

A Focus Group Study of Perceptions of
Quality of Care Among Nurses in Nursing Homes

Texas Long Term Care Institute

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Finally, both authors are thankful for the wonderful nurses who participated in this study. It was their responses and the giving of their time that made this research possible. They are the courageous individuals who cope with the challenges of working in nursing homes within the Long-Term Care industry every day. They are the individuals at the center of improving care for the elders residing in nursing homes whether it is a facility wide culture change movement or just the special attention of one individual nurse for one resident at a time.

Sincerely,

George C. Burke III, Dr. P.H.
Carmen Adams, Ph.D.

ABSTRACT

A research team conducted a focus group study of central Texas nurses over a period of several weeks during September and October of 2009, at four different long-term care facilities. The total number of respondents was 15. We sought insight into the experience of nurses in quality of care, the nurses' perceptions of management competence, and we sought the nurses' perceptions of their roles as contrasted with the roles of certified nursing assistants (CNAs). Basing our set of questions on those from a 2001 study of CNAs, we found that nurses view quality in a holistic manner - - meeting the physical, emotional and spiritual needs of the resident to the greatest degree possible. We found that nurses in one of the four facilities had made progress in cultural change. Nurses and families saw management competence as the effectiveness and speed in which managers responded to questions or complaints. The study found nurses to be motivated by the job itself, seeing it as a ministry to the elderly. Several managerial implications are included in the study, including management's role in quality, motivation, and cultural change.

INTRODUCTION

This study began with the aim of replicating a previous study on the opinions of frontline caregivers on quality of care and life within nursing homes. Burke and Summers studied the role of nursing assistants in 2001, with particular emphasis on their opinions about and effects on quality within their nursing home facilities. The research was fascinating and the findings were rich. That study begged the question: How do nurses see their role affecting quality in nursing homes and how do RN's see their roles in contrast with those of nursing assistants. In 2008, Burke and Adams began a study to find out the answer to those questions.

Essentially the same methodology was used in both studies. Both are qualitative research projects utilizing focus groups as the method of data collection. The beauty of focus groups is that a comment from one participant may beg another question or peak the interest of another participant. It is lively and fruitful method of uncovering the opinions of a specific group of individuals. During this research, the authors traveled up a number of such rabbit trails. This project allowed the authors to gather the opinions of actual nursing home staff members. Often in the field of long-term care (LTC) research, the voices of researchers, governmental representatives, and „experts“ may drown out the voices of actual nurses and nurse assistants.

When investigating quality of care and quality of life for the elders residing in nursing homes, it is common to ask the LTC consumers, residents and family members,

to give their opinion of the quality being delivered in a particular facility. However, this often produces a very individualized or personalized response based solely on the experience of one resident or one resident's family. In this situation, many factors influence the answers given beyond the actual care received. Past experiences with LTC, recent or past experiences with hospitalization, relationship with doctors, or previous care giving roles fulfilled by the family members can all influence the perception of the current quality of care. This research tries to investigate this issue of quality from the perspective of a different group of individuals. Nurses cannot be looked at as a neutral or bias-free group when discussing quality of care and life for LTC elders within a particular facility; however, they have the ability to view the overall picture rather than being fixated on the experiences and outcomes of a specific resident.

Quality of care and life in nursing homes is an issue that should not be ignored. Governmental projections say that if an American reaches the age of 65 he or she "will likely have a 40% chance of entering a nursing home" (Medicare, 2005, p. 1) for at least a short period in their lifetimes. Whether it is to recuperate from an illness, to rehabilitate after surgery, to alleviate the difficulties of living with dementia, or the myriad of other reasons, individuals use the services of LTC. Very few individuals living in the United States will complete their lives without some contact with the LTC community for themselves, their family, or their associates.

Two demographic factors will directly influence the LTC industry in the near future. First, the aging of the population or the graying of American will increase the demand for LTC and second, the stabilization of the population segment, which has traditionally represented the employees within nursing homes, will intensify the staffing

problems in LTC. The infamous „Baby Boomers“ are going to have a significant impact on the number of senior citizens and the age distribution projections for the United States. Figure 1 shows the dramatic increase of elders in the United States and the minimal increase of women age 25 to 44 who normally make up the LTC workforce. These figures definitely portend potential problems for the LTC industry (IOM, 2008; Paraprofessional Healthcare Institute, 2008).

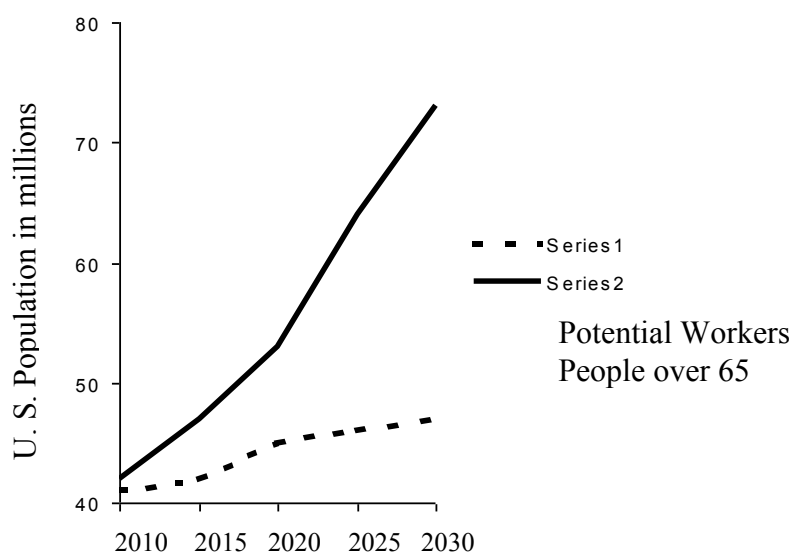


Figure 1. Differences in the population growth of elderly and potential nursing home staff.

Note: Paraprofessional Healthcare Institute. 2008

Figure 2 shows the projected increase in the number of individuals 85 and older in the United States during the first 50 years of the 21st century. This age group represents the average age of nursing home residents. This age group will have a dramatic increase, moving from composing 1.5% of the population in 2000 to 5.0% of the population in 2050 (U.S. Census Bureau, 2004a).

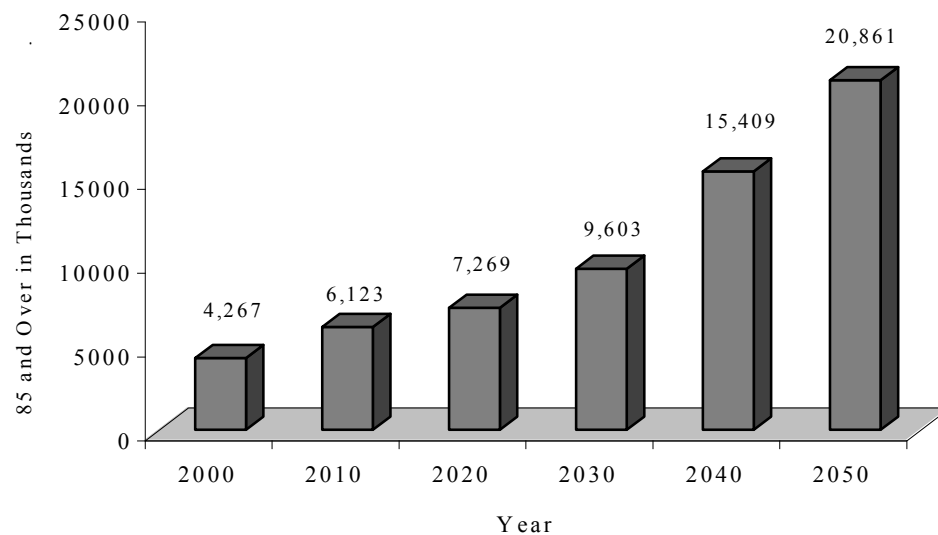


Figure 2. Population projections for the United States, 85 and older: 2000 to 2050.
Note: U.S. Census Bureau (2004a).

OBRA '87 is a major piece of federal legislation that influenced the LTC industry, specifically nursing homes, changing the emphasis from the ability to provide care to the quality of care and quality of life provided. “Quality of care” refers to technical and medical processes within nursing homes while “quality of life” involves resident issues, such as autonomy, choice, individualized care plans, staffing requirements, residents’ rights, chemical and physical restraints, unnecessary drug usage, and enforcement policies (Consumer Voice, 2007; Emerzian & Stampp, 1993; Wiener, 2003; Wunderlich & Kohler, 2001; Zhang & Grabowski, 2004). The authors of this monograph hope that studying the perception of quality within a nursing home from the perspective of licensed nurses will add to the knowledge base of all the stakeholders in the LTC industry and profession.

LITERATURE REVIEW

There are a vast amount of published articles regarding nursing homes and a plethora of articles regarding quality in healthcare. In our 2001 study, *A Focus Group Study of Perceptions of Quality of Care Among Nursing Assistants*, the background literature review was expansive with numerous studies regarding NAs (nursing assistants) and CNAs (certified nursing assistants). The expectation, therefore, was that a literature review regarding the role of nurses in quality would yield hundreds of articles. That did not prove to be the case. The articles regarding nurses in nursing homes dealt mainly with specialized nursing practices and staffing levels (Castle & Engberg, 2008; Maas, Specht, Buckwalter, Gittler, & Bechen, 2008; Zhang, Unruh, Liu, & Wan, 2006). When searching for articles on the role of nurses in nursing homes and their influence on quality of care, we found that much of the published information dealt with formal job descriptions, staffing, and nurse practice acts in various states. Arling, Kane, Mueller, Bershadsky, and Degenholtz (2007) found that much of the research on staffing and quality is inconclusive and their “findings offer little evidence that more staff time, per se, is associated with better process of care or outcomes” (p. 680). It was as if we had encountered the dark ages of literature on a subject that needed study and discussion.

Culture Change in Long Term Care

Thankfully, we discovered the excellent, leading edge efforts of the Pioneer Network, a collaborative research/think tank, which was discussing and writing about culture change in

nursing homes. The linkages between the Pioneer Network paper and this study were of great interest to us.

The Pioneer Network advocating culture change, have developed a vision and set of principles and goals for “a culture of aging that is life-affirming, satisfying, humane and meaningful” (Pioneer Network, n.d., *Our Vision* ¶1). The group defines and discusses the role of nurses in the transition from an institutional-type setting to a residential type setting within nursing homes. It acknowledges that culture change is difficult for many nurses who are comfortable wearing the clinical hat but not comfortable dealing with issues such as residents’ rights, measurable goals of care, and multidisciplinary teams. Nurses may view such changes as a threat to their autonomy (Pioneer Network). In our current study, we realized with some excitement that we were interviewing nurses about these very issues.

The Pioneer Network led us to a few articles on nurses and culture change. “In nursing homes, the movement away from institutional provider-driven models of care to more humane consumer-driven models of care that embrace flexibility and resident self-determination has come to be known as culture change” (Burger et al., 2009, p. 2). Culture change is a true attempt at implementing the ideas presented in OBRA ‘87. As nursing homes incorporate culture change into their facilities, “the clinical care provided and directed by professional nurses remains critical and central to both quality of care and quality of life” (Burger et al., pp. 2-3). Often culture change involves “flattening the organizational hierarchy” (Burger et al., p. 3); this may result in changes in the role of nurses within the facility. Their roles may change from being a provider of care to becoming a promoter and team leader in the provision of care. This “raises issues of

whether nurses are practicing within their scope of practice with regard to delegation of nursing responsibilities or whether they are violating professional and regulatory requirements (Burger et al., p. 3).

Registered nurses (RNs), Licensed Practical Nurses (LPNs), and Licensed Vocational Nurses (LVNs) provide the licensed workforce in LTC facilities. CNAs or nursing assistants provide the majority of direct care of the residents. Just over three and one half hours per day is the average amount of direct care time given an elder. Nurses provide approximately one half hour of this care daily with the rest being provided by nurse assistants or CNAs (Burger et al., 2009). In nursing homes, nurses are responsible for all of the nursing components of resident care, including admission assessment, care plan development (including care at the end of life); monitoring and evaluation of the resident's care; discharge planning; resident, family and staff education; and management/administration tasks (including responsibilities such as ordering supplies). (Burger et al., p. 7)

One of the difficulties with culture change and resident directed care in nursing homes is that nurses have been expected to maintain all of their current duties and responsibilities while taking on a host of leadership and team management tasks that are both time consuming and can be very stressful during the initial change periods. However, definitive "research on the role of nursing in nursing home culture change is almost non existent" (Burger et al., p. 8).

Quality in Long Term Care

The literature on quality presents several definitions for the term. Traditionally, quality in health service organizations focuses on service content, meeting specifications or standards (Longest, Rakich, & Darr, 2000, p. 406). Quality of care in nursing homes is frequently associated with quality of life for the residents. Residents spend 24 hours of everyday in a nursing facility receiving help with their activities of daily living. Because they are in constant contact with the caregiver employed by a facility, resident perceptions most commonly define quality of care. Researchers have hypothesized that residents experience a greater quality of life when their basic human needs are fulfilled (Brennet, 1980).

Quality is an issue that not only affects the residents and their families, but also the nursing facilities' staff and administration, as well as state and federal governments. Angelelli's (1999) article, *Multiple Stakeholders Have Multiple Approaches to NH Quality Indicators* states, "each of these constituencies has different information needs, places emphasis on different types of measures and has different abilities to interpret and act upon the information" (p. 48). Milakovich (1991) points out that customers are not just patients and external stakeholders but may also be any internal user of a unit's output. Quality is typically measured by surveying the customer, and in the long-term care industry, this should involve surveying the institution's departments, including the staff.

A search for information on the role of the nurse in the nursing home led to nurse practice acts on policies of large employers such as the V.A. The information, therefore, was objective and prescriptive, but failed to address the larger role of the dignity of the

patient. For example, the state of Michigan specifies staffing requirements, as do other states, and requires that each nursing unit have a licensed nurse on each shift to serve as the charge nurse. The section on nursing responsibilities simply indicates nursing staff provides coverage and defines that coverage in terms of nursing to patient ratios. Most telling is what the document states that nurses do NOT do.

An employee designated as a member of the nursing staff shall not be involved in providing basic services such as food preparation, housekeeping, laundry, etc. ... except in an emergency (Citizens for Better Care, 2004). What is noteworthy is the lack of interdisciplinary assistance that is necessary for culture change. The idea of resident centered care implemented by a team of caregivers does not fit this model.

While there is much research presented on quality of care, most of it is performed in the form of surveys or observations that only represent a "snapshot," point-in-time view of quality of care in long-term care facilities (Angelelli, 1999). Another way to assess the level of quality of care in nursing homes is to conduct focus group interviews with the employees of the facilities. As indicated above, much research has been conducted in terms of quality of care related to topics such as access to care, quality of life for the resident, and family and resident perceptions of quality of care. Owing to the gap in the research regarding employee perceptions, it is the purpose of this study to gather staff perceptions about quality of care and the quality of administration from nurses in a focus group setting.

Motivational Theories

When discussing quality, reliability, and care within nursing homes, the concept of what motivates the caregivers is often raised. "The concept of motivation refers to

internal factors that impel action and to external factors that can act as inducements to action” (Locke & Latham, 2004, p. 388). Motivational theories are normally divided into two categories, content and process theories (Pinnington & Edwards, 2000; *Theories of motivation*, n.d.). Content theories examine the attributes of a job that motivate employees or the needs that motivate them. Process theories examine decision-making and the ways by which management can motivate people. In the current study, the authors used two content theories to examine the motivation of the nurse participants in the focus groups. Maslow and Herzberg penned the two theories utilized.

See Figure 3 for Maslow’s famous pyramid. A psychologist by training, Maslow (1943), advanced a theory with two major premises: (1) that human beings, by nature, want things and are motivated to acquire things that they do not have, and (2) that once one set of needs are satisfied, those needs are no longer a motivator. Physiological needs air, water, shelter, and food that are necessary for survival. Safety needs involve protection, but could include job stability. Belonging needs are the social needs, the need to feel part of a greater whole. Esteem needs refer to feeling that one is worthy and loved by others. This level concerns confidence, achievement, respect from others, and self-esteem.

Self-actualization was, initially, the highest level that Maslow envisioned. It meant to reach one’s highest individual potential. Interestingly, after Maslow’s death, his widow published a manuscript that Maslow had written but heretofore had not published. The book, *Farther Reaches of Human Nature*, enlarges upon and essentially redefines self-actualization (Maslow, 1993). Green and Burke (2007) referred to this level as

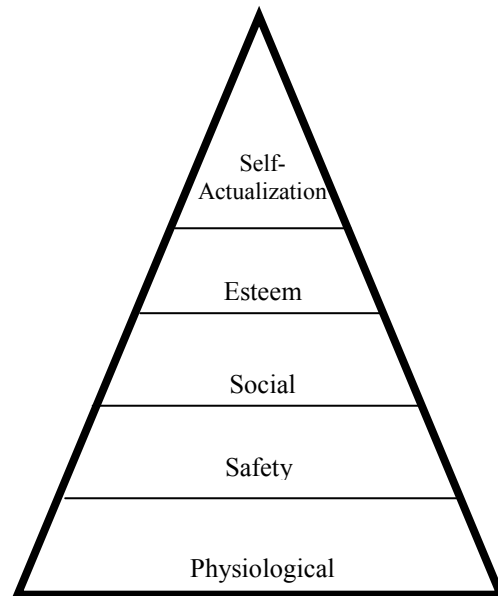


Figure 3. Maslow's Hierarchy of Needs.

Note. From Knowles, M. S. (1980). The Modern Practice of Adult Education: From Pedagogy to Andragogy. New York: Cambridge. p. 28.

“beyond self-actualization.” Maslow saw this level, as an unselfish giving of one's self to improve humanity.

When applied to long-term care staff's job satisfaction and motivation, Maslow's theory provides some contradictions. As discussed in previous research, one of the authors believes nursing assistants seem to defy Maslow's basic premise (Adams, 2010). For example, considering self-actualization, nursing assistants bravely display many of the characteristics of a person operating at this level on a daily basis. They are creative in their efforts to provide care and encouragement to elders despite the many constraints involved in their job. They certainly face reality by dealing with death, grief, and suffering each day at work (Adams, 2010).

Maslow talks about people who will never be self-actualized in their work because they are “dilettantes” (Maslow, 2000, p. 11), displaying all talk and no work. He claims

that he can identify this kind of person by asking an individual to do “a rather dull but important and worthwhile job” (Maslow, p. 11). Dilettantes will not complete the job, but nursing assistants would definitely pass this test. It is important to comb an elder’s hair each morning, however boring, and nursing assistants often do this with loving care. There are numerous anecdotes about nursing assistants coming in on their days off to be with extremely ill residents or forfeiting work hours (pay) to attend residents’ funerals. Both of these actions demonstrate the expanded version of the highest level of Maslow’s pyramid.

The contradiction in Maslow’s model when discussing CNAs comes from the fact that many nursing assistants appear to be self-actualized in their work while many of their lower needs, on his pyramid, are not satisfied or only partially satisfied in their lives. They struggle to survive economically (Blair & Glaister, 2005; Fitzgerald, 2001). They often believe that no one respects the work they do, and they often work in authoritarian organizations that do not encourage self-actualization (Bowers, Esmond, & Jacobson, 2003; Nursing Home Community Coalition [NHCC], 2003; Secrest, Iorio, & Martz, 2005). Thus, Maslow’s theory does not seem to apply to nursing assistants’ job satisfaction. The researchers believe the nurses’ attitudes and motivation factors may be more closely aligned with Maslow’s classic pyramid of needs.

The other classical motivational theory applied to the nurses in this study is the Two Factor theory of motivation. Herzberg’s two factors are hygiene and motivation. Hygiene factors control whether employees experience dissatisfaction with their work. Motivation factors encourage workers to perform at a higher level. See Figure 4 for visual interpretation of Herzberg’s model.

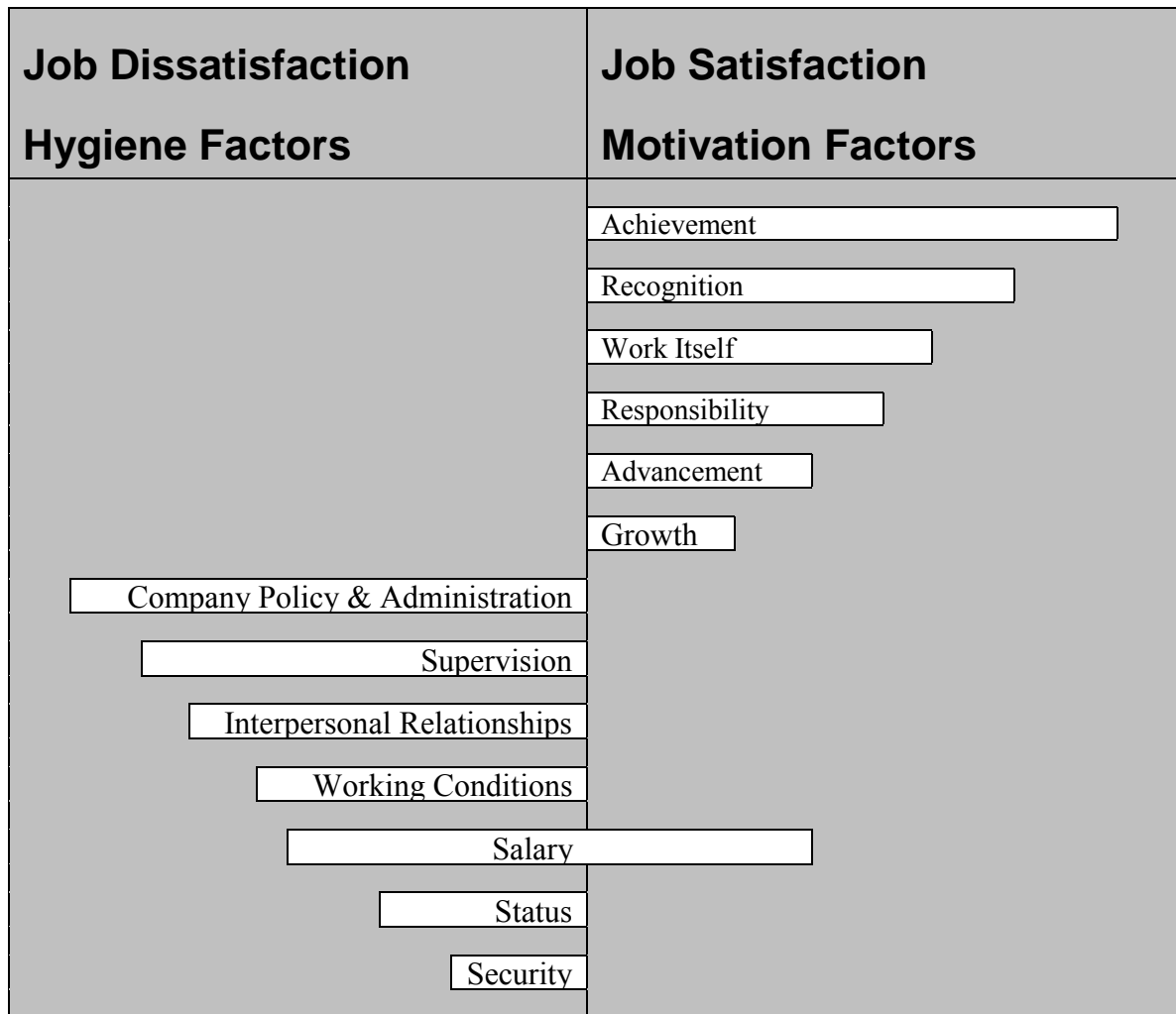


Figure 4. Motivator and hygiene factors: A classic distribution using Herzberg's theory. Notes. Salary is often both a motivator and a hygiene factor. From Herzberg, F. (1976). The managerial choice: To be efficient and to be human. Homewood, IL: Dow Jones-Irwin. p. 71.

Herzberg does not believe that job satisfaction and dissatisfaction are opposite conditions; rather, he believes they are independent and discrete factors. Motivational factors influence job satisfaction, and hygiene factors can either increase or decrease job dissatisfaction (Herzberg, Mausner, & Synderman, 1959).

In the best situation, a person's job would satisfy the hygiene factors by providing good pay, an excellent work environment, equitable company policies, etc. and would

fulfill the individual's need for achievement, recognition, chance for advancement, etc. However, Herzberg explains that there could be situations in which an individual favorably views only one of the two factors. Ask a starving artist about his job, and he or she is likely to respond, "I love my job but I hate starving" (Herzberg, 1976, p. 63). This does not mean that he or she is 50% satisfied with being an artist. Instead, it means the artist is very satisfied with the motivation factors and very dissatisfied because of the hygiene factors involved with his or her pursuits.

The starving artist example seems to apply to CNA's. In a study by Burke, Adams, and Shanmugam (2008), 1,216 to CNA's were asked to respond to the question, "What would make the quality of work life better in this facility?" Qualitative analysis of the responses resulted in six recurring themes in order of priority according to the to CNAs were:

- Improving interpersonal and workplace interactions,
- Management and Workplace Atmosphere,
- Compensation,
- Problems with Co-Workers,
- Being Treated Well, and
- Importance of Residents (Burke et al., 2008).

Clearly, the first four items would fall under the category of hygiene factors. CNAs expressed high levels of dissatisfaction with these areas. On the other hand "being treated well" (which includes recognition and praise) is a motivational factor. Most often, the CNAs felt they were not receiving the praise they deserved. The greatest motivational factor for the CNAs was taking care of the residents and stressing the Importance of

Residents even when not asked specifically about them. Since resident care is the essence of the job itself, Herzberg would have considered this a motivator. Adams (2010) found that the number one motivator of CNA is what they did for the elders. CNAs were highly motivated by caring for residents, despite the presence of dissatisfiers or lack of other motivators. “Without question, this is an intrinsic reward of the work itself and thus is a motivational factor” (Adams, 2010 p.119).

METHODOLOGY

This qualitative research project follows in the theoretical tradition of symbolic interaction. This “perspective places great emphasis on the importance of meaning and interpretation as essential human processes ... People create shared meanings through their interactions, and those meanings become their reality” (Patton, 2002, p.112). Using qualitative research is “the only real way to understand how people perceive, understand, and interpret the world” (Patton, p. 112). Group interviews or focus groups have become the preeminent method of investigating symbolic interaction.

Focus Groups

Focus groups are homogeneous samples. This is a divergence from the often-claimed need to find a representative, diverse sample to investigate. It allows a researcher to gain in depth knowledge of a particular subgroup of individuals within an organization or company. A focus group researcher uses the interviews with these homogeneous individuals to understand a specific topic.

Focus groups usually have between 5 and 10 participants, the sessions normally last approximately one to two hours. Focus groups were first developed as a method of market research in the 1920s. Robert Merton wrote the seminal paper on focus group interviews in the 1950s (Kitzinger, 1994; Patton, 2002). It is important to remember that focus groups are an interview method and should not be thought of as a problem-solving or decision-making meeting. In addition to this caveat, it is essential to plan focus groups.

They need to take place in a non-threatening environment. “Circular seating facilitates spontaneous responses and interchange” (Krathwohl, 1998, p.295). It is important to have a skilled interviewer or moderator conduct the focus group. It is helpful to have more than one researcher present. This can help with understanding or refocusing the discussion or the second person can be in charge of taking notes and monitoring recording equipment. The interviewer or moderator asks open-ended questions in a way that stimulates discussion among the participants. He or she creates a comfortable environment using small talk, and then administers his or her prepared questions, probing the participants when necessary, in a manner that gets the participants to thoroughly respond to the questions.

Focus groups have the advantage of encouraging opinion sharing. The multiple participants may give an individual a moment to compose their remarks, and the group dynamic may breakdown “the inhibitions of others who might not do so in a one-to-one situation” (Krathwohl, 1998, p. 295). This type of interviewing allows the researcher to understand “the extent to which there is a relatively consistent, shared view or great diversity of views can be quickly assessed” (Patton, 1998, p. 306). Focus groups can lessen the time commitment of researcher therefore having the potential to reduce costs. Focus group discussions allow the researcher to get detailed answers, as opposed to survey “yes or no” type answers, by allowing the participants to feel comfortable sharing their perceptions freely and openly.

Focus groups can present certain limitations. The interviewer must have a very limited number of questions. If the group is large, it may limit the response time of each individual participant. Managing the group so that one person does not dominate it or

only one set of ideas is heard requires a skilled moderator. Rather than producing detailed analysis of the subject under discussion, focus groups usually produce broad themes (Patton, 1998).

Research Questions

The first step in planning this research was the development of the research questions. These questions were modifications of the six questions used in the previous research with CNAs. Limiting the number of questions was due to the likely time constraints involved with interviewing nurses at their place of employment. In addition, during the CNA research the answers to two questions regarding reliability produced near identical answers so these questions were combined. Two questions addressing the responsiveness to the employees and how the CNAs knew they could or could not trust the management seemed to have limited responses and lowered the previously lively level of responses from the participants. Thus, the decision was made to eliminate these two questions. A question regarding how the employees knew their organization cared about quality produced rather obvious answers about professionalism. Moreover, comments about management's treatment of employees rather than discussing quality of care for the residents meant this question strayed from the purpose of this research. Since the questions came from a previous research study, no pilot study was done before commencing the actual focus groups. The following questions were used in 2008 focus groups:

1. In your experience as a nurse here, what do you think quality of care means in terms of resident care?

2. In your experience as a nurse here, would you please discuss the clues or signs you, residents, and families perceive that demonstrate the management of the organization is reliable. Are clues and signs different for each group?
3. From your perspective as a nurse here, how does your perception of quality of care differ from the CNA's perception of quality of care for the residents?

Ethical Issues

An online submission was submitted for an exemption from the Texas State University-San Marcos Institutional Review Board. This exemption was granted.

The research team constructed a consent form for the focus group participants (Appendix A). As required by the IRB, all participants were informed of their rights and asked to read and sign the informed consent form. The nurses were told they could stop participating at any time during the focus group sessions. Obviously, confidentiality cannot be given among participants in a particular focus group. However, the group participants were told that their remarks and opinions would remain anonymous outside of the actual group interviewing session.

Sample Selection

Criterion-based sampling versus random selection was used to find the participants in the focus groups. All participants were licensed nursing working in a nursing home. The authors contacted the administrators of four nursing homes seeking permission to conduct focus groups inside their facilities with their nursing staff. Each administrator believed they could recruit between five and eight nurses to participate.

Actual Interviews

Due to changes in work schedules, unanticipated sick leaves, limited staffing, a misunderstanding about time of interviews and other problems, 15 nurses took part in the focus group in four different nursing homes. Both authors conducted the focus groups; Dr. Burke acted as moderator or interviewer and Dr. Adams, took notes and handled the tape recording of the complete interview.

As the nurses gathered in the selected rooms at each nursing home for the focus group, the authors spoke with the participants to help establish a sense of rapport. The purpose and implementation of the research was explained to all the participants. Each participant was given and signed the consent form. The semi-structured interview guide explained above was used to allow the nurses to have the opportunity to express their personal ideas and opinions about quality of care in nursing homes. At the end of each focus group session, the moderator asked one final open-ended question inquiring if the nurses had any final thoughts or other issues. This question let the participants “take whatever direction and use whatever words they want to express what they have to say” (Patton, 2002, p. 354).

Data Analysis

Immediately after each focus group, the authors discussed and recorded in their notes the mood of the focus group, any unusual behavior, and other factors that could have influenced the answers and remarks made during the focus group. The Texas Long Term Care Institute staff and author, Carmen Adams, transcribed and printed out the information on the interview tapes. The printouts and tapes were checked for accuracy and any corrections necessary were made.

The authors did initial coding of the transcripts and developed themes from the interviews. Then the authors compared notes and discussed any variance in their opinions of the outcomes of the focus groups. Both computer and manual sorting and coding methods were employed. These findings, coupled with the literature review, provide an interesting slice of the life of a nurse working in a nursing home.

RESULTS

The researchers selected four facilities in four different cities. Two of the facilities were not-for-profit, while the other two were for-profit homes. To retain anonymity of facilities, they will be referred to as Home A, Home B, Home C, and Home D. In Home A, there were three respondents in the focus group. In Home B, there were five respondents. In Home C, there were four respondents. In Home D, there were three respondents. The total number of respondents was 15. Rather than reporting the results of each home separately, as in case studies, we are focusing on themes that cut across all four facilities, with occasional mention of unique findings in a single institution. The nurses in the study include both LVNs and RNs. Some of the nurses were new to long-term care and others had spent their entire career in this field. Both newly graduated and experienced nurses were members of the focus groups. Floor nurses and nurses involved in management positions came to talk with the researchers.

The idea behind this qualitative study was to gain insight into nurses' opinions of quality care for elders living in nursing homes. In addition, the researchers examined whether the nurses' thoughts and reflections differed from those of nursing assistants as reported in monographs authored by Burke, Adams, and Shanmugam, 2008 and Burke and Summers, 2001. The authors will discuss the themes they found during the conversations in the focus groups. The authors attempted to give representation to all the answers provided by the nurses during the data collection when developing the

Themes. The answers most often given and unique or thought provoking remarks are listed below.

First Question

The first question the researchers presented to each focus group was „in your experience as a nurse, what do you think quality of care means in terms of resident care?“ The most frequent answer was, “Every resident is taken care of to the best of the staff’s ability and based on the resident’s needs.” This definition recognized that each resident is a unique human being with unique needs. The nurses used the term “individualized care” which sounds much like patient-centered care in the acute care setting. One nurse built on that definition by noting that quality involved simply, “getting to know the resident.” Several nurses posited that quality involved treating the residents, as you would want your own parents to be treated. One nurse indicated that quality was “giving care with dignity and respect.”

Several nurses defined quality as “meeting all of the physical and the needs of the person as a whole.” As we discussed this second definition, there was agreement that, “to truly have quality of care, you have to meet the residents’ emotional, social, and spiritual needs” (in addition to physical). One nurse added that quality care is being able to evaluate the mental, physical and comfort needs and providing the residents a safe environment. In two homes, the term “holistic” was used when referring to this attention to the whole individual and situation. Several nurses mentioned that staff, management, and families needed to remember and emphasize the fact that the facility is the “resident’s home.” Another nurse noted that, “a positive outcome might be helping them live as positively as possible, joyful and pain-free.”

Other comments:

- “The nurse must anticipate resident needs, as some residents are unable to talk.”
- “Meeting and exceeding state and federal regulations is part of quality.”
- “Quality can be partially determined by architecture.”
- “Quality is present when staff comes in and really owns the job and are proud of what they do.”

Second Question

The second question was “In your experience as a nurse here, would you please discuss the clues or signs you, residents, and families receive that demonstrate the management of the organizations is reliable?” There was a great deal of overlap in clues that the three groups - nurses, residents, and families – identified as demonstrating management’s reliability. The most frequently mentioned sign or concept was how management dealt with problems. From the residents’ perspective, quality was often seen as how soon someone would answer the call light. One of the facilities had a policy that whoever is walking by a resident’s room with the call light on, that person – regardless of regular assignment or position within the nursing home hierarchy – would be expected to see what the resident needed. One nurse reported that residents sometimes counted the number of staff who passed by before someone looked in on them.

Nurses believed that to families, management’s reliability could be gauged by whether or not managers listened to their complaint, followed up on it, and informed the family of the outcome or resolution. There is the realization that not every problem can be solved immediately, but nonetheless management should follow-up with the family. At Home C, the management policy was to address family concerns within 24 hours.

Another indicator to families was whether the resident was fed on time, groomed, and never wet. If a family had a request and the nurse responded with either a positive response or at the minimum assurance that the issue would be addressed seemed to assure families that management was reliable. Families were reported to be pleased with informative newsletters from management. They also appreciated being included in a resident's care meeting.

Nurses at Home C were proud of their "Heart and Soul" program, developed by management, to increase quality. In that program, one staff person follows the resident for the first five days of admission to assure that the resident knows about all of the activities and is well-adjusted to the new environment. That staff person also keeps in touch with the family. To one resident and her family, the most important thing was to be able to have their pet Chihuahua in the nursing home. Management and the nursing staff made that happen. The dog was referred to as a "seeing eye dog."

The nurses' comments about the reliability of management, to a certain extent, mirrored the families' perceptions. If the nurses had a problem and presented it to upper management, they expected a response – even if it were that even if the request could not be granted. A sign of management unreliability would be a request sent to upper management that gets "lost in the system." Nurses found that to be demoralizing. In contrast, nurses were proud to be able to say, "Management has my back." One senior nurse, a part of the management staff, gave her cell phone number to families and invited them to call her night or day if there was a problem. She inferred that they used but did not abuse this privilege. Again, it gets back to responsiveness.

Other comments:

- “It is only when you have a good management team that everyone works together and the facility runs smoothly.”
- “A positive relationship between all caregivers was said to be a sign of good management and a good corporate culture”.
- “Nurses see it as a sign of positive culture when managers were willing to roll up their sleeves and help with the patient care work”.
- “I have a problem with management that wants you to do more with less. You work a double and the next time you say „no“. You are made to feel guilty about that.”

Third Question

The next question asked the focus group was, “From your perspective as a nurse here, how does your perception quality differ from the CNA’s perception of quality of care for the resident?” The most frequent response dealt with perceived differences in the scope of items that define quality. Nurses stated that CNAs look at the immediate impact of care, whereas nurses see quality in the long term. The respondents posited that nurses see the larger picture, while CNAs see the tasks.

One interviewee perceived that a CNA’s focus on the activities of daily living, such as bathing, dressing, and grooming of the resident are how they judge quality of care. Still another nurse paid tribute to the CNAs in saying “the nursing assistants would define quality as completing their tasks, with great pride, for a human who is in a weak and vulnerable stage of life.” One nurse stated that nurses are always assessing the needs and looking at the medical chart. A CNA might ask herself/himself, “Have I completed

the activities of daily living (ADLs) for my patients?” “Are my residents groomed and ready for a visit from the family?” Whereas a nurse might ask, “What are the lab results showing me?” “Do I need to phone the physician?” “How is the resident’s disease progressing and do we need to change the care plan?”

The consensus was that nurses better understood the psychosocial needs of the residents. Nurses may have taken courses in gerontology, sociology, and psychology. Nurses understand the disease process. It was acknowledged, however, that it is the CNAs who are actually satisfying the social needs of the residents by spending the most amount of time with them. One nurse stated that nursing assistants very “affect oriented” because residents become so attached to them. As some families infrequently visit their loved one, CNAs become like family. That description contrasts with the picture of the CNA as someone who only completes menial tasks. While the CNA is bathing, dressing, and grooming the resident, a relationship is built that is much deeper than that between the nurses and resident. A CNA might be seen reading the Bible to a resident or looking at pictures of the resident’s grandchildren. CNAs often give residents a hug or a pat on the back. A bond develops between CNAs and residents.

The issue of the relationship between nurses and CNAs became part of the discussion. At one facility, there was some criticism of younger CNAs who did not have the residents properly groomed. One nurse believed that a certain number of CNAs were just plain “lazy.” The more prominent point of view, however, was that CNAs were constrained by the number of residents they care for due to a lack of staffing. The nurses admitted it is close to impossible for CNAs to complete all their tasks perfectly all of the time. One nurse stated that the quality of CNAs’ work depends on time constraints,

attitudes, and length of service. The discussion of lack of staffing came up repeatedly at one home. One nurse discussed how when she first started, she would come to the aid of any staff member who was “swamped.” Now, she says, it is not possible to do so because staffing is so short. “Now when a colleague is drowning,” she said, “you have nothing left to give.” One nurse stated that, “CNAs do not really have much respect and consideration for us nurses.” It was apparent that there was a lack of understanding between nurses and CNA’s at Home A. One nurse believed that CNAs must see the world as cruel, because of the demeaning tasks that they perform. That statement is contradictory to the attitude that the researchers found in a previous study and will be explained in the discussion section.

Nurses at Home C stated that CNAs are very territorial and protective with regards to “their” residents. If another nursing assistant is taking care of a CNA’s patient, the CNA might say, “No, that’s not the way she likes her hair combed. Do it like this.” If a resident is transferred to another floor or unit, a CNA might visit the resident at the new location.

There was discussion of the fact that there is overlap between the roles of the nurses and CNAs. Nurses sometimes find themselves passing trays and CNA’s help meet psychosocial and spiritual needs. In most cases, nurses expressed thanks for the CNAs and believed that they should be members that are more prominent in the healthcare team. One nurse said that CNAs’ perceptions of quality are similar to that of nurses’. Both want to meet the needs of the whole person.

Other comments:

- “We have a policy that whoever sees the patient’s light go on, regardless of other duties, checks on the resident.”
- “Words that should never be heard: that’s someone else’s department.”
- “My job is a calling – a way to pay it back and pay it forward. I have a strong feeling that CNA’s feel the same way.”
- “While their [CNAs] tasks are narrower, they are so important!”
- “CNA’s don’t have to do the paperwork; nurses do. When we are in our office doing paperwork, they think we are hiding out.”
- “Good CNAs are your back-up.”

“We were taught in nursing school not to sit on the patient’s bed or to be emotionally involved with the patient. Residents, however, want someone to sit on their bed, talk with them, and look at pictures of their grandkids”. The CNA’s fulfill that need.

DISCUSSION

The discussion will elaborate on the results, then compare and contrast those findings with previous studies. Major sections will include perceptions of quality, signs of management responsiveness, motivation as well as comparison of nurse and CNA attitudes and motivation, culture change, and management implications.

Perceptions of Quality

Nurses perceived quality along two dimensions: application of maximum skills of nurses and meeting the unique needs of each resident. The nurses used the term “individualized care” which sounds much like patient-centered care in the acute care setting. Nurses in the long-term care facilities see their role as assessing the residents’ needs, based upon the nurses’ education and experience in geriatric medicine. It was stated that quality includes meeting external requirements, such as licensing.

Nurses also defined quality holistically, including residents’ physical, emotional, social and spiritual needs. Nurses also described care as being palliative. They acknowledged that in many cases a positive outcome might be helping them live as positively as possible, joyful, and pain-free. Providing such palliative care and maintaining joy requires an understanding of the dying process, patience, and a positive nature. With nursing homes short-staffed, it is not always possible to screen for nurses with those attributes.

Many of the perceptions given assume that nurses are skilled in geriatrics, whether through education, experience, or both. However, only a small portion of the respondents (RNs and LVNs) reported having had formal training in geriatrics. On the job training can be both positive and negative, as a novice sees both proper and improper techniques. Sorting through these experiences to find the proper handling of situations can be time consuming and confusing for some nurses. The perceptions also assume that the nurses have ample time to provide individualized care. Respondents acknowledged being short staffed and depending upon the CNAs to provide most of the individualized care.

The views of quality given are consistent with those in the literature. Several perceptions or definitions of quality are espoused. Traditionally, quality in healthcare institutions focuses on the service delivered to patients and meeting governmental or organizational standards (Longest, et. al, 2000, p.406). Quality of care in nursing homes is often stated in terms of quality of life of the residents. Since residents are in the home 24 hours per day, their interpretation of the level of care they receive is an important indicator of quality of care.

The nurses' comments about "individualized care" or "patient-centered care" were the focus of an article in the New York Times by Freudenheim, an author who frequently writes about health care and the baby boomers (2010). The author reports on "new ways to pay doctors to reward high-quality medical care" (Freudenheim, November 2007, p. C3). Payment would depend upon a team-based approach, based out the physician's office. Doctors and nurses would be paid extra for contacting patients via phone, email, etc. after hours. This along with a team approach between pharmacist,

nurses, doctors, and specialists should improve the quality of care provided. Many primary care physicians are lobbying for this approach. The formal name for this version of medicine is called the “patient-centered medical home (PCMH) is a model of comprehensive health care delivery and payment reform that emphasizes the central role of primary care” and provides comprehensive, coordinated care across the lifespan (Rittenhouse, Casalino, Gillies, Shortell, & Lau, 2008, p. 1246).

Research by Mary D. Naylor, a professor of gerontology in the School of Nursing at the University of Pennsylvania, shows that, “even fragile older people could avoid a quick return to the hospital if they are managed by teams of nurses, social workers, physicians and therapists, together with their own family members.” (Freudenheim, June 2010, p. D5L). The team aspect of care for residents of nursing homes is the center and vision of many culture change and/or quality improvement programs for long-term care. The nurses voiced support for these new and personalized approaches in caring for the elderly in nursing homes.

Signs of Management Reliability

The signs of management reliability were both similar and unique for the different stakeholders groups in nursing homes. All groups – residents, families, and nurses – considered reliability to be a function of the attitude and speed with which management responded to problems.

Resident’s perspective

From the residents’ perspective, quality and management reliability was often seen as how soon someone would answer the call light. Quality of care, according to nurses, can be interpreted as how soon someone answers a call light. One of the facilities,

where a focus groups was conducted, had a policy that whoever is walking by a resident's room with the call light on, that person – regardless of regular assignment – would be expected to see what the resident needed. Regardless of their regular duties, all staff members were instructed to acknowledge the light and try to facilitate a solution to the resident's needs or desires. The nurses discussed the importance of meeting each individual resident's needs, always remembering to personalize care, and honoring the elder's desires and beliefs. While a management policy is important, the real need in nursing homes is to see cultural change, whereby all staff would work cooperatively, elders would be treated as family members, and activities of daily living would be centered on residents' needs.

Families' perspective

The study found that families, judge management reliability based on whether or not managers listened to the families' complaints, followed up, and informed the family of the outcome. Management reliability therefore demands a manager who is actively engaged in the home, not one that spends her/his time only in the office. Families want to know and see the home's administrator. Managers can accomplish that by making patient rounds on a regular basis, taking time to listen to family members, staff, and residents. Another indicator to families was whether the resident was fed on time, groomed, and never wet. If a family had a request and the nurse could not immediately solve the problem, the families wanted to be kept informed on the progress and steps being taken to find a solution to the request. Families were reported to be pleased with informative newsletters from management. Families also appreciated being included in the resident's care meeting; especially if they were made to feel part of the care team rather than a mere

bystander to the decisions being made. These are low cost solutions that can pay big dividends in terms of good will.

Motivation

Nurses' expectations of management were not dissimilar to those of families. If the nurses had a problem and presented it to upper management, they expected a response – even if it were that a request could not be granted. A sign of management unreliability would be a request sent to upper management that gets “lost in the system.” Nurses found that to be demoralizing.

Nurses reported that praise and recognition for a job well done does a long way in motivating them. Such encouraging words are not heard enough in nursing homes. What is the solution to lack of follow-up and lack of recognition? One nursing home had a management policy that all management requests would be answered within 24 hours. These comments provide insight into what motivates and demotivates nurses.

Comments from the nurses indicate that sources of motivation include praise, a sense of calling or dedication to treat the elderly, and positive interactions with peers. Praise from supervisors and top management were cited as motivational to the nurses. It could be as simple as the words, “Well Done.” One nurse was proud to say, “Management has my back.” Yet, it was clear from these nurses that many senior managers did not recognize the power of praise and were reluctant to give it. Direct caregivers for the elderly often work amidst sorrow, as their patients' conditions worsen daily. In such an atmosphere, words of praise and encouragement are needed. A good manager recognizes this. In the previous study, praise and recognition of their work was a major motivator for CNAs; however, they were looking for this recognition mainly from

the nurses. In this study, the nurses desired to receive this same respect and acknowledgments; however, they desired it from their management.

In addition to praise, a sense of calling to care for the elderly was a motivator to many of these nurses. Some said it as their ministry. They stated that they visualized their own family members when caring for residents. This spiritual connection with their work was also since in the research previously done by these authors with CNAs in nursing homes.

A third motivator was positive interactions with peers. While some acknowledged friction among staff, it was clear that the teamwork and camaraderie helped to energize them.

Examining the motivation of nurses based on Maslow's model, this was discussed in the literature review. The researchers found that physiological needs are met, given the decent salaries of nurses; and that safety needs are met, unless perhaps the nurse was working in an unsafe neighborhood. Belonging needs were largely met as nurses in the study saw their endeavor as teamwork and identified themselves as part of the organization. Esteem needs served as a motivator, as nurses expressed the need for praise, a need that was not universally satisfied. The nurses who said they saw their work in nursing homes as a "calling" exemplified self-actualization. If one were to apply the "beyond self-actualization," the nurses can readily be seen as making a valuable contribution to society – giving of themselves to care for the elderly. Thus based on Maslow's hierarchy, the comments of the nurses in this study appeared to be highly motivated. The vast majority of the nurses displayed this motivation and dedication to the elderly they served, but it would be remiss of the authors to not mention that a few of the

nurses who had held the job for 20 years or so were just plain tired and motivation to strive for better care was difficult for them to find.

When considering Herzberg's model, the nurses in the present study had three complaints that could be categorized as hygiene factors. One area of dissatisfaction regarded company policy and administration. Nurses expressed frustration when their requests to management were either ignored or "lost." They also expressed dissatisfaction with inadequate staffing levels, which is a result of company policy or part of working conditions. A third area of dissatisfaction that nurses reported was occasional friction among staff (among nurses or between CNA's and nurses). This would fall under Herzberg's hygiene factor of interpersonal relationships.

Culture Change

There is no single definition of culture change and no single philosophy or program of implementation. It can be thought of as an attempt to deinstitutionalize nursing homes and can involve numerous initiatives such as redesigned facilities, introducing team care, promoting moving decision-making closer to residents, etc. (Robinson & Rosher, 2006). Discussion of nurses' involvement in cultural change is a fairly recent phenomenon. Casper, O'Rourke, and Gutman (2009) looked at empowerment of staff in long-term care comparing those in culture change homes and those in traditional institutions. The authors found that RNs did not report any increased access to empowerment when in a culture change facility. The RNs also did not see that the culture change activities increased personalized resident care. LVNs reported increased empowerment with culture change, but did not see that it changed the level or type of care. "Reports consistently document a positive relationship between RN staff

and higher quality outcomes” (Maas, et al., 2008, p. 130). However, these authors report that RNs with leadership training and Gerontological education backgrounds are in short supply. Burger and her co-authors portray culture change as a shift from medical-driven models of care to person-centered models that are more flexible, more humane, and recognize the physical, social, and psychological needs of the residents. Cultural change includes a multidisciplinary, team approach and a flattening of the bureaucracy. Nurses need to have the skills and education to lead such teams. Burger and his fellow authors (2009) acknowledge that often nurses feel ill prepared to lead initiatives in resident-directed care, as it is challenges nurses’ traditional model of care giving.

The Pioneer Network recommends nine competencies for nurses who will practice cultural change in nursing homes. Among the nine, three relate most directly to the current study:

- Position the nurse for leadership consistent with the principles of culture change and the climate of promoting a self-directed team of licenses and unlicensed staff.
- Address relationships among all nursing staff (e.g. advanced practice nurses, licensed practical nurses, certified nursing assistants) in culture change in nursing homes.
- Understand the value of, and being able to operate effectively within, interdisciplinary teams, recognizing the importance of disciplines other than nursing (e.g. social work, pharmacy, physical and occupational therapy) to the essential health of the resident. (Burger, et al., 2009, p. 13)

The Pioneer Network advocates that nursing educational programs incorporate culture change into their curriculums. One would hope that within several years, new graduates of nursing schools would be equipped to manage culture change in nursing homes.

One of the more interesting comments about the effect of culture change activities was uttered by one of the participants after the focus group had ended and the nurses were just milling around the interview table. This nurse remarked that culture change had a positive influence on staff. A CNA, who worked in the facility, could easily go down the street and earn at least a dollar an hour more working in a different nursing home as a CNA. However, the CNAs chose to stay at this facility due to the responsibilities and duties they have been given and activities they share with the nurses and administration.

Management Implications

Four management implications are apparent. First is that if nursing home managers seek to improve quality in their institutions, they must understand how their nurses and CNAs perceive quality. While nursing home managers may perceive quality in terms of good inspection reports from public agencies, nurses and CNAs define it quite differently. This study showed that nurses see quality as meeting the physical, emotional and spiritual needs of the resident to the best of the staff's ability. CNAs view quality as caring for residents' special needs, as if the resident were a family member. This includes bathing, dressing, and grooming the residents so that they take enjoyment in looking and feeling their best. When family members visit, CNAs take pride in the grooming of the residents. It would behoove nursing home managers to understand these motivations and to embrace them in their management practices. The holistic view of residents' health could be part of the nursing home's mission, vision, and practice. The décor of the

nursing home could be designed to reflect holistic healing, similar to the Eden Alternative philosophy. Managers should praise CNAs when making rounds and noticing a CNA doing a nice job of grooming a resident. By embracing the staff's own vision of quality, nursing home managers will be seen as champions of quality.

The second management implication is related to the first. Nursing home managers must understand the motivation of their nurses and CNAs in order to encourage them. Nurses in this study saw their job as a "calling" to help the sick elderly. The nurses' motivation, therefore, was intrinsic. While they acknowledged that they would appreciate more praise, their motivation came from seeing their job as a ministry. In a recent study, Adams (2010) found that CNAs were motivated by the job itself - - primarily by the personal relationships they developed with residents. The CNAs became like family members. While they acknowledged the need for praise and higher salaries, their primary motivation was - - similar to that of the nurses - - intrinsic. This motivation is consistent with Herzberg's two-factor theory as discussed previously. By better understanding the intrinsic nature of the staff's motivation, nursing home managers can adopt mission and vision statements that support such motivation. Nursing home managers would do well to embrace and share the same values as their staff, rather than being seen as only interested in the bottom line.

A third lesson emanating from the study is that nursing home managers must be fanatical about following up on requests and recommendations from staff and families. All nursing homes would be well served to have a policy that all questions or requests from staff get a management response within 24 hours. Another recommendation is that the residents' call lights be answered by the first staff person to hear/see it, regardless of

regular assignment. The “Heart and Soul” program described in the results section is recommended industry wide.

The final, and perhaps most important managerial implication, is that nursing home managers need to learn about and embrace cultural change. We saw in Home C that cultural change was well underway. Staff worked as teams and nurses and CNAs interchanged duties on occasion. Rules were relaxed to meet special needs of residents, such as the special comfort of pets, and the “Heart and Soul” program assured continuing care and an excellent orientation for new residents. Nurses will play a large part in cultural change. Nursing home managers must embrace and implement cultural change themselves. The quality of life of our elders in nursing home is at stake.

CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

Conclusions

The research led to five major conclusions. First, the nurses in the study viewed quality in two dimensions: clinically and holistically. By virtue of their training and position in the institutions, they saw themselves as the “keepers of the quality.” As physicians are not frequently on site, it becomes the nurses’ responsibility to personally execute or delegate physicians’ orders. By virtue of nurses’ life experiences, training in behavioral medicine, and – often – commitment to a calling, nurses also viewed quality as meeting the emotional, social, and spiritual needs as well.

Second, nurses view management competence as a function of how responsive management is to requests or reports of problems. If the nurses reported a problem – for example broken equipment – they expected a timely response, even if that response was not what they had wanted. If a request got “lost in the cracks” and nurses got no response, they considered the lack of a timely response to be an indication of management incompetence. Families judged management by the same yardstick. If families complained about the care, meals, or cleanliness of the home, they expected management to follow up and to communicate with them. Anything less was seen as an indicator of incompetence. From the resident’s viewpoint, an indicator of quality was how long it took a staff member to answer the call light. Reportedly, residents would count the number of staff members who passed by the room without responding to the

call light. For that reason, one facility had a policy that whoever sees a call light first should respond to it, regardless of whether that is her/his assigned area or not.

Third, there was both overlap and uniqueness in how nurses and Certified Nursing Assistants (CNAs) viewed their respective roles. Nurses reported that they often performed tasks typically assigned to CNAs, such as passing trays when necessary. While nurses' definition of quality included meeting the residents' social, emotional and holistic needs, it was largely the CNAs – the frontline caregivers – who assumed this role through the CNAs close and continuous relationship with the residents. It was the CNAs who read to residents, looked at their family pictures, and listened to their stories. Almost overwhelmingly, the nurses valued the dedication of the CNAs and considered them as an integral part of the care team.

Fourth, we found that nurses in the study were motivated by a sense of "calling" to provide the best possible care to the elderly. They achieved that goal through direct care and by supervising other staff. That motivation compares to the motivation of CNAs as reported by Adams (2010). In Adam's study of CNAs, she found that they were motivated by the job itself, that is, by their close relationships with residents. On Maslow's hierarchy of needs, nurses and CNAs could be considered to be in the "self actualization" category. Ironically, the low compensation of CNAs would also categorize them as low in meeting physiological needs. We found that while simple praise was a motivator for nurses, such praise from top management was scarce. Previous studies of CNAs revealed the same lack of recognition and praise (Burke, Adams, and Shanmugan, 2008).

Fifth, the researchers found evidence of cultural change in only one of the nursing homes in the study. As discussed in the literature review section, the Pioneer Network (n.d.) developed a vision and goals for culture change that “make resident-directed care the guiding or defined standard of practice for nursing homes.” The group defined and discussed the role of nurses in the transition from an institutional-type setting to a residential type setting. It acknowledged that culture change is difficult for many nurses who are comfortable wearing the clinical hat but not comfortable dealing with issues to as residents’ rights, measurable goals of care, and multidisciplinary teams. Nurses may view such changes as a threat to their autonomy. In our current study, the culture change home had numerous examples of flexibility in accommodating residents’ physical, emotional, and holistic needs. Pets were allowed (unofficially, but with the support of the staff). There was an atmosphere of acceptance and encouragement among and between nurses. Nurses did not express discomfort with the apparent transition from an institutional setting to a residential setting.

Limitations

The study had three major limitations. First, the budget was modest and therefore the overall number of focus groups and participants count was low. Given the fact that we used four sites, with differences in size and ownership, we believe that we garnered a range of answers. Second, the study was qualitative and therefore might be criticized for its lack of rigor. Answers are based on perceptions rather than hard data. A qualitative design, however, assisted us in gathering candid thoughts, particularly using the focus group method. Third, the study no doubt was weakened by selection bias. As the homes were short-staffed, in many instances the Director of Nursing recruited nurses for the

focus groups. That might have led to answers that were more positive than if subjects were chosen by random or self-selection.

Recommendations for Future Research

We believe that our study has just scratched the surface of an emerging, critical issue - - the changing role of the nurse in long-term care. With the burgeoning of the elderly population, more nurses will be needed for long-term care. The key question is what role they can take to be most effective. We believe that that role is in leading cultural change; assuming leadership in transforming institutions into homes. More studies, large and small, qualitative and quantitative are needed to assess and encourage cultural transformation in long term care.

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APPENDIX A

Consent Form

Effects of Nursing Staff on Quality In Nursing Homes

You are invited to participate in a study of how RN's and LVN's contribute to the quality of care in nursing homes and how they perceive their relationship with Nursing Assistants to impact to the quality of care. I am Dr. George Burke, a faculty member at Texas State University-San Marcos, Texas

This study is funded by a grant from the Texas Long Term Care Institute of Texas State University-San Marcos.

You were selected as a possible participant for this study because of your employment in one of four nursing homes that agreed to participate in this study. I will be interviewing groups of 6-8 individuals, depending on the number of volunteers.

If you decide to participate, I will describe the simple procedure(s) to be followed and the purposes. The only inconvenience to you will be your time. The direct benefits to you will be that you will be compensated \$20 for your time (no longer than 90 minutes) at the completion of the group interview. You will also have someone who is truly interested in listening to you tell the story of your elder care journey. The benefit to others will be profound. You will teach scholars, volunteers, other professionals such as yourselves, and others what it means to you to deliver high quality care.

I will assure that the information that I gather from this study will be confidential and that your employer will not be able to identify what statements you have personally made.

I plan to publish my findings in a monograph and a journal article that I will make available to the administrators of the nursing homes and to any other person(s) interested in reading the monograph and journal article.

You are under no obligation to participate. Your employer makes no request that you do so. Participating is voluntary. If you decide to participate, you will be free to discontinue your participation at any time.

If you have any questions, please ask me. If you have additional questions later, I will be happy to answer them at my office (512.245.3509) or my cell (512.xxx-xxxx)—George Burke. I will answer the phone directly or you may leave a message and I will return your call within three hours.

You will be offered a copy of this form to keep.

You are making a decision as to whether or not to participate. Your signature indicates that you have read the information proved above and have decided to participate. You may withdraw from the study at any time.

Signature of Participant Date

Signature of Witness Date

Signature of Investigator Date

Reminder: You are under no obligation to participate in this study.