Direct Care Workers Perceptions and Practices Related to Quality of Life in Long Term Care

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DIRECT CARE WORKERS PERCEPTIONS AND PRACTICES RELATED TO QUALITY OF LIFE IN LONG TERM CARE

by

Karen M. Kinyon

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Faculty of The Graduate College
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Advisor: Van Cooley, Ed.D.

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DIRECT CARE WORKERS PERCEPTIONS AND PRACTICES RELATED TO QUALITY OF LIFE IN LONG TERM CARE

Karen M. Kinyon, Ph.D.
Western Michigan University, 2010

The focus of this case study was to discover how DCWs define success in their practice and what institutional and individual factors contribute to their successful practices. It describes how DCWs perceive quality of life for NH residents and how their practices reflect quality of life indicators. The conceptual model for which this research is based on was developed around the concepts that individual and institutional factors contribute to the successful practices of direct care workers; and, how these DCWs perceive quality of life influences how they practice to promote quality of life for nursing home residents. Using a case study approach, data was gathered from a convenience sample of fifteen direct care workers employed in one long term care facility in southwestern Michigan. The study utilized in-depth interviews to obtain information on the perceptions and practices of DCWs. How direct care workers prioritized eleven quality of life dimensions was investigated to understand their perceptions of quality of life for nursing home residents. Seven prominent themes and three emergent themes identified the individual and institutional factors that contributed to the successful practices of DCWs as well as how their practices reflected quality of life indicators. How direct care workers (DCW) perceive nursing home resident quality of life was revealed. Results of the study may add to the body of knowledge of successful practices of DCWs
that promote quality of life of nursing home residents. These findings may also provide evidence to support revisions to the regulations guiding the content of DCW training.
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It is hard to believe this chapter in my educational journey is nearly complete. I have been very blessed to have the support of so many from the beginning, which started so long ago. I would like to dedicate this degree to my Mom, because she encouraged and provided support when I chose to go into the career of nursing 38 years ago. She sacrificed so much for not only me, but for my brothers as well so that we could all travel our chosen life paths. Mom, you are my role model, my mentor and my best girl-friend. I love you and all that you stand for. Thank you for always being by my side.

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CHAPTER I

INTRODUCTION

This qualitative case study discovered and described the perceptions and practices of direct care workers as they pertain to resident quality of life in long term care. Direct care workers play a significant role in impacting the quality of life for residents residing in long term care facilities such as nursing homes. The first chapter of this research discusses the background of the study, the conceptual framework, the problem statement, the purpose of the study, research questions, rationale for the study, and the limitations and de-limitations. A list of the definition of terms has been included. Finally, the chapter concludes with a summary and how the study is organized.

Background of the Study

Long term care facilities such as nursing homes (NH) will become home to millions of baby boomers in the coming years. Many people are afraid to move from their own home to a long term care facility because they do not know what to expect. In spite of the passing of The Nursing Home Reform Act in 1987, serious concerns regarding the quality of care and quality of life for nursing home residents remain (Doty, Koren, & Sturla, 2008; Kane et al., 2004; Reinhard & Stone, 2001). The Act emphasized the importance of quality of life and established quality standards for nursing homes (NHs) (Doty et al., 2008). Ten years after the Act was passed, the first meeting of the NH
Pioneers (currently known as the Pioneer Network) coined the term *culture change* (Rahman & Schnelle, 2008).

The two primary models of NH care well associated with the culture change movement are; the Eden Alternative and the Wellspring models. The Eden Alternative incorporates plants, animals, and children into the NH to combat feelings of boredom, loneliness, and helplessness (Thomas, 1996). The Eden Alternative moves decision-making to the residents and employees closest to the residents—the nursing assistants. Staff members are empowered to accept responsibility for managing themselves and their assignments (Barba, Tesh, & Courts, 2002). The Wellspring model focuses on delivering high quality of care by utilizing best practices and quality improvement systems (Reinhard & Stone, 2001). The six key elements that make up Wellspring’s model of quality improvement include: management’s commitment to making quality of resident care a priority, training by a geriatric nurse practitioner based on clinical guidelines, care resource teams, networking among staff across facilities, empowerment of staff to make decisions that affect quality of resident care, and, continuous reviews of performance data on resident outcomes (Reinhard & Stone, 2001).

Even though the culture change movement began after The Nursing Home Reform Act, it did not begin to grow until a report for the National Commission for Quality Long-Term Care concluded that culture change initiatives were struggling against regulations, limited resources, and established practices. They also found no empirical evaluation of the models and their impact on the quality of life and quality of care of NH residents (Rahman & Schnelle, 2008). However, these findings did not detour a landmark
meeting held in 2005 that was hosted by the Pioneer Network and Quality Partners of Rhode Island which brought together 400 long term care leaders to work toward hastening culture change in the nations’s NHs. Representatives from the Centers for Medicare and Medicaid Services (CMS) and State Survey and Certification Agencies that regulate NHs also participated in this meeting to endorse this needed change (Rahman & Schnelle, 2008).

Messages about the culture change movement are being disseminated by advocacy groups such as the Pioneer Network and also by CMS through their Advancing Excellence in America’s Nursing Homes campaign; however, this message has escaped critical peer review. Rahman and Schnelle (2008) suggested that culture change interventions are often advocated with little mention of their mostly untested premises. Instead, case studies and anecdotal reports are often presented as evidence of success.

In their review of literature, Rahman and Schnelle (2008) proposed a research agenda pertaining to culture change interventions that is organized around potential outcomes, care processes, staff implementation challenges, staffing costs and resident concerns. These authors suggested one of the first interventions to consider for study could be those that increase resident choice over daily activities because resident choice is a core value within the culture change movement. This quality of life domain possesses face validity and is widely accepted as important; however, we lack information about how to offer meaningful choices to NH residents. Additionally, regulatory quality of life expectations include the following: individualized care plans that reflect choice and accommodate individual needs and preferences; activity programs maximizing individual
interests; a comfortable, clean, homelike environment; ability to retain personal belongings; and a range of specific residents’ right (Kane et al., 2003). NH surveyors investigate and observe whether residents are provided these rights.

Conceptual Framework

We know that even though other factors such as personality, presence of caring friends and family will have a strong effect on quality of life, there is evidence that the behavior of caregivers and the environments in which care is given can influence quality of life for better or worse (Kane, 2001). Evidence has revealed the most important element of quality of life for older adults residing in NHs is having meaningful and genuine relationships with their care providers, who are mainly nursing assistants (Aller & Van Ess Coeling, 1995; Ford, 1995; Grau, Chandler, & Saunders, 1995; Kayser-Jones, 1989). People are social beings and have universal needs, and interacting with others provides support, comfort, love and affection to meet those needs (McGilton, 2002). Further, when older adults become institutionalized in NHs, social contact with friends and relatives may diminish, and many may experience intense needs for attachment, nurturance, and support (McGilton, 2002). Therefore, relationships with direct care workers (DCWs) are required and represent a resource for improving quality of life. We know that personal characteristics and special traits such as being “a nice person” and “getting along with people” accounted for positive relationships with residents. Other qualities deemed essential included patience, altruism, friendliness, and, in the words of one DCW, “the spirit in me” (Ball, Lepore, Perkins, Hollingsworth & Sweatman, 2009).
The conceptual model for which this research is based on is depicted below. A larger version of the model is presented in Appendix A. The model was developed around the concepts that individual and institutional factors contribute to the successful practices of direct care workers; and, how these DCWs perceive quality of life influences how they practice to promote quality of life for nursing home residents. Kane's 11 quality of life domains provide the underpinnings for the model (2001).

Figure 1. Resident Quality of Life.

Statement of the Problem

Quality of life has become a critical measure for assessing nursing home residents. Operationally, quality of life is measured as outcomes experienced by the resident rather than by structural features or processes thought to be associated with those
outcomes (Kane et al., 2003). What we do not know is how direct care workers perceive NH resident quality of life. Also, we do not know how direct care workers practice to promote quality of life. In addition, we do not know what individual or institutional factors contribute to their successful practices. The problem statement is captured in the following succinct statement. Evidence is lacking that explains how DCWs define success in their practice and what individual and institutional factors contribute to their successful practices. Also, there is no evidence that explains how direct care workers perceive NH resident quality of life or how they practice to promote quality of life for NH residents.

Purpose of the Study

The purpose of this study was to discover how DCWs define success in their practice and describe what institutional and individual factors contribute to their successful practices. How DCWs perceive NH resident quality of life was ascertained along with how their practices reflect quality of life indicators. Results of the study may add to the body of knowledge of successful practices of DCWs that promote quality of life of nursing home residents. Results may also provide evidence to support revisions to the regulations guiding the content of DCW training.

Research Questions

The study attempted to respond to the following five research questions. These questions were the centerpiece for this investigation and were developed based on the
conceptual model. There is a lack of research on the successful practices of DCWs and what institutional and individual factors contribute to their success. Also, how DCWs perceive resident quality of life and how they practice to promote quality of life provided the impetus to narrow the focus of this study on these two areas. Therefore, these questions concentrate on the perceptions and practices of DCWs and NH resident quality of life.

1. How do direct care workers (DCWs) define success in their work?

2. What are the individual factors that contribute to direct care workers (DCWs) successful practices?

3. What institutional factors contribute to the successful practices of direct care workers (DCWs)?

4. How do direct care workers (DCWs) perceive quality of life for NH residents?

5. How do direct care workers (DCWs) practice to reflect quality of life indicators?

Rationale for the Study

Nursing home care tends to be associated with a poor quality of life for consumers and quality of life should be a priority goal for long term care rather than an after-thought to quality of care (Kane, 2001). Edelman, Fulton, Kuhn and Chang (2005) reiterated this by saying “Although, good care may be a necessary condition for good quality of life, it is possible to provide good care without residents experiencing quality of life. Therefore,
assessment of residents’ quality of life should be a high priority in order to address unmet needs” (p. 27).

Even though The Nursing Home Reform Act of 1987 was intended to enforce regulations to improve quality of life for nursing home residents, there are still concerns about quality of care and quality of life for residents residing in nursing homes (Doty et al., 2008; Kane et al., 2004; Reinhard & Stone, 2001). Evidence has revealed that the behavior of caregivers and the environments in which care is given can influence NH resident quality of life (Kane, 2001). Relationships make life worth living (Kane, 2001), and, meaningful and genuine relationships between care givers and NH residents are important elements of NH resident quality of life (Aller & Van Ess Coeling, 1995; Ford, 1995; Grau et al., 1995; Kayser-Jones, 1989).

Revisions to CMS regulations also focus on NH resident quality of life (McKnight’s, 2009). Because DCWs provide 80%-90% of all care delivered to NH residents (Barry, Brannon, & Mor, 2005; Blair & Glaister, 2005; Kane, 1994; Stone, 2001), they are the eyes and ears of the healthcare team and are essential to improving quality of life for the residents they care for (Stone, 2001). DCWs have the greatest opportunity to influence QOL because of their regular contact with residents (Kane et al., 2006).

Understanding how direct care workers perceive resident quality of life and how they practice to promote quality of life may provide a strong argument for spending resources on educating direct care workers on quality of life. Results of this study may help to better prepare newly hired direct care workers for their role in providing services
to NH residents. Understanding how individual and institutional factors contribute to successful practices of DCWs may provide direction for organizational change.

Methodology

This research utilized a case study approach to discover and describe the perceptions and practices of direct care workers as they relate to quality of life for nursing home residents. Qualitative research uses a broad approach to study social phenomena in its natural environment and focuses on context (Marshall & Rossman, 2006). Qualitative research is conducted to understand the context or settings in which participants address a problem or issue (Cresswell, 2007). Case study research explores the issue through one or more cases within a bounded system or setting such as a nursing home.

The setting for this study was one nursing home which is a part of a large health care system. Fifteen direct care workers employed for at least one year at the nursing home were included in the study. In-depth interviews and a card sort exercise were carried out. DCWs were observed during the card sort exercise and field notes were documented.

Participants voluntarily participated in an in-depth interview that consisted of a series of questions designed to elicit DCWs’ perceptions of quality of life for NH residents. Participants’ were invited to describe their successful practices and what institutional and individual factors contribute to their success. They described their perceptions about resident quality of life. Interview questions were intended to extract the
DCWs descriptions of individual and institutional factors that contribute to their successful practices of caring for NH residents.

A card sort of the 11 QOL domains (Appendix H) by each DCW explored how DCWs ranked and prioritized those domains. The fifteen DCWs were given 11 cards with a simple description of the quality of life domains printed on them. The researcher met with each DCW individually and asked him/her to place the cards in order of the most important to the least important quality of life domain when considering the residents they cared for.

Interviews were digitally recorded and transcribed verbatim for analysis. To answer research questions 1, 2, 3, and 4 (RQ1, RQ2, RQ3, RQ4) inductive analysis and emergent coding for responses to interview questions one, two, three, four, five, six, seven, nine and ten was completed to discover patterns, themes and categories in the data. To answer research question 5 (RQ5), the quality of life dimension check list that was developed based on literature, Kane’s (2001) quality of life domains, and the quality of life regulations and interpretive guidelines (AHCA, 2009; Allen, 2007) as displayed in (Appendix I) was utilized.

A priori coding based on the quality of life dimensions on the checklist was used to code and analyze responses to interview question 8 that asked DCWs to describe how any of their practices might promote quality of life. The researcher was open to utilizing additional codes that emerged during the analysis (Cresswell, 2007). Codes emerging from this open coding were reviewed to identify themes and patterns. Prolonged engagement with the data resulted in the generation of other categories or salient themes.
Themes were identified from quotes that demonstrate the individual’s interpretation of their experience, which together with all of the participant’s feedback determines the structure of the experience (Cresswell, 2007). Criteria were developed for the identification of prominent themes and emergent themes. Prominent themes were identified when at least nine to twelve or 60–80% of DCWs mentioned the subject at least once in their interview. Emergent themes were determined when at least seven DCWs or 46% mentioned the subject at least once in their interview.

Limitations and Delimitations

This study has several limitations and delimitations. The study only reflected the opinions of fifteen direct care workers at one long term care facility from a large health system in Southwestern Michigan. Using qualitative research and a case study methodology limits generalizations to other healthcare organizations.

The investigation included interviews of a convenience sample of direct care workers who volunteered to be in the study. Marshall and Rossman (2006) suggested there are limitations and weaknesses to interviewing, as participants may be unwilling or uncomfortable sharing all that the interviewer hopes to explore. The small sample of direct care workers may also decrease the generalizability of findings to other healthcare systems. Also, Coghlan and Casey (2001) revealed researchers need to manage the political dynamics of their organization while performing their research by balancing the organization’s justification of what it wants in the project with their own personal justification for the project. Even though the researcher does not work at this specific
facility, performing research in one’s own organization may create the potential for role ambiguity and conflict (Coghlan & Casey, 2001).

One delimitation was confining the study to interviewing direct care workers in one long term care facility that is a part of a large health system in Southwestern Michigan. The researcher worked at the facility over 1½ years ago and knows some of the staff still working at the facility, which may be a delimitation if staff feel uncomfortable in refusing to participate in the study due to knowing the researcher and knowing the researcher’s position within the health system.

Definitions

Quality of Life

Definitions of quality of life are broad. The Institute of Medicine (2001) defined quality of life (QOL) as “subjective or objective judgment concerning all aspects of an individual’s existence, including health, economic, political, cultural, environmental, aesthetic, and spiritual aspects.” Research on quality of life, (Kane, 2001; Kane et al., 2003; Kane et al., 2004; Degenholtz et al., 2005) distinguishes 11 domains: a sense of safety/security/order, physical comfort, meaningful activity, relationships, enjoyment, dignity, autonomy/choice, privacy, individuality, spiritual well-being, and functional competence. Each quality of life domain will be described in its positive form, because even the absence of bedsores or depression is not enough to determine that they have a good quality of life.
Sense of Safety, Security, and Order

This QOL domain entails a sense of security about oneself in one’s own world. Residents need to feel they are living in an environment where people are well intended, and where ordinary ground rules and laws are understood. Residents need to feel free from danger and know they live in a non-threatening environment. Their personal possessions need to be safe and secure (AHCA, 2009; Allen, 2007; Kane, 2001).

Physical Comfort

This domain means includes being free from physical pain and discomfort. Discomfort may include shortness of breath, nausea, constipation, joint pain, and other physical maladies in which the resident should be free from. Physical comfort may mean different things to different people and may include temperature, body position to some or having freshly laundered sheets to others. The primary component of this domain is addressing a resident’s pain and discomfort (Allen, 2007; Kane, 2001).

Enjoyment

Enjoyment is an attribute most of us aspire to in our own lives. Therefore, it is not unreasonable for NH residents to experience enjoyment while residing in a nursing home. Enjoyment may be subjective and for those observing it may only be measured by outward expressions of happiness. Enjoyment may be in the form of satisfaction with food or experiencing delight in the outdoors or a type of entertainment (Kane, 2001; Mittal et al., 2009).
Meaningful Activity

Residents in NHs need to feel that their lives are full of interesting and meaningful things to do and see. Activities refer to any endeavor in which residents participate in to enhance their sense of well-being promote or enhance physical, cognitive, and emotional health. Meaningful activities may also promote self-esteem, pleasure, comfort, education, creativity, success, and independence. What is meaningful to one resident may differ depending on the physical status of the individual. Some residents may actively participate in activities while others prefer to watch or observe from the sidelines (Allen, 2007; Kane, 2001; Mittel et al., 2009).

Relationships

Relationships make life worth living, whether they are relationships of love, friendship, or even of enmity and rivalry. Reciprocal relationships where NH residents are able to give as well as receive support, advice, and confidences are best of all. These relationships may be with family and friends, with other residents, and with paid caregivers (Bowers, Fibich, & Jacobson, 2001; Kane, 2001; Mittel et al., 2009).

Functional Competence

Functional competence means that within the limits of the resident’s physical and cognitive capacities, they are as independent as they choose to be. This QOL domain considers the unique preferences, aspirations and capabilities of residents residing in
nursing homes, which makes it sensitive to the physical environment of the organization. Nursing homes must consider these individual needs and preferences when adapting things such as schedules, call systems, and room arrangements (Allen, 2007; Kane, 2001).

Dignity

Dignity is embedded into nursing home regulations and means that in their interactions with residents, staff carries out activities that enhance the resident’s self-esteem and self-worth. Examples of dignity include grooming residents as they wish to be groomed, assisting residents to dress in their own clothes appropriate to the time of day and individual preferences. It is also the resident’s perception that one’s own dignity is respected. Even residents that cannot perceive indignities are treated with dignity regardless of their cognition. Considerable self-awareness is needed to experience a sense of indignity (Allen, 2007; Kane, 2001).

Privacy

An outcome related conceptually to dignity, does not necessarily refer to having a private room and bath, but rather to experiencing a sense of privacy such as, being able to be alone when one wishes, to be together in private with others when one wishes, and to be in control of information about oneself. Privacy also includes solitude, intimacy, anonymity, and reserve. A private space and privacy of mail is another component to this QOL domain (Allen, 2007; Kane, 2001).
Individuality

Individuality refers to a sense of being known as a person and being able to continue to experience and express his or her identity, and to have desired continuity with the past (Kane, 2001). This includes focusing on residents as individuals when speaking to them and addressing residents as individuals when providing care and services (Allen, 2007). Research has shown that LTC providers in all settings pay insufficient attention to learning about the NH resident as a person, a prerequisite to helping the person preserve his or her sense of identity (Degenholtz, Kane, & Kivnick, 1997; Kane & Degenholtz, 1997; Kane, Penrod, & Kivnick, 1994).

Autonomy/Choice

Autonomy refers to the perception that one is making decisions and choices and directing one’s own life. Residents should have choices about when to get up, when to eat and what activities they want to participate in. Residents should also be able to make decision about significant aspects of his or her life (AHCA, 2009; Allen, 2007; Kane, 2001).

Spiritual Well-Being

Related to both psychological and social well-being, spiritual well-being cannot be ignored as a domain of quality of life. Spiritual well-being may incorporate but go
beyond and can be independent of religiousness and have been associated with health outcomes (Kane, 2001).

Nursing Home (NH) [long term care facility, nursing facility]

A nursing home is a facility that is primarily engaged in providing residents with skilled nursing care and related services for residents who require medical or nursing care. Skilled care is the care that can only be provided by a registered nurse under the direction of a physician. Nursing homes provide rehabilitation services for injured, disabled, or sick persons; or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which is available to them only through these facilities, and is not primarily for the care and treatment of mental diseases (Allen, 2007; CMS, 2004, p. 18).

Direct Care Worker (DCW) [nursing assistant, nurse aide, certified nursing assistant (CNA)]

Direct care workers who are primarily nursing assistants, orderlies or home health aides provide hands on care for nursing home residents or seniors living in their home. DCWs who work in nursing homes must be certified through their state. They assist residents with activities of daily living such as eating, dressing, bathing, and toileting (Bureau of Labor Statistics, 2001).
Nursing Home Residents [residents]

Nursing home residents reside in long term care facilities because they are totally dependent or need some type of assistance with bathing, toileting and transferring. Some are cognitively impaired and have dementia. These residents can no longer live independently in their homes alone due to physical or mental disabilities that limit their functioning (Jones, Dwyer, Bercovitz, & Strahan, 2004).

Summary

Americans needing long term care are projected to more than double by 2050. Nursing homes are a crucial component of the long term care system. The quality of nursing home care has been a long-standing concern. In spite of the passing of The Nursing Home Reform Act in 1987, serious concerns regarding the quality of care and quality of life for nursing home residents remain.

Direct care workers play a significant role in impacting the quality of life for residents residing in long term care facilities. Evidence suggests that the behavior of caregivers and the environments in which care is given can influence quality of life. An important element of quality of life for older adults residing in NHs is having meaningful and genuine relationships with their care providers, who are mainly nursing assistants.

Organization of the Study

Chapter II provides a review of literature on the history of nursing homes, the elderly population, the nursing home population, quality of life in nursing homes and,
individual and institutional factors that influence the practices of direct care workers. Chapter III includes the methodology used to conduct the investigation. Results of the study are included in Chapter IV, and finally, a summary, conclusions, and recommendations for additional research are presented in Chapter V.
CHAPTER II

REVIEW OF LITERATURE

The purpose of this study was to discover how DCWs define success in their practice and describe what institutional and individual factors contribute to their successful practices. How DCWs perceive NH resident quality of life was explored along with how their practices reflect quality of life dimensions. Relevant literature related to the history and regulation of nursing homes, the elderly population residing in nursing homes, direct care workers, individual factors, and institutional factors are reviewed. This chapter is comprised of nine sections. These include: (1) history of nursing homes, (2) elderly population, (3) nursing home resident population, (4) nursing homes or long term care facilities, (5) quality of life regulations, (6) nursing home resident quality of life, (7) direct care workers, (8) individual factors contributing to DCW practices, and, (9) institutional factors contributing to DCW practices. The chapter ends with a summary.

History of Nursing Homes

In the early 19th century, federal assistance programs were not available to help pay for the care of elderly or disabled, therefore, most states sent their impoverished to “poor farms” or “almshouses.” These almshouses served as the last refuge to the poor in their old age. Because the proportion of elderly increased so rapidly within these almshouses, many were renamed as homes for the aged (Foundation Aiding the Elderly,
Despite name changes, these institutions were considered a disgrace to the elderly where loneliness, humiliation, abandonment, and degradation were common.

By the 1930s, the rising population of aged in these institutions and reports of such horror stories, convinced government officials that it would be less expensive to provide small pensions to the elderly in order for them to move out and care for themselves or move to a private institution. The Social Security Act (1935) perpetuated the hope that it would save men and women from the “haunting fears” of the poorhouse (Foundation Aiding the Elderly, 2009). Any person receiving this pension, could not live in an almshouse, therefore, by the 1950s, most almshouses had been closed because they no longer received federal funding.

In 1954 Congress amended Social Security to allow federal support to individuals in public facilities. This new legislation also allowed for the development of public institutions for incapacitated older adults that required long term care. Many new public institutions were built as a result of the Medical Facilities Survey and Construction Act of 1954 (Foundation Aiding the Elderly, 2009).

With the passage of Medicare and Medicaid in 1965, the nursing home industry sky rocketed. The number of nursing homes grew by 140% between 1960 and 1976 resulting in a 302% increase in nursing home beds. By 1979, 79% of all institutionalized elderly resided in commercially run nursing homes (Foundation Aiding the Elderly, 2009).

Investigations into the nursing home industry during the 1970s identified a lack of medical care, food, and attendants to provide care, and most were considered not much
better than the previous almshouses of the past. Policy makers enacted numerous regulations to control the quality of long term care. The Office of Nursing Home Affairs was created to oversee numerous agencies responsible for nursing home standards. Reforms in the Social Security Act established regulations for facilities reimbursed by Medicare and Medicaid. The Older American Acts also provided and strengthened the nursing home ombudsman programs that encouraged residents and their families to voice any complaints about the institution (Foundation Aiding the Elderly, 2009).

Despite the changes in federal and state regulations, nursing home care did not significantly improve. A report by the Institute of Medicine (2001) on nursing home care resulted in the largest overhaul of federal regulations for nursing homes. The IOM report found that residents in nursing homes were being abused, neglected, and given inadequate care. The outcome of the IOM report became the basis for legislation contained in the Omnibus Reconciliation Act (OBRA) in 1987.

As a component of OBRA, the Nursing Home Reform Act was written to ensure that residents living in nursing homes received quality care that would result in their achieving or maintaining their “highest practicable” physical, mental, and psychosocial well-being (Klauber & Wright, 2001). The Act also required specific services be provided to each resident and established a Residents’ Bill of Rights. Any nursing homes that received Medicaid or Medicare payments were mandated to be certified by the state to be in substantial compliance with these requirements. Some of the required services included: periodic assessments for each resident; a comprehensive care plan for each resident; nursing services; social services; rehabilitation services; pharmaceutical
services; dietary services; and, the services of a full time social worker (Klauber & Wright, 2001).

The Residents' Bill of Rights established the following quality of life rights for nursing home residents: the right to freedom from abuse, safeguards against mistreatment and neglect; the right to be free from physical restraints; the right to privacy; the right to accommodation of medical, physical, psychological, and social needs; the right to participate in resident and family groups; the right to be treated with dignity; the right to exercise self-determinations; the right to communicate freely; the right to participate in the review of one's care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and, the right to voice grievances without discrimination or reprisal (Klauber & Wright, 2001). Under federal laws and regulations, all nursing homes must have written policies that describe the rights of residents. Nursing homes are required by law to make these policies on resident rights available to any resident.

Twenty years after the Nursing Home Reform Act and OBRA was passed, there was evidence of improvement in nursing home care. A report commissioned by the Henry J. Kaiser Family Foundation examined the progress and problems in quality assurance in nursing homes from 1987 through 2007. This report revealed that by 2007, there were fewer residents were restrained, nursing staff increased due to the mandates of OBRA 87, nursing assistants were required to complete 75 hours of training and demonstrate competency before caring for residents, and the average number of deficiencies cited at each facility declined. However, challenges still remain in nursing
home care and improvements have reached a plateau. Substantial proportions of nursing homes are still cited for inadequate care and the vast majorities continue to be significantly understaffed (Wiener, Freiman, & Brown, 2007).

Elderly Population

From 1950 to 2006, the population ranging from 65–74 years of age increased 1.5% per year, or from 8 to 19 million persons. The population 75 years of age and over grew the fastest (on average, 2.8% per year), increasing from 4 to 18 million persons. By 2029, all of the baby boomers (those born in the post World War II period 1946–1964) will be age 65 years and over. As a result, the population age 65–74 years will increase from 6% to 10% of the total population between 2006 and 2030. As the baby boomers age, the population 75 years of age and over will rise from 6% in 2006 to 9% of the population by 2030 and continue to grow to 12% in 2050. By 2040, the population age 75 years and over will exceed the population 65–74 years of age (U.S. Census Bureau, 2009). Many of these elderly people will require long term care such as nursing home care due to some catastrophic illness or debilitating disease. The most recent projections indicate that the number of Americans needing long term care is projected to more than double from 13 million in 2000 to 27 million in 2050 (HHS, 2003; Jones et al., 2004).

Nursing Home Resident Population

Of the 1.5 million residents residing in nursing homes, 88.3% are aged 65 years and older and 45.2% are aged 85 years and older. Of all nursing home residents, 71.2%
are female. About 59.5% of Hispanic or Latino nursing home residents are female, compared with 71.6% of their not Hispanic or Latino counterparts. Among black residents, 63.5% are female, compared with 72.6% of their white counterparts (Jones et al., 2004).

The primary admitting medical diagnoses or nursing home residents are: diseases of the circulatory system (23.7%), mental disorders (16.4%), diseases of the respiratory system (6.7%), diseases of the nervous system and sense organs (14%), endocrine, nutritional, and metabolic diseases (5.4%), and diseases of the musculoskeletal system and connective tissue (4.5%) (Jones et al., 2004). Since 1999, there has been an increase in the percentage of residents diagnosed with mental disorders. This increase has also been observed in non-institutionalized population as well.

Ninety-one percent of nursing home residents are totally dependent or need some type of assistance with bathing. Eighty-two percent are completely dependent or require assistance with dressing. Seventy-seven percent of nursing home residents are completely dependent or need assistance with toileting. Seventy-one percent of residents require complete or partial assistance with transferring. And finally, 35% of residents need complete or partial assistance with eating (Jones et al., 2004).

Nursing Homes (NH) or Long Term Care Facilities

Nursing homes are a crucial component of the long term care system. According to the 2004 National Nursing Home Survey, there are approximately 1.5 million residents currently residing in the 16,000 nursing homes in the United States (Jones et al., 2004).
There are 422 nursing homes in Michigan that contain 47,206 beds. Michigan has 40,626 nursing home residents for a nursing home occupancy rate of 86.1% (2004). Most nursing homes are proprietary (61.5%); 30.8% are operated as voluntary nonprofit facilities, and the remaining 7.7% are owned by government and other entities (Jones et al., 2004).

Long term care is constantly changing as new models, such as assisted living, are expanding and reimbursement is declining. The quality of nursing home care has been a long-standing concern that gained media attention when the Institute of Medicine reported some disturbing findings in their report *Improving the Quality of Care in Nursing Home* (Jones et al., 2004). Subsequently, federal regulations were created to closely monitor and improve nursing homes’ care of residents.

Recently the Centers for Medicare and Medicaid Services (CMS) made revisions to the interpretive guidelines affecting quality of life and environment regulations. These changes were based on public recommendations from a symposium co-sponsored by CMS and the Pioneer Network. The revisions were implemented June 17, 2009 and focused on creating person-centered living environments for residents residing in nursing homes. Nursing home surveys conducted after implementation have a heightened focused on areas such as care and service choices, creating a homelike environment, resident dignity, and accommodating environmental needs and preferences (McKnight’s, 2009).
Quality of Life Regulations

The quality of life regulations and interpretive guidelines require that a facility care for residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life. The quality of life regulations focus on six primary areas: dignity, self-determination and participation, participation in resident/family groups, accommodation of needs, activities, and the environment. The intention of these regulations is to create and sustain an environment that humanizes and individualizes each resident. Each of the six quality of life regulations and their interpretive guidelines will be described in Table 1.

Nursing Home Resident Quality of Life

Quality of life is recognized as a principal outcome for long term care. However, quality of life is difficult to define and measure. The Institute of Medicine defined quality of life as “subjective or objective judgment concerning all aspects of an individual’s existence, including health, economic, political, cultural, environmental, aesthetic, and spiritual aspects” (2001). Lawton (2001) also recognized that quality of life must be based on both subjective and objective aspects of the resident’s long term care experience. Bennett (1980) defined long term care quality of life in terms of satisfaction of basic human needs: physiological, safety and security, social, self-esteem, and accomplishment. Brod, Stewart, and Sands (2000) argued the subjective element is the only “true” aspect of quality of life, and other aspects such as the environment, individual function, and behavior are determinants of this subjective quality of life. Kane and
Table 1

Quality of Life Regulations and Interpretive Guidelines

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<tr>
<th>Dignity</th>
<th>Nursing homes must promote care for residents in a manner and environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality. Dignity means that NH staff carries out activities that assist the resident to maintain or enhance their self-esteem and self-worth. Examples include: grooming residents as they wish to be groomed; encouraging and assisting residents to dress in their own clothes instead of hospital gowns; assisting residents to activities of their choosing; labeling clothing in a manner that respects their dignity; promoting independence and dignity in dining by avoiding use of bibs, plastic cutlery, staff standing over residents while assisting them to eat and staff interacting or conversing only with each other rather than with residents, while assisting residents; respecting resident’s private space and property by knocking on doors and requesting permission to enter, closing doors as requested by the resident, and not moving resident’s personal possessions without permission; speaking respectfully to residents and avoiding labels such as “feeders”; addressing residents as individuals when providing care; maintaining an environment where there are not signs posted that include confidential or personal information; maintaining resident privacy of body by keeping them sufficiently covered while be taken outside of their room; and, refraining from practices demeaning to residents.</th>
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<tr>
<td>Self-Determination and Participation</td>
<td>Residents have the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with the community and make choices about aspects of his or her life that are significant to the resident. The intent of this regulation is to create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Choices include what type of activities the resident chooses to be involved in and choices about their schedules such as bathing, waking, eating or going to bed.</td>
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<td>Participation in Resident and Family Groups</td>
<td>Residents have the right to organize and participate in resident groups. The NH is required to listen to the resident and family group recommendations and grievances. The NH must seriously consider resident and family recommendations and try to accommodate those recommendations to the extent that is practicable.</td>
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Table 1—Continued

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<th>Accommodation of Needs</th>
<th>Nursing homes must provide reasonable accommodations of individual needs and preferences as they relate to the resident’s physical environment. This regulation includes making adaptations to the resident’s environment so he or she can open or close bedroom and bathroom doors and drawers as easily as possible; and, keeping personal items within reach. Also included is staff taking into account the resident’s physical limitations and assures communication, and maintains respect by getting down to the eye level with a resident who is sitting; speaking so a resident with limited hearing who reads lips can see their mouth when they speak, and using hearing amplification devices if required.</th>
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<td>Activities</td>
<td>Nursing homes must provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This requirement calls for nursing homes to provide activities that are relevant and valuable to a residents quality of life by ensuring they are meaningful and reflect that person’s interests and lifestyle, are enjoyable, and help the person feel useful and provide a sense of belonging. Examples meeting this regulation include: notifying residents of preferred activities; transporting residents who need assistance to and from activities; providing functional assistance such as toileting and eating assistance; timing the administration of medications to avoid interfering with the resident’s ability to participate in an activity; altering a therapy or a bath schedule so that a resident can attend an activity; providing higher levels of lighting for residents with visual impairments; providing sensory stimulation or cognitive therapy such as touch, visual, or auditory stimulation specific to the needs of residents with cognitive impairment; validating the resident’s feelings and words and engaging them in conversation; providing a calm, non-rushed environment that includes structured and familiar activities such as folding, sorting, and matching; and, focusing the resident on activities that decrease stress and increase awareness of actual surroundings.</td>
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<td>Environment</td>
<td>Nursing homes must provide a safe, clean, comfortable and homelike environment, allowing residents to use his or her personal belongings to the extent possible. A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A personalized environment recognizes the individuality and autonomy of the resident and promotes self-expression, and encourages links with the past and family members.</td>
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colleagues (2003) subscribed to the broader view and identified the following domains of long term care quality of life: emotional health, physical health, functional status, comfort and security, social function, and self-worth or personal agency. Today, there is a growing consensus that the conceptualization and measurement of quality of life should hinge primarily or exclusively on the resident’s subjective assessment of his or her quality of life (Gessert, et al., 2005).

Nursing home residents are the preferred source of information about their quality of life. However, it may not always be feasible to obtain information from residents due to conditions such as depression, dementia, and aphasia which may render the residents unwilling or unable to provide quality of life ratings. When residents are unable to provide their subjective assessment, information must be obtained from proxy informants such as family members or caregivers (Mittal et al., 2009).

Direct Care Workers

Direct care workers fall into three categories: Nursing Assistants, (usually known as Certified Nursing Assistants or CNAs), Home Health Aides, and Personal and Home Care Aides (Bureau of Labor Statistics, 2001). Nursing Assistants or Nursing Aides generally work in nursing homes, although some work in assisted living facilities, other community based settings, or hospitals. They assist residents with activities of daily living such as eating, dressing, bathing, and toileting (Bureau of Labor Statistics, 2001). According to the U.S. Bureau of Labor Statistics (BLS), in 2006 there were 1,447,233 direct care workers employed as Nursing Aides, Orderlies and Attendants. Nursing
assistants working in nursing facilities make up an estimated 24.7% (593,490) of the over 2.4 million paraprofessional workers (American Health Care Association, 2004 and Bureau of Labor Statistics, 2004). In 2007, Michigan had 48,860 direct care workers were employed as Nursing Aides, Orderlies and Attendants (Paraprofessional Healthcare Institute, 2009).

Direct care workers (DCWs) such as nursing assistants, form the centerpiece of the formal long term care system. These frontline workers provide hands-on care to NH residents. The hands-on care they provide is intimate and personal. Direct care workers are considered the key players in determining the quality of paid long term care as a result of their hands-on assistance with resident activities of daily living (ADLs). Because of their daily contact with residents and the relationships they develop with the resident, DCWs are considered the eyes and ears of the NH care team. These workers provide the “high touch” that is essential to quality of life as well as quality of care for chronically disabled individuals (Stone, 2001).

The majority of all nursing staff employed in nursing homes is certified nursing assistants. To date, there are approximately 600,800 certified nursing assistants employed in nursing homes (Jones et al., 2004). These direct care workers provide between 80%–90% of all resident care yet receive the least amount of training, receive the lowest pay in health care, and are rarely consulted when care decisions are made or implemented (Barry et al., 2005; Blair & Glaister, 2005; Kane, 1994; Stone, 2001). Direct care workers have considerable responsibilities yet they lack both authority and autonomy within the NH (Casper & O’Rourke, 2008). Kane (1994) suggested that DCWs have a perceived
and actual lack of power, which she feels is one thing in common with NH residents. This lack of power is problematic because DCWs possess the greatest ability to enable or impede resident autonomy. As a result, efforts to individualize resident care must take the needs of DCWs into account (Casper & O’Rourke, 2008).

Even though some studies indicate DCWs have a perceived lack of power, Kane et al. (2006) found in their study on NH staff’s perceived ability to influence quality of life, nursing assistants consistently perceived that they had more influence in more of the quality of life areas than either nursing professionals or physicians. The quality of life areas evaluated in this study included: comfort, dealing with pain, independence, privacy, choice, dignity, pleasurable activity, food and dining, (residents) do what (they) want, identity, relationships, personal safety, possessions (are) safe, spiritual needs met, values respected, not belittled, and anxiety/boredom. This study also found that nursing assistants are generally more optimistic about their ability to influence QOL and have the greatest opportunity to influence QOL because they have more regular contact with residents.

Individual Factors that Contribute to DCW Practices

Characteristics

What are the characteristics of DCWs taking care of NH residents? Eighty to 90 percent of direct care workers are women. The typical DCW is a non-white single mother aged 25–54 (Harris-Kojetin, Lipson, Fielding, Kiefer & Stone, 2004; Stone, 2001). The average age of direct care workers working in nursing care facilities is 38 years old
(Paraprofessional Healthcare Institute, 2009). Direct Care Workers are among the lowest wage earners in the United States, and many have little access to benefits (Ball, Lepore, Perkins, Hollingsworth & Sweatman, 2009; Harris-Kojetin et al., 2004; Stearns & D'Arey, 2008; Stone, 2001). The median annual earnings for direct care workers are $18,502 (Paraprofessional Healthcare Institute, 2009). Michigan's direct care workers average annual earnings are $16,446, and less than the state's self-sufficiency income—the amount necessary to meet basic expenses without relying on government or nonprofit assistance, as calculated by the Michigan League for Human Services (PHI, 2009).

Motivation

Nursing home studies reveal when DCWs feel emotionally close to their residents and spend more time socializing with residents, DCWs are more satisfied (Foner, 1994; Tellis Nayak & Tellis Nayak, 1989). Caring for and relating to residents in assisted living facilities contributed to job satisfaction and were a central factor for deciding to remain in their jobs (Ball et al., 2009).

Many direct care workers are motivated to work in long term care because of a desire to help people and they enjoy working with older people (Mickus, Luz, & Hogan, 2004). Others are internally motivated and define themselves as nurturing, caring, and compassionate people who help the sick. They view their role as a "religious calling or mission" (Heiselman & Noelker, 1991, p. 554). Mittal, Rosen, and Leana (2009) studied individual factors, on-the-job factors, off-the-job factors, and contextual factors associated with retention and turnover in the direct care workforce. One theme associated
with retention included being “called” to service where DCWs took “pride in and got emotional satisfaction from their jobs when they felt needed and were able to provide good care” (p. 628). DCWs who developed personal relationships with residents and their families experienced joy.

Training

The federal government requires training only for nursing assistants and home health aides who work in Medicare- and Medicaid-certified nursing homes and home health agencies (Michigan Department of Community Health, 2006; Paraprofessional Healthcare Institute, 2009). This mandatory training required by the Omnibus Budget Reconciliation Act (OBRA) of 1987 mandates that nursing assistants complete 75 hours of training and a written certification test (Federal Nursing Home Reform Act, 1987; Michigan Department of Community Health, 2006). In order to work in Medicare and Medicaid certified nursing homes, nursing assistants must be certified by the state to provide Medicare or Medicaid reimbursable services.

Nurse assistant training includes performance testing, clinical training and a final examination. Written quizzes are given daily and a passing score of 80% must be achieved to remain in the class. Performance testing includes demonstrations for each task listed on the achievement record. Core curriculum for training includes 38 hours of lecture about theory on some of the following topics: information on long term care facilities and long term care residents, resident rights, nurse aide as a member of the health care team, human interactions, infection control, safety and emergency, basic
personal care, care of the resident environment, care of the resident with cognitive impairment, creating a restraint free environment, care of the resident with developmental disability, depression, admission, transfer and discharge process, vital signs, height and weight, nutrition and hydration needs, elimination, restorative care, death and dying, and care of the resident with communicable disease (Lakeland HealthCare, 2008; Michigan Department of Community Health, 2006).

After all of the classroom work and performance demonstrations have been completed, students must complete a final exam prior to continuing on to the clinical practicum. The final exam covers all topic areas taught through lectures and demonstrations. The score of 80% must be achieved on the final exam in order to pass (Lakeland HealthCare, 2008).

Nursing assistant training also includes 21 hours of lab experience where the nursing assistant observes an instructor demonstrating a procedure or how to provide personal care. The lab experience is conducted in a classroom that allows demonstrations to be carried out on a life like mannequin. Instructors demonstrate how to provide personal care such as oral hygiene, skin care, hand and foot care, perineal care, bathing, dressing, hair care and shaving, vital signs, height and weight, nutrition and hydration needs, elimination, and restorative care (Lakeland HealthCare, 2008; Michigan Department of Community Health, 2006).

Twenty-four hours of clinical experience is another curriculum component of training. The clinical experience includes observing and assisting certified nursing assistants with resident care in a long term care facility. This clinical experience is
supervised by the nursing instructor for the program and provides an opportunity for students to participate in the actual hand-on care of residents. All skills performed during clinical training must be met at 100% accuracy in order to pass (Lakeland HealthCare, 2008). In spite of receiving 75 hours of federally mandated training, many nursing assistants believe this amount of training does not prepare them for the job (Nakhnikian, Wilner, Joslin, & Hurd, 2002).

Mental Models

Because of the minimal training nursing assistants receive, many times they rely on the “knowledge they have learned through life experiences (mental models) to shape the care they provide” (Anderson, et al., 2005, p. 1007). “Mental models are deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action” (Senge, 1990, p. 8). These images, assumptions and stories are carried in our heads and they shape what we believe and how we act.

Other professionals such as registered nurses, physicians and social workers have revised and expanded their mental models through professional education and years of socialization. Even though nursing assistants have socialization, they do not have the same amount of education and training. Therefore, nursing assistants use and build on the mental models that have been successful in their personal lives and experiences (Anderson et al., 2005). Anderson et al. identified two major themes that influence how
nursing assistants interpret and label resident situations and the action they take. The two themes are the “Golden Rule” and “mother wit” (p. 1011).

The Golden Rule means nursing assistants put themselves in the resident’s shoes as they provide care to residents and treat residents the same way you wanted to be treated (Anderson et al., 2005). Treating residents like they were “real people” was another component of the Golden Rule (p. 1011). The Golden Rule also assumed nursing assistants know what’s best for residents “rather than learning the resident’s preferences (p. 1011).

Anderson et al. (2005), defined mother wit as “acting from wisdom gained through experience as a mother” (p. 1011). Nursing assistants that utilized mother wit recognized a similar dependency between a child and an elderly resident in which residents are thought of as children. Nursing assistants were not offended by resident comments and behaviors when they used mother wit. Mother wit also provided the impetus for nursing assistants to remain patient and calm when faced with demanding residents.

Institutional Factors Contributing to DCW Practices

Nursing Home Structure

Nursing homes that have adopted culture change initiatives by undergoing organizational changes, such as supporting a team approach for workers or cross-training staff, makes the organization less hierarchical and empowers DCWs (Doty et al., 2008). Yeatts and Cready’s quasi-experimental research in 2007 compared five NH that
implemented culture change initiatives to empower DCW work teams to other NH that did not. DCW performance was higher in the NH that implemented the changes. The DCW sense of autonomy increased and they felt more competent in performing their work. Family members and residents reported that resident care had improved as a result of more time spent with residents and giving residents more control over their care. Another positive effect of these empowered work teams included more DCW awareness of resident health conditions which reduced the possibility that a resident health problem would go unattended for an extended length of time.

Jervis (2002) ethnographic research explored direct care worker-supervisory relationships within the context of a chain of command. Results confirmed the hierarchical organizational structure in nursing homes by nursing supervisors using language such as “delegating down” or “down at the unit level” in their conversations. Supervisors frequently attributed the cause of recruitment and retention problems to nursing assistants’ personal problems, dysfunctional family structure, being irresponsible and lack of respect for the job. Supervisory staff never mentioned organizational structure, or mistreatment or poor management by top-level staff, as a reason for turnover.

Castle and Engberg (2006) examined the association between nursing assistants and licensed nurse turnover and the organizational characteristics of 854 nursing homes. The one year turnover rates for nursing assistants were 56.4%. Results consistently revealed that for all caregivers, staffing levels, lower quality, for-profit ownership, and
higher bed size were associated with higher turnover. Results were particularly robust for the association between high turnover and lower staffing levels for nursing assistants.

Nursing Home Culture

The Eden Alternative is just one of the culture change models for long term care. The core concept of the Eden Alternative philosophy is to create places where residents “live as habitats for human beings rather than facilities for the frail and elderly” (Eden Alternative, 2009). Their primary work has been in deinstitutionalizing the culture and environment of nursing homes.

The Eden Alternative is a principle-centered philosophy for culture change that provides a new way of thinking and differs from the programmatic approach of delivering care in nursing homes that has been known in the past. It provides new values that become the foundation for dramatic and sustainable transformation of the organization and the people who come in contact with the organization (Eden Alternative, 2009). This new way of thinking and doing is based on 10 Eden Alternative Principles in Table 2.

Certified Eden Alternative facilities have experienced decreased resident behavioral incidents, decreased restraint use, decreased pressure ulcers, decreased urinary tract infections, decreased contractures, decreased weight loss, increased resident satisfaction, (Barba et al., 2002; Eden Alternative, 2009; Ransom, 1998) increased family satisfaction (Barba et al., 2002; Eden Alternative, 2009; Ranson, 1998; Rosher &
Table 2
Ten Eden Alternative Principles

| Principle 1 | The bulk of suffering among NH residents if from loneliness, helplessness, and boredom. |
| Principle 2 | A resident centered community is committed to close and continuing contact with plants, animals, and children. |
| Principle 3 | Human and animal companionship is the antidote to loneliness. |
| Principle 4 | A resident centered NH provides for opportunities for residents to give and receive care. |
| Principle 5 | The antidote to boredom in a NH is spontaneity and variety. |
| Principle 6 | Meaningful activity is essential to the health of NH residents. |
| Principle 7 | Medical treatment should be the servant of genuine human caring, never its master. |
| Principle 8 | A resident centered NH honors its residents by providing them a choice and decision-making authority into the operations of the NH. |
| Principle 9 | Creating a resident centered NH ongoing and a never-ending process. |
| Principle 10 | Wise leadership is essential to combat the plagues of loneliness, helplessness and boredom. |


Robinson, 2005), increased staff satisfaction and decreased staff turnover (Barba et al., 2002; Eden Alternative, 2009; Ransom, 1998).

One of the goals of the Eden Alternative is to provide an environment that is nurturing to everyone populating it. The Eden Alternative philosophy is built on the assumption that caregivers in nursing homes will treat residents the way the caregivers themselves are treated. Therefore, if caregivers feel nurtured and cared for, they will nurture and be caring toward residents. Also, if they feel valued, they will value residents (Barba et al., 2002).
The relationship between supervisory staff and CNAs is an important contributor to worker satisfaction (Bishop, Squillace, Meagher, Anderson, & Wiener, 2009; Harris-Kojetin et al., 2004). Supervisory style and relationships between workers and supervisors influence retention. Workers are more likely to stay in the job when they are treated with respect by their supervisors and participate in resident care decisions and work schedules (Eaton, 2000; Leon & Marainen, 2002; Mickus et al., 2004; Mittal et al., 2009). Retaining excellent workers is important because job quality and satisfaction are linked to quality of care as a result of DCWs spending more time with residents than any other NH care giver.

The relationship between management practices, DCW practices, and worker outcomes is well documented. McGilton, Hall, Pringle, O’Brien-Pallas, and Krejci (2004) interviewed direct care workers as a part of their study on supervisor relationships in nursing facilities. Their research identified personal and professional factors that affected whether supervisors displayed supportive behaviors. These factors included the supervisor’s attitude and personality, teamwork, mutual support, breadth of knowledge, ability to delegate, and willingness to share information.

Kemper et al. (2008) coded open ended responses from a baseline survey of 3,468 direct care workers conducted as a part of the National Study of the Better Jobs Better Care demonstration. Common themes emerged that a priority for management in nursing facilities should be improved work relationships, especially supervision and whether workers are appreciated, listened to, and treated with respect. Improving relationships
through training in communication, supervision, and team building; peer mentoring; and
greater involvement of direct care workers in care management decisions would improve
DCWs’ jobs.

Mickus et al. (2004) conducted a mail survey of 1,100 current and former direct
care workers in nursing homes and home health agencies in Michigan. Direct care
workers in nursing facilities did not feel valued by the organization and they were
dissatisfied with supervisors. DCWs leave this work because of these factors in addition
to low pay and heavy workload. Lack of respect by supervisors was significant in
whether nursing home workers left their job. Another significant finding in this study was
that regardless of the pay rate, improved supervisory support was likely to have retained
these workers.

The National Nursing Assistant Survey (NNAS) conducted the largest and most
visible research initiative of the long term care workforce. This survey, a supplement to
the 2004 National Nursing Home Survey, and was the first national probability survey of
nursing assistants working in nursing homes. The design was a stratified, multistage
probability survey where nursing facilities were sampled and then nursing assistants were
sampled within the facilities. The goal of the study was to provide useful information to
the industry and policy leaders to improve the attractiveness of long term
paraprofessional care-giving jobs and reduce turnover. The NNAS provided descriptive
data that would allow researchers to focus their studies on nursing assistants as a subset
of the larger, broader group of long term care workers. A total of 3,017 telephone
interviews were conducted resulting in a 53.4% response rate. Subject areas on the survey
included: recruitment; education, training, and licensure; job history; family life; management, supervision; client relations; workplace environment; work-related injuries; demographics; and, why nursing assistants left the field (Squillace et al., 2007). The NNAS survey data advance the knowledge available specific to nursing assistants working in nursing homes. It also provides a framework for future evidence-based policy, practice, and applied research initiatives to address the long term care workforce shortages. Results of several subject areas follow.

The median hourly pay rate for nursing assistants in nursing homes was $10.05 per hour. Median hourly rates increased for years experience and those working more than 10 years the median hourly pay rate was $11.15 per hour (Squillace et al., 2007). Forty-two percent of nursing assistants worked 40 hours per week while 16.2% worked 16–31 hours per week, 31.8% worked 32–39 hours per week and 9.4% worked more than 40 hours per week. Eighty-nine percent of nursing assistants were offered health insurance coverage; however, only 54% were enrolled in health insurance. Almost 43% of nursing assistants did not feel they had enough time to adequately assist residents with activities of daily living. Forty-three percent of nursing assistants did not think they had adequate time to perform nonresident duties. Facility practices in assigning nursing assistants to care for residents revealed nursing assistants usually cared for different residents 46.7% of the time and cared for the same residents 47.1% of the time. Nursing assistants’ satisfaction with selected aspects of current job showed that 26.8% were extremely satisfied with work place morale while 51.9% were somewhat satisfied. Forty-nine percent of nursing assistants were somewhat satisfied with doing challenging work
and 43.8% were extremely satisfied. Only 22.9% of nursing assistants were extremely satisfied with benefits and 18.4% were extremely satisfied with their salary. Satisfaction with learning new skills revealed that 44.4% of nursing assistants were extremely satisfied and 43% were somewhat satisfied (Squillace et al., 2007).

According to the NNAS survey results 36% of nursing assistants strongly agreed they were respected and rewarded for work, while 18.2% strongly disagreed. Sixty-nine percent strongly agreed they can decide how to work and 68% do challenging work. Fifty percent strongly agreed they can gain new skills and knowledge on the job and 58.6 strongly agreed they were trusted to make resident care decisions and have the opportunity to work in teams. Of significance, 94.2% of nursing assistants felt confident in their competence. Overall, 71.4% of nursing assistants felt they were respected a great deal by residents and 61.7% were respected a great deal by residents’ families, and 58.3% felt respected a great deal by supervisors (Squillace et al., 2007).

Bishop et al. (2009) analyzed data from the 2004 NNAS using multinomial logistic regression to estimate effects of compensation and working conditions on nursing assistants’ overall job satisfaction, controlling for personal characteristics and local labor market characteristics. Results showed that job satisfaction was associated with wages, benefits, and job demands as a ratio of nursing assistant hours per resident day. When nursing assistants felt respected and valued by their employers and had good relationships with supervisors, job satisfaction was greater, which is consistent with previous studies. Other findings included when nursing assistants had enough time to finish their work,
work was challenging, and did not have to work mandatory overtime, they were more satisfied.

Summary

The purpose of this study was to discover how DCWs define success in their practice and describe what institutional and individual factors contribute to their successful practices. How DCWs perceive NH resident quality of life was ascertained along with how their practices reflect quality of life dimensions. Results of the study may add to the body of knowledge of successful practices of DCWs that promote quality of life of nursing home residents. Results may also provide evidence to support revisions to the regulations guiding the content of DCW training.

Chapter II reviewed the history of nursing homes and why nursing home regulations such as the Nursing Home Reform Act were established. Trends in the elderly population were provided along with an explanation of the increasing nursing home population. Details of each quality of life regulation were included. Quality of life as it relates to nursing home residents was discussed along with resident quality of life information. Detailed information about the make-up of the direct care worker workforce and their perceptions about their work environment were described. Institutional factors and individual factors contributing to the work of direct care workers are summarized.

In Chapter II, literature related to nursing homes and long term care, the elderly population residing in nursing homes, and individual and institutional factors that
influence direct care workers was presented. Chapter III includes the research methods used to conduct the investigation.
CHAPTER III

METHODOLOGY

Introduction

Nursing homes will become home to millions of baby boomers in the coming years and in spite of passing many regulations, yet there is still concerns regarding the quality of life for nursing home residents. For many years quality of care was the focus of nursing home regulations and their survey process, but quality of care did not necessarily mean residents experienced quality of life. The Nursing Home Reform Act (1987) established quality standards for nursing homes and emphasized the importance of resident quality of life. Direct care workers play a significant role in impacting the quality of life for residents residing in nursing homes through the care they provide. However, direct care workers receive minimal training. The relationship between direct care worker practices and the knowledge base required to promote resident quality of life is poorly understood. This research is important to understand this relationship and how we might be able to better prepare direct care workers in the future.

The purpose of this study was to discover how DCWs define success in their practice and describe what institutional and individual factors contribute to their successful practices. How DCWs perceive NH resident quality of life was ascertained along with how their practices reflect quality of life dimensions. Results of the study may
add to the body of knowledge of successful practices of DCWs that promote quality of life of nursing home residents. Results may also provide evidence to support revisions to the regulations guiding the content of DCW training.

Organization of the Chapter

The chapter is divided into seven sections. The first section is a restatement of the research questions. The second section includes a discussion of the research design and the design selection. The next section includes a discussion of the sample and setting for the study in addition to how the researcher obtained access and approval. The following sections include how the data was collected and analyzed. The chapter ends with a summary.

Research Questions

The study attempted to respond to five research questions. These questions were the centerpiece for this investigation and were developed based on the conceptual model. There is a lack of research on the successful practices of DCWs and what institutional and individual factors contribute to their success. Also, how DCWs perceive resident quality of life and how they practice to reflect quality of life provided the impetus to narrow the focus of this study on these two areas. Therefore, these questions concentrated on the perceptions and practices of DCWs and NH resident quality of life. The research questions guided development of the data collection instruments and were used as a basis to analyze and report data.
1. How do direct care workers (DCWs) define success in their work?

2. What are the individual factors that contribute to direct care workers (DCWs) successful practices?

3. What institutional factors contribute to the successful practices of direct care workers (DCWs)?

4. How do direct care workers (DCWs) perceive quality of life for NH residents?

5. How do direct care workers (DCWs) practice to reflect quality of life indicators?

Research Design

This qualitative study was conducted using a case study approach. Cresswell (2007) wrote that qualitative research is the study of a research problem that incorporates a worldview and begins with assumptions and possibly the use of a theoretical lens to study the meaning individuals or groups attribute to social or human problems. Denzin and Lincoln (2005) provided these definitions of qualitative research: qualitative research involves an interpretive, naturalistic approach to the world that locates the observer into this world. It includes researchers studying things in their natural settings attempting to make sense of, or interpret phenomena through the meanings people bring to them.

Marshall and Rossman (2006) defined qualitative research as a broad approach to the study of social phenomena that takes place in the natural world and uses multiple methods that are interactive and humanistic. Qualitative research focuses on context, is emergent rather than tightly prefigured and is fundamentally interpretive. Marshall and
Rossman wrote that the qualitative researcher views social phenomena holistically and systematically reflects on who she/he is in the inquiry. Qualitative researchers are sensitive to their personal biography and how it shapes the study and use complex reasoning that is multifaceted and iterative.

Qualitative research encompasses a variety of traditions, historical and philosophical perspectives, ideas, paradigms, tensions, designs, and methodologies (Denzin & Lincoln, 2005; Marshall & Rossman, 2006). Qualitative research is conducted when we need a “complex, detailed understanding of an issue” and we want to “empower individuals to share their stories and hear their voices.” It is also conducted because we want to “understand the context or settings in which participants in the study address a problem or issue.” Also, qualitative research is conducted to help “explain” or “develop theories” …and because quantitative measures and statistical analyses simply do not fit the problem (Cresswell, 2007, p. 40). The three major purposes for qualitative research are to explore, explain or describe a phenomenon. Other terminology for these same terms include understand, develop or discover (Marshall & Rossman, 2007). Qualitative studies can be both descriptive and exploratory in order to build rich descriptions of challenging problems that are unexplored in the literature.

According to Denzin and Lincoln (2005), “case studies are a common way to do qualitative inquiry.” A case study may be simple or complex. An agency or organization may be a case as well as a single person or group. The case is a bounded system which may have activity patterns. Intrinsic case studies are undertaken when one wants a better
understanding of a particular case. A case study is organized around some form of conceptual structure and a small number of research questions.

Intrinsic case studies are conducted by those who have intrinsic interest in the case in order to understand what is important about that case within its own world. Intrinsic case work begins with cases already identified, and are of prominent interest to the researcher (Denzin & Lincoln, 2005). Some view case study research as a strategy of inquiry or methodology, while others view it as a type of design in qualitative research. Case study research is an approach in which the investigator explores a bounded system over time, through detailed, in-depth data collection involving multiple sources of information such as observations, interviews, audiovisual material, documents and reports, resulting in the description of the themes of the case (Cresswell, 2007).

In summary, qualitative research focuses on exploring the meaning of a human phenomenon and includes naturalistic and interpretive inquiry, sustained contact between researcher and participant, the quest for understanding and meaning, use of inductive reasoning, and the goal of attaining thick descriptive narratives that shed light on the meaning of the experience. Case study research involves the study of an issue that is explored through one group such as DCWs within a bounded system like a nursing home setting where multiple sources of information are collected.

Research Design Selection

Qualitative research questions are directed at the “what” and “how” of phenomena versus the “why” (Cresswell, 2003; Marshall & Rossman, 2006) and are
more focused on process than actual outcomes (Cresswell, 2003). This study utilized a case study design and its methodologies to discover how DCWs define success in their work and describe any institutional and individual factors that might contribute to their successful practices. Initially, DCWs were asked what success in their work looked like and how does it look and feel when they are unsuccessful. Describing how DCWs perceive quality of life and how they practice to promote quality of life was carried out by asking the following research questions: How do DCWs perceive quality of life for nursing home residents? And, how do DCWs practice to reflect quality of life indicators? Other questions explored the individual and institutional factors that contribute to their successful practices by asking the following two questions: What are the individual factors that contribute to DCWs successful practices? What institutional factors contribute to the successful practices of DCWs?

This case study was carried out in a nursing home to capture the experiences of DCWs in their natural setting. The nursing home itself is a bounded system as well as the group of DCWs being studied. Face-to-face interactions with DCWs in their own setting assisted the researcher in collecting data through the two lenses of interviews and card sorts to better understand the deeper perspectives of the perceptions and practices of DCWs. Observations during the card sort and field notes were also documented.

Sampling

Sampling size in qualitative research depends on many complex factors (Marshall & Rossman, 2006). In recent health research qualitative studies averaged one to four
informants. Case studies may be a single organization or a single group within an organization, as long as it occurs within a bounded system.

Sampling included a convenience sample of the 15 direct care workers out of 55 DCWs eligible for the study. The pool included 60 DCWs that were employed in one nursing home in South West Michigan. Five DCWs were ineligible for the study as a result of being employed less than 12 months. The sample was selected based on the first responses to the Recruitment Letter (Appendix B) until sixteen subjects were identified. The first 15 respondents were the sample and the remaining one respondent was selected as an alternative in case of attrition. There was no attrition of any of the 15 subjects therefore the 16th subject was not needed. The inclusion criteria identified DCWs that have been employed at the facility for at least 12 months prior to the beginning of the study in order to select DCWs that have experience as a DCW and at the facility. The exclusion criteria included DCWs that had been employed at the facility less than 12 months. This researcher contacted the Director of Nursing at the facility who provided a list of DCWs that worked in the facility for at least 12 months prior to the study. The Director of Nursing and her designee distributed individual invitations to participate to all DCWs on the list at the time they picked up their pay checks. A Recruitment Letter was posted at each of two nurses' stations at the facility. The Recruitment Letter informed interested direct care workers to telephone or e-mail the researcher of their willingness to learn more about the study. Because enough DCWs replied to the Recruitment Letter within five working days, a follow-up Recruitment Letter was not necessary.
Once the 15 DCWs volunteered to learn more about the study, the researcher contacted them individually to answer any of their questions before they volunteered to participate. After DCWs agreed to volunteer, this researcher arranged a time and place at the facility to complete the interviews and card sort. The researcher met with the participants, explained the study, reviewed the informed consent with them and answered all questions. After all questions were responded to, all 15 volunteers agreed to participate in the study, they signed the informed consent. Informed consent was obtained from each subject (Appendix C).

HSIRB and Data Storage

The protocol established by Western Michigan University’s Institutional Review Board (HSIRB) was followed (Appendix D). Permission to complete the research in the facility was obtained from the Executive Director for Post Acute Services. The research proposal was also presented to Lakeland’s Institutional Review Board and was determined exempt from their review (Appendix F). Informed consent was obtained from each participant and steps were taken to maintain confidentiality. Names of subjects were kept in a secured file in the investigators home and were not shared with the Executive Director or other employees at the facility. Subjects’ names were coded (e.g., DCW1, DCW2, and DCW3) to protect identity. Subjects were informed of the right to withdraw from the study at any time without resource. All components of the study were thoroughly explained before interviews or observations took place.
All data collected was kept under lock and key at the home of the researcher. Once the data were collected and analyzed, the master list with any names of the participants was destroyed. All other forms were retained for the duration of the project in a locked file in the investigator’s home office and when the study closes, the data will be retained on the WMU campus either in a locked file in the Principal Investigator’s office or in the University Archives for at least three years.

Setting

The study was conducted in one nursing home in South West Michigan. The nursing home has 111 long term care beds and is owned and operated by one health system. The NH is a not-for-profit facility. This NH employs approximately 120 employees including clinical, non-clinical, and management staff. Direct care workers constitute over half of the total patient care staff in the facility. This NH employs 43 full time certified nursing assistants and another 17 part time nursing assistants which make up 61% of the total patient care staff.

This particular organization was chosen because of its strong commitment to culture change initiatives. Implementation of culture change began at the facility over 11 years ago. This facility has completed all of the steps to be designated as a certified Eden facility.
Instrumentation

The researcher developed the interview protocol based on information found in the review of literature (Appendix G) in order to answer the research questions. The interview protocol began with general questions about what success in their practice looks like and what experiences or relationships in their life may have helped them be successful in their work. Questions should become more specific as the interview progresses (Cresswell, 2003). Specific questions were designed to elicit organizational influences on their practices and where they obtained their knowledge. The last questions focused on what quality of life means to them and how they would describe quality of life for NH residents and how any of their practices might promote resident quality of life.

Cards were created that display the 11 quality of life domains (Appendix H). The 11 domains are distinguished as: a sense of safety/security/order, physical comfort, meaningful activity, relationships, enjoyment, dignity, autonomy/choice, privacy, individuality, spiritual well-being, and functional competence (Degenholtz et al., 2005; Kane, 2001; Kane et al., 2003; and Kane et al., 2004). A simple description of each of the eleven domains was written on individual cards. Codes corresponding to each domain were also written on each card that was used during the data analysis process. Individual codes were identified as such: (SSO) for Sense of Safety, Security, and Order; (PC) for Physical Comfort; (E) for Enjoyment; (MA) for Meaningful Activity; (R) for Relationships; (FC) for Functional Competence; (D) for Dignity; (P) for Privacy; (I) for Individuality; (A/C) for Autonomy/Choice; and, (SW-B) for Spiritual Well-Being.
The quality of life dimension check list was developed based on literature and the quality of life domains (Kane, 2001). The quality of life regulations and interpretive guidelines were also incorporated into the check list (AHCA, 2009; Allen, 2007) (Appendix I). This research used the quality of life dimension check list to code and analyze responses to question 8. In this question, DCWs described aspects of their practices that promote QOL. DCWs answers were checked off next to each appropriate quality of life dimension that they mentioned during the interview. Their responses provided responses about how their practices reflected quality of life indicators.

Data Collection Methods

Generally, qualitative researchers choose one of four methods for gathering information: (a) participating in the setting, (b) observing directly, (c) interviewing in depth, and (d) analyzing documents and material culture (Marshall & Rossman, 2006). For purposes of this study, in depth interviews with DCWs, a card sort exercise, and observation of the card sort and field notes were completed to obtain answers to the five research questions. According to Marshall and Rossman (2006), in-depth interviews are like conversations to help uncover the participant’s views. This method of interviewing helps unfold the participant’s perspectives on the topic.

After identifying volunteers who were interested in learning more about the study, arrangements were made for a private space for the interviews to take place. The space used for the study was a small quiet area designated as a chapel that is also used for group meditation and relaxation meetings. A mutual date and meeting time was determined for
each volunteer. Times were scheduled during regular working hours, as the facility agreed to pay the participants for their regular worked time.

At the scheduled meeting time and prior to interviews or card sorts, the researcher met with the volunteers, explained the study, reviewed the informed consent with them and answered any questions they had. Only after all questions were answered and volunteers agreed to participate in the study were they asked to sign the informed consent. Informed consent was obtained from each volunteer agreeing to participate in the study (Appendix C).

With the door closed to the chapel and a sign posted on the outside asking no one to interrupt each DCW answered information on their age, years worked as a nursing assistant and years worked at the facility. Discernment of race of the DCW was completed by observation of the researcher. After the demographic information was obtained, in depth interviews were conducted using the interview protocol. DCWs were informed when the recorder was being turned on. Interviews were recorded on microcassettes. A new cassette was used for each interview. The recorder was turned off at conclusion of the interview. Notes were documented immediately following the interview when any comments were made after the recorder was turned off. The time of interviews ranged from 20–45 minutes depending on the length of the DCWs answers. A log of the dates, times and places where the data was collected was documented.

Data collection for question 4 also included the task of card sorting. After completion of the interview, each DCW was given 11 cards with the name of one of the QOL domains and its description on it to review. They were asked if they had any
questions about the definitions on the cards. Questions were answered regarding definitions and meanings on the cards. After all questions were addressed, DCWs were asked to place the cards in order of what they felt was the most important quality of life domain to the least important when considering the residents they cared for. DCWs were asked to place the most important card first and the least important last, or in the 11th position. Having DCWs rank order the cards provided insight into what they perceive as the most important aspect of NH resident quality of life. Field notes were completed while observing the DCW complete the card sort task. All comments made by the DCWs during the exercise were recorded. All of the notes recorded were detailed, nonjudgmental, and concrete descriptions of what the researcher observed and heard during the exercise.

Field notes were documented to reflect any “experiences, hunches, and learnings” by the researcher (Cresswell, 2007, p. 134). Notes were taken while observing DCWs completing the card sort and also immediately after each interview. This researcher was patient and considerate to allow participants to discuss the meaning of their experiences. Table 3 presents an overview of the data collection methods used for each question.

Data Analysis

Data analysis was guided by the central purposes of this study: (1) to collect information about how DCWs define success in their practice; (2) to explore and describe how individual and institutional factors contribute to their successful practices; (3) to describe how direct care workers perceive quality of life; and (4) to describe how DCWs
Table 3

Data Collection Methods

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How do direct care workers (DCWs) define success in their practice?</td>
<td>In depth interview with DCWs. Interview protocol.</td>
</tr>
<tr>
<td></td>
<td>Digital recording.</td>
</tr>
<tr>
<td>2. What are the individual factors that contribute to direct care workers (DCWs)</td>
<td>In depth interview with DCWs. Interview protocol.</td>
</tr>
<tr>
<td>successful practices?</td>
<td>Digital recording.</td>
</tr>
<tr>
<td>3. What institutional factors contribute to the successful practices of DCWs?</td>
<td>In depth interview with DCWs. Interview protocol.</td>
</tr>
<tr>
<td></td>
<td>Digital recording.</td>
</tr>
<tr>
<td>4. How do DCWs perceive quality of life for NH residents?</td>
<td>In depth interview with DCWs. Interview protocol.</td>
</tr>
<tr>
<td></td>
<td>Digital recording.</td>
</tr>
<tr>
<td></td>
<td>Card sort to prioritize 11 quality of life domains.</td>
</tr>
<tr>
<td></td>
<td>Document rank order of individual DCW choices.</td>
</tr>
<tr>
<td></td>
<td>Observation of the DCW completing the exercise and document field notes and any comments.</td>
</tr>
<tr>
<td>5. How do DCWs practice to reflect quality of life indicators?</td>
<td>In depth interview with DCWs. Interview protocol.</td>
</tr>
<tr>
<td></td>
<td>Digital recording.</td>
</tr>
</tbody>
</table>

practice to reflect quality of life indicators. There were three phases of the data analysis process. The first phase analyzed the transcripts from the personal interviews of the 15 DCWs. The second phase evaluated the results of the card sort for the 11 quality of life domains. And, the third phase analyzed observations of the card sort and any field notes taken during the interview process and card sort exercise.

In the first phase data was organized and prepared for analysis using the transcribed interviews. To facilitate analysis, all interviews were transcribed verbatim. A
log of the dates, times and places where the data was collected was documented. Transcribed notes were read four different times to obtain a general sense of the information and to reflect on its overall meaning (Cresswell, 2003).

Reading and rereading of the transcribed notes assisted the researcher to become intimately familiar with the data (Marshall & Rossman, 2006). Transcribed notes were also read without the context of the research questions and interview questions to get a general sense of any commonalities in the responses. To respond to research questions 1, 2, 3, and 4 (RQ1, RQ2, RQ3, RQ4) inductive analysis and emergent coding for responses to interview questions 1, 2, 3, 4, 5, 6, 7, 9 and 10 were completed to discover patterns, themes and categories in the data. Salient words and phrases that resulted in the prominent themes and emergent themes were generated through reading and re-reading of the transcripts at least five times. Patterns of frequent words and phrases were highlighted using different colored hi-lighters. These patterns of words and phrases were counted to determine the frequency. Counting can help researchers see what data they have and confirm their evidence with numbers (Burns & Grove, 2003). Comparing insights by using numbers is a good method of verification (Miles & Huberman, 1994). Criteria were developed for the identification of prominent themes and emergent themes. Prominent themes were identified when at least nine to twelve or 60–80% of DCWs mentioned the subject at least once in their interview. Emergent themes were determined when at least seven DCWs or 46% mentioned the subject at least once in their interview.

To address research question 5 (RQ5), the quality of life dimension check list that was developed based on literature, Kane’s (2001) quality of life domains, and the quality
of life regulations and interpretive guidelines (AHCA, 2009; Allen, 2007) is displayed in (Appendix I). The quality of life dimension check list was used to code and analyze responses to interview question 8 that asked DCWs to describe any of their practices that may promote resident quality of life. Individual DCW responses were checked off next to each appropriate quality of life dimension that was mentioned during the interview. Their responses provided information about how their practices reflect quality of life indicators.

Data generated from the check list were analyzed by entering it into an Excel spreadsheet. Individual DCW results are displayed in a cross-tabs table based on the quality of life dimension check list. Frequency of results for each dimension is also displayed in a bar chart (Table 18).

Results of the rank order of the card sort task were entered into an Excel spreadsheet. A cross-tabs table was produced that displays results by individual DCWs (Table 17). A sum of the rank orders was completed for the group and presented in (Figure 2).

After completing the coding process the researcher interpreted the findings and identified essential features and interrelationships among the data. Findings were challenged and alternative understandings examined. Table 4 presents a summary of how data were analyzed for each question and data collection method.

Researcher

This researcher is employed within the health system where the research was completed. The researcher previously (1½ years ago) was employed at the long term care facility
Table 4

Data Analysis

<table>
<thead>
<tr>
<th>Research Question/ Data Collection Method</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How do direct care workers (DCWs) define success in their practice? In depth interviews of DCWs.</td>
<td>In depth interviews were recorded on microcassettes and then transcribed. Transcribed notes were organized so that the researcher could be immersed in the data. Categories and themes were identified. Emergent codes were used and interpreted to identify categories and themes.</td>
</tr>
<tr>
<td>2. What are the individual factors that contribute to direct care workers (DCWs) successful practices? In depth interviews of DCWs.</td>
<td>In depth interviews were recorded on microcassettes and then transcribed. Transcribed notes were organized so that the researcher could be immersed in the data. Categories and themes were identified. Emergent codes were used and interpreted to identify categories and themes.</td>
</tr>
<tr>
<td>3. What institutional factors contribute to the successful practices of direct care workers (DCWs). In depth interviews of DCWs.</td>
<td>In depth interviews were recorded on microcassettes and then transcribed. Transcribed notes were organized so that the researcher could be immersed in the data. Categories and themes were identified. Emergent codes were used and interpreted to identify categories and themes.</td>
</tr>
<tr>
<td>4. How do direct care workers (DCWs) perceive quality of life? In depth interviews of DCWs; Card sort to prioritize 11 quality of life domains.</td>
<td>In depth interviews were recorded on microcassettes and then transcribed. Transcribed notes were organized so that the researcher could be immersed in the data. Categories and themes were identified. Emergent codes were used and interpreted to identify categories and themes. A priori coding was completed utilizing the quality of life domains and the codes assigned to them. Results of the rank order of the card sort task were entered into an Excel spreadsheet. A cross-tabs table displayed results by individual DCWs. A sum of the rank orders was completed for the group and presented graphically.</td>
</tr>
</tbody>
</table>
Table 4—Continued

<table>
<thead>
<tr>
<th>Research Question/ Data Collection Method</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. How do direct care workers (DCWs) practice to reflect quality of life indicators?</td>
<td>In depth interviews were recorded on microcassettes and then transcribed. Transcribed notes were organized so that the researcher could be immersed in the data. Categories and themes were identified. Emergent codes were used and interpreted to identify categories and themes. A priori coding was completed utilizing the quality of life dimension check list and codes. Data generated from the check list was entered into an Excel spreadsheet. Individual DCW results were displayed in a cross-tabs table based on the quality of life dimension check list. Frequency of results for each dimension was displayed in a bar chart.</td>
</tr>
</tbody>
</table>

where the research was carried out. According to Coghlan and Casey (2001), the research process may become more difficult and awkward when the researcher’s role is combined with her organizational role. It was important for the researcher to be aware of the strengths and limits of her perspectives and potential bias as the project was conducted.

Summary

Chapter III established a foundation for the analysis and explained the methodology and the data collection procedures used. The purpose of the study was to determine how DCWs define success in their practice and describe what institutional and individual factors contribute to their successful practices. How DCWs perceive NH resident quality of life will be ascertained along with how their practices reflect quality of life dimensions.

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Chapter IV includes the findings from the interviews and card sort exercise. The data were presented under each of the five research questions.
CHAPTER IV

RESULTS

Purpose of the Study

The purpose of this study was to determine how direct care workers define success in their practice and to discover what, if any, individual and institutional factors contributed to successful practices. How direct care workers (DCW) perceive nursing home resident quality of life was revealed along with how their practices reflect quality of life indicators. Results of the study add to the body of knowledge of successful practices of DCWs that promote quality of life of nursing home residents. These findings provide evidence to support revisions to the regulations guiding the content of DCW training.

The chapter is comprised of 10 sections which includes: (1) an overview of the research problem; (2) demographic information describing participants; (3) criteria used for prominent themes and emergent themes; (4) prominent themes and emergent themes; (5) a restatement of the research questions; (6) prominent themes and emergent themes identified that addressed each research question; (7) rank order of quality of life domains; (8) QOL card sort observations and field notes; (9) results for the quality of life dimension check list; and, (10) a chapter summary.
Overview of the Research Problem

Quality of life has become a critical measure for assessing nursing home residents. What we do not know is how direct care workers perceive nursing home resident quality of life. Also, we need to know how direct care workers’ practices promote quality of life and what individual or institutional factors contribute to their successful practices. Gathering data to explain how DCWs define success in their practice and what individual and institutional factors contribute to their successful practices will provide nursing home administrators and regulators with valuable information to inform practice and regulations.

Demographic Data

Participants were asked a series of demographic questions prior to beginning the Interview Protocol (see Appendix G). Information collected from the participants was compiled into three tables shown as Table 5, Table 6 and Table 7. There were five separate demographic questions. An analysis of this information is summarized below.

Fifteen participants were involved in the study. Demographic information collected included gender, age, race, years worked in a nursing home and years employed at the facility where the research was completed. Ninety-three percent of the participants were female (Table 5). This convenience sample was similar to the National Nursing Assistant Survey (NNAS) which identified 92.3% of the DCWs as female and 7.7% as male (Squillace et al., 2007). The NNAS was the first national probability sample survey of nursing assistants employed in nursing homes. The survey was designed to provide an
Table 5
Participant Ethnicity and Gender

<table>
<thead>
<tr>
<th>Race</th>
<th>N</th>
<th>Percent</th>
<th>Gender</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5</td>
<td>33.0%</td>
<td>Females</td>
<td>14</td>
<td>93.0%</td>
</tr>
<tr>
<td>Black</td>
<td>10</td>
<td>67.0%</td>
<td>Males</td>
<td>1</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

evidence base for understanding what draws individuals to careers as nursing assistants and to work in nursing homes, and what contributes to their satisfaction and likelihood of staying in their jobs.

Participants’ race is included in Table 5. Sixty-seven percent of the interviewees were Black and 33% were White. Squillace et al. (2007) reported in the NNAS that 53.3% of nursing assistants were white, 38.8% were black and 7.9% were Hispanic/Latino or other. The difference between the race of the case study group and Squillace’s findings may be the random sample of DCWs that agreed to participate in the study.

Table 6 identifies the average age of participants including the median and range of ages as well as the average years worked in a nursing home, and years worked at the facility where the research was completed.

Table 6
DCW Age and Years Worked, N=15

<table>
<thead>
<tr>
<th></th>
<th>Avg.</th>
<th>Median</th>
<th>Range</th>
<th>STDEV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>42.8</td>
<td>42</td>
<td>23–69</td>
<td>16.4</td>
</tr>
<tr>
<td>Years worked in a NH</td>
<td>12.8</td>
<td>9</td>
<td>1.5–42</td>
<td>12.09</td>
</tr>
<tr>
<td>Years worked at facility</td>
<td>9.4</td>
<td>5</td>
<td>1.5–41</td>
<td>10.49</td>
</tr>
</tbody>
</table>
Table 7 provides demographic information by individual DCW. The average age of participants in this study was 42.8 years old with a range of 23 years up to 69 years old. According to Paraprofessional Healthcare Institute (2009) and Squillace et al. (2007), the average age of direct care workers working in nursing care facilities is 38 years old, which is lower than the average age of 42.8 years at this facility. The percent of DCWs 55 years and over employed in nursing homes in the National Nursing Assistant Survey (NNAS) was 12.5% (Squillace et al., 2007), whereas the study group 55 years and older was 40%.

<table>
<thead>
<tr>
<th>Demographics by Individual DCW</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Age</th>
<th>Years worked in a NH</th>
<th>Years worked at facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1</td>
<td>F</td>
<td>B</td>
<td>46</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>DCW2</td>
<td>F</td>
<td>B</td>
<td>25</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>DCW3</td>
<td>F</td>
<td>B</td>
<td>34</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>DCW4</td>
<td>F</td>
<td>W</td>
<td>23</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>DCW5</td>
<td>F</td>
<td>B</td>
<td>31</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>DCW6</td>
<td>F</td>
<td>B</td>
<td>67</td>
<td>42</td>
<td>41</td>
</tr>
<tr>
<td>DCW7</td>
<td>F</td>
<td>B</td>
<td>23</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>DCW8</td>
<td>F</td>
<td>W</td>
<td>55</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>DCW9</td>
<td>F</td>
<td>W</td>
<td>55</td>
<td>33</td>
<td>12</td>
</tr>
<tr>
<td>DCW10</td>
<td>F</td>
<td>B</td>
<td>32</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>DCW11</td>
<td>M</td>
<td>B</td>
<td>25</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>DCW12</td>
<td>F</td>
<td>B</td>
<td>69</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>DCW13</td>
<td>F</td>
<td>W</td>
<td>60</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>DCW14</td>
<td>F</td>
<td>B</td>
<td>42</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>DCW15</td>
<td>F</td>
<td>W</td>
<td>55</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
The average number of years worked in a nursing home was 12.8 years with a range of 1.5–42 years. The average number of years worked at this particular facility was 9.2 years with a range of 1.5–41 years. This study did not include DCWs employed less than one year at the facility. Comparing the study results of years of work in a nursing facility to the NNAS results of DCWs worked as a nursing assistant identified the following similarities: NNAS revealed that 8.4% of DCWs worked 1 year but fewer than 2 years and this case study included 1 or 7% working 1.5 years; NNAS results identified 26.2% DCWs worked 2–5 years, while this study showed 33%; NNAS identified 19.2% working 6–10 years and this study showed 20%; NNAS identified 22.3% worked 11–20 years and this study showed 27%; lastly, NNAS identified that 12.4% of DCWs worked more than 20 years, while this study showed 13% of the DCWS worked in a nursing facility more than 20 years.

Criteria for Prominent Themes and Emergent Themes

Inductive analysis was utilized to discover the patterns, themes, and categories of the data generated from interviews. Indigenous typologies were created based on the responses expressed by the subjects. Each prominent theme and emergent theme was reviewed to incorporate salient points and to demonstrate the depth of their feelings and perspectives. A priori coding was completed using the QOL dimensions to identify DCWs perceptions of resident quality of life. Prominent themes were identified when at least nine to twelve or 60–80% of DCWs mentioned the subject at least once in their
interview. Emergent themes were determined when at least seven DCWs or 46% mentioned the subject at least once in their interview.

Prominent Themes and Emergent Themes for Each Research Question

Seven prominent themes were identified from the data. The seven prominent themes included: (1) Direct Care Workers (DCW) define success in their work and feel successful when their resident’s needs are met, they are comfortable and happy; (2) when DCWs can’t meet their resident’s needs or provide the care they think they should, they feel unsuccessful, unhappy and frustrated; (3) DCWs attribute their success from meaningful relationships with their family or others, how they were raised, and the desire to treat residents the same way as they or family members would like to be treated; (4) DCWs obtain knowledge for their successful practices from influential teachers and the training they received; (5) organizational or institutional factors such as other experienced DCWs or the team that DCWs work with contribute to the successful practices of DCWs; (6) incorporation of the Eden philosophy into the culture of the organization did not make a difference and did not change how DCWs practice, because they were already practicing the same way; and, (7) DCWs described a good quality of life (QOL) for residents when they are comfortable, happy and treated as individuals.

Each prominent theme identified will be reviewed as it relates to the research questions.

Three emerging themes were also identified. Emergent themes were: (1) DCWs need to have patience, love, understanding and kindness to be successful; (2) DCWs understanding about the Eden philosophy means the environment should be homelike for
residents; and, (3) QOL for residents means residents have meaningful relationships and are not lonely; they are as independent as possible attempting to live their lives as they previously lived before being admitted to the facility. Each emergent theme will be described under each of the five research questions.

Research Questions

The five research questions that guided the study were:

1. How do direct care workers (DCWs) define success in their work?

2. What are the individual factors that contribute to direct care workers (DCWs) successful practices?

3. What institutional factors contribute to the successful practices of direct care workers (DCWs)?

4. How do direct care workers (DCWs) perceive quality of life for NH residents?

5. How do direct care workers (DCWs) practice to reflect quality of life indicators?

These research questions were developed based on the incongruence between the literature and the successful practices of DCWs and their perceptions about nursing home resident quality of life. Utilizing a case study approach and triangulating the study by incorporating interviews, a card sort and observations provided perspectives from three different lenses.

In the following sections, data from participant interviews are reported under each research question.
RQ1 How do direct care workers (DCWs) define success in their work?

PROMINENT THEME 1: Direct Care Workers define success in their work and feel successful when their resident’s needs are met and they are comfortable and happy.

Twelve out of 15 DCWs identified this theme citing they defined success when their resident’s needs are met and they are comfortable and happy. Individual responses are reported in Table 8.

Table 8
DCW Responses Regarding Feeling Successful

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW2</td>
<td>I’ve done all that I’m supposed to do for my residents... As far as their needs, their personal needs</td>
</tr>
<tr>
<td>DCW3</td>
<td>I helped somebody, I made somebody feel comfortable today</td>
</tr>
<tr>
<td>DCW4</td>
<td>My residents are happy, they look nice and are happy</td>
</tr>
<tr>
<td>DCW5</td>
<td>residents get the proper care, ... they’re happy.</td>
</tr>
<tr>
<td>DCW7</td>
<td>It means a lot to have them be so happy every day.</td>
</tr>
<tr>
<td>DCW8</td>
<td>helping the residents to feel good or look good or laugh or smile</td>
</tr>
<tr>
<td>DCW9</td>
<td>They’re happy,... content.</td>
</tr>
<tr>
<td>DCW11</td>
<td>everybody’s needs are met and all taken care of and everyone’s happy...</td>
</tr>
<tr>
<td>DCW12</td>
<td>know my residents are happy</td>
</tr>
<tr>
<td>DCW13</td>
<td>when she came to us she was in a cardiac chair and now she’s in a wheelchair and she wheels herself around...</td>
</tr>
<tr>
<td>DCW14</td>
<td>doing things that they wasn’t doing before, I feel successful. I feel I’ve done my job.</td>
</tr>
<tr>
<td>DCW15</td>
<td>they’re happy and content and I helped get them there.</td>
</tr>
</tbody>
</table>
DCW 2 described her success as “Knowing that I’ve done all that I’m supposed to do for my residents, as far as their...personal needs... That’s what makes me feel I’ve done my job.” When DCW 3 stated she has “a sense of I helped somebody, I made somebody feel comfortable today. It gives you a good feeling.” DCW 4 revealed she feels successful when “My residents are happy, they look nice and are happy with the place here (meaning the NH) and with their care.”

When my residents “get the proper care...they’re happy...they feel warmth and welcomed and they are smiling especially after the care that we give them, that makes me feel happy and successful” according to DCW 5. DCW 7 stated: “Just to be able to help that person everyday... It means a lot to have them be so happy.” “Helping the residents to feel good or look good or laugh or smile you feel like you’ve succeeded” is what DCW 8 believes. DCW 9 defined success in her work when “…residents are up and dressed and well groomed. They’re happy...content. If I’m able to get them toileted so they aren’t incontinent on themselves, that’s important to me and I think that’s important to them.”

“When everybody’s needs are met and all taken care of and everyone is happy...” is what DCW 11 identified as being successful in her work. DCW 12 commented that: “when they give me a hug and sometimes maybe a kiss it makes me feel like I’ve done my job...I know my residents are happy.”

DCW 13 shared: “I can tell when I make a big difference because... when she came to us she was in a cardiac chair and now she’s in a wheelchair and she wheels herself around and we do transfers... so that was my pride and joy... that makes me very proud because I really love my job. I love taking care of people.”
DCW 14 felt successful: “When I see my residents that come in that was barely walking, barely moving, and all of a sudden they was up and about and doing things that they wasn’t doing before, I feel successful. I feel I’ve done my job.” DCW 15 indicated that when she felt successful is: “When I have a resident say to me, thank you so much or you can tell the look on their face that they’re happy and content and I helped get them there.”

DCW Job Satisfaction was Related to Resident Happiness

Six DCWs suggested that when residents’ needs are met and their residents are happy, that also made DCWs happy. DCW 1 described being successful is: “a comfort that you can only experience. And…something you can’t describe.” DCW 5 shared: “when I do my job and a resident says thank you and you’re really good, that makes me feel good. I feel like I’m actually doing what I’m supposed to do.” DCW 6 related when she feels successful it is: “Joy, to me. I feel joyful ‘cause I’m doing something that I enjoy doing. It makes me feel good.” DCW 7 related that: “It gives me a good feeling when I know that I’ve touched somebody for even just for the day. Just to be able to help that person everyday and hear them say thank you or I appreciate you or you do so much, all of that means a lot to me.” “I feel good, I feel real good when I think I’m successful in my work. It just makes you feel good cause your helping the residents” according to DCW 8. DCW 12 indicated: “As long as I know my residents are happy then I’m happy.”
Feeling Missed

Two DCWs also felt successful when their residents missed them when they were not at work. DCW 1 shared that: “Whenever you come to work and they’ve missed you after you’ve had a day off, you’ll know it.” DCW 10 stated: “It’s nice to see that the people you take care of recognize you, miss you when you’re gone.”

PROMINENT THEME 2: When DCWs can’t meet their resident’s needs or provide the care they think they should, they feel unsuccessful, unhappy and frustrated

Twelve DCWs indicated they felt unsuccessful when they can’t meet their resident’s needs or provide the care they think they should. They also suggested it made them unhappy and frustrated. Individual responses are reported in Table 9.

DCW 2 stated: “If there was a problem that a resident had and I’m not for sure what the problem is but if it’s unresolved by the time I leave I feel like I could have done more to find out what exactly the problem was. I felt so bad… That makes me feel like maybe I didn’t do all that I could have done.”

DCW 3 suggested that being unsuccessful is: “frustrating because you don’t feel like you did all that you could do. You’re not able to get all your tasks done. It just makes you feel like I want to do this but I don’t feel like I’m doing what I’m supposed to be. I can’t get everything done that I would like to do so it gives you a sense of sadness, disappointment within yourself. Sometimes there are so many demands that sometimes you might not be able to get everything done.”
Table 9
DCW Responses About Feeling Unsuccessful

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>Individual Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW2</td>
<td>If there was a problem that a resident had and... it’s unresolved by the time I leave...I felt so bad</td>
</tr>
<tr>
<td>DCW3</td>
<td>frustrating because you don’t feel like you did all that you could do</td>
</tr>
<tr>
<td>DCW4</td>
<td>If I can’t meet the residents’ standards for everything. It doesn’t make me feel good</td>
</tr>
<tr>
<td>DCW5</td>
<td>I don’t think that’s successful when the resident isn’t happy</td>
</tr>
<tr>
<td>DCW6</td>
<td>when I haven’t done my best... I don’t feel so good about it</td>
</tr>
<tr>
<td>DCW7</td>
<td>something’s not done right and they get upset, to me it doesn’t feel good.</td>
</tr>
<tr>
<td>DCW8</td>
<td>I feel sad and I’ll put guilt on myself</td>
</tr>
<tr>
<td>DCW9</td>
<td>When...I don’t have the time to do the things that they want or need done</td>
</tr>
<tr>
<td>DCW11</td>
<td>Their (the residents) needs aren’t met,</td>
</tr>
<tr>
<td>DCW13</td>
<td>Very sad...it’s very frustrating for me because I take pride in success</td>
</tr>
<tr>
<td>DCW14</td>
<td>It’s a bad feeling</td>
</tr>
<tr>
<td>DCW15</td>
<td>I’m probably not as joyful</td>
</tr>
</tbody>
</table>

DCW 4 said: “If I can’t meet the residents’ standards for everything. It doesn’t make me feel good.”

DCW 5 shared: “Unsuccessful is...when you are not able to perform your job up to the standards that’s a part of you and you do it anyway. As far as my residents, sometimes you can come in and help a resident and sometimes they don’t remember who we are and they’ll think that the person that just left them was me... and they say, “you left me in here in the bathroom ... you didn’t do this... you didn’t do that” and I think to
myself, oh my gosh I can’t believe they (the other staff member) didn’t do this or that. To me that’s not a successful setting for the resident as a team. I don’t think that’s successful when the resident isn’t happy.”

DCW 6 related when she feels unsuccessful she feels: “Terrible. I know when I haven’t had a good day. Some days when I come in I say oh God it’s just been a terrible day... I know when I’ve done my best and when I haven’t done my best and... I don’t feel so good about it when I walk out the door. I feel tomorrow I hope I can do better ‘cause I know what areas I didn’t do good in that day.”

Similarly DCW 7 indicated: “Sometimes it’s inevitable not for everything to go the way that you would want it to like a passing of a resident. I would determine as unsuccessful if you weren’t able to contain their end of life care. That is not a good feeling... you grow to love them and when they pass or something’s not done right and they get upset, to me it doesn’t feel good.”

DCW 8 shared thoughts about being unsuccessful: “I feel sad and I’ll put guilt on myself and it can ruin your whole day. That’s not a good feeling. So I try not to fail.” DCW 9 stated she felt unsuccessful: “When I feel hurried or rushed...I don’t have the time to do the things that they (the residents) want or need done for them because then they’re discontent.” DCW 9 also suggested that being unsuccessful is when: “Residents are still in bed, wasn’t able to get them up because I didn’t have enough time because we were short staffed.”

Likewise, DCW 11 also felt unsuccessful when: “Their (the residents) needs aren’t met, like they ask me to do something and you know how more than one person
asks you to do something at a time and you take care of that person and the other person might slip your mind...and they remind you about it...and that’s when you feel like, oh Man, I didn’t do my job and they’ll let you have it sometimes.”

DCW 13 related when she’s unsuccessful she feels: “Very sad. I have a couple gentlemen that for some reason can’t follow commands, whether it’s their illness or what and it’s very frustrating for me because I take pride in success...” DCW 14 shared that when she’s unsuccessful: “It’s a bad feeling. If a resident that was in good shape when they got here but needed just a little help and all of a sudden they go down then I feel like I’m unsuccessful. That’s a bad feeling.” DCW 15 related that: “some days you’re off and... you keep telling them (the residents) the same thing and that can wear thin... So on my off days I’m probably not as joyful and they’re probably not as joyful.”

Trying Harder When Things Don’t Work

Five DCWs suggested they tried harder when things aren’t working and adjust or change what they do to care for their residents. DCW 2 provided an example of trying harder when she shared: “I had a resident that at the beginning of the shift she was fine but by the end of the shift she became very combative and crying and I tried to do everything that I could to find out what was wrong.” DCW 4 stated: “I will try to do the best I can and try to make them as happy as they can be.” Similarly, DCW 7 stated: “It seems like you could try harder or you could interpret their needs a little bit more so that the outcome would have been successful.”
According to DCW 10, when she feels unsuccessful: "it mostly pushes me harder to try and overcome … even though you know you may not be able to change their mind or their perception about you, then you… try a little harder,… be a little nicer, maybe this will work, maybe it won’t but at least I know that I did my part in trying to make you (the resident) feel like you was wanted, you was safe and you was well taken care of when you came into this facility."

DCW 13 shared that when she feels unsuccessful, she doesn’t give up and stated: "I still plug along with them, we just have to re-arrange their care plan and I will continue working with them."

Two themes were identified that responded to research question one: Theme 1: Direct Care Workers define success in their work and feel successful when their resident’s needs are met and they are comfortable and happy; and Theme 2: When DCWs can’t meet their resident’s needs or provide the care they think they should, they feel unsuccessful, unhappy and frustrated.

Other pertinent comments that did not represent a theme were also made. Six DCWs suggested that when DCWs met their residents’ needs and their residents are happy, that also made them happy. When DCWs cannot meet their resident’s needs they feel frustrated and they tried harder when things are not working and adjust or change what they do to care for their residents. Two DCWs also felt successful when their residents missed them when they were gone.
RQ2 What are the individual factors that contribute to direct care workers (DCWs) successful practices?

PROMINENT THEME 3: DCWs attribute their success from meaningful relationships with their family or others, how they were raised, and the desire to treat residents as they would like to be treated or a family member treated.

Nine DCWs indicated they were influenced by family and how they were raised or meaningful relationships with others when they responded to the question about what individual factors contributed to their successful practices. Nine DCWs also revealed their desire to treat residents as they wished to be treated or they would want a family member treated contributed to their successful practices. Responses are depicted in Table 10.

DCW 1 attributed her success to: “The people that surround me. I’ve met some pretty unique people here and I try to keep myself around people who are positive. No matter what they’re making or what they’re not making they keep God first and it’s a beautiful thing when you have people like that around because they kind of keep you grounded.”

DCW 2 related: “so I put myself in that situation. If this was me wouldn’t you want someone to clean you and keep you dry and feed you?”

Likewise, DCW 3 affirmed: “My grandmother is how I got started doing it. Just treat people like I would want to be treated, or treating people like I would want to see my mother or my grandmother treated. Me being successful has a lot to do with the residents. I pray, Lord help me do what you called me to do, help me to treat people like I want to be treated, help me give good care to my residents.”
Table 10
DCWs Attribution to Their Success

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>Influenced by family and how they were raised or meaningful relationships with others</th>
<th>Desired to treat residents as they want to be treated or they would want a family member treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1</td>
<td>The people that surround me. They keep God first. They kind of keep you grounded</td>
<td>so I put myself in that situation</td>
</tr>
<tr>
<td>DCW2</td>
<td></td>
<td>treat people like I would want to be treated, or treating people like I would want to see my mother or my grandmother treated.</td>
</tr>
<tr>
<td>DCW3</td>
<td>My grandmother is how I got started</td>
<td></td>
</tr>
<tr>
<td>DCW4</td>
<td>the way I was raised. I was raised very family oriented. Mom... was the biggest influence.</td>
<td></td>
</tr>
<tr>
<td>DCW6</td>
<td>when my husband got sick. I had to take care of him</td>
<td>put myself in somebody else’s shoes</td>
</tr>
<tr>
<td>DCW7</td>
<td>watching my mom take care of my grandmother</td>
<td></td>
</tr>
<tr>
<td>DCW8</td>
<td>Dealing with my children and my grandchildren</td>
<td></td>
</tr>
<tr>
<td>DCW10</td>
<td>my Mom and my Dad for sure</td>
<td></td>
</tr>
<tr>
<td>DCW11</td>
<td>My family, our values, religion</td>
<td>Treat them like your family</td>
</tr>
<tr>
<td>DCW14</td>
<td>My father... We took care of him at home</td>
<td>Treat the residents as if that was your family member, our mother, your grandfather, or grandmother.</td>
</tr>
</tbody>
</table>

DCW 4 stated: “Probably the way I was raised. I was raised very family oriented, we all take care of each other and so I enjoy taking care of people. I’m close with my
mom and she is a very caring person. She isn’t in the nursing field but she is a good
mom. She was the biggest influence.”

DCW 6 shared: “One good thing that helped me with being successful here is
when my husband got sick. I had to take care of him at home, I took care of him for 20
years at home… when I came here it made me totally feel different. I felt good…so
coming here just made me feel good.”

DCW 7 related her success to being compassionate and watching her mom: “I
think I’ve always been a compassionate person and able to put myself in somebody else’s
shoes and see whatever they might need and how they might feel asking for help. My
great-grandmother was a dialysis patient for 15 years…and I remember helping my Mom
a lot with her…and just being around my mom and watching her take care of my
grandmother and my great-grandmother I think gave me a real good sense of what to do.”

DCW 8 indicated her success came from: “Dealing with my children and my
grandchildren help to give me more patience which I brought here into work cause
dealing with some of the elderly takes a lot of patience.”

DCW 9 shared that thinking about family members as customers contributed to
her success: “I always just felt how I would feel that with my grandma or my mother and
I always had a perception of them being the customer and trying to please them and do
what they needed and not just be a job. I don’t know if that’s the way I was brought or if
I always just felt that way. Try to think about what it would be like if it were themselves
or their parents or grandparent in that situation that they would want to try and give them
the best care and make sure that they were happy and had the things they needed and wanted around them.”

When responding to what contributed to her success DCW 10 stated: “I think my mom and my dad for sure” contributed to her success.

DCW 11 commented: “My family, our values, religion values and all that. That’s helped me a whole lot cause we were taught everybody is equal and you should always feed your enemy (I don’t have any enemies) cause they’re in need and need your help. Just love the residents and be there for them. Treat them like your family cause they almost like your family cause you be here a lot and around them so much and just treat them like your family.”

“So understanding and compassionate because that could be you someday. I treat people the way I want to be treated and that’s the bottom line” according to DCW 13.

Caring for an ill family member helped her become successful is what DCW 14 related: “My father, he passed away, he had cancer. We took care of him at home…until he passed away. That made me want to go more in depth than what I’m doing now. Treat the residents as if that was your family member, your mother, your grandfather, or grandmother.”

Spiritual or Religious Influence

Even though this was not a theme or emergent theme, at least six DCWs attributed their successful practices to a calling from God, the Lord, or a spiritual or religious influence. DCW 2 commented: “I think that’s just something that comes from
within. I think God has a lot to do with why I do the things that I do and how I feel and
the outlook that I have on different things.” DCW 3 shared: “I look at it (being
successful) as I was just called to do this and that’s what I’m gonna do.” DCW 6 said:
“This is my calling from the Lord. I love it and enjoy it.”

DCW 10 reiterated: “being brought up in church I think that helped a lot. A lot of
my aunts and uncles are all missionaries, ministers, preachers, all that, so I think my
church background and my family history gears me for this type of job here.”

DCW 11 stated: “our values, religion values and all that” is what contributed to
DCW 11’s success. DCW 12 also indicated that: “I just felt like this is the thing the Lord
has me to do.”

PROMINENT THEME 4: DCWs obtain the knowledge for their successful practices
from influential teachers and the training they received

When asked where they obtained the knowledge for their successful practices at
least nine DCWs related they obtained their knowledge from teachers who had a strong
influence on them and the training they received in their nursing assistant program.
Salient comments are documented to support the theme. Individual DCWs who
responded to Theme 4 is depicted in Table 11.

DCW 1 related she obtained her knowledge from: “Zelma Feld. Zelma Feld was
one of those women that kind of steered you into it. She was a CNA Teacher and she
scared me so bad because she made me think I was unsuccessful but all the time she was
pushing me to be successful. I didn’t realize it until years later. If I could see Zelma
today I’d tell her thanks for pushing me that hard. So I would say Zelma Feld.”
Table 11  
Origin of DCWs Knowledge for Successful Practices

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>DCW Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1 CNA Teacher</td>
<td></td>
</tr>
<tr>
<td>DCW3</td>
<td>I got my CNA license through SMC but prior to that I did Home Care</td>
</tr>
<tr>
<td>DCW4</td>
<td>I went to St. Joe and that’s a good school and then I got my CNA through Lakeland and Kelly was actually my teacher and she’s a good teacher so I learned a whole lot from her</td>
</tr>
<tr>
<td>DCW5 Southwestern Michigan College</td>
<td></td>
</tr>
<tr>
<td>DCW9</td>
<td>I took the Eden training … and education that they do with us here</td>
</tr>
<tr>
<td>DCW10</td>
<td>Between high school and Lakeland</td>
</tr>
<tr>
<td>DCW11</td>
<td>Lakeland…provided the education through the CNA program</td>
</tr>
<tr>
<td>DCW14</td>
<td>went to school for it in Kalamazoo</td>
</tr>
<tr>
<td>DCW15</td>
<td>School… I went to SMC</td>
</tr>
</tbody>
</table>

DCW 3 stated her knowledge came from not only the college she attended but also previous experience through another agency: “I got my CNA license through SMC but prior to that I did Home Care so just through agencies.” DCW 4 shared that her knowledge was initially obtained from her high school and then through the training program where she currently works, as well as the instructor for the program: “Maybe school, I went to St. Joe and that’s a good school and then I got my CNA through Lakeland and Kelly was actually my teacher and she’s a good teacher so I learned a whole lot from her.” DCW 5 commented: “I went to Dowagiac, Southwestern Michigan College was offering three month classes. I went there and did a two and half month program out there and that’s when I first decided this is really what I wanted to do and I liked it.”
DCW 9 cited several sources for her knowledge: “I don’t know, I think a lot of it is just the experience, the numbers of years I’ve done it. I have read books about long term care and I took the Eden training and I have Dr. Thomas’ books and through meetings and education that they do with us here.”

DCW 10 also attributed her knowledge from high school as well as the training program where she currently works: “Between high school and Lakeland them are the only two places I really been for training for a CNA.” DCW 11 also cited her employer: “A lot of people have played in that. I would say Lakeland cause they’re the one that provided the education through the CNA program.” DCW 14 said: “I went to school for it in Kalamazoo.” DCW 15 indicated: “Definitely school, ‘cause this is new to me. I went to SMC.”

Other Sources of Knowledge

Besides school, DCWs also obtained knowledge for successful practices from other sources such as being around family members or taking care of family members, working with other DCWs, and on the job training. DCW 3 shared she also obtained her knowledge from: “watching other people and picking up things from them.” DCW 6 said her knowledge came: “From my grandmother. When I was a little girl I always hung around her whether in the kitchen or the garden.” DCW 7 similarly commented about obtaining her knowledge from family: “I’m going to say when I was younger being around my grandmother and great-grandmother with my Mom and making sure they were cared for and their needs were met.” DCW 8 also indicated her knowledge came
from working and observing others when she stated: “Through my years of working and seeing how others work and deal with the elderly, aides, nurses, activities people and working at other nursing homes and just seeing how everybody helped.”

DCW 12 said when asked where she obtained the knowledge for her successful practices: “From a very big family, the oldest girl and had a lot of siblings and I had to take care of them and that let me know this is the type of work I wanted to do.” DCW 13 related her knowledge came from; “On the job training. I started working in a nursing home in Lawton, you didn’t have to be certified. I worked there for three years, I went to Montana and worked in a Psych ward and did odd jobs and transferred to OB, transferred to surgical just off and on and found out geriatrics was my style.” DCW 14 said: “before I even went to school for it, I took care of my father and I learned how to do it there, so it made it more easy for me when I went to school for it.” According to DCW 15, “just by working” is where she obtained the knowledge for her successful practices.

Emergent Theme One

EMERGENT THEME 1: DCWs need to have patience, love, understanding and kindness to do this work and be successful.

Eight DCWs indicated that in order to be successful in their work, DCWs needed to have patience, understanding and kindness. DCW responses that support Emergent Theme 1 is depicted in Table 12.

DCW 1 commented about not doing this type of work unless you have a heart for it when she stated: “I think that if you don’t have the heart for what I do you shouldn’t be
Table 12
Attributes Needed for Success

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>DCW Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1</td>
<td>if you don’t have the heart for what I do you shouldn’t be here</td>
</tr>
<tr>
<td>DCW2</td>
<td>like in any profession that you do you have to love what you do</td>
</tr>
<tr>
<td>DCW3</td>
<td>It takes a special person to do this so even without the Eden you should have some of that in you already to want to give good care, to show love, to show compassion and all those things.</td>
</tr>
<tr>
<td>DCW4</td>
<td>You have to have a heart and compassion and patience</td>
</tr>
<tr>
<td>DCW6</td>
<td>It takes patience, love, understanding and kindness</td>
</tr>
<tr>
<td>DCW11</td>
<td>Just love the residents and be there for them</td>
</tr>
<tr>
<td>DCW12</td>
<td>The main thing is patience</td>
</tr>
<tr>
<td>DCW13</td>
<td>be understanding and compassionate</td>
</tr>
</tbody>
</table>

here…or anywhere else because this is a hard job.” DCW 2 shared: “I feel like in any profession that you do you have to love what you do. You can’t just do it because “Oh it’s a job and we get paid for it.” DCW 3 said: “It takes a special person to do this so even without the Eden you should have some of that in you already to want to give good care, to show love, to show compassion and all those things.” Similarly, DCW 4 also stated: “I really enjoy working as a CNA. I like taking care of people. You have to have a heart and compassion and patience.”

DCW 6 expressed very strong feelings about knowing this is the type of work that you want to do before you start working in the field when she said: “The first thing I say is know this is what you want to do when you come here. I tell everybody this job is not for everybody. Know that this is what you want to do when you come here. You’re not coming for a paycheck. It takes patience, love, understanding and kindness, all that and
if you ain’t got a portion of that, then it’s not the field for you. If you walk through this place before an interview and see what you see and you know this ain’t what you want to do but your mind is saying you’re going to get a paycheck every two weeks, it’s not about that. I don’t feel it’s about that. It’s about coming in here and take care of the patients.”

DCW 11 commented: “Just love the residents and be there for them.” DCW 12 said: “The main thing is patience. That’s what we need when we work in a place like this.” According to DCW 13, in order to be successful you have to: “be understanding and compassionate”.

Responses to RQ2: What are the individual factors that contribute to direct care workers (DCWs) successful practices identified two themes and one emergent theme. Themes identified were: Direct Care Workers attribute their success from meaningful relationships with their family or others, how they were raised, and the desire to treat residents as they would like to be treated or a family member treated; and, DCWs obtain the knowledge for their successful practices from influential teachers and the training they received. Emergent themes identified were: DCWs need to have patience, love, understanding and kindness to do this work and be successful.
RQ3 What institutional factors contribute to the successful practices of direct care workers (DCWs)?

PROMINENT THEME 5: Organizational or institutional factors such as other experienced DCWs or the team that DCWs work with contribute to the successful practices of DCWs

When asked what organizational or institutional factors contributed to their successful practices DCWs primarily mentioned other experienced DCWs that had a significant influence on them and the team that they worked with. Most considered the team as other DCWs rather than other staff in the facility. Responses regarding organizational and institutional factors that contributed to DCW successful practices are depicted in Table 13.

DCW 1 identified organizational factors that contributed to her success as: “The people that I work with. The team I work with help each other out and I guess by newcomers coming in they see how we work and they fall into the same plan that we’re already in.” DCW 2 reiterated the same: “I’d say my other aides…”

DCW 3 shared: “Starting out as a new CNA, there was some things that I didn’t know, because you don’t learn everything in a classroom, you learn stuff hands on, and watching some of the senior employees that have been here, watching them give good care. You think, OK maybe I should be doing that, and that made me a better CNA.”

DCW 5 commented that her successful practices were influenced by another DCW that had a significant amount of experience: “When I first started working here there is a CNA, she’s been here for either 28 years or 30 years, something like that and when I first heard that I thought, are you kidding me, how could you be somewhere that
Table 13
Factors Impacting DCW Successful Practices

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>DCW Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1</td>
<td>The people that I work with. The team I work with</td>
</tr>
<tr>
<td>DCW2</td>
<td>I'd say my other aides</td>
</tr>
<tr>
<td>DCW3</td>
<td>Watching some of the senior employees that have been here...give good care</td>
</tr>
<tr>
<td>DCW5</td>
<td>A CNA, she’s been here for either 28 years...she really inspires me to become a better person</td>
</tr>
<tr>
<td>DCW6</td>
<td>The people here, my coworkers</td>
</tr>
<tr>
<td>DCW9</td>
<td>A lot of your success depends on your coworkers... you all have to work together to be successful.</td>
</tr>
<tr>
<td>DCW10</td>
<td>The people that I work for that have been doing this for a long long time like, Miss Annette, Sheila and all of them that have been doing it for over 10 or 15 years</td>
</tr>
<tr>
<td>DCW11</td>
<td>Everybody has played a part. From the staff to the residents</td>
</tr>
<tr>
<td>DCW15</td>
<td>Who you’re working with</td>
</tr>
</tbody>
</table>

long. How did you do this job for that long and to see her still smile and still wanting to come here and still happy every day. Not a day goes by when she doesn’t smile. She’s “how you doing”. I was like, WOW, that really inspired me. I thought OK this is someone I can look up to and she’s an older lady, she’s old enough to be my grandmother and she moves around. She really inspires me to become a better person, to smile, to speak to people when they’re walking past no matter who it is.”

DCW 6 also suggested: “the people here, my coworkers” were organizational factors that contributed to her successful practices.

DCW 9 stated: “I think a lot of your success depends on your coworkers, the ones you work with on a daily basis because if you don’t work together as a team and help
each other out when you’re running behind or have a crisis situation, you all have to work together to be successful.”

DCW 10 commented: “I think some of the people that I work for that have been doing this for a long long time like, Miss Annette, Sheila and all of them that have been doing it for over 10 or 15 years and you sit there and sometime wonder what motivates to keep getting up and coming in and doing it. So you know they sort of encourage me sometime to come in here and do my job a little better. To see, well they made it, I can make it too.”

DCW 11 related about organizational factors that made her successful: “Everybody has played a part. From the staff to the residents everybody’s played a part.”

Likewise, DCW 15 also stated: “I think sometimes who you’re working with can make for a good day or a bad day. When you’re a team, if you’re all working together to get the shift done and get them what needs to be done, so that when you leave you know what you were supposed to do is done.”

Other Organizational Factors

Other organizational factors that DCWs identified as contributing to their successful practices included management staff such as their supervisor, charge nurse, director of nursing or administrator. DCW 2 stated: “I’d say...some of the nurses” contributed to her success. DCW 6 said: “my nurses and my director of nurses. I feel like I can go to them and whatever I talk about it stays there.”
DCW 8 observed: "Kelly, the restorative nurse, who is now my supervisor, I like how she deals with the residents. I like her attitude towards them and how she deals with them. Even Fay, she’s an RN here on the Hawthorne side, I like how she deals with the residents. I would say they help to impact the way I work here. I like how they deal very positive. To see how they do it, cause not all nurses treat elderly the same and I just like the way Fay and Kelly do it. There’s others too, Petrona deals with them really good, I like how she deals with them. Just about anybody that I see that has so much patients and treats the elderly almost like there one on one, just so good. I can’t pinpoint exactly, they just treat them, not really like they’re patients but ordinary people, with respect and caring and love and I like that.”

DCW 9 shared: I also think the administrative staff has played a role in that as well.”

DCW 14 commented: “Actually, you do. (Meaning the researcher who had previously been the Administrator at the facility about 1½ years ago) When I see people that are caring and more concerned about the residents come out to the floor and make it their business to get to know the resident, not just, they seem, you know they actually come and talk to them and really get to know them and know who they are and things about them.”

Direct care workers also identified residents and family as factors that contributed to their success. DCW 4 suggested: “Probably the residents” were organizational factors that contributed to her successful practices because: “If they’re happy then everybody else is happy ‘cause that’s what we’re here for. If your residents are happy then it’s a
successful place.” DCW 6 also said: “The patients families, they help. I enjoy communicating with them.” DCW 7 commented: “I would say the happiness of the residents really impacts, because as long as their happy it makes you want to come to work and try your best at what you do.”

According to DCW 12 an organizational factor that helped her become successful is: “When I come in the morning time and know that my residents, when they are ready to eat, they’ll tell me, I like you, I like the way you do things, when they are pleased with my work.”

DCW 13 suggested residents contribute to her success by stating: “I can’t think of just one person except for the lady (a resident at the facility) that I was telling you about that was in a cardiac chair and now she’s wheeling around and transferring with one assistance. I feel I’m impacted everyday that I do things with people and if I’ve been gone for a while I hear, where have you been, I’ve missed you, I didn’t want to work with that other person, I wanted to work with you. So that kind of makes me proud.”

PROMINENT THEME 6: Incorporation of the Eden philosophy into the culture of the organization did not make a difference and did not change how DCWs practice, because they were already practicing that way.

The Eden Alternative is just one of the culture change models for long term care. The core concept of the Eden Alternative philosophy is to create a home-like environment where residents feel nurtured and caregivers are valued. When asked what the Eden philosophy meant to their practice, at least nine DCWs mentioned that the Eden philosophy did not make a difference to their practice and did now change how they
practiced because they were already practicing that way. DCW responses for Theme 6 are depicted in Table 14. Salient comments from the interviews are described in the paragraphs below the table.

DCW 1 commented: “Before Eden got here I had the same practice. I just figured that when we got Eden in this building we were already doing those practices so it just helps along newcomers to me.” DCW 2 indicated she did not have a clear understanding of Eden when she said: “I never think about it. Like I said I don’t have an absolute clear understanding.”

Table 14
Impact of Eden Philosophy on DCW Practices

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>DCW Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1</td>
<td>Before Eden got here I had the same practice… we were already doing those practices</td>
</tr>
<tr>
<td>DCW2</td>
<td>I never think about it.</td>
</tr>
<tr>
<td>DCW3</td>
<td>Eden didn’t change how I practice because it’s something that I would do anyway.</td>
</tr>
<tr>
<td>DCW4</td>
<td>I don’t really know that Eden has anything to do with it, I’m just the way I am so it really doesn’t influence me</td>
</tr>
<tr>
<td>DCW7</td>
<td>Eden doesn’t make a difference because I’ve always just incorporated it into what I do</td>
</tr>
<tr>
<td>DCW8</td>
<td>I don’t think I practiced any differently here versus a non-Eden facility.</td>
</tr>
<tr>
<td>DCW9</td>
<td>I don’t know if it really made a difference because I’ve always had that concept</td>
</tr>
<tr>
<td>DCW12</td>
<td>The Eden doesn’t make that much difference to me</td>
</tr>
<tr>
<td>DCW14</td>
<td>Eden didn’t change how I practice. I’m doing it on a daily basis</td>
</tr>
</tbody>
</table>

96
DCW 3 stated: “Eden didn’t change how I practice because it’s something that I would do anyway. I would show love and show that I care, that’s what I’m here for. Not everybody is called to do this type of work. It takes a special person to do this so even without the Eden you should have some of that in you already to want to give good care, to show love, to show compassion and all those things.”

Likewise, DCW 4 reiterated: “The way I work I try to carry on conversations so I try to make their life good. I don’t really know that Eden has anything to do with it, I’m just the way I am so it really doesn’t influence me as much as it does the facility. I know this is an Eden facility and things are done the Eden way but I do things kind of the Eden way but it doesn’t really influence me.”

DCW 7 also commented: “I guess Eden doesn’t make a difference because I’ve always just incorporated it into what I do since this has been the only facility that I’ve worked at, I guess I just tried to incorporate it into what I already do.”

DCW 8 indicated: “This is the only nursing home I’ve worked for that’s had the Eden way of life so I can’t say that it has been the whole part of it cause I’ve worked in other nursing homes and have always tried to treat somebody like I would want my Mom or Grandma or even myself being treated. So I can’t say that Eden…has helped. I don’t think I practiced any differently here versus a non-Eden facility.”

DCW 9 shared: “I don’t know if it really made a difference because I’ve always had that concept to try and bring happiness and meaning to their lives and not just come in and care for them and do what you have to do and go home.”
DCW 12 said: "my work is knowing that I'm able to help them do what they can't
do and my work is that I love doing it. The Eden doesn't make that much difference to
me because as long as they feel like they doing then it makes me feel like I'm helping
them any kind of way that they need."

DCW 14 noted: "Eden didn't change how I practice. I'm doing it on a daily basis
with my residents."

Even though over half of the DCWs did not feel the Eden philosophy changed
how they practiced, several DCWs felt it positively influenced how they and other DCWs
practiced and it also had a positive impact on residents.

DCW 5 commented: "It's important, when you're in a nursing home...So doing
things that's not part of the normal everyday activities as an individual, as a person, I
think it makes the residents feel happy and makes them feel loved, cause sometimes they
might not have the family member to come see them every week or every day and when
you have an employee take the time out to do little things with you I think that's
important as a company, especially a nursing home to have the residents feel that, the
need to do something other than, we know they have the 10 o'clock exercising on
Mondays, its routine, but when you come on your day off, in your street clothes and say
'hey, can I take you out to lunch? Or can we color and make some picture?' they love
that. I think that's important to residents that they have that feeling needed, happy,
appreciated, that someone cares enough to take the time out to do that with them."
DCW 6 suggested Eden: “makes us communicate more with the patients. We do more things with them instead of doing it for them, we let them help us do more things. I think it’s a good thing. I don’t know how to word it.”

DCW 9 also indicated Eden was important when she said: “I guess it’s (Eden) made a difference in the fact that others around me feel the same way and I can see a difference in the home and the way the care is given and I feel the residents seem to be more satisfied and content.”

DCW 11 said: “It (Eden) means a lot. I think every CNA has their own way with the residents.”

DCW 13 commented: “I try to follow it (Eden) because I whole heartedly believe in it so I feel like sometimes I go beyond in helping them feel this way. So anything that I can do to make a residents quality of life feel better...then I’m all for it. The Eden has changed how I practice. It’s not so mundane, like ‘I have to come in and get so and so up at 6:00, it was like bam, bam, bam. Now, ‘do you want to stay in bed for 10 or 15 minutes?’” So, I’ve relaxed more. So, you don’t want to eat, let’s go get a peanut butter and jelly sandwich, it’s their choices and it makes me feel like this could be me and I know what I’d want to do. So it changes my way of thinking too.”
EMERGENT THEME 2: DCWs’ understanding about the Eden philosophy means the environment should be homelike for residents

When asked during the interview what they understood about the Eden philosophy, seven DCWs mentioned the environment of the facility should be homelike for the residents. Emergent Theme 2 is displayed in Table 15. Salient points that support the emergent theme are documented in the paragraph below the table.

Table 15
DCW Understanding of Eden Philosophy

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>DCW Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1</td>
<td>this is not just a place but is home</td>
</tr>
<tr>
<td>DCW7</td>
<td>Make sure it is as close to home as possible... and making this their home.</td>
</tr>
<tr>
<td>DCW9</td>
<td>This is actually the residents home</td>
</tr>
<tr>
<td>DCW10</td>
<td>To make it more homey feeling</td>
</tr>
<tr>
<td>DCW12</td>
<td>It makes them (the residents) feel more homey</td>
</tr>
<tr>
<td>DCW13</td>
<td>You can live longer, if you are in a home environment</td>
</tr>
<tr>
<td>DCW15</td>
<td>Have the philosophy of a home</td>
</tr>
</tbody>
</table>

DCW 1 commented about what the Eden philosophy meant to her practice: to make this place as homey as possible...what I understand about it (Eden) is that we and they (the residents) are supposed to feel that this is not just a place but is home. It is supposed to be a home thing and that’s what we try to do here.
DCW 7 also indicated: “When a resident comes into a facility to make sure it is as close to home as possible. Making them comfortable and making this their home.”

Likewise, DCW 9 said: “I feel that it is a whole different way of looking at nursing homes and they’re not just a medical institute and that this is actually the residents home and we look at this being their home as now we need to respect them and their home and their belongings and we need to try to bring the joy of life into this home that they would have had in their home before they came here.”

DCW 10 commented: “I think it’s to promote quality of life and to make it more homey feeling in the facility for the residents that stay here, especially on a long-term basis.” DCW 12 also suggested: “The Eden philosophy…It’s a good thing…because it makes them (the residents) feel more homey.” DCW 13 commented on the Eden philosophy: “I love the Eden philosophy. I whole heartedly believe you can heal better, you can live longer, if you are in a home environment…because at home you just do what you want to.” According to DCW 15: “the Eden philosophy is that you try to bring healing in to care and maybe almost have the philosophy of a home. That we’re all in this together.”

Other Understandings about the Eden Philosophy

DCWs had various other comments regarding their understanding about the Eden philosophy. DCW mentioned the Eden tree, which was given to the facility by the Eden organization when it committed to becoming a certified Eden facility. DCW 1 also suggested: “They like spontaneity. Gosh…the Eden philosophy, the tree.”
DCW 2 had this to say about the Eden philosophy: “I kind of understand but then again I don’t. Initially when I first heard about the Eden project it was about animals and different things like that so I kind of understand but then I don’t. I know that we have to do something once a year for the residents that has nothing to do with work related or something like that but that’s kind of where it’s at.”

Being a certified Eden facility, management requires each staff member to complete a special project once a year for a resident. Examples of special projects that staff complete include: making cookies for a resident, purchasing special books that the resident enjoys and giving them to the resident as a gift, a special project may also include making residents a special article of clothing such as pajamas or night gowns. DCWs at this facility choose which resident they would like to complete the special project for and what the project will be. DCW 5 also referred to the once a year project when saying: “Basically, it’s something that we do every year to get the residents involved in an activity of your choice.”

DCW 14 stated: “They have you do something once a year that we tend to do all year round. These are things that we do on a every day basis with the residents and then for them to say once a year you do this, no, we do this every day. So, I kind of, you do that 8 hour session with them and stuff and a lot of that you don’t really remember all that stuff yet when you’re here on a daily basis these are things, these instruments that you have into your job and you do on an everyday basis and these are things that we like to do on our own as well.”
DCW 10 did not feel she understood the concept of Eden and the required project when she shared: “I never really, really quite understood the whole aspect of the Eden project. The training we go through and all the stuff they talk about, I never really quite grasped it.”

DCW 3 commented on the Eden philosophy: “I think the Eden is more about caring for our residents and just reaching out to them and showing them love and showing them that we care.”

DCW 4 suggested Eden being something different: “I think that having kids and activities and plants and animals here really helps them not to be lonely, all the activities that are here. I think it’s a good thing. I know for a lot of the residents, plants and animals and kids are a big thing and I know a lot of the residents love kids and when kids come and animals it keeps their day going.”

DCW 8 stated: “Sometimes it’s hard for me to even remember that they are trying at least to alleviate loneliness and boredom with kids and animals and plants and things like that.” When referring to alleviating loneliness and boredom DCW 8 was referring to one of the Eden principles. This principle states: The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering among our Elders.

DCW 9 said: “I feel that it (Eden philosophy) makes a difference in a nursing facility because it brings out the importance of the role that we as frontline caregivers, the importance of our role but in the resident side as well as going up the administrative chain because they respect and value our opinions more I think than they did before. It also is important to the residents because we try to look at their lives in a different way
and we try to implement things that help take away the helplessness and the loneliness and the boredom.”

DCW 11 understood Eden to mean: “Quality of life.”

Responses for RQ3: What institutional factors contribute to the successful practices of direct care workers (DCWs), provided two themes and one emergent theme. The two themes included: Organizational or institutional factors such as other experienced DCWs or the team that DCWs work with contribute to the successful practices of DCWs; and, incorporation of the Eden philosophy into the culture of the organization did not make a difference and did not change how DCWs practice, because they were already practicing that way. The emergent theme identified: DCWs’ understanding about the Eden philosophy means the environment should be homelike for residents.

RQ4 How do direct care workers (DCWs) perceive quality of life for NH residents?

PROMINENT THEME 7: DCWs describe a good QOL for residents when they are comfortable, happy and treated as individuals.

DCWs were asked to describe a good quality of life for residents during the interview. Nine DCWs described a good quality of life for residents was when residents were comfortable, they were happy and they were treated as individuals. The DCWs that mentioned the topics for Theme 7 is depicted in Table 16.
Table 16
DCWs Describe a Good Quality of Life

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>DCW Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW1</td>
<td>Comfortable and happy</td>
</tr>
<tr>
<td>DCW2</td>
<td>A resident that’s happy</td>
</tr>
<tr>
<td>DCW3</td>
<td>Making them feel good and special</td>
</tr>
<tr>
<td>DCW4</td>
<td>If they’re happy</td>
</tr>
<tr>
<td>DCW5</td>
<td>Making sure they are comfortable, making sure they are happy... you say their name when you are speaking to them</td>
</tr>
<tr>
<td>DCW6</td>
<td>Making things comfortable for them. I do it by involving them in what I’m doing for them</td>
</tr>
<tr>
<td>DCW7</td>
<td>Encourage some independence... maintain some dignity</td>
</tr>
<tr>
<td>DCW11</td>
<td>Being comfortable with staff here and make them happy</td>
</tr>
<tr>
<td>DCW15</td>
<td>If they enjoy doing some of the activities here</td>
</tr>
</tbody>
</table>

DCW 1 said about a good quality of life (QOL) for residents: “That means that they have gotten to a point in their life where they had to come here and live. They probably given up a lot of stuff including family to have to come here so it’s my job to make sure that everything that they can’t do for themselves I can at least assist or do it to the point where their quality of care is good, they’re comfortable, they’re comfortable with me, they’re comfortable in this environment. If you gotta live here... you want to be comfortable and happy.”

Likewise, DCW 2 stated a good QOL consists of: “A resident that’s happy. That’s kept nice and clean and fed, you know different things like that.” DCW 3 described a good QOL as: “giving them what they need. Everybody’s needs are different
so just giving them what they need and not what we think they need but what “they” need. We are making them feel good and special.”

DCW 4 commented about a good QOL for residents is: “How they are taken care of day to day. How good they are taken care of, if they’re happy here and we are doing the best to our ability to make them happy.” DCW 5 felt that: “Making sure they are comfortable, making sure they are happy, making sure that you talk to them, you say their name when you are speaking to them” is a good QOL for residents. DCW 6 also said: “Making things comfortable for them. I do it by involving them in what I’m doing for them.”

According to DCW 7: “I would say to continue to encourage some independence but also letting them know that you’re there to help them or assist them with whatever they need and also that they don’t have to put themselves in harms way but you also want them to maintain some dignity and independence while being in such a place.”

DCW 11 commented about a good QOL: “Being comfortable with staff here and make them happy.” DCW 15 shared: “I think if they enjoy doing some of the activities here, I think they have a certain quality of life”.

Emergent Theme Three

EMERGENT THEME 3: QOL for residents means residents have meaningful relationships, are not lonely, they are as independent as possible living their lives as they had previously lived before they were admitted to the facility

DCWs were asked to describe what resident quality of life meant to them. Seven DCWs responded that resident quality of life meant residents have meaningful
relationships, are not lonely, they are as independent as possible and living their lives as they had previously lived. DCWs who mentioned these topics included in Emergent Theme 3 is depicted in Table 17.

DCW 3 described what resident quality of life meant to her: “What we can give them for the rest of their life, while they’re here. I had a resident yesterday who, her mouth was kind of chapped and sore and I walked past… and I took care of her… I made her feel comfortable and she thanked me. So, that helped her and that gave her the feeling that somebody does care and she’s not here alone. She told me she loved me and I told her I loved her too.”

Table 17
What QOL Means for Residents

<table>
<thead>
<tr>
<th>Subjects that responded</th>
<th>DCW Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCW3</td>
<td>What we can give them for the rest of their life, while they’re here</td>
</tr>
<tr>
<td>DCW5</td>
<td>Let them do things for themselves... Involve them in conversations... Make them feel special</td>
</tr>
<tr>
<td>DCW7</td>
<td>Making sure... they’re able to live their life as closely as possible to what they would have before they were here</td>
</tr>
<tr>
<td>DCW9</td>
<td>They are getting the most out of their daily existence that they can... feel like they are needed and wanted and loved and they have to be able to return that love to somebody. They have to feel useful</td>
</tr>
<tr>
<td>DCW12</td>
<td>When I see that they are doing things that they like, that they are living the age that they are living and things that they can do for themselves</td>
</tr>
<tr>
<td>DCW14</td>
<td>Do things that they would normally do with everyday life when they were up and about for themselves. We try to make them feel the same way</td>
</tr>
<tr>
<td>DCW15</td>
<td>They enjoy seeing other residents and spending time with them, they see their family</td>
</tr>
</tbody>
</table>
DCW 5 said to her, resident quality of life meant: “Making sure ... that you talk to them, you say their name when you are speaking to them. If it’s something that they want to do... let them do things for themselves if they are able. Involve them in conversations when you’re talking. Make them feel special.

To DCW 7, resident quality of life means: “Making sure that while they’re here they’re able to live their life as closely as possible to what they would have before they were here.”

Similarly, DCW 9 stated: “Their quality of life means that they are getting the most out of their daily existence that they can at wherever they are mentally and physically and spiritually. They have to feel like they are needed and wanted and loved and they have to be able to return that love to somebody. They have to feel useful and they have to feel their spiritual and emotional needs are being met. They have to feel like they have friends and family and people that care about them around them and even though there are people that have no family per say, it...then becomes, more important for the staff to interact with them and make them feel needed.”

DCW 12 commented: “When I see that they are doing things that they like, that they are living the age that they are living and things that they can do for themselves, live and do for themselves without anybody having to help them.”

Likewise, DCW 14 also suggested quality of life meant: “We try to do things that they would normally do with everyday life when they were up and about for themselves. We try to make them feel the same way, like, activities, still going to church, when we do
their hair and fix them up and stuff, take them around, outside, even when we bring our kids in to visit with them.”

DCW 15 also commented about meaningful relationships and not being lonely when she said: “they enjoy seeing other residents and spending time with them, they see their family.”

One theme and one emergent theme responded to RQ4: How do direct care workers (DCWs) perceive quality of life for NH residents? The theme: DCWs describe a good QOL for residents when they are comfortable, happy and treated as individuals, was identified. The emergent theme identified was: quality of life for residents means residents have meaningful relationships, are not lonely, they are as independent as possible living their lives as they had previously lived before they were admitted to the facility. The next section provides another perspective regarding how DCWs perceive resident quality of life looking at it through the lens of a card sort exercise.

**Rank Order of Quality of Life Domains**

DCWs were asked to a card sort to answer research question four and to understand how DCWs perceived quality of life for residents. After completing the interview, each DCW was asked to sort 11 cards and rank order the 11 quality of life domains. Eleven cards with the description of each QOL domain (Appendix H) was given to each DCW and they were asked to place the cards in order of what they felt was the most important quality of life domain to the least important when considering the residents they cared for. Beginning with the first place as the most important and ending
with the last card in the eleventh place being the least important. Table 18 identifies the rank order completed by each DCW. The collective rank order of the QOL domains is presented in Figure 2.

Dignity (D)

Dignity includes activities that enhance a resident’s self-esteem and self-worth. Examples include: grooming residents as they wish; assisting residents to dress in their own clothes appropriate to the time of day and individual preferences. Direct Care Workers ranked dignity as the most important quality of life domain when considering

| Table 18 |
| DCW Rank Order of Quality of Life Domains |

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<th>D9</th>
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<th>D12</th>
<th>D13</th>
<th>D14</th>
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<td>3</td>
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<td>3</td>
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<td>4</td>
<td>5</td>
<td>2</td>
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<tr>
<td>Sense of Safety, Security, and Order (SSO)</td>
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<td>1</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>11</td>
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<td>2</td>
<td>5</td>
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<td>5</td>
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<tr>
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<td>Spiritual Well-Being (SW-B)</td>
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<td>8</td>
<td>5</td>
<td>8</td>
<td>11</td>
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<tr>
<td>Enjoyment (E)</td>
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<tr>
<td>Meaningful Activity (MA)</td>
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<td>11</td>
<td>8</td>
<td>11</td>
</tr>
</tbody>
</table>

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Figure 2. DCW Rank Order of Quality of Life Domains.

the residents they cared for. At least seven DCWs ranked dignity first or second. No one ranked dignity lower than eighth.

Physical Comfort (PC)

Physical comfort was ranked the second most important QOL domain by DCWs. Physical comfort means: free from physical pain and discomfort such as shortness of breath, nausea, and constipation. This may also include room temperature and positioning (AHCA, 2009; Allen, 2007). At least nine DCWs ranked this QOL domain first, second or third when considering importance to the residents they cared for.
Sense of Safety, Security, and Order (SSO)

The definition for this QOL domain is being free from danger and threat. It also means personal possessions are safe and secure (AHCA, 2009; Allen, 2007). A sense of safety, security, and order was ranked the third most important QOL domain out of the eleven domains. Five DCWs gave this domain a first or second priority ranking.

Individuality (I)

The QOL domain individuality was ranked the fourth most important when considering the residents that DCWs cared for. Individual is a sense of being known as a person and being able to express his/her own identity. It also means being treated as an individual (AHCA, 2009; Allen, 2007). At least five DCWs gave this QOL domain a rank order of first or second.

Privacy (P)

Privacy is being able to be alone when one wishes; being together in private with others as one wishes, and, being in control of information about oneself. It also means a private space and privacy of mail (AHCA, 2009; Allen, 2007). Privacy was ranked the fifth most important QOL domain. Four DCWs rank ordered this QOL domain first or second.
Autonomy/Choice (A/C)

Autonomy and choice includes making own decisions and choices about when to get up. This domain also includes when to eat and, what activities to participate in (AHCA, 2009; Allen, 2007). Autonomy/choice was ranked the sixth most important QOL domain by DCWs. Three ranked this QOL domain first or second.

Relationships (R)

Relationships with family, friends, other residents or even care givers describe this QOL domain (AHCA, 2009; Allen, 2007). DCWs ranked relationships as the seventh most important QOL domain when considering the residents they cared for. Only two DCWS rank ordered this QOL domain first or second.

Spiritual Well-Being (SW-B)

Spiritual well-being means residents participate in religious or spiritual activities of choice (AHCA, 2009; Allen, 2007). When considering the residents they cared for, DCWs ranked spiritual well-being as the eighth most important QOL domain. At least two DCWS ranked this as the first most or second most important domain.

Functional Competence (FC)

The domain of functional competence means that residents are as independent as possible within their physical and cognitive capacities. It also means residents are independent as they choose to be (AHCA, 2009; Allen, 2007). Functional competence...
was considered the ninth most important QOL domain by DCWs. The highest order this domain was ranked was fourth by three DCWs.

Enjoyment (E)

Residents experience enjoyment when satisfaction and delight by expressions of happiness. Enjoyment may also include satisfaction with food, entertainment, activities or outdoors (AHCA, 2009; Allen, 2007). Enjoyment was considered the tenth most important QOL domain. Only one DCW ranked ordered this QOL domain higher than fifth. At least five DCWs ranked it 10th.

Meaningful Activity (MA)

Finally, meaningful activity was ranked 11th or least important QOL domain when DCWs considered the residents they cared for. Meaningful activities include activities that promote self-esteem, pleasure, comfort, education, success, and independence for residents (AHCA, 2009; Allen, 2007). Meaningful activity may be different for each individual. At least eight DCWs ranked this QOL domain 10th or 11th. The highest ranking this QOL received was third.

QOL Card Sort Observations and Field Notes

The third lens of understanding how DCWs perceive resident quality of life was evaluated by observing DCWs completing the card sort that rank ordered the QOL domains. It was interesting to observe the DCWs during the card sort exercise. Most
DCWs deliberated over the order they placed the 11 cards. They would arrange them one by one as they read them, and then rearrange them at least three or more times. Several DCWs commented about how hard it was to choose which domain was the most important. Comments from some of the DCWs during this exercise included: DCW 8 said: “this is hard to do because it depends on what resident you have in mind. I put religion last because being older, they probably already have this.” DCW 9 commented: All of these are important and ranking them is not going to be easy.” DCW 10 struggled trying to decide how she was going to rank dignity and choices when she shared: “It’s important letting residents have choices, but dignity and appearances are important too.” DCW 11 thought that: “spiritual was the best” but “being safe and pain-free” were important too.” DCW 12 indicated: “being known as individuals and free from pain were the most important.” DCW 13 related: “Dignity is the most important because we need to treat residents as we want to be treated.” DCW 14 said she “wanted to group all of them into one” because they were all important. DCW 15 suggested “dignity is the most important because I’m not sure if I could have someone help me go to the bathroom. I also think being dressed like I want and no pain is very important.”

Responses provided that answered RQ4: How do direct care workers (DCWs) perceive quality of life for NH residents, resulted in identifying one theme and one emergent them. The theme was: DCWs describe a good QOL for residents when they are comfortable, happy and treated as individuals. The emergent theme was: quality of life for residents means residents have meaningful relationships, are not lonely, they are as independent as possible and living their lives as they had previously lived prior to being
admitted to the facility. The card sort exercise completed by DCWs provided another lens regarding DCWs perceptions of quality of life. Dignity was rated the most important followed by physical comfort, sense of safety, individuality, privacy, autonomy/choice, relationships, functional competence, enjoyment, and lastly, meaningful activity. Observing DCWs rank order the quality of life domains provided insight on how difficult it was for DCWs to rank one QOL domain higher than another. DCWs commented on how it was difficult to choose one QOL domain before others.

**RQ5  How do direct care workers (DCWs) practice to reflect quality of life indicators?**

During the interviews, DCWs were asked to share their practices that promote resident quality of life. Transcribed responses to this question were coded for each quality of life dimension when the DCW mentioned the specific dimension in their comments. Results by individual DCW for each QOL dimension is presented in Table 19. Examples of prominent comments are included for each dimension.

**Comfort**

The definition for the QOL dimension for comfort is: covers the resident so they remain warm. Positions or repositions the resident. Staff speaks in a calm, quiet voice so as not to disturb the resident while sleeping or relaxing (AHCA, 2009; Allen, 2007). DCW 1 responded about her practices that promote resident quality of life: “it’s my job to make sure that everything that they can’t do for themselves I can... assist or do it to the point where... they’re comfortable” DCW 3 provided the following example of how she...
Table 19

Quality of Life Dimensions

<table>
<thead>
<tr>
<th>DCW Respondant</th>
<th>1</th>
<th>2</th>
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practiced to reflect quality of life: “I had a resident yesterday who, her mouth was kind of chapped and sore and I took care of her ... I made her feel comfortable.” DCW 5 said:

“Making sure they are comfortable” is how her practices promote quality of life. DCW 6 also said about her practices: “Making things comfortable for them.” DCW 8 provided this example of how her practices promote quality of life: “By asking if they’re bed ridden, if they need their pillows fluffed.” DCW 13 thought about how her practices promote quality of life and responded: “Well, what I do for residents is like the range of motion, I have this lady that arthritis has set in to the right shoulder and she’s having trouble so I’m putting warm blankets on her, the care plan says warm blankets.” DCW 15
shared: “I try to learn what they like, sometimes they just like getting laid down after lunch.”

Privacy

The QOL dimension for privacy means staff steps out of the room while the resident is on the phone or has visitors. It also means staff knocks on the door and waits for permission to enter (AHCA, 2009; Allen, 2007). During the interviews, none of the DCWs mentioned privacy in their responses to the question about how their practices promote resident quality of life.

Dignity

The definition for the QOL dimension of dignity includes treating residents politely and respectfully. It also means handling residents gently during care and respecting the resident’s modesty. In addition it means: listens and pay attention to residents when they are speaking; grooming residents as they wish to be groomed; encourages and assists resident to dress in their own clothes rather than hospital gowns; sits next to resident instead of standing over them when assisting them: interacts/converses with the resident while assisting them rather than with other staff; refrains from practices demeaning to the resident such as keeping catheter bags uncovered and/or refusing to toilet resident when they wish to (AHCA, 2009; Allen, 2007). There were only five DCWs that responded regarding their practices that reflected resident dignity.

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DCW 2 shared: “I want to take my time because I want to make sure I’ve brushed their teeth, I want to make sure I’ve clipped their nails, you know everything that I would do for myself. Instead of just going and get you dressed and move to the next person I kind of take my time when I’m doing that.”

DCW 4 said: “I do finger nails and I do their hair all the time...I took the curling iron to two peoples hair today and they really enjoy that. They love getting their hair done... and their nails and sometimes I’ll put make-up on them and I think it makes them feel good.”

DCW 5: “I trimmed her nails and filed them and polished them. She was so excited and I’m telling you, all day, the whole day she kept, “I just love may nails!”

DCW 9 shared about how her practices promote resident quality of life: “get somebody to the bathroom when they ask to go and not making them wait very long. If I’m able to get them toileted so they aren’t incontinent on themselves.” DCW 11 said: “they love to talk about how they used to work and about their life. They love it when I listen. I ask questions.” DCW 14 shared about how her practices reflect quality of life when: “I’m sitting with the residents and talking to them about their past lives.”

Accommodation of Needs

The definition for the QOL dimension accommodation of needs includes: places call light or other personal items such as grooming items within reach before leaving the room. Interacts with resident taking into account any limitations such as speaking loudly if needed or inserting hearing devices if indicated; making sure they have their glasses on
Communicates at eye level or remove resident from noisy surrounding if resident having difficulty hearing what is said (AHCA, 2009; Allen, 2007). DCW 4 said: “I’m a hard worker so if they need anything I’m on it for them.”

DCW 12 provided this example of accommodating a resident’s needs when she said: The things that I do to promote a good quality of life for the residents is that when they need help and I’m there for them to know that whatever they need, if I can do it for them I’m there to do it or help them do what they have to do.

DCW 15 also indicated in her response how she accommodated her resident’s needs: “There are certain residents I try to learn what they like, if they like coffee with cream and sugar, if there more of a breakfast eater than a lunch eater, I guess just certain things about them so I try to have that set up for them when I bring them their tray, or if they like going to a specific activity or maybe sometimes they just like getting laid down after lunch. You try and learn their routine.”

Meaningful Activity

The QOL dimension for meaningful activity includes the following: transports residents to activities of their choosing. Asks residents what they would like to do or where to go (AHCA, 2009; Allen, 2007). DCW 1 provided this example of meaningful activities: “I watched old movies in my lifetime and some of those old movies that I’ve watched, they were probably teenagers...so I like to bring those in every now and then. Lots of them don’t like to go outside so we make a group thing around our table where the TV is. I just took a couple of people there a few minutes ago and Animal Planets got
the top ten animals and they have them doing what capabilities they have. I like to figure them out. If I find something they’re interested in I try to go with it.”

DCW 8 commented how she practiced to promote resident quality of life: “by helping a resident to an activity or just with anything that they need and going out of my way.” DCW 9 shared: playing a game with one of them” is how she practices to promote quality of life.

DCW 15 stated: “I try to learn what they like or if they like going to a specific activity.”

Relationships

The QOL dimension for relationships is when staff takes time to have a friendly conversation with a resident and takes time to converse with families during visits (AHCA, 2009; Allen, 2007).

When asked about her practices that promote resident quality of life and reflect a relationship between her and her resident DCW 3 said: “I guess encouraging. I had a resident that did not want to go to fitness but I know she needed to go and I just encouraged her, “Go down and you’ll feel better just to get out of your room”. Sometimes one of them may come back and say, I’m happy you did make me get out of here cause I do feel a little bit better.”

DCW 5 provided this example of how she practiced: “making sure that you talk to them, you say their name when you are speaking to them. Involve them in conversations when you’re talking. There’s a resident… I went to her and said I noticed that your nails
need to be shaped and trimmed, do you mind if I do that, she said, Oh, and got really excited, really excited. She was so excited and I’m telling you, all day, the whole day she kept, “I just love my nails!” The whole shift, so I felt good doing that for her.”

DCW 9 commented: “I try to talk with them and ask them how’s your family doing and talk about my family and little things just to make them feel more like they are part of what is going on around them and I’m not just here to care for their physical needs but I’m there to take care of their emotional needs as well. When I have extra time I try to spend it sitting and talking with a resident.”

DCW 10 shared: “we work with them and try to encourage them. They say, “I’m not doing this right and we say don’t worry about it honey you’re doing it OK, you’re doing just fine, they say I hate to have you helping me, I say well that’s what I’m here for, I get paid to come in here and help you do stuff that you can’t do, let’s keep working on it and maybe one day I won’t have to come in here and do it for you, you’ll be able to do it for yourself.” And so one day you go in there and the things that they complained about you having to help them with they are doing it and then they tell you, look I did this by myself and see I told you, you was going to be able to do it, that’s good.”

DCW 11 stated: “Just talking to them. Asking them about what they used to do when they were younger. They love to talk about how they used to work and about their life. They love it when I listen.”

Likewise, DCW 14 observed: “You know when I’m sitting with the residents and talking to them about their past lives, that right there does it because they enjoy it and it sparks something in them. Once again, when I bring my kids up and visit with them.”
Enjoyment

The QOL dimension of enjoyment is when staff asks the resident what they would like to eat (AHCA, 2009; Allen, 2007). Two DCWs commented about food and food choices. DCW 5 described how she practiced: “making sure that they’re getting enough food.” DCW 15 shared: “There are certain residents I try to learn what they like, if they like coffee with cream and sugar, if there more of a breakfast eater than a lunch eater…”

Spiritual Well-Being

The spiritual well-being QOL dimension is when staff assists the resident in participating in religious activities (AHCA, 2009; Allen, 2007). No DCWs specifically mentioned this when they responded to the question asking about how their practices promote resident quality of life.

Safety and Security

The definition for safety and security includes staff answering call lights quickly. It also includes taking precautions with possessions (AHCA, 2009; Allen, 2007). Only one DCW mentioned responding quickly. DCW 8 shared: “If somebody needs something and I hear them I’ll volunteer as quick as I can to help them.”
Individuality

Individuality QOL dimension definition includes when staff asks the resident about their interests and what they like. It is also when staff asks the residents about their experiences (AHCA, 2009; Allen, 2007). Three DCWs responded about how they practiced to promote quality of life that express individuality. DCW 6 said about her practices: “I ask them what did you do before you came here.”

DCW 11 stated: “Just talking to them. Asking them about what they used to do when they were younger. They love to talk about how they used to work and about their life. They love it when I listen. I ask questions. It’s amazing how some of their lives were and things they’ve went through. They were hard workers.”

DCW 14 related: “You know when I’m sitting with the residents and talking to them about their past lives, that right there does it because they enjoy it and it sparks something in them.”

Autonomy and Choice

The dimension of autonomy and choice includes asking the resident about their preferences such as when to go to bed, when to get up, what clothes to wear, and what to eat (AHCA, 2009; Allen, 2007).

At least one DCW (DCW 6) mentioned choices when she said: I give them choices and include them and the ones that can’t I always think if I was in their place I would put this on or I would do that. I ask them, Good morning, do you feel like getting up today, do you want to get up now? I let them choose what they want to put on.
Encouraging

Even though encouraging is not one of the QOL dimensions, at least two DCWs commented about this when they were answering the questions about how they practice to promote quality of life for their residents. DCW 10 related: “we work with them and try to encourage them. They commented: “I’m not doing this right and we say don’t worry about it honey you’re doing it OK, you’re doing just fine.” Likewise, DCW 12 stated: “One thing I tell them is, “You can do it!” As long as you can do it, do it and that makes you feel better and makes you feel stronger.”

Summary

Seven prominent themes were identified in this study. The prominent themes included: (1) Direct Care Workers define success in their work and feel successful when their resident’s needs are met, they are comfortable and happy; (2) when DCWs can’t meet their resident’s needs or provide the care they think they should, they feel unsuccessful, unhappy and frustrated; (3) Direct Care Workers attribute their success from meaningful relationships with their family or others, how they were raised, and the desire to treat residents as they would like to be treated or a family member treated; (4) DCWs obtain the knowledge for their successful practices from influential teachers and the training they received; (5) organizational or institutional factors such as other experienced DCWs or the team that DCWs work with contribute to the successful practices of DCWs; (6) incorporation of the Eden philosophy into the culture of the
organization did not make a difference and did not change how DCWs practice, because they were already practicing that way; and, (7) DCWs described a good QOL for residents when they are comfortable, happy and treated as individuals.

Three emerging themes were also identified. The three emergent themes were: (1) DCWs need to have patience, love, understanding and kindness to do this work and be successful; (2) DCWs understanding about the Eden philosophy means that the environment should be homelike for residents; and, (3) quality of life for residents means residents have meaningful relationships and are not lonely, they are as independent as possible and living their lives as they had previously lived.

Direct care workers shared their thoughts and comments about how they perceived resident quality of life and what they considered a good quality of life for residents. They also responded freely about how they practiced to promote resident quality of life. From their comments, it seemed evident DCWs participate in the hard work of care giving because they love taking care of their residents. Their sincerity comes from the heart.

When asked about their understanding of the Eden philosophy, DCWs suggested it meant the facility should be “home-like” or, as close to a resident’s previous home as possible. Even though the facility had incorporated the Eden philosophy over 10 years ago, several DCWs still did not understand it, nor, do they feel it makes a difference in how they practice. It did not necessarily matter if the DCW had been working there for some time or they had worked there for at least one year. At least three DCWs suggested
Eden was more about the special project for residents that they were required to complete once a year.

When DCWs were asked to prioritize the importance of the eleven quality of life domains, it was a difficult task. Direct care workers deliberated over the process and spent time placing the cards in the order of what they felt was the most important domain when considering resident quality of life. Four DCWs mentioned one isn’t more important than another and that they were all equally important when it comes to quality of life for the residents they care for.

Chapter V contains a summary, conclusions, discussion of the findings and recommendations for additional research. The final section includes a complete bibliography and appendices.
CHAPTER V

SUMMARY, CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

Summary

The number of people who will require nursing home care in the future is significant. There are concerns regarding quality of care and quality of life for (NH) nursing home residents (Doty et al., 2008; Kane et al., 2004; Reinhard & Stone, 2001). Therefore, culture change initiatives such as the Eden Alternative have been established to improve NH resident quality of care and quality of life. Quality of life is a critical measure of nursing home care and a focus for culture change in long term care. A good quality of life for residents is important because many nursing home residents spend the last days of their lives in a nursing home. Maintaining personal dignity, being independent as possible and building relationships between staff and residents maximizes quality of life for NH residents.

Direct care workers influence quality of life for the nursing home residents. The time DCWs spend with residents is significant and accounts for 80–90% of their entire work day. Studying and understanding the perceptions and practices of DCWs as they relate to quality of life for the residents is important to those that influence the culture of the nursing home. Understanding DCWs perceptions and practices is also essential to policy makers for writing and revising regulations that impact DCW training. In addition,
understanding how DCWs describe success in their work may provide Nursing Home Administrators valuable information that could be incorporated into hiring, orientation, training and staffing models that may promote successful DCW practices and improve resident quality of life. These results also present important information that may have a positive effect on DCW retention.

Chapter V is comprised of five sections which begin with a discussion of the prominent themes and emerging themes in the context of the five research questions and conclusions. Relevant literature examples will be incorporated into the discussion as further examples of common trends and patterns in the perceptions and practices of DCWs. Section two provides a summary of the research questions. The next section provides an overview of limitations of the investigation. The final section includes recommendations for long term care facilities and recommendations for further research.

Discussion and Conclusions

The discussion and conclusions are presented under each of the five research questions. Specific recommendations for this long term care facility are provided following the discussion of findings under each of the research questions.

Research Question 1: How Do DCWs Define Success In Their Work?

Discussion

Two prominent themes were identified by DCWs that address Research Question 1: (1) direct care workers define success in their work when their resident’s
needs are met, their residents are comfortable, and happy; (2) when DCWs can’t meet their resident’s needs, or provide the care they think they should, they feel unsuccessful, unhappy and frustrated. These results can be attributed to DCWs finding meaning in their work when resident care outcomes are positive and when their outcomes are negative it affects their feelings of success.

Conclusion

Based on findings, it can be concluded that DCWs need to have clear successes and support from management when they are unsuccessful. It was evident from DCWs they worked hard to meet resident needs. DCWs provided examples of meeting their resident’s personal, physical, and emotional needs. Examples included: making sure residents look nice by making sure they are dressed and well groomed; when they are toileted and aren’t incontinent; and, when they express happiness by giving DCWs hugs and they’re smiling.

DCWs experienced success when their residents showed progress in their physical functioning. DCWs provided examples of being successful when residents who were not able to transfer independently or walk when they were admitted progressed to a point where these activities became possible as a result of the work and assistance of the DCW. When residents were appreciative of the care provided by the DCW and expressed it, that also made DCWs feel successful in their work.

When resident’s needs were met and they were happy, this also made DCWs happy. DCWs felt good about the work they did and being successful was rewarding and
provided them with comfort and joy. DCWs mentioned that when they know their residents are happy, they too are happy and feel they have accomplished their jobs. This is also what Ball, Lepore, Perkins, Hollingsworth and Sweatman (2009) found in their study reinforcing that DCWs feel good when they make their residents happy and their residents feel good. Two DCWs indicated they felt successful when their residents missed them when they were not at work. In other words, a relationship developed between DCWs and their residents and there was an emotional connection.

When DCWs couldn’t meet their resident’s needs or provide the care they thought they should, they felt unsuccessful, unhappy, and frustrated. Not meeting a resident’s needs included not being able to get everything done for the resident that the DCW thought should be done or forgetting to do something when a resident asked. When DCWs do not understand why the resident is unhappy or what the problem is, it is frustrating to the DCW because he or she does not know what to do to resolve the problem. These findings are similar to what Ball et al. (2009) identified in their study on the reasons DCWs go to work. Participants in Ball et al.’s study suggested DCWs frustration came from their inability to accomplish the necessary tasks and make residents feel better and, thus, affirm their caregiving roles. Therefore, when DCWs meet their resident’s needs, their role as caregivers is affirmed.

The finding that DCWs feel they could have prevented or that they have not done enough for the resident and the resident dies, tells us that DCWs really own the care they provide. This also suggests that in many ways, DCWs may need affirmation from the nursing staff in what they did well to facilitate a peaceful death. Given the feedback, it
may increase DCWs happiness and satisfaction in the work place. It is not necessary that
DCWs take on this huge burden and feel responsible for someone’s death, when it may
be an expected outcome. One DCW said she felt bad when one of her residents died,
because she grew to love the resident. This is very similar to what Berdes and Eckert
(2001) found in their study of caregiving relationships between residents and nurse’s
aides when they suggested DCWs suffered emotional stress from interacting with
residents who are in pain or dying. Losing a resident they hold dear is stressful to DCWs
(Ball et al., 2009; Black & Rubinstein, 2005).

At least five DCWs shared they experienced feelings of guilt when they feel they
have failed, which prompted them to try harder in order to not fail. DCWs spoke freely
about trying harder and doing everything they could do to make their residents happy and
meet their needs. One DCW mentioned she didn’t give up when she felt unsuccessful;
she just adjusted or rearranged the care she provided. These findings suggested DCWs
are motivated to succeed and not interested in failing.

Research Question 2: What are the Individual Factors That Contribute to DCWs
Successful Practices?

Discussion

The finding that DCWs success is attributed to meaningful relationships with
family, how they were raised, and the desire to treat residents as they would like to be
treated or a family member treated suggests that NHs could provide education and
training on empathy to help develop and strengthen those relationships. Given that not all
DCWs come from positive and caring home environments this type of training might also help those DCWs learn how to build those relationships. DCWs obtained the knowledge for their successful practices from influential teachers and the training they received. Findings suggest a positive role model and mentoring strongly influence DCW success. The finding that DCWs need to have patience, love, understanding and kindness to do this work in order to be successful support the need to be motivated by those intrinsic attributes.

Conclusions

DCWs attributed their success from meaningful relationships with their family or others. DCWs mentioned how these positive relationships with their family such as mother or grandmother influenced their feelings about how they should practice. DCWs offered examples of watching and observing their mother or grandmother caring for other family members, and how their observations influenced how they felt they should practice. One DCW provided the example of helping her mother care for her dying father helped her understand the right way to care for her residents. Another DCW shared the example of caring for her sick husband.

Still another DCW indicated how caring for her own children and grand-children contributed to her success because she learned how to be patient and dealing with the elderly also calls for patience. Anderson et al. (2005) labeled the mental model of DCWs treating residents as they would treat their own children as mother wit. Anderson et al. defined mother wit as acting from the wisdom passed from daughter to mother. These
authors suggested DCWs’ behavior was guided by analogies made between caring for children and caring for elderly residents.

In their study about the factors that influence the development, quality and meaningful relationships between residents and DCWs, Ball et al. (2009) found the values of DCWs for helping elders and caregiving jobs stemmed from past family experiences. These past experiences included caring for a parent, or living with grandparents. Thirty-two percent of DCWs in a study by Mickus, Luz, and Hogan (2004) indicted they chose direct care work because they had the experience of taking care of a family member.

DCWs also attributed their success to how they were raised. DCWs provided examples of how their parents contributed to their success by teaching them the values of treating everyone equal and caring about others. One DCW shared that being raised very family oriented by taking care of each other resulted in the enjoyment she receives as a DCW taking care of people.

DCWs suggested the desire to treat residents as they would like to be treated or a family member treated contributed to their success. DCWs mentioned thinking about caring for residents like it was their mother, grandfather or grandmother. Others mentioned treating residents how they would want a family member treated. Ball et al. (2009) similarly identified DCWs treating residents the way they would want their mother or family member treated. This is also similar to what Anderson et al. (2005) identified as the Golden Rule. DCWs treating residents as they wish to be treated or a
family member treated was defined as the Golden Rule in their nursing home case study on DCW mental models, sense making and care actions.

At least six DCWs attributed their successful practices to a calling from God, the Lord, or a spiritual or religious influence. DCWs provided examples of this “calling” or being “called” to perform their work. This “calling” or “being called” was from God or the Lord. Other DCWs suggested being brought up in a religious or church environment that included family members as missionaries and ministers contributed to their success. Mickus, Luz and Hogan (2004) found in their study of recruitment and retention of DCWs, that 34% of DCWs in their study chose direct care work because they felt it was their personal calling. DCWs in Heiselman and Noelker’s study (1991) saw their DCW role as a religious calling or mission. Likewise, Mittal et al. (2009) identified two similar themes associated with DCW retention: being “called” to service, and, religion or spirituality. Not all DCWs expressed their success was a result of this calling. These DCWs may be more motivated by extrinsic factors such as the need for a job and to remain employed. They may feel successful by the check they bring home to support their family.

DCWs obtained the knowledge for their successful practices from influential teachers and the training they received. DCWs provided examples of teachers in their CNA training program that encouraged and pushed them to be successful. The training they spoke about was provided by a community college or the training program through their employer.
In order to become successful, DCWs suggested one had to have patience, love, understanding and kindness. One DCW thought her success came from within and “the spirit within me.” Ball et al. (2009) also found the qualities of patience, altruism, friendliness, and in the words of one DCW, “the spirit in me” essential to meaningful relationships between residents and staff. Some DCWs felt that if you didn’t have a heart for what you do, then you shouldn’t be providing this type of care. Others commented on knowing this is what you want to do before you even start because direct care work is not a job for everybody. Several spoke about it being hard work and it’s not just about getting a paycheck. Their reflections were similar findings to what Schirm, Albanese, Garland, Gipson and Blackmon (2002) found in their study of the views of DCWs on caregiving in nursing homes. DCWs in Schirm et al.’s study suggested that DCWs should not go into the field unless they have the inner qualities of caring and a lot of patience. This same study also suggested one cannot learn how to provide good care unless you have those caring qualities, which makes doing direct care work much more than just a job. DCWs from Ball et al. (2009) study felt the same way when they expressed that you have to care and love elderly people, because you can’t do this job just for money. Similarly, internal factors motivated DCWs to choose this line of work. In a study on recruitment and retention of DCWs, 68% of DCWs indicated they chose direct care work because they enjoy working with older people and another 72% suggested they chose direct care work because they wanted to help people. Altruism and an interest in health care was a primary motivator for choosing direct care work (Mickus et al., 2004).
Research Question 3: What institutional factors contribute to the successful practices of direct care workers (DCWs)?

Discussion

Other experienced DCWs and the team DCWs worked with contributed to the successful practices of DCWs can be attributed to the socialization experienced by DCWs when they engage in this type of work. New DCWs learn the ropes of the trade from experienced DCWs by observing them and being mentored.

Incorporation of the Eden philosophy into the culture of the organization did not make a difference and did not change how DCWs practice, because they were already practicing that way by providing good care. DCWs’ understanding about the Eden philosophy means the environment should be homelike for residents. Seven DCWs mentioned the environment of the facility should be homelike for the residents residing there. The facility being homelike meant similar to what the resident would have experienced in their own home.

Conclusions

DCWs identified other experienced DCWs or the team that they worked with as organizational or institutional factors that contributed to their successful practices. Several DCWs mentioned specific DCWs by name that had a positive influence on them. These influential DCWs had over 10–30 years of experience being a DCW. Experienced DCWs took the inexperienced DCWs under their wings and showed them how to give good care by mentoring and coaching them. This similar peer mentoring and coaching
had a positive effect in a three-year demonstration project in New England as well. The project focused on improving the quality of direct care jobs at 12 participating nursing homes. Peer mentoring and coaching supervision training throughout the organizations resulted in reductions in both turnover and call-offs (Barbarotta, 2010).

DCWs mentioned the team they worked with as contributing to their success. Coworkers that you can count on to help you and work together as a team was important to success. Team members encouraged others by their positive attitudes and assistance when DCWs were behind schedule. Schirm et al. (2002) identified cooperation among DCWs as a factor that strongly affected quality of care. When DCWs worked together and helped each other, the workplace was perceived as more pleasant and the quality of work was perceived as better.

Other organizational factors DCWs mentioned as contributing to their success included those who supervised their work or were a part of management. Supervisors, charges nurses, the director of nursing and the administrator were all mentioned. Those mentioned influenced the DCWs by treating and dealing with residents in a positive manner, and with respect and caring. Schirm et al. (2002) also found in their study that coworkers’ attitudes toward caregiving affected the ability to give good care. The relationship between DCWs and supervisors can be one of the most influential factors in whether DCWs feel respected and valued and whether they choose to remain in their jobs (Bishop et al., 2009; Eaton, 2000; McDonald, 2007; Mickus et al., 2004; Mittal et al., 2009). DCWs committed to staying in their jobs interact more positively with residents, thereby, providing better relational care (Bishop et al., 2008).
DCWs also identified residents and family as organizational factors that contributed to their success. They suggested when residents were happy, they felt successful and prompted them to work harder and try their best. These positive relationships between DCWs and residents are important and can make direct care work gratifying or heartbreaking (McDonald, 2007). Family members were also identified as contributing to DCW success by communicating with DCWs about the resident. These same factors, personal relationships with residents and their families, were found in another study to be associated with DCWs staying in their positions (Mittal et al., 2009).

Incorporating the Eden philosophy into the culture of the organization was not a contributing factor into the success of DCWs. Even though DCWs thought the Eden philosophy meant making the facility home-like for the resident, Eden did not change how they practiced. DCWs indicated that in spite of Eden they would practice the same because that is how they have always practiced, by providing good care.

At least five DCWs felt incorporation of the Eden philosophy had a positive impact on residents, even though it didn’t change how they practiced. DCWs spoke clearly about Eden making the work schedule less rigid by being able to give residents choices as to when to get up, and what time they wanted to eat. DCWs also thought Eden encouraged more activities for the residents which made the residents happier and more content. The home-like environment also provided a better quality of life for residents by making it less institutional.

In spite of being a certified Eden facility for over 10 years, not all DCWs could articulate what the Eden philosophy was all about or any of its principals. Several DCWs
mentioned the Eden project that they are required to complete once a year which involves doing something special such as buying a gift or meal for residents. Several others suggested they did not fully understand the Eden philosophy, even though the concepts, principals and practices of Eden are incorporated into orientation for every new employee. Time spent during orientation and other trainings about the Eden philosophy might not be sufficient for staff to fully understand the principals and how to incorporate them into their practice.

Research Question 4: How do direct care workers (DCWs) perceive quality of life for NH residents?

Discussion

The finding that DCWs described a good QOL for residents when they are comfortable, happy and treated as individuals can be attributed to the pride DCWs take in their work and the satisfaction they receive from providing good care. One emergent theme emerged from the data related to this research question as well: quality of life for residents means residents have meaningful relationships, are not lonely, they are as independent as possible and doing or living their lives as close to before they were admitted to the facility. Seven DCWs responded that meaningful relationships, not being lonely, independent as possible, and doing or living their lives as close to before as possible meant resident quality of life.
Conclusions

Being comfortable had different meanings for individual DCWs. Some suggested being comfortable included residents being comfortable with their environment or being comfortable with the individual DCW as their care provider. Others suggested being comfortable was involving residents in the care DCWs provided.

Being happy meant making their residents feel good and special. DCWs indicated happy meant residents being involved with activities and residents being kept clean and fed. One DCW suggested that if someone has to live in a nursing home they would want to be comfortable and happy.

Treating residents as individuals was considered a good QOL by DCWs. Being treated as individuals meant giving residents what they needed and not what DCWs thought what residents needed. Helping residents maintain dignity and independence was another way DCWs described treating residents as individuals.

When DCWs were asked to describe what resident quality of life meant to them, they indicated it meant: residents had meaningful relationships, were not lonely, they were as independent as possible; they were doing and living their lives as close to before they were admitted to the facility as possible. One DCW shared an example of meaningful relationships and not being lonely was when she noticed a resident with chapped lips and she took the time to care for her, speak with her, and make her feel comfortable. The resident responded that she loved the DCW, which also made the DCW feel good. Several DCWs considered spending time with residents, talking to them, and making them feel like they have friends that care about them as resident quality of life.
DCWs were asked to complete a card sort of 11 QOL domains and prioritize them from the most important to the least important when considering the residents they cared for. The 11QOL domains were ranked in this order: (1) dignity, (2) physical comfort, (3) sense of safety, security and order, (4) individuality, (5) privacy, (6) autonomy/choice, (7) relationships, (8) spiritual well-being, (9) functional competence, (10) enjoyment, and (11) meaningful activity. It was not surprising to find that dignity and physical comfort were ranked first and second. During the interviews, DCWs frequently indicated a good quality of life for residents meant they were comfortable. DCWs also mentioned treating residents as they would wish to be treated or a family member treated, which I believe would be equivalent to being treated with dignity.

What was surprising in the order of the QOL domains however, was the rank of enjoyment in the 10th place or next to the last. The reason this was surprising is because DCWs indicated in their interviews that a good quality of life was when residents were comfortable and happy. I would consider enjoyment and happy to be similar because enjoy means having a good time and to take pleasure and happy means delighted or pleased. It can be concluded that DCWs felt it was more important to maintain dignity rather than being comfortable and happy.

During the card sort to prioritize the 11 QOL domains, DCWs struggled and took their time to place the cards from the most important to the least important. It appeared to this researcher that this was not an easy task and it was difficult for them to place one before the other. DCWs mentioned it was a difficult task because they were all equally important. They also suggested that the order of the cards would be dependent on which
resident you had in mind. I understood this to mean that DCWs would individualize the QOL domains to the residents they cared for.

Research Question 5: How do direct care workers (DCWs) practice to reflect quality of life indicators?

Discussion

DCW responses that described how their practices might promote resident quality of life were coded using the quality of life dimension checklist. Even though DCWs freely shared thoughts about how their practices promoted resident quality of life, using the check list framed their responses by the definition of each dimension on the list. The most frequent response included DCWs mentioning comfort or comfortable.

Conclusions

DCWs offered different examples of providing comfort than what was included on the check list such as range of motion or even care for chapped lips. Fluffing residents pillows as well as laying them down after lunch or putting warm blankets on residents were examples of how DCWs provided comfort. No DCWs mentioned speaking in a calm, quiet voice so as not to disturb the resident as one of their practices. DCWs may not have mentioned this as it may just be a routine and not something they would ordinarily think of.

DCWs shared more specific examples of the dimension of dignity when they spoke about their practices. Providing dignity included grooming the resident by clipping
their nails, combing their hair, and brushing their teeth. DCWs also mentioned getting a resident to the bathroom on time and not making them wait in order to avoid incontinence, was another example of providing dignity. Still another example of dignity was when one DCW mentioned sitting and talking to residents about their past lives. The examples DCWs provided included specific items on the quality of life dimension checklist.

Three DCWs commented on how they accommodated residents’ needs. DCWs identified accommodating a resident’s needs included responding to a resident’s request quickly and doing whatever they needed to help them. It also meant getting them whatever they like to eat and learning their routine. None of the DCWs identified placing a resident’s call light or personal items within reach of the resident as one of their practices. Also, DCWs did not mention they spoke loudly to account for hearing limitations. Nor did they include removing a resident from noisy surroundings if residents were having difficulty hearing what was said as one of their practices. Not mentioning these tasks may indicate DCWs consider these common task and do not consider these practices as caring, which in fact they are.

DCWs offered examples of providing meaningful activity for their residents. Providing meaningful activity included bringing in old movies for residents to enjoy. It also included taking residents outside, and helping residents to an activity program of their choosing. One DCW suggested it was playing a game with residents. DCWs reported both QOL dimensions for meaningful activity such as transporting residents to
activities of their choosing and asking residents what they would like to do or where to go.

DCWs shared instances of taking time to have friendly conversations with residents and families as an example of the relationships dimension. Conversations included making sure DCWs say the resident’s name when speaking to them and talking about their past lives. DCWs provided examples of relationships by taking time to encourage residents to participate in activities. DCWs mentioned both of the QOL dimensions for relationships.

At least three DCWs shared examples of the individuality QOL dimension. One provided the example of asking residents what they did before they came to the nursing home. Another DCW shared the example of just talking to residents and asking what they used to do when they were younger. Still another DCW commented on just sitting and talking to residents about their past lives.

Two DCWs identified the QOL dimension enjoyment when they made sure residents were getting enough food and DCWs provided the food the resident liked to eat. One DCW provided the example of autonomy and choice when she shared that she gave residents choices.

No DCWs mentioned the QOL dimensions of spiritual well-being or privacy by assisting the resident in participating in religious activities. And only one DCW mentioned getting to residents as quick as possible as an example safety and security. The second QOL dimension for safety and security regarding taking precautions with possessions was not mentioned by any of the DCWs that were interviewed. These
findings are interesting, as maintaining privacy, responding to residents quickly by answering call lights and not losing possessions are routinely evaluated by NH surveyors to determine compliance with state and federal regulations. These practices might be another part of routine, care provided by DCWs every day.

Summary of Research Questions

Five research questions provided an overview of the perceptions and practices of DCWs as they relate to QOL in long-term care. DCWs defined success in their work when their resident’s needs were met, their residents were comfortable, and happy. When DCWs couldn’t meet their resident’s needs, or provide the care they thought they should, they felt unsuccessful, unhappy, and frustrated. In other words, DCW caregiving roles are affirmed when their residents are happy and their caregiving roles are not affirmed when they can’t meet their resident’s needs. When residents die, DCWs sometimes feel they have not done everything they could for their residents and they suffer emotional stress when they lose a resident they are close to.

Direct care workers attributed their success from meaningful relationships with their family or others, how they were raised, and the desire to treat residents as they wish to be treated or a family member treated. DCW mental models are influenced by the positive and meaningful relationships with their family and how they were raised. DCWs provided examples of other mental models that informed their practice such as “the golden rule” and “mother wit” as described by Anderson, et al. (2005). The “golden rule”
was treating others as you wished to be treated or how one wished a family member to be treated. Mother wit included treating residents as they would treat their own children.

DCWs obtained the knowledge for their successful practices from influential teachers and the training they received. Influential teachers provided the instruction in their training program. The training program was provided by a community college or a training program through their employer.

To become successful, DCWs need to be intrinsically motivated and have the attributes of patience, love, understanding and kindness. DCWs must demonstrate the qualities of altruism and friendliness which come from “within.” Those intrinsic factors and the desire to care for others especially the elderly are important to the successful practices of DCWs.

Organizational or institutional factors that contributed to the successful practices of DCWs included other experienced DCWs or the team that DCWs worked with. This peer mentoring and coaching by other experienced DCWs had a positive effect on DCWs by showing inexperienced DCWs how to provide good care. Team members provided encouragement through their positive attitudes and assistance. Supervisors also contributed to the success of DCWs by treating and dealing with residents in a positive manner. This positive relationship between DCWs and their supervisors can benefit the residents as well when DCWs are committed to their work and desire to stay. Committed DCWs interact more positively with their residents.

DCWs also identified residents and family as organizational factors that contributed to their success. When residents were happy, DCWs felt successful and
worked harder. When family members communicated with DCWs about the resident, that also contributed to DCW success. These positive relationships can make direct care work gratifying or heartbreaking. One study found personal relationships with residents and families to be associated with DCWs staying in their positions (Mittal et al., 2009).

The 10-year culture change initiative of incorporating the Eden philosophy into the organization did not contribute to the success of DCWs. DCWs indicated the Eden philosophy had a positive impact on resident quality of life by making the facility more home-like for residents and less institutional. The culture change of incorporating Eden into the culture of the organization did not change how DCWs practiced, as they practiced the same way prior to Eden.

DCWs perceptions of quality of life and a good quality of life were described as their residents being comfortable, happy, and treated as individuals. Helping residents maintain dignity and independence were other ways DCWs described a good QOL. DCWs described meaningful relationships, not being lonely, independent as possible, and doing and living their lives as close to before as possible as other indicators of a good quality of life. Examples of spending time with residents, talking with them and treating them as they wished to be treated or a family member treated were additional measures of a good quality of life.

When asked to rank order the 11 QOL domains and prioritize them from the most important to the least important when considering the residents they cared for, DCWs had a difficult time ranking one before the other. DCWs suggested they were all important and the order depended on which resident the DCW had in mind when ranking the cards.
DCWs took their time with this task and deliberated over the order before sorting the cards. DCWs ranked the quality of life domain dignity first and meaningful activity last. It was surprising enjoyment was ranked next to last in 10th place because enjoyment and happy were mentioned so many times during the interviews.

DCWs provided examples of 9 of the 11 indicators for the quality of life dimensions. Comfort and enjoyment were the most frequently mentioned indicators that DCWs identified as how their practices might promote resident quality of life dimensions. Two quality of life dimensions were not mentioned: privacy and spiritual-well being.

Recommendations for this Long Term Care Facility

Ten recommendations emerged from this investigation. The recommendations are intended to increase management understanding of how to recruit, hire and train DCWs that have the intrinsic attributes of kindness, patience, love and understanding that contribute to the success of DCWs. Recommendations will also include examples of DCW training for peer mentoring as well as supervisor training that support the successful practices of DCWs. These recommendations, if enacted, may strengthen the hiring process and ensure potential DCW candidates are selected based on motivational fit for the organization. Recommendations will also provide the facility with examples of possible resources for continued and on-going training for DCWs to further enhance their commitment to the organization and quality of life for residents.
Recommendation 1: Review the job description for DCWs, identify and incorporate core behavioral competencies into the job description

These behavioral competencies should include: attitude, conflict resolution, communication, compassion, customer service, integrity, and teamwork. These competencies would assess the altruistic attributes needed to enhance DCW successful practices. A well written job description that includes core skills and behavioral competencies will provide the framework for interviewing potential candidates.

Recommendation 2: Assess future DCW candidates for motivational fit

Motivational fit is defined in two ways: job fit motivation and organization fit motivation. Job fit motivation is the degree to which the activities and responsibilities of a job are consistent with the activities and responsibilities that an individual finds personally satisfying (DDI, 2005). In other words, will somebody want to do the job? Organization fit motivation is defined as an individual’s compatibility with an organization’s values and mode of operation. This is also referred to culture fit. While both are important, 90% of human resource respondents believe organizational or culture fit is the key in making effective hiring decisions.

Recommendation 3: Incorporate behavioral interview questions and a cultural fit questionnaire into the interview process

Behavior interviewing is the most common method to assess for culture fit (DDI, 2005). Behavioral questions used during an interview can reveal insights about a
candidate’s ethics and integrity. Cultural (motivational) fit questionnaires were found to be the second most effective method for assessing fit.

Assessing for motivational fit is important because not only does it reduce absenteeism and turnover, it also helps increase employee satisfaction and morale. Satisfied employees lead to better performance and productivity. Motivated employees are more likely to contribute positively to the bottom line success of the organization (DDI, 2005).

Recommendation 4: Determine ideal answers for each behavioral interview question within each competency and identify “red flag” answers for each question within each competency

Ideal answers for each behavioral interview question should address some of the intrinsic attributes of patience, kindness, compassion, and understanding. Responses should include how the candidate successfully functions as part of a team and address teamwork. An example of a red flag response might include: does not see benefits of working in a team (The Advisory Board Company, 2008).

Recommendation 5: Define a standard rating methodology for assessing each candidate during and after the interview

A standard evaluation grid should include the questions asked for each critical competency along with any probing or follow-up questions. The grid also needs to include the ideal responses and the red flag responses and a space for any notes taken during the interview. Rating scales for responses might include: strong evidence skill not present, no evidence skill is present, some evidence skill is present and strong evidence
skill is present (The Advisory Board Company, 2008). Finally, the grid should also include a determination if the interviewer would recommend the candidate for hire.

Recommendation 6: Develop training materials to educate managers about behavioral interviewing techniques

Managers need to be trained to accurately determine whether a candidate has the requisite behavioral skills to be successful in a position. Interview training needs to include: how behavioral interviewing is used, legal guidelines for interviewing, how to isolate critical competencies, how to write appropriate interview questions, and how to create and interview template. Training also needs to include: how to conduct the interview, scripting, how to listen, how to take notes, and, how to evaluate the candidate. After the training, managers should practice the interview technique using role playing.

Recommendation 7: Train experienced high performing DCWs to become peer mentors and incorporate peer mentoring into DCW orientation

Peer mentoring contributes to the successful practices of DCWs. Peer mentoring programs can provide new staff with support to help them learn and grow professionally. Examples of programs that include this training are: Growing Strong Roots, the LEADS program and LEAP for Long-Term Care Communities.

Recommendation 8: Provide training for nurse managers, supervisors and charge nurses in leadership, role modeling and team-building skills

The teams DCWs work with contribute to their success. These teams include nursing managers, supervisors and charge nurses. Managers and supervisors with positive
attitudes provide role models for DCWs. Positive working relationships with managers and supervisors are an essential element to DCW job satisfaction and retention. Examples of programs for this type of training include: LEAP for Long-Term Care Communities, Coaching Supervision: Introductory Skills, and Pathways to Leadership.

Recommendation 9: Research and implement a career ladder program for the advancement of DCWs

Better trained staff results in better care for residents. Career ladders provide training to upgrade the skills of DCWS, increase career commitment and job satisfaction as well as provide rewards and recognition. One example of a career ladder program includes the WIN A STEP Up program. This program is based on three principles: education, compensation, and commitment.

Recommendation 10: Work with the Employee Assistance Program to design and implement an educational program for DCWS to learn coping skills for dealing with resident deaths

When DCWs experience the loss of a resident they cared for and a strong relationship has developed, it can be traumatic for the DCW when the resident dies. Humans may experience strong emotions when they lose someone they cared for and have to go through the grieving process. Grieving takes place in several stages and DCWs need to understand those stages and how to deal and cope with their emotions during those different stages.
Limitations

This study has several limitations. The study only reflected the opinions of 15 direct care workers at one long term care facility from a large health system in Southwestern Michigan. Using qualitative research and a case study methodology limits generalizations to other healthcare organizations.

The investigation included interviews of a small random sample of direct care workers who volunteered to be in the study. The small sample of direct care workers may also decrease the generalizability of findings to other healthcare systems. The sample included 14 females and only one male, which limited the understanding of the perceptions and practices of other male DCWs. Sixty-seven percent of the interviewees were Black and 33% were White. The ethnicity of the group that participated may not be representative of the entire population at the facility.

Also, Coghlan and Casey (2001) revealed researchers need to manage the political dynamics of their organization while performing their research by balancing the organization’s justification of what it wants in the project with their own personal justification for the project. Even though the researcher no longer worked at this specific facility, performing research in one’s own organization may create the potential for role ambiguity and conflict (Coghlan & Casey, 2001).

Recommendations for Additional Research

Based on the findings of this research there are three areas for further exploration related to the successful practices of DCW and a good quality of life for nursing home
residents. These recommendations will compliment this investigation and add to the body of knowledge on the successful practices of DCWs employed in nursing homes.

Recommendation 1: Evaluate the outcomes of hiring a retention specialist in a long term care facility

Retention specialists could provide peer mentoring, follow-up with orientation and training of new DCWs, evaluate turnover and retention problems. DCW turnover is significant, and high turnover results in poorer quality of care for residents. High turnover also impacts the relationships between DCWs and residents because those who leave in a short period of time do not have the time necessary to develop relationships with residents. Strong relationships between DCWs and residents are important to resident quality of life.

The retention specialist could also evaluate the implementation of the behavioral interviewing in long term care. There is a plethora of literature on recruitment and retention; however, none of the literature mentioned hiring DCWs for motivational or cultural fit.

Recommendation 2: Research the impact of different culture change models and their effects on the practices of DCWs and quality of life for residents

Is one model better than others such as is Eden better for improving the quality of life for residents than the Wellspring model. Also, is one model better than another for building a culture in the organization conducive to promoting relationships between
residents and DCWs? Or, should culture change be a collective of environmental and organizational changes rather than a specific model.

Recommendation 3: Conduct further research on the mental models of DCWs and the teams members they work with

It would be important to know the effect of shared mental models on team processes and effectiveness. Would teams with similar positive mental models perform better? And, would these positive mental models improve resident quality of life?

Summary

This study provided insight into the perceptions and practices of 15 DCWs at one long term care facility in Southwest Michigan. Seven prominent themes emerged from this study included: (1) Direct Care Workers define success in their work and feel successful when their resident’s needs are met, they are comfortable and happy; (2) when DCWs can’t meet their resident’s needs or provide the care they think they should, they feel unsuccessful, unhappy and frustrated; (3) Direct Care Workers attribute their success from meaningful relationships with their family or others, how they were raised, and the desire to treat residents as they would like to be treated or a family member treated; (4) DCWs obtain the knowledge for their successful practices from influential teachers and the training they received; (5) organizational or institutional factors such as other experienced DCWs or the team that DCWs work with contribute to the successful practices of DCWs; (6) incorporation of the Eden philosophy into the culture of the organization did not make a difference and did not change how DCWs practice, because
they were already practicing that way; and, (7) DCWs described a good QOL for residents when they are comfortable, happy and treated as individuals. Each theme was reviewed as it related to the five research questions.

Three emerging themes were also identified. The three emergent themes were: (1) DCWs need to have patience, love, understanding and kindness to do this work and be successful; (2) DCWs understanding about the Eden philosophy means that the environment should be homelike for residents; and, (3) quality of life for residents means residents have meaningful relationships and are not lonely, they are as independent as possible and living as they had previously lived prior to being admitted to the facility. Each of the emergent themes was described in the context of the research questions.

Ten recommendations were made for the nursing home where the study was conducted. These recommendations included: (1) Review the job description for DCWs, identify and incorporate core behavioral competencies into the job description, (2) Assess future DCW candidates for motivational fit, (3) Incorporate behavioral interview questions and a cultural fit questionnaire into the interview process, (4) Determine ideal answers for each behavioral interview question within each competency and identify “red flag” answers for each question within each competency, (5) Define a standard rating methodology for assessing each candidate during and after the interview, (6) Develop training materials to educate managers about behavioral interviewing techniques, (7) Train experienced high performing DCWs to become peer mentors and incorporate peer mentoring into DCW orientation, (8) Provide training for nurse managers, supervisors and charge nurses in leadership, role modeling and team-building skills, (9) Research and
implement a career ladder program for the advancement of DCWs, and, (10) Work with
the Employee Assistance Program to design and implement an educational program for
DCWS to learn coping skills for dealing with resident deaths.

The work of DCWs is both challenging and rewarding. DCWs become frustrated
when they cannot meet their resident’s needs. When DCWs are able to make their
residents comfortable and happy, they too are happy. Many DCWs are intrinsically
motivated to care and help the elderly. The mental models that inform their successful
practices come from how they were raised, influential family members, watching family
members care for another family member or actually caring for a family member
themselves. DCWs also attribute their success to other experienced DCWs that mentored
and coached them while learning the job. Supervisors and charge nurses and their
positive attitudes also have some bearing on the success of DCWs. When supervisors and
charge nurses treat residents with kindness and compassion, they lead by example, and
therefore, DCWs treat residents the same way. DCWs at this particular facility did not
feel culture change initiatives such as the Eden philosophy made a difference in how they
practiced; however, they did indicate it positively impacted resident quality of life by
making the facility more home-like and less institutional. In spite of 10 years of culture
change initiatives, not many of the DCWs interviewed could articulate the Eden
principles.

The over-65 population is projected to double by the year 2030 (Thornhill &
Martin, 2007). Baby boomers will live longer because our current healthcare system in
America is geared to do anything and everything to keep patients alive. Long term care
facilities such as nursing homes (NH) will become home to millions of baby boomers in the coming years. Many Americans say they would choose death over life lived out in a nursing home because of past scandals and negative outcomes.

Hopes for the future of long term care can be boosted by the demand for culture change in nursing homes to make them more home-like. Conscientious caregivers such as DCWs spend the majority of their time caring for residents that reside in nursing homes. The care DCWs provide is personal and intimate. The relationships between DCWs and the residents they care for can positively or negatively influence resident quality of life.

We can enhance the quality and compassionate care that is provided by hiring DCWs with the altruistic attributes required to not only help them succeed, but also provide relationship centered care to those they serve. Additional training can also enhance commitment and help stabilize the extraordinary turnover rates of these DCWs.
Appendix A

Conceptual Frame
RQ1: How do DCWs define success in their work?

RQ2: What are the individual factors that contribute to DCWs' successful practices?

RQ3: What institutional factors contribute to the successful practices of DCWs?

RQ4: How do DCWs perceive quality of life for NH residents?

RQ5: How do DCWs practice to reflect quality of life indicators?
Appendix B

Invitation to Participate
Invitation to Participate:

My name is Karen Kinyon and I am completing my doctoral dissertation from Western Michigan University. I am sending you this letter to invite you to participate in my study because your thoughts about your successful practices plays such an important role in resident quality of life. Your involvement in this process will include a one hour long interview between you and me which will focus on your thoughts about quality of life in long term care and how your practice influences quality of life for the residents you care for. I will also ask you to complete a card sort of what you think are the most important quality of life domains. I will schedule the time so that we can meet at your convenience. This is not a mandatory event for you. Other associates at Lakeland will not know whether or not you have participated in the interview. There will be no repercussions if you choose not to participate. Your involvement may help me understand how we can assist others to be as successful in their practices as you are. The results of this study will be used for my dissertation and may be used in the future for publication since the influence of direct care workers on resident quality of life is a focus in long term care. Please respond to this letter by leaving me a voice message at 1-269-369-1856 or sending me an e-mail at kkinyon@lakelandregional.org within a week to let me know if you are interested in learning more about the study.

Thank you in advance for your support.

Karen Kinyon
Appendix C

Consent Form
You have been invited to participate in a research project titled "Direct Care Workers Perceptions and Practices Related to Quality of Life in Long Term Care." This project will serve as Karen M. Kinyon’s dissertation for the requirements of the Degree of Doctor of Philosophy in Educational Leadership." This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and please ask any questions if you need more clarification.

What are we trying to find out in this study?
This research is intended to gather information that adds to the body of knowledge of the successful practices of direct care workers and their perceptions related to quality of life in long term care.

Who can participate in this study?
Fifteen direct care workers employed at Lakeland Continuing Care Center for at least 12 months prior to the study will be included. Those working less than 12 months prior to the beginning of the study will be excluded. Invitations to volunteer for the study will be given to all direct care workers employed at the facility for the prior 12 months. The first 15 respondents volunteering to participate in the study will be included in the study.

Where will this study take place?
This study will take place in a quiet conference room located at Lakeland Continuing Care Center in St. Joseph, MI.

What is the time commitment for participating in this study?
The interview with you should take no longer than 45 minutes. The card sort exercise should take no longer than 15 minutes. All together, your commitment should take no longer than one hour. We will only meet one time for you to complete the interview first and immediately following complete the card sort.

What will you be asked to do if you choose to participate in this study?
You will be asked to participate in an in-depth interview, no more than one hour in length. Your interview will be audio recorded so that your comments can be transcribed. You will also be asked to complete a card sort exercise by rank ordering 11 cards. The cards will have a simple description about quality of
for at least three years. Your name and identity will remain confidential for any results of the study presented at a conference or published in any form.

**What if you want to stop participating in this study?**
You can choose to stop participating in the study at anytime for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience NO consequences if you choose to withdraw from this study. The investigator can also decide to stop your participation in the study without your consent.

Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Van Cooley at 1-269-387-3891 or van.cooley@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

Please Print Your Name

Participant’s signature   Date
Appendix D

WMU IRB Form
Date: May 4, 2010

To: Van Cooley, Principal Investigator
   Karen Kinyon, Student Investigator for thesis

From: Amy Naugle, Ph.D. (Chair)

Re: HSIRB Project Number: 10-04-16

This letter will serve as confirmation that your research project titled "Direct Care Workers Perceptions and Practices Related to Quality of Life in Long Term Care" has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 4, 2011
Appendix E

Lakeland Healthcare Approval
April 28, 2010

To Whom It May Concern:

Karen Kinyon has permission to complete research for her dissertation at Lakeland Continuing Care Center in St. Joseph Michigan. This includes access to staff, contact information and communication with them in order to collect data for her research. This research will be conducted during the staff’s working hours. Staff have permission to be dismissed from their work duties for one hour to participate in the interview and card sort exercise. Staff will be paid their regular pay.

Jim Schlaman
Executive Director, Post Acute Services
Appendix F

Lakeland Healthcare IRB Exemption
To: Western Michigan University  
Principal Investigator: Dr. Van Cooley  
Student Investigator: Karen M. Kinyon

Re: Title of Study: Direct Care Workers  
Perceptions and Practices Related to Quality of Life in Long Term Care

Date: April 28, 2010

This is to acknowledge the above referenced study has been determined to be exempt from full board review according to the Standard Operating Procedures and Claim of Exemption Checklist set forth by the Lakeland Hospitals Niles and St. Joseph IRB #1.

The IRB operates in compliance with GCP and applicable laws and regulations to the best of its knowledge. In compliance with such procedures, laws and regulations, Investigators do not participate in the review and voting process for studies in which they participate. The IRB consists of members of the clinical and scientific communities, non-scientists, as well as members of the community as required by Federal regulations to assure a fair and thorough review process.

It is not the Institution's policy to submit individual lists of IRB members. I can assure you, however, that a quorum of the members were present at the meeting to authorize the chairperson to make decisions regarding a studies exemption status.


Please call me if you have any questions about the terms of this approval.

Jarafi Tozke, IRB Chairperson  
Lakeland Hospitals Niles and St. Joseph, IRB #1

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Appendix G

Interview Protocol
Interview protocol: Direct Care Workers Perceptions and Practices Related to Quality of Life in Long Term Care

Time of interview: Date: Place:

Interviewer: Interviewee Number:

Description of the project: You have been invited to participate in the research project entitled: Direct Care Workers Perceptions and Practices Related to Quality of Life in Long Term Care." This research is intended to gather information that adds to the body of knowledge of the successful practices of direct care workers and their perceptions of quality of life in long term care.

Questions:
Male: Female: Age: Ethnicity: Yrs worked in a NH Yrs. Employed Here:

1. Describe what it looks like when you feel successful in your work.
2. Describe what it looks like when you’re unsuccessful in your work.
3. What experiences or relationships have helped you become successful in your work?
4. Can you tell me if there is anyone or anything in the organization that influences your success?
5. Where did you obtain the knowledge for your successful practices?
6. When I ask you about resident quality of life, what does that mean to you?
7. Can you tell me how you would describe a good quality of life for residents?
8. Can you tell me about any of your practices that may promote a resident's quality of life?
9. What do you understand about the Eden philosophy?
10. What does the Eden philosophy mean to your practice?

Thank you for participating in this interview. All of the information collected from you is confidential. That means that your name will not appear on any papers in which this information is recorded.
Appendix H

Card Sort of Quality of Life Domains and Coding Scheme
<table>
<thead>
<tr>
<th></th>
<th>Sense of Safety, Security, and Order (SSO)</th>
<th>Physical Comfort (PC)</th>
<th>Enjoyment (E)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Free from danger and threat; personal possessions are safe and secure.</td>
<td>Free from physical pain and discomfort such as shortness of breath, nausea, and constipation. This may also include room temperature and positioning.</td>
<td>Satisfaction and delight by expressions of happiness. May include satisfaction with food, entertainment, activities or outdoors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meaningsful Activity (MA)</td>
<td>Relationships (R)</td>
<td>Functional Competence (FC)</td>
</tr>
<tr>
<td>Description</td>
<td>Activities that promote self-esteem, pleasure, comfort, education, creativity success and independence. May be different for each individual.</td>
<td>Relationships with family, friends, other residents or even care givers.</td>
<td>As independent as possible within a resident’s physical and cognitive capacities. As independent as they choose to be.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dignity (D)</td>
<td>Privacy (P)</td>
<td>Individuality (I)</td>
</tr>
<tr>
<td>Description</td>
<td>Activities that enhance a resident’s self-esteem and self-worth. Examples: grooming residents as they wish; assisting residents to dress in their own clothes appropriate to the time of day and individual preferences.</td>
<td>Being able to be alone when one wishes; being together in private with others as one wishes; control of information about oneself; and, private space and privacy of mail.</td>
<td>Sense of being known as a person and being able to express his/her own identify. Being treated as an individual.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Autonomy/Choice (A/C)</td>
<td>Spiritual Well-Being (SW-B)</td>
<td>(this cell intentionally left blank)</td>
</tr>
<tr>
<td>Description</td>
<td>Making own decisions and choices about when to get up, when to eat, what activities to participate in.</td>
<td>Participates in religious or spiritual activities of choice.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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Appendix I

Quality of Life Dimensions Coding Scheme
Quality of Life Dimensions Coding Scheme

<table>
<thead>
<tr>
<th>Quality of Life Dimensions</th>
<th>Mentioned in the Interview</th>
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</thead>
<tbody>
<tr>
<td><strong>Comfort:</strong></td>
<td></td>
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<tr>
<td>covers the resident so they remain warm.</td>
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</tr>
<tr>
<td>positions or repositions the resident.</td>
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<tr>
<td>speaks in a calm quiet voice so as not to disturb the resident while sleeping or relaxing.</td>
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<tr>
<td><strong>Privacy:</strong></td>
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<tr>
<td>steps out of the room while the resident is on the phone or has visitors.</td>
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<tr>
<td>knocks on the door and waits for permission to enter.</td>
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<tr>
<td><strong>Dignity:</strong></td>
<td></td>
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<tr>
<td>treats residents politely.</td>
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<tr>
<td>treats residents with respect. handles residents gently during care.</td>
<td></td>
</tr>
<tr>
<td>respects resident’s modesty.</td>
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<tr>
<td>listens and pay attention to residents when they are speaking.</td>
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<tr>
<td>grooms residents as they wish to be groomed.</td>
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</tr>
<tr>
<td>encourages and assist resident to dress in their own clothes rather than hospital gowns.</td>
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</tr>
<tr>
<td>sits next to resident instead of standing over them when assisting them:</td>
<td></td>
</tr>
<tr>
<td>interacts/converses with the resident while assisting them rather than with other staff.</td>
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</tr>
<tr>
<td>refrains from practices demeaning to the resident such as keeping catheter bags uncovered and/or refusing to toilet resident when they wish to.</td>
<td></td>
</tr>
</tbody>
</table>
**Accommodation of needs:**

places call light or other personal items such as grooming items within reach before leaving the room.

interacts with resident taking into account any limitations such as speaking loudly if needed or inserting hearing devices if indicated; making sure they have their glasses on if needed.

communicates at eye level or remove resident from noisy surrounding if resident having difficulty hearing what is said.

**Meaningful Activity:**

transports residents to activities of their choosing. asks residents what they would like to do or where to go.

**Relationship:**

takes time to have a friendly conversation with a resident.

takes time to converse with families during visits.

**Enjoyment:**

asks the resident what they would like to eat.

**Spiritual well-being:**

assists the resident in participating in religious activities.

**Safety & security:**

answers call lights quickly.

takes precautions with possessions.

**Individuality:**

asks the resident about their interests and what they like.

asks the resident about their experiences.
**Autonomy & choice:**

asks the resident about their preferences such as when to go to bed, when to get up, what clothes to wear, and what to eat.

**Other Behaviors and Practices Mentioned**
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