

**DIMENSIONS OF NURSING HOME CARE: PERSPECTIVES OF PATIENTS,  
FAMILY MEMBERS, AND CARE PROVIDERS**

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**Doctor of Philosophy**

**by**

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**DEDICATION**

**TO**

**AUNTIE**

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# DIMENSIONS OF NURSING HOME CARE: PERSPECTIVES OF PATIENTS, FAMILY MEMBERS, AND PROVIDERS

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## ABSTRACT

Conflict among care participants in the nursing home setting concerning the expectations for care-giving and care-seeking behavior has been well-documented. The question explored in this study is whether substantial differences exist among nurses', nurses' aides', patients' and family members' interpretations of the meaning of care, care requirements, and distress states that influence decision-making and care-seeking behaviors. A related question addresses whether other factors within the nursing home environment, such as the organizational structure of nurses' work and the functional model of care delivery influence the cultural models of care of care participants. The fit between a formal model of care, the self-care deficit nursing theory, and the actual cognition of care of patients, family members, nurses, and nurses' aides is also examined.

A critical hermeneutic approach frames the ethnographic and ethnosemantic methods used to collect terms and attributes of care and to relate these to the context in which care takes place. Resulting care models are presented and compared using both taxonomic and spatial representations of data from multiple sources. The effects gender and other role have on the particular configuration of care each participant holds in mind are compared. Critical examination of the meaning of these findings for the improvement of nursing home care is presented. A relatively consistent model of care was found to hold among three different groups of consultants from five nursing homes. Two dimensions, a home/hospital dimension, and a generalized/specialized knowledge dimension defined the spatial configuration of terms and attributes.

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# CHAPTER ONE

## DIMENSIONS OF NURSING HOME CARE: AN OVERVIEW

### Introduction

Within medical anthropology, illness and disease are studied as subsets of cultural knowledge. (Other) cultural aspects of the care of persons experiencing an illness -- such as the disposition to care and the act of caring -- have been given little attention by both medical anthropologists and actors in the health care system. Most heuristic theories explaining human and medical responses to episodes of illness have theories of caring embedded within them. While scholars believe that there is general agreement about who should be or is doing the caring and about what constitutes care, there is evidence to suggest that this agreement within a given culture is actually limited and dependent upon differences related to role. Traditional healers, mothers, ill persons, and relatives may see very different pictures of the causes, cures, and care responsibilities associated with a particular illness.

### Origins of the Research

That there might be differing models of care was first brought to my attention by a colleague who had observed that a disabled member of a couple, when queried about his ability to shop, replied in the affirmative, although he personally never left the house. The weekly trips by the spouse to the grocery store were appropriated by him as acts of self-care.

Similarly, I once noted a mother's comment as she paced up and down to quiet her crying newborn. "He likes to walk around," she told me. While she was doing the walking, she attributed the act of walking directly to the infant and omitted mention of herself as agent. In both instances the act of assistance was perceived as an act carried out within the self system in one case by the care recipient and in the other by the care-giver.

Interest in this study originated in my personal experiences working in nursing home settings and as a family member and conservator of a 95-year-old aunt. Experiences of dissonance between the nurses' and nurses' aides' views of patients and the patients' views of themselves engendered my interest in studying differences among cognitive models of care. The following accounts from my journal illustrates these different points of view. Martha, 96, became totally blind as a side-effect of an inflammatory process at the age of 94. Julia, 76, was confined to a bed or wheelchair with rheumatoid arthritis in her knees and back. Both women had difficulty hearing.

It's Tuesday again and I go to the nursing home to see Martha and get her laundry. As usual, she is lying down. "Thinking," she says. She has nothing to do between meals except on the days when the priest comes to say Mass. I reach out my hand to touch hers and she automatically raises herself. She explores that hand; she knows it; it is part of her vocabulary. As soon as she realizes it's me, she relaxes. "Oh, hello," she says. She is grateful for the touch, the connection, the affection that flows between us. I smile inside, full of love for this woman who has known me always; as long as I've been, she's known me. She reaches for my hair, the hair she combed when I was small. Even when her mind is confused and she begins to forget who she is, to touch my woolly head full of curls allows her to remember. We hug and sit down on the bed side-by-side.

In between my visits Martha compiles a list of changes she would like to see made in her small world. At each visit she presents her list of problems to me for my suggestions and solutions. The main problem this month has been that she has no one to talk to, no way to write letters. (I cry inside.) She had a friend once. She tells me how she misses her. Her friend was Julia.

About a year ago Julia was admitted to this home after a fall that left her with a broken hip. Julia and Martha were roommates then. The two women got along well. They sang Irish songs together and they had a special love between them. Yet, Julia missed her own home and her dog, Puppy. So, as she began feeling better, she wanted to leave. When Julia left, Martha grieved.

Six months have now passed between Martha's and Julia's last days as roommates and today, Tuesday, I have found Julia. Julia has been back in the home for a week in a room four doors away from Martha. I try to tell a nurse how excited I am to see Julia and how happy Martha will be that Julia is back. She is distant and preoccupied, apparently unaware of the intense feeling these two women have for each other, although she has cared for them daily for four years. I am surprised and I look for explanations. Why would someone so caring and so important to these women fail to attend to their friendship? I go to Julia. She is warm and gracious, but morose and fearful. I tell her how happy Martha will be to know she is back, but Julia isn't as strong as she was before. "Perhaps Martha will be disappointed because I can't sing," she tells me. She had to give away all of her belongings and doesn't have anything to give Martha to express her love.

I tell Julia I am going to the store to get Martha some port wine and some graham crackers. The life springs back into her face. "Oh!" she says, "let me buy the wine. We can drink a toast to our friendship. How much is it?" "A couple of dollars," I say. "Okay, here they are." Out of her drawer comes her wallet and two dollars.

When I get back from the store, I tell Martha that Julia is back, but worried that she won't "be pleasing to her any more." Martha bolts up, her face full of intent. "Let's go," she insists, clutching my arm firmly. As we march down the hall together, Martha is trembling; she holds on tight to my arm. As we approach Julia's bed Martha reaches out to touch Julia's. I guide Martha's hand to Julia's. Martha holds that hand in both of hers and kisses it. "Hello my beloved friend," she says softly.

"I have some wine for you," Julia says. "Let's drink a toast to our friendship." I pour two medicine cups full of port wine. Each friend holds her cup high. They are both full of ceremony. "You must toast with us," Julia says, so I pour one for myself. "To the friendship we shared in the past..." Martha echoes the words, "and to the friendship to grow into the future..." "... the future." Martha echoes each word as we all sip our wine. It is a sacred moment. In all the years I've known her, she has never expressed for any other friend the depth of affection she has for Julia. Only here in this nursing home, at the age of 96, has she finally experienced the richness of such loving friendship.

Martha and Julia sit silently full of contentment at being reunited. They sing a love song together. Then there is silence again. They share the graham crackers. Like lovers, what they say is unimportant; that they are together is everything.



One of the nurses' aides walks by. "Awww," she says. "Isn't that cute!" I feel estranged, (existentially dissonant) All around me the nurses and their aides carry out the day's tasks while in Julia's room there is only an instant of timeless love and contentment. An invisible sacrament is taking place—imperceptible, misunderstood, and misinterpreted. . .

#

. . . For the last six weeks Julia and Martha have lived four doors apart, never meeting unless I bring them together. I have asked the nurses and the their assistants; I have asked the activity director, the housekeeper, and a volunteer. Once in a while the physical therapy assistant will walk with Martha down to hall to Julia's room. But Julia and Martha are both hard of hearing. For them to enjoy a conversation they frequently need someone to repeat the other's words, or they tire too quickly. Julia and Martha don't ask because "everyone is always busy."

In the world they came from, feelings and friendship took second place to hard work. They were not something to bother others about, not important enough to interfere with the day's tasks. Yet, here, in this hospital world, feelings and friendship are bursts of warmth and light in a monotonous endless twilight. Sometimes I feel like standing in the corridor and screaming, "Can't you see, there is life here and passion and feeling. Vibrant beings live in this home!" But the staff don't seem to see. So, I come on Tuesdays to get the wash, to sit and listen to Martha's troubles, and to take her to visit her friend Julia.

why don't they see?  
Assume -  
it is their job to see

Julia and Martha have talked of moving to the same room, since they never see each other, but they fear it will erode their friendship.

What they want is to be neighbors, to be together three times a week, to visit. Why do the nurses not see the importance of bringing these two

\*

# women together? Why does it fall outside the nurses' conception of caring or even of duty? In my 20 years experience working in and around nursing homes, I never witnessed such a friendship develop between two patients. But Martha is my aunt and through her I have new eyes and ears. Although these two women are both considered chronically ill by medical standards, the unbearable reality is not just the pain of arthritis or the aggravation of perpetual night, it is the impact of these disabling illnesses upon their daily struggle to experience life fully. (February 4, 1989)

This narrative illustrates the dissonance I have observed and experienced among patients and the staff who assist them. Their views of each other, the communication between them, and the work that they perform together are all affected by their positions relative to each other both inside this nursing home and in society. Studying the cognition of care of these participants in the day-to-day life at Twin Oaks, a nursing home, is a way of investigating their cultural knowledge, attitudes, and perceptions of care and the rules that govern caregiving and those who participate in it. In this study the ethnosemantic methods for collecting data about cognitive elements of culture are coupled with the methods of ethnography for discovering the interactional and material traces of culture and to discover the root of conflict among staff, patient, and family member.

### Aims of the Research

To understand the differences among these participants, along with the evidence of different cognitive models, we must examine context, expressions of emotion and



emotional distance, and the action or inaction of the nursing staff, patients, and family members. All actors in the nursing home community do not necessarily have the same understanding of the word "care." Patients seem reluctant to call the nurse for things they need. Some nurses' aides seem to think that certain required tasks are not part of their job, such as taking the patient to the activity room to participate in an activity. One aim of this study is to explore questions arising from these observations: Do persons standing in different relationships to the patient role hold different prototypes of care in mind? Do they have different ideas about what constitutes good care, about who should perform various caring practices, and about what constitutes a need to receive care?

Another aim of the study is to discover whether other constructs of care present in the nursing home community influence participants' understandings of the meaning of care and their perception of a need for care. A task-based system of nursing care based upon the medical construction of illness is utilized as the basis for staff assignments, patient charges, and acuity of patients' care requirements. Does this model, which controls the work lives of the staff and the day-to-day activities of patients and family members, have an impact on the models of care participants hold?

A national trend in nursing homes is marketing the nursing home personified as a caring person. As part of this campaign, administrators have developed programs to promote a "caring attitude" among the staff.

On the other hand, activities such as ice cream socials, concerts held on the premises, or administrative staff participation in the distribution of meals to the homebound elderly through the Meals on Wheels program draw local media attention and contribute to the effort to convince the public that the nursing home "cares." Recognition of this trend raises another question to be explored in this study: Has the commercialization of care and its used as a public relations tool influenced the patients,' family members,' nurses,' and nurses' aides' understanding of care?

Within the healthcare system, nursing is on a level with other low-status occupations (Ward 1986). Wolf (1989) postulates that this low status is due, in part, to the hidden and personal nature of the work of nurses. Much of the personal care performed by nurses takes place only in the presence of the patient. Wolf stresses the need to explicate and make explicit the work of nursing in order for nursing care to be understood and for nurses to be adequately compensated.

This study will help determine the extent to which the understanding that patients, family members, nurses, and nurses' aides have of the concept of care resembles the technical and scientific definitions of care that have been explicated by nurse theoreticians. By comparing characteristics of nurses with their varied levels of education and experience and the different cognitive models of care and decision-making strategies used by each in the act of delivering care, we may discover factors influencing care delivery. This report will also make appropriate recommendations for revisions in care delivery based on the findings of this research.

I cannot claim objectivity or distance from my topic. I have assumed many roles in relation to the nursing home community. As a nurse, I have served both as a director of nurses and as a consultant to nursing homes similar to those in this study. As an ombudsman and lobbyist for the California Association of Long-Term Care Ombudsmen, I became familiar with the political issues surrounding legislation governing health care policy and care of the aged in the United States. As a family member, I struggled to support my aunt Martha in her efforts to remain independent while I supported the nurses' aides and nurses who cared for her. As an anthropologist, I have stood as insider and outsider to learn from care participants their understanding of care and to share my understanding and perceptions with them. I have been astounded more than once by the recognition of how much my experience in nursing has shaped my view of reality and how much it prevented me from seeing. The patients, nurses, and family members who shared in this work taught

me to see with new eyes. To ensure the validity of this study, I have chosen a method of inquiry that permits me to reduce the effect of my subjectivity upon the results. I will compare results from my ethnographic observations, from documentation of patients' experience of day-to-day life, and from interpretations of taped interviews with the study consultants with formal ethnosemantic methods for exteriorizing the meanings of care that are outside the consultants' awareness.

By so doing, this study aims to answer Harwood's (1990) challenge to medical anthropologists and Quinn's (1987) challenge to cognitive anthropologists to "redefine the conventional boundaries of knowledge to produce a new, more complete understanding of the human enterprise" (1990, 147). To do so, Harwood suggests, we must develop theory that "comprehends the interplay among biological-technological, political-economic, and conceptual-symbolic processes" (1990, 148). To satisfy this aim, we must understand not only how these strands play out in the culture under study, but also how they can be woven into a whole cloth - a research project that meets requirements for both rigor and relevance.

Quinn (1987), D'Andrade (1984), and Keesing (1987) have addressed the need for research that will help us understand the degrees to which cultural knowledge is shared among members of a group and across sub-groups of a particular culture. In some studies of cultural knowledge, persons belonging to an undifferentiated category of individuals or, at times, even a single individual is interviewed for the purpose of understanding the elements of cultural models or of the metaphors that inform them. These studies often overlook the actual uses of models in everyday life in interactions among members of groups or members of groups with similar roles who inhabit the same cultural world.

A second aim of this research is to understand the creation and transmission of nursing home culture. Nursing homes, like other closed institutions, have well-established and stable environments. Many who have attempted to effect changes in the routines by which care is provided have met with defeat. Knowing those factors that influence and stabilize

the cultural environment in the nursing home is crucial to understanding how best these systems can be improved.

In open discussion with the participants about the findings of the study, the researcher can bring an etic perspective to the assessment of the emic views of those inside the practice setting and jointly evaluate the truth of the claims made there. Together, consultants and anthropologists can more closely approach a correct interpretation of events than either group of us could do alone.

### Theoretical Framework

The theoretical framework for this study of care participants' knowledge of nursing home life and work embeds ethno-science in the critical hermeneutic paradigm. This framework is grounded in the basic tenets of anthropology. The focus upon daily life in the nursing home stems from Boas's (1911) assertion that it is everyday life more than the exceptional event that holds the key to understanding the creation and transmission of culture. Early ethnosemanticists studied terms for plants (Berlin, Breedlove and Raven 1974), diseases (Frake 1961, D'Andrade 1976), terms for kin (Lounsbury 1956), and color terms (Berlin and Kay 1969) shared by members of cultural groups. Some more recent studies have continued this tradition, for example studies of terms for animals (Boster 1987), reasoning (Hutchins 1979), anger (Lakoff 1987). More recently, cultural anthropologists have studied common social relations such as marriage (Quinn 1987), dating (Holland 1987), planning strategies (Gladwin and Gladwin 1971, Furbee 1989), and medical choice (Young 1980).

People are both culture bearers and culture creators. The question of authenticity and naivete with respect to cultural construction of cultural identity are current topics of interest



within the field of anthropology. The ideas that people within a culture hold in mind about their own identities, and the identities of others who co-habit their worlds and their relationships to them, influence and are influenced by the cultures they create and bear. Intracultural research seeks to discover variation among and within subcultural groups in cultural models of the world they hold.

The physical environment, the social environment, and the political environment affect the space/time universe in which people live and work. These environments influence the emotional climate, the presence or absence of physical and mental activity, the types of activities performed, and the personal and socioeconomic constraints under which people live and work. All of these, in turn, influence individual perceptions of everyday life.

The unit of analysis in studies of human cognition is the relation between words and the material phenomena they signify to individuals in cultures and the various ways knowledge of these relations are organized. Fraake (1962) described the goal of cognitive anthropology to be ascertaining the referents for particular terms. It is the task of "discerning how people construe their world of experience from the way they talk about it" (Fraake 1962).

Ethnosemantic analysis, adapted from linguistic anthropology methods, is used in cognitive anthropology to discover the meaning of words within a cultural context. Its impetus derives from interest in the nature of the possible relationships between language and culture (Whorf 1956). Terms relating to a particular cognitive domain or general subject matter are elicited from members of a cultural community. An attempt is made to discover the class-inclusion relationships among these terms and the rules for use by the culture to categorize these terms. In traditional ethno-science, categories are assumed to be in contrastive distribution to each other, and a representation of categories of the domain is constructed (Bright and Bright 1985). Questions have been raised about aspects of traditional ethnosemantic analysis. Crick (1982) questioned whether the cognitive models produced by anthropologists actually reflect the thought processes of members of a cultural group. Burling (1964) challenged cognitive anthropologists to produce all possible

combinations of complementary terms within a domain and then demonstrate that the configuration selected provided the one best representation of that cultural community's cognitive model. Tests for validity have been instituted by some ethnographers to address this concern (Furbee & Benfer 1983). Questionnaires constructed from information about terms and attributes of terms are distributed to a broad spectrum of the community and results are analyzed using statistical methods where degree of agreement among subjects is used as a measure of correspondence with the group's own cognition. Anthropologists such as Gardner (1976), Christian and Gardner (1977) and Furbee (1987) have studied individual variations in responses from members of cultural groups.

In cognitive anthropology, psychological models of cognition are used as analogs of different cultures' and individuals' organizations of knowledge. Models for a domain are constructed from the terms, attributes, and consultants' perceived similarities and differences in the terms and the reasoning methods they use to relate these terms (Goodenough 1956). Cognitive anthropologists believe that these models may not be known directly to native speakers and therefore cannot be discovered by direct questioning of consultants about their cultural models. Rather, they are discovered through analyses of the responses given by consultants. Contributions from artificial intelligence and cognitive psychology have provided new deductive and inferential methods for understanding how cognitive models are produced and learned.

The proponents for a critical hermeneutic perspective within nursing, Thompson (1987), Allen (1985), and Herda and Abascal - Hildebrand (1987), have drawn heavily on concepts from cultural anthropology. The three main premises underlying the critical hermeneutic approach are: (1) that research is needed which presents an analysis of the power relationship within the culture under study to emancipate the individuals being studied by illuminating for them sources of oppression and alienation; (2) that the individuals most affected and therefore most knowledgeable about a situation should be

empowered by study results to change their circumstances; (3) that practice theories should lead to understanding rather than prediction.

The critical hermeneutic tradition draws on the work of Geertz (1974) who placed culture in the discourse between culture bearers. Thick description of interactions among members of a cultural and their contexts provide one means for understanding both power relations implicit in the knowledge and behavior of interacting individuals. Because culture is continuously being created and changing, Turner (1989) argues that culture is best understood through analysis of productions such as texts, plays, and rituals, because they provide insight into the shared interpretations of cultures. Wolf (1986) describes the rituals performed by nurses in the care of the sick. In this current study I examine the rituals present in nursing home life and work to illuminate the cognitive models of care participants.

Critics of empirical/analytical methods of scientific inquiry have questioned the applicability of empirical findings for human situations. The "reductionism" required to make human attributes and characteristics -- such as language or social networks -- measureable or definable requires that the "object" be re- (con)textualized in the human situation to correct the distortion that arises in the process of study.

Critical anthropologists have argued that the error of much biocultural and ecological analysis is that social "rules" are transformed into facts, and that they lead to a denial of the influence of social forces upon phenomena of interest. Singer (1986) proposed that a political economic approach to the systems of medicine, health care, and healing was missing from medical anthropology. He claimed that "the singular contribution that a critical medical anthropology has to offer social science is a synthesis of the micro-level analysis of forces shaping the lives of those working and living within societies with the macro-level analysis which is the hallmark of political economic perspectives." He advances six propositions that constitute the core of critical medical anthropology:

- (a) The world of humankind constitutes a manifold, a totality of interconnected processes. Therefore, inquiries that disassemble this totality into bits and pieces and then fail to reassemble it falsify reality. - e.g. ritual theory
- (b) The most significant transcending social processes are expressions of the development and expansion of capitalism. T
- (c) Critical medical anthropology is concerned with investigating the social origins of illness.
- (d) A central arena of analysis within critical medical anthropology is the nature and organization of the health care system that diffused with capitalism, the system variously known as biomedicine, scientific medicine, Western medicine, allopathic medicine, and cosmopolitan medicine. The important point for critical medical anthropologists is the relation between this system and the larger political economic system in which it is encompassed. }
- (e) Critical medical anthropology recognizes the importance of power relationships within medicine and calls attention to the existence of several levels of core capitalist and "peripheral" nations in the health care systems.



(f) Critical medical anthropology is concerned with the diversity and changing patterns of health and health-related behavior found around the globe as they are penetrated by "threads of the capitalist mode of production and distribution.

(Singer 1986, 36)

These six propositions represent what I will call the strong form of critical medical anthropology. To the detriment of medical anthropology at large, they represent to many the worst kind of science. It is evident from the construction of these propositions that the researcher is told beforehand what he is supposed to find; research is then reduced to the task of simply finding examples of the inroads of capitalist power upon the lives of people.

Proponents of the critical theoretical tradition within medical anthropology, such as Lazarus and Pappas (1986), Scheper-Hughes (1990), and Martin (1987), who are proponents of more liberal feminist theoretical and neo-marxist traditions, recognize that social and economic forces on the macro-level and social domination on the micro-level represent important segments of culture that impact the cognition of individuals. As a result, the rigid marxist tradition espoused by Singer (1986) and Baer (1986) has come under criticism from Scheper-Hughes and Lock (1986), Kuiper (1989), and others. Scheper-Hughes and Lock (1986) observed that traditional critical analysis overlooks the idiosyncratic individual in favor of the "masses" in analysis of human behavior in social situations of domination. On the other hand, Kuiper (1989) discussed the fallacy of thinking that macro is micro writ large. He argued for the use of meticulous, detailed observation and analysis to discover what is occurring on the micro level rather than assuming that the social forces at work are the same in each instance or that those known to the anthropologists are the most salient to the participants.

Social forces and unequal distributions of power are important factors in any ethnographic study, but the mere existence of these forces does not assure that they are factors of influence, nor can it be assumed that they are the only factors influencing communication and knowledge in a culture being studied. Rather, they are potential influences and their power must be demonstrated, not taken for granted. It falls upon us, then, to establish the connection between social forces and the thought and behavior of actors in a setting. By using ethnoscience methods, we can bring to the task an external framework to allow us to locate those social forces that are influencing participants' decisions and behavior (Young 1980, White 1990).

e.g.  
Laird's  
narrative

Kearney (1984) opposes concern for relevance to concern for rigor in his critique of "idealistic anthropology." This position reflects the extreme polarization of anthropology to the demise of groups with opposing views by posing the two essential features of human inquiry against each other. A intermediate form of critical analysis will be evident in this study through inclusion of historical analysis of the influence of social, physical, and cultural environments in the analysis of field work data. One solution to the conflicting demands of rigor and relevance is that posed by Schweder (1985): that both sides accept the validity of differing constructions of truth and modes of inquiry and agree to disagree. Both contributions are necessary for a balanced anthropology. The second is that posed by Hill (1988), which is a stronger version of the first solution. That is, a common ground must be sought where the issues raised by each side are partially answered. This study attempts to demonstrate a common ground by utilizing the scientific, and critical hermanentic approaches in the study of care of the aged. For the purposes of operationalizing them in this study, the six propositions above are recast as follows:

- (a) The world of humankind constitutes a manifold, a totality of interconnected processes. Therefore, inquiries that

disassemble this totality into bits and pieces and then fail to reassemble it provide information that is of limited value in the applied human science fields.

- (b) Social processes that are expressions of the development and expansion of capitalism are important, but are not the only significant social processes at work in a society.
- (c) Social origins of illness should be included along with biological and cultural origins for an investigation to be complete.
- (d) A central arena of analysis is the nature and organization of the health care system, the historical and cultural roots of that system, and the role of hegemonic ideology and social relations upon the development of that system. An important focus is the relationship between this system and the larger sociocultural system in which it is encompassed.
- (e) Power relationships within and among the strata and divisions of health care systems are important and critical medical anthropology seeks to understand, describe, and compare these relationships in nations with differing economic and political structures.

- (f) The diversity and changing patterns of health and health-related behavior found around the globe as they are affected by emerging political and social realities.

### Contributions to Cognitive Anthropology

Most cognitive studies of knowledge of indigenous people focus upon domains of knowledge that are shared within the everyday experience of the community, such as disease terms or soil usage. Care, the domain that is the focus of this study, is the shared experience of the community in this study, but it is largely out of awareness. The terminology is not commonly held and must be negotiated among the community members.

*is how much shared?*

The usual practice is to focus upon one homogeneous group within the community, such as farmers or healers. In this study we are constructing and comparing the cognitive models of care for four categories of care participants—patients, charge nurses, nurses' aides, and family members.

*What it contributes to Cog. Anthropology is comparison between rather than 71+ groups*

### Contributions to Medical Anthropology

Studies of interaction between patients and care providers center upon physician-patient interaction and compare explanatory models of physicians and patients. The central role of nursing staff and family members, as well as other patients central to the caregiving process, have been overlooked. This study addresses models of divergent groups within a single setting and offers a better means for understanding the different explanatory models at work. It also examines the power relations existing among workers, family members, and patients.

Care, claimed as foundational by all health related occupations, has only been broadly conceived by scholars and theorists writing within the various disciplines in which health care is a focus of study (Aamodt 1984). Within nursing, Watson (1979) argued that care is the "core" of nursing. Leininger (1984) claims that care is the "essence of nursing." In a recent review of the nursing literature on care and caring, Morse et al. (1990) performed a content analysis of 35 authors' definitions of care and the main features of each of their perspectives. She identified five perspectives on the nature of care. The five perspectives on caring were: caring as a human trait, caring as a moral imperative or ideal, caring as an affect, caring as an interpersonal relationship and caring as a therapeutic intervention. Additionally, two outcomes of caring were also identified. These were the patients' subjective experience and the patients' physical responses. No outcomes relative to nurses, such as burnout, job satisfaction, or staff turnover, were identified. In her critique of current literature on care, Morse (1990) calls for research to focus upon the patient and the connection between caring and patient outcomes. The present study addresses this need. I argue that the effect of care or caring on the nurse-related outcomes is also needed. My study describes factors that may influence job satisfaction and rate of turnover for both nurses and nurses' aides.

Three scholars, Leininger (1989), Watson (1979), and Orem (1990) have developed theories of nursing that use care as a central construct. However, Orem's Self-Care Deficit Theory of Nursing has served as the foundation for the largest number of research projects. Neither of the other two theories has been tested. Prior studies have identified serious problems of quality of care in nursing homes and have given varying solutions to the remedy these problems; these studies have overlooked areas of possible cognitive disagreement and variations in the knowledge of care provider.



## CHAPTER TWO

### METHODOLOGY

#### Introduction

A major assumption underlying this study is that to understand cultural differences in individuals' constructions of reality, the investigator must be clear about both his or her own interpretations of reality as well as the consultants'. By viewing the models produced by ethnosemantic methods in light of these two views of realities, one should find that the formal models point to the cultural systems of thought that inform them. Therefore the cognitive approach is being embedded in a critical hermeneutic one. It was with this in mind that I began my ethnographic work <sup>Assump</sup> searching for models of care used by care participants in a nursing home setting, one that could explain shared and unique components. Multiple methods of data collection were used to verify and to interpret information gathered from consultants by more formal methods. In this Chapter I describe in detail the materials and methods of data collection.

#### Participant Observation as a Family Member

Studying one's own culture at home has advantages and disadvantages different from those encountered by investigators working across geographic and cultural boundaries. Observation and analyses are not demarcated by time. In this study,

a library search, participant observation, and interviewing were incorporated within my normal routine-- working, living, and caring for Martha. Life and work were inseparable. I was ethnographer, nurse and family member.

My first acquaintance with Twin Oaks was not as an ethnographer but as a family member looking for a bed for Martha, because caring for her at home was becoming unsafe and unhealthy for us both. My orientation to the facility was that of a relative. After Martha was admitted to Twin Oaks, I began writing a journal; that was long before this study was formulated. I kept a personal account of Martha's experience at Twin Oaks, from her admission in 1985 until her death in December 1989. This journal did not document the day-to-day events experienced by those involved. Rather, it described in detail a few events that typified Martha's usual interactions with the staff as I saw them. Sleepless nights led to connections being drawn; new inferences found their way into my notebook. Only later did they become part of my field notes. My early writing was undertaken to help me through my times of anguish over Martha's circumstances.

More formal participant observation was conducted during a three-month period between June and August 1989. During this time I observed and recorded numerous interactions among patients, nurses, nurses' aides and family members: I collected written documents, nursing home newsletters, policies and procedures, and orientation materials for employees and for family members. I also attended structured events, such as an awards ceremony for the nurses' aides receiving their certification, the orientation programs for both volunteers and employees, family council meetings, and Thanksgiving dinner.

The notes and letters that Martha had written to the staff, friends, relatives, and to me became invaluable sources of information. These materials provide insight into the kinds of day-to-day problems that Martha experienced as important and troubling. As a result of my ongoing relationship with the staff caring for Martha, my consultants knew me as I participated in Martha's care. My first male consultant was one of the patients.

He began his interview by telling me tearfully of his love for Martha and his admiration for her strength. Although I hardly knew him, I was not an anonymous interviewer but someone he knew, someone connected to an important part of his life through his own interest in Martha. Before I could concentrate on my agenda, I was made to see that he had a reality of his own very different from mine. It was at that moment that I began to recognize my nursing bias. I saw a vision I had never seen before: a patient's view of nursing home life. He told me how it grieved him to be surrounded by so much overwhelming need and to be helpless in the face of it. He told me how he would help the nurses if he were asked.

From that point, I began to participate in the world as lived by this man and to recognize its similarity to my own. How could I have failed to notice that the patients, too, see the anguish that I see and feel as helpless as I do to offer comfort? My training as a nurse had given me both a nurse's bias and a trained eye for noticing subtle changes in physical and emotional states. The distance I was to travel was the distance from my old viewpoint to several new ones.

Many facets of this story were not written down because they are part of my abiding knowledge of nursing home life. I wrote little on the ordinary day-to-day routine. What constituted my field notes were incidents, like the one above, that were unexpected-- incidents that were examples of the cognition of my consultants with regard to their experiences of care and incidents of strong emotional content for me. In a sense, I tried to discover different meanings in a world where I have an established world view. One investigating an unfamiliar culture would be less hindered by the vast quantity of out-of-awareness knowledge I shared with the consultants in the study. As a result, I didn't spend time making sense out of what everyone took for granted. I was getting a second



opinion about a culture for which my opinion was the first. One major limitation of this study, then, is that I have undoubtedly overlooked some of the common elements and focused on the less common.

The ethnographic focus of this study began four years before the more formal aspects of the investigation. Then, during the fall and winter of 1989, Martha's condition worsened. She died in the middle of December of the same year. By her death she provided me a unique and precious moment in which to see the failures and the glories of her nursing home care as a piece of whole cloth. how?

After Martha's death I was less able to maintain the discipline needed to continue the intensive ethnographic work. Martha died as I was finishing the interviews with the eight primary consultants. I then turned to the formal interviews with the secondary consultants and found both comfort and structure in them. As I began the second phase of formal interviews, I continued with the ethnography in a less intense manner. Nonetheless, incidents occurring during my time in the nursing home led to new understanding of the data. As I asked questions, I took careful note of the rationale behind the answers. The ethnographic prelude to the formal work seemed so essential to me because the domain of care is one with fuzzy boundaries. That period helped define those edges by providing me the opportunity to observe interactions among staff, patients, and family members occurring in their natural settings and in natural language. I began to see evidence of the scenarios in which care is contextualized: parenting, visiting the hospital, and caring for the sick. The boundaries and the structure of the domain emerged from the informant's sense of care rather than from my own. I took care that they were not artificially imposed. how?

As I reviewed my earlier notes and returned to discuss issues a third and fourth time with consultants, the shape of care began to emerge, fashioned from bits and pieces of information gathered throughout the days and nights. I began to see nuances and differences in the way people spoke, and I began at the same time to notice how/polysemic/care is, and how fluid is its use.

## The Ethnosemantic Method

The the design used in this study to discover formal models of care was developed and tested by Furbee and Benfer (1983) for their work investigating the domains of disease and illness, and of soil usage by indigenous people in Chiapas, Mexico and the Peruvian Andes (Furbee 1989). The methods employed are described in detail in, Benfer, Brent and Furbee (1991). However, in previous studies, the domains for which terms were being sought (for example, diseases and soil types, plants, and symptoms of high blood pressure) were more clearly bounded and defined by class inclusion. As a result, Furbee began asking consultants to name kinds of soil or diseases they knew about. These questions might even be heard as part of natural conversation. The domain of care, like that of marriage, is less clearly defined (Quinn 1987). The question "What kinds of care are there?" invoked the answers "good or bad" during a pilot study conducted in preparation for this work. This question is not one commonly asked. Only in nursing are many types of care named such as wound care, mouth care, and self care. For this reason I elected to conduct interviews, during which both open ended questions and directed questions were asked. I hoped that the interviews would provide text for discourse analysis as well as a source of terms for care practices.

The design consisted of three phases. Phase one was directed toward the development of a questionnaire. Terms for the domain under study were elicited from a small number (N=8) of knowledgeable (members of a cultural) group who served as primary consultants. Through the use of sorting tasks (serial pile sorts and triadic sorting tasks), attributes used by these consultants to describe domain terms were discovered. The terms and attributes were then introduced into a frame format in which a number of questions

N=8 per  
Group  
or  
total  
Sample

where do the "attitudes" come from

based upon the attributes of the domain are asked about each term. Responses were analyzed using a non-metric multidimensional scaling procedure (INDSCAL, Tukane, Young, & de Leeuw 1977, Young & Yewycky 1979, Carroll and Wish 1989). This procedure does not make assumptions that a linear relation holds between the similarities one has measured by percentage agreement and the true underlying dissimilarities among the points (Furbee 1987). The salience of each dimension may vary among consultants. A weighted group representation is obtained by accounting for differences in salience on each dimension among consultants. A group representation of individual differences produces, along with the weights for each dimension for each subject, a direct comparison among consultants. The adequacy of a frame based study is tested by the more general triadic sorting of terms by each primary consultant. From these analyses, tentative models-one for the group and one for each of the different consultants-are drawn. In phase two the models are tested by repeating triadic sortings and administering an improved questionnaire with a second set of consultants (N=16) from the same nursing home community. These, too, are analyzed with INDSCAL.

how is diff in salience determined?

In phase three the model is tested for its generalizability with a third set of consultants (N=64) drawn from four other nursing homes in the community using the same questionnaires in phase one and two. The data collected from all three phases are submitted to multivariate statistical analysis. From these results, models of cognition are produced. It is this research design that has been placed within a critical hermeneutic approach to ethnography and modified for use with a loosely-defined domain.

?

## Phase One: Developing the Questionnaire

The first phase of the formal portion of the study began with the selection of eight primary consultants, <sup>why?</sup> (one male and one female) from each of the four categories of care participants: <sup>1</sup> nurses' aides, <sup>2</sup> charge/medication nurses, <sup>3</sup> patients, and <sup>4</sup> family members. Staff members were introduced to the project through letters in their pay envelopes, and family members by an enclosure in the monthly newsletter. I spoke with patients personally.

By the time I was ready to conduct the formal interviews, I had already established a solid rapport with many staff members and patients at Twin Oaks. I had received enthusiastic agreement to participate from those I knew well, and they, in turn, supported me when other staff members were skeptical. Most of the nurses and nurses' aides talked at length about their work. They told of their love for their patients and deep frustration over their perceived barriers to giving the care: short staffing, lack of supplies, and unqualified and uncaring staff. Patients also were very willing to talk. They were glad to be able to help. Some saw the University as important and were proud to be "doing something with the University." Their cooperation also assured them of at least some visiting time with someone who wanted to hear what they had to say. The family members as a group were busy people who were pushed by the time demands of the interview process. I was nonetheless able to find two who agreed to participate. Both completed the entire sequence of interviews.

In order to collect natural discourse using language about care from which to extract care terms to accompany the formal elicitation, I provided the opportunity for participants to share their daily experiences of care and caring. I interviewed these eight primary consultants combining semi-structured and structured questions with informal discussion. Most interviews took between two and four hours. Interviews were conducted in a variety of settings. Staff and family members were usually interviewed at home or in a restaurant because it was more convenient for them. Some expressed concern that there could be



reprisals for criticizing the facility and they wanted to be able to speak freely, away from the facility. Two interviews, one with a family member and one with a nurse, were conducted in the facility in a private office.

All patients were interviewed in the facility, sometimes in their rooms, sometimes in an office or a quiet area of the dining room. All interviews (except one) <sup>why?</sup> were taped and transcribed by me. I also took handwritten notes during the interviews. The conversation in which the following questions were embedded varied among consultants. The female nurses' aide said she was really happy that someone wanted to hear her explanation of the shortcomings of nursing home care. I began her interview with the question, "What would you tell a Congressional committee that was investigating nursing homes?" She responded with two hours of talk.

The male nurse was cooperative but wanted to waste no time with conversation. I began his interview with the first structured question. In the course of responding to the interview questions all consultants interjected narratives about their experiences. The following questions were asked of all eight primary consultants:

1. What kinds of people take care of other people?
2. What kinds of people need taking care of?
3. What do people who take care of other people do for them?
4. What do people need who are taken care of?
5. Think of the person you know who gives the best care.

What does this person do that makes their care so good?

6. Now, think of the worst care you can imagine.

What is it that makes the care so bad?

7. What is abuse?

8. What is neglect?

These questions were used to "elicit care terms"

*Caring as instrumental  
rather than affective*

### Elicitation of Care Terms and Attributes

Care terms were gathered from the text of the taped interviews in all cases but one. Formal elicitation of terms was done by asking the question: "What things do people who take care of other people do for them?" Consultants responded with a list of descriptions of actions, such as "feed them," "dress them," and "take them to the bathroom." Within two days after each interview was completed, I reviewed the entire text of each interview and recorded each phrase that described an act of caring. These phrases became the terms for care practices. Terms were reviewed, and phrases having identical meanings were condensed. I took a very conservative approach in this process and included all phrases that had shades of difference in meaning. For example, "see that they get enough to eat," "see that they are fed," "feed them," and "help them to eat" were all retained in the list of care terms. By this method a sample of 187 phrases and terms was assembled.

Two criteria were used to determine which care terms should be included in a smaller representative subsample: saliency and frequency. Saliency is the rank order in which the terms were mentioned, with terms mentioned first considered more salient than those mentioned later. Frequency is the number of consultants who mention each care term.

*across  
cultural  
groups?*

Responses in answer to the question, "What are some things that people who take care of other people do for them?" contained the most salient care terms. Other care terms were included in the order in which they appeared in the transcription of the interview text of each consultant included. A table was constructed that presented the 187 care terms by gender and role of consultants. The most salient terms for each gender and role were tallied. Terms were included that either were found to be salient by all groups or were found to be salient by one group and therefore could be used to distinguish one group from another. Frequency scores were calculated by counting the number of consultants who mentioned each care term.



model - as analogous to a reality

" - as heuristic

The final list of 80 terms was produced by combining the frequency and saliency scores for each care term and collapsing phrases with very similar meanings. Three additional terms that were omitted by all consultants but were identified as care needs by an expert in the self-care deficit theory of nursing: care practices pertaining to maintaining adequate fluid intake, to maintaining a balance between rest and activity, and to providing mouth care were added to this list. These terms care practices were included because they are either critical to life, as in the case of getting enough to drink, or to mental and physical well being, as in the case of mouth care or of getting enough sleep.

#### The Frames Questionnaire

Forcing a model?

The frames questionnaire was constructed of terms for care developed using characteristics attributed to the care terms by the eight primary consultants and perfected with the 16 secondary consultants to examine systematically the nature and structure of the attributes. Following the production of the list of 80 terms, I printed each term on an index card. Each consultant<sup>n=8</sup> then sorted the 80 cards into categories and explained the rules by which they grouped terms together. Subsequent sorts on all piles were carried out until no more divisions were produced. The reasons for division at each juncture were then elicited from the consultants. These reasons provided a list from which attributes of care that were salient to each consultant could be drawn.

Eight taxonomic trees were drawn depicting the clustering of terms by each consultant, the characteristics of these clusters, and the terms found in each. The taxonomic trees were analyzed to select attributes that represented a branch for which three or four levels of decision were made and, to select terms that represented breadth of the different branches and that distinguished different consultants' categorizations of care terms during the serial sorting tasks.

Explanations given by consultants as the reasons for their grouping of terms provided salient attributes of care to form the frames questions used in the questionnaire. I observed that the processes followed by the consultants as they accomplished the general sorting task revealed some categories of attributes of care. These categories seemed to show an ordering of saliency of the attributes that all consultants followed. Not all the categories were present, in every sort, but when they were present the order remained constant and no example existed in which the consultant reversed the order of presentation of the attributes. The first division made by nearly all consultants addressed was by whom the care was provided. <sup>the dichotomy</sup> Nurses' aides, nurses, and patients all distinguished between what they did and what was done by others, what was their job and what was not. Included in this category were things I do because it's my job, things I did for my boys, things I do, things nurses do, things P.T. (physical therapy) does, things I do as part of being a human being, and things patients do for themselves. The second division grouped attributes of patients that influenced whether or not they would receive a particular care practice. Important attributes in this category included things we do for patients in the back, (i.e. severely disabled people housed in the back of the facility), things we do for all patients, and things you would do for sick people, for injured people, for old people, or for children. No specific patient illnesses or disabilities were used to categorize kinds of care. The third grouping of characteristics included attributes of care itself. This category included: things that are very important to do, things that require training, and things that are part of routine care.

The fourth category of attributes includes those things which refer to conditions of work. Attributes in this category included "things I do when I have time," "things I don't do when staffing is short," "and things the night shift staff should do but don't do."

The fifth and sixth groupings included the general and specific labels respectively for types of care. These included protection, things that increase patient's self worth, supervisory versus hands on activities, assessment, getting around, personal hygiene,

grooming at the general level and, in some areas, a further breakdown to the individual care tasks at the specific level. These include: offering them a drink, seeing that they are fed, and seeing that they are dressed properly.

The following is the list of questions derived from the attributes:

1. Is \_\_\_\_\_ something nurses would do for patients?
2. Is \_\_\_\_\_ something nurses aides would do for patients?
3. Is \_\_\_\_\_ something family members would do for patients
4. Is \_\_\_\_\_ something patients would do for patients? ✓
5. Is \_\_\_\_\_ something the administrator would do for patients?
6. Is \_\_\_\_\_ part of routine care?
7. Is \_\_\_\_\_ something that requires training?
8. Is \_\_\_\_\_ very important to do?
9. Is \_\_\_\_\_ needed by confused patients?
10. Is \_\_\_\_\_ needed by bedridden patients?
11. Is \_\_\_\_\_ needed by patients who can't use their hands?
12. Is \_\_\_\_\_ needed by all patients?
13. Is \_\_\_\_\_ something one would do for a spouse?
14. Is \_\_\_\_\_ something one would do for a friend?
15. Is \_\_\_\_\_ part of child care?
16. Is \_\_\_\_\_ needed by everyone?
17. Is \_\_\_\_\_ part of nursing care?
18. Is \_\_\_\_\_ part of care?
19. Is \_\_\_\_\_ something patients would do for themselves?
20. Is \_\_\_\_\_ something that would be done when staffing is short?

A second set of questions motivated selection of terms at this juncture: "What were the different referents for the attribute, 'part of nursing care'?" and "Which terms are semantically related and able to indicate differences among the models of the various consultants?."

I had discovered that the term "nurse," clear to me, was ambiguous to my consultants. However, I was unable to see just what were its differing referents. Therefore I selected a term for an action that all consultants agreed were done by the nurse: "Hand out the pills." This task was not done by anyone except a medication nurse, who passes medications or charge nurse, who supervises the floor. In this way, if the consultant answered "Yes" to the question, "Is 'hand out the pills' something that would be done by the nurse?" I could demonstrate that the med/charge nurse was a referent for the term "nurse" if the consultant answered "no" to this question, I knew that the term "nurse" was being used to denote someone other than the med/charge nurse, such as the nurses' aide. I could identify whether the term "nurse" was being applied to this role. If a consultant indicated that the "med/charge nurse" indeed did "hand out the pills" and also performed some of the other practices included in the list of terms, I could then decipher which things were "part of nursing care" and done by the "technically trained nurse." In order to discover which were the focal terms of semantically-related subsets, a preliminary analysis of the eight sorting trees was used to reduce the list of 80 care terms to a subset of 20 to be used in the frames questionnaire. Words and phrases from the general sort that were semantically-related, such as terms related to feeding or dressing, were analyzed as subsets of the taxonomic trees using a modified scaling technique. The frequency with which terms were placed together in a semantically-related subset was used to determine the focal term

for each subset. The term that was paired with the most like terms became the focal term.

Using this method the following care terms were each determined to be the focal element of a set of semantically-related terms:

1. Helping them to eat
2. Seeing that they are dressed properly
3. Taking them to the bathroom
4. Listening to their troubles
5. Handing out the pills
6. Checking on them daily
7. Hugging them
8. Helping them get around
9. Washing their faces and hands.

*single same 26  
meaning?*

This step was necessary because the domain of care lacks monolexemic labels for "care practices." My eight primary consultants and I negotiated a set of names for familiar but not conventionally labeled practices. After focal terms were determined for semantically-related groupings, the other salient terms were selected for inclusion in the frames questionnaire to make a set of 20 terms. The following terms were selected:

*Criteria?*

1. Rinsing their dentures
2. Helping them figure things out
3. Making them comfortable
4. Seeing to their wants and needs
5. Helping them to eat.
6. Seeing that they get enough to drink
7. Handing out the pills



8. Seeing that they are dressed properly
9. Listening to their troubles
10. Helping them get around
11. Taking care of their cuts and bruises
12. Hugging them
13. Offering them a drink
14. Checking on them daily
15. Putting their glasses on
16. Taking them to the bathroom
17. Stopping in their rooms for a visit
18. Washing their faces and hands
19. Keeping them painfree
20. Taking them to visit other residents

Terms and questions were used to create a questionnaire in which all 20 questions were asked about each term. The questionnaire is contained in Appendix II. Questionnaires were distributed to each of the eight informants. Staff members could take the questionnaires home or complete them during a scheduled break but not during work time. Family members completed the questionnaires during their visits to the facility. Patients were assisted in responding to the questionnaires. Questions were read to them in 20 minute periods with a five or 10 minute break. Sometimes they were completed on consecutive days. The time of day was constant for each patient. Variability in ability to concentrate made mid-morning or early afternoon the best times for the patients.

Staff and family members were instructed to answer the questions without assistance from anyone. All said they complied. Multiple methods of gathering questionnaire data were justified because Benfer et al. (1980) found that oral versus written



responses produced no appreciable differences. After the responses from the primary informants were analyzed the questionnaire was revised. The new version of the questionnaire was distributed to the 16 secondary informants three times at one month intervals during Phase Two of this study.

revision  
are  
where  
?

each got it 3x's?

## Phase Two: Testing the Validity and Reliability of the Questionnaire

In order to test the reliability of the frames questionnaire over time, it was administered at three times at one-month intervals to each member of a second group of consultants (N=16) also from Twin Oaks. These consultants were judged to be knowledgeable about the nursing home using the same criteria used in selecting the primary consultants. All care participants who were approached agreed to be part of the study. The consultants who had to be replaced due to attrition were one female family member who never returned the questionnaires and three male consultants who were terminated or resigned. All three of the men had been employed less than three months. Of the initial 16 consultants recruited for this phase of the study, 14 finished. The two male nursing assistants who completed the study were both relatively long-term employees. One had left the facility to attend a local LPN school during the study period but dropped out of school after six weeks. When he returned to full-time work as a nursing assistant, he continued with the study. The other male consultant was a long-term employee who also works at the local university hospital.

### Phase Three: Testing the Model for Generalizability

The third phase of the study was conducted in four nursing homes in the same town as Twin Oaks. The purpose of this phase of the study was to discover the extent to which the context of the specific nursing home determines the cognitive models of care of the participants in each facility. The four facilities, The Laurel, Clifton Manor, Beechwood Retirement Center, and Castlebury Care Center range in size from 45 to 140 beds. Clifton Manor and Castlebury Care Center are privately owned for-profit facilities. Beechwood Retirement Center was previously owned and operated by the state of Missouri but is currently part of a not-for-profit nursing home chain. The Laurel is a church-affiliated not-for-profit operation. The Laurel and Castlebury Care Center are part of larger complexes having different types of housing arrangements available for residents needing different kinds of assistance. Individual apartments, a large manor house with single rooms where meals are served in a common dining room, and homemaker and emergency services are available are part of both campuses along with the nursing homes. The Laurel has a special care unit for patients with Alzheimer's disease, a residential care facility, and a children's day care center in the same building with the nursing home. The residents of this complex who are potentially the future patients in the nursing home serve on the board of directors for the nursing home along with the medical director, the nursing director, the social worker, dietician, and administrator.

Each of the four nursing homes has both intermediate and skilled care beds. Sixteen consultants--two males and two females--were recruited from the populations of patients, family members, nurses' aides and med/charge nurses of these four nursing homes. The Laurel is the only facility that utilized registered nurses in charge nurse positions and Licensed Practical Nurses (LPN) in the medicine nurse positions on the day shift and Certified Medication Technican (CMT's) in the med nurse position on the night shift.

For this reason, four charge/med nurses and two RNs were recruited from this facility to participate in the study as well as the other categories of consultants.

Frames questionnaires were distributed by members of administration in the facilities. Research assistants were used to collect information from the patients and family members. These data were also analyzed using INDSCAL. Results were compared with those in the original facility to determine which aspects of the model of care were specific to the facility and which were common to the other nursing homes.

## CHAPTER THREE

### THE SETTING AND THE SAMPLE

#### Introduction

In this chapter I set the stage for the presentation of the ethnosemantic analysis of the domain of care as it has been expressed by the patients, family members, and nursing staff of Twin Oaks. I begin by describing the context in which care is conceptualized: the structure and organization of the facility and the people who work there. Next I present a description of the processes by which patients are admitted to and families affiliated with the nursing home and by which the staff are hired and oriented to the care of the patients. Finally I describe the participants in the activities of care: the nurses, nurses' aides, patients, and family members.

Although I have tried to reflect as accurately as possible what I have seen and heard, this description must be understood to be a text based upon material compiled and remembered. Much was seen by my eyes directly. Some was seen first through the eyes of my consultants who shared their 'truths' with me, and then interpreted by me as I compared the different 'truths' I have collected.

This description is also at risk of distortion by the language I use. The choice of the words--patient instead of resident or client, nurses' aide instead of nursing assistant or technician, nursing home instead of skilled nursing facility--each represents particular points of view of the relationships that exist among the care participants, different values towards the care workers, the elderly, men and women, and the family. I have purposely chosen the words "patient," "nurses' aide," and "nursing home" because historically these terms were the first labels used. The other terms, "resident," "client," "nursing assistant,"

and "technician" were consciously adopted by nursing homes around the country to mask the power relations inherent within this setting and to change the feelings rather than the realities of those who are most closely affected by the words. The term skilled nursing facility is inaccurate because the facility is a mix of skilled and intermediate care beds. This type of facility has no term to designate it.

### The Haddock Corporation

Twin Oaks Health Care is a private nursing home in the town of Forest Hills, a midwestern college community with a population of approximately 70,000. The Haddock Corporation, a subsidiary of American Health Care Corporation (AHCC) owns Twin Oaks. AHCC also owns lumber yards, free standing dialysis units, and a host of other subsidiaries. Haddock, with upwards of 500 nursing homes, is the second largest nursing home chain in the country. Byerly Enterprises is the largest, with over 1000 facilities. Twin Oaks is one of 12 nursing homes owned by Haddock in this state. Six of them operate in the red, according to the administrator. Twin Oaks is one of those six.

The facilities owned by the corporation are categorized by geographic regions, and the staff members of different regional offices vary in their response to the needs of the facilities. In the second year of the study, corporate restructuring led to the transfer of Twin Oaks from a less responsive region to a more responsive one. The policies governing patient care in all facilities are written in corporate headquarters and are universally applied. This makes innovation on the local level nearly impossible. Working for a nursing home chain is seen by the nursing director as a mixed blessing. The bureaucracy is many layers deep; therefore it takes much time to change anything. However the bureaucracy also provides support.

## Twin Oaks, The Place

### The Home That is A Hospital

Twin Oaks sits on an open grassy knoll in a relatively new and modest neighborhood in Forest Hills. The circle drive landscaped with trees, and seasonal flowers welcome the visitor and the new patient. During the day, chairs and benches inside the entrance way are usually occupied by patients visiting and smoking. On weekdays, a stream of visitors passes through the front entrance, and the patients can keep busy greeting and commenting on the comings and goings of family, volunteers, ambulance drivers, patients, and staff.

On weekends, when staffing is short, a visitor will frequently find some patients in bed throughout the day, others incompletely dressed, and the odor of stale urine throughout. Whereas on most weekdays the facility is clean and free of the odor of urine.

The entrance brings the visitor into the public area of the building. The administrative offices, staff lounge, and the small store are adjacent to the spacious dining room and kitchen. At the ends of the hall are the beauty shop and a small patient lounge where patients sometimes play cards and visit. Outside the dining room is a large garden enclosed by a privacy fence. The garden has a continuous path where patients who are so inclined can wander safely on foot or in wheelchairs. Few actually do amble in the garden, preferring the bustle of the front entrance.

The garden was originally landscaped with trees and shrubs donated by family members and volunteers. Depending upon the interest and priorities of the maintenance workers and activity staff, the garden is more or less unkempt. Perennial bulbs and flowers



bloom each year and weeds, and bushes become unruly and are cut back when the need is seen. Some of my sweetest memories with Martha took place in this garden in the summer. Chilled by the air-conditioning indoors, she would relish the warm sun on her face. As she walked with me and, in later years, rode in her wheelchair, she touched the pussywillows and daisies and joyously proclaimed how blessed she was to be alive.

The dining area is spacious and well-lighted. Each square table seats four patients and is decorated with a small vase of silk flowers. All condiments are brought on trays with the food at mealtime. The dining room is the location for most of the group activities planned throughout the week. Weekly bingo games, movies, musical entertainment, daily exercises, current events, and numerous religious services all happen in the dining room. The small store serves candy and the soda machine provides soft drinks for those staff, patients, or visitors who can afford them. Greeting cards and toilet articles can also be purchased.

The staff lounge, a colorless institutional-looking room, is across from the dining room. Here staff congregate around the small square table before work and during their scheduled breaks. The most distinctive feature of this room is the amount of smoke it contains. The weekly schedule is posted here, and the time clock and timecards hang on the wall. A stove and washing machine occupy one wall, remaining from the time when this was the patient's activity room. At the opposite end of the room is a bank of lockers and a long table where the administrative staff eat lunch together.

The patients' living area is set off from the more easily accessible public areas and is divided into three wings. Each wing has its own nurses station, shower room, and utility room. Approximately 45 patients live on each wing. Wing One and Wing Two have beds occupied by patients requiring few medical treatments. These are called intermediate care beds. Wing Three houses those patients requiring medical treatment. These are known as skilled care beds or Medicare beds because they have been authorized by the state agency to be occupied by patients eligible to receive Medicare.

There are few private rooms in the facility. Most of the rooms are double, and each patient has a 12 X 6 foot space. A mirror, two built-in sets of drawers, and two small closets are shared by the two patients. The closets and drawers are more for the convenience of the staff, since patients in wheelchairs and those who are bedridden are unable to reach the clothes in the closets and the drawers. Some staff leave their personal belongings with trusted patients and hang their coats in the patient's closet for convenience and safe keeping. Families are encouraged to bring a few personal belongings, including small pieces of furniture, pictures, and momentos to help the patients feel at home. The circumstances under which patients are admitted usually influence whether and how the patient's room is decorated. Most patients are admitted directly after discharge from an acute care hospital. Patients are frequently admitted without family members present, either because they have outlived their families or because they are out of contact with them. These patients often have no personal belongs. Other patients are admitted by their families, who bring treasured belongings on the day of admission. There is one ward on each wing that has room for six patients. Here there is little room for personal belongings or furniture.

Between every two rooms is a bathroom accessible by a door leading into each double room. The bathroom has a toilet and a sink, neither of which is handicap accessible. The sink has a front piece that prevents a wheelchair from fitting under it so that a patient in a wheelchair cannot use the sink to wash. The walls are so close to the toilet that a wheelchair cannot be maneuvered close enough to the toilet to allow a patient to help himself or herself.

The nurses' station, midway down the hall, is set off by a counter. On the desk are the telephone, the policy manuals, and the patients' charts. As a rule, nurses' aides and patients are not allowed behind the counter. During the day the hallway on each wing is a congested and busy place. Laundry carts, clothing racks, carts with water pitchers, the

nurses' medicine cart, and the carts carrying meal trays at meal time impede the passage of patients, workers, and visitors. Patients in wheelchairs who are incapable of participating in activities line the halls. Some of these patients call out, repeating the same words and phrases; one shouts, another claps rhythmically, a third answers from an room nearby. Those who are at risk for falling and who try to get out of the wheelchair and geri-chair (a recliner with wheels) are tied with a soft white belt called a "posey" to prevent them from falling. These patients are placed near the nurse's station to be watched. The pace of my study was impeded because I could never pass down the hallway without stopping to console a patient or to translate a patient's request to one of the nursing staff members. My frustration at so much discomfort, at so many unanswered pleas for help, is a force driving this work.

#### The Staff Who are Like Friends

#### The Nursing Department

The nursing department is the largest department in the facility. The director of nursing service (DNS) is responsible for the overall management of the nursing service as well as for related departments within the facility, such as central supply, medical records, and transportation. The director is a registered nurse who received her nurse's training in a hospital-based nursing school and has been the director of nurses at Twin Oaks for fifteen years. She has survived at least three administrators and the purchase of the facility by the Haddock Corporation. Normally, the assistant director of nursing hires, fires and schedules staff members on all three shifts. In the three-year duration of this study three nurses have been in the position of assistant director of nursing. Presently the DNS hires and fires the nursing staff. Scheduling the nursing staff is now done by a nurses' aide.

The position of day supervisor was also held by a registered nurse. Her job was to look after "what's going on in patient care," according to the DNS. She is called by the charge nurses when they need help. When the last day supervisor resigned, these duties were again performed by the assistant director of nursing. Currently these positions have been combined.

Central supply dispenses all personal care items, medicines in stock, and general supply items such as toilet paper and towels. Medical records is responsible for keeping the records complete and in compliance with state and federal regulations. Physicians are required to assess their patients once each month, and an assessment must have been made within seven days before the patient dies. If this is not done, the facility receives large monetary penalties from the state inspectors. Medical records staff inform the nursing director about which physicians are not making visits as required. The nursing department, in turn, must remind the physician in order to avoid the penalty from the state.

The transport clerk is also supervised by nursing service. He drives patients to doctor's appointments. He is a licensed chauffeur and has experience driving a limosine. The facility van is rarely if ever used for recreational purposes; instead it is used only for transporting patients to appointments with their physicians.

The physical therapy department provides services to patients whose insurance pays for the treatment. The treatments provided by the physical therapy department are physical therapy (PT), occupational therapy (OT), and speech therapy. The national Medicare insurance program, providing medical insurance to those over 65 years old, covers patients only during a brief period after an illness episode or an injury, when the patient is recuperating or can demonstrate improvement in his or her physical function. Most of the patients need maintenance therapy to prevent further deterioration of hands, arms, and legs from disuse. This therapy is not available, even though three therapists in the facility are able to provide this needed service. Family members are not informed of these services and are discouraged from paying privately.



One nurse's aide, supervised by the nursing service, is assigned to work with the physical therapist. This aide assists the physical therapist and provides minimal assistance when patients are discharged from PT, OT, or speech therapy when their Medicare funding is cut off. After this, the nurses' aides are supposed to walk the patients who depend upon them for exercise. However, this exercise is rarely performed. Lack of time is the reason given for failure to walk with patients.

### The Activity Department

The activity staff consists of a director and her assistant. This staff serves 141 patients. The "activities" consist of a calendar of events put on by the activities staff, depending primarily on volunteer entertainment from the community. Some of the family members volunteer. One of my male consultants volunteers to call bingo games. Another family member, the daughter of a former patient, brings bananas every week to all the patients who want them.

The nurses' aides are responsible for taking the patients to activities. This is a problem for the activity director because patients are dependent upon the nurses' aides for transportation. The nurses' aides say that they are too busy to transport their patients to activities. Some are still giving morning care to patients when an activity begins. Others are taking their morning breaks. Attendance at activities fluctuates with the motivation of the nurses' aides to take the patients to activities.

### Housekeeping and maintenance

Housekeeping is responsible for maintaining a clean and attractive environment. Their primary work is to keep the linoleum floors clean, polished, and free from the odor of urine. They also maintain all the offices and the public areas of the building. The nurses' aides make all the patients' beds. Dusting does not appear to be done by anyone. The

patients drawers are cleaned out rarely if the patients' families or the patients do not do it. They are always cleaned out by nurses' aides just before the state inspection. Food spilled or found in a patient's drawer can result in a fine by the state inspectors. The maintenance department and the dietary department are separate from the nursing department. The maintenance department repairs and maintains all non-medical equipment and maintains the lawns. When the workers have time or when directed by the administrator, they also replenish the plants for landscaping.

### The Twin Oaks Councils

The families', employees', and patients' councils are mandated to exist where possible by the Haddock Corporation. They have no influence on the nursing care routines of the facilities and exist primarily for public relations purposes. Nonetheless, the patients' council (called the residents' council) is mandated by government regulation. The patients' council acts as an advisory committee to the Activity Department about the kind of entertainment they would like. They also assist with the monthly newsletter, which is sent to all family members. The patients' council also runs the small store, which supplies patients, staff members, and visitors with candy, popcorn, cards, and toilet articles.

The family council met during the first year of the study. It was organized by the ombudsman from the State Division of Aging. This group tried to improve the patients' daily lives, making suggestions to the administrator about the need for more consistent supervision during all three shifts. They also recommended that a volunteer coordinator be hired to coordinate the volunteers and to produce the newsletter, thus freeing the activities director to provide activities to the majority of the patients in the facility who are unable to participate in activities currently being planned. All suggestions were dismissed as



unfeasible, too costly, or too time consuming. The hostility of family council members toward the administration intimidated some family members and disgusted others. The meetings were finally stopped. The employee council selection of activities are limited to the employee of the month and year. It also organizes various activities for the patients during the year. At Christmas, each employee "adopts" patients for whom they buy small gifts.

### Connections with the outside world

#### State and Local Governmental Licensing Agencies

Nursing homes are licensed by the state, either as intermediate care or skilled care facilities. Some facilities are licensed to provide only one level of care, either skilled care or intermediate care. Other facilities, predominantly intermediate care facilities, may be licensed by the state to have a certain number of beds that are for patients requiring skilled nursing care. Twin Oaks is such a facility and, accordingly, has nine skilled care beds. For some patients who require skilled care, Medicare insurance pays the room rate and pays for other necessary therapies, such as physical and occupational therapy. This represents increased revenue for the facility, since the reimbursement rate by Medicare is higher than the public medical assistance program, which covers most of the remainder of the patients. If no patients are admitted who are eligible to receive skilled care, these beds are occupied by patients who need intermediate care. These intermediate care patients are then required to give up their beds and are moved to another room when a patient is admitted who is eligible for skilled care.

## State Inspectors

The Scheduled Inspections. Frequent inspections of nursing homes are conducted by employees of the Division of Aging, the state agency responsible for the welfare of the older citizen, and by the nurses employed by the Missouri Department of Social Welfare to monitor the care given to patients receiving state support. These inspections are of two types, scheduled inspections and "spot" inspections.

Nursing homes have scheduled inspections by the Division of Aging once a year. Additionally, the Department of Social Welfare assesses the care of the patients on public assistance every three months. The patient's chart is the main means of communication between state inspectors from state departments and the nursing home administration. It is the chart that documents work done by the nursing staff. The nurses are frequently reminded that "if a task or observation is not charted it is not done." This is indeed the position of the state inspectors, who spend hours pouring over patient's charts during the annual inspection to determine whether or not the state regulations are being followed. While they also make a walk-through inspection of the facility, the administrators know when the inspection is taking place and make necessary changes in the physical condition of the facility. The staff are directed to clean the patients' rooms. Additional staff are called on duty for the duration of the inspection and the administration assure the availability of supplies (linen, soap, etc.). Nurses, aides, family members, and patients told me that the staffing and the food served in the dining room are never better than when the state inspectors are in the building. Whether or not this is actually the case, it is a strong belief held by workers, family members, and some patients.

A local newspaper reported that this facility was found to have had four deficiencies related to patient care during a recent inspection by the state Department of Aging in comparison with one deficiency (the best ) and ten (the worst ) given to other nursing homes in this community.

The Spot Inspections. "Calling the State" refers to a call made to the Division of

Aging by a staff member, a family member, a patient, or an ombudsman to report an incidence of abuse or neglect or an infraction of the rules and regulations. On-the-spot inspections are held when a charge of abuse is made. The response to other calls must be made within a "reasonable time period." I am aware of two instances when the Missouri Division of Aging was called. The first call was by the made ombudsman assigned to this facility to report a patient with a bedsore who she believed was receiving improper care. The second instance occurred when a family member, one who has a reputation for being angry and troublesome, "called the state" to report that the patients were not receiving the required amount of food at mealtime on a particular weekend.

The state inspections affect the reputation of the facilities within their communities and can result in fines being levied. Although suffering from a past reputation for poor care, Twin Oaks has successfully changed its image in the community since it was purchased by the Haddock corporation. According to a recent newspaper article, the state inspectors found Twin Oaks to be among the nursing homes with the fewest deficiencies in patient care.

## The Volunteers

### The Ombudsman.

There is in place a volunteer program that dispatches ombudsman, or patient advocates, to nursing homes. This program is national, but the regulations governing the program differ from state to state. In this state, the ombudsman has the right to act as a mediator between the patient and the facility when difficulties arise. He or she can also call the state -- as can staff, patients, or family members -- to report incidents of abuse, neglect, or poor care. The ombudsman assigned to Twin Oaks was an activist for the aging community for many years. She became discouraged by the lack of responsiveness by the

Division of Aging to her calls, and she stopped coming to the facility. She organized the family council and tried to hold meetings where the facility administrator was not present to allow family members to express their feelings without fear of retaliation against the patient. However, this practice was resisted by the administrator of the facility.

Clergy and Charitable Organizations. Clergy from many different denominations come to Twin Oaks and conduct services for the patients. Some patients go to all services, regardless of their own religious affiliation, finding the events uplifting and helpful, saying that they inspire them to be patient and kind to the staff while they endure the life in the nursing home. Clergy and persons of the churches also visit patients who are confined to their rooms. For some they are the only visitors to enter their doors. Musicians frequently play at the facility. A pianist plays old familiar tunes; a country ensemble plays fiddle music. School children make field trips. All of these are distractions from the boredom of institutional living for patients who can attend.

### The Informant Groups

This study's focus is on the day-to-day interactions occurring between the nursing staff and the patients because of their continuous and extensive involvement in the intimacy of personal caregiving activities. Family members who are frequent visitors to the facility are included because of their role in the patient's personal care and because many have had prior responsibility caring for the patients. The following is a description of the four groups from which the population of consultants were taken.

## **The Nurses**

Each wing is staffed by licensed practical nurses (LPN), certified medication technicians (CMT), and nursing assistants, some of whom are certified (CNA) and others uncertified (NA). The charge nurse, usually an LPN, rarely is a registered nurse (RN) responsible for seeing that the day-to-day patient care is routinely performed on his or her shift. Generally a second nurse, the medication nurse, also passes medications to the patients on his or her wing during the shift. The medication nurse is either an LPN or a Certified Medication Technician (CMT). CMT's are nurses' aides who have a high school diploma and who have been certified by the federal and state regulatory agencies to dispense medications. They receive added training to learn the technique for passing medications. In some instances, when staffing is short, the medication nurse acts as the charge nurse as well as performing his or her usual duties. Under these circumstances either an LPN or a CMT is in the position of the charge nurse.

In actual practice, the charge nurse is responsible for seeing that all the physicians' orders are transferred to the chart and that the orders are actually carried out. When a CMT is acting as charge nurse on a wing, the shift supervisor, an LPN or RN, calls the physician and receives the physicians' orders for treatment and medication.

## **The Nurses' Aides**

The nurses' aides are responsible for giving personal assistance to the patients. This is the largest category of workers in the facility. Many of the nurses' aides have "been hired right off the street" and have never worked as a nurses' aide before. Every nursing home is required by law to provide training and certification for all nurses' aides during the first six months of employment at the facility. Twin Oaks has a number of nurses' aides with



many years of service to the facility. New recruits are given an official orientation by the director of staff development and an informal orientation by the seasoned nurses' aides. Those nurses' aides who "don't fit in" leave or are fired during their three month probationary period or leave shortly afterwards.

## The Patients

The patients of Twin Oaks are as varied as the population of the mid-American town and the surrounding rural areas where they lived. Retired farmers, mine workers, mechanics, shop keepers, railroad workers, teachers, clerical workers, cooks, college professors, housewives, and childcare workers are some of the patients' occupations represented at Twin Oaks.

When the state mental hospital began discharging elderly mental patients, those who were unable to adjust to a non-institutional environment were admitted to local nursing homes. Twin Oaks has a number of former mental patients. I am aware of at least three such patients at Twin Oaks. They were often among the most satisfied patients in the facility.

Between ten and twenty patients with Alzheimer's or Alzheimer-related disorders also reside at Twin Oaks. These patients are not given special treatment or housed on a separate wing. They are mixed in with the other patients in the facility. Most Alzheimer's patients who are not in the last stages of the disease are physically strong and able walk and do many things for themselves. However, they often lose the ability to communicate, to recognize common objects, and to remember what they need to do to manage themselves. The rationale given by the DNS is that allowing patients with Alzheimer's to live with the



other patients permits them to live in a normal environment and to relate to people other than those like themselves who also have limited communication skills.

Young patients who have had serious head injuries or who have conditions that require them to have help with everything they do have been admitted to Twin Oaks in larger numbers in the last three or four years. The inability for family members to manage their care at home is a frequent reason for their admission. Twin Oaks has between five and ten such patients. These patients, many of whom are unable to bear any weight on their legs, are very heavy and require two people to lift. Often their speech is impaired, and it is difficult to understand them.

Other patients include stroke victims and other wheelchair-bound patients who cannot walk or whose walking is severely limited. Many of these patients also have difficulty speaking and some have difficulty understanding what is being said.

The last group of patients is rarely seen by visitors to the facility. These are patients who have become so incapacitated that they are no longer able to sit in a wheelchair and are confined to bed as a result. These patients stay in their rooms and often see only the nurses, aides, and the other patients in their rooms.

As I describe general groups of patients, I remind the reader that these categories are part of a meta-description of the setting and its people. When these categories are allowed to dictate the perceptions of those who would interact with the patients, they often abort the interaction by directing the care-givers to relate to their idea of the patient rather than the patient himself or herself. One result is that for some patients real and serious concerns go unrecognized. A second result is that the patient is viewed as a static entity, existing at a persistent and stable level of mental acuity or lack thereof; this mental state may be thought to be the result of a medical condition. My observations at Twin Oaks are that the elderly and frail patients are actually in a very fluid state mentally. They are very vulnerable to changes in their environments. The effects of occurrences in the external environment lead

to wide swings in the patient's mental status. Many examples of this effect occurred, but I will mention only three. Martha experienced visual hallucinations for three days after Julia moved out of the facility. It became obvious that Martha was hallucinating because she would begin describing what she saw. Since she was blind, her reports of a visual environment were notable.

A second patient, Mrs. Painter, had previously moved out of state to be close to her family. She was flown from California back to the midwest to be placed in Twin Oaks after her granddaughter was unable to care for her. Mrs. Painter was unprepared for the move: she was not told or she did not remember that she was going to be living in a nursing home. Mrs. Painter never recovered from this experience. She sat in her wheelchair all day, asking anyone who came by, "What did I do wrong?." If she were distracted from her questioning, she could carry on a conversation but she never adjusted to the move and died six months after coming to Twin Oaks.

A further indication of the strength of the effects the environmental has upon the mental states of frail patients can be seen in the responses of some of the consultants to answering the questions during the interviews. Often those who answered the frames questionnaire became tired and as a result confused. Some had difficulty remembering which question they were answering. When the patients began to show signs of fatigue, I would stop and return the next morning. Most often the questionnaire required 20 minute interviews on three consecutive days. These patients had to be interviewed during the morning because by the afternoons they were often too tired to follow the conversation.

In order to avoid studying only the mentally and physically well who were minimally reliant upon the nursing staff for assistance or who were still adjusting to relocation to nursing home life, patients interviewed for this study were selected using the following criteria: ability to understand the questions asked during the interview; residence in the

facility for more than three months; and representativeness of a range of dysfunctional states that required help from the nursing staff.

### The Family Members

Family members are as varied as the patients. Daughters and sons, husbands and wives, nieces, grandchildren and friends were all patient visitors. Most spouses and siblings of patients were retired; a few still worked. Most of the patients' children and grandchildren were working and raising their families and the needs of the patient in the nursing home competed with the demands of active family and work life.

Staff and patients often commented upon how often a family member visits the patient and how involved they were in the patient's care. A few family members visited the patient every day; some came three times a day to help feed the patient at mealtime. These family members often did not trust that the staff would take the necessary time to feed the patient and be sure that they were eating. Ann, whose mother was bedridden and unable to communicate, visited once or twice a day and fed her mother. She had decorated her mother's room with artificial flowers. A live canary sings in a cage over the bed where her mother could see and hear it. Ann provided care for her mother and her canary while she was raising her ten year-old grandson, managing an apartment building, and attending to the needs of her own family. Other family members came once or twice a week and took the patient's dirty clothes home to wash. This not only saved the patient's spending money but also prevented the clothes from being lost or damaged in the facility's laundry.

Most family members came on weekends for a social visit. Some took the patient home for a visit or overnight. Others visited at the facility and brought in treats of flowers, fruit, and candy. Holidays and summer vacation were the usual times for visits by family who lived further away. Some family members did not visit, write or call. I tried

unsuccessfully to help Julia reach her son, who worked out-of-state. This left some patients with no visitors that they knew before they came to live in a the nursing home. While the patient may have enjoyed the visits from volunteers, they mourned the absence of the family members and friends who had been in their lives for decades. Misunderstanding about the patient's need to be in the nursing home was often a source of friction that could lead to abandonment of patients by family members.

The family members who were interviewed for this study were chosen from among the more frequent visitors to the facilities. Since the study was designed to look for differences among participants' models of care, this choice was made in order that consultants be knowledgeable about nursing home care at Twin Oaks and that consultants would be more likely than not to share a common model with the patients and staff were are in constant contact with the facility. This choice strengthened the validity of the results by omitting lack of familiarity with the facility as a possible cause for differences existing among the models of care.

If a common thread can be drawn for the nurses, nurses' aides, and family members it is that they are caregiving people who are called upon to fill multiple care-giving roles in their lives beyond the nursing home. To friends and family members they are the 'curanderos' of the western society. For example, in the area of family care, one nurse-informant was simultaneously caring for her mother, the daughter of her sister who had died from cancer, her three children, and her husband, as well as her grandfather, who was a patient at Twin Oaks. Another nurse informant was making trips to Kansas City on her days off to care for her daughter-in-law, who recently had lost her vision. She was also the main support for her sister, whose son had been killed in an automobile accident and was caring for her husband, at home who was recovering from both a heart attack and a head injury that occurred when he had suffered a heart attack consequent on a fall down a flight of stairs. I interviewed one nurse's aide-informant in his trailer while three men,



temporarily homeless and jobless, slept on the floor. A second nurses' aide was providing shelter to another nurses' aide who worked parttime and could not afford a home.

Family members, too, are often caring for children and parents. What struck me in the case of the nursing staff is that while they generally have many of the same care responsibilities as the family members, their knowledge of the health care system, and their health related skills position them to provide advocacy and care for a larger number of people than the family members who are not trained in nursing care.

The patients are not markedly different from the family members and nursing staff in their care-giving patterns. While the general perception of nursing staff and family members is of patients as recipients of care, the patients perceive themselves as actively involved in the care-giving process in some interesting ways. Some patients saw themselves as capable of providing care if they were asked to do so. One male patient, perceiving the tremendous need of the patients around him, wept that he was physically not able to help them. However, he also told me that if he were asked he would help the nurses by handing out the pills or helping other patients to eat.

Some patients saw themselves as taking care of the staff when they saw they were overworked, underpaid, and very, very tired. They did this by treating them with kindness and saying "please" and "thank you," and more importantly by not asking for help when they needed it because the staff was "working short." A patient may climb over the side-rail or slide down to the bottom of the bed to get out rather than ask a busy 'nurse' to help her to the bathroom. Others would simply "wet the bed" rather than bother someone when "they were too busy." Ellie, A long term patient transferred from the local state mental hospital provided assistance to Martha. She brought her to meals and brought her back to her room. I observed her attempt to place Martha on her commode and caught them both as Martha stumbled and they both nearly tumbled to the floor. Anna, did laundry for some patients whose family members were unavailable. She also worked in the facility store.

The first phase of this project was conducted with 8 consultants who were affiliated with Twin Oaks nursing home--one male and one female member of each of the categories: patients, family members, nurses' aides and charge/medication nurses. The names of the family members and patients were sought from the director of activities. Rather than feeling the need to protect the institution, she felt strongly that this study was needed and tried to point me to the patients who would be able to give the best answers or the families who would cooperate. The staff members were solicited by me with the help of the director of nursing, who gave me the names of night staff, particularly the four males who met the criteria of the study.

### Getting into the System

#### Entrance for Nurses and Nurses' Aides

Nurses' aides come to the facility after hearing about an open position from a friend, reading an advertisement in the newspaper, or transfers from another facility or hospital. The Director of Nursing Service (DNS) explained how are nurses' aides and nurses are hired. Nurses' aides and nurses comes to the facility, ask for an application, and complete it . Sometimes they are interviewed on the same day and start work and orientation within 24 hours before any references can be checked. The DNS stated:

Well everyone knows the hazards of employing. Applications are made to look how the prospective employee likes. For instance someone can say "I worked for such and such nursing home from 1973 to 1978 and then it closed and the owner died." So you can't trace the performance or verify the reference. Also no one will give references over the phone any more. We



have some good employees and some bad but some of our best aides weren't too great to start with.

Despite the abbreviated training, informal orientation produces a uniformity in the amount and kind of "service" the aides' give to the patients. A kind of work norm has evolved that governs the aides' behavior towards the patients. Certain patients are discredited, labelled "spoiled or demanding;" when they ask for help they are said to be "trying to get attention." Others are "not in their right minds." When they ask for help they are ignored.

#### Entrance for Patients and Family Members

The experience of admitting a loved one to a nursing home is different for every one depending upon the prior relationship existing between the two individuals. Because most of my family consultants have been and continue to be involved in the lives of the patient, my personal history is not too different from theirs. I will, then, contribute notes from my journal that express the inner turmoil and conflict I experienced about placing Martha at Twin Oaks. Since I did not question family members and patients about the experience of admission, my perceptions will be compared to those of others through the ethnosemantic portion of the study.

When Martha began living at Twin Oaks I went to visit her daily for a week or two. Even though I was a nurse and experienced at caring for nursing home patients, I didn't know what to do as a family member. I didn't have a role, I didn't have any more responsibility for her physical care. I was to do her laundry, take her home for visits, and talk with her. I couldn't think of anything else to do. Everything I used to do was being done by somebody else. This was a total care center. I was a visitor, extraneous to the real

work going on. The facility staff were doing their job, I thought, which left me with no essential tasks to do.

As time passed, I began to discover that I had a critical role to play in Martha's comfort and survival at the nursing home. Indeed her needs were not being met fully. It is clear from my June 11, 1985 journal entry that Martha wanted to die. She was miserable. Any needs she had that required actions of the staff that were not part of the usual and customary routine or that were one of the "little extra things" the nurse's and nurses' aides do for their "specially favored patients" were left undone.

Martha was bored. Her blindness made it impossible to participate in many activities. Besides, her major occupation for the past ten years had been writing letters to friends and mailing them clippings out of the newspaper and various magazines. These things she could not do without help. She also needed extra fluids because she couldn't pour water from a pitcher to a glass without spilling it and she wouldn't drink from her sports bottle because the water often was stale since the nurses never changed it. Martha had a hearing aide when she was admitted to the facility, but never once was it put in her ear before it was lost with the bed linen in the laundry. Without it she couldn't easily converse with anyone. She was gaining weight and needed new underwear. As a full-time student and full-time faculty member, I was overwhelmed by work. I wasn't free to manage her needs as I saw them. She was confused more often. Sometimes she cried when I came. She always had a list of things for me to fix. In my nurse's world view, around the clock, individualized patient care was the work of the nursing staff. I resented doing their work. I brought Martha juice, so that she would get adequate fluids, I came in the morning to be sure she had her hearing aide in place. She didn't. I brought in her talking book machine and came to see whether she had used it. No one had turned it on. I frequently emptied Martha's commode and rinsed it with Lysol when it had been left unemptied from early in the day and the stench was overpowering. On top of this, Martha's safety seemed questionable.

For reasons unknown, she had begun to hallucinate at times. She also became dizzy and fell. So I was not only concerned for her comfort, I questioned her safety. During the first year of Martha's residence at Twin Oaks, I became anxious whenever I left town and would call the nurse on her wing to check on her. I didn't sleep well.

I had gone from feeling useless to feeling indispensable, from having no job to having to do someone else's job. Martha was slowly slipping away from me. I was losing her and I couldn't stop her from going. I felt totally inadequate, guilty for not being there three times a day like Ann was. I withdrew. I hated going to visit Martha; I started visiting less often. Sometimes 10 days to 2 weeks would go by between visits. I had no recognized role of my own.

The next summer I took an extended vacation and went out of town for three and a half weeks. When I returned I waited a few days before going to see Martha. When I saw her I was sickened. Not only did she not recognize me, she didn't know who she was. She couldn't remember. For four weeks she had been without contact with anyone who had known her, who really knew her. There had been no visitors, no letters, no conversations. Desperately I worked to bring back to mind the remnants of a forgotten life. I told her all her stories, from her childhood and mine. I told her the stories she told me. Once she believed I was who I said, I lay down on on her bed and held her, rocking her until she felt the old familiar feeling we had when I was a child. Slowly she came back to herself. I was shaken; I felt horribly guilty for staying away. Later, when I reflected upon this day, I recognized my legitimate role, my unique place in the work of caring. My work was the task of being Martha's connection with her historical world. No one else but friends and family could help her keep track of her memories. Without that, her world became a foggy present surrounded by things and people who held meaning only in connection with her personal comfort.

The family members who visited found their place in the lives of their loved ones. I wonder what has caused those who don't visit to stay away. Is it feeling that they aren't needed? Is it too painful to face their impending loss on a regular basis? Or to face their guilt at having institutionalized a loved one? Are they too busy and overwhelmed by their own problems? Had they been taught how to be the family member to a nursing home patient? Would they too be able to make a difference?

#### Economic Relations Between the Corporation, and the Staff, Family Members, and Patients.

The economic relations existing among the participants in this study strongly affect the staff members' feelings about their work, and the patients' and family members' expectations about the care received. Discussion around money permeated talk about care. Here two realities, the first being the perception of the administration, and the second that of the staff, family members and patients. First, I present the position of the corporation, represented by nursing home administrator and director of nursing, and the second, that of the patients, family members and staff members. The majority of information about the history and financial status of the facility was collected from reports made by the administrators at formal family council meetings, employee orientation, public relations material designed by the corporation. The for-profit status of the nursing home and perceptions about the corporation that owns it strongly influence attitudes of study participants towards care.

The administrator reflects the views the nursing administration: That the mission of the facility is to make money. At one family council meeting the administrator was asked about services perceived by the family council to be needed: a volunteer coordinator, and

more activities staff. His responses were that 1) We can't afford it 2) We don't need it because we are no different from any other nursing home and better than most. 3) No one will pay for it. Medicaid and Medicare don't pay enough.

On another occasion I asked him about the high staff-patient ratios. He responded by repeating the same three reasons given above and added that he had recently read an article by an administrator of another facility. The article ended with the following quotation: "Staff always think we need more staff, corporate office thinks we need less and I'm not the Messiah." This is an image that well depicts the powerless position of the administrator, agent of the corporation and buffer against the feelings of the family members and staff.

Previously the administrator had told me that Twin Oaks is one of the five facilities in the state that consistently operates in the red. This fact he attributes to the low reimbursement rate paid to this facility for Medicaid patients by the state. I asked him just how the home "made money" when it was in the red all the time. He said that one way capital is generated is by collecting the interest on the money paid into the home on the first of the month and paid out to the employees and creditors at the end of the month.

### Care and the Profit Motive in the Nursing Department

Within the facility, Nursing is the largest department. Each department has a philosophy and goals. According to the director of nurse's report to the Family Council, the goals of the nursing department are three: "to meet the needs of the patients, to meet the needs of the staff, and to make money." She argued that if the home did not make money, there would be no place for the patients to live and the staff to work. "

### Employees' Salaries, Raises, and Incentives

The nursing staff are aware of the costs to themselves and the patients resulting from



short staffing, inadequate supplies, and an underpaid workforce. Salaries for all levels of nursing staff are far below the comparable positions of employees in acute hospitals. The starting pay for a newly employed nurses' aide when this study commenced in 1986 was \$3.55 an hour. This starting salary precluded living in a one bedroom apartment in the area. Few of the nurses' aides owned a car. Most of the nurses' aides interviewed for this study live in mobile home parks. In order to make ends meet, the nurses' aides often worked more than one job. One worked in housekeeping at the headquarters for a large corporation. Another worked in a local hospital as a clerical worker. Others are available to the facility to work overtime to cover vacant shifts for which the facility pays time and a half. The facility also has a plan by which workers can opt to receive a larger salary and no benefits.

#### Working short

A constant complaint among all informants is that the facility is frequently short staffed. This view is not shared by the administration. In fact short staffing is denied by the Director of Nursing. Each nurses' aide on the day shift is assigned between 8 and 10 patients to care for during the shift. On the evening shift three nurses' aides are assigned to each wing and usually assist each other to care for the patients. On the night shift one nurses' aide is assigned to each wing and assists all the patients who need help during the night.

How is staffing determined? According to the director of nursing, state and federal regulations determine what is the minimum level of staffing for "safe care" for both intermediate care and skilled nursing facilities. The director of nurses calculates staffing based upon a formula for determining time it should take to perform each prescribed task and adding these together. This is called an acuity system. Acuity refers to the seriousness of the patients medical condition. The number of patients each of these nursing assistants

will care for is calculated based upon the acuity formula. The patient's medical diagnosis, mental status, and physical limitations are calculated into an equation to determine how many minutes of staff time each patient will need. The acceptable level of patients may be as many as 13 patients for each nurses' aide. When staff call in sick, the facility attempts to find other staff who will either work a double shift, or "come in on their days off." The corporation has a policy not to use temporary employment agencies to supplement staffing. When the nurses are unsuccessful in finding additional staff, the nurses' aides "work short."

I asked E.D. how many patients she would have on a day when she is working short. She said 19 or 20. At one meeting of the family council, Mary was more angry than usual because of "the terrible staffing shortage." I defended the administration saying staffing is always low in summer, people move, students graduate, people change jobs. It is the case in all nursing homes. I regretted not thinking of what June, the charge nurse, later suggested that they consider giving some incentives to people for coming to work.

There are two alternatives the administration will not consider. The first is using temporary help called "registry personnel." The administration, argues that it is demoralizing to bring on temporary workers who are making more than the permanent full time workers to relieve staffing pressures. The administrators also risk losing permanent workers to the temporary pools. The second alternative is paying workers a competitive wage. This reality affects the nursing assistants and registered nurses, but not the LPNs. A local hospital started using nursing assistants to relieve their shortage of nurses. The starting salary offered by this hospital was equivalent with the wage of an LPN in Twin Oaks. A number of nursing assistants left Twin Oaks to work at the local hospital. The director of nurses claims that LPN salaries are competitive and that she can hire an excellent LPN at the present salary level. Registered nurses' salaries at the charge nurse level are far below those of the local acute care hospitals.

As a result, only registered nurses who are unable or unwilling to work in the acute hospital will work at a nursing home for a reduced wage. In the second year of the study, the Director of nurses hired five registered nurses in administrative positions: all quit to return to acute hospitals.

It is not that there are no alternatives, only that they are unacceptable to the corporate management. Jane, a charge nurse, recently told me that during the summer she hates her job because the staffing is so short. It eats at her that they (the nursing staff) can not do a good job. The aides are exhausted from working double shifts. Jane worries about the patients while she is at home as well as at work. "They just don't care about it. They don't give them [the nurses' aides] any incentives. They don't try to keep the staff."

#### Room Rates and the Personal Needs Allowance

The patients are paying approximately \$2100 a month to live at the home. By spending their life savings at the rate of \$50,000 every 24 months, they are assuring that they will never be able to afford to leave. Their home must be sold before they become "Medicaid eligible." The federal Medicaid program will pay for the cost of nursing home care only after the patient's savings total less than \$2,000. The patients who receive state aid have their benefits distributed to the nursing home. The facility is mandated by state regulations to provide \$25 to each patient for "incidental expenses." However those items are essential, not incidental to the patients. This sum of money is called the Personal Needs Allowance. In reality the nursing home takes most of this money to pay for personal laundry done by the facility. Laundry costs \$25 a month. Katie, one of my informants has asked me for \$1 or \$.50 at each visit to buy a soda. Her allowance allows her "one sody a day." But by the end of the month she has run out of cash. Another day she asked me if I had any old birthday cards because she wanted to give one to her roommate whose birthday it was. To buy that card she would have to forfeit three sodas, so I bought the card. When I asked the administrator and the business office why Katie needs to beg for money (which

she frequently does from the Director of Nurses as well as visitors), I was told that she took out \$5 at once to buy something. Now she is short. He told me that the nursing home doesn't have the funds to buy Katie extra soda. Or to provide soda to the patients. Staff members frequently buy patients sodas, candy and other items with their own pocket money at the small in house store run by the patient's council.

Now, personal monies are also kept in an account at a local bank. Interest accrues in this fund but is not returned to the patients. It is retained by the facility. Patients have to ask for the money, or if unable to ask, there account is charged when personal supplies such as tooth brush, paste, lotion, shampoo are purchased for them by the nurses' aides.

When Martha died, no money was returned either to me or to the state from Martha's account. Until recently the difference in care given to "private pay" patients (patients paying their own bill) and patients "on Medicaid" (those receiving public funds) was negligible in this facility. However, the administrator told me that he had recently been to a marketing seminar sponsored by the industry where he was told that solid marketing practices dictated that he should treat private pay patients differently than Medicaid patients because it made the private pay patients feel poor and degraded when they received the same treatment as the "indigent patients."

### **Consultants' Perception of the Wealth of the Corporation**

Mary, the secretary of the family council, is a very vocal critic of the profit-making mission of the facility. She is perpetually angered by what she perceives as the top/bottom discrepancy regarding money. She views the care of the patients against an image of the rich stock holders and corporate executives who drive big cars, live in mansions, wear fine clothes, and make grand salaries while they sit on the boards of directors of the Haddock

corporation and others like it. This view is shared by other family members who are less vocal.

Were the nursing home chains truly poor, then this tension would not be as virulent as it is. Mary told me in disgust when I recounted an exchange with the administrator in which he told me that the Twin Oaks is one of six facilities in the state that are "in the red," that "the corporation is not losing one dime on Twin Oaks. It simply uses Twin Oaks to show a loss to offset the taxes on the corporate profit made on the other private pay facilities." Whether this is the case or not, and I imagine it to be so, it is a belief that is heard repeatedly in the talk of family members, staff and patients. I found myself smoldering with rage as I experienced my powerlessness to affect Martha's care. While I struggled with a benevolent but powerless administration, I too saw in the background the corporate shareholders and remembered the advice of a stockbroker who told me that the nursing home industry was one of the best buys in stock. The nursing home industry is thought to be so lucrative that those staff, family members, and patients who know it, carry a smoldering anger about the injustice of it all. This anger is ubiquitous and pervasive.

### Summary

This chapter has set the stage for the analysis of the interviews and cognitive tasks performed by the consultants in this study. I presented the contextual climate of Twin Oaks, the facility, the staff that work there, and described the informant groups who participated in this study. In this context lie the clues to the meanings the consultants give to care and the terms for care acts presented in the following chapters.



## **CHAPTER FOUR**

### **EXPERIENCING A DAY**

#### **Introduction**

A nursing home is a place where some people work, others live and others come to visit. In this chapter I present the results of my personal observations and experiences as well as the consultants descriptions of their experiences with the caring process in the ethnographic. I will present a day, as it is lived by each group of consultants: patients, nurses, nurses' aides, and family members.

#### **The Patients' Day**

For many patients the day has no beginning and no end. Because the sleep of many patients is short and dispersed throughout the day and night, some are awake as many hours during the night as they are during the day. The patients' experience of living at Twin Oaks is primarily determined by one factor: how dependent the patients are on the staff. Through my observations at Twin Oaks I discovered three states that condition patients experience of life in the nursing home. These states result in experiences of day-to-day existence that are very different from each other. The first state is that of the patients who are in possession of his or her physical and mental faculties to the extent that he or she is able to move physically from place to place and have social skills such that they are able to engage in a relationship with the nurses' aides. These patients can eat when they wish by getting snacks from the store and keeping them in a can in their nightstand or dresser. They

are able to go to the bathroom when they need to. They can "take a sponge bath" at the sink in their bathroom and if they can't sleep, they can sit in the lobby and read. Their existence is self-determined. Although they may have the aggravation of incontinent, noisy, or non-communicative roommates or table mates, they frequently socialize and play cards with other patients like themselves. They participate in many of the activities planned by the activities department. If they have family and friends available they are often taken home even overnight. This description fits only a very small percentage of the patients at Twin Oaks.

The second state is that of patients who are physically and/or mentally dependent upon the nurses' aides. For these patients, life is an excruciating mix of physical discomfort, asking for help often by ringing the call light, and then waiting for their pleas to be answered. These patients spend hours at a time with nothing to do. While the nurses' aides are rushing around carrying out their assigned tasks, their patients wait. If the patient has a communication disorder and is unable to express his or her needs, he or she may or may not be relieved of the discomfort. For those patients who have a regular nurses' aide, the nurses' aide may have learned to decipher the patients' attempts at communication. Commonly however, these patients are labeled "attention seeking" by experienced nurses' aides as well as the inexperienced.

Because of the resemblance between dependent noncommunicative adults and toddlers, the nurses' aides transfer their experience in a parent-child relationship to that of the dependent patient. Often, the patients are erroneously thought to be confused and their pleas are routinely ignored. These patients begin to act out, to take off their clothes, to scream, or to cry. This increases the belief on the part of the nurses' aide that they are "spoiled children" or "just trying to get attention. At least one incident of this "parenting" behavior occurred almost every time I went to Twin Oaks.

The third state is that of the patient who has a complete loss of physical and mental capability. These are the patients referred to by the nurses' aide consultants as "the patients

in the back." These patients may be in this condition for years or days, but the condition usually ends in death. These patients may in actuality receive better care than those in the second state provided their nurses' aides are experienced. The routine for giving care to "the patients in the back" is more intensive, more closely prescribed and supervised than for the patients who are more alert and physically able. Patients in the back are usually fed. They are supposed to be turned from side to side in bed every two hours, and at these times their beds should be changed if they have defecated on themselves. These patients are bathed in bed, as needed. However, when the nurses' aides are inexperienced, these patients suffer most. For the new nurses' aide, "heavy" or bedridden patients are very difficult to care for. Learning to make a bed while the patient is in it and remove the wrinkles is not easy. Learning to care for these patients efficiently takes much practice and the new recruit is less concerned with the consequences than with trying to survive in the job and pull his or her share of the load. Patients may be neglected in favor of those who are able to complain and bring the attention of the nurse.

Feeding these severely disabled patients is often done with a large syringe and can result in aspiration when the patient is fed lying down. During the time when Martha was dying I witnessed a nurse feed her pills, crushed in apple sauce while she was lying flat on her back. I intervened. On another day a nurses' aide attempted to "push fluids" by inserting a large syringe into her mouth past her tongue and injecting water down her throat while she was lying flat on her back.

While inexperienced nurses and nurses' aides can create life-threatening conditions for these patients, experienced nurses and nurses' aides seem to provide more adequate care for them than for patients with more ambiguous conditions. This finding was new to me. As a director of nurses and as an ombudsman, I had always thought that the most dependent patients were the hardest to care for and received the worst care. My experience with Martha and my observations at Twin Oaks demonstrated that experienced nurses'

aides "know just what to do" and do it. When Martha was dying there was a marked change in the way the nurses' aides and nurses explained her condition and provided her care. They believed she had given up. They expected her to die and knew it would likely come soon. The charge nurse called frequent visitors and informed them that Martha was close to death and suggested they visit her soon if they so desired.

Patients at Twin Oaks move among the different states of dependence with more or less fluidity, but generally the direction of movement is from more to less dependence. The boundaries of these states are fuzzy. Patients may be physically able to move about but relatively limited in their mental capacity to recognize and make known their needs for assistance. One might be completely bedridden and mentally aware, but it is the patients' ability to move, to think, and to communicate that determines the life they lead.

No activities directed to the less capable patients are available at Twin Oaks. Although some of the less mentally capable patients enjoy listening to music and sermons, being read to, and eating, the majority of activities are geared to the most able patients in the facility.

Now at Twin Oaks, many patients act as "patient volunteers" and one of the works these volunteers do is to take other patients to activities. One patient will take patients to the dining room, another is paid by family members to do a patient's laundry in the small washing machine available in the activity room. Others help other mentally deteriorated patients to eat by telling them what the food is, helping them to prepare it, (for example reminding them to put milk on the dry cereal), and reminding them to keep eating when they become distracted. The patients who help each other are usually the ones who can move around. These are the patients who help guide the others in the dining room to eat. Some patients help the other patients to eat by telling them to do so if they don't know.

E.D. gives an example:

One woman doesn't know if she's supposed to eat dried cereal, unless you put milk or something on it, and they help her there.

E.D. continues:

Usually the ones that are able to get up and move around, are the ones that helps. . . Because if they didn't, I don't know, they'd have nothing else to do. And they enjoy doing it. They really do.

(Transcription E.D., Female Nurses' Aide)

## The Nurse's Day

### Change of shift report

For the medicine and charge nurses, the work of the day shift begins with the change of shift report. This report is focused upon the more serious medical occurrences that happened to the patients during the previous shift as well as the actions that were taken at the time of the occurrence. The staff arrive and begin making rounds to check on their patients to see whether or not they are dry or need changing.

On the skilled nursing unit, wing 300, the nurses' aides listen to the report that the night nurse gives to the charge nurse on the day shift. However, the other wings are staffed by aides only and the report on those wings (100 and 200) is abbreviated and the nurses' aides don't attend it. This is a major source of the difficulty according to E.D, a nurses' aide and a particularly perceptive consultant:



We don't get no reports, of how a patient is, if she's supposed to stay in bed or get up. whether we're supposed to get them up . . .if that patient slept well, if she had a good night, if she fell, was she bruised, how bad. Is she able to feed herself? [I don't know whether ] I would have to help her and why, what happened that she had this kind of thing where she can't get up to go to the dining room. We do have patients that don't go to the dining room. They may tell us, Go check this patient, cause you may have to assist her but she may want to go down but you have to assist her, and you go and she's out of it -- completely, totally out of it. I don't know if its the medication they're giving her, or if its too strong or what. There's one patient you go in one time and she's ok and you go in the next time and she can't even move -- can't even get up. She always gets the shower so what am I to do? That is not a nursing home. They're not coordinated, they're not organized and nobody knows what they're doing. All they know is they're taking care of people. And that's it. But they really don't know why.

(Transcription E.D., A Female Nurses' Aide)

### Calling the doctor

Radical changes in the patient's condition require a call from the nurse to the patient's physician, who dictates over the phone the orders he or she wishes to be carried out relative to the problem being reported. If the physician is not reached on the one shift, or if the problem is not thought to be life threatening, the problem is reported to the day shift nurse, who makes the call to the physician's office. Commonly reported incidences include falls, pressure sores, chest pain, shortness of breath, incontinence, fevers, confusion or

delerium, absence of bowel movements for four days, a drop in weight of more than five pounds in a week, and headaches. The call to the physician is made and the patient's symptoms are described by the nurse. The physician then orders a medication or a treatment over the phone, without seeing the patient.

### Passing medications

Medications are passed by the medication nurse or the certified medication technician three times a day. This is called "passing meds" by the nursing staff members, and handing out the pills by the patients. The morning meds are passed between eight and ten o'clock. This poses some problems for the nursing staff. Some medications are most safely administered before meals, others after meals. The nurses try to follow the directions given for each medication but they are driven to pass the morning medications before it is time to begin passing the noon medications. This time pressure leads to the valuing of efficiency over safety and caution because the efficiency with which the medications are passed determines whether or not the patients receive their medications on schedule. The fact that the medications are passed for the most part, in the same order each time--that is, the patients who receive their medications early in the morning also receive them early in the afternoon and evening--allows for the the spacing between the medications to be maintained. If the nurse is slow, morning medications may be received by the patient right before lunch instead of after breakfast. If he or she is very slow or very busy they might not be received until after lunch.

The press of time and the difficulty some medication nurses have getting the patients to take the medications leads to some unconventional and illegal practices that are not evident

in the patient's chart and are unlikely to be discovered by the state inspectors. In fact, they are unlikely to be discovered at all.

E.D. describes some of the practices she observed:

Pills fall on the floor, they're not taking 'em; they (the med passers) just set 'em down on their tray and tell us (nurses' aides) to take 'em (to give them). When they (the patients) go to the dining room it's fine because they can take their's, but the one's on the wing cannot. They get Metamucil or eye drops. I don't think V.M. has had any drops in her eyes for three weeks. And she's supposed to get 'em all the time. (This patient has glaucoma and missed drops can lead to lost sight.) When she gets pills, they (the med passers) just set 'em down, or they fall out of their mouth. They're not there to make sure they are down. Once they give 'em, they say, "E.D. make sure they get 'em"; and it's not my job. And then you go in there and say "Why haven't you taken your medicine?", I've said several times. "Hey, you need to take this." But its not my place to do it; I can't distribute the medicine. I don't know what they're getting. I'm only an aide. You got to make sure she takes 'em. Half the time you'll give it back (to the med passers) and they'll throw it away but they'll chart it as given. That's wrong. What they should do is stand right there, and make sure that medicine is down. But they don't do it. I found a little orange pill on the floor I said "Hey, this must be O.E.'s," I know most of what they get, you know. So I said "here," They said, "she didn't take it?" I said "Nope." So just toss it but yet they've charted that they have had their medication. See, they give it, but whether they (the patients) take it or not is beyond the point. Yet they don't stand there to give it to 'em because they want to get it

over with now. And you can't give 'em another one because you don't know for sure that that's the patient that didn't get it. Now they'll put it in their mouth, I don't know if they spit it out or if they're not taking 'em but they're not staying there to make sure. And they say E.D., make sure she takes these, poke it down her.

Some of the things I've seen, I know its leftovers from the day before. You mix it with orange juice or something and before it thickens you have to make sure its down her and swallowed, sometimes she will and some times she won't. Now I can't be sure its the LPN's fault because she's not there making sure it's down her. Before she leaves her, but they just come in like that, and give em to 'em and they're out. If the aide is there they say make sure she takes it. Sometimes it's put in syrup, like CM. You got to put it in her cereal, and cover it with sugar or she won't take it. I guess it's 'cause of her religion.

(Transcription E. D., Female Nurses' Aide)

## Doing Treatments

Treatments are done by the licensed nurses only. The nurse has a cart with equipment needed to perform various treatments ordered by the physicians for thei patients. Patients with skin tears, with decubitis ulcers (pressure sores) are given treatments that consist of regular dressing changes. Treatments are usually done once or twice a shift. A common problem with treatments is that when the nurses are busy or if they do not believe the treatments are necessary they may omit them. If this is done too many times in a row, infections may develop in the wound or cut. Nurses usually initial the tape used to secure a



dressing. When they discover their tape on a dressing two days later they know that the dressing was not changed as scheduled.

### Care conferences

Three or four times a week the nursing care planning conferences are conducted by the social worker, attended by the nutritionist, the charge nurse, the med nurse, the physical therapist, and the activities coordinator. Two or three different patients are discussed at each conference. The nursing care plan is accorded by nursing tradition the cornerstone of nursing care. A patient is assessed upon admission to determine his or her need for nursing care and a care plan is constructed to describe the care needed. The care plan is then placed in the chart. The state requires that the nursing care plan is to be revised every three months. The director of nurses does not attend. When I first began this study the facility did not employ an assistant director of nurses. To my knowledge, the presently employed assistant director of nursing does not attend the nursing care conferences.

In theory this procedure should ensure that nursing care is tailored to the individual patients' needs. In fact, the degree of influence the care plan exercises over the actual care given by the nurses' aides is minimal. On wing 100, where Martha lived and where all primary informant nursing assistants worked, most of the time the nurses and assistants agreed that no one ever looked at or referred to the nursing care plan. The plan was written for the state, not for the nursing team.

I found this to be true in Martha's case as well. During Martha's entire stay of five years, never once did anything written in in Martha's care plan become integrated into her care unless was already part of the general nursing routine.) Her hearing aide wasn't put in, she was never assisted to dress herself (rather than being dressed by the nursing assistant),



her books for the blind machine was never turned on, and no one helped her write letters. Her water bottle, a non-spill joggers-type bottle was never filled, and she never could get water without ice. The record of her activities that was to be posted in her room was abandoned after the first three weeks. For all intents and purposes, the nursing care plan had no effect upon Martha's care. The nursing care plan, while present in the chart, was rarely communicated to the nursing assistants and when or if it was (usually by me), it was considered by them to be unrealistic for their workload and beyond their regular assigned work.

### **The Nurses' Aides' Day**

The work day for the nursing staff members begins in the break room where each staff member must "clock in" at the beginning of each shift. Some staff members arrive early and sit and have a cigarette and a cup of coffee and a visit with their friends. nurses' aides, some few nurses, maintenance, and dietary workers and their friends make up the majority of those who gossip in the breakroom. Although family obligations usually determine who arrives early and who does not, those who are free to do so and who are "part of the crowd" get in on the informal gossip. The talk covers personal matters at home, what went on during the previous 24 hours, and what the administration and the corporation are up to. There are families with two or more members working at the facility, mothers and daughters, and married couples. There are also nurses' aides, housekeepers, and maintenance workers who have been recruited by their friends to work there. Since members of these constellations of workers are in management and staff positions, gossip travels far and fast. It is this comraderie that keeps some of the staff coming to work; for others it is their patients. Most nurses, and a few nurses' aides, arrive just in time to "clock

in" by 7:00 a.m. and go directly to the wing where they have been assigned. When the shift begins many of the nurses' aides congregate in the utility room on each wing where smoking is allowed. The administrators and most department heads arrive by 8:30 A.M. on the day shift.

The work of nursing is organized into sets of routines. With slight variation these routines are performed in every nursing home in the country. Their origin has long been lost to the memory of most practitioners of the nursing arts, but the uniformity with which they are prescribed and performed make them solid pillars of the status quo. The strength of these routines has been further enhanced by their inclusion in both state and national regulations governing the management of nursing homes.

The first routine of the day shift is getting the more active patients ready to go to breakfast in the dining room at 7:30 A.M. The patients who stay in their rooms for breakfast are prepared to sit up in bed and to eat or to be fed.

### **Morning Routine**

The morning routine is the set of tasks done to prepare the patient for breakfast and for the rest of the day. E.D. describes it as follows:

[The morning routine is we] dress 'em, wash their face and hands. We toilet 'em, we comb their hair, put their glasses on. If they have dentures we get them. We take 'em down to breakfast, put 'em in a wheelchair, if they wear bibs, well, they have to have a bib and then when they come back they may lay down, then we lay 'em down, We always toilet them. (Transcription E.D., Female Nurses' Aide)

## Taking Them to Activities

The activities department is outside the department of nursing. The activities staff consists of an activities director and an activities assistant this for 141 patients. The "activities" consist of a calendar of events put on by the activities staff and primarily using volunteer entertainment from the community. Some of the family members are volunteers.

The nurses' aides are responsible for taking the patients to activities. This is a problem for most activity directors because patients are dependent upon the nurses aides' for transportation. E.D. describes the dilemma the nurses' aides face when they take the patients to activities:

Well we like to take them and get them as much of activities as they can get. Enjoy the activities to occupy their minds. They watch movies, they go down to the dining room to watch movies we take them down. Sometimes they'd just rather lay down and sleep.

(Transcription E. D., Female Nurses' Aide)

Frequently nurses' aides must choose between the patient's expressed wishes and the nursing homes' policy, carried out by means of the charge nurse's directives. This nursing home, like many, has a strong prescription to have patients up out of bed and dressed in street clothes for the day. The origin of this mandate comes from the state and resulted from past experience with nursing homes in which patients' clothes were lost, patients were without proper underwear, sometimes without shoes and socks, all lost in the laundry. There seem to be three reasons supporting this prescription. First, a facility in which patients are found sitting around in the halls, calling out for help, half dressed, and smelling of old urine gives a very bad impression to visitors, and is the very scene that has given nursing homes a bad reputation. Second, facilities receive heavy fines for patients

found in this condition. The third reason is a belief expressed in the gerontologic literature, a heuristic rule born from the influence of the self-help movement: patients ought to be as active as they are capable of being.

The administration has a legal mandate to adhere to the "Patient's Bill of Rights" a document that dictates that patients' rights should not be violated. Often these two prescriptive admonitions to have the patient up and dressed, and to honor their wishes, are in conflict. The charge nurses and nursing administration most often follow the first dictum and direct the aides to get the patients up and dressed, often over the expressed desires of the patient. The nurses' aides side with the patients and together they criticize the nurses for "violating the patients' rights." In some cases the patients have asked their physicians to intercede for them.

One example concerned Julia, who had been very depressed during most of her stay at Twin Oaks, and refused to get out of bed and leave her room. Since Julia attempted suicide while on leave from another nursing home, were she younger, she might have been admitted to a psychiatric unit for her own protection. Although staying in bed all day would not be allowed were she a patient on a psychiatric unit, at Twin Oaks she was allowed to stay in her room most of the time as much as she liked. Her physician, a family practice doctor, supported her in this effort and ordered the nurses to honor her wishes.

### **The Evening Shift: Putting Them to Bed**

After supper the nurses' aides begin putting the patients to bed. The evening staff are supposed to help the patients out of their clothes and into their night clothes, wash their faces, brush their teeth or rinse their dentures, help them to the toilet, and put them to bed.

Around ten the evening snack is delivered to each wing by the kitchen staff. The nurses' aides pass out the evening snacks to those patients who have ordered them.

### Family Members' Days

For some family members who are frequent visitors to the nursing home visits are made to fit into an already busy schedule. For those who are employed outside the home, visits are scheduled around work shifts and family responsibilities. For those who are retired or who work at home, visits are competing with the needs of other family members. Both of these situations are causes of tension. In spite of these obstacles, family members provide care essential to the well being of the patients.

Below is a description of one daughter's contribution to the quality of life of her mother:

I take her things every day, I try to get some little something to her. I bring her things from home to show her. Tell her things that's happened even if I know somebody that's died, I tell her. I don't hold anything back from her. And I try to keep her in as nice a clothes as I can. And clean. Cleanliness is a big thing. Which is kind of hard to do sometimes around here. I try and keep flowers in her room. Try and keep her as happy as you can, that's about all you can do. Also, she likes to get mail and I think that's one big thing. Like I have three sisters who live in California who try to come once a year. I'm always tellin' 'em, "Hey, just send a card. You don't have to send anything just a card. Or put a candy bar in it if you want to. Send her just some little something to let 'em know their gettin' it". I know mom is pleased. And she does have a bulletin board, and I think that's



important in a room, is a bulletin board where you can put pictures or cards. Yesterday, I brought some leaves, just a little branch of leaves. She was just really delighted, such a simple little thing can make people happy.

(Transcription B.P., Female family member)

### Summary

The day shift begins at 7:00 A.M. and ends at 3:00 P.M.. The evening shift begins at 2:30 P.M. and leaves at 10:30 P.M.. The night shift arrives at 10:30 A.M. and leaves at 7:00 A.M. The terms day, evening, and night shift apply both to the work shift and to the workers. The cycle of work is carried out by three teams, seven days a week, three hundred sixty-five days a year. The "heavy" work and the extremely low pay are frequently cited by the nursing staff as lending a sense of meaninglessness to the work. Nearly all nursing staff members say they believe that they do a better job than other nursing staff members. One LPN told me "Some days I hate to go home because I know that the nurse on the next shift is new and doesn't know the patients ." Her sense of the continuous cycle is expressed in a sense of worry about what is occurring in her absence. They each feel specially needed by the patients and perceive that they are doing well by their patients.

E.D. told me :

I keep thinking , " Aw gees these poor people", and the way some of the aides treat 'em, you know. It just makes ya feel so bad, ya go home and you're so tired, ya sit there and ya think, " What can I do the next day?" and then you work so hard and the next day ya go in and ya don't speak to 'em

and they say, " Evelyn, are you mad at us ?" "No. I'm just tired."

You know this is it, this is the whole thing , you're just so tired you don't want to talk to 'em . You just get 'em ready, and they think, "What's wrong ?" You know, I've done the same thing, I was so tired I didn't even say a word all day, and the patients'll say, "Well how come are you mad at us?" I say , "no, I'm just tired." They say, "Okay ," then I'd love 'em a little bit, ya know, and the next day I go in and I'll say, "Hi, I got you", and they know, they can tell and they sense it too, because when we're ok they can tell, but when there's a change, they know it. Especially the ones that have their right minds. They can tell there's a change. You're worked too hard. B.S. pulled five doubles [a double is two sequential eight hour shifts], in a row and that's too many. His blood pressure was 90/40. He used to be a paramedic for nine years.

(Transcription E.D., Female Nurses' Aide)

In this chapter a day in the life of nurses, nurses' aides, patients, and family members was presented. The contrast between the extreme busyness of the workers and the long frequently empty hours of patients is marked. The clear contribution to the welfare and quality of life made by family members to their own relatives as well as other patients is notable, considering the findings of the more formal aspects to this study. Lastly the overarching real as well as perceived role of wealth and poverty in the outlook of all concerned will be further discussed in the final chapter.

model as heuristic  
vs  
model as existing

## CHAPTER FIVE

### RESULTS

#### Introduction

In this chapter I present the shared model of care and discuss the differences among the consultants' models uncovered through formal ethnosemantic analysis. Evidence for the existence of a model comes from the interviews and from observation of interaction and care-giving behavior in the nursing home setting. The dimensions of the domain and the arrangements of the terms and features of care within that space are derived from the representation of group space created through the three-way scaling analysis of the consultants' responses to the revised frames questionnaires. The revised version of the questionnaire produced essentially the same two dimensions, the human relatedness scale and specialization scale, which were more equally important than in the first version. The overall importance of each dimension for the second set of data was 0.55 for the first dimension and 0.44 for the second, as opposed to 0.71 and 0.27 for the results of the primary consultants' responses to the first version of the questionnaire.

#### Description of the Shared Model of Care

The group space for terms for the secondary informants' is shown in Figure 1; the group space for the questions posed to the secondary informants is shown in Figure 2. The revised questionnaire was administered three times at one-month intervals to the group of secondary informants. The data from all three tests were analyzed together.

*in what way  
consistent*

Responses to questions were consistent from all consultants among the three trials in all but eight instances in which there was a slight variation in a single trial as compared with the other two trials.

By viewing Figures 1 and 2 together one can see which care terms were judged to be similar with regard to the questions asked about them. For example, if helping them to eat was believed to require no training and handing out the pills was believed to require training by most informants, then these two terms would be far from each other in the group space. Similarly, the important features of care that made up the questions asked about the various care practices will be close to or far from each other based upon the number of times they were answered affirmatively or negatively by the consultants. The resulting positioning of the terms produces a kind of map of the domain of care. By using the other sources of information about the consultants' ideas of care such as the interview transcriptions and the results of the listing and sorting tasks, the names of the dimensions that define the group space can be ascertained. The model presented here is for the second group of consultants. Figures 1 and 2 demonstrate the salient dimensions that are common to all 16 consultants. The 20 terms and 20 attributes were sampled from the total population of 80 terms and 40 attributes found to be salient to the original eight primary consultants during the free listing task. The complete list of 80 terms is given in Appendix I.

The terms are exemplary members of a semantically related set of like terms. The point here is that although only 20 terms appear in the scaled space, each term is a member of a class of terms that share characteristics of the focal term presented here. The terms and attributes are representative of the taxonomic trees created by the sorting task and were used in the frames questionnaire.

## The Terms for Care Practices

Figure 1 is the group representation of the common distribution of terms for care practices for the whole second group consultants. Within the group spatial representation, three categories of care terms are distinguishable. The first, emotional care, was influenced by similarity among responses to questions, "Is (emotional care) something that would be done by family members or nurses aides?," "Is it something one might do for a spouse, or a friend?" Care practices included in the category emotional care include washing their face and hands, hugging them, listening to their troubles, and helping them figure things out. There are two kinds of care represented by the terms in this category: hugging them, and helping them figure things out were related to terms labeled "providing emotional support" by some consultants; "treating them like friends" was the label for a similar set of terms that included washing their faces and hands, bringing them a branch or a flower, taking them to visit other residents, and sitting up with them at night when they need it.

Instrumental care describes a second care category of care terms. These care terms are clustered by their responses to the questions, does (personal care) require training, is it very important to do? Is it part of routine care? Is it something a patient would do, or that the administrator would do? Would it be done when staffing was short? Instrumental care is a covert category and is not found in the talk of consultants.

Personal care is a kind of instrumental care required by individuals who are limited in their ability to do for self and therefore need assistance from others. Children, all patients, bedridden and confused patients, and patients who cannot use their hands would all be recipients of this kind of care. The clustering of terms in the category personal care varies among consultants. It will be discussed further in the description of consultants' different models of care. Making patients comfortable, taking them to the bathroom, and helping them to eat are kinds of personal care required by patients who are not able to move about



unaided, who are confused, or who do not have full use of their hands. This care is very important to do. It is generally done when the staffing is short and is part of routine care, part of nursing care, and part of care. Personal care is considered menial by nurses and physicians. Doing personal care is believed to contribute to nursing's low-status.

Medical/technical care is the second of the two categories of instrumental care. These care tasks might be done even if the recipient of them were physically and mentally able. Medical/technical care is done to manage illness or injury. The care acts in this category are handing out the pills, taking care of their cuts and bruises, and keeping them pain free as much as possible. The Primary feature of medical/technical care is that these terms are considered by all consultants to require training. They represent those tasks most highly valued by nurses, those tasks thought to give nurses a higher status in the eyes of physicians and the public.

Other labels for kinds of care are polysemic. Care was located by some consultants where it would indicate a connection with emotional care; by others it was considered nursing care. Yet other consultants indicated that care and care needed by everyone were associated. Each of these locations indicates a different connotation for the term "care": emotional care is one, nursing care is a second, and a more general category, human care is a third referent for care.

### The Attributes of Care

Figure 2 is the representation of the common distribution of attributes of care by the whole group of consultants. The attributes of care form the frames for the questions asked about each of the terms for care practices. Clusters of attributes are created from questions respondents answer similarly. Three clusters of attributes of care were distributed in the group space. The cluster, personal relationship as a context for care, has four members:

family as care-giver, nurses' aide as care-giver, friend as care-recipient, and spouse as care-recipient. The relationship is reciprocal in nature. This can be inferred from the fact that the participants in this cluster are all adults who are relatively well-functioning.

The second cluster is labeled "need for assistance as a context for care" and contains attributes that describe situations in which one individual is attended to by another of greater capability of action. These situations include: things done for a patient by another patient or by the administrator; things done for confused patients, for all patients, for patients who can't use their hands, and for patients who are bedridden. Included within this category are the attributes, done when staffing is short and importance. Both of these questions are measures of the importance the consultant places upon the care term. Care, nursing care, and routine care are all glosses for one or all parts of this category. These three terms are polysemic. One goal of the study was to discover the different referents for these terms.

A third cluster of attributes has a single member: whether or not the consultants believed training was required in order to perform a particular care task. The isolation of the item requires training indicates that most consultants did not indicate that care tasks requiring training were the same as those that were important or were needed by disabled patients. No terms other than the most technical care acts, passing medications, taking care of their cuts and bruises and keeping them pain free were believed to require training by most consultants.

### Specialization of Knowledge

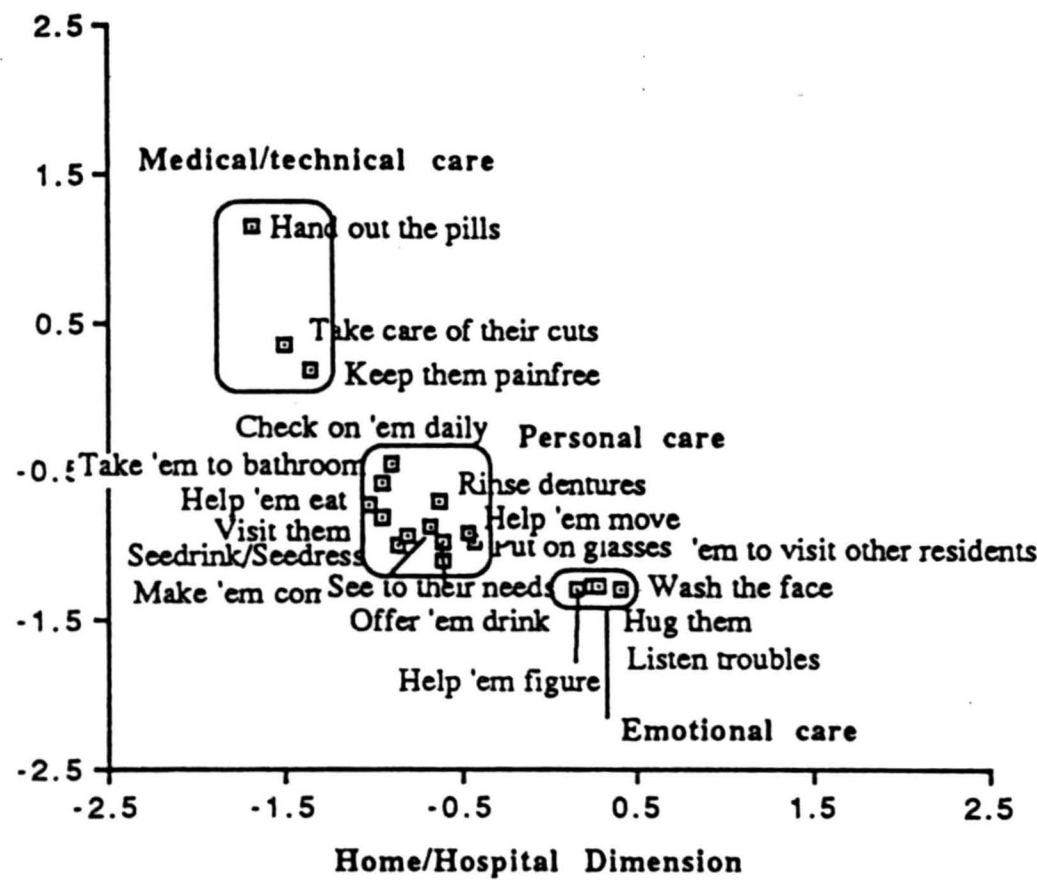


Fig. 1 Group Space for Terms

The horizontal dimension is the home/hospital dimension and the vertical dimension is the specialization of knowledge dimension.

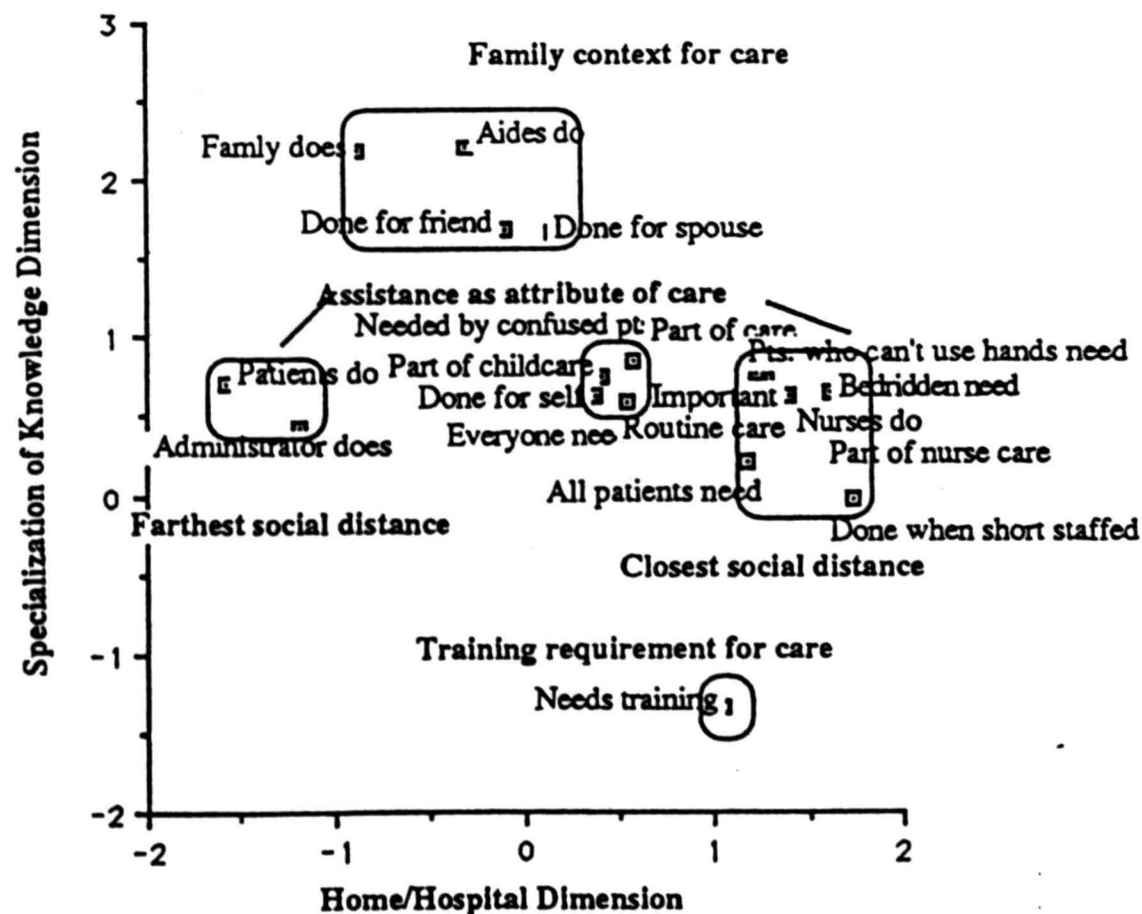


Fig. 2 Group Space for Frames (Attributes)

The horizontal dimension is the home/hospital dimension and the vertical dimension is the specialization of knowledge dimension.

Represented in this set of attributes are four families of attributes that are distributed through the three clusters of attributes of care. These families were identified through the sorting task. Not all families of attributes were not salient to all consultants but the order of appearance of these families was consistent throughout all of the sorts by all of the consultants.

### Kinds of Care-Givers

Nurses' aides, nurses, patients, family members, and the administrator are categories of individuals the consultants believed would perform certain care tasks. The patient as a care-giver and the administrator perform care acts that are less personal in nature than the nurse or perhaps the nurses' aide. Indeed the location of the administrator and the patient on the opposite pole from the nurse bore out the saliency of "personalness" as an attribute of nursing care in the consultants' configuration of care.

### Kinds of Care-Recipients

The attributes of patients receiving care act as a a measure of personal assistance required. Confusion, confinement to bed, and inability to move around or to use one's hands, all require different kinds and amounts of assistance. These demonstrate consultants' impressions regarding the relationship between the degree of incapacity of the care recipient and other attributes of care, for example, between incapacity and the person expected to give care and the relative importance of the care they would receive.

These tasks were identified during the sorting task as associated with the nurses' work, the term "nurse" was not located in the proximity of these terms in the group space. Nursing care and things nurses do were both associated with the care of bedridden patients, important care, routine care, and things done when staffing is short in other words, the provision of continuous essential care to those unable to do them for themselves. This fact

calls into question the referent for the term "nurse." This finding may indicate that there is a strong association between the term nurse in the lay model of care and the provision of continuous essential care to the disabled.

The nurse is located at the patient's bedside, not next to the medicine cart. The fact that within the nursing home setting these care practices are not done by the nurses but by the nurses' aides is an indication that the "idealized" referent for the "term" nurse is anyone who provides personal care to patients.

### **Dimensions of Care**

Two dimensions of care control the representational space for both individuals and the groups as a whole. The first dimension is labeled the "home /hospital" dimension is the horizontal dimension. The second, the vertical dimension is the "specialization of knowledge" dimension.

### **Differences Among Individual Consultants' Models of Care**

Difference among the four categories of consultants patients, family members, nurses and nurses' aides is judged on the basis of their subject weights for each dimension of the spatial representation, as well as the differences among the terms found salient to each consultant, and the differences among the attributes of care evident in the taxonomic trees that depict the consultants' sorting of the terms for care. As further evidence for different models of care, I present data from the interview transcriptions.



## Individual Spatial Representations

The individual subject weights indicate the importance of a particular dimension to the consultant. The range of within-group variation for the primary, secondary, and tertiary consultants was evident through analysis of the individual subject weights and the variant produced.

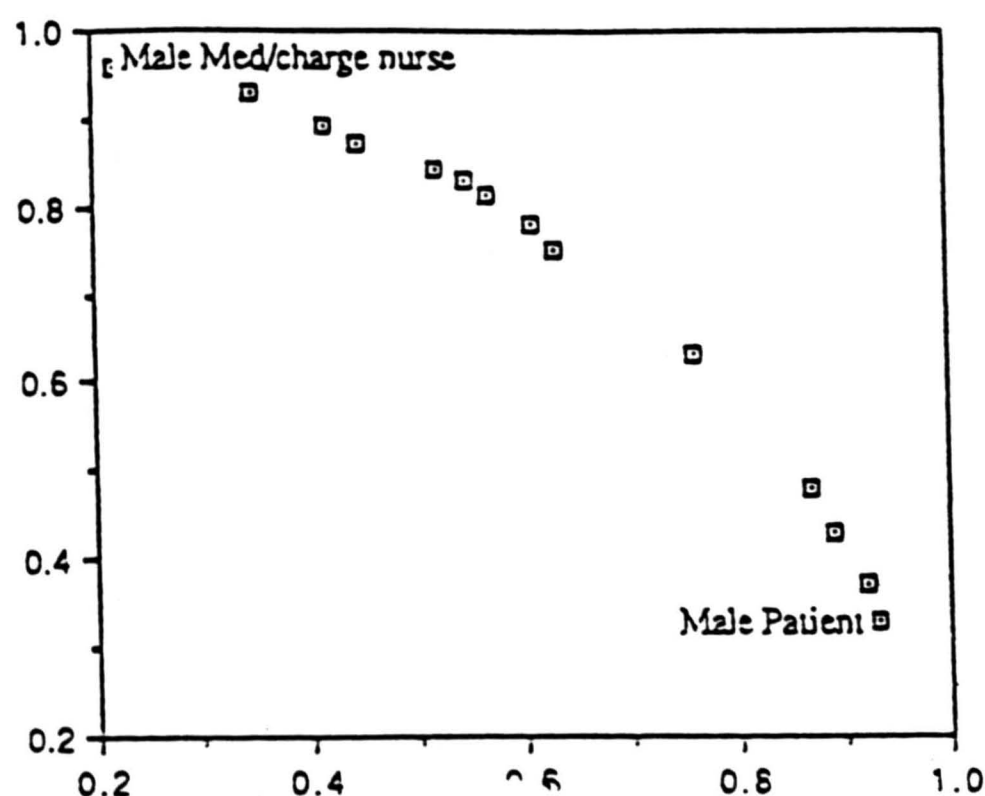


Fig. 3 Subject Weights for 16 Secondary Consultants for trial No.1.

The horizontal dimension is the home/hospital dimension, and the vertical dimension is the specialization of knowledge dimension.

Figure 3 is the plot of the subject weights for the secondary consultants. The consultants' distribution indicated that the nurses' aides and patients had similar subject weights and were high on the second dimension. The medication/charge nurses had similar subject weights and were high on the first dimension. By multiplying the points by the minimum and maximum subject weights, the range of variation from the modal model is depicted. Below are presented the two individual spatial representations for the secondary

consultants with extreme deviations from the modal pattern. The spatial representation for terms for the male patient is presented in Figure 4. The other patients and nurses' aides had similar arrangements to his. However, his deviated the most from the group representation. The individual representation for terms for the male nurse is shown in Figure 5. The remainder of the nurses had similar patterns and were less extreme than his.

A pictorial representation of the difference between patients and nurses' aides, and nurses' models can be observed in Figures 4 and 5, and 6 and 7. Here the patients' and nurses' aides' representations indicate that the home/hospital dimension had more significance for them than did the specialization of knowledge dimension. In other words, variance from emotional to instrumental care was more meaningful than the variation in the specialization of knowledge required to perform the various care acts. The opposite was true for the nurses. In their case, the specialization required to do their job was of greater importance.

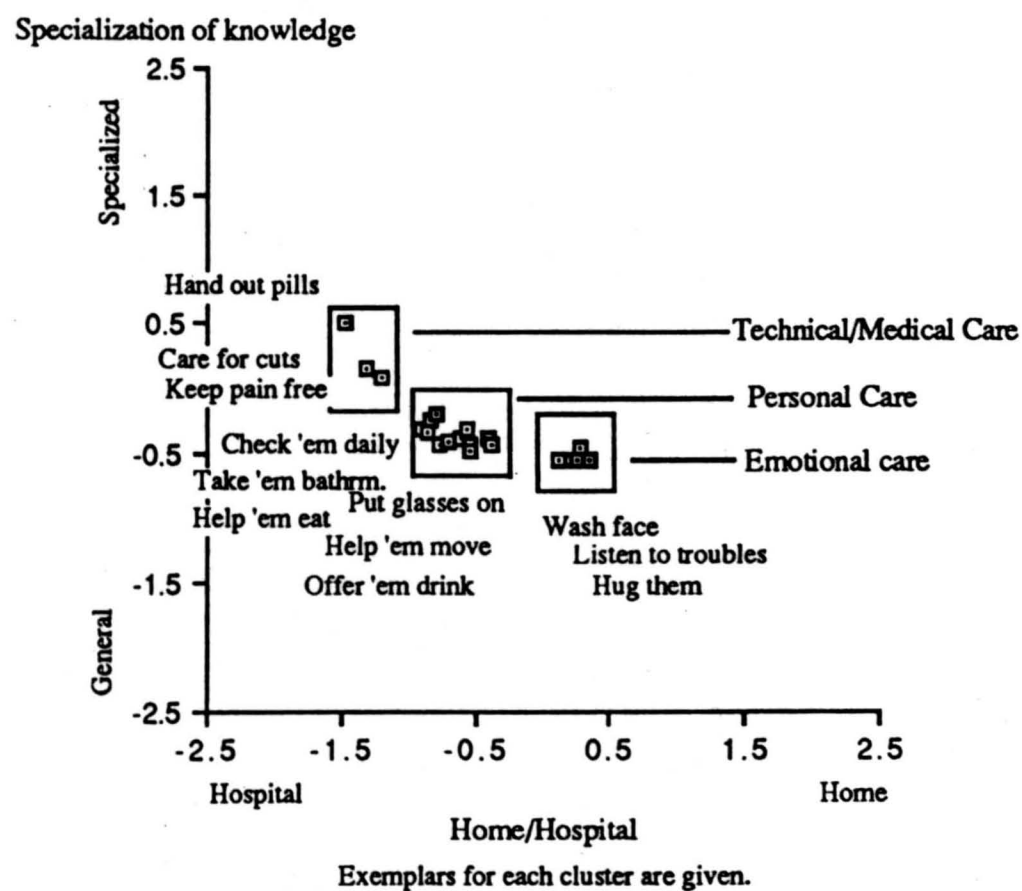


Fig. 4 Male Patient Space for Terms

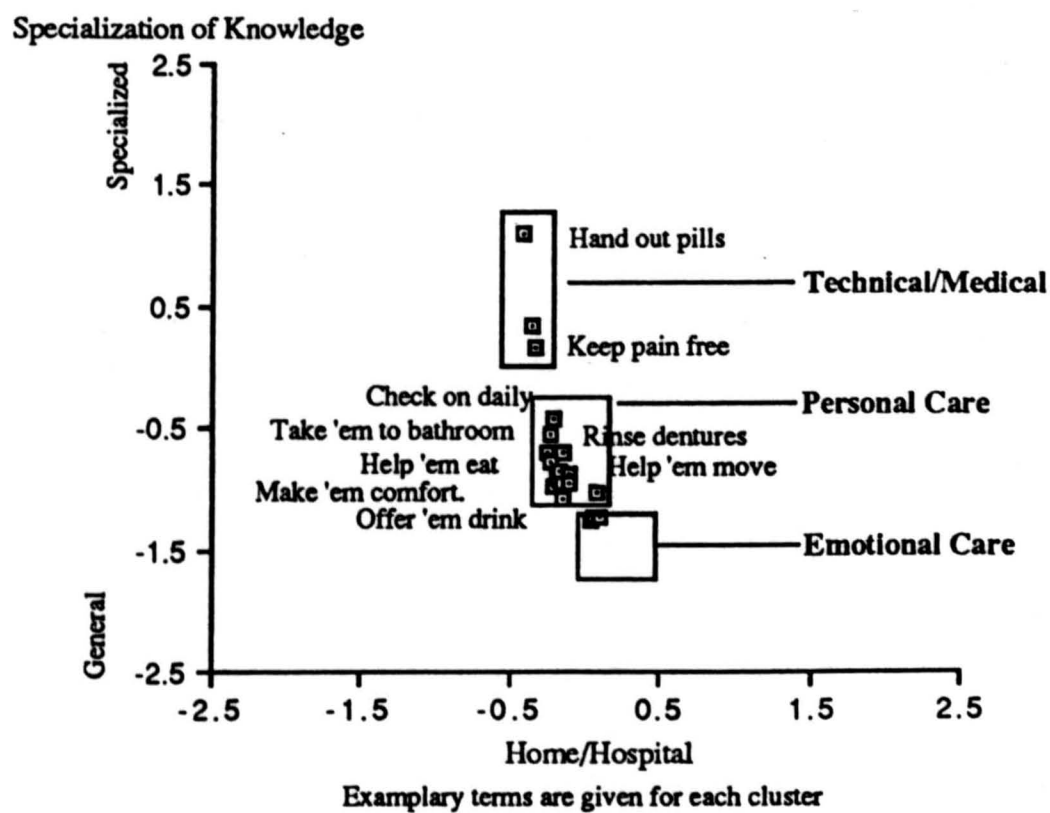


Fig. 5. Male Nurse's Space for Terms

# Specialization of Knowledge Dimension

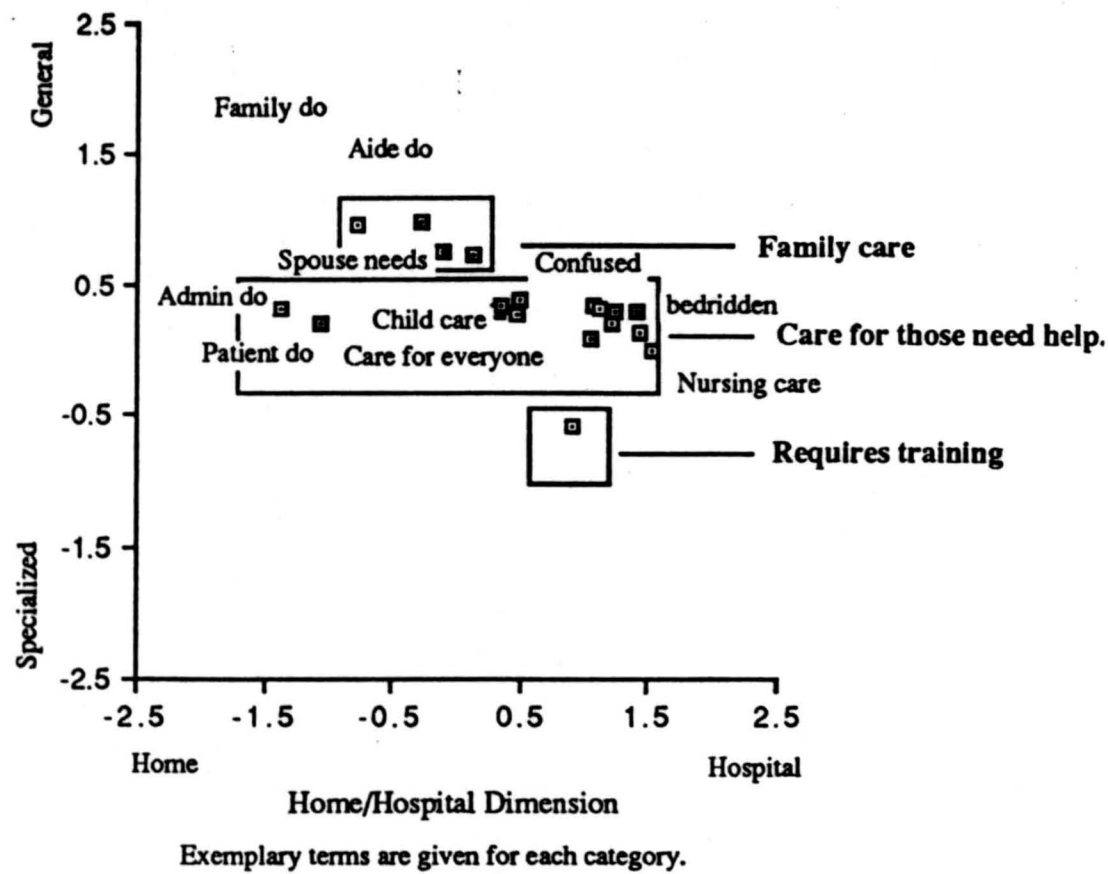


Fig. 6. Male Patient's Space for Attributes

# Specialization of Knowledge Dimension

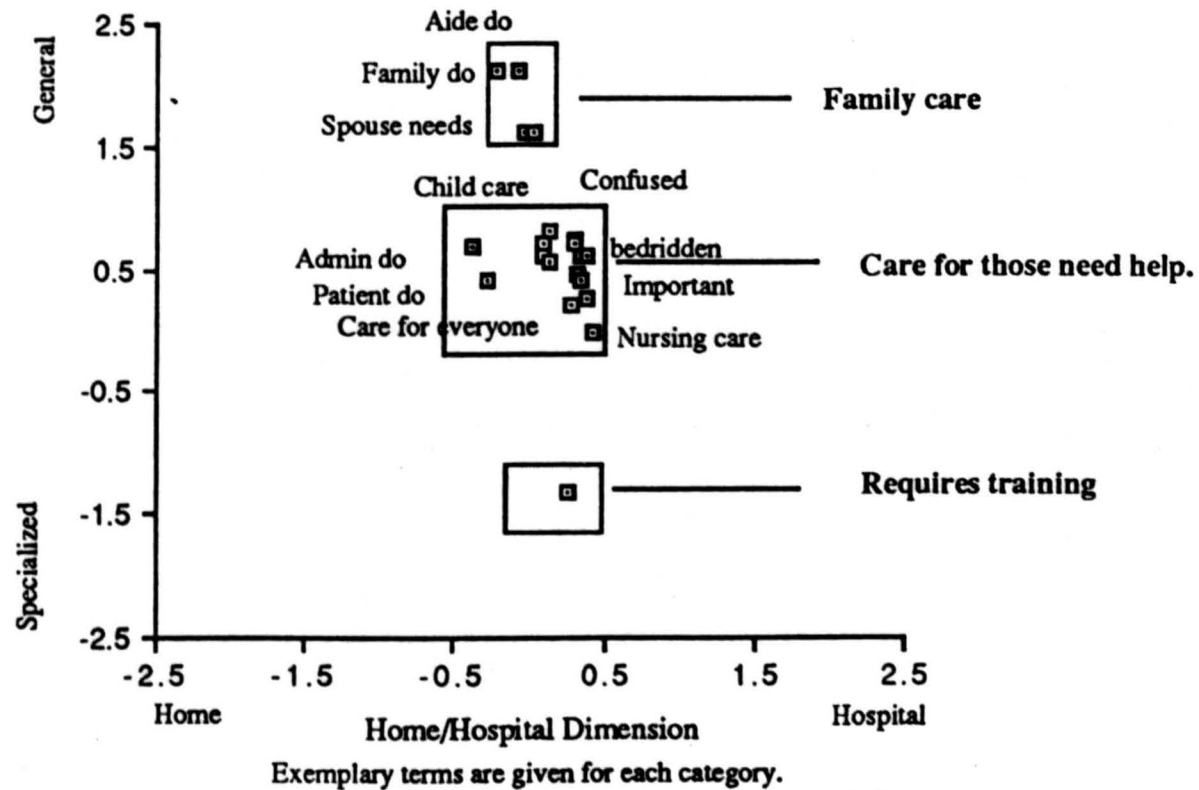


Fig. 7. Male Nurse's Space for Attribute

## Difference in Consultants' Salience for Terms

Differences in the importance of terms to the consultants was determined through the order of terms given in response to the question "What do people who take care of other people do for them?" Table 1 lists the terms that were salient to each consultant.

	<u>Aide</u>	<u>Nurse</u>	<u>Family Member</u>	<u>Patient</u>
<b><u>Male</u></b>	Range of motion Keep comfortable Take 'em to bathrm See they get snacks Get 'em up & down Comb hair Put nail polish Get them a drink Make 'em feel at home Take to visit residents Be sure dry & clean Do extra things for 'em	Feed Protect Provide shelter Safe environment Preserve dignity Protect from illness " financial worry " from injury Aggression of others Prov. Social activities Relieve stress Give companionship	Dispense Medications Look aft. pts. welfare Notify of Activities Change their clothes See clothes changed Clean up their rooms Make their beds See that they're fed Change them See to bath Be there continuously Take course to learn	See to wants/needs Change my clothes Put to bed/get up Talk/joke with 'em Take to appoint. Helps serve tables Hand out the pills Take care of cuts Go to garden with 'em Pat ya Comb hair/Tie shoe Shop for ya
<b><u>Female</u></b>	Give 'em clean clothes Feed them Wash face & hands Take 'em to bathroom Comb their hair Put their glasses on Get their dentures Take 'em to breakfast Take 'em to activities Keep 'em clean/dry Provide good food Get them outside	Get 'em up Put to bed Feed them Dress them Give 'em baths Shave them Mouth care Socialize Take 'em to shop Check on them Listen to them Wash their face	Keep 'em dry Clean them Keep 'em well fed Pull up in chair Concentrate on person Do their laundry Bring em something Sing with 'em Give 'em b'day cards Bring a branch/leaves Take to see flowers Visit them	Keep house Change the beds Take to bathroom Sit up at night Treat 'em like friends Listen to ya Wipe your tears Say nice things to 'em Be considerate of me Visit them Bring treats to eat Answer the call light

Table 1. Salient Terms by Group and Gender



## The Serial Pile Sorts

The 8 primary consultants collectively contributed 187 terms and phrases for caring acts and dispositions. By counting synonyms for a single care term as one item, the list was reduced to 80 terms. The 80 terms and phrases were sorted by each consultant in response to the directive "Please place these cards in piles in any way that makes sense to you. Continue to make piles until there are no more piles to make." The trees depicting the categorization of terms by each consultant are presented in Appendix 2. One example is given in Figure 8. Here I summarize only the most pertinent findings from the serial pile sorts.

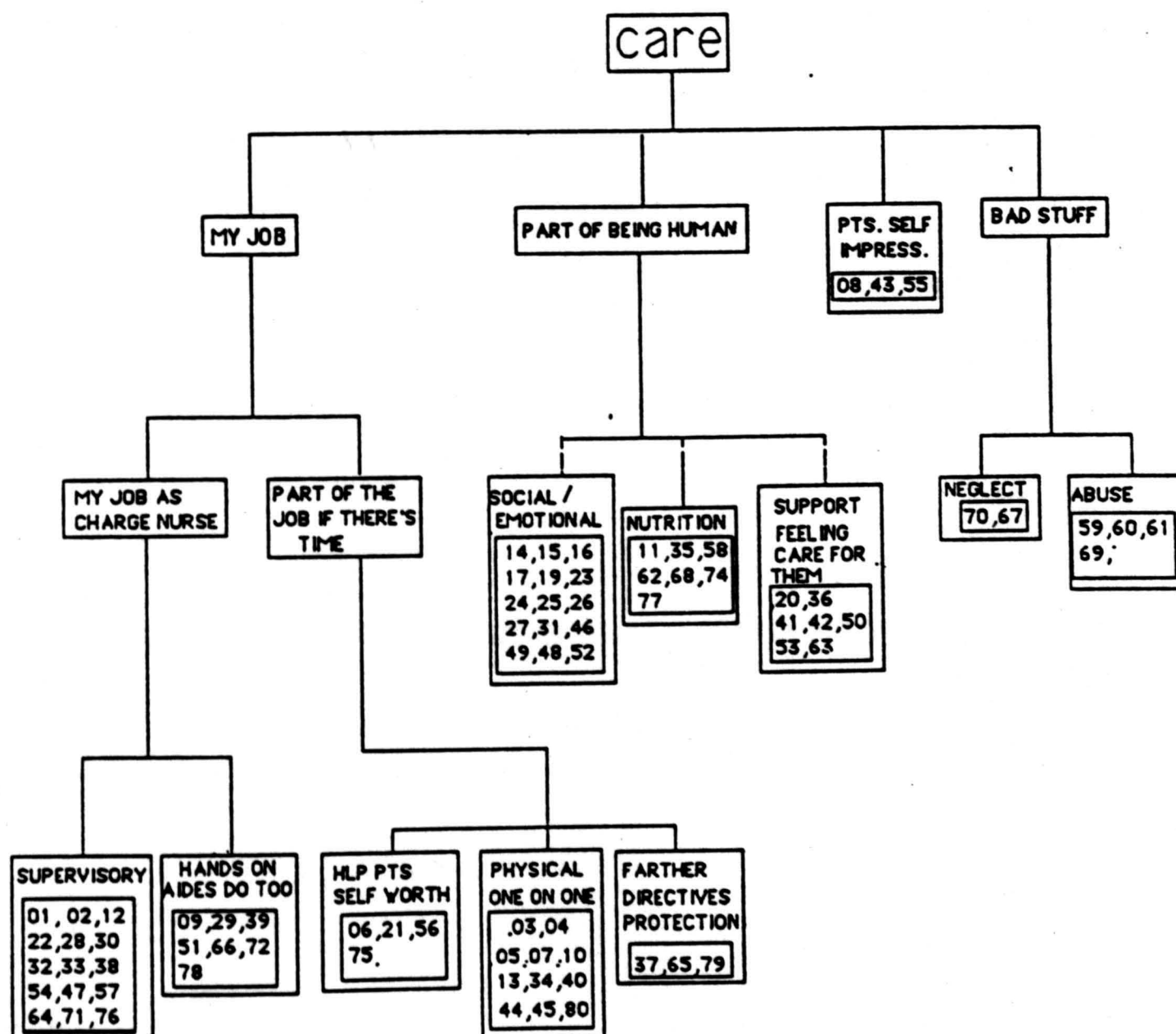


Fig. 8. Taxonomic Tree by Male Nurse

## Content Analysis of Interview Transcripts

### What is Care?

During the course of the interviews, consultants addressed the meaning of care and the activities involved in caring in many different ways. By analyzing the text of the interviews with consultants I sought to discover the various referents for the term "care," particularly using consultants' responses to the question: "What is care?" I also examined the answers to two other questions: "Considering someone who gives the best care, what makes their care so good?" "Considering someone who gives the worst care, what makes their care so bad?" First, I will discuss the different referents for good care and poor care. The answers to these questions provide some insights into the meanings of the dimensions of care and the similarities and differences among consultants' interpretations of care-giving activity.

### Characteristics of Good Care

The ability to give good care is considered by the medication and charge nurses to involve the emotional life of the individual. For care to be judged "good" it must be supported by motivations that are intrapersonal. Below are excerpts from the interviews demonstrating this fact.

I would say a special nursing assistant is the ones that give the best care, . . . It takes a lot to be one because they have to have a good caring personality to meet a lot of demands of residents and people that they take care of, . . . cause they're the ones that are with the patients.

J.D., Female Nurse

Here the nurse speaks of the nurses' aide as the one who gives the best care. To be "the best" she must show caring through her personality and meet the demands of the patients. The phrase, "meet the demands," is a statement that more is needed than the nurses' aide is able to give. A conflict is implied between the needs of the patient and the needs of the nurse. However, the nurse makes no reference to the context of employment. Rather she contextualizes care within the relationship between care-giver and care-receipient. The demand is from the patient, not the employer.

It's not just a job to them, it's more like, the people she takes care of are her family. They're very very close and dear to her. That's probably it, she deals with each patient as though they were a blood relative.

E.A. Male Nurse

In contrast, the male nurse begins his statement by linking care with work, by saying "It's not just a job," indicating that it is a job and more. The addition of familial affection as a requirement of the relationship between the nurse and the aide is evident in the phrase "they are very close and dear to her." For the care to be good, the affection must be real. Yet, while he speaks of real kinship, not by blood, but by intention, he returns to the mode of work saying "she must deal with each patient as though they were a blood relative."

. . . That's the only thing I can say, and I love em. I really love em.

E.D., Female Nurses' Aide

I love my job, I don't just like it, I love it, but its not really the job it's these people. You know my mother died when I was very young. I was only

eleven years old, I don't really remember her. I told J.Y. that she was like a second mother to me because she reminded me so much of my mother. J.Y. never forgot that. I really do care for these people.

B.S., Male Nurses' Aide

Again the contrast between male and female cognition is apparent. The female nurses' aide speaks of loving them and the male speaks of loving his job. The two nurses' aides both report genuine feelings of affection for the patients. In this case it is a matter not of having the right characteristics, the right personality, but of having a real affection, a bond.

When a person is sick [the nurse] has to listen to what the person is saying. [Caring is] not building up any hostility. Nurses should know that the patients don't know medical terms.

J.Y., Female Patient

[Care is] the love in her eyes. She treats you like a friend, she listens to ya. If ya cry, she wipes your tears and doesn't scold ya she goes right along with ya. They love me and I know it.

M.B., Female Patient

For the female patients, care is the expression of love, love in the eyes, listening. In the first example J.Y. describes one type of emotional work management of hostility. The second example describes the nurses' aide in terms of the emotional work required within the family schema. In the phrase, "if ya cry, she wipes your tears and doesn't scold ya," the care-giver performs two acts associated with mothering, wiping your tears and refraining from scolding. The next phrase may qualify the previous one. "Go along with ya" in the next phrase is ambiguous. It might mean that the nurses' aide is emotionally

connected, which is demonstrated by the expression of empathy, in which case the power inequity implied in the expression of being mothered in the previous statement is neutralized. Alternatively "going along with ya" may mean going along with what the patient wants to do. In the latter case, the patient implies that the expected behavior in the relationship would be not to "go along with ya"; the power remains unequal. It is the genuine love in the relationship between herself and the nurses' aide that both gives satisfaction to the relationship and at the same time places her in the position of the child.

For M.B., the entire discourse on the characteristics of good care lies within the realm of emotional care. A second view demonstrates an orientation to the tasks of care-giving. In this case, the focus of good care is on the work itself. Some of the consultants, namely all except the female patient, the male patient and the male family member, mentioned both emotional care and instrumental care as essential to good care. The female patient mentioned only emotional care, while the male patient and family member spoke only of instrumental care. There are two ways in which performance of instrumental care tasks is measured and found to be good. The first is when the care-giver excels by doing essential required care in such a way that it produces a positive, observable affective response in the patient. The second is by exceeding the demands of the job, by doing "little extra" things that are not part of the formal responsibilities of the job.

Once they get past all the normal washing the faces and hands making sure they're clean and dry and combed and dressed, the patients have smiles on their faces or will verbalize extra and not a frown or a scared look in their eye. A smiling or a happy resident, you can tell, is one that is getting good care from their aides.

J.D., Female Nurse



If something's wrong she observes for any changes and not just physical condition but mental changes, or change in appetite. She takes the time to dress them so that they have their dignity.

She wants to be proud of her work. Her patients reflect it.

E.A., Male Nurse

In the first example, the nurse refers to the basic personal care tasks, typical care, normal care. To be good care, the care-giver must do more than this. He or she must produce in the patient the expression of positive emotions -- the patient's affective expression of satisfaction: a smile on the face, more talk than usual; and the absence of negative ones -- the absence of displeasure: without a frown or a scared look in their eyes.

The next line recalls a training class in any service industry: "a smiling or a happy resident, you can tell, is one that is getting good care from their aides." The customer's satisfaction becomes the measure of performance.

I keep my residents clean, I feed my residents as I would want to myself. I try to dress 'em properly, I see that their clothes is not too warm or too hot for the weather. I see that they is warm when it's cold. I see they also have covers. I try to give 'em their showers when they want em. If they don't I'm not going to force em. I try to do my best to do what I can for 'em (so) that they'll appreciate me for it and want more from me. I say the best care I can give to 'em is doing to the best of my ability the care I can give 'em. and hope they like it. and know what I'm tryin' to do to help 'em.

E.D., Female Nurses' Aide

They'll go out of their way to help people. Miss their fifteen minute breaks to do extra things for people. One woman brings finger nail polish and does her finger nails. If we get caught up on our work (we can pretty well handle it, the right three). There's a time lapse after we get them all to bed, 'til we make our final rounds 'til we go home at night, they're not sitting up in the utility room talking, they're not down in the dining room watching TV, they're doing the extras. . . there's a lot of people in there that's incontinent, . . if we go in these rooms, they going to smell this, and if we got fifteen minutes, we're up there moppin' rooms out. Wipin' bedside tables off, its amazing what a little Pinesol do to a room that doesn't smell good. Mopping the rooms that's not included in this personal care for the residents but it makes their life a lot more comfortable and bearable. . . . Some of the residents just give up. the guys I work with we try to give 'em a reason (to live).

#### B.S., Male Nurses' Aide

The two male consultants who have not been initiated into the female world through nurses training exhibit a different pattern from the previous consultants. Their examples demonstrate the absence of emotional care as essential to the domain. For them, it appears that only instrumental care is essential. This is the case in spite of the fact that one example is of a female family member giving care to her mother while the other is of a nurses' aide caring for a patient.

I don't know any one that has done anything special. I do know of a person, her mother is in a nursing home in another state she practically looks after her; just about all day and night, she is with her and sees that she is taken care of...she does her laundry, goes down at feeding time and makes sure that she is fed, usually does it herself, she'll be in there and they bring the food in to her. She takes care of changing her and seeing that she has a bath.

J.K., Male Family Member

Care means [people being] interested in taking care of ya, seeing to your wants, your needs, if ya need any change or anything like that they'll take care of ya, like that. Like changin' your clothes. The girl in the laundry, she brings your clothes up. I ask her to take clothes down to the laundry. Anything you want well shy you can get a hold of C.F., she's outside and she comes over here to work awhile. she gets stuff I want down town.

P.G., Male Patient

What is Poor Care?

### Characteristics of Neglect

The characteristics of the negation of care were sought in the consultants' responses to three questions: "Considering the worst care you know about, what makes the care so bad?", "What is abuse?" and "What is neglect?". With respect to bad care, the following are some relevant responses. The responses to this question demonstrated a similar pattern to

those of the questions about the "good care". One characteristic of bad or poor care, like good care, is its root in innate personal qualities. For example,

We're going back to the people that's hired, they're not always the most desirable people.

B.P., Female Family Member

The question must be asked, what constitutes desirable people. The answer to this question is embedded in the responses by the consultants. Three connotations of care as "work" are implied in text about the worst kind of care: failure to do the assigned tasks, failure to manage the frustration of the work, and being incompetent, i.e. not knowing how to do the work. Failure to do the Assigned Tasks. For the male nurses' aide the question about the worst care led immediately to a discussion of responsibilities of the job.

You know there are several kinds of abuse, you got people there they want to come in and do there eight hours which is quite possible, pick up their check every two weeks and go home. To me that's poor care. Not only are they not going to do anything extra for these people. they aren't even there to do the job to start with. The only thing they're interested in is coming and getting there job and going home. To me that's the worst kind of care: not doing your job to start with. . . and to me that is abuse of these people.

B.S., Male Nurses' Aide

This consultant uses the phrases "do their eight hours," and "not doing anything extra," and "not doing the job to start with" to describe the worst kind of care. He ends his description by equating the worst kind of care with abuse. There are two referents for the label "job" implied here. In the first case "not doing the job to start with" means coming to work and doing less than the assigned work. The job then, is equal to the assigned or mandated work. In the second case "getting the job" means coming to work and doing the minimum. So, "the job" can mean either to do what is assigned, or to do less than that which is assigned. In neither case does doing one's job mean doing more than that which is assigned. The consultant continues and clarifies one instance in which an individual might "get the job" but do less than the assigned work.

Neglect is not doing things at the time they're supposed to be done.

'I don't feel good tonight, I'll give so and so a shower tomorrow night' . . . these people have to have at least two showers a week, especially the ones that's incontinent all the time, so they got Monday and Friday showers, you don't feel like it on Monday, then your short on Tuesday, you don't have time to do it, how long will that person go without a shower? That's from Friday to Friday. That's, neglect, and that's one of the worst kinds because these people get rashes so bad.

B.S., Male Nurses' Aide.

"Not doing things at the time they're supposed to be done" is his example of not doing the assigned work. He attributes this breach of rule to omitting certain care tasks because "I don't feel good." The consequence, "these people get rashes so bad." is the indicator of the magnitude of the omission. It is "the worst kind of neglect."



The male and female nurses both limit "the worst care" to the minimum in the realm of assigned tasks. The "job" then is less than the assigned tasks.

Well those people are strictly here for the pay check. It's a factory job, everything is a big assembly line, they go in and they turn the patient, they go through the routine just go through the motions, its a set pattern, rarely do they talk to the patients going through the motions."

E.A., Male Nurse

The male nurse equates working "strictly for the paycheck" with doing only those routinized tasks that constitute the functional work mandated by the facility. He calls this "a factory job, [where] everything is a big assembly line. In fact, this accurately describes the major portion of the work of nurses' aides. This is "the routine" the aides must "go through." His objection is that they do not talk to the patients while they are "going through the motions." For the male nurse, doing only the mandated routine is equivalent to "the worst care."

While the male nurse describes the work of nurses' aides, the female nurse discusses the nurses' work. She describes this omission not in terms of its impact upon the patient, but its inconvenience to the other nurse. She includes failure to supervise the nurses' aides as "poor care."

Nurses that don't call the doctor when something first happens with a patient and they push it off onto another nurse or another shift to do instead of calling themselves. Nurses that just sit behind the desk and don't get up and see that their aides are doing their work.

J.D., Female Nurse

The nurses see the mandated workload as neglectful. They see that good care requires that the nurses' aides do more than their assigned tasks. For female nurse, nurses' and patient, and for the male nurse and patient, the absence of essential care is neglect. It is not doing those things which are needed by a patient for his or her safety and/or comfort. Below are examples of essential care:

They won't answer the lights, won't give em a bed pan, won't change their pads if they void in the pads, hates to get em up.

E.D., Female Nurses' Aide

Neglect would be like getting somebody up and not washing their face, not taking them to the bathroom, not dressing them properly, being sure they're shaved, not taking them to activities, letting a patient become socially isolated, not repositioning a patient just letting them sit, that's a fine line that could become abuse too."

J.D., Female Nurse

Leaving the patient wet and dirty for a prolonged period of time, longer than normal rounds are given, every two hours, knowingly. Not giving them oral care or hygiene of any type. A lot of things I gave under abuse are also neglect. Ignoring complaints of discomfort because they repeatedly make the same complaints, you think of the cry wolf syndrome because they repeatedly make the same complaints. You have a tendency to ignore it.

E.A., Male Nurse

Essential care consists of those tasks, primarily physical care tasks that need to be done every day, but are not done as part of the prescribed time sequenced set of tasks that constitute the routine on the morning and evening shifts. These acts are done when the patient acts as the stimulus by signaling that he or she has a need. Answer the call light, give 'em a bed pan, change their pads if they void in the pads, get 'em up (to go to the bathroom) are all acts initiated by a nurses' aide in response to a signal from the patient. Such signals include pushing the call light button, voiding in bed or in the chair, and asking to be taken to the bathroom. So, for the female nurses' aide, the "worst care" is not only an omission of the routine care, or of only doing the routine care tasks, but a failure to respond to a call for help from the patient.

The patient's concern is with the way care is given as well as whether that it is given. The female patient considers failing to answer the call light, as poor care. However, the next example is the only one in which the way in which a physical care task is performed is considered poor care. The patient did not complain that the nurses' aide failed to put her dentures in her mouth, rather that ne never "rinsed her mouth, or washed off her teeth [dentures].

Not answering the call light. . .

This morning I had a man. he never even rinsed my mouth or washed the teeth off.

M.B., Female Patient

Not taking care of 'em. Not changing the bed when he had to have it changed. Not giving him what he wants and things like that. We have a good chance for it there in our room. The old boy in the first bed as you go in on the corner on the left. He lain in that bed all the time. If ya want to neglect him. why just don't wait on him. And Mr. Swift in the back bed. If

they tell him to shut up, that would be neglect. Hawkins is the man, the first man, and he is bed-ridden, he can't walk and he can't talk. And they have to take care of him and feed him by tube all the time.  
And they change him every so often -- roll him over in the bed, oil him and everything. Neglect would be letting him go.

P.G., Male Patient

The male patient describes "the worst care" in terms of the most disabled patients. Rather than referring to himself whom, he has stated, is "better off than most" he looks at the plight of the other men in his room. Like the male nurses' aide's reference to the patients who get rashes from missing showers, the result designates the care as poor. In this case it is the severity of a patient's condition that is used to designate "the worst care." The implication might be here that the worst care is that which could produce the worst results. In the case of the patient that is unable to do anything for himself, failing to "wait on him" is a life threatening situation. So the worst care is produced when the patient's condition renders the consequences dire, and the failure to act on the part of the nurses' aide brings about the situation in which those consequences occur.

Failure to Manage the Frustrations of the Work. A number of consultants described instances when nurses' aides attempted to repress patient's calls for help by using intimidating language and tone of voice.

People with a sharp tone of voice, someone that becomes angry very quickly about anything a resident asks them to do, or they get mad because a resident has an accident on themselves and they get mad because they have to clean it up.

J.D., Female Nurse

He's smart acting to 'em. He told one resident to stay on the pan all night, that he wasn't giving it to her again. I'd say that was bad wouldn't you? He definitely was abusive at times ... he's argumentative, makes 'em cry. He got to cussing over there. O.E. is a cousin to him, she said she asked him for a bed pan one night and he slapped her.

E.D., Female Nurses' Aide

Quit your hollering or I'm going to stuff a wash rag in your mouth. You know that's not actually physical abuse but it's personal abuse. Ignoring somebody that needs help, that's personal abuse.

B.S., Male Nurses' Aide

These instances describe situations in which care is supposed to be given in response to a signal from the patient rather than performing the prescribed routines. The attempt here on the part of the staff is to prevent or to restrict the signal from being given. It is often in these cases that patients are called "spoiled, attention-seeking, and demanding." These occurrences happen in cases in which a relationship has not been established between the nurses' aide and the patient.

Family members characterizations of poor care also have to do with the relationship between neglect, abuse and the responsibilities of care beyond the prescribed routines. They are situations in which the patient has signaled a need and the response is either delayed or not given.

I think it would be terrible for someone that didn't have control over their bowels or their kidneys to be left any 'length of time at all. I've heard them say. You just wait until such and such a time and I'll change your



pants. I don't like to see old people or people that can't sit up straight all slumped over and asleep in their chairs. You know they are hurting and I don't know, but I don't think that should be.

B.P., Female Family Member

Well one thing, I don't think is just right is when the residents, they know that there's things that the residents dislike, and they keep feeding it to em anyway. Also, when one of the residents has problems like diabetic problems with their feet, or legs get to bothering 'em. I think they should be checked on daily, instead, what happens is that mostly, when one of the family members comes over here and notices it, and its been brought to their attention then they'll come in and check it. I think a lot of the patients' cleanliness is neglected. I know they say they're scheduled for baths twice a week, but I don't believe they're always given. . . changing their clothes, helping to feed them. . . not helping them from one place to the other.

J.K., Male Family Member

Leaving the patient wet and dirty for a prolonged period of time, longer than normal rounds are given, every two hours, knowingly. Not giving them oral care or hygiene of any type. A lot of things I have under abuse are also neglect. Ignoring complaints of discomfort because they repeatedly make the same complaints, you think of the cry wolf syndrome because they repeatedly make the same complaints; You have a tendency to ignore it.

E.A., Male Nurse

Not answering their lights, that's one of the main things they always go through in any question. Not changing 'em, not keeping 'em clean and dry. not feedin' 'em properly. Not giving them their showers properly, (not) looking for their glasses and stuff to put on 'em.

J.D., Female Nurses' Aide

### Characteristics of Abuse

Abuse is considered either active physical or verbal attack only, or is inclusive of both poor care and neglect as indicated in the previous section. The following are examples of the first category.

Well, setting me down on the commode too hard. it didn't fit my seater too good. It isn't like when you're at home. You can't wipe, old crippled hands.

M.B., Female Patient

I've heard of people getting slapped, I don't know if its, you know, hearsay. I have heard also of people talking to the patients at night when they were upset and in pain or whatever and calling em names. Like I say this is from patients. . . And makin' 'em so scared to even sleep. And I really and truly bet that does happen.

B.P., Female Family Member

Maybe even worse than rough treatment is rough talk. . . jerking a patient, like that, grab 'em by the arm and maybe grip too light or that way would hurt em or bruise em. Naturally slapping the patient or shove 'em.

J.K., Male Family Member

Striking a resident, not checking their restraints frequently enough is Physical abuse. Mental abuse would be, "I'm going to tell your family that you're doing this all the time." Just harassing the patient even though they may not be able to control their own behavior.

J.D., Female Nurse

Not giving medical assistance when its needed, that's more neglect than abuse but sometimes its abusive. Talking loudly, striking or swearing at a resident, handling a patient roughly when you're transferring him. Giving them something that's too hot. Leaving them exposed: not pulling the privacy curtain, not closing the door. . . anytime you aren't preserving their dignity that's abuse.

E.A., Male Nurse

### Exemplars of Care and Neglect

Evidence for the various referents for the terms care, good care and poor care have been presented. For some consultants, care is distinguished from good care. In this case good care is equivalent to doing more than one's job. It includes either doing, the emotional work of treating the patients like friends or family or doing little extra things for them. Good care may include both emotional care and non-essential instrumental care. In this

case, the unmarked case, "care", refers to ordinary care, routine care, that which is expected and part of one's work. Care and good care are complementary and united under the covert category, good care, and opposed to poor care.

Poor care is parallel to good care. It has two components: abuse and neglect. Poor Care can be the absence of care, or it can be the absence of good care. In the first case, the individual simply doesn't do the job required, either because he or she doesn't know how to do it, or because of the absence of the right kind of personality or moral character, innate qualities. In this case, good care is above and beyond what is thought to be the essential care, or the basic care required by the job. This differentiation is illustrated in Figure 9.

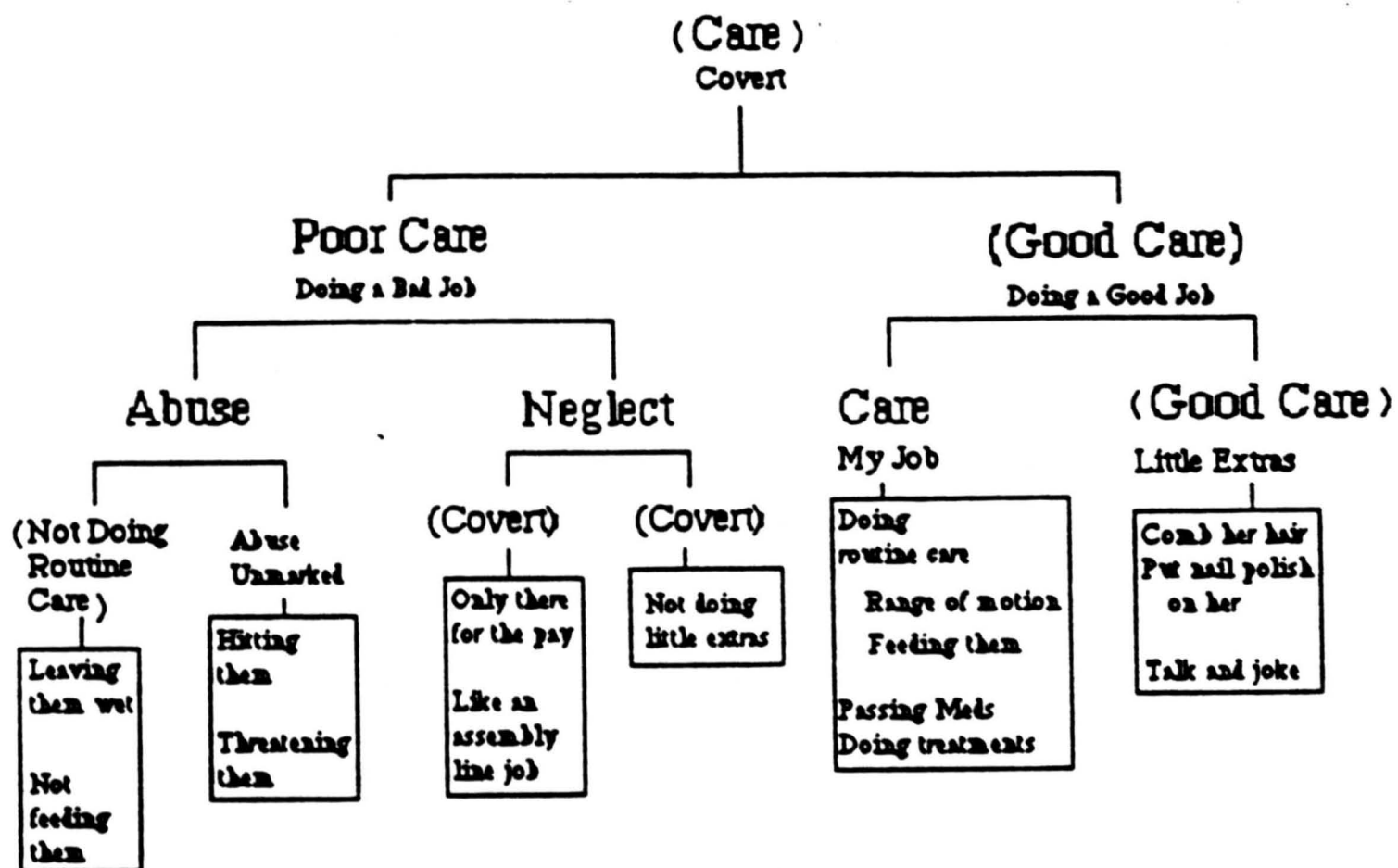


Fig. 9 "Male" Model of Care

In the second model, care and good care are co-extensive and are in opposition to neglect which is synonymous with poor care. There is not a distinction made between degrees of goodness of care. All care is considered good, essential; none is extraneous. In this model, care is either done or not done. Emotional care, essential and non-essential instrumental care are all part of the category: care. In this case, care is opposed to neglect or poor care which are often synonymous. Failure to manage one's emotions, to control one's anger, to speak gently are failures to care. Care is not discussed in terms of one's job requirements, rather in terms of the patient's needs within the relationship between care-giver and care-receipient.

In this model, treating them like family is an essential member of the category care, as are helping them to eat and putting their glasses on. This model is pictured in figure 10.

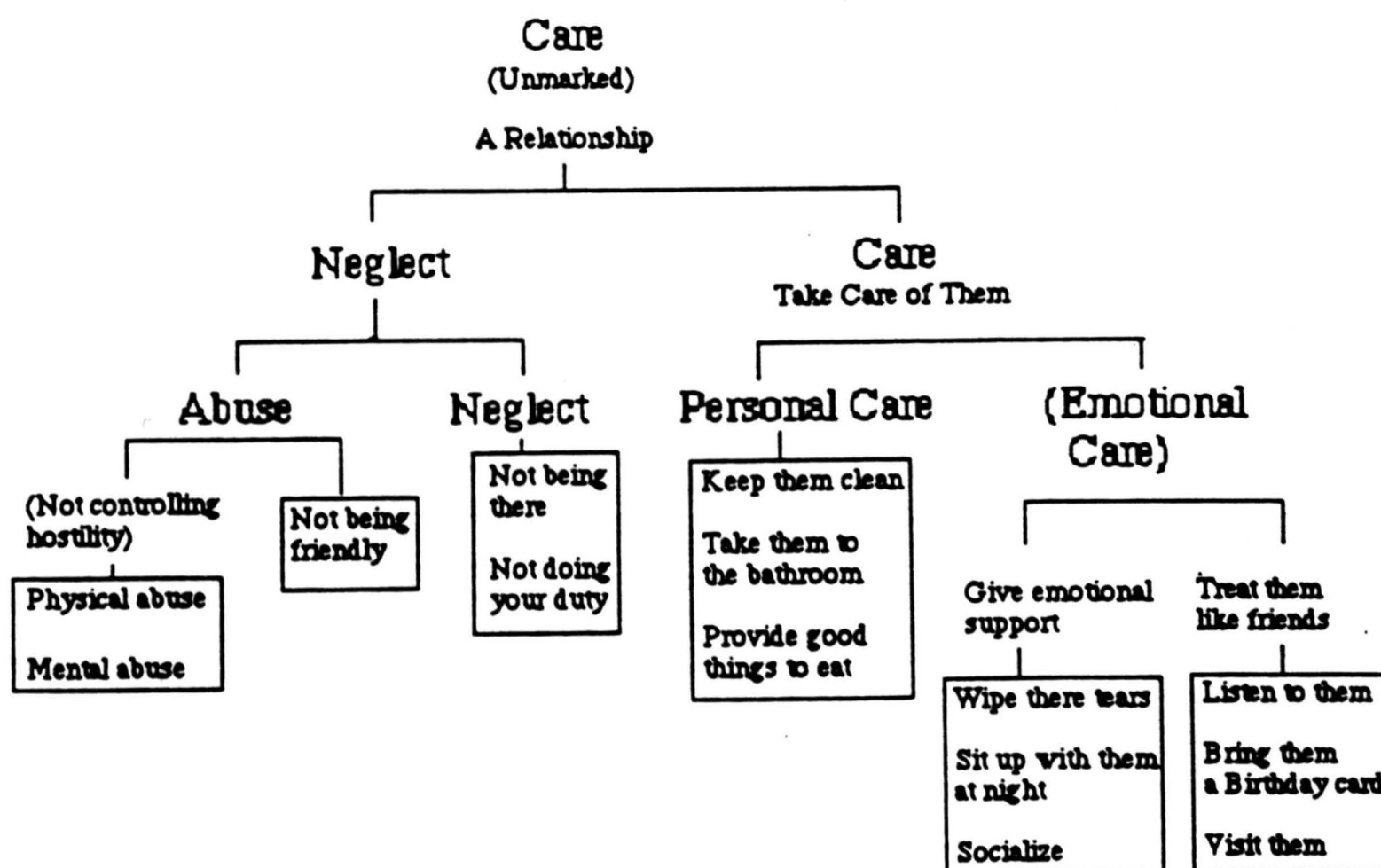


Fig. 10 "Female" Model of Care



## Gender Differences in the Referents for Care

There seems to be a loose correlation between gender and particular referents for care. The two consultants, the male nurse and the nurses' aide were more likely to distinguish between essential care and "little extras": things which one needed to do and things that were nice to do. The male patient and family members, who had not been initiated into the nurses' model, excluded emotional care from the category non-essential care acts. Further, males tended to define care as a protective function.

Care means to protect, to watch or look over, to preserve, maintain  
... life, everything associated with being alive.

E.A., Male Nurse

That would be like, how the home would look after their patients,  
and how the nurses take care of them, see to their needs and things like  
that...look after the welfare of the patient.

J.K., Male Family Member

Females consider care to be the totality of what one does for another. Their sense of caring is that of nurturance, of tending to the needs of the other. For them, there is no distinction between essential care and non-essential. All parts of the domain are essential. Their definition was all inclusive. Nothing was excluded. Emotional works, such as to smile when you feel tired or to manage the frustrations of care-giving, are expressed in terms of the relationship with the patient, rather than from the perspective of an occupation.

Evidence for the various referents for the terms care, good care and poor care have been presented. For some consultants, care is distinguished from good care. In this case

good care is equivalent to doing more than one's job. It includes either doing, the emotional work of treating the patients like friends or family, or doing little extra things for them. Good care may include both emotional care and non-essential instrumental care. In this case, "care", the unmarked case, refers to ordinary care, routine care, that which is expected and part of one's work. Care and good care are complementary and united under a covert category and opposed to poor care.

### Extension of the Model of Care

In the third phase of the study, I sought confirmation that this model was present in care participants in other nursing homes than the one in which the study was originally conducted. Forty-four questionnaires were collected from four other nursing homes. These questionnaires were combined with the data from the first trial using the sixteen consultants from Twin Oaks for a total of 60 respondents. This data was run using INDSCAL. Again the RSQ. (0.99) indicating that the model accounted for 99% of the variance in the data set. The stress was 0.10. The overall importance of each of the two dimensions was 0.49. The model derived from the tertiary consultants' responses is almost identical to that of the secondary consultants.

### Summary

Two models of nursing home care have been explicated from the primary consultants at Twin Oaks nursing home. In the First model, care is the domain label and good care and poor care are two sub-categories of care. Good care is defined by the presence or absence

of the categories of care: emotional care, non-essential instrumental care and essential instrumental care, that is, routine or ordinary care. Poor care consists of two categories of care: abuse and neglect. The relationship between the two is variously construed by different consultants but the absence of emotional care, non-essential care, and essential care are associated with neglect. Abuse can be the absence of essential care and the failure to manage one's emotions leading to the physical threat or physically harming the person through rough handling or physically striking the individual. The harm deriving from lack of care is associated with the plight of the most vulnerable and most dependent patients. The absence of emotional care even though it does not lead to physically or psychologically abusing the patient, as well as failure to provide non-essential care is considered to be poor care. This model of care assumes care to be the essential work expected of the nurse or nurses' aide. Good care is not-part of the "real work" but must be done to avoid abusing or neglecting the patient.

The second model appears to place nursing home care in the domain of human interaction. In this case, care is opposed to abuse. Care is like family care but is done within the nursing home context. The three subcategories of care -- emotional care, non-essential instrumental care, and essential instrumental care -- are all essential parts of care. Care is not seen as a job; rather it is a role-identified set of tasks. The role identification is that of nurse or mother. These two models roughly seen to represent male and female models of care. They are not the property of any particular consultants, or categories of consultants. Rather they are two models that are used by consultants at different times although one seems often to be in the discourse of the male consultants and the other in the discourse of the female consultants. The interpretations of the models take on different forms in the talk of the various categories of consultants. The different interpretations of these models and their potential for generating conflict will be presented in Chapter six.

## CHAPTER SIX

### SUMMARY AND CONCLUSION

#### Introduction

In this chapter I frame my study of nursing home patients', family members', and nursing staff members' cognitive models of care in the larger task of investigating social discourse (Scherzer 1987, Geertz 1974) and relating it to the analysis of care in nursing homes more generally. What follows is a summary of the study: the statement of the problem, purpose and need for the study, the method and the findings of the study. I present the cultural models of care and their specific variants expressed in the talk of participants in care-giving and receiving within the nursing home context. Next I discuss the cultural models of care in relation to a critical examination of the organization of care in nursing homes. I explain the home/hospital dimension of care from my study in relation to the commercialization of domestic work and the commercialization of emotional labor. Then I discuss the specialization of care dimension in light of the historical development of the functional organization of care in hospitals. I end the discussion with the question: Is there a goodness of fit between expert nurses' educated in a structural model of care, and care participants' cultural models of care? I conclude the chapter by discussing the limitations of the study and the goals for further research.

## Review of the Study of Care

### Statement of the Problem

The nursing home has become the last home for the aged. One out of five adults over the age of 65 will be in a nursing home sometime in his or her life (Harrington, Newcomer and Estes 1985). Early in my fieldwork it became evident that the conflicting values and expectations among the nurses, their aides, patients and their family members resulted from their differential experiencing of time, place, and person and the constraint placed upon that experience by the organization of the workload. The fast-paced yet routine nature of nursing home work stands in stark contrast to the slow-paced empty waiting of nursing home life.

Studies of patients' and nurses' attitudes towards care corroborate these observations (Brown 1986, Drew 1986, Mayer 1986, Swanson-Kauffman 1986, Kitson 1987, Rieman 1987, Cronin and Harrison 1988, Hernandez 1988, and Benner and Wrubel 1989) For example, Swanson -Kauffman (1986) found five kinds of caring wanted by women who had suffered miscarriages: knowing that the woman's loss is unique to her as a person, being with the woman in an engaged manner, doing for the woman by providing comfort and support, enabling the woman to grieve for the loss, and maintaining the belief that the woman could bear a child. Reiman (1987) asked patients to identify non-caring interactions with nurses. Non-caring was defined by the patients as not being present with the patient, and as being there only to get the job done. Patients said they felt dehumanized, devalued, angry, and fearful when nursing care was hurried and distant. Drew (1986) interviewed 35 hospitalized adults to better understand the phenomenon of patients' experiences with caregivers. The exclusion and confirmation were two kinds of experiences that the patients



described and named. Exclusion occurred when the care-givers exhibited what was described as a lack of emotional warmth, the patients descriptors included starchy, cold stiff, mechanical, indifferent, bored, impatient, irritated, flip, close-minded, superior, disinterested, insensitive and preoccupied. They described the facial expressions of these care-givers as "dead pan" or "like a robot" they felt that they were "just another job on a list of things to be done."

In the experience of confirmation care-givers were described as "wanting to be there," "caring what happens," "liking their work," and "having personality." They described actions indicating a desire to understand the patient, for example, using phrases like "he leaned forward" and "I could see in her eyes she wanted to understand what I was trying to say."

### Need for the Study

Studies such as these have been used in nursing to make a case for the primacy of emotional caring and empathy in the nurses' interactions with patients (Benner 1989, Rawnsley 1990). All of the above studies have been conducted with patients who were either in hospitals or receiving nursing care at home. In these settings patients receiving care either from registered nurses or licensed practical nurses were studied. Little research of this nature has been done in nursing homes where the primary care providers are nurses' aides. One study (O'Brien 1989) simultaneously studied patients, family members nurses' aides and nurses' perceptions or attitudes.

O'Brien examined the social system within the institution in an attempt to understand whether a nursing home is a home, an institution or an amalgam of the two (1989: 3). Her study "identifies and describes the attitudinal and behavioral patterns operating in the adaptation and care of the institutionalized elderly" (1989, xxi). The study is organized around two foci, the residents, family members, medical and nursing care-givers, and ancillary care providers who the author argues are the key actors in the social system; and the stages of adaptation to nursing home life: admission, early adaptation and long-term adaptation to the home.

The primary strength of this study is the systematic interviewing methods used to collect data from staff members, and from both cognitively impaired and cognitively intact residents. No interviews were conducted with family members. However, in addition to interviews conducted with nursing staff and patients, these two groups were also systematically observed. The main problem with O'Brien's study is a common one that occurs when nurses import methods from other disciplines into the discipline of nursing, namely that even as the method is utilized, the original theoretical basis for the methodology is lost. Thus, in this case, a thorough and precise method of data collection is used to conduct a study which merely describes in detail the organization of care, O'Brien fails to interpret her findings in light of her original question.

Most of the work on nursing homes has taken place within the traditions of social gerontology, and anthropology. Two studies, Gubrium (1975) and O'Brien (1989) just discussed, employed social systems analysis as a means of interpreting their findings. Gubrium (1975) analyzed the social organization of care in a single nursing home. He focused on the accomplishment of care in a nursing home by the people who participate in its every day life. This study promised to be an explication of care, instead it led to a description of the processes by which care is carried out. The meaning of care was defined as "whatever the participants consider to be part of life in a nursing home as distinguished

from life in other places" (1975, ii). Just what these participants conceived of as care was never elaborated.

Diamond (1986) reports in his critical ethnography on the work of nurses' aides and the lives of patients inside nursing homes. He studied the creation of the nursing home industry as it is perceived by the nursing assistants most of whom in his study, are female and black. O'Brien and Diamond both explored the trajectory of the nursing home resident. Diamond examined the economic course that ends in poverty and terminal placement in a nursing home that accepts patients on the public dole. O'Brien examined the process of adaptation to nursing home life from admission to death.

Three anthropologists, Henry (1963), Kayser-Jones (1981), and Shield (1988), explored the role of care in the culture of nursing home life. Henry's early observational work was a study of three nursing homes in the United States and an attempt to discover why the nursing care in nursing homes was so poor.

Kayser-Jones, (1981) expanded the work of Gubrium to a comparative analysis of the social organization of two nursing homes, a state-supported home in Scotland and a proprietary home in the United States. Her purpose was to investigate criteria for quality care for the institutionalized elderly and to discover what institutional arrangements would encourage the maintenance of high standards of care. Her work is informed by two models of behavior, the social and economic processes that move within the two institutions and the processual or interactional analysis of the interpersonal transactions that occur between the patients and staff. Kayser-Jones found exchange theory to be useful in explaining the interactions among nursing staff and residents.

The most recent account of nursing home life is Shield's (1988) Uneasy Endings: Daily Life in an American Nursing Home. Shield's analysis of the ingredients of the "uneasy life" in one nursing home, is to my knowledge the only study other than the one reported here to attempt to uncover the cultural beliefs of nursing home residents about

nursing home care. She advances three explanations of the residents' uneasiness and supports them with observations and excerpts from interviews.

### Ethnographic Methods

In this research I explored the meaning of care through three ethnographic methods: participant observation, interpretation of natural language texts and ethnosemantic analysis. The goal of the research was to establish a theory that grew from and was informed by the practice of participants in nursing home life and work. By observing the day-to-day giving and receiving of care, evidence was sought for differential interpretations of care by participants. Interview texts were examined for overt and covert categories of care and indications of the underlying structure of care. A listing task asked the question, "What do people who take care of other people do for them?" A sorting task looked for salient attributes of care through the identification of similarities and differences among types of care acts. A frames questionnaire was designed in which information learned through the sorting task was cast as questions that were asked about a sample of the care terms given as responses to the listing task. This questionnaire was distributed to two additional groups of consultants to test the stability and generalizability of the model. A multidimensional scaling analysis of responses to the frames questionnaire provided a spatial representation of these terms and their attributes by which individual variants of the structure of care could be identified.

## Results

### The Cultural Models of Care

In the previous chapter, I presented two gender-related models of care. The first, a model found primarily in the language of men, is a model in which care viewed as being of two types: either as an occupation or as a favor, and in which only technical and personal care are considered members of the occupational care category. Care done as a favor is beyond one's duty. Emotional care is part of this category of care as a favor and excluded from care as an occupation.

The second, a model evident primarily from the language of women, is one in which emotional, personal and technical care are all members of a category of care as a matter of duty and devotion derived from the relationship to one's patients or family members. Two dimensions of care emerged from the data and are present in both models of care. The first, home-hospital dimension contains within it the dichotomy between emotional and instrumental care. The second, the specialization of knowledge dimension is a continuum of the relative knowledge expected to be required to perform various care tasks. These labels are not those of the consultants; they are descriptions of the dimensions which exist outside the awareness of the consultants.

Care terms were arranged in three clusters situated in the space within these dimensions: affective care, personal care, and technical/medical care. The attributes of care were also arranged in three clusters: Personal interaction as a context for care, Need for assistance, and Training as a requirement for doing a particular care task. Care requiring little knowledge was distinguished from care requiring specialized knowledge especially for those terms and attributes related to the personal care required by people needing assistance. The relevant schema in which care terms and attributes are contextualized are family care and nursing care. Family care includes emotional and personal care. But is believed by most consultants to require no training. Nursing care is viewed differentially by



men and women. For women, all of care is nursing care. For men, it includes some aspects of personal care and the technical/medical cluster. Technical/medical care requires training according to their position on the second axis.

Within the nursing home environment, those acts of emotional caring, such as, hugging patients, listening to their troubles and helping them figure things out are part of the nurses' aides' care. In the model, the nurses' aides were positioned closest to family members as care givers. In other words, their position in the model, and therefore the care they would be expected to give, is more closely allied with that of the family members. Thus, for them, the emotional and personal care are the essence of their care-giving. Women considered these to be equally central to their duties, while men thought that the personal care was central to the work and emotional care was done as a favor. However, the male patient and male family member, did not mention emotional care in relation to the work of nurses' aides. It can be argued that these two men may best typified a "pure" male viewpoint since they have not been socialized through nursing training. In their model, emotional care was excluded from the work of seeing to the patients' needs.

Although consultants recognized emotional care as an essential component of the schema family care, the emotional care practices were not included by consultants in the category of things done by family members of nursing home patients. According to the sorting task results, only doing the laundry was actually said to be done by family members who visit. Emotional care practices appear to be things that would occur in the idealized family. Generally, the care by family members was not considered to be an important component of care within the day to day traffic in the nursing home.

Similarly, the term "nurse" appeared in the region of bedridden patient, and at the upper limit of the specialization of knowledge dimension. It appeared from the representation that the term "nurse" was closely associated with the work of caring for the disabled although in actual practice of the "nurse" hands out the pills, takes care of their

cuts and bruises and oversees the work of the nurses' aides. Therefore the link between the nurse and the personal care of the disabled can be assumed to be a statement of the "ideal" situation in which the "nurse" is actually caring for the bedridden patient rather than a representation of the actual reality within the nursing home structure.

When the representations of the different categories of consultants are examined separately, they reveal separate but similar schematic explanations for care in the model. Three separate sources, the interview texts, the free listing task, and the responses to the questionnaire all demonstrated the different meanings associated with care. The differences among the various connotations of care hinge upon the position of emotional caring in relation to the care-providers and the care recipients.

#### Patients and Nurses' Aides Models of Care.

The importance of the two dimensions varied among the groups of consultants. The patients and nurses' aides found the specialized knowledge dimension to be more important than the home/hospital dimension. For the patients and nurses aides, work and life merge. To the patients, the nurses' aides are their life. I was told this repeatedly. What the patients need from the nurses' aides is everything: see to my wants and needs, change my clothes, put me to bed/get me up, keep house, change the bed, sit up at night with me, treat me like a friend, wipe my tears, say nice things to me.

For the nurses' aides, the emotional care acts are used to describe the best care they give. The work is thereby transformed into family-like care. In the case of males, emotional care is given gratis therein lies its value. For females, it is essential to the caring relationship and therein lies its value. The familial nature of caring for patients creates a bond between the patients and the nurses' aides. Feeling needed, essentially and irreplaceably needed is what many aides report keeps them coming to work each day. In other cases, since emotional care is not prescribed, it is not always given: here the family

care schema works against the patients. In the absence of a strong positive affiliation between patient and nurses' aide, the schema of family care links the dependent patients with the child.

So, one hears in a nursing home phrases like, "Oh, she is so spoiled," "She's always trying to get attention; "You just have to ignore her." " The tragedy here is that the some of the patients are left without care, because caring for those who cannot respond is drudgery; it is not satisfying. Such care is not infused with affection or understanding that is afforded some, feelings that can bring to the patient's side a warm touch and a gracious voice. Having been the sorry recipients of a denuded and deskilled version of the craft that once was the mark of the nurse, the aides are left with care tasks to do for patients they are untrained to understand in any scientific way. In order to make sense out of patients' incomprehensible behaviors, the nurses' aides readily interpret patients' behavior the way they interpreted their own children's behavior. However, good or bad might have been their experience with child rearing, it is from that source that their beliefs about caring have been drawn. It is in this context that we must understand the notion of infantilization that Kayser-Jones (1981) reported. Whereas a less disabled adult may resemble a young child in the view of the nurses' aides, the more incapacitated a patient becomes, the more he or she resembles a dependent infant. So the double-edged sword is that while acting as if they were members of the patients' family makes the aides work tolerable, it allows them to explain away and ignore some patients' futile attempts to communicate. This belief by the aides robs the patients of being understood fully as persons.

#### Nurses' Models of Care.

he nurses' model demonstrated that the specialization of knowledge dimension was of great importance to nurses, while the home/hospital dimension was of little importance. The model of the female nurses was most like that of the expert nurses' description at the

end of this chapter. The listing task demonstrated that protecting the patient from harm, including physical harm and emotional harm, was most salient to the male nurse, while assisting patients with personal care and emotional support were most important to the female nurse. Neither nurse included technical/medical care tasks in the list of most salient terms. Both nurses gave care by nurses' aides in their examples of best care. So even to the nurses, personal care for bedridden patients is the referent for nursing care.

#### Family Members' Model of Care.

The family members' interpretations of the group space were closest to the modal configuration for all consultants. The family members, themselves, also expressed some ambiguity about the categories along the home/hospital dimension. However, for them there was one salient domain, nursing care. Nursing care was the work done by nursing staff members for which the family members paid dearly. The role the family members performed was not part of that work. While the family members acknowledged the affection that some of the staff exhibited towards the patients, it was not a salient part of the staff member's work role. The contribution of family members to the overall care of the patients was generally unrecognized by any consultants. The family members expressed the most concern that the work-related care was being done, that patients were being fed, that they were taken to the bathroom, and that they were not mistreated.

The primacy of nursing care is evident from observing the salient terms contributed by family members to the model: Dispense medications, look after patients welfare, notify them of activities and change their clothes, keep them clean and dry, keep them well fed, and concentrate on the person are the most salient terms for the family members.



## Critical Interpretations of the Models of Care

The nature of social conflict surrounding these dimensions is of critical importance in understanding the differing interpretations of the care model. Previous investigations of nursing home life and work have sought to explain various aspects of care. The five ethnographic studies of nursing homes examined above discussed beliefs and attitudes towards care uncovered by participant observation and/or interviews. Two aspects are particularly relevant to this study: they are dependency and affiliation.

### Dependency and the Functional Organization of Nursing Home Care

Dependent care is that which is required for the survival of a disabled person, or a child whose abilities are not yet developed. This category was associated in the consultants' model with nursing and paralleled the specialization of knowledge. The care of disabled persons requires more specialized knowledge and the care of able persons requires more general knowledge. Aspects of dependent care are also included in the idealized familial model of care although they are not thought to be done for patients by family members. Dependent care includes tasks which are needed by everyone as well as those which were only needed by those who would not have been able to perform them for themselves. Within the context of nursing homes, these personal care tasks are primarily functional; they must be done swiftly and mastered in order to be certified as nurses' aides. Gubrium (1975) referred to this work that as "body work" and reported that is shunned by those who seek additional training or education in nursing. This work is the remnant of an archaic division of labor that is still in evidence in nursing homes today. The process by



which this "body work" became divorced from the craft of nursing as it was performed by visiting nurses in the first half of this century is described here. In The Physician's Hand: Work Culture and Conflict in American Nursing, Melosh (1982) puts forth the following description of the creation of the current organization of hospital nursing. The formal organization of nursing care in nursing homes nationally is based upon efficiency studies done in the 1930's. Prior to this time nurses worked independently outside the hospital. Student nurses staffed hospitals and remained within the hospital walls for two of three years. The move from student staffs to graduate nurses led hospitals and nursing leaders alike to move toward "scientific management to improve nurses' working conditions and to enhance their authority" (1982, 174).

Time-motion studies were done that attempted to pare down hundreds of procedures to their essential components and then base staffing upon these standardized procedures. Although these time studies proved impractical, the principles of scientific management spread through the hospitals of the United States. Hospital nurses were experiencing "speed-up." The requirement to do more with less time. The introduction of auxiliary workers (nurses' aides) into the workforce was another outcome of the efficiency movement in industry. Hospitals were no exception. Originally the auxiliary workers were to work under the guidance of the professional nurses. Indeed, this is the expectation under the law today within the nursing home industry. However, no professional nurse is present on the units when the nurses' aides are performing their duties.

The rigid hospital routines described at Twin Oaks, the early hour of rising, the set times for meals, the large patient assignment and lack of attention to patients quality of life are the product of the efficiency movement and the deskilling that occurred when the nurses' work was divided up so that some of it could be delegated to unskilled personnel (Melosh 1982).

The present system described in the study of Twin Oaks is a product of the denuding and deskilling of the act of caring, in the name of higher productivity and efficiency. It is this "factory model", where each nurses' aide is responsible for "turning out" between eight and nineteen well dressed patients by mid-morning, or put to bed between 13 and 25 patients in the evening, and toilet and medicate half the wing on the night shift, that is the backdrop against which the beliefs about nursing expressed by the consultants must be examined. Within the nursing home setting degree of dependency translates into classification of patients. In the previously cited two studies, this classification determined where in the institution the client would live. In Gubrium's study, all occupants of the nursing home are called clients. They are of two salient categories to floor staff and patients. The "residents" are those who need only supervision and minimal assistance with personal care. They live on the first floor and can leave the facility at will. The label "patient" is reserved for those clients who have medical problems requiring treatments by licensed nurses, and more extensive assistance with their personal care.

In the O'Brien study, all clients were segregated into different floors. All carried the label "resident." Residents were housed on separate floors depending upon the nature and degree of their dependency. Those who required little intervention by the nursing staff members lived on the first floor. Those with extensive personal care needs but few medical (skilled nursing) requirements on the second and fourth. Residents with cognitive deficiencies on the third floor, and those with extensive medical problems and physical disabilities on the fifth.

Shield's study finds residents who are "self-care" housed in a separate but connected building. The floor upon which her study is conducted houses "heavy" patients, those requiring extensive intervention on the part of the nursing staff. The other floors house patients requiring lesser degrees of assistance.

The part of Kayser-Jones (1981) study conducted in the United States was done at a facility having only patients requiring medical (skilled nursing). In order to compare these

five facilities in terms of the degree of the dependency of the study subjects, I will refer to the legal definitions of levels of care common within the United States. These definitions are not particularly salient to floor staff and residents, but allow for cross-facility comparisons. Residential or domiciliary care refers to the care provided patients on the first floors of the facilities in Gubrium's and O'Brien's studies and in the self-care unit of Shield's facility. This level of care was absent from Kayser-Jones' study and mine. Intermediate care refers to patients requiring all various levels of assistance with personal care but no skilled nursing care. This level of care was present in all facilities. At Twin Oaks and the other studies, all of which are outside the state of California, except Kayser-Jones, skilled care refers to those patients who are eligible to have skilled nursing care paid for through the national Medicare Insurance Program. In the state of California, where Kayser-Jones facility is located, most facilities are skilled nursing facilities. Some patients who would be labeled as intermediate care patients in the rest of the country are housed in the facility with patients requiring higher levels of personal care assistance as well as skilled nursing care. While some of these skilled care patients are Medicare reimbursable, others are not. At Twin Oaks intermediate care patients are separated from skilled care patients who are housed on a single wing.

The functional model of nursing utilized by hospitals and nursing homes is made to fit well with the medical explanation of illness. Patients go to the hospital to get treatment and prevent accidental death, while in reality it is the loss of ability to care for self which requires hospitalization.

Nursing homes, are long-stay hospitals -- long term care facilities. It is attributes and rules contained within the merger of the functional model of nursing and the medical model of illness that govern the actions of the nurses' and the nurses' aides.

It is this routine care that consultants mean by the phrase, "He only does his job." Yet

surrounding this assembly line approach to care, life unfolds minute by minute, hour by hour, day by day.

### Affiliation and The Commercialization of Domestic Work

Affiliation is the degree of connectedness the patients and nursing staff members feel toward each other. Evidence for the differential affiliation between nurses' aides and some patients was found in all five ethnographic studies of nursing homes. All studies reported aides' preferences for certain patients. Diamond reports that one nurses' aide expressed this with the phrase, "Some patient's shit don't stink." Some patients' reports the "Girls seem to like them." (1983: 36.) . Although this was an important feature of each report, it was not linked to the differential affect of the patient group membership, relational patients versus those unable to relate, upon access to the care provided and to the quality of their lives.

At Twin Oaks, it became evident that the patients who are well liked by the staff are often those who are able to engage the staff members and therefore receive care or good care. Virtually all of the patients who can get around by themselves and who can engage the staff members and other patients share a higher quality of life and satisfaction. Those patients who are minimally dependent upon the staff, and who can engage the staff members, share more in common with those patients who are independent of staff intervention for their participation in nursing home life than they do with other dependent patients who are unable to engage the staff members in satisfying relationships. These patients are absent from skilled nursing facilities and their absence is notable. The fact that Kayser-Jones found little interaction among patients in the facility she studied is undoubtedly related to the greater degree of frailty and disability in her population. I, too,



found in the skilled nursing facilities of California a deficit in the social interactions among the patients.

#### Care: Occupation or Relationship.

Within the feminist literature, the nature of caring work has been a topic of debate (Moore, 1988). What people consider work is influenced by their cultural attitudes and by the class, status, and gendered positions they hold in a society. Only recently has the debate included the possibility that different members of society may hold differing beliefs about the relative importance of different kinds of work. My study demonstrates such a difference of viewpoint based upon gender about the nature of care.

The dominant feature of work within Western culture is that its prestige is related to the fact that it is paid for. One's job or occupation is that which one is paid to do. This belief seems to be prevalent among male interpretations of the model of care. For the three males in the study, excluding the male patient, the first dimension represents a non-work/work dichotomy. For them, emotional care tasks were not considered work and were seen as non-essential, or gratuitous. Personal care and technical/medical care were considered essential to one's occupational role as nurse.

The female consultants, however, made no distinction between the centrality of the three types of care to the care-giving process, all three were essential and required. Care was part of the relationship. In fact, the female patient attributing the emotional domain to herself, identified a desire and a duty she felt to treat the nurses' aides with kindness, to limit her demands upon them, and to thank them for their kindness to her even when performed in the line of duty. It is evident from the pile sorting task that the distinction among the categories distributed along home/hospital dimension vary between the male and female consultants. For the female consultants family care and dependent care were not distinguished by the work vs. non-work dichotomy as it appeared to be for the men. For



the women, the provision of continuous care to dependents and competent adults alike has been the lot of women.

Traditionally women have been the primary care givers in the home and in the community. Indeed nursing is and was part of woman's work; Florence Nightingale's Notes on Nursing begins with the statement, "Every woman is a nurse" (Nightingale, 1852, 1). Reverby (1987) describes care in the role socialization of Victorian Women. Rather than consider the distinction between family care and dependent care to be one of work vs. not work, for the women in the study, it was for them a matter of role: the role of mother and the role of spouse. The care-giver role within the home and the nurse providing of care informally for friends and neighbors and formally for patients is a relationship. All these roles are roles requiring duty and devotion, sometimes the work is drudgery, at other times it is rewarding. It is woman's work, the caring for friends and family.

#### Emotional Labor.

Hochschild (1983) in her classic work, The Managed Heart identifies a construct akin to the emotional care component in the model. Emotional labor she describes as "a distinctly patterned yet invisible emotional system -- a system comprised of individual acts of 'emotion work,' social 'feeling rules,' and a great variety of exchanges between people in private and public life" (1983: 156). Hochschild argues that men's work and women's work require the accomplishment of emotion work in different ways. Her study of bill collectors and flight stewardesses investigated the general differences between the two. She leaves for others the task of exploring men and women working in non-traditional occupations.

Emotional labor, she says, originates in the domestic realms. Taught as part of early gendered and class influenced socialization, it is inculcated into the socially-constructed self. Hochschild argues that when these socially and class-influenced constellations of behavior and feelings that constitute the modes of social interaction are transmuted into job

expectation then they become commercialized. They become part of the service that is being bought and sold.

I find this to be a useful model for understanding the variant expressions of the role of emotional care in the consultant's models. For women the bestowal of a kiss or a hug may be freely given, it is often required both inside and outside the family. The requirement for affection was evident in E.D.'s account of the patients response when she neglected to treat the patients in a particular room with her usual warmth because she was tired. They wondered what was the matter, whether she was angry at them. E.D.'s regret was that she couldn't be there for them all of the time because she was too tired.

Men who engage in the work of women must also deal with these cultural attitudes towards the work. Within Twin Oaks, the men who became my consultants as well as those who did not, were on the whole more marginal to the dominant cultural stream than were the women. Some of the male consultants, had dealt with the cultural attitudes by avoiding "women's" work. For example, a male nurses' aide who had become a medication technician who told me that he probably would be of little help to me because now he was a nurse and did the more technical work and didn't do the aides' (translated women's) work any more. Other male nurses' aides embraced the female aspects of the work and actively rejecting the dominant cultural messages. One male nurses' aide had been a medic and actively drank prior to coming to work each day. He had "been to the bottom" and back again and had been liminalized by the passage. To him roles and stereotypes weren't important. What was important was his relationship to these patients. One consultant dropped out of the study to do time in jail, two others were painters who were out of work and needed the money but quickly returned to their former occupations when circumstances permitted. Another was educationally disadvantaged and was exceptionally caring, and quite feminine in his appearance and behavior.

I mention these men not because I have negative perceptions of them but because I perceived that they were all in positions in their lives that marginalized them and allowed them to reject the dominant cultural male stereotypes of appropriate work for men. In this way they were able to deal with a nontraditional male role. The men in this study dealt the requirement to give affection freely by excluding it from their conceptualization of the job. The men spoke of these familial care acts as "little extras," and "things I do because I am a human being."

The implication here is that they are not required by the job -- that they are over and above one's duty or obligation. They are not part of the male expectation of emotion management. For Hochschild males are expected to express and control anger and threat of violence. These are the emotional requirements in many traditionally male jobs -- bill collecting being the example she investigated. Among the consultants at Twin Oaks, management of anger was required of everyone, particularly males. To engage in expressions of anger toward patients are instances of patient abuse. For women, the unsolicited bestowal of affection has always been part of ones' duty or obligation. It is not part of being human, it is part of being a woman at least in Western cultures. Hochschild claims that managing emotions is part of the middle-class work behavior, but not of the blue-collar and unskilled workers. She identifies prostitution 'maid work' as exceptions. The work of nurses' aides, one of the largest populations of women in traditionally female dominated occupations, is excluded from her formulation of the problem. However, nursing too is women's work, not just because it is usually been done by women, but because nursing shares the characteristics presented above with the work of women in the home. The performance and maintenance of the activities of daily living, and the management of the emotional tone of social relations, and the unsolicited bestowal of affection are intrinsic to domestic work as well as nursing.

But nursing requires other emotion management than that associated with social relations. Wolf (1989) argues that nurses stand between two distinct cultural categories: the "clean:" clothing, bathing and feeding patients, and the "dirty:" touching bodily excrements; the "sacred", attending to the person, and the "profane" touching and dealing with the naked body. Each of these associations with the extremes of the culture evokes its own set of emotions. These emotions, especially in reaction to cultural taboos, must be managed to allow one to carry out the work of nursing.

Emotional work of caring performed in the nursing home setting is problematic in a way that it is not in the roles described by Hochschild. The recipients of care are dependent upon emotional care in ways not experienced by the airline travelers. Hochschild speaks of the signal function of emotional expression. To the nursing home patient, the expression of affection signals the existence of family care in the relationship between nurses' aide and patient. It means that the patient can rely on a nurses' aide that is likely to be available and willing to help her. The absence of the signal means that family care is absent, and he or she is slated to become one of those unfortunate individuals lining the corridors and without being recognized. I extend this argument to suggest that affection is not just an added 'little extra', it is a necessary component of care as the system is currently structured. Indeed the presence of a negative signal, a harsh word, or a slap is cause for great fear not simply the threat of inconvenience.

### Payment for Care

The failure of women to see care as an occupation explains nurses' discomfort with connecting caring and money. Duffy (1986) in her response to Ward's (1986) article on women, gender, and work, argues that nurses, including the nurse leaders of the profession in the past, have eschewed involvement with the financial aspects of their nursing activities. Accepting money for caring work is in conflict with the cultural value system with regard to the free giving of care. The acceptance of payment for caring services



taints the value of the work. The work then, is not freely given. Those who become prostitutes, or who do "menial" work, for wages must deal with these prevailing cultural attitudes. My experiences with the nurses' aides was that both males and females, all of whom badly needed a second job or overtime work, accepted the overtime work because the patient's needed them, and were uncomfortable telling me that they needed the additional money. When I inquired as to why they accepted the overtime work when they were so tired, I was either told, "no one could pay me enough to do this work."

### **Fit Between Self-Care Theory and the Cultural Models of Care**

Numerous nursing theories, most at the descriptive stage, attempt to capture the interaction between nurse and patient, providing nurses with an overriding cognitive model to direct their course of action. One such theory, the Self-Care Deficit Theory of Nursing (Orem 1991) seems particularly suited to address the problems of nursing home care presented in this paper. This theory has as its proper object, the patient, in his or her role as principal actor in the provision of care to self. In other words, the patient as he or she lives out the experience of attending to his or her personal needs is the central focus. The role of the nurse is substitutive. Whenever the patient is limited in the care of self, the nurse assesses the need for assistance, reflects the observation back to the patient, and negotiates with the patient to provide the supplemental assistance needed. The areas of need addressed by the theory are in concert with the consultant's model of care. The individuals day to day experiences: eating, drinking, breathing, eliminating urine and feces, managing the balance between rest and activity, and the balance between solitude and social interaction, preventing hazards and maintaining normalcy, encompass all of the dependent care activities present in the model, as well as providing clarity for those with ambiguous



positions, such as offering them a drink or washing their face and hands. Both of these acts are essential to patients who are dependent upon others to monitor their needs.

Activities related to changes in health state, such as taking medication, using assistive devices and making and keeping appointments with health providers are also included in both the self care model and the consultants' model. Nursing actions are prescribed and calculated on the basis of the difference between the patient's ability to care for self and the requisite needs he or she has relative to health state, age and stage of development and sociocultural factors which may influence one's performance of self-care actions. By using this theory, a nurse in collaboration with the patient or patient's family member is able to address the 24 hour lived experience of caring for self in any environment. Once calculated, the patient's needs can be addressed by either family or nursing care givers.

No nursing home staff can replace the continuity and stability provided by family and friends in regular contact with the patient, provided an amicable relationship exists and that friends and family are properly oriented to their role in caring for and visiting their loved one. It is equally true that the system of continuous care required by nursing home residents is not affordable without supplementation by volunteers. This fact is obscured by the growing profit margin seen in the for-profit nursing home system which currently provides for most housing of the institutionalized elderly. But a nursing model alone will not create the familial environment so essential for the patients' security and safety.

The acceptance of a nursing model is hindered by the absence of competition within the nursing home industry. The combined lobbying efforts of the American Medical Association and the nursing home industry have kept nursing salaries in nursing homes far below those of hospital - based nurses. The current establishment of priorities has left women as the unpaid as well as the low paid providers of care to the dependent members of the community.

I must argue that the under-utilization of registered nurses educated in the assessment, planning and organization of care to nursing home patients as well as the relative obscurity of nursing theory over the competing and well established medical model are some of the factors which perpetuate the current system. The failure to pay a living wage to care-givers is a result of the failure to recognize the level of skill and education required to interpret, assess, plan, assemble needed materials, and execute a continuous nurturant and supportive environment matched to a patients' fluctuating and variable individual capability and disposition to engage in the process of caring for themselves.

## Conclusions

### Directions for Future Study

Some systems being designed today -- data management systems and educational systems -- are also based also upon the functional organization of care of patients and their needs. Information is needed which will allow for the creation of organizational structures that can which will support life, love and friendship and not simply strive to prevent accidental death. The patient's experience of long term care is continuous, and the major part of this experience takes place in the vast expanses of time in between the medicalized events: receiving medications, taking treatments, eating, being taken to the bathroom, baths and showers. This time, for those who are dependent upon others to initiate, decide for or assist them with anything they need or want to do, is a vast wasteland of boredom and monotony, aggravation and for some pain and withdrawal.

Nursing staff members are needed who can bring the hands of two old friends together, who can repeat the inaudible words -- to facilitate without monopolizing the meetings of frail old friends. Systems are needed that can create a small scale space of

beauty and warmth, to be experienced by those whose world is only a fraction of the size of our own.

In the experience of illness, distress states can persist with or without a name and may be beyond the physician's power to cure. The degree of difficulty or discomfort caused by the distress state is also important to the patient and causes worry whether or not it is important to the physician's diagnosis and treatment of the patient's chief complaint. Many distress states such as sore heels at night, itching skin, runny nose or wanting to be with a friend, have little bearing on anything of consequence to the identified mission of the corporation. Often the facility has no remedy to cure such conditions because under usual circumstances they would be treated with an over-the-counter or a home remedy. Comfort measures, home remedies and over-the-counter topical remedies are not suggested by the nurse because they fall outside the realm of medical treatment. Systems are needed that can allow for the management of distress as a life event rather than a medicalized event.

Understanding the relationship between nurses' aides and patients with low interaction and communication skills can be modeled using expert systems. The recognized distinction between care needed by the sick and care needed by all humans in the patients' and nurses' aides' version had more saliency than the amount of training thought to be required for acts of care. This is borne out by the interview texts, by the sorting tasks and by the observations. The acuity system used by the hospital to assign the needed number of nursing staff members, nurses' aides and patients is irrelevant to the present level of allowable needs which the facility is willing to meet. The consultants identified three salient patient attributes. First is an intact personality and ability to emotionally engage the nurses' aides. Questions about these specific categories would be indications for future research. Regardless of the degree of physical care they require, this facility permits the aides to include them among the reasons for coming to work. Engagement of nurses and patients was mentioned many times by both patients and nurses' aides.

Second is the patients' capability to provide for their own needs. In this facility, the ability to walk was required for the patients to independently go to the bathroom at will. For those who could not walk, the ability to move their own wheelchairs, and to ask the nurses' aides for assistance was critical to getting their needs met in a timely manner at least some of the time. Those who were unable to ask, and unable to move about were greatly affected by changes in staffing, shift changes, and variability in the commitment and ability among staff members.

These patients constitute the unmarked category of patients. The director of nurses called them the "foolers" when I described their condition to her. The rationale behind this label is that they fool the staff, not consciously but because their behavior is subject to interpretation and because the nurses' aides are ill-prepared to accurately pinpoint the strengths and limitations of their ability to meet their own needs. It is with this group that greatest need for advanced nursing knowledge lies. This fact was acknowledged by the aides. It was also evident from the observations of treatment of patients' changes in condition.

Third is the complete or near complete lack of capability to do for self. Patients who are bedridden and who are limited in their ability to communicate their needs are at the complete mercy of the nursing staff, specifically of the nurses' aides who are without supervision much of their working hours.

In the case of these patients, the quality of care they receive varies with the personal integrity and experience of the nurses' aides. For these patients, the inability of the facility to hire and retain qualified nursing personnel is a life threatening situation. The absence of qualified management level nursing staff on all shifts is a serious problem for patients and nurses' aides alike. The personnel presently holding the responsibility for supervision of the unit are the medication and charge nurses. They are Licensed Professional Nurses who have no management training as part of their nursing program, and Certified Medication



Technicians who are, with the exception of their course in the administration of medications, equal in preparation with the nurses' aides.

The nurses' aides spoke during their interviews of the need for information about the patients, which is not consistently given. They also spoke of "having had all the inservices that have ever been offered" and having "nothing new to learn." Supervision by the charge/med nurses is resisted by the nurses' aides who perceive them to know less about the individual patients than the aides themselves do. The facility administration and the corporation do not give priority to the need for well trained managers capable of motivating, assisting and supervising the nurses' aides or the staff, nor do they feel they have the resources to hire them.

Future study should examine what factors within the nursing home setting perpetuate the functional division of labor within the nursing home hierarchy and what changes would best allow the replacement of these systems with those that recognize the salient categories of patients and their needs for care. Rather than divide work into tasks which are supposed to require more or less mental capability to perform, an erroneous and incomprehensible way to the thinking for nurses' aides and patients alike, organizational systems can be created that reflect the focus and skill of both home care providers, and nursing care providers. Such systems would utilize fully responsible nurses to manage the care of patients whose needs make them too complicated for either family members to manage at home or for nurses' aides to manage within the hospital walls. Patients and nurses' aides could jointly make decisions about when they wish to rise in the morning and what they would wear. They could also negotiate when and what they would like to eat for breakfast chosen from a limited selection, provided the nurses' aides had the necessary information about the patient's condition and the patient's needs. In this way additional support staff could be assigned to assist disabled and cognitively impaired patients with meaningful activities throughout the day. Family members or friends would be intimately involved in



the social efforts of patients to contribute to their community, to help around the facility, or to manage their own laundry. Further nurse-specialists who are able to assess the capabilities and limitations of the those patients with high day to day variability in their self-care and health conditions would be seen and utilized in a consultant capacity consultation and give advice to the nursing staff about their care. The family members' role has been shown in this study to be critically important to the life, health and well-being of the patients. Family members would be well incorporated into the expected routine of patients. Patients with families would expect to retain an integral position within their family. Patients without families would be supported and encouraged to form new social units for mutual support and encouragement.

One drawback to the implementation of new programs is the expense. Modeling alternative systems of nursing care delivery through computerized models would allow for experimentation with various systems for the organization of care without the programs being aborted in real life. Expert system designs based upon this research are the next step in this project.

## **APPENDIX I**

### **THE LIST OF TERMS FOR CARE TASKS**

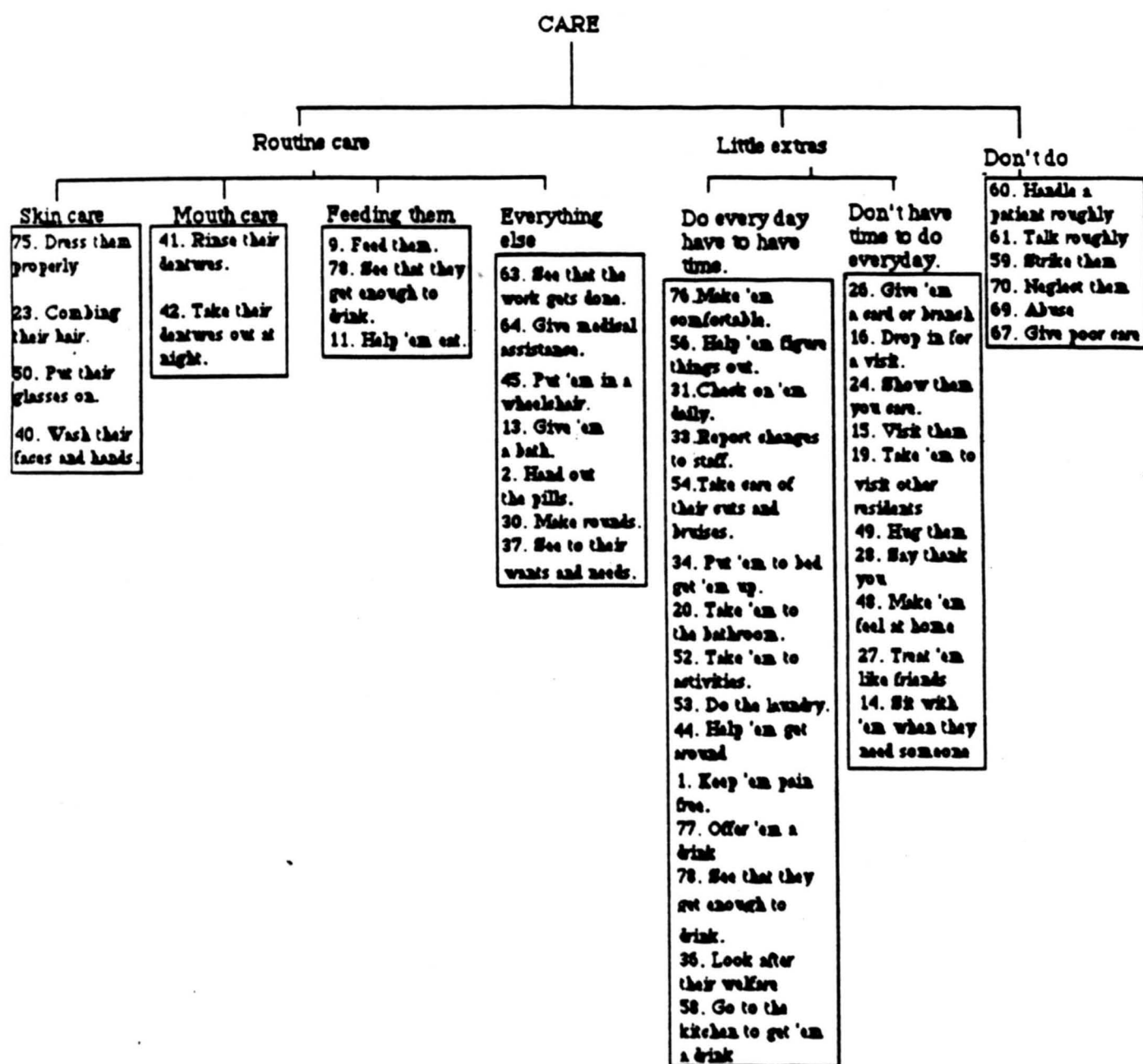
- |   |  |
|---|--|
| 01. Keeping them pain free as much as possible      | 21. Cleaning up their rooms and making their bed   |
| 02. Handing out the pills                           | 22. Listening to their pleas and troubles          |
| 03. Dressing them                                   | 23. Combing their hair                             |
| 04. Dressing them for warmth in the winter          | 24. Showing that you care                          |
| 05. Dress them for coolness in the summer           | 25. Saying nice things to them                     |
| 06. Giving them clean clothes                       | 26. Giving them a card, a branch or some flowers   |
| 07. Taking care of changing their clothes           | 27. Treating them like a friends                   |
| 08. Being clean and neat and wearing clothes nicely | 28. Always saying thank you when someone helps you |
| 09. Feeding them                                    | 29. Keeping them clean and dry                     |
| 10. Assisting in feeding them                       | 30. Making rounds                                  |
| 11. Helping them to eat                             | 31. Checking on them daily                         |
| 12. Seeing that they are fed                        | 32. Notifying a nurse of any changes               |
| 13. Giving them their baths or showers              | 33. Reporting any changes to the staff             |
| 14. Sitting up with them when they needed someone   | 34. Putting them to bed and getting them up        |
| 15. Visiting them                                   | 35. Doing what you can for them                    |
| 16. Dropping in when you have a spare moment        | 36. Looking after their welfare                    |
| 17. Talking with them when they're down             | 37. Seeing to their wants and needs                |
| 18. Giving them mouth care and personal hygiene     | 38. Seeing that the work gets done                 |
| 19. Taking them to visit other residents            | 39. Turning and positioning them                   |
| 20. Taking them to the bathroom                     | 40. Washing their face and hands                   |

41. Rinsing their dentures
42. Taking their dentures out at night
43. Trying to get around by yourself
44. Helping them to ambulate with a walker
45. Putting them in a wheel chair
46. Getting them out in the fresh air
47. Doing range of motion
48. Making them feel at home
49. Hugging them
50. Putting their glasses on each morning
51. Taking care of their skin
52. Taking part in all activities
53. Doing the laundry
54. Taking care of their bruises and cuts
55. Taking care of themselves
56. Helping them figure things out
57. Protecting them from accident and injury
58. Going to kitchen to get them a drink
59. Striking them
60. Handling a patient roughly when transferring them

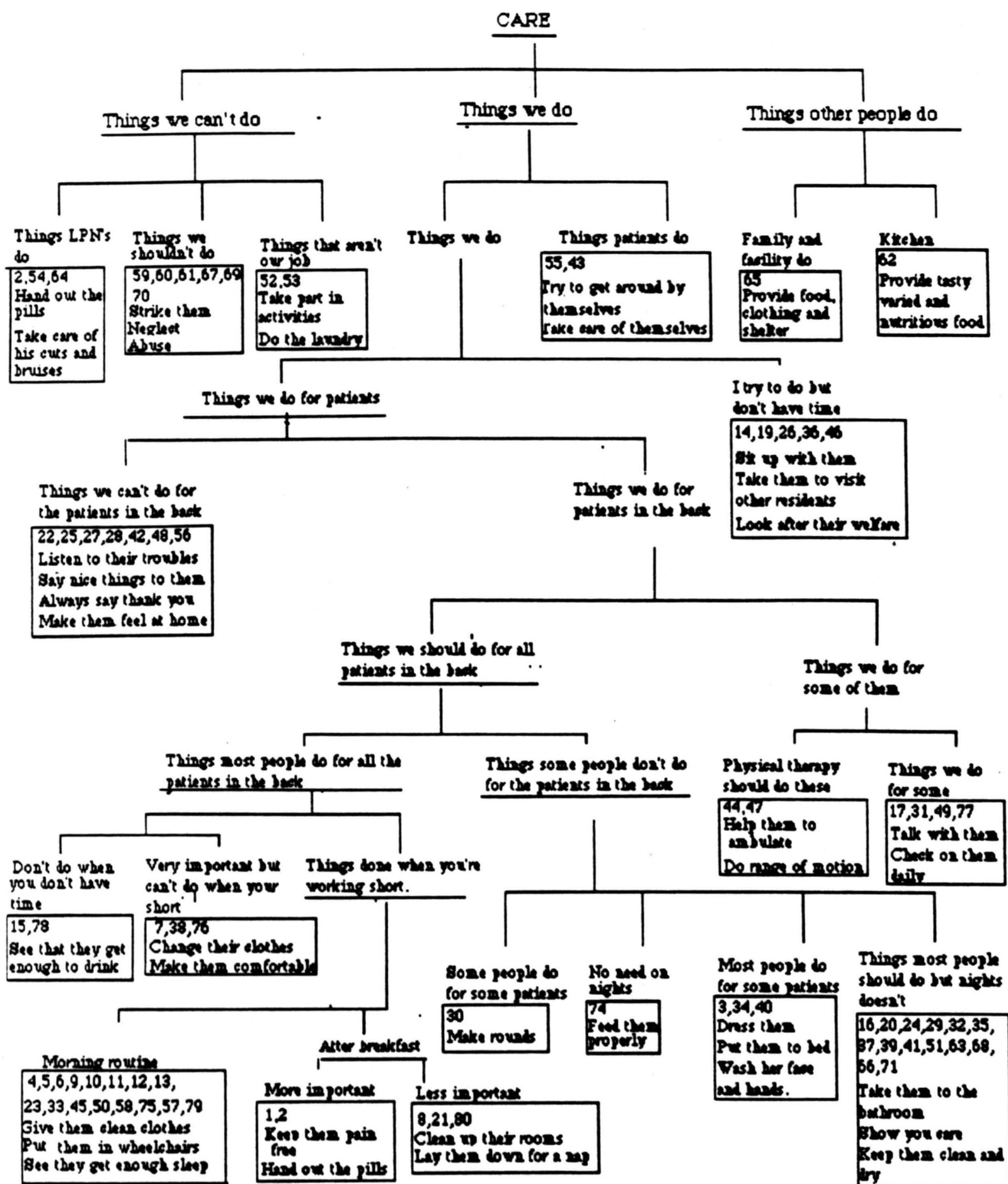
61. Talking roughly, telling them to shut up.
62. Providing tasty, varied and nutritious food
63. Answering the call light
64. Giving medical assistance when it is needed
65. Providing food, clothing, and shelter
66. Giving good care
67. Giving poor care
68. Giving proper care
69. Abusing
70. Neglecting
71. Checking restraints
72. Applying restraints
73. Talking down to a resident
74. Feeding them properly
75. Being sure they are properly dressed and groomed
76. Making them comfortable
77. Offering them a drink of water
78. Seeing that they get enough to drink
79. Seeing that they get enough sleep
80. Laying them down for a nap

# APPENDIX II

## TAXONOMIC TREES FOR PRIMARY CONSULTANTS



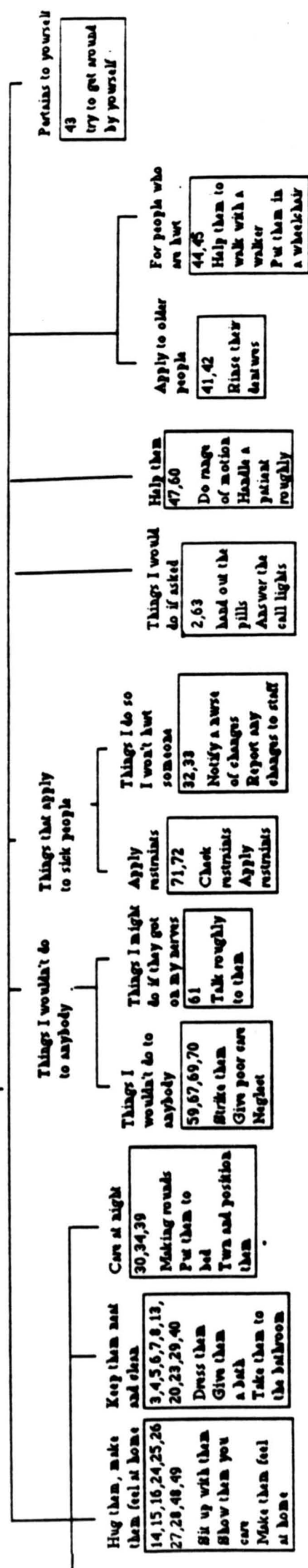
Male Nurses' Aide



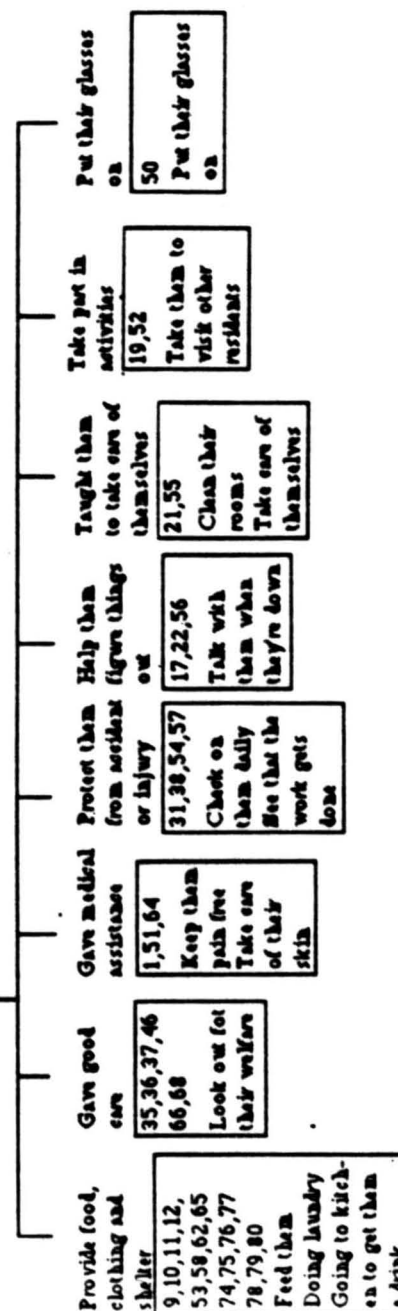
Female Nurses' Aide



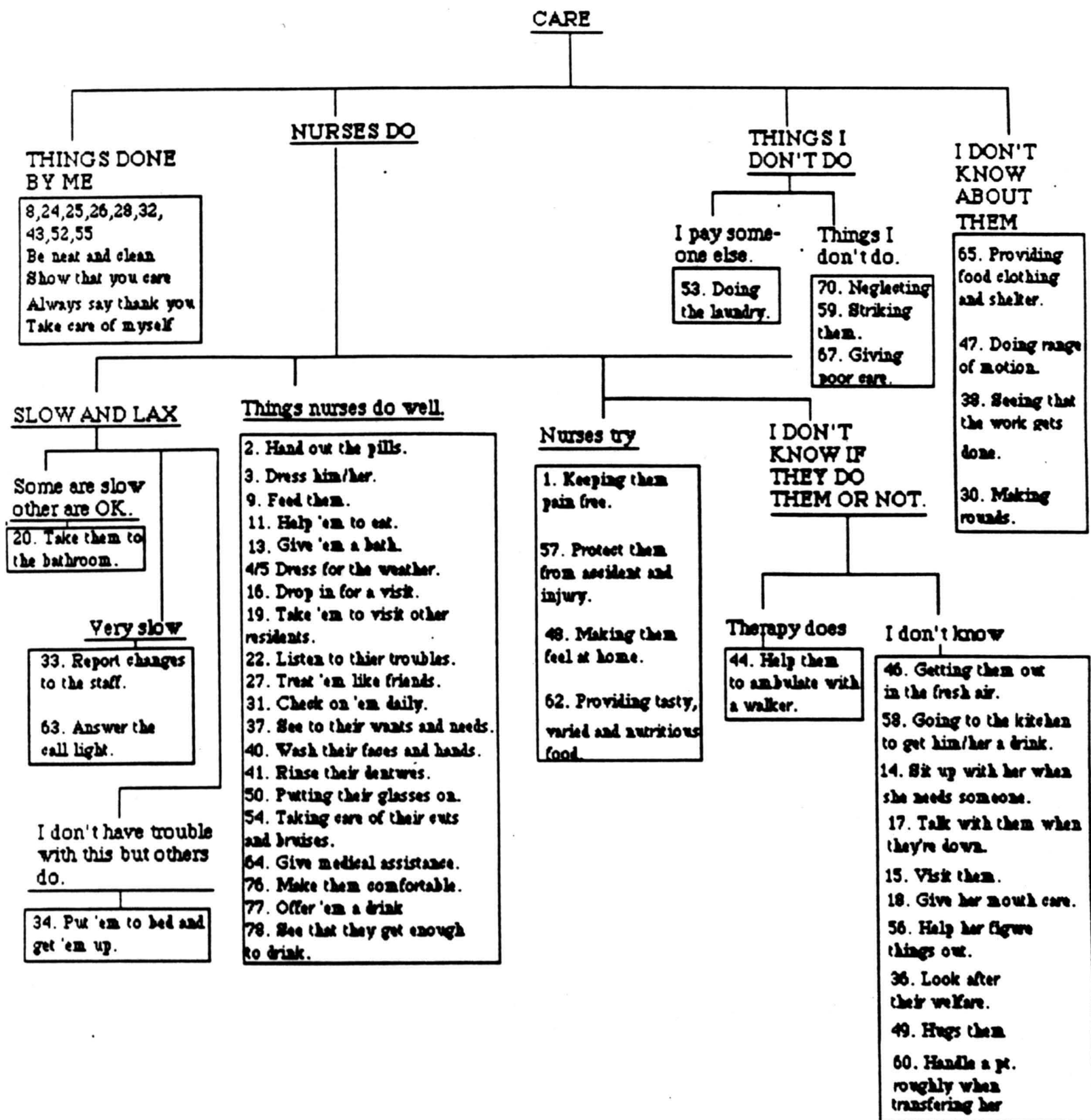
# CARE



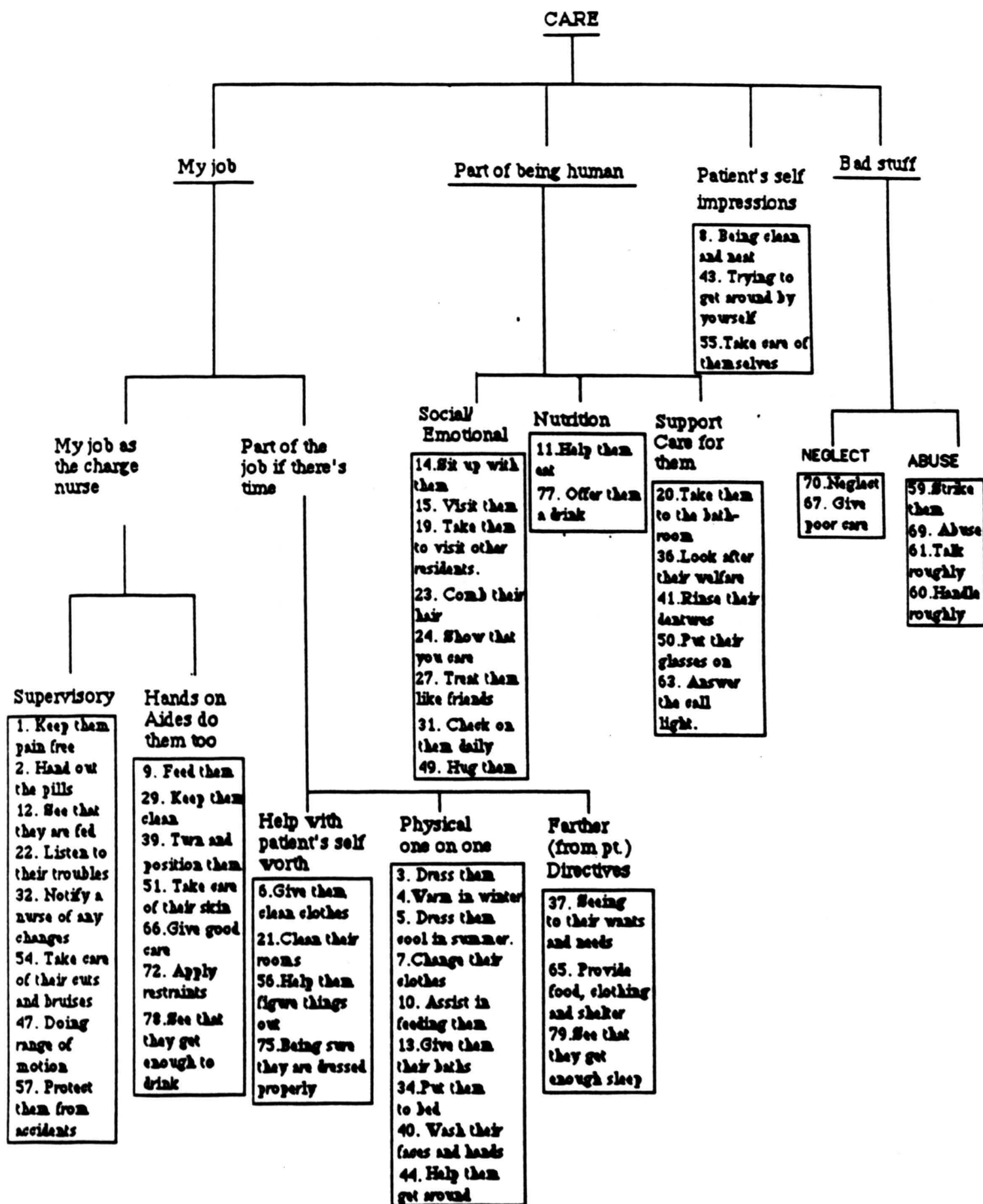
## Things I did for my boys



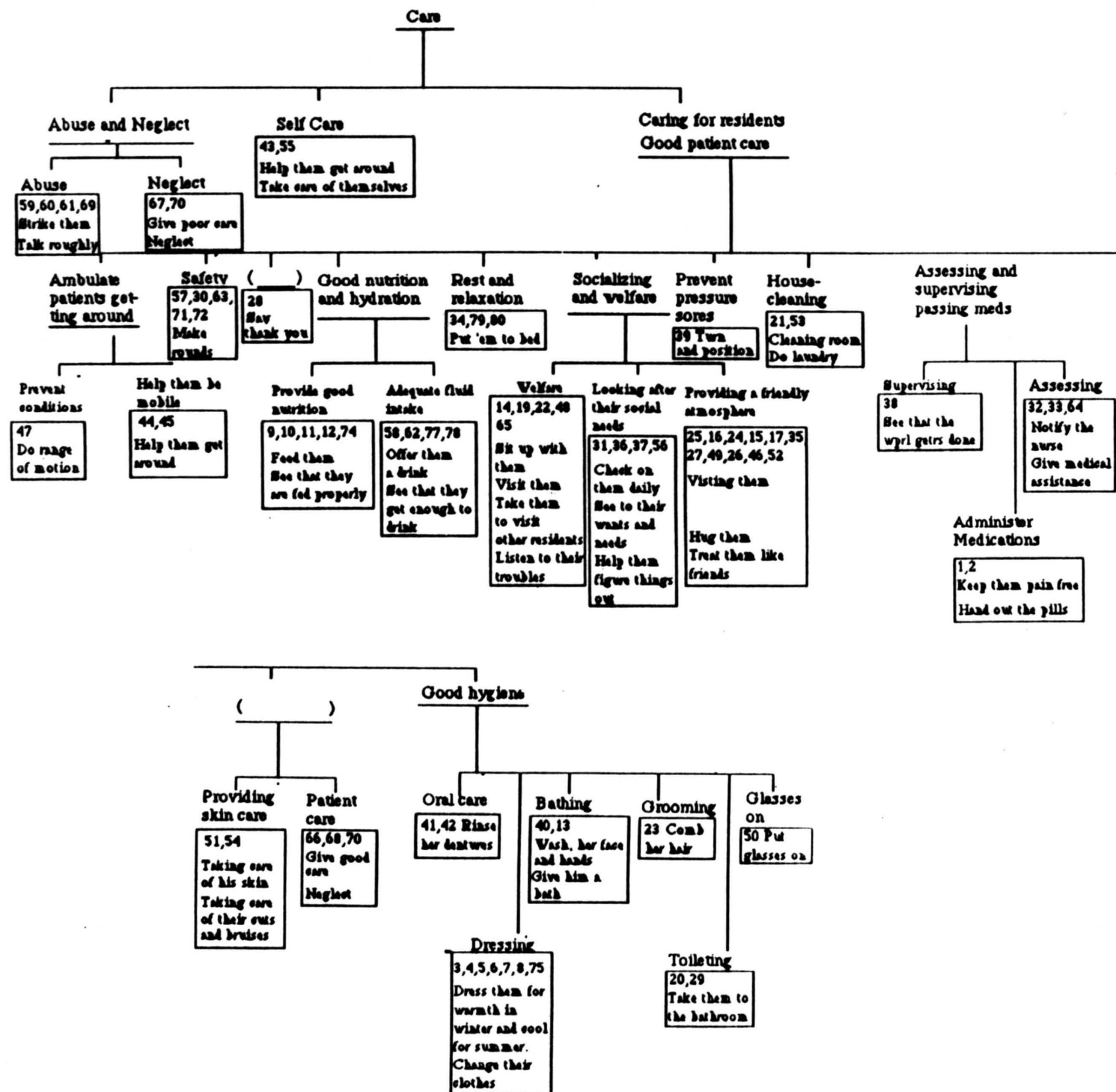
Male Patient

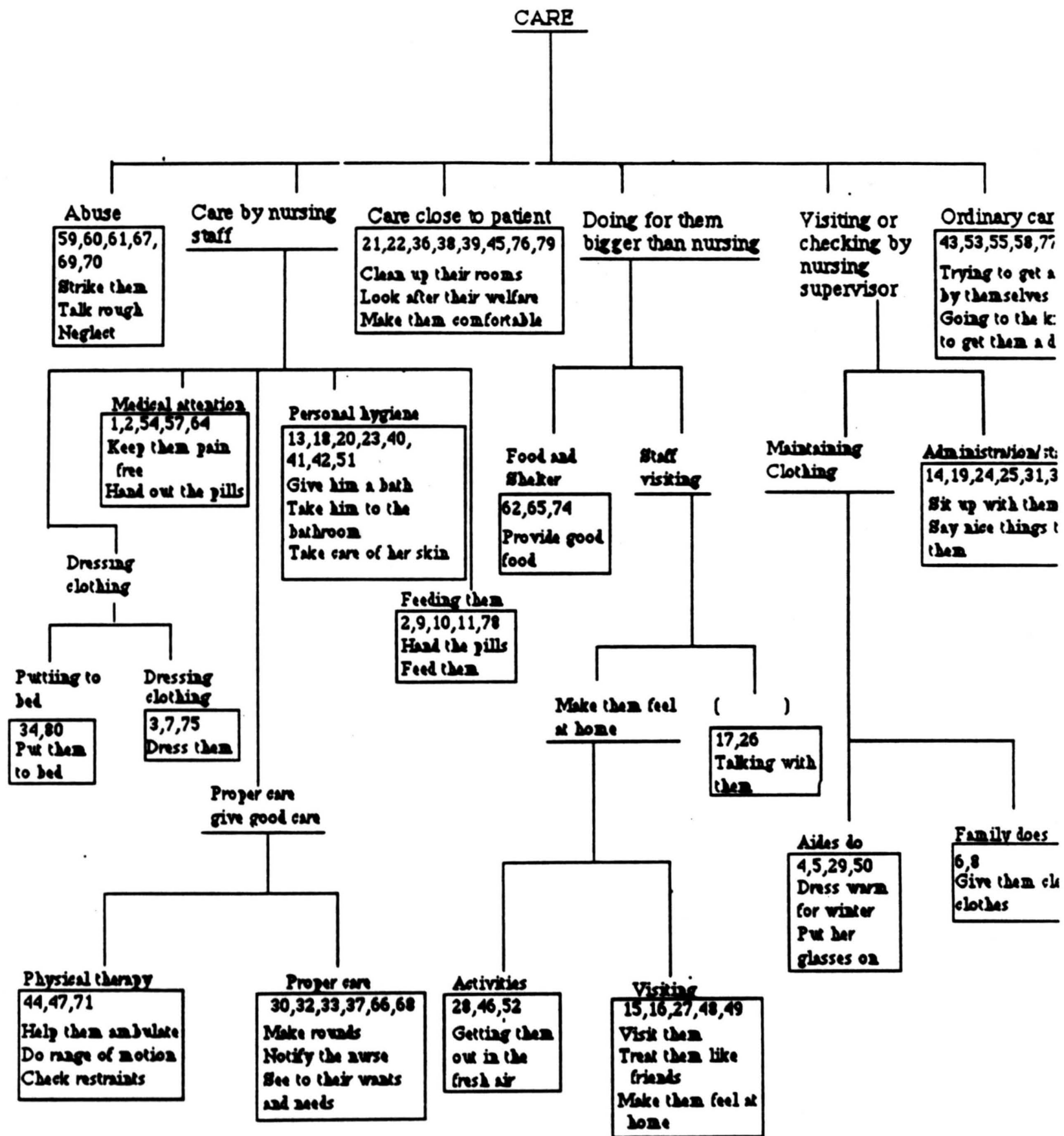


Female Patient



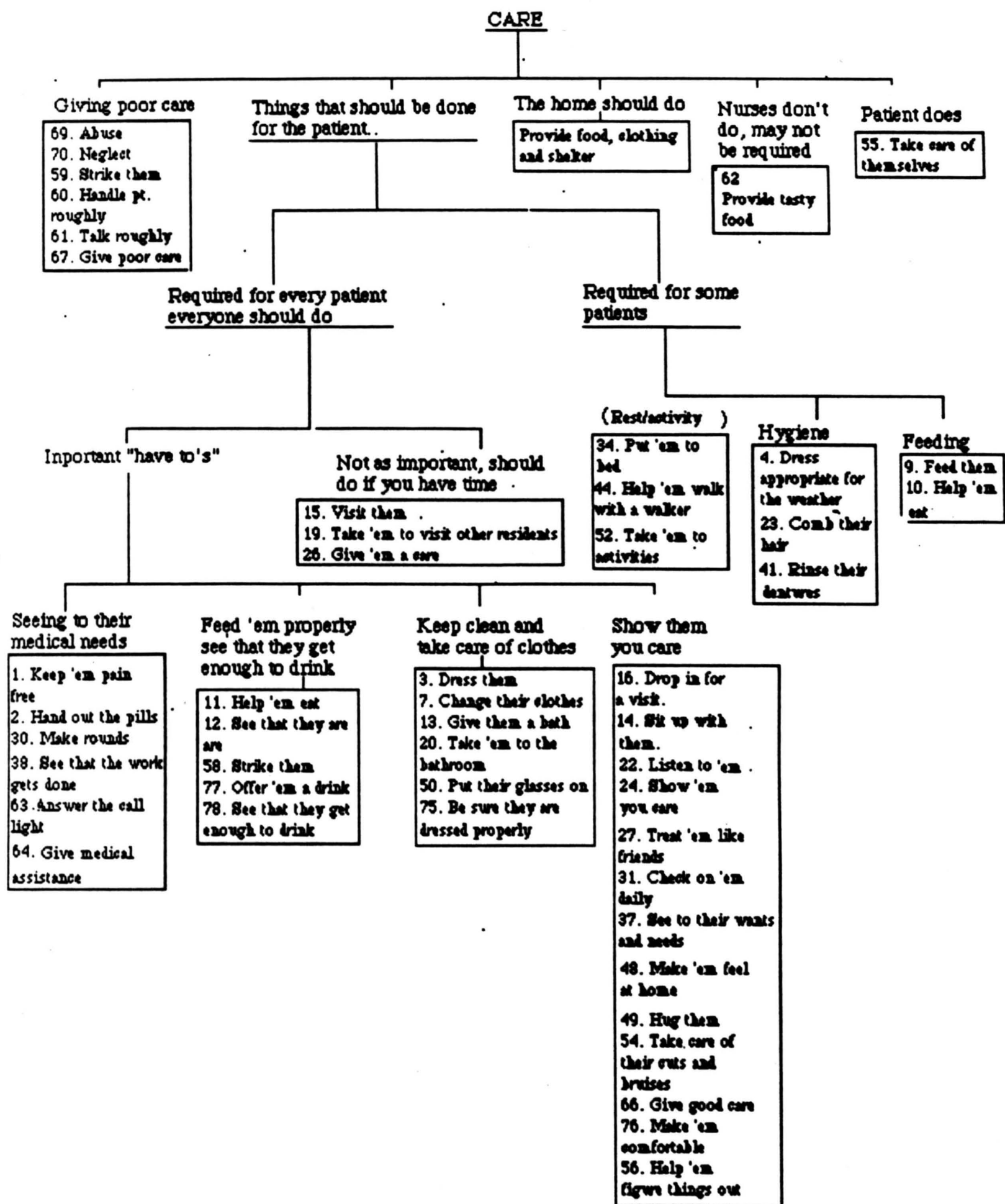
Male Nurse





Male Family Member





Female Family Member

### APPENDIX III THE FRAMES QUESTIONNAIRE

1. Is rinsing their dentures something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is rinsing their dentures part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is rinsing their dentures needed by all patients?	Yes	No
13. Is it something one would do for a spouse?	Yes	No
14. Is it something one would do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is rinsing their dentures needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is helping them figure things out something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is helping them figure things out part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is helping them figure things out needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is helping them figure things out needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is making them comfortable something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is making them comfortable part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is making them comfortable needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is making them comfortable needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

..1. Is seeing to their wants and needs something nurses would do for patients?	Yes	No
..2. Is it something nurses aides would do for patients?	Yes	No
..3. Is it something family members would do for patients?	Yes	No
..4. Is it something patients would do for other patients?	Yes	No
..5. Is it something the administrator would do for patients?	Yes	No
..6. Is seeing to their wants and needs part of routine care?	Yes	No
..7. Is it something that requires training?	Yes	No
..8. Is it something that is very important to do?	Yes	No
..9. Is it needed by confused patients?	Yes	No
..10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is seeing to their wants and needs needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is seeing to their wants and needs needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No



1. Is helping them to eat something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is helping them to eat part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is helping them to eat needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is helping them to eat something that is needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is seeing that they get enough to drink something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is seeing that they get enough to drink part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is seeing that they get enough to drink needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is seeing that they get enough to drink needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is handing out the pills something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is handing out the pills part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is handing out the pills needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is handing out the pills needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is seeing that they are dressed properly something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is seeing that they are dressed properly part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is seeing that they are dressed properly needed by all patients ?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is seeing that they are dressed properly needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is listening to their troubles something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is listening to their troubles part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is listening to their troubles needed by all patients ?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is listening to their troubles needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No



1. Is helping them get around something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is helping them get around part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is helping them get around needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is helping them get around needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is taking care of their cuts and bruises something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is taking care of their cuts and bruises part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is taking care of their cuts and bruises needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is taking care of their cuts and bruises needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is hugging them something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is hugging them part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is hugging them needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is hugging them needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is offering them a drink something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is offering them a drink part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is offering them a drink needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is offering them a drink needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is checking on them daily something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is checking on them daily part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is checking on them daily needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is checking on them daily needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No



1. Is putting their glasses on something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is putting their glasses on part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is putting their glasses on needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is putting their glasses on needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is taking them to the bathroom something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is taking them to the bathroom part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is taking them to the bathroom needed for all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is taking them to the bathroom needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is stopping in their rooms for a visit something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is stopping in their rooms for a visit part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is stopping in their rooms for a visit needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is stopping in their rooms for a visit needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is washing their faces and hands something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is washing their faces and hands part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is washing their faces and hands needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is washing their faces and hands needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

1. Is keeping them painfree something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is keeping them painfree part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is keeping them painfree needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is keeping them painfree needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No



1. Is taking them to visit other residents something nurses would do for patients?	Yes	No
2. Is it something nurses aides would do for patients?	Yes	No
3. Is it something family members would do for patients?	Yes	No
4. Is it something patients would do for other patients?	Yes	No
5. Is it something the administrator would do for patients?	Yes	No
6. Is taking them to visit other residents part of routine care?	Yes	No
7. Is it something that requires training?	Yes	No
8. Is it very important to do?	Yes	No
9. Is it needed by confused patients?	Yes	No
10. Is it needed by bedridden patients?	Yes	No
11. Is it needed by patients who can't use their hands?	Yes	No
12. Is taking them to visit other residents needed by all patients?	Yes	No
13. Is it something one might do for a spouse?	Yes	No
14. Is it something one might do for a friend?	Yes	No
15. Is it part of child care?	Yes	No
16. Is taking them to visit other residents needed by everyone?	Yes	No
17. Is it part of nursing care?	Yes	No
18. Is it part of care?	Yes	No
19. Is it something patients would do for themselves?	Yes	No
20. Is it something that would be done when staffing is short?	Yes	No

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