales were used in studies by Banziger and Roush (1983) and Rodin and Langer (1976) with elderly residents in personal care homes. Rodin and Langer pointed out the problems with staff (nurses) ratings due to the difference in daily living activities of residents observed by the day shift and by the night/evening shift. The graduate student also experienced problems with staff-ratings. The staff ratings were originally designed to be administered by the head nurses of each unit. This plan was restructured when it became evident that the head nurses had insufficient staff time to administer the measurements. The self-rating measurements were redesigned, omitting the two health related scales, and were administered by the activity workers. The change of staff raters was a prudent step as the graduate student realized, over the course of the practicum, that the activity workers have more personal contact with each resident than do the head nurses, due to the differences in job descriptions and

responsibilities.

Each measurement was administered three times. The first (T_1) one week prior to the intervention, the second (T_2) one week after the intervention, and the third (T_3) three weeks after the intervention.

The first rating scale was a residents' self-rating of happiness and level of activity, using a 7-point scale (7 representing the highest value). This scale was administered with the morale scale by research assistants. The second scale, a 7-point scale, of alertness was scored by the research assistant immediately after leaving the room of the resident. The third questionnaire, administered by the activity workers consisted of (a) five 7-point scales on happiness, activity, alertness and grooming, and (b) four 4-point scales that measured the proportion of time residents spent visiting with other residents, talking to staff, sitting alone and watching T.V.

Behavioral measures. Since it was predicted that involvement in activities would be affected by the interventions, records of the level of participation in activities by each resident from T_1 to T_3 were

submitted to the graduate student for analysis. Due to missing data in the records and inconsistent data reporting (due to lack of clarity by the graduate student) the activity records were omitted.

Independent Variable (Intervention)

The intervention differed for each member of the control group as the intervention was determined by the data produced by the Residents' Preference Survey. Rodin and Langer's study (1976) and Banziger and Roush's study (1983) have demonstrated the powerful effect on behaviour that can be exercised by slightly increasing the degree of choice even though the choice intervention was identical for all participants. Hale, Hedgepeth and Taylor, (1985-86) investigated the issue of locus of control. In this study Hale and his colleagues suggested that Rotter's Social Learning theory was important in understanding the particular behaviour of the elderly. The Social Learning Theory views behaviour as being influenced by both expectancy and by the <u>value</u> of the reinforcer one expected to obtain and/or control. Thus it is the value one puts on the reinforcer that is significant.

The Residents' Preference Survey was conceived as a method of identifying a significant reinforcer (intervention) for each resident.

The Taché administration committed to continue the interventions after the field study was complete, as it was considered unethical to withdraw the choices that had been provided to the residents in the experimental group.

RESULTS

The means for responses to the 13 measures were calculated for both the experimental groups and control group at T_1, T_2 and T_3. The pre-test (T_1) indicated that on six measures the experimental group started at a more positive level than did the control group, on three measures the experimental group started on a less positive level than did the control group, and on four measures the two groups began at the same level. The difference scores at T_1 between the experimental and control groups on all measures are found in Appendix L. The change scores for all measures, T_1, T_2, T_3 for both groups are described in Appendix M.

A summary and comparison of the control group and experimental group changes over T_1, T_2, T_3 of all measures is to be found in Table 3.

TABLE 3: Summary of Control and Experimental Group Changes over time - All Measures Combined

$T_1 - T_2$

	Control	Experimental
Improves	5	4
Decreases	2	4
Same	6	5

$T_2 - T_3$

	Control	Experimental
Improves	1	3
Decreases	3	5
Same	9	5

$T_1 - T_3$

	Control	Experimental
Improves	2	2
Decreases	3	3
Same	8	8

At T_2 (one week post intervention) the experimental group changed positively in four measures, decreased in four measures, and remained at the same level in five measures. At T_2 there was slightly more improvement in the control in the control group than in the experimental group. the long term change ($T_1 - T_3$) scores reveal that there is significantly little change in either the experimental or control groups. The data indicates that the interventions have not resulted in effectively increasing the level of morale, happiness, activity, grooming, sociability and inter-personal communication of the experimental subjects.

DISCUSSION

After analyzing the data in Table 3, it would appear that the predicted change in the experimental group did not occur. In an attempt to understand and explain the results the graduate student conducted a personal interview with the 11 experimental subjects five weeks after the intervention. The goal of the qualitative interview was to discuss the residents' recall of the intervention and attitude toward receiving the intervention. One subject was hospitalized, one was

ill, three did not recall the intervention but six did recall the intervention. Of the six with recall, five subjects spoke very positively and/or enthusiastically about the intervention. The intervention was judged by the graduate student to be significant in their lives. The one negative response to the intervention resulted from the subject not receiving the intervention as often as desired (daily). An inspection of the individual morale and happiness scales for the six recall subjects shows no relationship between attitude and responses expressed in the qualitative interviews. This finding calls into question the appropriateness of the scales selected for the study as they do not appear to be sensitive to the feelings expressed by the recall subjects.

The appropriateness of quantitative research with this target population is also questioned. The graduate student has more confidence in the data produced by the qualitative interviews than by the data produced by the quantitative measures. This confidence evolved from the qualitative interviews conducted with the residents by the graduate student. In these interviews the residents talked about the interventions with enthusiasm and willing discussed the emotional impact

of the interventions. The quantitative measures had not reflected this impact. A difficulty with quantitative studies is that the target population, due to their physical health, age, and place of residency, are prone to illness and hospitalization, thus affecting consistent participation in over-time studies. It is acknowledged that qualitative research with an elderly population has its own set of difficulties that need to be addressed. One difficulty is the length of time required to conduct individual interviews with subjects whose level of loneliness may be high and who respond to the interviewer with lengthy descriptions and/or answers. It was found in the study that several residents attempted to redesign the quantitative measures into qualitative interviews, thus creating time difficulties for the research assistants.

Further examination of studies utilizing choice-induced interventions revealed a significant difference in the type of interventions employed. In the studies by Banziger and Roush (1983) and Rodin and Langer (1976), the interventions of, respectively, a choice of plants and of bird feeders, were known to the other subjects in the study pool and to staff who provided care to the residents. As the interventions were

highly visible they may have had a reinforcing effect that impacted on the feelings, attitudes and behaviour of the experimental group. Banziger and Roush provide anecdotes of the effect of the bird feeders on the subject's mental stimulation and of the opportunity for an inter-subject discussion and learning.

The interventions in the graduate student's study do not possess the same qualities and thus may not exert sufficient power to significantly register statistical change. The food interventions in the practicum study were not highly visible, as they were known only to the respective subject and were unknown to staff providing direct care. This low visibility may have eliminated any reinforcing effect. It is the writer's belief that, although there was no statistical change in the experimental group, the interventions had a positive influence on the recall subjects. Three anecdotes illustrate this belief. The first involved a subject for whom the intervention had been roast chicken served 3-4 times a week. When questioned as to the significance of roast chicken the response was:

> Roast chicken reminds me of being in my own home. Every time I eat chicken, all the pleasant memories of home flood through my mind. I feel good that I asked for chicken more often and I got it more often, it gives me a feeling of control over things.

The second anecdote involved a subject whose intervention was that of receiving salads more frequently. The subject had both sight and hearing impairments and enjoyed the opportunity to share his "life stories" with the research assistant. Due to the length of the interviews with this subject at T_1 and T_2, the graduate student administered the T_3 measurements. The student had also administered the Residents' Preference Survey to this subject prior to the intervention period so was therefore familiar with the subject's "life stories." During the T_3 measurements, a new story was added to the subject's repertoire. When specifically asked how satisfied the subject was with life today, (Question 11 on the morale scale) the subject responded in the following manner;

> Satisfied? I have a good life here. I can have whatever I want. Several weeks ago a lady came and asked me about salads. I told her that I would like more salad. At home, I would eat cabbage salad ... yes, I told her how much I like salads and now I get salads every day.

The subject's body was animated with excitement as he told his 'new' story. A sense of power and control flowed through his voice.

The final anecdote was told by a Native subject who had been receiving bannock regularly at the evening meal. The bannock intervention had registered no statistical change on the morale or happiness scales yet in discussion with the subject, she shared intense feelings of pleasure;

> I have bannock every day! The cook makes it just for me because he likes me and cares about me.

In the administration of the Residents' Preference Survey the writer recalls the subject as being rather sad and frustrated with her life situation. In the follow up discussion regarding the bannock intervention the subject was exuding pleasure and contentment.

How does one measure the power of interventions of this nature? Perhaps it is invalid to attempt to do so, rather as Tim Booth contended in his 1986 study, it is not the degree to which choice and control influences the dependency level of residents that should be the factor that determines whether the resident is afforded greater choice and control in their lives, rather choice and control should be afforded on the basis that such choice and control is the irrefutable right of every resident.

B. Delivery of Benefits

i) Staff: Choice and Control Committee

The staff members of the Choice & Control Committee were engaged in the development of the practicum. Brain storming techniques were employed in committee meetings to illicit the members' ideas. This process was instrumental in assisting the graduate student to design the practicum so as to be of benefit to both staff and residents. The anticipated benefits to the committee members were:

1. Personal empowerment resulting from the ability to influence change that will enhance the quality of life for residents.

2. Increased awareness of the pertinent literature relating to the program of intervention.

3. Increased knowledge of the research process as a result of participation in the design of the field study.

4. Provision of a forum for discussion of concerns relating to psychological abuse of residents and of staff within personal care homes.

Self-rating scales with a pre-committee involvement measurement (T_1) and a post study report measurement (T_2) were administered to nine committee members. (Appendix N) Six, 6-point scales measured:

i) personal empowerment to effect change

ii) individual knowledge level regarding elder abuse

iii) the perception of financial abuse at Taché

iv) the perception of physical abuse at Taché

v) the perception of emotional abuse at Taché

vi) the value of choice and control for residents.

A summary of T_1 and T_2 mean scores are described in Table 4.

TABLE 4: Summary of Mean Scores on all measures, T_1 AND T_2 (9 Respondents)

MEASUREMENT	PRE-COMMITTEE (T_1)	POST-COMMITTEE (T_2)
1. Personal empowerment	3.0	5.3
2. Knowledge of elder abuse	2.6	3.8
3. Perception of financial abuse	2.6	2.7
4. Perception of physical abuse	2.7	3.1
5. Perception of emotional abuse	3.0	3.7
6. Value of choice and control	4.5	5.3

All measures in Table 4 changed in a positive direction. This positive movement correlates with the findings from a 5-point scale administered to evaluate the committee's value, the mean value score being 4.1 (very valuable).

The committee members' perception of emotional (psychological) abuse being the most common form of abuse is supported by similar findings by other investigators (Harrington, 1984; Tarbox, 1983).

Table 5 describes the findings of a third measurement of benefits to committee members. The high response to a number of benefits underlines the effectiveness of the committee experience for its membership.

TABLE 5: Summary of Committee Evaluations
(9 Respondents)

	Below is a list of ways committee members responded to being on the committee.
6/9	Enjoyed meeting staff from other departments.
7/9	Became more knowledgeable about elderly abuse.
5/9	Became more knowledgeable about Taché.
3/9	Enjoyed getting away from their regular job and seeing Taché from another perspective.
4/9	Felt more a part of a team now.
6/9	There are other staff to whom they could talk if they had concerns.
8/9	People of the committee were willing to listen to the member's opinions.
9/9	Felt that they were not alone with some of their concerns about residents.
0/9	Thought the meetings were a waste of time.
0/9	Were glad when there are no more committee meetings.
8/9	There is value in having the committee.
8/9	Wished to remain on the committee.
9/9	Felt the residents should be given more choices.

Staff: Specific Departments

The program of intervention conducted by the graduate student has produced both the (Revised) Residents' Preference Survey (Appendix D) and the Committee Assessment and Recommendations Report (Appendix M) that are available to all departments at Taché.

1) The Residents' Preference Survey that could be applied as an assessment tool in the admission process for new residents. The survey can also provide a method of ascertaining ways that present residents could be accorded greater personal autonomy. A further function of the survey may be as a teaching tool in the Nursing Assistant Course offered at Taché.

2) The assessment report containing recommendations, could be employed by the nursing, dietary, administration or activity departments as a framework for further exploration of the specific environmental changes that would in turn foster a richer quality of life for residents.

Residents: Participants in Field Study

The direct beneficiaries of the program of intervention

are the residents who comprised the experimental group in the field study and who were able to recall the intervention and to provide a positive response to the intervention. Although the data resulting from the selected measurements does not support this contention, the information generated from the qualitative interviews does support the conviction that the specific interventions held positive value for the subjects.

Residents: Total Residential Population

Although it is acknowledged that the field study experimental group participants are the short-term direct beneficiaries of the intervention, it was predicted that the general population of the residence would be the long-term beneficiaries. This prediction evolved from the graduate student 's clinical observation of the process that had already been set in motion by the abuse workshops and by the practicum. An increased awareness of the significance of choice and personal control as a factor in contributing to the quality of life of the residents had been established with the members of the committee and with staff who attended the second abuse workshop.

This awareness, coupled with the commitment of the committee, and supported by the instruments for identifying the desired choices and required changes, could eventually influence practices and policies at Taché. The graduate student's stance that raised awareness leads to reconsideration of present policies and procedures and to eventual change, is supported by the study of Couchman and Ferris (1987). The findings of this study did not indicate high levels of dissatisfaction by residents even though there were significant differences between pre-admission and post-admission routines in such activities such as hours for rising and retiring, but the author noted that the study lead to a reexamination of the admission procedures of the nursing home. The reexamination resulted in the initiation of a data-gathering process on pre-admission habits and routines. The goal of the process was to establish post-admission routines that are as similar as possible to pre-admission routines. Similarly, the writer contended that the enthusiastic commitment indicated by the committee would lead to a reexamination of policy and procedures and ultimately to changes that would benefit the residents.

CHAPTER 4. SUMMARY

The practicum, conducted at Taché Nursing Centre, has allowed the graduate student to examine the gerontology literature related to elder abuse, quality of life and choice and control philosophies and interventions. In doing so it became apparent to the writer that there is strong support for increased control and greater choices in the lives of residents living in personal care homes. (Banziger & Roush, 1983; Moos 1981; Tarbox 1983; and Wyckoff 1988)

Personal control over daily life activities is instrumental in affording a sense of independence and personal control over life events is influenced by the degree to which one is involved in decision-making activity. It is the limited opportunity for decision-making that is characteristic of many personal care homes. Therefore the creation of opportunities for decision-making is critical if there is to be true commitment to the philosophy of personal autonomy for residents. The need for structures, such as Resident Councils, committees, and grievance procedures, allow residents to be involved in decision-making opportunities. (Katlan & Bergman, 1988; Clark 1988; Roper 1988; and Stein, Linn & Stein 1987) Such structures can either be vehicle for raising false expectations of residents or they can be truly

powerful agents for change. The strength or weakness of the structure depends on the willingness of the facility to provide meaningful decision-making opportunities, so that the residents can be engaged in a process of personal empowerment.

It is the writer's belief that the process that was set in motion by the abuse workshops and has been advanced by the work of the Choice and Control Committee will continue to evolve.

The process has heightened awareness by staff on issues pertaining to psychological abuse and to the value of increased choice and control for the residents of Taché Nursing Centre.

The committee members commitment to the continuation of and further work by the Choice and Control Committee is predictive of eventual reexamination of existing policies and procedures. Such reexamination functions to exert pressure on the facility to evaluate and ascertain whether changes in policies and procedures would enhance the quality of life for the residents of Taché.

It is the graduate student's conviction that the program of intervention has met the objectives and has rendered the proposed benefits to staff and residents of Taché Nursing Centre.

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APPENDIX A.

TACHE NURSING CENTRE

PREAMBLE TO BELIEF STATEMENTS

The care and service provided at Taché Nursing Centre flow from the example set by Marguerite d'Youville who served with compassion, love and faith all those in need without distinction or discrimination. Her service was inspired by Christ who taught that those who serve the needy serve Christ Himself.

Therefore in keeping with the Mission and beliefs of the Grey Nuns, and in recognition of the fact that we are providing, not just institutional care, but a home to our residents and a positive work environment for our staff, we affirm our commitment to the care and service we provide through the following statements:

RESIDENT CARE BELIEFS (VALUES)

1. We believe that each resident is a unique individual who has worth and the right to live a life of dignity.

2. We believe in the sacredness of life that is characterized by care of the whole person - social, emotional, spiritual and intellectual, as well as physical.

3. We believe in the protection of privacy and personal autonomy of each resident, and in the development of choice and control (self-determination) for the individual.

4. We believe that residents have the right to the level of independence they are capable of attaining.

5. We believe that each resident has the responsibility and right to participate in decisions affecting their care and lifestyle.

6. We believe in the protection of rights of those residents who are vulnerable/mentally frail and unable to speak or act on their own behalf.

7. We believe that the family is an integral part of the resident and recognize this by encouraging ongoing commitment and involvement of the family in the life and care of the resident.

8. We believe that cultural customs and practices are important to the resident, and recognize this through the nurturing and/or provision of such customs and practices.

9. We believe that the religious beliefs of each resident are to be respected and nurtured.

RESIDENT CARE BELIEFS (VALUES) - continued

10. We believe that quality of life includes having a peaceful death, which we recognize by offering the necessary care and support to both resident and family through the death experience.

11. We believe that recognition of the personhood of each resident enhances the delivery of compassionate and competent care.

12. We believe that a warm homelike and safe environment contributes to the quality of life of residents.

MANAGEMENT BELIEFS (VALUES)

1. We believe in mutual trust and respect that recognize the worth and dignity of the individual.

2. We believe in communication that is characterized by openness, honesty, discretion and respect for confidentiality.

3. We believe that employees are our most valuable resource and that we have a commitment to invest the necessary time in training and development.

4. We believe that the primary role of effective leaders is to coach and develop people to achieve autonomy and commitment to the job.

5. We believe in the interdependency of all departments working in a collaborative manner, focused on a common goal.

6. We believe in the empowerment of employees to act and to make decisions and judgments as appropriate, within the parameters of their job.

7. We believe that effective leaders encourage innovation and risk-taking and allow for failure recognizing that life entails risks and that failures can be opportunities for further learning and growth.

8. We believe that positive work environment is fostered by the ongoing recognition and appreciation of staff for their efforts and achievements.

9. We believe that we are strengthened by working in a community of faith, dedicated to Christian principles which promote love, justice, service and compassion.

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APPENDIX B.

CANADIAN ASSOCIATION OF SOCIAL WORKERS CODE OF ETHICS (1983)

Approved by the Board of Directors June 3, 1983

Introduction

Social workers are engaged in planning, developing, implementing, evaluating and changing social policies, services and programs that affect individuals, families, social groups, organizations and communities. They practise in many functional fields, use a variety of methods, work in a wide range of organizational settings, and provide a spectrum of psychosocial services to diverse population groups. Therefore, the basic principles of ethical conduct are necessarily broad and quite general. The purpose of a detailed Code of Ethics, outlining the professional attributes and conduct are necessarily broad and quite general. The purpose of a detailed Code of Ethics, outlining the professional attributes and conduct expected of the social worker, is to provide a practical guide for professional behavior and the maintenance of a reasonable standard of practice within a given cultural context.

The Preamble identifies the philosophy, purpose and accountability of the profession in general terms. The Declaration sets out in code form the ethical attitudes expected of the social worker regardless of educational or experiential preparation, role classification, field of practice location, methods of practice, place of work or population focus. The Commentary is a more detailed statement of the reasonable standard of practice expected from the social worker's commitment to the Declaration. The Code of Ethics is presented with full knowledge that specific conduct will be further guided by professional judgments and situational circumstances. However, in all instances the social worker is expected to practise competently and to refrain from conduct unbecoming to a professional.

Certain terms used in the Code require definition as follows:

Client
means the person(s) on whose behalf a social worker provides or undertakes to provide professional services.

Workplace
means any place of employment, public, private or self-employment of persons who ordinarily are recognized as social workers regardless of classification or job title.

Profession of Social Work
refers to social workers collectively.

Social Worker
means an individual who is duly authorized to practise social work, including students in post-secondary social work education programs.

Regulatory Body
means the body charged under the laws of a particular jurisdiction with the duty of governing the profession of social work or the body voluntarily recognized in a particular jurisdiction by professional social workers as having the duty to govern the profession of social work.

Standard of Practice
means the standard of care ordinarily expected of a competent social worker. It means that the public can be assured that a social worker has the training, the talent and the diligence to provide them with professional social work services.

Conduct Unbecoming
means the behavior or conduct that does not meet standard of care requirements, which is subject to discipline.

Malpractice and Negligence
means behavior that is included as "conduct unbecoming" which relates to practice behavior within the parameters of the professional relationship that falls below the standard of practice and results in or aggravates an injury to a client. It includes behavior which results in assault, deceit, fraudulent misrepresentations, defamation of character, breach of contract, violation of human rights, malicious prosecution, false imprisonment or criminal conviction

Person
includes individuals, families, social groups, public and private organizations, associations and recognized community entities

Preamble

Philosophy:

The profession of social work is founded on humanitarian and egalitarian ideals. Social workers believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination and respect of individuality. They believe in the obligation of all people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity.

Social workers are dedicated to the welfare and self-realization of human beings; to the development and disciplined use of scientific knowledge regarding human and societal behaviors; to the development of resources to meet individual, group, national and international needs and aspirations; and to the achievement of social justice for all.

Social workers are pledged to serve without discrimination on any grounds of race, ethnicity, language, religion, marital status, gender, sexual orientation, age, abilities, economic status, political affiliation or national ancestry.

APPENDIX C.

RESIDENCE PREFERENCE SURVEY

_____

_____

Good morning (afternoon, evening), my name is Bonnie Griffiths. I am a student at the University of Manitoba. I am gathering information about what it is like living in a personal care home. The information is very important, as I would like to truly know your concerns and preferences. Would you be willing to have me ask you some questions? It will take about 20 minutes.

1.a. What time do you presently go to bed? _____

b. What time would you prefer to go to bed? _____

2.a. What time do you get up in the morning? _____

b. What time would you prefer to get up? _____

3.a. How many baths a week do you have? _____

b. How many baths a week would you prefer? _____

4.a. What time do you have your bath? _____

b. What time would you prefer your bath? _____

5.a What time do you eat breakfast? _____ lunch _____ dinner _____

b. What time would you prefer breakfast? _____ lunch _____ dinner _____

6.a. How many times a week do you go to physio-therapy? _____

b. How many times a week would you like to go to physio-therapy? _____

If there is a discrepancy between a and b in no. 1-6, then ask.

"I notice there is a difference between the time (s) you <u>have</u> to do certain things and the time you would <u>like</u> to do in regards to . . . (name the areas mentioned in No. 1 to 6). If you could change one of these which would be the most important for you to change?

1. _____

2. What would be the next most important? _____

_____

7. I would like to ask you some questions about the type of assistance you receive from staff, whether you are satisfied with the time the assistance is given and the way in which it is given. If you are not satisfied, in what way would you want it to change.

7. TYPE OF ASSISTANCE	NO	YES	SATISFIED? YES, NO SOMEWHAT	IN WHAT WAY WOULD YOU WANT THE ASSISTANCE TO CHANGE
a. GETTING OUT OF BED				
b. GETTING IN AND OUT OF A CHAIR (WHEELCHAIR)				
c. MOVING FROM ONE AREA TO ANOTHER AREA OF THE BUILDING				
d. GETTING CLOTHES FROM THE CUPBOARD				
e. GETTING DRESSED AND UNDRESSED				
f. EATING				
g. WASHING YOUR HANDS				
h. BRUSHING YOUR HAIR				
i. BRUSHING YOUR TEETH				
j. SHAVING				
k. USING THE TOILET, URINAL, COMMODE, BEDPAN				
l. HAVING A BATH				
m. DESCRIBE ANY OTHER ASSISTANCE YOU RECEIVE				

3

Interviewer: "I have a few more questions.

8. Are there activities that you do not get to attend that you would like to attend? Yes ____ No ____

If yes ___, what activities would you like to attend? _____

_____

Why do you not attend them now? _____

_____

9. Do you have a choice of foods at mealtimes? Yes ___ No ___. Are you satisfied with the choices? If No, what would you change?

_____

_____

Are mealtimes a pleasant event for you? Yes ___ No ___. If no, what makes them unpleasant? _____

_____

What would you like to eat that you don't presently get served? _____

_____

10. Are you satisfied with where you sit to eat? Yes ___ No ___ If no, what would you change? _____

_____

11. Do you have enough opportunities to communicate?

a. with other residents? Yes ___ No ___. If no, what would you change?

_____

_____

b. with nursing staff? Yes ___ No ___. If no, what would you change?

_____

c. by telephone? Yes ___ No ___. If no, what would you change?

_____

d. by letter writing? Yes ___ No ___. If no, what would you change?

_____

12. Since moving to Tache Centre, are decisions about your daily living activities made for you by others? Yes ___ No ___. If yes, ask

What type of decisions are made? _____

_____

_____

What decisions would you like to be making yourself? _____

_____

13. Do you have enough privacy? Yes ___ No ___? If no, ask in what way(s) do you not have enough privacy? _____

_____

14. Are you shown respect by the staff? Yes ___ No ___. If no, ask in what way could the staff show more respect. _____

_____

15. What would you change about the way your room is decorated or arranged

_____

_____

16. If you could change two things about your life at Tache, what would they be?

1. _____

_____

2. _____

_____

3. _____

_____

17. What have you missed most since moving to Tache Centre _____

_____

5

18. What is it about living at Tache Centre that you enjoy most? _____

_____

19. Any additional comments that you would like to make? _____

_____

_____

I would like to thank you for spending time in completing the survey. It has been very helpful.

APPENDIX D

(REVISED) RESIDENTS' PREFERENCE SURVEY

NAME: _____ ROOM _____

1. What time would you prefer to go to bed? _____

2. What time would you prefer to get up in the morning? _____

3. How many baths a week would you prefer? _____

4. What foods did you enjoy at home that you do not get served at Taché? _____

5. Are there specific foods in your culture that you do not have served to you at Taché? Yes _____ No _____

   If yes, please describe them. _____

6a. What foods for BREAKFAST would you like to be served more often? _____

   b. less often? _____

7a. What foods at the NOON MEAL would you like to be served more often? _____

   b. less often? _____

8a. What foods at the EVENING MEAL would you like to be served more often? _____

   b. less often? _____

9. Do you have enough privacy? Yes _____ No_____

If No, in what way do you not have enough privacy?_____

_____

10. What would you change about the way your room is decorated or arranged?

_____

_____

11. If you could change two things about your life at Taché, what would they be?

1. _____

_____

2. _____

_____

12. Would you like to have more visitors? Yes_____ No_____

13. What is it about living at Taché that you enjoy most?

_____

_____

14. Any additional comments that you would like to make?

_____

_____

_____

APPENDIX E:

COMMITTEE ASSESSMENT REPORT AND RECOMMENDATIONS

The goal of the assessment is to report on the feasibility of and barriers to providing greater personal autonomy to the residents of Taché Nursing Centre.

It is the writer's belief that to fulfill this goal three factors need to be addressed:

a) The determination of the areas in which residents desire greater choice and control.

b) The ability, willingness and flexibility of staff to institute the changes in routines and procedures in order to accommodate increased choice and control.

c) The ability of the facility to respond to the changes required.

Although the factors are interdependent, each will be discussed independently, followed by specific recommendations.

a) POTENTIAL AREAS FOR GREATER CHOICE AND CONTROL.

The Residents' Preference Survey that was administered to twenty-one (21) residents as part of the study indicated a desire for greater choice and control in the areas of bathing, food and rising times. Four residents stated that they had no desire for any change.

BATHING: Six of the twenty-one residents interviewed indicated a desire for more than one bath a week.

Recommendation: 1.0 That a study be done to determine the total number of residents desiring an additional bath.

FOOD SERVICE: Eleven of the twenty-one residents indicated a desire for change in the foods that they were served. There were twenty-three different food requests. There was no major difficulty with the scheduled times for the meals.

Recommendation: 2.0 That a 6 month follow-up be done after admission of new residents, and yearly thereafter as is presently done, regarding food preferences and changes in foods desired.

Recommendation: 3.0 That all staff be encouraged to give feedback to the dietary department as to any specific food preferences required for individual residents.

Recommendation: 4.0 That cultural preferences of foods be explored with each resident.

Recommendation: 5.0 That bannock be available for native residents and served minimally three times a week.

Recommendation: 6.0 That the Revised Residents' Preference Survey be made available to the Dietary Department as a tool that may be used in part to meet Recommendations #2 and #3.

RISING TIME: One resident wished to rise earlier while one wished to rise later.

Recommendation: 7.0 That each new resident be asked 3 months after admission whether the present rising time is desirable and changes made accordingly. Present residents could be polled to establish whether adjustments need to be made in their rising schedules.

b) STAFF RELATIONSHIP TO CHANGES IN ROUTINES/PROCEDURES

Greater personal autonomy for residents will require changes in existing procedures and routines. For such change to occur it will require a willingness and commitment of the staff. It must be recognized that change occurs slowly and only when the parties involved are willing to make that change. Willingness can be enhanced by education so that the parties understand and accept the need for such change and do not feel personally or professionally threatened by the change.

Recommendation: 8.0 That on-going staff education take place regarding the importance of personal autonomy for residents living in personal care homes. Methods by which personal autonomy can be increased need to be part of the education process.

Recommendation: 9.0 That the Choice and Control Committee continue to meet and that it be restructured in the following ways:

9.1 The objectives of the new committee to be developed by the committee, based on the recommendations contained in this report.

9.2 The composition of the committee to be made up of the following representation.
Nursing staff (2 RN, 2 LPN, 2 nursing assistants)
2 Pastoral Care
3 Dietary
2 Rehab/Activities
1 Staff Development
1 Housekeeping
1 Maintenance
1 Social Work
1 Volunteer Department

9.3 The committee chair to be from the Nursing Department.

Recommendation 10.0 That permission for academic research which may result in recommendations for change in policy, procedures and routines be granted only after all department heads have concurred that there is sufficient staff time and staff willingness to be involved in such an undertaking.

c) ABILITY OF THE FACILITY TO RESPOND

The provision of greater personal autonomy for residents is dependent on the ability of the Centre to respond to changes recommended by committees. Implementing the recommendations may require one or more of the following changes.

i. a redesigning of staff job descriptions.
ii. a reorganization of staffing schedules.
iii. an innovative approach to the utilization of volunteers.
iv. additional staff.
v. assessment of the utilization of the present bathing equipment, in particular the Hoyer lift.
vi. purchase of new equipment.

APPENDIX F.

CRITERIA FOR SELECTION OF RESIDENTS

Residents must be:

1. 60 years or older.

2. Lucid, able to comprehend the meaning of questions asked by interviewer.
   eg: "Do you feel angry quite often?"
   "What time of day do you write letters?"

3. Capable of either, hearing interviewer's verbal questions or of reading the questions.

4. Capable of responding to the interviewer's questions verbally, in writing or by use of a spelling board.

5. In a state of physical and mental helath that would not be unduly taxed by a 15-20 minute interview.

6. Not being considered for discharge in the period between January 1, 1990 to March 15, 1990.

7. Not scheduled to be away from the centre for more than 3 days between January 1, 1990 and March 15, 1990 (excluding scheduled hospitalization).

APPENDIX G.

STUDY DESCRIPTION AND CONSENT FORM

A study is being done at Tache Centre by a Masters student from the Faculty of Social Work at the University of Manitoba.

The purpose of the study is to increase knowledge in the field of aging.

Fifty (50) residents are needed for this study. As a volunteer in the stuoy you would be interviewed 3 - 4 times within the next few months. Each interview will be about 20 - 25 minutes and will be done either by Tache staff members or by the graduate student. The questions will be about your life as a resident. The information you provide will be helpful to the University and to people working in the field of aging.

Your participation in the study would be very much appreciated, but it is your choice to participate or not to participate. If you agree to participate, you may withdraw from the study at any given time and your level of care will not be jeopardized in any way.

Confidentiality will be respected. The paper resulting from this study will not contain the names of any residents.

Would you like to participate in this study? If so I would ask you to sign the form below.

CONSENT FORM

I have read (or have had read to me) the description of the study being done by the graduate student, Bonnie Griffiths, of the University of Manitoba, and I want to participate in this study.

_____
Signature

_____
Room

APPENDIX H.

PHILADELPHIA GERIATRIC CENTRE MORALE SCALE

REVISED LAWTON 1975

Please reply YES or NO unless indicated otherwise	RESPONSE
1. THINGS KEEP GETTING WORSE AS I GET OLDER	
2. I HAVE AS MUCH PEP AS I DID LAST YEAR	
3. HOW MUCH DO YOU FEEL LONELY (NOT MUCH, A LOT)	
4. LITTLE THINGS BOTHER ME MORE THIS YEAR	
5. I SEE ENOUGH OF MY FRIENDS AND RELATIVES	
6. AS YOU GET OLDER YOU ARE LESS USEFUL	
7. I SOMETIMES WORRY SO MUCH THAT I CAN'T SLEEP	
8. AS I GET OLDER, THINGS ARE (BETTER, WORSE, SAME) THAN/AS I THOUGHT THEY WOULD BE	
9. I SOMETIMES FEEL THAT LIFE IS NOT WORTH LIVING	
10. I AM AS HAPPY NOW AS I WAS WHEN I WAS YOUNGER	
11. I HAVE A LOT TO BE SAD ABOUT	
12. I AM AFRAID OF A LOT OF THINGS	
13. I GET MAD MORE THAN I USED TO	
14. LIFE IS HARD FOR ME MOST OF THE TIME	
15. HOW SATISFIED ARE YOU WITH YOUR LIFE TODAY (SATISFIED, NOT SATISFIED)	
16. I TAKE THINGS HARD	
17. I GET UPSET EASILY	

RESIDENT SELF EVALUATION

Resident's Name _____ Room _____ Date _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS BY CIRCLING THE NUMBER THAT CORRESPONDS TO YOUR OPINION.

1. ALL THINGS CONSIDERED, HOW HAPPY ARE YOU THESE DAYS?

1	2	3	4	5	6	7
EXTREMELY HAPPY	VERY HAPPY	UNHAPPY	FLUCTUATED BETWEEN	HAPPY	VERY HAPPY	EXTREMELY HAPPY

2. HOW ACTIVE ARE YOU IN THE THINGS (SUCH AS ACTIVITIES) THAT GO ON AROUND HERE?

1	2	3	4	5	6	7
EXTREMELY PASSIVE	VERY PASSIVE	PASSIVE	FLUCTUATED BETWEEN PASSIVE AND ACTIVE	ACTIVE	VERY ACTIVE	EXTREMELY ACTIVE

INTERVIEWER'S EVALUATION

Residents Name _____ Room _____ Date _____

Please complete the following evaluation after you have completed the Philadelphia Geriatric Morale Scale. Please do so after you have left the interview.

Please answer the following question by circling the number on the scale that best describes the person that you have just interviewed.

1. (S)he appears to be mentally -

1	2	3	4	5	6	7
extremely confused	very confused	confused	fluctuated between confusion & alertness	alert	very alert	extremely alert

ACTIVITY WORKER'S EVALUATION

RESIDENT'S NAME _____ ROOM NO._____ DATE _____

Please answer the following questions by circling the number on the scale below that best describes this resident.

1. (S)he generally is

1	2	3	4	5	6	7
extremely unhappy	very unhappy	unhappy	fluctuates between happy/unhappy	happy	very happy	extremely happy

2. (S)he is active in the things (such as activities) that go on around her/him.

1	2	3	4	5	6	7
extremely inactive	very inactive	inactive	fluctuates between passive/active	active	very active	extremely active

3. (S)he appears to be mentally

1	2	3	4	5	6	7
extremely confused	very confused	confused	fluctuates between confusion & alertness	alert	very alert	extremely alert

4. (S)he shows interest in his/her grooming.

1	2	3	4	5	6	7
no interest	very uninterested	uninterested	fluctuates between interest & non interest	interested	very intested	extremely interested

6. With other people s(he) is usually

1	2	3	4	5	6	7
extremely withdrawn	very withdrawn	withdrawn	withdrawn 50% of time	sociable	very sociable	extremely sociable

Using the scale to the right, does the resident engage in the following activities.

Sitting alone doing nothing _____
Visiting with other residents _____
Watching T.V. or listening to the radio _____
Talking to the staff. _____

4 = frequently
3 = sometimes
2 = infrequently
1 = never

APPENDIX L:

Differences in average scores between experimental (E) and Control (C) group at $Time_1$ (one week prior to intervention). All 13 measures reported.

MEASUREMENTS	Difference score * T_1 (C-E)
1. Happiness (Self-Rating)	-.64
2. Activity (Self-Rating)	-1.09
3. Morale (Self-Rating)	-1.73
4. Alertness Interviewer-Rating	-.90
5. Happiness *(A.W.R.)	=
6. Activity (A.W.R.)	-.45
7. Alertness (A.W.R.)	+.27
8. Grooming (A.W.R.)	+1.0
9. Sociability (A.W.R.)	=
10. Visiting other Residents(AWR)	-.27
11. Talking to Staff (AWR)	=
12. Sitting Alone (A.W.R.)	+.72
13. Watching T.V. (A.W.R.)	=

+ sign means that C is higher than E.

- sign means that C is lower than E.

= sign means that diference between C and E is .25 or less.

* A.W.R. - Activity Worker Rating

APPENDIX M:

Average of individual subjects change scores on all 13 measures, T_1-T_2, T_2-T_3, T_1-T_3 reported for experimental (E = 11) and control (C = 11) groups.

MEASUREMENTS	CHANGE SCORE					
	$T_1 - T_2$		$T_2 - T_3$		$T_1 - T_3$	
	C	E	C	E	C	E
1. Happiness (Self-Rating)	+.37	-.51	=	=	=	-.30
2. Activity (Self-Rating)	+.27	-.62	+.36	+.32	+.63	-.30
3. Morale (Self-Rating)	-.46	-1.45	-.36	+.90	-.82	-.52
4. Alertness Interviewer-Rating	+.63	=	-.27	=	+.36	=
5. Happiness **(A.W.R.)	=	=	=	=	=	=
6. Activity (A.W.R.)	-.36	+.28	=	-.28	-.55	=
7. Alertness (A.W.R.)	=	=	=	=	=	=
8. Grooming (A.W.R.)	+.45	+.91	=	-.45	-.36	+.46
9. Sociability (A.W.R.)	+.63	=	-.72	-.55	=	=
10. Visiting other Residents(AWR)	=	-.27	=	+.37	=	=
11. Talking to Staff (AWR)	=	+.36	=	=	=	+.27
12. Sitting Alone (A.W.R.)	=	+.55	=	-.36	=	=
13. Watching T.V. (A.W.R.)	=	=	=	-.27	=	=

* A.W.R. - Activity Worker
= sign means .25 or less change in either direction (+ or -)

APPENDIX N.

COMMITTEE MEMBERS

Please indicate APPROXIMATELY the number of committee meetings that you were able to attend. The total number was 9.

The following scales are designed to measure change that may have occurred during the period you have been on the Choice and Control Committee.

There are two measurements for each scale. The first measurement indicates your level BEFORE you were a member of the committee.

The second measurement indicates your level as of TODAY.

I would appreciate any comments that you wish to add. Your name will not be attached to any comments that you make.

SCALE I. PERSONAL EMPOWERMENT

Would you please rate your DEGREE OF POWER TO AFFECT CHANGE AT TACHE both BEFORE becoming a committee member and your level as of TODAY. Please indicate with a check (√)

BEFORE COMMITTEE	AS OF TODAY
___ 1. No power to affect change.	___ 1. No power to affect change.
___ 2. Power only very occasionally.	___ 2. Power only very occasionally.
___ 3. Power in a few situations.	___ 3. Power in a few situations.
___ 4. Power in a lot of situations.	___ 4. Power in a lot of situations.
___ 5. Power in most situations.	___ 5. Power in most situations.
___ 6. Complete power.	___ 6. Complete power.

COMMENTS _____

PLEASE READ SCALE 2 AND SCALE 3 BEFORE ANSWERING SCALE 2.

SCALE 2. KNOWLEDGE ABOUT INSTITUTIONAL ELDERLY ABUSE

Would you please reate your KNOWLEDGE ABOUT INSTITUTIONAL ELDERLY ABUSE (FINANCIAL, PHYSICAL, EMOTIONAL) both BEFORE becoming a committee member and your level of knowledge as of TODAY. This scale deals with the amount of information you had and now have about elderly abuse. IT DOES NOT DEAL WITH WHETHER ELDERLY ABUSE OCCURS AT TACHE.

BEFORE COMMITTEE	AS OF TODAY
___ 1. No knowledge at all.	___ 1. No knowledge at all.
___ 2. Very little knowledge.	___ 2. Very little knowledge.
___ 3. Some knowledge.	___ 3. Some knowledge.
___ 4. Knowledge about some forms of abuse but not about other forms of abuse.	___ 4. Knowledge about some forms of abuse but not about other forms of abuse.
___ 5. A great deal of knowledge.	___ 5. A great deal of knowledge.
___ 6. Extensive knowledge.	___ 6. Extensive knowledge.

COMMENTS _____

SCALE 3 - AWARENESS OF THE OCCURRANCE OF ELDERLY ABUSE AT TACHE

BEFORE becoming a committee member how would you have rated the occurrance of each type of abuse at Tache Centre? Please check (\/) appropriate level.	AS OF TODAY, how would you rate the occurance of each type of abuse at Tache Centre? Please check (\/) appropriate level.
FINANCIAL ABUSE ___ 1. Never occurs. ___ 2. Very seldom occurs. ___ 3. Occasionally occurs. ___ 4. Frequently occurs. ___ 5. Very frequently occurs. ___ 6. Regularly occurs.	**FINANCIAL ABUSE** ___ 1. Never occurs. ___ 2. Very seldom occurs. ___ 3. Occasionally occurs. ___ 4. Frequently occurs. ___ 5. Very frequently occurs. ___ 6. Regularly occurs.
PHYSICAL ABUSE ___ 1. Never occurs. ___ 2. Very seldom occurs. ___ 3. Occasionally occurs. ___ 4. Frequently occurs. ___ 5. Very frequently occurs. ___ 6. Regularly occurs.	**PHYSICAL ABUSE** ___ 1. Never occurs. ___ 2. Very seldom occurs. ___ 3. Occasionally occurs. ___ 4. Frequently occurs. ___ 5. Very frequently occurs. ___ 6. Regularly occurs.
EMOTIONAL ABUSE ___ 1. Never occurs. ___ 2. Very seldom occurs. ___ 3. Occasionally occurs. ___ 4. Frequently occurs. ___ 5. Very frequently occurs. ___ 6. Regularly occurs.	**EMOTIONAL ABUSE** ___ 1. Never occurs. ___ 2. Very seldom occurs. ___ 3. Occasionally occurs. ___ 4. Frequently occurs. ___ 5. Very frequently occurs. ___ 6. Regularly occurs.

COMMENTS _____

_____

_____

_____

SCALE 4 - IMPORTANCE OF CHOICE AND CONTROL

Would you please rate the IMPORTANCE THAT YOU THINK CHOICE AND CONTROL plays in the lives of the residents both BEFORE becoming a committee member and the rating that you would give for the IMPORTANCE OF CHOICE AND CONTROL AS OF TODAY.

BEFORE COMMITTEE I thought the importance of choice and control in the lives of the residents was:	AS OF TODAY I think the importance of choice and control in the lives of the residents is:
___ 1. Not important at all.	___ 1. Not important at all.
___ 2. Very unimportant.	___ 2. Very unimportant.
___ 3. Unimportant.	___ 3. Unimportant.
___ 4. Important.	___ 4. Important.
___ 5. Very important.	___ 5. Very important.
___ 6. Extremely important.	___ 6. Extremely important.

COMMENTS _____

_____

_____

_____

SCALE 5 - COMMITTEE EFFECTIVENESS

The Choice and Control Committee has provided a setting for the discussion of emotional (psychological) abuse of residents. Please rate its effectiveness in doing so by checking (\/) the appropriate boxes.

Discussions were of:

___ No value at all.

___ Very little value.

___ Some value.

___ Very valuable.

___ Extremely valuable.

COMMENTS _____

GENERAL COMMITTEE EVALUATION

Below is a list of ways you may have responded to being on the committee. Please check (\/) any of the responses that apply to your personal thoughts as a committee member. Please feel free to add any specific thoughts.

___ I enjoyed meeting staff from other departments.

___ I became more knowledgeable about elderly abuse.

___ I became more knowledgeable about Taché.

___ I enjoyed getting away from my regular job and seeing Taché from another perspective.

___ I feel more a part of a team now.

___ There are other staff to whom I can talk if I have concerns.

___ People of the committee were willing to listen to my opinions.

___ I feel that I am not alone with some of my concerns about residents.

___ I think the meetings were a waste of time.

___ I will be gald when there are no more committee meetings.

___ There is value in having the committee.

___ I would like to remain on the committee.

___ I feel the residents should be given more choices.

OTHER RESPONSES:_____

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