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Health Care Financing: Challenges and Realities for the Nurse Administrator in Long-Term Care Facilities

by

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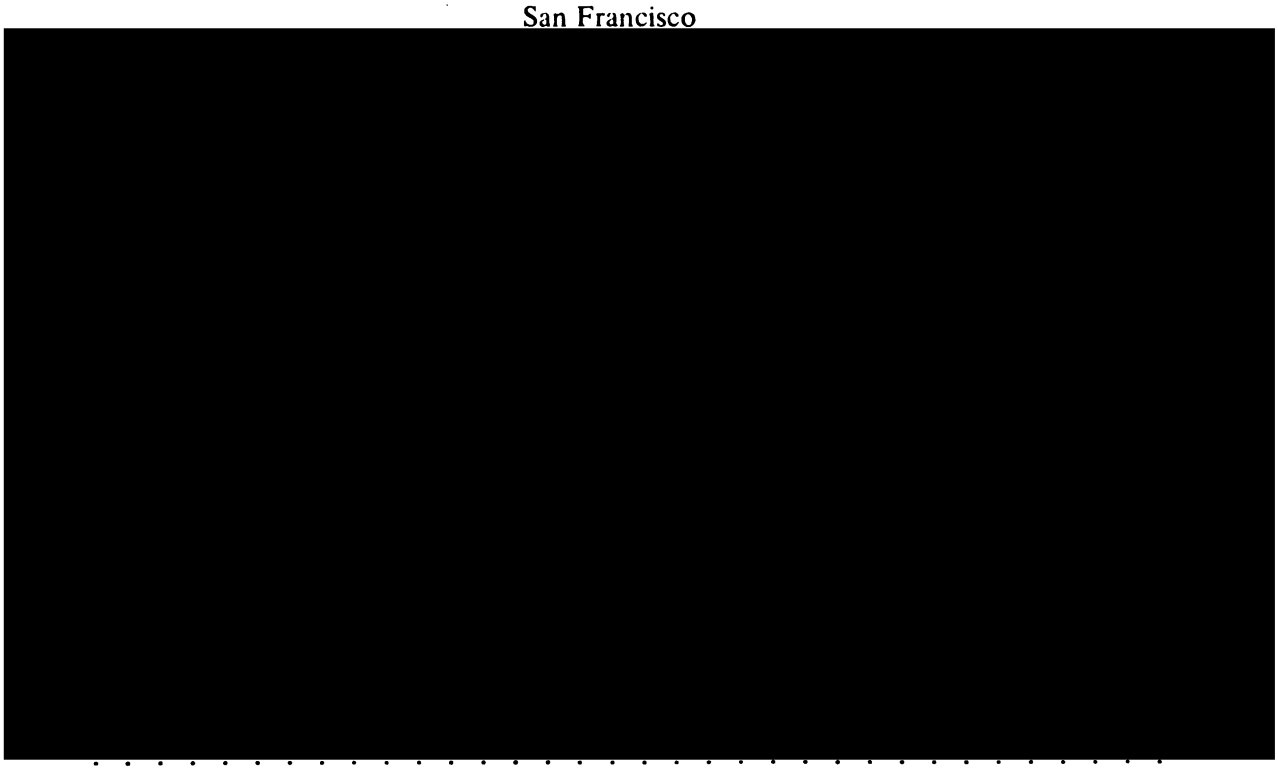

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Dedication

To my friends on both sides of the United States and Canada border without whom this dissertation could not be completed. My family members are some of my best friends.

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Health Care Financing: Challenges and Realities for the Nurse Admistrator in Long-Term Care Facilities

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Abstract

In 1984, $25 billion were spent for nursing home care in the United States. Today, more than ever before, nursing service is seeking methods to accurately assess the cost of nursing care. Nurse administrators in every health care setting are expected to meet the challenge of cost containment while providing quality nursing care to patients. Similar demands are made on nurse administrators in skilled nursing facilities where approximately five percent of all persons over the age of 65 reside.

The purpose of this dissertation is to explore and describe characteristics associated with skilled nursing facilities and with nurse administrators of such skilled nursing facilities. The focus of investigation is the perceptions, issues and problems surrounding management practices of nurse administrators. The study seeks answers to the question: How do nurse administrators in skilled nursing facilities manage the environment and resources to deliver quality care to an ever increasing percentage of patients over 75 years of age, and at the

same time demonstrate cost constraint?

Grounded theory, a form of field research, was generated from interviews of nurse administrators in selected skilled nursing facilities using the constant comparative analysis technique of content analysis. A survey data form designed by the researcher and the Moos Work Environment Scale (Moos, 1981) were completed by respondents and the results used to verify or refute interview data.

Findings are a conceptualization of the data along three dimensions of grounded theory building; descriptive, analytic, and substantive theory. Recurrent management themes of working conditions, resource acquisition, staffing, patient acuity, quality care, record-keeping, and cost containment led to delineation of the descriptive and analytic concepts; power relationships, management dissonance, competing agenda and clinical power-administrative powerlessness. Theory building concluded with the main finding, nurse administrators' capability of image making. These findings describe the current work environment in skilled nursing facilities and the management challenges and realities faced by nurse administrators.

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Chapter 1

Aged persons in the United States are receiving over three percent of the gross national product for health services. In 1984 an estimated two-thirds of this percentage was spent for institutional care of persons aged 65 and over; $25 billion alone were spent for nursing home care. Medicare, and Medicaid, the Veterans Administration, and private health insurance paid over one-half of the total health care costs of the aged, the remaining costs were borne by the aged person or the family (Rice, 1985).

The enactment of Medicare and Medicaid in 1965 was part of a major public commitment by Americans to finance health care for its poor and aged citizens. The Medicare program was designed to reduce the financial burden of illness and hospitalization for the aged. The Medicaid program was designed to promote access to health care services for the financially disadvantaged including the aged (Litman, 1984). C.K. Davis (1983) points out that Medicare and Medicaid programs were enacted at a time of robust economy in the United States. These same programs are in jeopardy as a result of the inflationary and constricted economy of the 1980's.

Since the enactment of Medicare and Medicaid in 1965,

many factors have contributed to the restructuring of the health care system: (a) the numbers and proportion of the population aged 65 and over that are projected to continue to increase well into the middle of the next century, (b) the rising health care costs, consuming 19 percent a year of the Medicare program between 1979 and 1982 because of inflation and increased per capita use of services, (c) increasing demand for services, and (d) the projected depletion of the Hospital Insurance Trust Fund (C.K. Davis, 1983; Rice, 1985).

The restructuring of the health care system entails a change from a reimbursement to a prospective payment system. The prepayment system has been phased in since the enactment of Public Law 98-21 in 1983. The prospective payment system currently affects Medicare participating, acute-care hospitals only. Long-term care, including skilled nursing facilities, has to date been excluded from the prospective payment system (C.K. Davis, 1983), remains on the existing reimbursement system. Long-term care as a part of the total health care system is nevertheless influenced by the new prospective payment system implemented for acute care.

As a result of changes in financing, the health care industry has begun cost containment activities and at

the same time is determining "true" health care costs.

Today, more than ever before, nursing service, which accounts for 30-60 percent of any hospital budget, is seeking methods to accurately assess the cost of nursing care. Nurse executives in every health care setting are expected to meet the callenge of cost containment while providing quality nursing care to patients. Similar demands are made on nurse executives in skilled nursing facilities where approximately five percent of all persons over the age of 65 reside.

Purpose and Significance of the Study

The purpose of this dissertation is to explore selected characteristics associated with skilled nursing facilities and with nurse administrators of such skilled nursing facilities. The focus of the study is on the perceived management responsibilities of nurse administrators in skilled nursing facilities. Key issues of the study are: (a) the current climate in skilled nursing facilities; that is, the physical, emotional and social environment perceived to be present in skilled nursing facilities, (b) the management priorities and stragegies nurse administrators use to ensure the provision of quality care, (c) the methods used to procure, utilize and allocate resources, and (d) the perceived influence

of prospective payment on skilled nursing facilities. The questions central to this investigation are: (a) What are the perceived management responsibilities of nurse administrators in skilled nursing facilities?, (b) What is the climate of their workplace?, and (c) What expectations, demands, issues and problems in skilled nursing facilities shape the work of the nurse administrator?

A literature search revealed a modicum of information or research on skilled nursing facilities facilities and nurse administrators. Survey studies, primarily conducted by government agencies, identifying identifying numbers of skilled nursing facilities and numbers and types of users of skilled nursing facilities, as well as media exposés regarding the abuse of patients in skilled nursing facilities, constitute most of the available literature. Little is written about nurse administrators or their perceptions of management responsibilities in skilled nursing facilities. Yet, approximately five percent of all persons over the age of 65 are being managed by nurse administrators in skilled nursing facilities at any given time. It is projected that one in five persons over the age of 65 will spend some part of their remaining years in skilled

nursing facilities (Eliopoulos, 1983). As the "ratio of elderly to nonelderly persons continues to increase to the expected one to three by the year 2025" and the numbers of those "85 years old and over increase fivefold by the middle of the next century" (Special Committee on Aging, 1984), these projections take on added significance for users of skilled nursing facility services and for managers of those services. Nursing service, which constitutes up to 60% of any nursing home budget challenges the nurse administrator in skilled nursing facilities to exercise cost containment while providing quality care services.

Based on these projections and concerns, this study seeks answers to the question: How do nurse administrators in skilled nursing facilities manage the environment and resources to deliver quality care to an ever increasing percentage of patients over 75 years of age, and at the same time demonstrate cost constraint?

Following this introduction to the topic of study, the reader will be presented with a literature review and a conceptual framework for inquiry. Next, the research methodology is described and the findings discussed. The dissertation concludes with a discussion of the implications and recommendations derived from the results of the research.

Chapter 2

Background

Shifting Ideologies

A review of the literature regarding aging and the health care system in the United States since the 1920s indicates significant changes. The increasing numbers of retirees from the work force, the sophistication of health care technology, and the increasing demands on health care dollars to meet the health care needs of all Americans have brought about social and political change. Health policy, health care financing, and models of care delivery have shown evidence of shifts to accommodate a graying America.

Aging

In the early 1900s, Congress established age 65 as the age of retirement. Although chronological age itself has little meaning, age 65 took on social relevance. It means the passing point from middle to old age with all the attendant physiological and social status changes at hand or imminent. But aging is a dynamic process of physical and social changes and psychological adjustments (Hendricks & Hendricks, 1981). Gerontologists usually

regard "oldness" in the following manner; ages 65 to mid-70's, young-old, and after 75, old-old, thereby recognizing the vitality of the first group and the increasing vulnerability of the second (Butler & Lewis, 1982).

Demographics

According to the latest report of the Special Committee on Aging, (1984), certain trends evidence that America is an aging society. The rate of increase for the older population since 1960 exceeds the rate of increase of the general population. The older population has grown twice as fast in the last two decades. Other data regarding population growth are:

> The 85-plus population grew especially rapidly, up 165% from 1960 to 1982. This "very old" population is expected to increase fivefold by the middle of the next century.
>
> Not only are the numbers of elderly persons increasing, but the porportion of elderly in the population as a whole is also expanding. Over 25% of the population will be 55-plus by the year 2010.
>
> Life expectancy improved dramatically

over the last century. The average person born today can expect to live 25 years longer that if he were born at the beginning of the century. Women live longer than men. In 1981, the life expectancy of females (78.2 years) was almost 8 years longer than the life expectancy of males (70.8 years). Elderly mortality (or death) rates, a statistical measure of the frequency of deaths in population groups, fell considerably over the last 40 years, especially for women. The ratio of elderly persons to nonelderly has increased from 1 to 25 at the beginning of the century to 1 out of 9 in 1980. This ratio is expected to be at least 1 to 5 in 1990 and 1 to 3 in 2025.

Today, the 65-plus population is about equal to the teenage population, those aged 13 to 19 years. By the year 2000, there will be

> an estimated four 65-plus persons for every three teenagers and, by 2025, elderly persons will outnumber teenagers by more than 2 to 1 (p. 2).

Futrell et al. (1980) attribute this phenomenal growth of the over-65 age group to three factors: high birth rate during the late 19th and early 20th centuries, the post World War II "baby boom", increased immigration before World War I, and dramatic increase in life expectancy due to advances in technology and medicine.

The Study of Aging

Although the study of aging is relatively new, the search for secrets of prolonging life and the puzzlement over the causes of aging have been pondered by Aristotle, Cicero, and Bacon (Hendricks & Hendricks, 1981). Scholars in search of answers to questions of longevity have investigated the population for differences in age-related abilities. London in 1880 was the setting for the first large-scale survey of this nature. Francis Galton collected data on over 9,337 people aged 5 to 80 to demonstrate that many physical abilities such as hearing, vision, and grip differ with age (Birren & Clayton, 1975).

Although Quetelet, an 18th century Belgian, is now recognized as the first gerontologist, gerontology, the systematic study of the process of aging, was not recognized until the early 20th century and in Europe long before the United States (Hendricks & Hendricks, 1981). Birren and Clayton (1975) state that growing interest in gerontology was evidenced by a number of publications in the 1920s devoted to the process of aging, and that by the 1930s, some basic concepts of gerontology had been accepted. Also influencing a growing interest in gerontology was the shift in the focus of medicine in the 1930s from infectious to chronic disease with its inherent involvement in aging physiology.

Since World War II, interest in the United States in aging issues and concern at individual group, and governmental levels has increased. The Gerontological Society began publication of the Journal of Gerontology in the 1940s; the National Institute of Aging was established in 1974. Conferences and publications since the 1940s attest to the work of gerontologists and the growth of gerontology (Hendricks & Hendricks, 1981).

Since the study of aging is broad and complex,

many facets of the aging process have been investigated. Research in the biological and clinical aspects of aging preceded research in the behavioral and social aspects. The term social gerontology, was not used until the 1950s.

Research in aging has been and continues to be plagued by many conceptual and methedological problems. Hendricks & Hendricks (1981) suggest that professional biases and attitudes have influenced inquiry by excluding significant variables such as culture, individual physiology, or physical condition. They suggest researchers should view aging as a combination of biological, social, psychological, and environmental variables. Birren (1968) reminds the researcher that many questions related to aging cannot be studied in humans because of the harm or potential harm to subjects; Birren cautions that the same studies in animals may have little applicability or generalizability to humans.

The four most discussed methodological problems facing the gerontologist are: (a) ethical considerations, (b) age as an independent variable, (c) confounding variables, and (d) sampling and generalizability.

Strain and Chappell (1982) raise ethical concerns

regarding consent and researcher obligation. They suggest that the use of signed consent may not always be possible or appropriate, and that alternatives should be sought, for example, verbal consent followed with participation that implies consent. Regarding obligation, Strain and Chappell (1984) point out the ethical dilemmas when the subject requests service or information and the researcher feels an obligation to provide service or obtain the requested information. One recommendation to overcome this dilemma is for the researcher to establish a link with a service delivery agency which can serve as a referral source to subjects who seek service and information from the researcher.

The methodological issue concerning age as an independent variable is discussed by Schaie (1977) and Botwinick (1978). Both authors recognize that most researchers in aging want to generalize as regards age changes. They caution that age does not cause behaviors and that researchers cannot conclude that age differences such as social isolation, memory retention or learning ability, are causally related to the effects of aging. Rather, age differences may be related to an historical event or to the effects of a social situation on the subjects; for example, the great depression or unexpected

loss of loved ones. Schaie (1977) suggests that a proper quasi-experimental design that attends to the threats to validity and controls for significant variables will provide results that address rates of change that may be linked to age. He suggests that when age differences and age changes are to be distinguished, the nonequivalent control group design is the one of choice. Botwinick (1978), on the other hand, contends that the longitudinal method is the only one permitting analysis of change in an individual over time.

Maddox and Wiley (1976) also address the methodological problems associated with confounding variables suggest that inconsistencies in the study findings regarding age differences and age changes point up the significance of age, cohort, period, and environment as confounding variables. They believe that the problem is caused by attaching formal, dependent operational definitions to variables; for example, age = chronological age, cohort = date of birth, and period = date of observation, and by attempting to measure influence on behavior in late life. Although Maddox and Wiley acknowledge the influence of these variables and of environment on behavior, they state that our capacity to measure the extent of influence is

limited. Cross-sectional, time, and cohort sequential designs anyhow take these confounding variables into consideration. Botwinick (1978) states that a longitudinal design is preferred when studying change over time.

Sampling and generalizability present another problem. Since disability and mortality increase with age, attrition rates in elderly populations are higher than other populations. Schaie (1977) suggests three ways to select aged subjects that afford generalizability: (a) select a representative sample (suitable for one point in time investigation) from the population to which one wishes to generalize, (b) use data only from subjects who remain in the study until completion, and (c) specify a sample appropriate to the variable under study that does not imply representation of any population group.

Beliefs and Values

Until 1900, the average survival age was fifty years. The few persons of higher age were considered unique and remarkable (Woodruff, 1975). Although the earlier times old age was often revered, a negative or at least an avoidance view also prevailed. Hendricks and Hendricks (1981) report that in the Han Dynasty of China,

it was believed that aging represented an imbalance in the physiological process that signalled disease and the end of life. An ancient Egyptian scroll is entitled "Book for Transforming an Old Man into a Youth." In ancient Greece and Rome, Aristotle and Cicero voiced conflicting views about the intellectual abilities of old age. Aristotle condemned old age as a time of extreme conservatism and smallmindedness. Cicero portrayed old age as a time of wisdom and an opportunity to influence and advise others based on accumulated knowledge and experience. Both recognized the physical deficits and disease associated with old age. In the 16th century, Elizabethan writers wrote of old age as a time of many defects in one's character. Disease and old age as inevitable companions persists to some extent today; the theory that aging is a disease continued into the 19th century.

Butler (1975) refers to "The Tragedy of Old Age in America." He states that two divergent views operate in our society. On the one hand, there is the image of the "golden years" when one lives out one's life in retirement communities in comfort, safety and fulfillment; on the other hand, the image of old age is one of being a burden, useless and dependent. Butler (1975) also suggests that

these two extreme views of old age arise from a combination of wishful thinking and fear. He further states that neither view is realistic and that an attitude toward old age as a natural progression through the life cycle is desirable. Reed (1983) supports this view and states that age and development, rather than age and decline, are correlates. Butler (1975) and Reed (1983) provide examples of shifting beliefs and values of modern day Americans from negative toward a more neutral, if not positive, view of growing old.

Hendricks and Hendricks (1981) suggest that negative perceptions of old age in the United States hail from the period of industrialization and urbanization. So long as the elderly in America controlled property, held political power through seniority, and were the bearers of tradition and history, they were held in high esteem. With industrialization came a high regard for productivity and a shift in value to those most able to produce the monetary gains associated with productivity. The older, slower workers lost status and worth in the eyes of their employers and soon in the eyes of American society. As agriculture was replaced by urbanization, the prestige afforded the elderly because of large land holdings became eroded. Society seems to hold in highest esteem

those who control the resources. In America, the control of resources has shifted away from the elderly since the beginning of the 20th century.

Achenbaum (1983) suggests that as America changed, the image of old age turned into one of a "social problem." By the end of World War I, the old person was perceived as obsolete and unable to keep up with accelerating societal change. Aging was seen as a process of pathological deterioration and eccentric behavior. Such perceptions were amplified as youth, with its strength, creativity, and flexibility, was concurrently being extolled. Mandatory retirement was instituted in part, to make way for the young. Age discrimination in hiring and training practices became commonplace. Achenbaum (1983) suggests that the position of America's elderly failed to modernize in a rapidly modernizing society. Since 1920, he states, American society has witnessed changes and shifts in numbers and proportions of aging persons as well as changes in the elderly persons' needs; yet policies and programs relative to the social well-being of aging individuals remained unenlightened.

Health Politics, Policy and Aging

An information paper on "Older Americans and the

federal budget: Past, present, and future," submitted by the Special Committee on Aging (1984) states that 28 percent of the Federal budget is spent on 11 percent of the population that is, those over 65 years of age, and that this 28 percent ranks just below that of national defense. This information together with growing awareness and concern for the size of the national budget deficit has focused attention on the share of the Federal budget used by older Americans. Information of this nature serves to support the contentions of Achenbaum (1983) and Estes (1980) that old age in America is viewed as a social problem. Further, the budget deficit is described by many as representing political and economic crisis. Old age as a social problem has been identified with the crisis and, by association, is itself a crisis or at best a reason for the crisis. Estes (1980) states that the view of old age as a social problem that has reached crisis proportions is a political strategy used by two groups: (a) those who seek expansion of government resources to combat the so-called crisis, and (b) those who seek to deflect others from blaming the crisis on earlier social inaction or economic policy and to blaming it on increased

numbers of social and health service users and decreased birthrates.

An examination of the historical and contemporary role of government in shaping policies associated with health and the aged follows.

Competing Political Approaches

Battistella & Begun (1984) point out the pressures on government to raise the amount of health spending is based on such developments as increases in numbers of those with chronic diseases, costlier forms of treatment for disease, increased life expectancy, and increasing demands for equity in distribution and quality of services. These authors state these developments and demands are occurring at a time of diminishing resources, unemployment and inflation. The demand for health spending and the declining availability of resources are irreconcilable. The policies, in the last ten years, that attempted to reconcile them failed. Demands for equity stem from beliefs and values about what is fair and just. The bases of these beliefs are found in four major political frameworks from which health policy is formulated (Battistella & Begun, (1984).

Until recently, the normative approach was predominant and was generally reflected by divergent philo-

sophical views known as liberal and conservative. Regarding health, individuals and groups have tried to influence government on strong conviction about what is valued or ought to be valued. An example are the many efforts to establish the principle of health as a right dependent on medical need rather than ability to pay. The passage of Medicare in 1965 rewarded, in part, these efforts.

The battle for a national health insurance plan, waged since 1935 when the first government health insurance bill (Epstein Bill) was introduced in Congress, is marked by an intense, ideological struggle over whether access to health care is a right or a privilege. Professional interest groups, most notably the American Medical Association (AMA), have taken the position that health care is a privilege. Underscoring this position is a conservative view that professional self-regulation, governance and autonomy, as well as the freedom to pursue unbridled monetary reward, would be taken over by the government. Proponents of health care as a right underscore the moral and utilitarian benefits to the whole society; that is, good health is an investment in national well-being and in economic growth. The United States remains the only leading industrial power without

a comprehensive national health insurance plan. The right or privilege issues surrounding health policy prevailed into the 1960s. Since then the normative approach has lost favor. Critics of the normative approach have dubbed it value laden and have called normative politics rhetorical and self-serving (Battistella & Begun, 1984).

For a variety of reasons outlined by Battistella and Begun (1984), the role of government has become increasingly heightened since the mid 1960s. Enactment of Medicare and Medicaid, escalating demands for biomedical research, and growing recognition that the usual supply and demand relationships of the marketplace are not applicable to the health field, have stimulated more and more government involvement and created a shift toward a rationalist approach to health politics.

The rationalist or empirical approach seeks objectivity and quantification to bolster political decision-making. It emphasizes efforts to quantify costs and benefits to society of government programs. In the late 1960's and during the 1970's cost-benefit analysis, systems analysis, program budgeting and other techniques associated with scientific management principles found in business, became part of the health sector management methods.

At the same time, health politics of the 1970's focused on transforming health services from a "cottage industry" to a corporate structure. It was desirable to have fewer, but larger, units of production (hospitals) caring for defined populations. Consequently, one-third of all nongovernmental hospitals and approximately one-fourth of all hospital beds in the United States are found in multihospital complexes. Further evidence of the influence of the rationalist approach can be found in these statistics: (a) the number of hospitals joining group arrangements rose by 33 percent between 1975 and 1979, and (b) the number of physicians associated with group practice in 1969 was 18 percent, while in 1975 those in group practice were nearly 25 percent and rising. Professional standards review organizations (PSRO) since 1972 purportedly provided objective means of accounting for productivity. They highlight the search for quantifying organizational efficiency and competency by proponents of the rationalist approach.

Objectivity and quantification, hallmarks of the rationalist/empiricist approach to health politics, proved less successful than originally hoped for according to Battistella & Begun (1984). These authors describe some of the shortcomings of this approach: (a)

the facts were not valid or value free, nor were the analytical methods for accumulating facts value free; (b) health and the perception of health is a subjective phenomena; and (c) quality issues, such as care and environment are not readily quantifiable.

Pragmatism, coupled with restraint and compromise, is emphasized by the neoconservative approach. Neoconservatives are interested in redefining the partnership between government and the private sector; they value individual opportunity and achievement over group parity; they seek to balance goals of equity with efficiency; they recognize the reality of resource scarcity and the necessity for negotiation and trade off to reach this balance (Battistella & Begun, 1984).

The neoconservative approach became visible during the 1970's as disillusionment and disappointment regarding successes of past and present health policies increased. Critics of neoconservatism point out the danger of possible sacrificing equity in health services delivery to the exigencies of health care cost containment. The critics also suggest that in the zeal for a workable (pragmatic) system, the vision of a just society may be lost (Battistella & Begun, 1984).

Since the peak of the normative approach a last

competing political framework is the neo-Marxist approach. The major Marxist themes of social class oppression and capitalism have been adjusted by neo-Marxists to the power concentrations found in industrialized societies. Their themes are the working class or consumer and the corporate elite. As regards the health sector, neo-Marxism sees patients pitted against the bureaucracy in the form of the medical profession and the health care system. Neo-Marxists argue that change and equity are not brought about by altruism, but by the manipulation of events by self-serving interest groups such as health insurance, hospital supply and pharmaceutical companies, and health care providers, primarily physicians.

The neo-Marxists have been instrumental in dispelling two societal myths: (a) the belief in the benevolence of the medical profession, and (b) the belief that hospitals provide primary health care to underserved populations, and that they are operating in a cost effective manner. In short, neo-Marxism heightens awareness that reform policies do not always work toward humanitarianism. Shortcomings of the neo-Marxist approach identified by Battistella & Begun (1984) are that: (a) the underlying pessimistic and denigating assumption that selfishness and self-interest are universal in human nature, (b) there

is a heavy reliance on assertion rather than data in these generalizations, and (c) neo-Marxist writing is heavily Marxist in nature and language causing some readers to feel unsettled.

Proponents of each of the four competing political approaches persist and the demand for health services rises as the balance between equity and efficiency in health care delivery is sought. Health policy since the 1920's reflects the successes and failures of this struggle particularly for the elderly. Health policy, however, is inextricably linked with the role of government in health care and the growth of health services as enterprise.

The Health Enterprise

Before 1900, health care was mainly delivered in the home by physicians on a fee for service basis. Two medical-technical discoveries sparked the development of the modern hospital system--antisepsis and anesthesia. Both made surgery comparatively safe from infection and painless. Since surgery was best performed in a hospital setting, it was this specialty which prompted the growth of the hospital as a base for episodic health care delivery. By 1900, there were 4000 general hospitals in the United States. Approximately two-thirds

of funding came from private patients; the remaining third from philanthropy, public funds and charities. The fee for service concept became firmly entrenched in the American health system. As early as 1909, the middle class who comprised the largest consumer of health service began to find it difficult to pay for hospital care. The rich could afford care, the poor received free care, and the middle class was finding it increasingly unmanageable. However, middle income groups did nothing to change the health service infrastructure since 1930 and it remains so to this day. An acute-disease oriented personal health service was needed, and until the 1930's the people of the United States paid for it without aid of government or private insurance. The role of government was to license and oversee standards, but was not to direct the health care system (Anderson, 1984).

The period from 1930 to 1965 was characterized by the development of a third party system to pay for the day-to-day operation of the hospital. The Great Depression of the 1930's prompted the initiation of hospital-sponsored prepayment plans. The first of these was Blue Cross. Concurrently, prepayment plans for physician services in the hospital, mainly for surgery.

emerged. These plans are now known as Blue Shield. By 1952, over one-half of the United States population was covered by some form of health insurance (Anderson, 1984).

The enactment of the Social Security Act of 1935 was tangential to development of health services, but central to the policies affecting the aged. The average survival age was fifty years before 1900. Increased immigration and birth rates and the advent of anesthesia, antisepsis and antibiotics gradually changed the number of people living past 50 years of age. The depression years awakened a realization of the vulnerability of all Americans, but particularly the young, the old, the disabled and the poor.

In August 1935, Congress passed and the President signed the Social Security Act which provided grants-in-aid to states for maternal-child care, aid to the blind, to crippled children, to the aged, and to other health-impaired people. Health insurance was considered but not included because it was feared that opposition to a national health insurance plan would jeopardize passing the Social Security Act (Litman, 1984).

Aged persons who needed relief from a desperate social situation, and who could no longer work to provide

the resources they needed to sustain life were to be covered, in part, by the Social Security Act. The intent was to provide against abject poverty in old age through both a pension system and public assistance (Spitler, 1981). Thirty years later, the special health and social service needs of the elderly were formalized by policy.

From the late 1930's to the 1960's, visits to physicians and admissions to hospitals of people of all age groups increased dramatically. The supply of hospital beds and physicians increased, but could not meet the demand. In 1946, the Hospital Construction Act (Hill-Burton) supplied grants to public and private hospitals for start-up costs. These costs were matched by the participating hospital. Thus, government support buttressed the private nonprofit sector at a time when philanthropy and community funding sources were becoming scarce. In the 1950's the general economy and the health services economy were in full swing (Anderson, 1984).

Anderson (1984) proposes that in the 1950's the proponents of a national health insurance plan portrayed the aged as a burden on the voluntary health insurance system and therefore on the middle income segment of the population. Increased numbers of aged persons, especially over age 75, were portrayed as experiencing

chronic illness, disability and helplessness, and were considered a tax on family resources. Anderson's statements dovetail Achenbaum's (1983) and Estes's (1980) claims that old age is viewed in our society as a social problem.

Three concurrent federal policies, enacted into law in 1965, influenced the health enterprise and specifically the aged: (a) the Older Americans Act, (b) Medicare, and (c) Medicaid.

The Older Americans Act focused on developing programs to meet the special service needs of the aged. The act's aim is to maintain the health, dignity, and constructive independence of older persons throughout their lifetime. A federal agency, the Administration on Aging, was created to administer these social service programs (Spitler, 1981).

In 1973, amendments to the act shifted funding and program responsibilities to state and local levels. Declining federal appropriations were distributed among the fifty states and seven territories and over 600 area agencies to serve 23 million older Americans. Since the 1980's, more and more funding is expected to be generated at the local level. As resources continue to decline at all three levels, federal, state and local,

targetting of existing resources becomes a vital issue (Newcomer et al., 1983).

Medicare is in fact an amendment to the Social Security Act and is officially under Title 18. The amendment provides for federally assisted medical care for the elderly (Litman, 1984), and was designed to take the burden of cost of care to the aged away from insurance agencies and families. Medicare has two parts; Part A is directed at defraying hospital care expenses; Part B covers in part physician and laboratory expenses. Both parts focus on services to the patient while in acute care hospitals. Part A will pay for 100 days of skilled nursing care in a long-term care institution or in the patient's home so long as it is prescribed by the physician and preceded by three days hospitalization in acute care. Part B provides for limited home health care. Requiring skilled nursing care and being homebound are provisos for qualifying for home health services under Medicare. Neither parts A or B of Medicare provide for preventive care (Spitler, 1981). Because of the limitations and provisos, Spitler (1981) contends that Medicare/Medicaid as a national health program has failed to provide, as was hoped, community based long-term care thereby fostering the goal of the Older Americans Act--

to maintain aged people in an environment of choice and avoid institutionalization unless appropriate.

Like Medicare, Medicaid is an amendment to the Social Security Act and is Title 19 (Litman, 1984). The Medicaid program is jointly funded by the federal government and participating states and is provided to aged persons with low incomes (Spitler, 1981). Medicaid, according to Anderson (1984), assuaged national conscience regarding the poor, and eased the financial burden of states toward their aged poor. Medicaid benefits vary from state to state, but one uniform benefit is the provision of long-term care in the home or long-term care institution. Because home health services have tended to lag in development, most Medicaid users are in long-term supportive care environments (Spitler, 1981). This, Spitler claims fosters inappropriate use of the institutions for the aged.

Anderson (1984) claims that by the time of enactment of Medicare/Medicaid in 1965, the stage was set for a dramatic rise in health costs and use. The infrastructure of the health services enterprise, firmly entrenched, was fed by increasing demands for service and fuelled by unquestioning payment systems.

Medicare/Medicaid added an additional support to

the health enterprise by imposing no cost controls on the system. But in the late 1960's, there arose a general concern for the cost expenditure ratio. Consumer costs for services, supplies and advancing technology were spiraling as were hospital and physician expenditures. The general public was interested in keeping out of pocket costs down. Government, employers, insurance companies and prepayment agencies such as Kaiser Permanente were interested in low premiums to consumers and low reimbursements to health care providers (Anderson, 1984).

Long-Term Care

Medicare and Medicaid along with the increased availability of third party reimbursement have increased health care use among the poor, and encouraged the phenomenal growth of the nursing home industry (Greenberg, 1984). Long-term care refers to services required by people who have functional limitations as a result of or in conjunction with chronic diseases and conditions. This definition is particularly applicable to the aged whose chronic conditions remain severe despite advances in acute-care medical technology (Greenberg, 1984). Long-term care encompasses health services, social services personal care services. Long-term care transcends the acute-care concepts of hospital-home and illness-cure.

Acute hospitalization, home care, institutionalization and wellness despite functional impairment or chronic disease are the concepts of long-term care. Greenberg (1984) claims that the problems that plague long-term care parallel those of acute care: escalating costs, misuse of services, overuse of institutions, inability to articulate quality care, and underfinancing of home, ambulatory and preventative services.

Toward a New Health Enterprise

Since the late 1960's, government has attempted to curb escalating health costs and expenditures. Professional Standards Review Organizations (PSRO) mandated Medicare, rate review boards, Health Planning Act committees and Health Maintenance Organizations (HMO'S) are examples of these unsuccessful attempts. In 1976, Medicare and Medicaid were transferred from the Social Security Administration to a new agency, Health Care Financing Administration (HCFA) (Litman, 1984). Meanwhile, the health enterprise flourishes with government paying 40 percent of all health expenditures in an economy where per capita health expenditure has increased from $217 in 1965 to $1078 in 1980 (Anderson, 1984).

Anderson (1984 suggests that the equity of health

services issues has been replaced by issues of cost containment and government's share in paying health expenditures. In the name of cost containment and in an effort to decrease the federal budget deficit, the Reagan administration is reshaping the health enterprise. Block grants, reduced federal spending for health programs, transfer of programs to state levels, and promotion of competition in the spirit of choice for health dollars are the current strategies (Feingold & Greenberg, 1984). In June 1983, Congress and the President established a new Medicare hospital prospective payment system based on the use of diagnostic related groups (DRG's). In September 1984, HCFA began administering the plan for implementing the DRG based prospective payment system (Litman, 1984). This system is being phased in throughout the nation in all participating Medicare hospitals and is expected to be completed in Fall, 1986. Although long-term care institutions are exempt from the system at this time, as part of the total health enterprise, they are not exempt from experiencing the ramifications of the changes occurring in acute care.

Shifting ideologies surrounding and shaping the events of aging and health services in American society are reflected in the preceeding background. This chapter

continues with presentation of a framework for inquiry suggested by this background material.

A Framework for Inquiry

Conflict and Power

Throughout the previous discussion on background, the words conflict, diminishing resources, competition, struggles for control, and power suggest a theoretical and conceptual orientation, described in the sociologic and organizational literature as conflict and power.

The following assumptions underlie the concepts of conflict and power: (a) conflict is an inevitable and pervasive feature of social systems, and is a normal condition of social life, (b) conflict tends to be manifested in the bipolar opposition of interests, (c) change and conflict are inseparable, (d) conflict most frequently occurs over the distribution and use of scarce resources, (e) power is context or relationship specific, (f) power characterizes relationships among social beings, and (g) power has a relationship to decision-making (Duke, 1976; Pfeffer, 1981).

Pfeffer describes the relationships of these two concepts. There are three social conditions that produce conflict and that require the use of power to deal with the conflict, and that a significant aspect of power is

politics. Pfeffer proposes that use of power cum politics results in certain decisions whether they are legal, policy or personal. The three conditions that elicit this chain of events are: interdependence, heterogeneity of beliefs or goals, and scarcity. Pfeffer assumes that the "greater the scarcity as compared to demand, the greater the power and effort expended...". He argues that decisions regarding interdependence, heterogeneity and scarcity issues are the outcome when power is used to mediate the conflict(s) surrounding these issues. Power is the only way to resolve conflict issues and arrive at decisions because of the diverse values, beliefs and preferences held by conflict parties, and the scarcity of the resource(s) sought that precludes all parties having what they want (Pfeffer, 1981).

Current economic and political pressures make clear the conflict over existing and future resources. Local, state and federal levels of government are experiencing large deficits in all areas because of the overall recession resulting in declining tax revenues and heavy demands for spending. Since 1980 the federal government has made substantial reductions in expenditures for health and human services.

According to K. Davis (1981), the Reagan adminis-

tration's economic and health policies have resulted in major reductions in nearly all health and human service programs. All of these reductions are under the rubric of balanced budget. Underlying Reagan's health and economic policies is a strong ideological position of deregulation that shifts the burden of financial responsibility from federal to state and to local levels. Cuts in Medicare and implementation of the DRG prospective payment system foster competition among health care providers for consumers who can afford their services. What does this mean for the aged client who is already experiencing diminishing personal, social and economic resources? Will he/she have access to health service when required?

Actual and potential conflict situations in long-term care reflect interdependence as described by Pfeffer in that relationships among and between clients, their families and staff have elements of longevity, bonding, surrogate attachments and dominance/subordinance. Living arrangements, life styles and quality of life over long periods of institutionalization characterize interdependence as well. Heterogeneity abounds in long term care institutions as patients, families and staff from varying heritages and sociocultural backgrounds

interact daily. Scarcity of resources in long-term care are legendary with the three most pressing: money, personnel and service. As resources continue to diminish, decisions about allocation of resources become increasingly crucial.

Pfeffer explains the conditions under which power is used; French & Raven (1972) identify five sources of power: (a) reward, (b) coercive, (c) legitimate, (d) referent, and (e) expert. Reward power is the ability of one person or group to supply positive reinforcers while mitigating negative ones. Coercive power includes elements of reward power and is characterized by manipulation of the reinforcers to obtain the desired results. Legitimate power is the power of those who believe that the codes or standards exercised by an office will be The power of the presidency is regarded as legitimate power. Referent power is reflected in association or identity. Referent power is the outcome of being associated with, attracted to, or identified with someone who is prestigious, popular or influential. Expert power emanates from possession of knowledge, experience and educational and professional preparation (Bacharach & Lawler, 1980; French & Raven, 1972). These conceptualizations of conflict and power as described by

Bacharach & Lawler (1980), Duke (1976), French & Raven (1972), and Pfeffer (1981) are useful when examining organizational behavior. Equally useful in analyzing organizational behavior in health care institutions is a summary of organization theory.

Organization Theory

Scott (1978) states that organization theory is an outcome of logical progression in management thought. He elucidates his thesis by describing three theories of organization that have influenceed modern management thought and practice: classical doctrine, neoclassical theory of organization, and modern organization theory.

Classical doctrine held four key elements. They are division of labor, scalar and functional processes, structure, and span of control. Division of labor that is, specialization of tasks and responsibilities, is the cornerstone of classical doctrine. Scalar and functional processes refer to chain of command, delegation, responsibility and obligation. Structure is the relationship of functions arranged to accomplish the goals. Span of control relates to supervision-subordination and the numbers of subordinates a supervisor can effectively manage. Classical doctrine emphasizes the nature of organization, especially, its formal anatomy, but

neglects human relations (Scott, 1978). Health care organizations, like any business, retains aspects of classical doctrine and management practices but also incorporates modern management thought.

Neoclassical proponents, striving to compensate for the deficiency of human relations found in classical doctrine, focus almost exclusively on human behavior and its impact on the organization. Probably the most valuable contribution of the neoclassical theorists is the concept of informal organization in the work setting. The informal organization refers to natural groupings of people within the work situation who inhabit a common locality, who have the same occupation occupation and interests, or who have common problems, issues and solutions to problems. Informal organizations usually have an informal leader and have status although not necessarily visibility (Scott, 1978).

Modern organization theory, according to Scott, attempts to cover the shortcomings and incompleteness of both classical and neoclassical thought. Characteristics of modern organization theory are its conceptual-analytical foundations, its application of empirical research data, and its integrative nature. A meaningful way to examine modern organizations is to

use systems analysis that provides a means for viewing organizations as a totality of mutually dependent variables. Scott admonishes, however, that the use of a systems analysis technique does not equate modern organization theory with systems theory. Modern organization theory, he claims, is still in search of a framework and an integrated set of constructs and concepts to form a common conception of organization. Decision theory, information theory and cybernetics may contribute to this framework as well as systems theory (Scott, 1978).

Current writers in organizational development and behavior have embraced the concept of strategic planning, an essential characteristic and requirement in today's competitive marketplace (Peters & Waterman, 1982; Tichy, 1983). As the economy tightens and competition for dwindling resources heightens, big business is employing whatever power strategies it can to control its share of resources. Strategic planning, a current management power tool, is being used to "sell" products to consumers and to acquire scarce resources. Can health care organizations, big business of the health industry, afford to do less?

The Focus for Study

Long-term care, although not prominent until the 1960's, has existed since the advent of community health service in the 1900's. Community health serves the aged and disabled in their homes. Today's nursing home, a direct descendant of old age homes and poorhouses, serves the aged and disabled as a long-term care institution. Community health and nursing home services comprise the long-term care components of the health care industry. This research focuses on long-term care institutions, specifically skilled nursing facilities and their nurse administrators.

Since 1965 and the implementation of Medicare and Medicaid, long-term care institutions have mushroomed in size and number. With Medicare came unprecedented abuse of the health care system in general and long-term care institutions in particular. Physicians and insurance companies have ranked among the top abusers (Butler, 1975). Medicare also stimulated growth of long-term care institutions as money making ventures.

Implementation of Medicare occurred with such speed that inadequate time was devoted to planning a physical plant conducive to long-term patients or adequate working conditions for staff, preparing health professionals for

long-term clients, or educating the consumer about the benefits and risks of being a Medicare recipient. As a result, a typical long-term care institution looks every bit as hospital-like as an acute-care setting. Health professionals in long-term care have maintained an acute-care mentality and the consumer has become a target for and sometimes a victim of a rapidly growing industry. In the twenty years since the advent of Medicare, little has changed. Will the prospective payment system (DRG's) being implemented in acute-care also initiate changes in long-term care?

By the late 1960's, Senate Committee on Aging hearings brought to the public's attention that the quality of nursing home care provided to Medicaid recipients was poor. The term, nursing home, was coined after the passage of the Social Security Act in 1935 to reflect the boarding-home like arrangements for elderly and disabled persons cared for by retired or widowed nurses, or women who called themselves nurses. Often, nursing homes were operated by these women (Eliopoulos, 1983). Exposes on nursing homes or skilled nursing facilities reported the deplorable conditions that existed in many of them, and exacerbated many negative feelings that many people had concerning nursing homes.

Nursing home owners, interested in making a profit, hired many nurses who were considered to be unsafe, incompetent or undesirable in acute-care settings. These nurses were viewed by owners as the minimum personnel necessary to meet licensure requirements and obtain reimbursement and were usually "in charge." Profit motives caused many nursing homes to pay salaries to these nurses which were considerably less than acute-care salaries, and to hire mainly unlicensed, untrained staff to provide the actual care to patients. Good nurses, sensitive about their professional image or wishing to avoid noncompetitive salaries stayed away from nursing homes (Eliopoulos, 1983).

Medicare cutbacks are a current reality. However it is interesting to note that the cutbacks are not because of unacceptable levels of care being provided and the abuse of the system that has occurred. Rather, cutbacks are because the money is needed elsewhere.

Many surveys about long-term care patient populations have been conducted, usually instituted by the government for statistical or policy planning purposes. Also the Senate Special Committee on Aging has submitted reports of investigations into the problems of long-term care. Perhaps the most widely read and compelling book to date

has been Bruce C. Vladeck's (1980) Unloving care: The nursing home tragedy. Funded by a private foundation, the book is an exposé of the misdirection of public policy leading to mismanagement and abuses in nursing homes.

Appropriately or inappropriately placed, more than one and a quarter million Americans are served by long-term care institutions. One in ten of these elderly Americans is over 75 years of age (Vladeck, 1980). While nursing homes have moved from being primarily owned by independent, private owners to being primarily owned by corporations, the organizational and administrative structures have remained virtually unchanged and replicate, on a small scale, that of acute-care hospitals. Administrators in long-term care institutions are not required to have educational preparation at the college level, or to have any health care education or experience. As in acute care, nursing comprises the majority of staff, and in many instances comprises the only professional group present on a day-to-day basis. The number of Registered Nurse staff is required by the State and based on number of beds in the long-term care institution. The director of nursing must be a licensed nurse, and if the institution is over 99 beds, a registered

nurse must be on the premises twenty-four hours a day. Although the director of nursing is required to have professional licensure, he/she needs to have no further educational preparation or experience in either long-term care or in administration.

Recently the American Nurses Association (ANA) completed a study sponsored by the W.K. Kellogg Foundation. The ANA surveyed the needs of directors of nursing in long-term care institutions and found them lacking in management knowledge and skills. As a result of this study, an intensive educational program began in 1984.

The nurse administrator (director of nursing) in long-term care institutions is the area of study of this dissertation. The focus of investigation is the perceptions, issues and problems, surrounding management practices of nurse administrators in skilled nursing facilities.

Summary

This chapter has presented some background information on aging and health politics, a framework for inquiry, and has identified the focus of the study.

Chapter 3

This chapter describes field research as a methodological approach to the study of phenomena, in particular, the concern of this dissertation, the study of skilled nursing facilities, nurse administrators of these facilities, and issues and dilemmas these institutions and administrators perceive as challenges. The philosophical bases for field research will be presented followed by a discussion of the grounded theory, a particular approach to field research from a nursing research perspective.

Philosophical Base

Field research is concerned with understanding and explaining human social interaction its meaning and processes, at a conceptual level. The field researcher bases his inquiry on humanistic perspectives, rather than on mechanistic explanations and on pragmatism rather than on logical positivism (Kaplan, 1963; Schatzman & Strauss, 1973). Schatzman & Strauss (1973) suggest that the field researcher ascribes to four assumptions related to humanism: (a) man holds perspectives about himself and acts on these perspectives; (b) man holds many perspectives about himself, others, events and situations simultaneously; (c) man's perspectives

emanate from personal involvement in social situations and processes; and (d) man's perspectives impel him toward certain actions. Thus, the universe of selected objects of study comprised of their perspectives, definitions, experiences and social processes becomes the "field" of the field researcher. The field of inquiry is assumed to be complex in that reference points are not fixed but subject to changing perspectives, re-definitions, and redirected social processes. The challenge to the field researcher is to conceptualize the emergent reality of the field in a way that yields understanding of, or explanation for, what is being studied. To meet this challenge, the field researcher's approach should be that of a methodological pragmatist.

It is not the intent or the purpose of field research to generalize from the select world of study to a like group or setting. Nor it it the task of the field researcher to suggest a definitive explanation for what is occurring in the field.

The philosophical basis of semantic empiricism postulates that meaning (e.g., of behavior) is dependent on experience. Pragmatism holds that meaning is found in acts or action, including the act of language. Analysis of meaning, therefore, examines the context or situation

in which action is performed as well as the purpose of this action (Kaplan, 1963).

Interpretation or analysis of social processes that result in understanding of meanings inherent in action and explanation of action can only come from those who have immersed themselves in the phenomena they wish to interpret and understand (Denzin, 1983).

The field researcher uses any form of inquiry that elicits information about the object of interest and that facilitates the conceptualization of answers to such questions as, What is happening in this situation?, or What is the meaning of certain acts or actions? Direct observation, inquiry by questionnaire, interview, and diary are some of the methodologic tools of the field researcher. Though not bound by any technique the field researcher's method of inquiry generally evolves with the research process. Techniques of the field researcher however, must be characterized by: (a) adequate consistency with the research questions posed, (b) adequate adaptability to the objects of examination, and (c) adequate evidence or perspectives. Therefore, reshaping of the design is possible throughout the entire field research experience (Schatzman & Strauss, 1973)

Grounded Theory, a Form of Field Research

The basic question in any field research study is, What is it? Answers to this question can be found through survey, case study, historical research and others. A glossary of terms used in grounded theory is given in Appendix A.

Glaser & Strauss (1967) propose that grounded theory research provides relevant, meaningful interpretations, explanations and predictions about behavior that point the way to theory. More importantly, theory is discovered by the researcher through data that is systematically obtained and analyzed. Theory, when discovered in a systematic manner results in categories, postulates, and hypotheses that can: (a) be verified in present or future research, and (b) be used in quantitative studies when appropriate. Grounded theory research is expected to generate theory. Generating theory and the process of process of research are synonymous; that is, concepts and hypotheses not only come from the data, but are systematically processed in relation to the data during the entire course of research, namely, through comparative analysis (Glaser & Strauss, 1967).

The task of the field researcher using grounded theory is to develop theory that accounts for much of the relevant behavior found in the phenomena being studied.

In developing theory, the field researcher offers a running theoretical discourse on discovered conceptual categories and their properties found in the field. Two basic kinds of theory may be generated: substantive and formal. Both kinds of theory are considered to be "middle-range" in nature; formal theory is expressed at the conceptual level of generality and substantive theory is expressed at the empirical level of generality. Comparative analysis of data, either internal or external to the field, facilitates a progressive building of information through categories and their properties to concepts and through substantive theory to formal theory Glaser & Strauss, 1967).

Glaser & Strauss (1967) repeatedly stressed that the grounded theory form of theory building is not a linear process reaching fruition with formal theory. Comparing and linking data within the field generates categories that describe relationships within the phenomena being studied. In addition, comparing and linking field data with formally accepted concepts and theory further clarifies and verifies existing theory. Comparative analysis that results in identification of categories and their properties and that describes the phenomena being studied may be the culmination of a piece of field

research. At another point of comparative analysis, a category or categories may emerge with their properties from the data that were conceptualized to explain relationships within the phenomena being studied. The field researcher in this instance generates substantive theory. Comparative analysis may also lead to conceptualizing categories and their properties into a set of constructs, propositions and hypotheses thath describe, explain and predict interrelationships within and outside the field. and formal theory may result.

A Nursing Research Perspective

In a series of articles, Dickoff and James challenged nurses to consider four levels of theory building when attending to the professional task of theory development. These four levels were factor-isolating (naming), factor-relating (correlating), situation-relating (predicting), and situation-producing (prescribing) (Dickoff & James, 1975). In accordance with the four levels of theory development proposed by Dickoff & James, Donna Diers (1979) has applied these four levels to the nursing research process. In her work (1979) she refers to the factor-isolating level of theory building as factor-searching. This dissertation falls into the domain of factor-searching theory building.

Factor-searching research in nursing is descriptive, exploratory and formulative. Theory developed from factor-searching studies is characterized by conceptualization of data derived from a selected situation, event or phenomenon. The purpose of factor-searching studies is to understand the situation, event or object being studied in conceptual terms. Diers (1979) acknowledges Glaser & Strauss' grounded theory approach as a factor-searching form of theory building. In addition, Diers (1979) states that grounded theory intends to conceptualize as opposed to describe. Factor-searching studies, Diers states, are compatible with the tenets of field research (Schatzman & Strauss, 1973) and grounded theory (Glaser & Strauss, 1967).

The following research design and methodological components are derived from Diers' (1979) view of conducting a factor-searching study, and reflect application of field research and grounded theory approaches.

The Problem

Problems of factor-searching studies stated in the simplest terms can be expressed by the question, What is it?" (Diers, 1979; Glaser & Strauss, 1967; Schatzman & Strauss, 1973). The problem statement delimits an area,

a topic, a focus, or phenomena of study. The statement must be broad enough to allow for emerging themes, categories, and dimensions, but narrow enough to give direction for setting, sources of data, and data collection techniques

This dissertation reports a study of nurse administrators in long-term care institutions, referred to as skilled nursing facilities, and the nurse administrators' perceptions of the issues and dilemmas facing them in the workplace. Although clinical and environmental studies of residents of skilled nursing facilities are becoming more apparent in the literature, little is known how the nurse administrator manages resources in skilled nursing facilities. Yet responsibilities for providing quality care to patients and for exercising cost control are identical to nursing counterparts in acute-care hospitals. The question, then, was, Are expectations, resources, involvement in decision-making and management strategies identical as well?

Background/Conceptual Framework

In Chapter 2 the background/conceptual framework of this study was presented. Background information regarding changing beliefs, values and perspectives about aging, about health politics and about nursing

in long-term care was presented. A point of view regarding the usefulness of the concepts of conflict and power as a framework for inquiry was offered.

Diers (1979) states that the factor-searching component of the research process in nursing studies is not unlike that found in other levels of theory development studies. In factor-searching studies a perspective or point of view is offered rather than a theoretical framework. Diers (1979) cautions that for the sake of clarity of the problem under study, as many assumption, priciples and philosophies as possible, must be included.

Study Design

Factor-searching studies require as open an approach as possible to allow for immersion in the components of study. Understanding of the phenomena being studied is guided by the data emerging from the situation. The collected data generates the need to discover new or additional data. New data is compared with all collected data. Only the researcher knows when "saturation" is reached and conceptualization accomplished (Diers, 1979).

This study, then, uses field research, specifically, the form of field research that is a grounded theory approach. As data is generated, the interview guide, designed to elicit nurse administrator's perceptions

about their management responsibilities, is revised to accomodate new data as it emerges and until saturation is reached.

Setting

Diers (1979) states that the setting used in factor-searching research should be typical to avoid the risk of generating theory that is unique to a unique setting. A setting that is typical rather than atypical facilitates the development of categories and concepts that can be submitted to comparative analysis of data found in other settings. The setting, or field, of the researcher is comprised of all aspects relating to the phenomena being studied. In this study, the environment and social climate of skilled nursing facilities, as well as the perceptions of nurse administrators about their work and working conditions in these facilities is sought. Although several aspects of the setting in this study are unique, for example, the client, the staffing patterns and ratios, and the type and amount of service provided, there are commonalities of the workplace (skilled nursing facilities) for example, bureaucratic management styles, and nursing procedures that are typical of other types of health care settings.

Sample

The sample in factor-searching research is representative of the reality under study. A sample constitutes the participants in the events or situations or phenomena being studied. Unfettered by numbers or selection, the sample, as a primary requirement, should possess richness. Pieces of reality are chosen without concern for boundary or control (Diers, 1979).

In this study, reality represents the perceptions of nurse administrators in skilled nursing facilities. Nurse administrators, representing a cross-section of size of corporate and noncorporate, profit and nonprofit institutions, and one governmental agency were sought throughout five San Francisco bay area counties.

Instruments/Measurements

Since measurement is not a critical issue in factor-searching studies, standardized instruments are rarely used. However, there is concern for reliability of the sources of data and for the recorder of data. Diers (1979) suggests that the ultimate test of reliability in this sense is the richness of the data, the adequacy of instruments and analysis, and the completeness of conceptualization.

Two non-standardized instruments were used. An

open-ended interview guide designed by the researcher and pilot tested with three nurse administrator interviewees. Pilot testing was done to ensure that the length of time for the interview, the quality of the responses, and the interviewing skills of the interviewer-researcher were adequate. A survey data form was designed by the researcher in consultation with three experts in the field of long-term care administration. The purpose of this form was to: (a) supplement, verify, and therefore enrich interview data; (b) provide a profile of nurse administrators in relation to experience and education; and (c) provide provide environmental information as background of and context for the workplace of the nurse administrator in skilled nursing facilities.

One standardized instrument was used: the Moos Work Environment Scale (Moos, 1981). The instrument was chosen because of its sensitivity to assessing the extent to which employees are concerned about and committed to their jobs, as well as friendly to and supportive of each other. The Moos Scale also asseses the extent to which management is supportive of employees and encourages employees to be supportive of each other. As with the survey data form, the instrument was an adjunct to the interview in that the results obtained verified or refuted

interview data regarding work environment. These three data collection forms are found in the Appendixes B, C & D.

Data Collection Procedure

The most used techniques in factor-searching studies are participant and nonparticipant observation and interview. Chart audits, written reports and records are not used often. Field notes are the most common procedure, video and audio recording is also frequently used (Diers, 1979). Data collection, processing and analysis occur simultaneously. Contemplation, constant comparative analysis, and conceptualization are ongoing once data collection begins (Diers, 1979; Glaser & Strauss, 1967; Schatzman & Strauss, 1973).

Before data collection, access to each institution was obtained through administrative approval and agency research committee approval when required. Interviewees were initially contacted by phone to establish a date and time for the researcher to present the study and request participation. Records were kept of the nurse administrators who had been contacted, their response to the request for an appointment, and the schedules for appointments when confirmed. Of twenty-five possible respondents, twenty-one consented to and signed the

consent form to participate. Two nurse administrators, on telephone contact, refused to schedule an appointment; one because of time problems and one because she said that she already knew the results. A third nurse administrator made an appointment, but refused to participate after our meeting because she was "feeling overwhelmed," and a fourth scheduled an appointment, but was unable to meet or to participate because of illness. If saturation had not occurred with the remaining nurse administrators others would have been sought before data collection and analysis could have ended.

At the first scheduled interview with each nurse administrator, the purpose and procedures of the study were explained. Consent forms were signed and another appointment scheduled. The survey data form and Moos Work Environment Scale were left with each nurse administrator for completion before the next appointment. Field notes were written following each appointment that described the facility, its locality, who was observed, what was observed, and impressions about the respondent and the responses.

The second scheduled interview lasted approximately forty-five minutes and my interview questions and the

nurse administrator's responses were audio recorded, and the survey data form and Moos scale were collected. In several instances, the forms had not been completed and arrangements were made to mail them to the researcher as soon as possible. One respondent did not complete and return the forms despite two telephone reminders; another was no longer employed when I called two weeks later to remind her to complete the forms. Field notes were written regarding impressions of the nurse administrator during the interview. The researcher listened to the audio tapes the first time in the car after the interview; then the notes were written. Each interview tape was transcribed as soon as possible and analyzed. In every instance, code numbers were used on all forms and on the audio tapes to insure confidentiality of participants.

Data collection and analysis began in June and the last interview was held in early September, 1984.

Data Processing/Analysis

As previously stated, the researcher is immersed in the data and the "field" during data collection and analysis, a simultaneous process. In factor-searching studies, conceptualization is attained by noting themes, categories and concepts as well as the linkages among them. The field researcher engages in constant

comparative analysis (Diers, 1979). This process is described in Chapter Four of this study.

Interpretation

Interpretation, according to Diers (1979), is an integral part of data collection and analysis in a factor-searching study. Reporting, Diers claims, is the final stage in the factor-searching research process. The product of reporting is generated theory in the form of conceptualization of the phenomena being studied, or formal hypotheses which may stimulate further theory building at a different level.

In addition, conceptualization of one dimension of of a pheomenon being studied may lead to generation of substantive theory. This study, using the constant comparative analysis technique of grounded theory building, generated substantive theory. Constant comparative analysis also suggested that some categories derived were typical of categories and their properties found in other settings. Concepts and theory related to conflict and power were verified by the data and the categories generated in this study.

Summary

In this chapter, the philosophical basis for field research, and the grounded theory approach as a framework

for generating theory, were discussed. A compatible nursing research framework, including the methodology of this research were described.

Chapter 4

Research Findings by Grounded Theory

Descriptive Background

The participating skilled nursing facilities represented government, proprietary and voluntary agency run institutions located in a large metropolitan area of northern California.

By and large the organizational structure of these facilities was perceived by nurse administrators to be centralized with a non-nurse administrator in the top management position. Reasons given for the preponderance of a centralized , rather than a decentralized organizational structure in skilled nursing facilities were: (a) the region or corporation maintains management responsibility, (b) most skilled nursing facilities are too small for decentralization, and (c) most non-nurse administrators are unwilling to share management responsibility with nurse administrators.

Decision-making, often viewed by nurse administrators as a primary element in organizational process, centered on patient care services and administration of these services, rather than on budget, finance, or resource allocation and utilization. The data suggested that nurse administrators lacked information

and input into the financial operation of their skilled nursing facility.

Because decision-making for most of the informants centered on patient care activities, it was important to understand the nature of nursing care delivery. Size of a facility and State regulations for licensure dictate the presence of the total number of licensed and nonlicensed staff as well as the distribution of staff on days, evenings and nights.

According to State regulations, a skilled nursing facility of 99 beds or fewer need not have a registered nurse on the premises at night or in the evening. Consistent with these regulations, the data indicated that the greatest number of each type of nursing personnel were on days, fewer were on evenings and the least number were on nights. Reduced numbers of personnel at night is a usual staffing pattern for most health care facilities. Absence of licensed nursing personnel, specifically registered nurses, is atypical in acute-care settings, in skilled nursing facilities the absence of these personnel is typical.

State regulations do not dictate how care is to be organized and delivered but require that exact documentation on care delivery be provided. For this

reason, care plans, required by the State to maintain skilled nursing facility licensure, were maintained in each facility. Many nurse administrators suggested that record keeping is an onerous task for all staff, and that, for them, organizing and delivering care in a manner that meets the demands of everyone concerned is an onerous management responsibility.

Most of the nurse administrators reported that they accepted full responsibility for nursing personnel to meet the established requirements for record keeping and, in addition, took on the responsibility for overseeing the record keeping activities of other departments and services offered by the facility. When asked whose responsibility it was if noncompliance or deficiencies were determined to be present in the facility, several nurse administrators replied, "they are all my responsibility."

Description of the demand for accurate and current record keeping in skilled nursing facilities is consistent with the demands in acute-care hospitals. Unique to skilled nursing facilities was the ratio of licensed staff to unlicensed staff to meet the demands of record keeping.

No description of skilled nursing facilities and

nurse administrators would be complete without reference to patients, the recipients of care. The age of patients in the facilities in this study ranged from 68 to 89 years with an average age of 81 years. Many patients were the victims of a cerebral vascular accident, or suffered from senile dementia, arteriosclerotic heart disease, organic brain syndrome, hip fracture, diabetes and other conditions. Many patients were also affected by the primary mental health problem of old age, cognitive impairment. Failure in cognitive functioning is one of the principal reasons for an aged person to be in a skilled nursing facility (Special Committee on Aging Report, 1984). Many nurse administrators stated that the conditions of these patients, both physical and mental, contributed to inordinate workloads and negative working conditions.

The majority of patients in skilled nursing facilities require assistance with many activities of daily living: bathing, toileting, dressing, transferring, eating and ambulation. The degree of physical and cognitive limitation found in these patients was related to the focus of management responsibility perceived by the informants. Adequate staffing numbers, efficient care delivery methods, and record keeping were

some of the management realities perceived by these nurse administrators.

A brief profile of the educational and work experience of these nurse administrators helps us to understand their background as well as their management actions in and perceptions of their workplace. The majority were diploma prepared registered nurses who had been in nursing for 20 years, had held a supervisory position, had been in long-term care approsimately ten years, and had worked in the present facility six years. As content analysis unfolded, these data seem to take meaning, particularly as they relate to the influence of nurse administrators on the management climate of skilled nursing facilities.

This descriptive information provided background and context for the analysis and discussion of grounded theory findings. Additional quantitative data can be found in Appendix E.

Content Analysis

Power Relationships

Interactions among staff and between staff and those in positions of authority constituted themes of climate, working conditions and working relationships pertinent to the management responsibilities of nurse administrators.

Perception of who was in charge and over what domain comprised the category, power relationships. The above themes and those of top-down decision making, feelings of helplessness in obtaining resources, and a paternalistic working relationship with the non-nurse administrator were evidenced by the following series of quotes:

> ... (administration) set up the budget for us...it's what we think we need, what they say we can have and what we get...if they (the corporation) see that we have a heavier load (of patients) they will no doubt increase the numbers of staff...when the administrator hired me he said, `what's your weak spot?' I said..., you tell me what I have to do and I'll do my best to do it...

Lack of input into the budget process and lack of control over acquisition of resources was evidenced in the data and supported the possibility that the management climate in these skilled nursing facilities deterred nurse administrators from being managers of human and material resources.

Data also suggested that a maternalistic working

relationship existed between nurse administrators and staff, "...I went out and bought the vinegar because I wanted them (the staff) to use it to scrub mattresses with. It (vinegar) takes away the smell of urine..."

Management power was passed either overtly or covertly from the non-nurse administrator to the nurse administrator.

> ...(the administrator) considers me second in command when he isn't in the building...I know it's not in my job description...but I feel I'm responsible (for other departments)... pharmacy, infection control, medical records are all my responsibility (including nursing)...

These quotes indicate the willingness of nurse administrators to take on management responsibility beyond the scope of their designated position. Overall, the perceived climate and management responsibilities connected with power relationships were reported as primarily positive with statements regarding non-nurse administrator support expressed by the majority of the nurse administrators.

Consistent with the assumptions about power referred

to in Chapter Two that is: (a) power characterizes relationships among social beings, (b) power is context or relationship specific, and (c) power has a relationship to decision making (Duke, 1976; Pfeffer, 1981), the data indicate that power relationships, although perceived as friendly and supportive, were intense. Theory X assumptions regarding the worker and his need for direction, his lack of initiative and inherent dislike of work (McGregor, 1960) undergirded the classical approach to management taken by these nurse administrators. Characterized by a top-to-bottom decision-making organizational structure and paternalistic-maternalistic organizational process, power sources for these nurse administrators were legitimate, referent and expert (French & Raven, 1958).

They had legitimate power by virtue of their position, referent power by virtue of association with the administrator and their own willingness to be formally or informally designated as "in charge"; and expert power by virtue of experience and professional background, that drives the day-to-day work of these nurse administrators.

The power relationships gleaned were not unlike those found in many health care settings and in industry. Unique to skilled nursing facilities was lack of a clear

articulation of the management responsibilities and expectations of nurse administrators vis-á-vis the non-nurse administrator.

> ...I don't feel I'm in charge of (other) departments (but) they usually come to me with a problem...I have to communicate with the heads of other departments in order to coordinate any problems between them...I know it's not in my job description, but I'm made to feel that I'm kind of responsible for other people (staff) here...

These remarks indicate that nurse administrators were influential in shaping climate, and often contructed the reality of working conditions by their own management attitudes and practices. It was apparent from analysis of all the interviews that interpersonal relationship skills and dynamics were not emphasized, nor was the informal organization recognized or valued by the nurse administrators; both were further evidence of their use of a classical approach to management.

As issues of environment and management responsibilities, demands, and rewards were explored during

interviews, the concept of management dissonance emerged.

Management Dissonance

Analysis of interview data suggested that the nurse administrators experienced a cognitive gap regarding task orientation; that is, good planning and efficiency according to Moos (1981). The nurse administrators reported an attendance to organizing and implementing care delivery methods that met the management demands and responsibilities of the past. There was no evidence in the interview data to suggest an attendance to good planning and efficiency for meeting the demands and responsibilities of a changing health care system. Yet these same data suggested that the climate in long-term care is changing, "the types of patients that we're going to see are not the same type of patients that we've had before."

This cognitive gap in task orientation was evidenced in the interview data when exploring with nurse administrators the changes they perceived to be occurring in the health care system. The majority of these nurse administrators were aware of the prospective payment system currently operating in acute care; most were aware of changing, or impending change in, environment in long-term care because of the difference in patient

acuity.

> ...there's a lot more (patients) with tubes, with IV's...on ventilators, needing blood transfusions, on hyper-alimentation...(patients with) surgical incisions, needing dressing changes, COPD patients not yet stabilized and fresh colostomies...

Most of the nurse administrators viewed these changes in acuity as positive ones because registered nurses, they said, will be more attracted to a more acute-like care setting rather than the traditional long-term care, their skills will be better utilized, and they will experience more job satisfaction. But these nurse administrators were not clear about the ramifications for their institutions of increased patient acuity for staffing numbers, ratios and patterns.

Staffing numbers were seen by some as being inevitably increased with increased acuity, but nurse administrators did not see an inevitable increase in budget to meet the acuity demand. Although the data indicated a strong ability on the part of most of the nurse administrators to articulate the problems and concerns associated with a changing environment in long-

term care, there was little evidence to suggest that they used a conscious, informed decision-making approach toward planning viable management solutions. Rather, the data suggested an approach of wait and see what the company or the administrator will decide, then we'll know what to do.

One nurse administrator expressed her feelings of restriction to do as she felt the nursing department was capable of doing. "I do not have ultimate control...I'm ready to move and should administration give the go, I'm really ready to put a more definitive acuity system in place, to generate data on lengths of stay, break that down by level of care provider. I'm willing to change the way we do things and have more case management, whatever is required." In direct conflict with these statements were perceptions of nurse administrators of experiencing a high degree of autonomy and innovation in their workplace. Recurrent themes of helplessness, workload demands, and lack of input into the financial operation of the organization contributed to the emergent descriptive category, management dissonance.

The theme of helplessness was further expressed by these nurse administrators when management practices and responsibilities regarding staff availability, recruitment,

absenteeism, turnover and unionism were discussed in interviews. As stated above, involvement with the budget was practically nonexistent. Helplessness and powerlessness were expressed in terms of feelings of professional and job insecurity, in contrast to the mainly positive comments regarding their perceived support from staff, especially licensed staff, administrators, consultants and facility owners.

Despite the sense of helplessness and powerlessness, there was a confirmation by most nurse administrators that this portrayal of management expectations and responsibilities of the nurse administrator in long-term care is the norm, and that it is "ok" so long as they get what they want and need. In other health care settings, this is not the norm for nurse administrators today, nor do nurse administrators experience the sense of powerlessness in determining staffing needs or resource acquisition and allocation on the day-to-day operational level. Moreover, modern hospital management practices involve nurse administrators in budget issues to a greater or lesser extent of control depending on the complexity of the organizational structure. The management tasks and responsibilities undertaken by nurse administrators in long-term care are not unique but the context in which they are enacted is different from their

counterparts in acute-care settings.

A cognitive gap regarding task orientation was experienced by these nurse administrators. This cognitive gap was addressed as management dissonance (the second descriptive category). The third descriptive category was competing agenda.

Competing Agenda

There exist conflicting definitions and competing goals relative to quality care provision. The nurse administrator was faced with juggling competing demands for quality care by the state, families, patients, the administrator, facility owners, the profession and themselves.

Although quality care and cost containment is the mandate of all nurse administrators, in long-term care, quality care was perceived differently, the most imposing perception was the State licensure set of standards. In general, nurse administrators expressed concern that there is little relevance between the State demands for documentation that is, State survey standards, and the real or actual quality of care provided daily in their facilities.

> ...(quality care) not limited to
> medical or physical problems, it

> includes psychosocial, it includes just about everything that would be dealing with human beings and human behavior and their needs...emphasis is on patient rights and their maximal use of whatever they have physically or emotionally...

Several nurse administrators described quality care in this conceptual way and as it ideally existed or was becoming in their facilities. It was not clear from the data whether or not the ideal was an actuality, but it was implicit that they were striving for the ideal to become a reality. The major concepts referred to by this group were holism and total patient care needs. These concepts were couched in the larger personal and professional views of man, health and nursing held by each of these nurse administrators. Philosophy of of nursing, of life, and of people were intertwined with their beliefs about quality care, quality of life, and nursing in long-term care facilities.

Other nurse administrators addressed the question of quality care in more concrete terms.

> ...every day everybody will have good oral hygiene...clean clothes,

> good skin care...well groomed...when patients smell good...

Personal appearance, absence of odor and decubiti, and the happiness or comfort level of the patient characterized the comments about quality care offered by some nurse administrators. Unlike comments by other colleagues, these data were explicit in that their beliefs about quality care were concrete and observable and were enforced by nurse administrators.

Many perceptions of what constitutes quality care, and the demand for observable evidence of the quality defined, bears on the day-to-day work of the nurse administrator in skilled nursing facilities. Patients, their families, the community, and the media are critics of care in any health care institution; skilled nursing facilities have a short (30 years) but painful history of misuse and abuse (Vladeck, 1980).

Among often conflicting definitions and competing goals relative to quality care provision, the nurse administrator endeavored to balance demands for quality care. While their counterparts in acute-care hospitals are accountable for quality nursing care overall, the nurse administrator in long-term care was accountable for quality patient care and was involved in the

maintaining of quality expectations in a constant, intimate manner.

Power relationships, management dissonance, and competing agenda comprised the categories of the descriptive dimension of grounded theory in this study. From a descriptive and contextual basis, the inductive process yielded the analytic dimension consisting of a dual concept.

Analytic Dimension

Categories and their properties may emerge from the data that identify one or more aspects of "what is it?" within the phenomena of study (Glaser & Strauss, 1967). Discussion of the findings continues with a dual category, clinical power-administrative powerlessness. The category, clinical power-administrative powerlessness emerged from and grew out of the descriptive dimension categories of power relationships, management dissonance and competing agenda. The category was conceptualized by the researcher as a phenomenon that is unique to the field that is, the world of nurse administrators in skilled nursing facilities.

Administrative powerlessness derived from the data was associated with organizational processes specifically planning, decision-making, and budget. Analysis of the

data gave evidence of clinical power:

> ...we don't take patients that are on IV's or NG tubes and things like that ...I am responsible first (for) the care to the patients...my first concern is for the patient...I am out on the floor most of the day...I do a lot of the directing of patient care... if there's a complaint (about patient care) right here...I screen the patients so that I do not take anyone if we cannot meet their needs...I define the information we get from discharge planners, can we effectively care for this patient...

These quotes, extracted from interview data, verified the value and significance nurse administrators placed on the clinical component of their jobs. Several of these nurse administrators were purposefully clinical role models for their staff which is unique to long-term care. Seldom, if ever, is a nurse administrator in acute-care hospitals seen doing patient care, admission or discharge planning, or involved in any aspect of direct care giving activities.

But the interpretation of the interview data did not support that the nurse administrators perceived themselves

as possessing clinical power, only that their duties and responsibilities lie significantly in the clinical arena. This is consistent with the emphasis these nurse administrators placed on quality care provision. They will not accept patients whom they believe they cannot care for properly given the number of staff and the existing conditions of other patients.

Emphasis on care plans, on assessment, on clinical competence and judgment on the part of licensed staff and on the need for consistent, adequate staff was evident in interview data. These statements were made straight forward with a no-nonsense conviction that this was the essence of their job as nurse administrator in a skilled nursing facility. The fact that they had and exercised clinical power by their chosen methods for interpreting and deliverying care was not articulated, or even alluded to, in the interviews.

Clinical power, although not openly expressed and perhaps not recognized by the participants may be explained in part, by the reported perception of experiencing a high degree of autonomy. The clinical power exhibited by nurse administrators is offset by administrative powerlessness. Although these nurse administrators regulated quality care provision through control over admission of patients to

their facilities, and through their attendance to the development and maintenance of sound clinical judgment on the part of licensed staff (clinical power), they exhibited no control over the acquisition of resources (administrative powerlessness).

Clinical power-administrative powerlessness was the category within the analytic dimension deemed significant and unique to the phenomena being studied, nurse administrators and skilled nursing facilities. Further analysis of the data indicated the final dimension of grounded theory building, that of substantive theory. This level of theoretical formulation emerged from the conceptualizations of the descriptive and analytic dimensions. In addition, it provided an overriding conceptualization in the form of theory.

Substantive Theory

Substantive theory comes from the empirical data and is conceptualized to explain relationships within the phenomena of study. The concept identified with substantive theory is an overriding one which explains the relationships among themes, categories and other concepts discovered in the field (Glasser & Strauss, 1967).

The themes associated with power relationships, management dissonance and competing agenda led to the

conceptualization of the concept, clinical power-administrative powerlessness. This concept is dichotomous in that it depicts nurse administrators' control over patients and their care, and at the same time their lack of control over the acquisition of resources that they perceived as being needed to provide the kind of care expected and demanded by patients, families, peers, and colleagues. Recurrent themes emerged from interview data. These themes were expectations of quality care, strenuous working conditions, patient workload demands, and unfavorable public opinion toward skilled nursing facilities. The recurrent themes and concepts delineated thus far culminated in the conceptualization of an umbrella concept, Image making.

Image making is a term that is operationally defined in this dissertation as consciously and conscientiously moving negative attitudes and image toward positive attitudes and image regarding skilled nursing facilities. Image making, strongly supported by interview data, forms the conceptualization underlying substantive theory. Concepts and themes linked to the descriptive and analytic dimensions, but superceeding them pervaded the data that suggested image making.

The themes are historical in that the roots of long-

term care institutions as we know them today are the poorhouses of yesterday. People who went to poorhouses in the early 1900's were the sick, old, destitute and deprived. The majority of those in todays nursing homes can be described in the same way (Shield & Kick, 1982). Most are mentally or physically unable to maintain themselves at home and are without immediate family or resources to care for them outside an institution. Most are women and over seventy years old, and most are financially dependent on social security, and therefore must rely on Medicaid assistance. This profile of dependence flies in the face of the American image of an adult that is, a productive, independent and self-reliant individual.

A stigma of dependency and therefore undesirability clings to the patient in long term care institutions. This stigma is transposed by virtue of association to those caring for these patients. Over the years, as unfavorable situations in long-term care institutions have been exposed and condemned (Achenbaum, 1983; Hendricks & Hendricks, 1981; Vladeck, 1980), the stigma was intensified for all associated with long-term care. The following quotations reflected some of this historical negative image.

> ...it's depressing...there's a problem of staff burnout...it's just a very hard, difficult environment to work in...families complaining; they have guilt, and they're putting all their quilt onto you...physicians who really don't want to come in and see these patients ...(there is) a stigma that care is poor and that residents are...treated poorly, neglected, ok, not only neglected, but hurt physically by the staff...

In nursing, long-term care has traditionally been seen as lacking in glamour, drama and worth. Salaries and working conditions are usually second rate and rewards are seen as minimal. The value nursing places on a nurse administrator in long-term care institutions has historically been subordinate to the counterpart in acute-care hospitals or community health. Perhaps in no other field of nursing has the paradox of social stigma and professional image coexisted. In psychiatric nursing and correctional nursing, the professional image of nursing has not been tarnished despite the stigma

associated with mental illness and criminal behavior, but not so with nursing in skilled nursing facilities. Here are further comments by nurse administrators:

> ...years ago...heard a lot how bad care was in a nursing home and how nurses or medical profession looked down on the nurses or on the staff that worked in long term care...many of the older generation call it (skilled nursing facilities) the "poorhouse" or the "old age home"...the climate is gradually changing...any nurse who works in a nursing home well, `she's over the hill' and `she doesn't know anything' or `she can't race up and down' so she goes to a nursing home...they (the public) think we keep everybody tied in bed and wet...there is a lot of feeling that this is the end and there isn't any more...put here to die...

Concerning the image of long-term care today, most of the nurse administrators acknowledged that a negative image by the public and within the nursing profession exists, and that historically, and to an extent currently,

is deserved. They criticized the media for perpetuating a negative image of long term care institutions to the public. They related the continued negative image among nurses to low salaries, type of patient care, workload demands, and working conditions in long-term care. Nurse administrators in their discussion about the image of long-term care today and their facilities, expressed awareness for and optimism about positive changes in attitude:

> ...it's going to take time to change society's attitudes...the media has a lot to do with negative stereotyping...I feel very positive, more people are getting interested, more nurses are actually getting interested...the public is beginning to realize that we aren't really such bad guys or not always, if you will, dens of iniquity...

The nurse administrators agreed that major strategies for combating negative public image are to openly display their facilities, to willingly and honestly answer questions about care and service and to advertise their strengths through word of mouth by ensuring that users

of their facilities are satisfied. These nurse administrators saw themselves as the messengers to the public of a changing image. Although they suggested ways for informing the public and therefore changing public image, they offered no ideas or strategies for changing the image of long-term care among nurses. Rather, the data imply that change for the better in this area must come from outside the long-term care industry that is, from public demand, from professional associations, and even from union negotiations for comparable salaries and benefits.

The image of skilled nursing facilities bears a stigma imposed by perceptions of the condition of those who have required their services in the past. Currently stigma arises from poor quality of service amd poor management practices. These nurse administrators believed that attitudes and image can change, that self-esteem can be raised and stigma removed. Interview data indicated their wish to take an active role in fostering a positive image. Image making is the conceptualization for accomplishing the self-appointed task of these nurse administrators.

Corroboration: the Moos Work Environment Scale

The purpose of the Work Environment Scale (WES)

(Moos, 1981), was to supplement the perceptions of nurse administrators regarding their work environment. Descriptive information was derived from the scores obtained of nurse administrators to verify or refute their perceptions during the interview.

Subscales of involvement, peer cohesion, supervisor support, autonomy, task orientation, work pressure, clarity, control, innovation and physical comfort focus on measurement of perceptions of the work environment (Moos, 1981). Data from the WES indicated that these nurse administrators perceived their work environment to be one in which: (a) relationships are friendly and supportive (peer cohesion and supervisor support), (b) employees are concerned about and committed to their work (involvement), (c) personal growth is fostered through encouragement to be self-sufficient (autonomy), (d) the organizational emphasis is on good planning, efficiency and getting the job done (task orientation), (e) time and work pressures dominate (work pressure), (f) system maintenance and change of perspectives promote the need for communication of explicit rules and policies (clarity), (g) control of the employee is ensured (control), (h) the emphasis is on variety and new approaches to work (innovation), and (i) there is an attendance to physical surroundings in order

to inspire a pleasant work environment (physical comfort). environment (physical comfort).

Perceptions of the work environment relative to supervisor support and clarity were consistent and supportive of interview data themes; that is, theory X management, staff support, and satisfying and satisfactory working relationships. Supervisor support concerns the extent to which management is supportive of employees and encourages them to be supportive of one another (Moos, 1981). Clarity refers to the extent to which employees know what to expect in their daily routine and how explicitly rules and policies are communicated (Moos, 1981).

Perceptions of the extent of autonomy, self sufficiency, decision-making and innovation nurse administrators were allowed to express in the workplace were inconsistent with interview data. This was evidenced in the data by their stated lack of input into financial, administrative and organizational processes. Additionally, the themes of job insecurity, vacillation of feelings regarding being in charge, helplessness, and a sense of being isolated peppered the data and contributed to the conceptual

formulation of the categories power relationships, management dissonance and clinical power-administrative powerlessness.

Perceptions of the work environment concerning task orientation to job performance, work pressures and the need for control over employees in the WES responses substantiated the informants interview data. Task orientation, the degree of emphasis on good planning, efficiency and getting the job done (Moos, 1981) was reflected in the willingness of these informants to: (a) take on management responsibility in lieu of the non-nurse administrator, and (b) monitor the compliance of all staff to State regulations. Work pressure, the degree to which the press of work and time urgency dominate the job milieu (Moos, 1981) was evidenced by recurrent themes of record keeping requirements, patient care demands, and unsatisfactory staffing conditions. Control, the extent to which management uses rules and pressures to keep employees under control (Moos, 1981) was suggested in interview data regarding workload allocation and types of nursing personnel managed by nurse administrators.

Overall, the nurse administrators consistently reported a positive work environment on both the WES

and in the interview. However, categories that evolved from the interview data on content analysis suggested that a less positive environment was present. The categories of power relationships, management dissonance clinical power-administrative powerlessness were not supported by informants' reports of perceived encouragement for expression of autonomy and innovation. Additional information regarding the WES (Moos, 1981) can be found in Appendix F.

This chapter has presented grounded theory findings. Content analysis and presentation of findings included the following: (a) a descriptive background and context of skilled nursing facilities and nurse administrators, (b) delineation of a conceptualization of the data along three dimensions of grounded theory building, descriptive, analytic and substantive theory and, (c) presentation of quantitative data that served to verify or refute interview data.

Chapter 5

Conclusions and Implications

The purpose of this dissertation was to explore and describe the characteristics of skilled nursing facilities and nurse administrators in these facilities. The focus of the study was on the perceived management responsibilities of nurse administrators in skilled nursing facilities. A field research design using Glaser & Strauss's (1967) grounded theory approach with constant comparative analysis provided the methodology for the study. Content analysis and presentation of findings focused on the perceived management responsibilities of nurse administrators in skilled nursing facilities as well as on the social and economic climate and context of their workplace.

The data were obtained from interviews. A survey data form and the Work Environment Scale (Moos, 1981) were used to control the interview findings. The technique of constant comparative analysis was used to lead to conclusions regarding the study questions: (a) What are the perceptions of nurse administrators regarding the current social and economic climate in in skilled nursing facilities, their management

responsibilities , and their work conditions? (b) What are the demands, expectations, issues and problems inherent in skilled nursing facilities that shape the work of the nurse administrator? and (c) What is it that nurse administrators in skilled nursing facilities do to manage their environment and resources--to deliver quality care to an ever increasing percentage of patients over 75 years of age--and at the same time demonstrate cost constraint?

Conclusions

Analysis of the data suggested that the current social and economic climate in skilled nursing facilities is a negative one. A negative image of patients, services and care providers, as well as a negative attitude toward patients and care providers in skilled nursing facilities was clearly evidenced. This negative climate or "stigma," the nurse administrator perceived as the historical and contemporary misuse and abuse associated with skilled nursing facilities and their predecessors, old age homes and poorhouses. The work of nurse administrators to combat this stigma was conceptualized as image making. Image making was defined as consciously and conscientiously moving negative attitudes and image toward positive attitudes and image regarding skilled nursing

facilities.

The magnitude of the task of image making that these nurse administrators have assigned themselves was evidenced by their responses about perceptions of their management responsibilities and the conditions in which they work. Demands for, and expectations of, quality care, often contradictory and always varied, were present in facilities where the resources, especially manpower resources to meet demands and expectations were inadequate in number, type and competencies. The task of image making was further complicated by a general lack of involvement of nurse administrators in the financial operations of the skilled nursing facility. Nurse administrators were expected to take full administrative responsibility for quality care provision but were excluded from the budgetary process that governed their daily work. Their positions and responsibilities combined administrative powerlessness with clinical power. The majority of the nurse administrators demontrated a willingness to assume responsibility without involvement or control over cost, and viewed the situation as acceptable.

The data suggested that image making for the time is encumbered by the current changes in the health care

system; especially by the prospective payment system of financing now being implemented in acute-care settings. The generally earlier discharge of patients from acute-care hospitals, and the increased acuity of patients being admitted to skilled nursing facilities, influenced nurse administrators' management responsibilities. They perceived their management responsibilities of providing quality care to be intensified and their administrative powerlessness to be increased.

The awareness of the power relationships exhibited to nursing staff by superiors and by staff to patients and families may have influenced the image of long-term care institutions held by the public. There were indications that the degree of powerlessness furthered the classical approach to management that espouses a clear cut division of labor and function, a chain of command and a designated span of control of supervisors over subordinates. Patients, and sometimes families, were at the bottom of the chain of command and were the recipients of workload allocation systems designed by the managers. The nurse administrators' efforts toward image making would seem to be impeded by the use of a classical approach to management, especially as our society is moving toward a modern management mode.

The management dissonance concept that emerged from conceptualization of the data may further complicate the task of image making for these nurse administrators. The interview data suggested that nurse administrators recognized that the social and economic climate in long-term care is changing that is, acute care is discharging patients earlier to meet the demands of the prospective payment system, the public is more knowledgeable about the health care system, patient acuity at the time of admission to skilled nursing facilities is steadily increasing, and existing competency of licensed staff in skilled nursing facilities is not adequate to the care requirements of patients currently seeking admission. However, recognition of these changes in the climate may not be enough to move the negative attitudes held by the public about skilled nursing facilities toward more positive ones. To facilitate image making, nurse administrators may have to take action by ensuring that the numbers and competencies of nursing staff are adequate to meet the care requirements of patients now being discharged earlier from acute-care hospitals.

The concept of competing agenda also emerged as a conceptualization from interview data. State licensure standards, patient and family expectations, and professional demands for the provision of a high level of

care coupled with cost constraint in skilled nursing facilities promoted an array of conflicting views about what constitutes quality care. The realities of long-term care included a payment system that promotes misuse of services, a change in climate that reflects the prospective payment system used in acute care, and a budget and staffing pattern that emphasizes profit making rather than cost:benefit activities. These realities would seem to militate against a concensus on a definition of quality care. Nurse administrators may have the opportunity to take a leadership role in clarifying and establishing an agreed upon view of what constitutes quality care in skilled nursing facilities. From this consensus could begin the work of image making by bringing cost as well as care and service provision into a positive perspective.

As administrative powerlessness seemed to inhibit image making, clinical power seemed to enhance nurse administrators' potential for successful image making. Clinical power was described by nurse administrators as control over patient admissions and delivery of care. The nurse administrator exerted clinical power by screening patient admissions and streamlining the workload of the staff. Patients were not admitted whose condition would overtax the staff and their ability to provide quality care. Organizationally

efficient care delivery methods such as functional and team nursing approaches were predominantly used in these skilled nursing facilities. Interestingly, the data indicated that nurse administrators wield, but do not acknowledge, clinical power. Acknowledgement of this power, at least to themselves, could augment their task of image making. To some extent their clinical power offset the helplessness and powerlessness associated with acquisition of resources. Clinical power, probably the greatest strength of these nurse administrators, may be the key to successful image making.

Significance of Findings

The significance of the findings of this study lies in its research base. The concepts of power relationships, management dissonance, competing agenda, and clinical power-administrative powerlessness describe the challenges and working conditions of the nurse administrator in skilled nursing facilities. Although these concepts do not provide a startling revelation or insight to the initiated, they attain visibility and credibility from the research base.

The substantive theory that emerged as the main finding that is, the nurse administrators' capability of image making, may surprise the nursing and long-term care

communities. The contribution of this finding is twofold: (a) it increases our understanding of the concerns and issues in skilled nursing facilities faced by nurse administrators, and (b) it adds to the body of research literature relative to skilled nursing facilities and nurse administrators.

Imagemaking: Discussion of Implications

Image making is defined in this dissertation as consciously and conscientiously moving negative attitudes and images toward positive ones. Successful image making has implications for society, nursing, and the health care system.

Society

Chapter Two traced the heritage of gerontology, of political action for the aged, and of skilled nursing facilities in our society since the early 1900's. A general theme of this review was that over the past 70 years the image of the aged person was gradually diminished in value, that a stigma became attached to being old, needy, and institutionalized, and that this stigma was extended to those who cared for the aged.

The strategies developed by nurse administrators could, over time and with persistence, change the negative attitudes and image about the aged in general and skilled

nursing facilities in particular that are currently held by society. These strategies should begin with honest and open communication about services and the current environment in skilled nursing facilities. Such communication would result in more accurate knowledge and impressions about these facilities. Positive experiences rather than negative ones would be passed on by word of mouth to others who may or may not be using skilled nursing facility services.

Parallel to the strategy of communication is the strategy of documentation. Nurse administrators, the monitors of quality care, are in a unique position to arrange staffing ratios and patterns, as well as implement care delivery methods that enhance the environment of skilled nursing facilities. Documenting these successes and failures for nurse colleagues and non-nurse administrators will make their efforts and intentions visible.

Finally, policy makers and politicians respond to the public. When nurse administrators who are in pivotal positions in skilled nursing facilities perceive their work and themselves as worthwhile and deserving, patients, their families, and health care colleagues will perceive themselves in the same manner. We as the public,

individually and collectively, can influence policy making in our society. Image making, on the part of nurse administrators in skilled nursing facilities may be instrumental in ultimately influencing policies impinging on the aged, needy, and institutionalized.

Nursing

Nurse administrators in health care facilities generally hold management and leadership positions and are, for the most part, involved in decision-making at the organizational level. The nurse administrators in the skilled nursing facilities were usually excluded from decision-making at the organizational level, yet were expected to take management responsibility for the day-to-day operation. The majority of these nurse administrators were dependent on basic nursing preparation and years of experience to qualify them for their positions. The decision-making power of which these nurse administrators were deprived, created nonparity with their non-nurse administrators and health professional colleagues and caused them to be viewed in a lesser light by their counterparts in the profession and by the public.

Workshops and coursework on assertiveness training, modern management approaches, marketing, the budget process, decision-making, policy formulation, program

evaluation, and a host of other skill development activities may raise the self-esteem of these nurse administrators. Once their performance is viewed positively both within and outside the profession, image making will no longer be the nurse administrators' task, and a positive image will be a reality in skilled nursing facilities.

Interview data suggested that a major management responsibility for these nurse administrators was the provision of quality care. Nurse administrators in long-term care cannot meet this responsibility in isolation from the rest of the health care system. Professional colleagues from all areas of health care can collaborate to establish and maintain the standards of nursing care that will meet the requirements of today's health care consumer.

Nurse administrators in skilled nursing facilities could share their strategies for maintaining clinical power and learn from their colleagues in acute care how to turn administrative powerlessness into administrative power. There is much to be gained professionally by communication and collaboration among the major components of nursing practice, long-term and acute care. This is, moreover, a role for the professional

association at national, state and local levels.

The nursing profession has achieved concensus about the major concepts that constitute the domain of nursing: man, health, nursing and environment (Fawcett, 1984; Meleis, 1985). Environment includes the context, context, meanings, beliefs and attitudes, as well as actions and physical characteristics, of any setting in which nurses practice. Of the four concepts inherent in the domain of nursing, environment is related to image making. It seems likely, from this study, that nurse administrators can contribute to a general description and delineation of environment by documenting existing attitudes and beliefs about skilled nursing facilities, and by determining workable (and unworkable) strategies to shift from a negative to a positive environment. Image making may be pertinent to further describe settings in which nurses, in this instance nurse administrators, practice. Image making may contribute to the development of nursing theory and the profession.

The Health Care System

The Health care system, although fragmented into many components such as hospitals, home care, ambulatory care and others, might be conceptualized along a continuum of care extending from acute to long-term care. Skilled

nursing facilities can be associated with the long-term care aspect of the continuum.

An advantage to viewing health care as a continuum is that the fragments become the gestalt of a whole. This is useful in considering some of the concerns faced by nurse administrators in skilled nursing facilities: early discharge of patients from acute-care hospitals, increased patient acuity on admission to skilled nursing facilities, and the negative image of care currently existing regarding skilled nursing facilities. The gatekeeping efforts of these nurse administrators to control the effects of increasing patient acuity and to maintain an acceptable level of care given their existing resources, is likely to make an impact that is perceived by their counterparts in acute care as obstructive and non-cooperative, as well as offer an opportunity for collaboration and concerted influence on the total health care system.

Nurse administrators in skilled nursing facilities have a unique opportunity to communicate with their counterparts regarding mutual issues and concerns about the prospective payment system. Such communication could lead to mutual understanding of the health care system as a whole and the role of nursing along the health care

continuum. Nurse Administrators from both acute and long-term care aspects of the continuum could strategize for attaining acceptable levels of care and for influencing negative attitudes and images about health care in general. Collusion might result in greater benefits to patients, families, and nursing.

Limitations of the Study

Researcher biases regarding the field of study may have interfered with data interpretation. To reduce bias as much as possible, the following techniques could be used: (a) observation of respondents' activities in selected settings in addition to interviews, and (b) validation of findings by participants confirming what they said was what the researcher heard.

Other limitations are the lack of generalizability of the findings to like settings, populations, and time. Lack of wide generalizability is inherent in field research. Time influences the situation under study and contributes to making a situation unique. Time is not controlled in field research, but should be recognized as part of the context of study. Time influences the responses of participants, and may influence the work of the researcher in generating theory through constant comparative analysis of the data.

Implications for Further Research

This dissertation has delineated major concepts conceptualized from the data. The several concepts that emerged are power relationships, management dissonance, competing agenda, clinical power-administrative powerlessness and image making. Pertinent variables inherent in these concepts are identifiable. Working conditions and work relationships were derived from power relationships. Management dissonance produced the variables climate, staffing, and patient acuity. Competing agenda produced the variables quality care, record-keeping, and cost containment. Clinical power-administrative powerlessness produced the variables gate keeping, control, and helplessness. Finally, the variables stigma and intervention characterized image making.

Replication of this study which includes observation as well as interviews would seem to be warranted. If another sample of nurse administrators from different skilled nursing facilities provided data from which the same variables could be identified, verification and clarification would be attained. Replication of this study could answer the primary question of grounded theory research, that is, What is it that is occurring in a selected situation or in this instance? What are

the variables operating in skilled nursing facilities that influence the management responsibilities of of nurse administrators?

Further research regarding the characteristics and the impact of patient acuity on skilled nursing facilities would contribute to our understanding of changes in the present health care financing system in acute care, that is, prospective payment. In skilled nursing facilities, the relationships of patient acuity and workload, and image could be described. To explore the influence of increased patient acuity on staffing requirements and competencies as well as on the gatekeeping and image making activities of nurse administrators could contribute to our knowledge of how these variables interrelate. Once the descriptive research on patient acuity is accomplished, instrument development would be warranted. Instrument development would include item construction, content and construct validity testing, and reliability testing. The ultimate aim of the instrument would be to measure patient acuity in skilled nursing facilities.

Further research could build on the discovery in this study's substantive theory, image making. A repeated study could add credibility to that discovery by con-

firming with additional samples in like settings that the concept of image making did indeed emerge. The more grounded the verification, the more confidence we can have that image making is a significant, albeit self-appointed, part of the role of nurse administrators. One research step further, subsequent to confirming the existence of image making in skilled nursing facilities, would be to conduct studies with nurse administrators in other health care settings such as acute care or home care. Such research might indicate the presence of image making as a perceived part of the management responsibilities of nurse administrators regardless of setting. This finding could move image making into the realm of formal theory, an ultimate goal of grounded theory building research.

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Appendix A

Glossary of Terminology used in Grounded Theory

Category: a concept indicated by the data that stands by itself. A category is a conceptual element of the theory (Glaser & Strauss, 1967).

Concept: a relevant theoretical abstraction about what is going on in the area of study (Glaser & Strauss, 1967).

Comparative analysis: a general method of research using the logic of comparison. Comparative analysis is used in analyzing social units and is a strategic method for generating theory (Glaser & Strauss, 1967).

Field: refers to some relatively circumscribed and abstract area of study. There are no spatial boundaries and no absolute beginnings or ends. The parameters of the field are conceptual discoveries (Schatzman & Strauss, 1973).

Phenomenon: a selected situation or event (Diers, 1979; Polit & Hungler, 1978; Schatzman & Strauss, 1973).

Property: a conceptual aspect or element of a category (Glaser & Strauss, 1967).

Theoretical saturation: means that no additional data are being found whereby properties of categories can be developed (Glaser & Strauss, 1967).

Appendix B

Interview Guide

The following open-ended questions were used to guide the interviews with nurse administrators in skilled nursing facilities:

How would you describe the current climate in long term care?

How would you describe the current climate in this institution?

What factors influence patient care delivery in this institution?

What factors influence your responsibilities as a manager in this institution?

How did you do on the last State survey?

Given that the State requirements for direct nursing care are 2.8 hours, how are staffing patterns and patient needs determined?

What is your most pressing need at this time?

Where do you turn for assistance, support, consultation?

Please tell me your understanding of the DRG's.

Appendix C

Survey Data Form

The survey data form was designed by the researcher to elicit information from the nurse administrators in skilled nursing facilities that would support or refute interview data. The form is attached.

Nurse Executives in Skilled Nursing Facilities

S U R V E Y D A T A F O R M

1. How many beds are in this institution? _____

2. What is your occupancy rate? _____

3. Do you have a waiting list for patients? _____

   How many patients are on the current waiting list? _____ men

   _____ women

4. What is the average age of patient in your facility? _____

5. What is the total number of nursing staff? _____ Registered Nurses

   _____ Licensed Vocational Nurses

   _____ Licensed Attendants

6. How many nursing staff members work each shift?

   Registered Nurses Days _____ Evenings _____ Nights _____

   Licensed Vocational Nurses Days _____ Evenings _____ Nights _____

   Nursing Attendants Days _____ Evenings _____ Nights _____

7. What system do you use to allocate workload? _____

   Briefly explain how it is used. _____

   _____

   _____

8. Using the list below, please check the following positions held by registered nurses in your institution. Also, please note how many and number of hours/week they work:

	Number	Hours per Week
[ ] Supervisor	_____	_____
[ ] Head Nurse	_____	_____
[ ] Assistant Director	_____	_____
[ ] Director of Staff Development	_____	_____
[ ] Inservice Coordinator	_____	_____
[ ] Research Coordinator	_____	_____
[ ] Quality Assurance Coordinator	_____	_____
[ ] Patient Care Coordinator	_____	_____
[ ] Clinical Specialist	_____	_____
[ ] Other _____ (please specify)	_____	_____

9. Are there written job descriptions for each type of nursing position? _____

10a. Are there written evaluations kept for each member of the nursing staff? _____

10b. How often are evaluations done? _____

11. What is the top management position here? _____

12. Would you describe management here as centralized? _____

decentralized? _____

Please explain. _____

_____

_____

13. What is the average cost per patient day in this institution? $_____

14. What percentage of patients here pay by:

[ ] Private source _____ %

[ ] Third party payee plan _____ %

[ ] Medicare _____ %

[ ] Medical (Medicaid) _____ %

[ ] Combination of above

_____ _____ %
(please specify)

[ ] Other _____ _____ %
(please specify)

15. What is the budget system used here?

[ ] Zero based

[ ] Year end

[ ] Program based

[ ] Other _____
(please specify)

16. How long have you been employed here in your present position? _____

17. How long have you been in long-term care? _____

18. How long have you been in nursing? _____

19. What is your highest degree achieved in nursing?

[ ] Diploma

[ ] Associate in Arts/Science

[ ] Baccalaureate

[ ] Master's

[ ] Doctorate

20. Please state degrees achieved in majors other than nursing. _____

21. Are you currently enrolled in any academic program leading to a degree in nursing? _____

In a major other than nursing? _____

22. Please check all of the leadership positions you have held in the past:

[ ] Director of Nursing

[ ] Patient Care Director/Coordinator

[ ] Assistant/Associate Director

[ ] Supervisor

[ ] Head Nurse

[ ] Other _____
(please specify)

23a. Do you have in this institution a written philosophy of nursing care? _____

23b. Do you have in this institution a written philosophy of management? _____

23c. Do you have in this institution a written philosophy of teaching/learning? _____

24. What decision-making meetings do you regularly attend? _____

_____

_____

25. What meetings do you regularly hold with your staff? _____

_____

_____

26. In addition to weekly charting, what is the recording system here?

[ ] Problem-oriented record

[ ] Nurse notes

[ ] Progress notes

[ ] Negative charting

[ ] Critical incident

[ ] Other _____
(please specify)

27. Who charts? _____

28. How often is charting done? _____

29. How do you define the problem in your problem list? _____

_____

_____

30a. How do you define short-term patient goals? _____

_____

_____

30b. How do you define long-term patient goals? _____

_____

_____

31. What is the delivery of nursing care method here?

[ ] Team nursing

[ ] Primary nursing

[ ] Functional nursing

[ ] Other _____
(please specify)

32. What are the usual or most common diagnoses on patient admission? _____

_____

_____

33. What were the usual or most common diagnoses on patient admission one year ago? _____

_____

_____

34. What areas of activities of daily living most often require assistance?

[ ] Dressing
[ ] Bathing
[ ] Transferring
[ ] Toiletting
[ ] Grooming
[ ] Ambulating
[ ] Mealtimes and eating
[ ] Other _____
(please specify)

35. What are the usual support systems for patients? _____

_____

36a. Do you use nursing care plans? _____

36b. Who develops care plans? _____

37. Do you use nursing diagnoses? _____

38. Do you write nursing orders? _____

39. Would you regard most of your current patients as requiring:

[ ] Total assistance with activities of daily living.
[ ] Average to above average assistance with actitivies of daily living.
[ ] Minimal assistance with activities of daily living.

40. One year ago would you regard most of your patients as requiring:

[ ] Total assistance with activities of daily living.
[ ] Average to above average assistance with activities of daily living.
[ ] Minimal assistance with activities of daily living.

41. If amount of assistance has changed, what do you believe accounts for this change? _____

_____

42a. How would you describe patient turnover rate in your institution? _____

_____

42b. What is the average length of stay of patients in your institution? _____

42c. How many patient admissions do you have each month? _____

THANK YOU FOR PARTICIPATING IN THIS STUDY.

Appendix D

Moos Work Environment Scale

The Work Environment Scale (WES) (Moos, 1981) is a standardized instrument designed to measure perceptions of work environment. Its purpose in this dissertation is to support or refute interview perceptions of nurse administrators in their work environment, skilled nursing facilities. Form R by P. Insel & R. H. Moos is attached.

74. Employees function fairly independently of supervisors.
75. People seem to be quite inefficient.
76. There are always deadlines to be met.
77. Rules and policies are constantly changing.
78. Employees are expected to conform rather strictly to the rules and customs.
79. There is a fresh, novel atmosphere about the place.
80. The furniture is usually well-arranged
81. The work is usually very interesting.
82. Often people make trouble by talking behind others' backs.
83. Supervisors really stand up for their people.
84. Supervisors meet with employees regularly to discuss their future work goals.
85. There's a tendency for people to come to work late.
86. People often have to work overtime to get their work done.
87. Supervisors encourage employees to be neat and orderly.
88. If an employee comes in late, he can make it up by staying late.
89. Things always seem to be changing.
90. The rooms are well ventilated.

WORK ENVIRONMENT SCALE

FORM R

PAUL M. INSEL & RUDOLF H. MOOS

INSTRUCTIONS

There are 90 statements in this booklet. They are statements about the place in which you work. The statements are intended to apply to all work environments. However, some words may not be quite suitable for your work environment. For example, the term supervisor is meant to refer to the boss, manager, department head, or the person or persons to whom an employee reports.

You are to decide which statements are true of your work environment and which are false. Make all your marks on the separate answer sheet.

If you think the statement is *TRUE* or mostly *TRUE* of your work environment, make an X in the box labeled T (true).

If you think the statement is *FALSE* or mostly *FALSE* of your work environment, make an X in the box labeled F (false).

Please be sure to answer every statement.

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1. The work is really challenging.
2. People go out of their way to help a new employee feel comfortable.
3. Supervisors tend to talk down to employees.
4. Few employees have any important responsibilities.
5. People pay a lot of attention to getting work done.
6. There is constant pressure to keep working.
7. Things are sometimes pretty disorganized.
8. There's a strict emphasis on following policies and regulations.
9. Doing things in a different way is valued.
10. It sometimes gets too hot.
11. There's not much group spirit.
12. The atmosphere is somewhat impersonal.
13. Supervisors usually compliment an employee who does something well.
14. Employees have a great deal of freedom to do as they like.
15. There's a lot of time wasted because of inefficiencies.
16. There always seems to be an urgency about everything.
17. Activities are well-planned.
18. People can wear wild looking clothing while on the job if they want.
19. New and different ideas are always being tried out.
20. The lighting is extremely good.
21. A lot of people seem to be just putting in time.
22. People take a personal interest in each other.
23. Supervisors tend to discourage criticisms from employees.
24. Employees are encouraged to make their own decisions.
25. Things rarely get "put off till tomorrow."
26. People cannot afford to relax.
27. Rules and regulations are somewhat vague and ambiguous.
28. People are expected to follow set rules in doing their work.
29. This place would be one of the first to try out a new idea.
30. Work space is awfully crowded.
31. People seem to take pride in the organization.
32. Employees rarely do things together after work.
33. Supervisors usually give full credit to ideas contributed by employees.
34. People can use their own initiative to do things.
35. This is a highly efficient, work-oriented place.
36. Nobody works too hard.
37. The responsibilities of supervisors are clearly defined.
38. Supervisors keep a rather close watch on employees.
39. Variety and change are not particularly important.
40. This place has a stylish and modern appearance.
41. People put quite a lot of effort into what they do.
42. People are generally frank about how they feel.
43. Supervisors often criticize employees over minor things.
44. Supervisors encourage employees to rely on themselves when a problem arises.
45. Getting a lot of work done is important to people.
46. There is no time pressure.
47. The details of assigned jobs are generally explained to employees.
48. Rules and regulations are pretty well enforced.
49. The same methods have been used for quite a long time.
50. The place could stand some new interior decorations.
51. Few people ever volunteer.
52. Employees often eat lunch together.
53. Employees generally feel free to ask for a raise.
54. Employees generally do not try to be unique and different.
55. There's an emphasis on "work before play."
56. It is very hard to keep up with your work load.
57. Employees are often confused about exactly what they are supposed to do.
58. Supervisors are always checking on employees and supervise them very closely.
59. New approaches to things are rarely tried.
60. The colors and decorations make the place warm and cheerful to work in.
61. It is quite a lively place.
62. Employees who differ greatly from the others in the organization don't get on well.
63. Supervisors expect far too much from employees.
64. Employees are encouraged to learn things even if they are not directly related to the job.
65. Employees work very hard.
66. You can take it easy and still get your work done.
67. Fringe benefits are fully explained to employees.
68. Supervisors do not often give in to employee pressure.
69. Things tend to stay just about the same.
70. It is rather drafty at times.
71. It's hard to get people to do any extra work.
72. Employees often talk to each other about their personal problems.
73. Employees discuss their personal problems with supervisors.

Appendix E

Quantitative Data Derived from the Survey Data Form

Descriptive statistics were used to compile some of the data derived from the survey data form. The reader interested in knowing the frequencies and averages of selected items of data will find the following:

(1) The size and occupancy rate of the 21 skilled nursing facilities in this study ranged from 34 to 239 beds. Of these, three were 99 bed facilities. The figure 99 is important because according to State regulations a skilled nursing facility with 99 beds or fewer need not have a registered nurse on the premises at night or in the evening.

Occupancy rates ranged from 89% to 100%; four of the reported a 95% occupancy rate. An additional four facilities reported a 100% occupancy rate.

(2) The average number of registered nurses (RN's), licensed vocational nurses (LVN's), and nursing assistants (NA's) on days, evenings and nights were:

RN			LVN			NA		
days	eves	nights	days	eves	nights	days	eves	nights
3.5	1.1	1.1	2.9	2.3	1.3	12.1	7.0	4.3

These data indicated that the greatest number of each type of nursing personnel work days, an average of 18,

fewer in the evenings, an average of 10; and the least number at night, an average of 6. These data show that the least number of licensed nursing personnel work at night.

(3 The amount of assistance with activities of daily living was reported as minimal to above average. Patient activities of daily living comprise the following list of capabilities: ambulating, bathing, transferring, dressing, toileting, grooming and eating meals. Nurse administrators were asked to rank their patients' ability to perform activities of daily living in relation to the amount of assistance required from nursing staff, e.g., minimal, average and above average. One nurse administrator ranked her patients as requiring above average assistance with activities of daily living. The remainder of the respondents ranked their patients as requiring average to above average assistance with activities of daily living. None of the respondents ranked their patients as requiring minimal assistance with activities of daily living. These rankings reflect the functional level of most patients in these skilled nursing facilities and the workload demands made on staff for daily assistance.

Appendix F

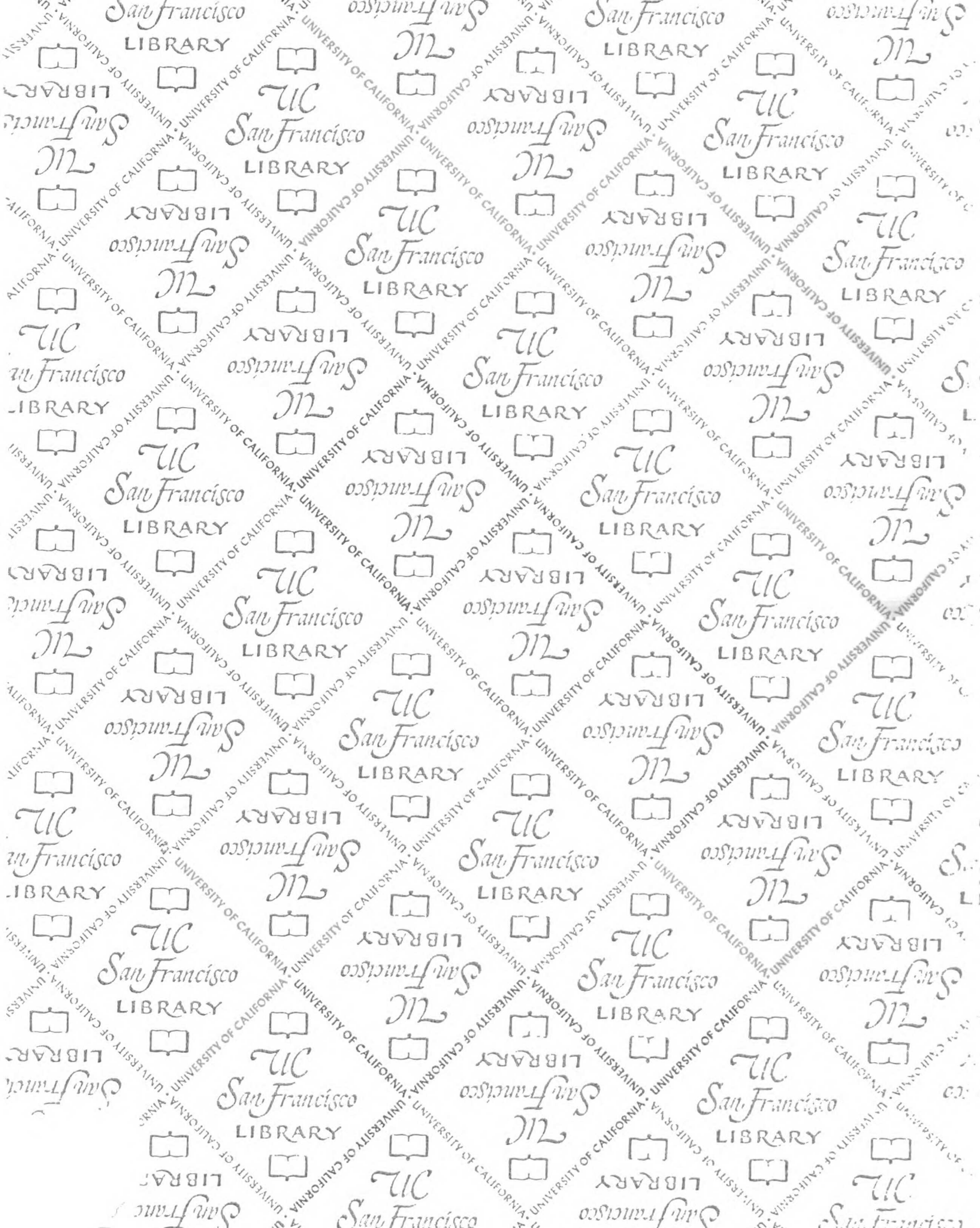
Moos (WES) Subscales Mean and Standard Deviation

The following table shows each of the ten Work Environment Scale (WES) subscales, the mean of nurse administrators' responses, and a normative mean derived from studies of 1607 employees in a variety of health care work groups (Moos, 1981).

Means for nurse administrators and health care work groups

	Nurse Administrators (n=19)		Health Care Work Grps (n=1607)	
	Mean	SD	Mean	SD
Involvement	7.58	1.87	5.56	1.54
Peer Cohesion	7.11	1.73	5.22	1.40
Supervisor Support	7.74	1.10	4.99	1.40
Autonomy	6.21	1.69	4.98	1.46
Task Orientation	6.84	1.43	5.63	1.31
Work Pressure	5.47	1.74	4.87	1.57
Clarity	7.58	1.50	4.44	1.41
Control	7.11	1.79	5.43	1.42
Innovation	5.32	2.31	4.37	1.82
Physical Comfort	5.37	2.24	3.72	1.28

Because of the small number of respondents in this study no statistical inferences can be drawn when comparing their scores with those of the normative group. The purpose of the WES in this study was to use the scores of the responses of nurse administrators to support or refute their perceptions voiced during the interview regarding their work environment.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