A COMPARISON OF PRIOR HEALTH CARE EXPERIENCE TO SUCCESSFUL RELOCATION IN LONG-TERM CARE

DISSERTATION

Presented to the Graduate Council of the North Texas State University in Partial Fulfillment of the Requirements

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By

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The problem of this study is to compare prior health care experience with satisfactory adjustment in a long-term care facility. Both quantity and quality of prior experience in a health care facility are examined in terms of the significance to successful relocation. Demographic data and perceived control of health are examined in relation to significance of the findings.

Quantity and quality are measured by the response of the participants to questions regarding the specific number of times of prior admission and the perception of the individual regarding quality of care. A ten item questionnaire measures specific factors regarding previous health care as perceived by the participant to be favorable, unfavorable.

Each of these predictors is compared to measures of satisfaction. These measures are number of room changes following admission, number of times a doctor is consulted during the first year following admission, and the score on the *Life Satisfaction Index* (LSIZ). A comparison is also made of age, sex, race, ethnicity, religion, and length of stay to criterion variables. A measure of perceived control...
of health, the Health Attribution Test, was also administered and compared to the criterion variables.

Statistical analysis included factor analysis, multiple regression, and Pearson’s product-moment correlation. Significance at the .05 level was found between one factor on the ten item questionnaire, religion, and perception of internal control of health on the Health Attribution Test when compared with measures of satisfactory adaptation to long-term care.
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CHAPTER I

INTRODUCTION

One of the most discussed demographic trends in health care is the effect of the aging pattern of the population (4). As of 1980, 11.3 per cent of the population was over age sixty-five. This figure is rapidly increasing. It is projected that by the year 2030 this age group will have increased to 20.9 per cent. Such a large per cent of the population will need safe and comfortable housing. Many of these people will need medical supervision. About 5 per cent of the elderly live in group housing (1). It is estimated that 20 per cent of the population will enter a nursing home during their lifespan. At least 85 per cent of the elderly have at least one chronic condition (4). If the providers of health care are to meet the needs of society it is imperative that consideration be given to the needs of this ever expanding segment of our population. Educating nursing students to meet the needs of this group of people which is steadily increasing in numbers is an exciting challenge to nursing education.

The study of care of the aged is a topic that has received more emphasis in the curriculum of schools of nursing in recent years. This topic has been discussed at
numerous professional meetings. Burton stated that one especially challenging aspect of health care delivery to the aged is the lack of trained health professionals in gerontology. There is a lack of gerontologic content in the curriculum of schools of medicine and nursing (4). The House Committee on Aging, in 1978, reported that less than 50 per cent of the medical schools in the United States and only twenty seven out of 512 nursing schools offered programs or courses in gerontology (16).

In its fiscal year (FY) 1984 budget report the House Committee on Appropriations requested the Department of Health and Human Services to submit a report with a plan of action to improve and expand training in geriatrics and gerontology. Included in the recommendations of this report were to "Develop modes of nursing education which respond to the specific needs of nurses planning to work in long-term care, and strengthen the gerontological and geriatric didactic and clinical content in the curricula of basic schools of nursing" (5, p. 31). These reports and statements emphasize the increased need for gerontological emphasis in schools of nursing. Pearson agreed with this when she stated, "The majority of the nurses of today have received little or no training in dealing with the elderly. . . . They have received no special training to modify their services according to the conditions of the older patient and the care that he or she needs" (12, p. 24).
Many professional positions are becoming available for nurses in the area of Gerontology. Nursing graduates are called on to consult or teach staff in nursing homes and sometimes work in nursing home (2). If nurses are performing this function, nursing education must respond to the challenge of preparing practitioners in the area of gerontology. White and others stated that recent years have seen an increase in the number of people over sixty-five seeking help in the health agencies designed to serve them. Therefore, new knowledge, skills and related research must be coordinated into useful curricula for the providers of care (19).

Brower concurred when she said,

Curriculum content within the nursing major should reveal the ability of the program to prepare future leaders in gerontological nursing. Aspects considered essential by many gerontological leaders for a program in gerontological nursing include curriculum organization and content (2, p. 390).

Course content regarding care of the elderly encompasses many areas. One aspect of this is the topic of relocation into long term care. Nursing educators have encountered difficulties in trying to help students assess their patients correctly and select the appropriate intervention strategy.

The effect of relocation to a long-term care facility has been a problem that has puzzled nurses for some time. Brunner stated, "Sometimes the transition to a new
environment may bring on temporary states of anxiety, confusion, regression and disorientation. The patient may be misjudged as being senile when the real causes are fear, depression, and a feeling of hopelessness" (3, p. 254). Lieberman compared the problem stated above to mortality rates and found significant results (11).

Since adjustment to relocation has such an impact on the welfare of nursing home residents this topic is of utmost importance to nursing educators who are preparing nursing students to meet the needs of these residents. It is essential that specific content regarding adjustment to relocation be isolated and incorporated into the curriculum of students of baccalaureate, master's and doctoral levels of nursing education. Brower stated, "The long-term sector is perhaps the one in most dire need of change" (2, p. 390). If nurses are to be change agents in this area, both basic and graduate programs must provide students with the knowledge and skills needed to provide care for these clients. This includes course content related to assessment criteria dealing with the adjustment process which accompanies relocation.

Robb stated, "Nurses can and should prepare old people for institutional living" and "the nurse should identify the best mechanism for the elderly person to use in coping with the crises of relocation to a long-term care facility" (13, p. 156). These statements are very broad in scope. Nurses
are performing client preparation with only minimal nursing educational preparation for this function. There is a definite need for increased information regarding this specific aspect of the nursing process.

Before the nurse can select appropriate intervention strategies certain data must be collected. Both practicing nurses and students of nursing need education regarding the kind of questions that are appropriate to ask the client. Questions might be: what factors influence the adjustment of clients to institutional living? Do previous hospitalizations have any effect on this adjustment process? Is the effect positive or negative? How would knowledge of this relationship affect the intervention selected by the nurse? How can this information be incorporated into the curriculum of a school of nursing? Examination of these questions is relevant and important. A study which focuses on factors affecting the adjustment to relocation is beneficial to consumers of the health care system. Gerontology content would be strengthened and nursing graduates would be better prepared to meet the needs of these clients. Understanding the relationship of predictors of satisfactory relocation would facilitate effective nursing interventions.
Statement of the Problem

The problem is to identify and compare prior health care experiences and adjustment to relocation in a long-term setting of selected current residents in nursing homes.

Purpose of the Study

The purposes of the study are

1. To increase and strengthen curricular content in gerontologic nursing by investigating a factor which may influence the degree of successful adaptation to nursing home living;

2. To facilitate more effective methodology in teaching assessment of client problems in nursing education;

3. To identify selective criteria which may be used by health care professionals such as nurses, social workers, occupational therapists, and nursing home administrators who are involved in the admission of clients to long term care;

4. To identify selective criteria which may be used by health care professionals such as nurses, social workers, occupational therapists, and nursing home administrators who are involved in the admission of clients to long term care;

5. To identify factors which will increase the quality of nursing assessment of client problems;

6. To examine the number and nature of previous admissions to a health care facility, in regard to the effect on successful relocation;
7. To determine if the perception of the client regarding quality of health care admissions has any relationship to successful relocation; and

8. To identify selected factors which clients perceive as favorable or unfavorable regarding health care.

Research Question

To carry out the purposes of this study the following research questions were studied.

1. Will residents who have had more experience with an in-patient facility show a higher degree of satisfactory adaptation to nursing home living?

2. Will residents who perceive their previous experience with the health care facility as favorable have a more successful degree of adaptation?

3. What are some factors that clients identify as causing a health care experience to be perceived as favorable or unfavorable?

Limitations

This study was subject to the following limitations:

1. The sample was limited to institutionalized clients who were able to answer the questionnaire either written or orally.

2. Response to the questions was limited by the patient's physical or mental condition of the patient.
3. It is difficult to generalize beyond similar institutional settings and locations.

Definition of Terms

The following terms are defined for the purpose of this study,

Previous experience with a health facility is defined as admission and treatment for a period of twenty-four hours or more. The admission and dismissal are considered one experience regardless of length of stay.

In-patient facility is a health care facility in which patients are actually admitted and spend the night for purposes of health care.

Successful adjustment is the adaptation to nursing home living which involves incorporation of changes in life style in such a way that the client is able to find satisfaction in living.

Favorable experience is experience described as or perceived as favorable by the resident.

Intermediate care facility is the section or area of a nursing home where residents are not completely bedfast and are able to participate in their care.

Loss of memory was determined to exist if the resident was not oriented to time, place, and person and if the resident is able to recall recent events as determined by the Director of Nursing.
Significance of the Study

Improving the level of content in gerontology in nursing has been documented as a need in nursing education. Gioiella said, nursing must expand its efforts to ensure that graduates of professional nursing programs have the knowledge and skills necessary to care for the elderly. She also stated,

No matter what setting in which they choose to practice, nurses care for elderly clients. Age-appropriate practice is long overdue and must be included in the curriculum. A greater breadth of knowledge must be introduced in the basic nursing programs. The need for research in gerontological nursing is acute. Rigorous research in this area is sparse. Research is needed if nursing is to base its practice with the elderly on tested theory and effective nursing protocols (8).

This study is significant in both of these areas. Investigation of one assessment parameter would assist nurses in giving the support the elderly clients need during relocation. Knowledge of this factor would expand the theoretical base regarding age-appropriate nursing practice and strengthen curricular content in gerontology. Gunter reported a study of 162 senior nursing students. Her study showed negative stereotypes regarding the aged were reduced after the students had taken a course in gerontology (9).

Attitudinal change is not the only area of concern to educators. Dye addressed herself to types of content when she stated, "At professional and academic levels priorities can and must be defined--a degree of balance between
physiological, psychological and social gerontological content should be developed" (6, p. 14). One area of psychological course content deals with relocation.

The problem of this study was addressed by the Department of Health and Human Services. In the administrative document published by that department the statement was made,

To meet the needs of the elderly population, almost all health professionals and allied workers will require knowledge and skills with respect to aging and the aged. . . . Aging issues must be addressed in basic, graduate and continuing education programs. . . . Educational programs should emphasize sensitivity to the unique health, emotional, social, cultural, ethnic and other circumstances of older adults (5, pp. 15, 16).

The significance to nursing was emphasized in the same report by saying, "the need for nurses with specialized knowledge and skills in gerontological nursing is very great. Such preparation is required to strengthen practice, education, research, and administration" (5, p. 27). Changes in health care financing will probably affect the quality of services in long-term care facilities. Nursing responsibilities and roles in caring for the elderly will be expanded. The increased demand for practitioners with knowledge and skills in geriatrics and gerontology is significant. The department report also stated,

Benefits can be realized from research that would lead to more effective methods of care for the aging and aged. More adequate education and training in geriatrics and gerontology should result in higher quality of care for older people, including more
effective maintenance of health and functional abilities and also have an impact on the costs of care (5, p. 10).

Tollett concurred when she said, "Specific content areas regarding gerontology need to be identified to include social change as well as physiological change. Emphasis needs to be placed on means of adaptation used by the elderly" (17, p. 23). Reaction to relocation is an example of adaptation. There is a definite need in nursing education to emphasize problems associated with relocation and to identify assessment parameters which would facilitate identification of the appropriate interventions by the nurse. This study is significant to nurse educators in identifying this area of nursing content.

Rosswurm conducted research that identified the fact that relocation results in feelings of helplessness and loss which frequently results in depression and physical deterioration (14). Other researchers have found a positive correlation between relocation and mortality rate. These studies indicate a serious problem exists for the nursing home resident. Studies are needed to identify predictors of satisfactory or unsatisfactory relocation. This study is an attempt to identify one possible set of factors which could be used to predict a satisfactory relocation.

Hartford stated, "Curriculum content in aging should have meaning in application—the applied biopsychosocial sciences are the heart of aging education. . . . Graduates
who work in aging should be taught a mixture of intervention modalities . . . " and "all workers in gerontology need a knowledge of methods for working with individuals and families" (10, p. 178). This study is significant to nurses and other health care personnel as they attempt to collect data and select interventions which will facilitate a successful adjustment process.

This study is also significant to nurses and administrators who are developing a data base as a part of the admission procedure to determine what information should be obtained from families in order to give more support to the prospective resident. Moving residents is an expense to every nursing home. It involves considerable output of staff time. Decreasing the necessity to move residents will affect the budget of the nursing home, the cost to the resident and ultimately the cost of health care delivery. More satisfactory relocation would decrease this cost.

This study is significant to nursing education. Interest in the educational preparation of practitioners who are dealing with health problems of the elderly has existed since the enactment of the Older Americans Act in 1965, which was later amended in 1981. Title IV, Part A of the Older Americans Act provides grants to train and recruit personnel for the field of aging (15). The emphasis placed on this topic by the federal government indicates there is indeed a need in this area which educators and researchers
should investigate. Leaders in nursing education have recently demonstrated a high level of interest in identifying content in the nursing curriculum which is directly related to gerontological nursing. Nursing educators are becoming more and more aware that needs of the elderly cannot be met if the curriculum of a professional nursing education program contains only fragmented content that is difficult to identify. Hartford stated, "Students need to be prepared with approaches to help the older person avoid being a part of the self-fulfilling prophecy that causes them to behave in a way that perpetuates the stereotype of learned helplessness of aging." (10 p. 175).

Nursing organizations are interested in this topic also. The Council on Gerontological Nursing of the American Nurses Association is presently collecting data to revise the Statement of the Scope of Gerontological Nursing Practice.

The American Nurses Association, at the present time, is conducting a comprehensive survey to determine the amount and type of gerontologic content in both graduate and undergraduate nursing programs. An additional study is being done to determine dimensions of practice of members of state nursing associations who are involved in gerontological nursing. The data from these surveys were discussed at the 1986 American Nurses Association Convention (18). A similar study is being conducted by the Association for Gerontology in Higher Education. This study is
significant to members of these organizations as they strive to identify amount and quality of content in gerontological nursing. It would be significant to the nursing educators individually both in the classroom and in the clinical area.

Clinical teaching is another area is affected by this study. In many nursing programs the first clinical contact a student has is in a nursing home dealing with geriatric clients. The success of this practice was documented by Everett and Hooks, who reported a very positive response from students, residents, and administrators following clinical experience in a nursing home for sophomore nursing students (7). There is a definite need to identify specific assessment parameters that will assist nurses and students in identifying needs of geriatric clients. This study is an attempt to identify one possible assessment parameter prior to relocation.

A problem area for students is to see clients admitted who gradually lose their ability to respond appropriately to questions or demonstrate inappropriate social behavior. Nursing instructors need to be able to help students deal with that problem. If one area could be demonstrated to be a predictor of unsatisfactory adaptation then this could be communicated to the student as one means of identifying clients who need additional support. This would help the student deal with the problem more satisfactorily. Other
disciplines involved in helping geriatric clients can profit from information in the present study.

Gerontology departments in higher education can also be affected by the addition of this research to the presently existing content in courses in gerontology. Gerontology is a multi-disciplinary field. Other disciplines such as social work, physical therapy, or occupational therapy can profit from information contained in this study.

In this chapter the demographic changes in society in relation to the gerontological population have been presented in terms of the significance to nursing education. Nursing education has an obligation to prepare nurses to care for this segment of the population. Literature has been cited to indicate that a void exists in regard to gerontologic content in nursing education. Because the void exists this study was developed to increase and strengthen curricular content in gerontologic nursing.

Three research questions are presented dealing with the relationship of quality and quantity of previous health care experience to successful relocation in long-term care and with factors that effect the perception of quality. Limitations of this study are identified and terms are defined. The significance of this study is presented in relation to nursing education, nurses, nurse administrators, and gerontology departments in higher education.
Since the significance of this study has been established, it is important to examine the literature on this topic. The changes accompanying relocation have been intriguing to scholars in gerontology for a number of years. Many practitioners have been aware of physical and mental deterioration that frequently accompanies relocation in the elderly. It is important to examine previous research studies in this area. Such an examination is presented in Chapter II.
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CHAPTER II

SELECTED REVIEW OF LITERATURE

Introduction

In preparation for this study, a review of literature was conducted to (1) study the status of gerontology in the United States, (2) examine the status of nursing education regarding gerontology, (3) study the process of nursing assessment of the elderly, (4) investigate the effect of relocation on the elderly, (5) identify predictors of successful relocation, and (6) describe interventions which may be used to facilitate successful relocation.

The first section, Status of the Elderly in the United States, is an introduction to gerontology and the rationale for studying problems associated with relocation.

Status of the Elderly in the United States

The role of the elderly in the United States has been a major concern of many individuals for quite some time. This awareness started in the 1960's when emphasis was placed on zero population growth and concern was expressed for the lifestyle, concerns and needs of older people.

As of 1980, 11.3 per cent of the population was over age sixty-five. Atchley has projected that by the year 2030
the percentage will have increased to 20.9 per cent (5). Even though only 5 per cent of the population over age sixty-five are institutionalized at one time, Robb estimated that approximately 25 per cent of the total population will spend some of their time in a nursing home. Single individuals living alone and without children have been identified as older people most likely to need institutionalization (33). These statistics reveal the importance of the needs of people in this age group. This large segment of our population will have a need for help in adjusting to changes which result in institutionalization. If this help is to be provided, nurses and other health care workers need educational preparation to facilitate assessment and implementation of nursing intervention strategies.

The Status of Gerontology in Nursing Education

Identification of gerontology content in nursing education programs has been an area of concern of many nursing educators for quite some time. In many nursing programs this content is integrated into other courses. Many times both the quality and the quantity of this content is difficult to ascertain. Martensen shared this concern when she stated,

The gerontology component of basic nursing programs needs to be strengthened. Most programs incorporate gerontology principles into existing courses with
students receiving varying amounts of instruction and clinical experience with the elderly. The disparity between the need and supply of gerontological nurses is an issue that affects nursing education (27, p.8).

This disparity is accelerated by a lack of understanding of specific gerontologic concepts. Alford stated,

Colleges of nursing can and should set the model for a professional gerontology practice. . . . Our main priority must be to make gerontology nursing a major part of a nursing curriculum. Unless faculty are convinced that the aging process and resultant nursing care are an essential component of the curriculum students will not have role models from whom to learn the rewarding aspect of caring for the aged (2, p. 547).

In defining gerontologic nursing, Martensen said, "Gerontologic nursing is the nursing speciality concerned with nursing older adults. Geriatric nursing is a part of the broad context of nursing. It certainly is not simply a matter of being kind and sympathetic to older people" (27, p. 9). Although caring is a basic component of the nursing process, nursing interventions need to have a scientific base. Others have attempted to define gerontologic nursing. The Division of Gerontological Nursing Practice of the American Nurses Association (1976) gives this definition of gerontological nursing: "Gerontologic nursing is concerned with assessment of the health needs of older adults, planning and implementing health care to meet those needs and evaluating the effectiveness of such care" (27, p. 8). Certainly if the gerontologic nurse is to fulfill these responsibilities his or her own level of gerontologic
nursing knowledge must be in depth. There is a definite need for a strong gerontologic nursing component within all basic nursing programs and to have nurses with specialized knowledge serving on the staffs of nursing homes. "Nursing has a paucity of nurses--educators, practitioners and researchers--with specialized knowledge and clinical practice in gerontologic nursing. It is imperative that priority be given to graduate preparation for gerontologic nurses" (27, p. 50).

Content relevant to nursing is being questioned in the literature. A study was conducted by Barbara Hoshiko at Kent State University. A questionnaire was mailed to 284 nurse educators in an attempt to determine what is critical content in nursing. One criterion identified was service to society in meeting health needs. Considering the percentage of the aged population (in the age group of gerontology) and the wide variety of health needs of this particular segment of the population gerontologic content certainly meets this criterion. Another criterion was obligation to relevant groups and values. Nursing education indeed has an obligation to the relevant group of elder individuals in our society (22).

Because of a concern for incorporating aging content in the curriculum, the faculty at the University of Rochester School of Nursing received a grant to establish such incorporation into its undergraduate curriculum. This
project utilized a consultant to help evaluate this content and facilitate the needed change. Student experience was established in a skilled nursing facility. They utilized simulation to allow students to experience restraints, sit in a room alone, be called honey or Gram, and move in a wheelchair. Teaching strategies included using plastic covered glasses when they tried to eat, select clothes, and participate in activities of daily living. Aging content which was identified included normal healthy aging, attitudes toward aging, community health problems, and long-term care. Other concepts included the economics of aging, the role of the family of an institutionalized person, the value of age in society, continuity of care, and death (15).

The University of Miami School of Nursing also obtained a grant to integrate gerontology content into the present nursing curriculum. The faculty identified gerontology content as a major concept throughout the entire curriculum. Student experience in Adult Day Care was the primary contact with the elderly per se. The curriculum design included the wellness illness continuum as a major concept. However, prior to this time no attention had been given to the sub-concepts of sexuality and aging, acute brain failure, Alzheimer's disease, depression and suicide in the elderly, demographic long-term care issues, or family relations of the elderly. Efforts were made to incorporate this content.
The new curriculum was based on cross-cultural concepts. They introduced attitudes toward aging, and theories and developmental tasks of aging. The concepts which had been identified as missing were integrated into three major courses. These were successful versus unsuccessful adaptation, the older person's response to stress, and long-term care. After communicating with the project consultant the nursing faculty stated they had become "gerontologized" (40).

A need exists to investigate graduate education in gerontologic nursing to determine the level of preparation of gerontologic specialists. Celeste Dye studied thirty-five graduate programs in nursing in an effort to ascertain how much and what gerontologic nursing content exists. She found the curricula to be grossly inconsistent. Reference was made to broadly defined areas. In the vast majority of these programs greater attention was given to research preparation or theory development. Less than 10 per cent of the content dealt with gerontologic nursing. She stated, "There is a need for the profession to clarify what is taught and determine what should be taught" (12).

Brower was also concerned with the preparation at the graduate level. She stated, "Curriculum content within the nursing major should reveal the ability of the program to prepare future leaders in gerontological nursing" (7, p. 390). In order to determine the status of graduate programs
In gerontological nursing, she conducted a survey of graduate programs in nursing. Out of forty-seven respondents, twenty-eight programs had a functioning major in gerontological nursing. Credit hours in the major varied from five to forty-five. The questionnaire revealed faculty concerns. Primary concerns stated by the faculties were: motivating and stimulating interest in the major, viability of the major, and availability of positions for their graduates. She believes that one factor influencing the problem with recruitment was the lack of undergraduate preparation in gerontological nursing.

In a later article Brower stated,

Gerontological nursing curriculum should be incorporated and integrated in both undergraduate educational programs and other graduate majors. All nurses concerned with the importance of gerontological nursing education can work toward strict mandates to require that gerontological nursing be included in all nursing programs. Gerontological nursing must be an identifiable entity of the licensure examination.

The same view was endorsed by Everett when she said "One of the professions most urgent needs is the inclusion of gerontological content in all nursing programs." She also described positive experience with providing clinical experience for sophomore nursing students in a nursing home. The problem is not whether the content is integrated throughout the curriculum or taught in a block. The problem is to make sure the content is provided in one way or the other. The concern for this area of
content is shared by many nursing educators. There is an interest in emphasizing both physiological and psycho-social content. New content also needs to be identified. All aspects of this topic are very broad in scope and would be beyond the realm of this study. This study will attempt to deal with one aspect of psycho-social needs of geriatric clients. This aspect is adjustment to relocation.

Interest has also been expressed in increasing research in this area. Martensen said, "In the area of research there is a need for more studies to be done in the area of gerontologic nursing. . . . Nursing now has a nucleus of research prepared nurses who can guide the profession towards reaching this potential and to increase the knowledge base upon which to build gerontologic nursing practice. . . . With the leadership of doctorally prepared nurse researchers the health care of the elderly can be improved" (27, p.16).

The expansion of knowledge base is important to faculty as they expand and implement curricular content in gerontology. Nursing is at a crossroads in terms of gerontology content. Numerous authors in nursing literature have expressed a concern regarding content dealing with the elderly. Some schools have obtained grants to investigate this problem. Content is being examined in the undergraduate as well as the graduate curriculum. Increased research is needed in the area of gerontologic nursing.
Research is needed regarding nursing actions specifically related to assessment of health needs and implementation of interventions for the assistance of the elderly client. These areas must be identified and then incorporated into the curriculum of basic and graduate programs in nursing.

Assessment of the Elderly

The process of client assessment, the first step in the nursing process, is essential in the care of the elderly. Components of successful assessment are addressed in nursing literature. Rossborn stated, "A nurse clinician can obtain a thorough health history and perform the functional assessment to ensure the most appropriate environment for meeting older people’s needs and goals" (35, p. 632). Mayfield also said, "Assessment of the elderly client must be adapted to meet their needs. Since elderly clients need additional time to respond or react to verbal stimuli and their movements are slower, sufficient time must be allowed for the examination so that the client and the examiner need not feel rushed" (28, p. 195). She developed a detailed health assessment tool with special considerations for the elderly (28).

Yurick expanded the process of assessment to include psycho-social needs. She stated, specific needs must be considered in the assessment of an elderly person... Significant is the way the older person views himself. A negative reaction to change affects the degree in which a client will...
participate in his care. The way a client has reacted to crises situations in the past will give the nurse a clue regarding how he will react to present changes. The aged person may want to tell about his feelings of loneliness, feeling unwanted, or fear of death" (47, p.6).

These needs are important to identify whether or not the client is receiving the support he needs. Depression in the aged is one possible problem the nurse should be aware of. Archibald described depression in older patients. She stated depression is more likely to be evidenced in an attitude of apathy or complaints of physical problems. She emphasized that the assessment phase of the nursing process is the first step in identifying this phenomenon, and further stated, "Determine how he functioned prior to hospitalization. . . . Once you discover the reason for depression you're in a good position to alleviate the situation" (4, p. 50). Problem solving regarding the reason for the depression is therapeutic. However, empathetic support is as important as identifying the problem.

Patient assessment must be individualized. There can be no objectivity in collection of data if the goal of assessment is based upon stereotyped untested notions (29). Nursing care plans must always be based on individual problems and interventions.

The collection of data for the psycho-social aspect of the assessment process is very important. The interview itself many times is the first association with the client
and sets the tone for additional contacts later on. It establishes the relationship as being therapeutic and professional with the focus of the interaction being on the client's needs. It also establishes baseline data to be used for comparison later on as changes occur in this particular individual. Sometimes the nature of the interview will be the stimulus to cause the individual to think about his situation more objectively (10).

Adapting to change is another problem the nurse frequently is asked to help the client. The nurse is not contacted until a problem exists, or until some loss threatens the lifestyle of the client (45). At that time support is needed to assist in coping.

Data collection is an intervention utilized by the nurse to identify possible problems the patient may experience. It is important to identify specific predictors which may give the nurse a clue that the patient may have a particular problem. This is especially true when the nurse is interviewing the client prior to relocation. If the nurse knows what type of information to obtain and asks those specific questions, then he or she will be able to identify possible problem areas and take the appropriate nursing interventions. It is important that research be conducted to identify which data are relevant in predicting successful relocation, thus endorsing the importance of this information in a nursing education program with emphasis in
Effects of Relocation

In assisting the elderly, the problem the nurse frequently is asked to deal with is the problem of relocation. Relocation is a potentially stressful event for anyone at any age. For the elderly individual this decision is usually aggravated by change in health status, financial problems, death of a spouse, or urban renewal (35).

Hasselkus defined relocation as a change in environment that takes place when an individual moves from one location to another. She stated, "For an older person the move is likely to be in one of four directions— from one community setting to another, from the community to an institution, from one institution to another or from an institution to the community" (21).

Shore expressed concern for this topic when he stated, "Any relocation is stressful for an elderly person. Therefore it is important that all concerned—physican, the family, and the housing personnel try to achieve the best possible match between housing and the present and future needs of the elderly client" (38, p. 121). It does not matter which direction the relocation takes evidence has shown that a relationship exists between relocation and a decline in function. Individuals relocating from residence

gerontology. Hopefully, the end result will be the facilitation of a more successful relocation.
to institutions for the first time experience more change (35).

Such a change is composed of many aspects. "At its worst, displacement means moving from a supportive, long-term environment to an alien area where substantially higher costs are involved for a more crowded inferior dwelling" (20, p. 23). Lange described aging in terms of its effect. She stated,

Relocation in older persons frequently involves a greater change in lifestyle because at the same time they experience life changes associated with aging. Consequently many older persons may need assistance to manage successfully the changes that accompany relocation. Usually they have moved several times during their lifetime. In general it is true that adequate financial resources make relocation easier (24, p. 405).

Brown stated that the effect of relocation can be attributed to depersonalization—individuals feel devalued when they are no longer contributing members of society. Sometimes in long-term care the staff does not call the individual by his real name. The difference may be material. The facility may not have the type equipment he is used to using at home. The difference may be routines such as everyone taking a bath at the same time (9) Gubrium described some of these changes. He described some patients who said, "It's the little things that you really miss. . . . The long term absence of familiar trivia is alarming for it signals change. Others describe life at Murray Manor as a situation without the ties of familiar places and state they
miss not being able to do what you want when you want. Conformity such as wearing a wrist band is another adjustment" (18, p. 82).

Ebersole stated that relocation is likely to create disequilibrium in the elderly. Places and belongings are very significant. There may be a strong attachment to places and things. She concluded, "Who is to say it is better to be placed in a protective environment he does not like rather than die sooner in a place he enjoys?" (14, p. 272). Buckelew agrees with this idea. She described a young boy who said, "a nursing home is where they keep dead people that ain't buried yet!" (11, p. 405). Many people in today's society conceptualize nursing homes in just that way.

Tobin and Lieberman did some observation of life in a nursing home. They described a nursing home as being, "a world of very old people who are frail and in need of care. There is no escaping from this world. The future is foreshortened and hopefulness regarding an extensive gratifying and controllable future cannot be maintained" (42, pp. 163-4). The detrimental results of change which is precipitated by relocation necessitate investigation of this process. Factors should be isolated which make nursing home living more acceptable— not a place to die.

Many research studies have been conducted regarding relocation. One of the most well-known studies was
conducted by Lieberman. He investigated the relationship between mortality rate and entrance into an institution. He found a mortality rate of 24.7 per cent the first year following admission to an institution. This was compared to a mortality rate of 10.4 per cent of a similar population prior to admission. The difference was more than 50 per cent (26). Gray reported a study which compared the effect of relocation on two groups of elderly people. One group was relocated because of highway construction—the other group was not. The relocated group had a greater number of major and minor physical difficulties and had been forced to spend a greater length of time in bed. They also perceived their health as worse. The relocated group had lower scores on measurement of health status, health activities and health attitudes. His conclusion was that "involuntary relocation appears to be a stressful experience for older persons whose roots are generally more firmly established" (17, p. 49).

In another study Aldrick, Knight and Mendkoff stated, "Since declining health in an elderly person often brings about the decision to place a person in an institution it is difficult to evaluate the extent of the influence on relocation" (1, p. 186). Also, it is difficult to determine if the changes are due to separation from family or to relocation in a new environment (1).
A similar study occurred following the closing of the Chicago Home for Incurables. One hundred sixty-five patients were transferred to fifty-six nursing homes in the Chicago area. One year later the death rate was 32 percent. This was compared to the death rate ten years previously as a control group. The control group percentage was nineteen. The study was significant because the decision to relocate was not made in relation to the physical health of the patient or condition in the family. The authors attribute the changes to the social and psychological results of change (1).

Some studies have been contradictory. Haddad conducted a study involving 389 elderly patients who were transferred to an intermediate care facility, a skilled care facility, or a psychiatric care facility. Before and after analyses were made on a behavior rating score and a comparison was made of the mortality rate. There was no measurable deterioration in measured behavior nor did the move cause sufficient stress to impact mortality. Some patients showed a positive change after relocation (19).

Thomas reported a study which dealt with morbidity. She was employed as a relocation specialist and observed certain signs and symptoms of morbidity. A study was developed to differentiate normal morbidity from encroaching morbidity. Normal morbidity was defined as illness at time of admission. Encroaching morbidity was illness after
relocation. Thirty patients were admitted sequentially to skilled nursing facility. Morbidity was obtained in a two-part interview, conducted twenty-four hours after admission and again twenty-eight days after admission.

Although no statistical significance was found, she made some interesting observations. At the time of admission 41 per cent reported being angry and 27 per cent were depressed. After admission the single most common symptom was confusion. Fifty per cent complained of sleeplessness, loss of appetite, depression, and despondency. No subject failed to report at least one new symptom. The body systems most frequently affected were the digestive and the cardiovascular systems. Aching all over and urinary frequency decreased after admission, while poor appetite, confusion, sleeplessness, feelings of hopelessness, and helplessness increased. She stated, "Health care workers should know that the patient has been exposed to a potent stressor. Symptoms of encroaching illness develop sometimes without being noticed" (41, p. 271).

Another study was conducted at Stockton, California. Killian examined variables such as age, sex, race, organic diagnosis, and length of stay. Six hundred geriatric psychiatric patients were transferred from their facility. They were divided into groups. Group I included seventy-one males and eight females. This group was transferred to
another state hospital. Group II consisted of twenty-one males and forty-four females who were transferred to other facilities in the community (nursing home, convalescent home, or boarding house). Group III contained fifty-two males and fifty-seven females who remained in the hospital. Each group was divided into control and experimental groups that were matched on age, sex, race, ambulatory status, and organic diagnosis. Four months later a comparison was made of the mortality rate. In Group I the control group mortality rate was 1.27 per cent as opposed to 6.33 per cent of the experimental group. In group II the control group was 1.54 per cent and the experimental group 13.65 per cent. In Group III the control group mortality was 3.676 per cent and the experimental group was 2.75. The high percentage in Group II was attributed to the fact that the clients had no input into the decision (23).

Numerous studies have been done in which there was no attempt made to control confounding factors. One example of such a study by Borup, Gallego, and Hefferman included thirty of thirty-four homes which were closed. By random selection nineteen of these homes were chosen and the mortality rate calculated prior to and following relocation. The mortality rate had dropped considerably more following relocation. Examination revealed that the group with the higher mortality rate had more old old clients and therefore
the data were affected. The conclusion in this study was that the increased mortality was actually due to age (6).

One of the more revealing studies was conducted by Lieberman and Tobin as described in their book *The Experience of Old Age*. This book describes four studies dealing with relocation. Half of these subjects showed adaptive failures such as psychological disability, serious illness, or death following moves. These four studies were conducted over an eight year period. The first was entitled "Unwilling Old Ladies." Forty-five physically and psychologically healthy elderly females were forced to move from a small to a large institution. The second was "Home for Life." Eighty-five people voluntarily entered a home for aged. In "Deinstitutionalized Elites" eighty-two patients were discharged from a geriatric ward to community-based institutional settings. The last was called "Death of an Institution." Four hundred twenty-seven geriatric patients were relocated from a state mental hospital to a variety of other settings. In all four studies predictors of adaptation were assessed and the effect of stress assessed afterwards. They concluded, "How individuals address their historical self—how well it is integrated into current life—is a useful indication of how well they can respond to any and all crises or stress in their life." Both respondents and controls were examined up to a year prior to
the move, giving baseline data and predictor information, and then were examined again one year after the change.

The study had interesting outcomes. In the "Unwilling Old Ladies Study," nine months after relocation 52 per cent had deteriorated, 9 per cent died, and 2 per cent had improved. In the "Home for Life" group one year after relocation 48 per cent had deteriorated, 18 per cent died, and 6 per cent had improved. In the "Deinstitutionalized Elite" group one year after relocation 49 per cent had deteriorated, 2 per cent died, and 21 per cent had improved. In the study called "Death of an Institution," one year after relocation 56 per cent had deteriorated, 18 per cent were dead, and 20 per cent had improved. For a control group the mortality rate for the previous three years at the institution that closed was 10.7 per cent. The "Unwilling Old Ladies" and "Home for Life" groups were contrasted with a sample already moved and they found that the mortality was the same. All of these subjects knew about the move ahead of time. As a result of this study the authors developed a framework for understanding the unique psychological characteristics of aging. They state,

Old age is invariably accompanied by a sense of already having lived a lifetime. Discontinuity with previous psychological attitudes is expressed. There is an overriding motivation to maintain a sense of self-continuity, self-integrity and self-identity. The task is to maintain a coherent, consistent self, an inner task that is more critical than maintenance of an accepted self. The sense of self does not change—rather, what we see is the utilization of
strategies by the elderly to maintain this sense of selfhood (25, pp. 347-47).

The literature contains numerous studies which deal with effects of relocation. Several studies reveal a relationship between relocation and mortality rate. Some studies have been contradictory and revealed no significant relationship. In some instances the methodology of the earlier studies has been questioned. The possibility that changes attributed to relocation were confounded with changes due to age or poor physical condition has been suggested. Increased morbidity has also been associated with relocation. A need exists to isolate possible predictors of satisfactory relocation.

Research on Predictors of Relocation

Many studies have demonstrated that relocation is stressful and many times detrimental. Other studies have been conducted as an attempt to identify predictors of successful or unsuccessful relocation. Isolation of these predictors would be helpful to health care workers attempting to facilitate a satisfactory adjustment.

Ebersole said "The theory of relocation mortality is an example of an operational belief that has been perpetuated because it has an emotional appeal" (13, p.235). She also said there are several variables that are significant in determining a positive outcome of relocation. These variables include younger age at time of relocation,
stable health status, decision-making power present, adequacy of new living situation, convenience to needed services, prior preparation for move, few concomitant stressors experienced, involvement of family or significant others, personality characteristics, environment similarity to previous living site, and absence of preexisting severe physical, mental, or social impairments (13, p.238).

Sims, Jones and Yoder conducted a study to determine characteristics of a satisfactorily adjusted person. They interviewed fifty nursing home residents. Several characteristics were identified. The highly adjusted person was found to have no difficulty living with unrelated others. They reported a lack of change in sleep and in being able to find humor in everyday happenings. They stated they had enough to do, and viewed life as worthwhile, and had many visitors. They felt useful as persons, and found satisfaction with their current life. The findings seem to indicate that interventions need to be found to provide residents with meaningful activities, a means to provide humor and to allow them to continue their former sleep pattern (39).

Yawley and Slover were also interested in predictors. They stated that moving for older persons may be compounded by social isolation, inter-generational conflict, or feeling imposed upon as well as disruption of social relations,
decline in morale, disorientation. Many times there is a sense of helplessness and powerlessness and low self-esteem.

There are wide variations in successful relocation adjustment. Many times there is a tendency to idealize the lost environment. This tendency, and a loss of positive relationships, contributes to the grief process. The higher the social status the less the grief. They identified certain characteristics which affect relocation. For instance senile psychotic patients are less able to cope. Poor health or advanced degenerative changes affect coping behavior. Depression, previous successful coping behavior, and being able to appraise the situation realistically are also factors. Characteristics of the post-relocation environment are powerful predictors. These include institutions providing primarily custodial care, those with unacceptable noise levels, poor safety factors, or the inability of the resident to identify with others in the institution (46).

Wells and Grant stated, "Since relocation of the elderly is often unavoidable it is essential to replicate factors which might reduce undesirable effects" (43, p.178). They conducted a study which dealt with 180 residents who were forced to move due to the closing of a home. There was no choice regarding moving but they could choose where to move. A program for preparation was designed. Prior to the move, subjects were asked to identify residents, staff,
family and friends to whom they felt close. The Life Satisfaction Index was used as a tool to measure the effect of these support groups on satisfactory relocation. This study was limited in that there was no control group, although the results seemed to indicate that relocation substantially disrupts primary relationship networks of many residents. They stated, "This indicates inter-personal networks are a salient dimension to consider in relocation. The number and stability of close relationships with family and with friends outside the institution is of particular importance in minimizing undesirable effects of relocating elderly people" (43, p. 183).

This review of literature did not reveal any studies which compare the relationship of experience in a health facility with successful relocation. Examination of predictors of successful relocation is significant to health care workers who are attempting to identify clients with a potential for unsatisfactory adjustment. Important factors are certain personal characteristics, availability of support systems, and characteristics of the post-relocation environment.

Research on interventions in relocation

Research has also been conducted in the area of interventions which will facilitate successful relocation. White describes a study conducted in a psychiatric facility.
The staff had observed that following relocation from a psychiatric facility to a nursing home, patients experienced increasing confusion and sometimes combative behavior and often wandered away. The decision was made to utilize a consultation team to work with the staff. Patient problems were discussed and care individualized. The result of this intervention was less acting out behavior and increased cooperation of patients with the staff (44). Thus, individualization of care proved important.

Shamian, Clarfield, and Mark describe a study which investigated the effect of preparation. Although this study has a small sample size ($N = 20$), it describes two groups of patients. The experimental group was relocated following extensive preparation of the patients and their families. The control group was not relocated. There was no significant difference in mortality, morbidity, or ability to perform activities of daily living in the two groups (37).

Yawley and Slover also advocated the use of preparation when they said,

Social work referral is helpful. Provide a visit and tour of the facility with a meal in the dining room. Make available community resources, and diagnostic medical studies. Some homes have a room for the prospective resident to use before they move in. Discuss with the family disposal of belongings before he moves in. Make sure he maintains a central role in the decision making process. Utilize the family to increase involvement with the older person. Both family and workers should build on the patient's strengths and hopes. Concentrate on improving the
residents' physical condition and restoring self-care activities (46, p. 94).

Hasselkus concurred when he said, "Relocation to a nursing home should not take place abruptly--ample time is needed to explore various nursing facilities, to experience a sense of choice among the institutions and to become acquainted with the staff and residents" (p. 631). The preparation should include reassurance regarding expectations for discharge and return home to the family. Once within the institution, the resident can decide on placement of personal possessions and arrangement of furniture. This gives a feeling of individuality.

Continuance of friendship bonds is of primary importance. Meaningful friendships rarely develop in a nursing home. Residents should be encouraged to maintain contact with family and friends and participate in familiar activities (21).

Nirenberg investigated another intervention. He stated that inconsistencies regarding relocation are confounded by methodology. Therefore, he separated high and low functioning clients in his study. Twenty high functioning and twenty low functioning adults were assessed prior to, immediately after, and again at three months after relocation. One half of the low functioning group participated in a behavior skills program and one half of the high functioning group participated in a cognitive
skills program. The behavior skills program led to a favorable post relocation change; the cognitive skills program did not. None of these patients died within the three months period. Those exposed to this behavior skills program displayed fewer adjustment problems (30).

Preparation also interested Pino and Rosica. They compared clients prepared for the move with clients transferred without preparation. The preparation consisted of five counseling sessions regarding negative feelings regarding the move, positive aspects of relocation, questions about the new building, choices in room, roommate and progression of construction. A visit to the facility was also included as well as a letter to the families. Inservice programs were conducted regarding the effect of the move. The group of patients receiving the preparation demonstrated less decline in mental alertness and ability to perform activities of daily living than those unprepared (32).

Amenta, Amenta and Weiner (3) used preparation but also investigated the effectiveness of choice. This study involved three groups of patients. The first group moved involuntarily, the second group agreed to move to accommodate the home, the third group chose not to move. All three groups received preparation for the move. The preparation program involved information regarding the new facility. Seven months prior to the move verbal and written
information was given. This was followed by film strips with answered questions. Three months prior to the move residents selected possessions they wanted to take and were given a choice of roommate. Six months after the move the death rate of each group showed no increase over the previous year. Group I and group II showed a significant decrease in mortality rate. In the stationary group the mortality rate remained the same. All groups deteriorated over six months with the stationary group showing less deterioration. They said, "In this study a reasonable amount of preparation with the opportunity for choice provides geriatric residents with increased autonomy" (3, p. 360).

Therapeutic use of self was the subject of a study by Robinson. This was defined as purposeful, sharing and caring as a mode of crisis intervention. Four disoriented persons were placed alternately into an experimental or control group according to order of admission. Four daily periods of therapeutic interaction of twenty minutes each were conducted for the experimental group. Interaction focused on the problems, needs, and feelings of the residents. On the sixth day following admission both groups were again evaluated. Quantitative analysis revealed general improvement in the experimental group as compared to deterioration in the control group. The designated
intervention was statistically significant in decreasing disorientation and disorganized function (34).

Since there are so many studies dealing with relocation some authors have summarized current literature. Pastalan attempted to do this. He stated contradiction exists in the literature regarding relocation due to a lack of consideration of five major factors: (1) degree of choice, (2) degree of environmental change, (3) degree of health, (4) degree of preparation, and (5) methodology. The greater the choice and control the individual had in being relocated the less negative effects. Choice reduces the feeling that they had no control over their lives. Generally people who are angry about the move showed a better adjustment. Complete passivity has been shown to be detrimental. Moving seems to be less traumatic for males than females. Counseling sessions were most dramatically associated with decreased mortality in advanced age groups. Involuntary moves showed a greater decrease in life satisfaction. Pre-relocation preparation programs increase predictability of new environment and reduced mortality (31).

Schultz and Brenner also wrote on this topic. They stated two specific mechanisms affect response to the stress of relocation. These are the perceived controllability and predictability of the events surrounding the move, and differences in environmental controllability between pre- and post-location environments. . . . Studies of the
home-to-institution move show a clear distinction between the voluntary and involuntary components of relocation. Consistently, those subjects who moved voluntarily fared better than those moved involuntarily. Moreover, the degree of control individuals had over their pre-relocation environment was shown to predict scores on a life satisfaction index after institutionalization (36).

Care of the elderly is a topic that will have increasing significance in the future. Many elderly will be institutionalized at some time. It is important to identify factors which will make adjustment to institutionalization satisfactory.

Client assessment is the first step of the nursing process. Assessment criteria need to be established which are specifically related to the needs of the elderly. One aspect of assessment is determining what data to include which would predict unsatisfactory adjustment following relocation.

The effects of relocation have been investigated by a number of different researchers. In some studies a direct relationship has been demonstrated between relocation and an increased mortality rate. Increased morbidity has also been correlated with relocation. Some studies in this area have been contradictory.

Because of the observed deleterious aspects of relocation, studies have been done to determine predictors
of unsatisfactory relocation and to identify interventions. Factors such as personal characteristics, decision making power, availability of support systems, maintenance of previous friendships and characteristics of the post re-location environment have been identified as factors which effect this adjustment. Interventions which have been examined include preparation for re-location, allowing the client to participate in decision-making, and counseling sessions. Therapeutic use of self by the nurse has also been demonstrated to be an effective intervention.

Although these studies have been significant and helpful these variables need to be investigated further. Research is needed identify possible predictors of unsatisfactory adjustment which will prove helpful to health care workers in long-term care. This present study dealt with investigating two possible predictors of unsatisfactory adjustment. Those predictors were quality and quantity of previous contact with a health care facility. Specific factors which affect the perception of the previous experience were identified.
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Chapter III

PROCEDURES FOR COLLECTION AND ANALYSIS OF DATA

The purpose of this chapter is to describe the procedure involved in collection of data. The selection of the sample, development of the instrument, and the process for collection of data are presented. The technique for the analysis of data is also discussed.

Selection of the Population

This study involves administration of a questionnaire to residents in a nursing home. Nursing homes in the Rapides, Grant, or Avoyelle Parish in Louisiana were selected which provided a population of 100 from which a sample of fifty residents were obtained. The names of the residents were received from the Director of Nursing, who determined which residents had not demonstrated a loss of memory as defined in the definitions section of this study. Another criteria for selection was residents who were in the intermediate care facility section (also defined in the section on definitions) and thus were receiving the same type of nursing care. These two criteria were the only requirements for selection.

Random selection was obtained by utilizing the table of random numbers. In using the table of random numbers names
of all residents were numbered. The procedure for using the table of random numbers followed the procedure described by Borg and Gall and used the table found in the appendix of their text (2, pp 651, 905).

Permission to participate in the questionnaire portion of the study was obtained from the residents or their families as well as the administration of the facility. Provision was made to ensure privacy and confidentiality. The questionnaires were numbered and coded. Only questionnaire numbers were used in the study. The population was large enough to provide a sample of fifty residents. This sample size is consistent with the study by Nirenberg which was conducted with a sample of forty (7), the study by Sims, Jones and Yoder which utilized a sample of fifty (9) and that of Amenta, Weiner and Amenta which was performed with a sample of forty seven residents (1).

Consideration of human rights is important. For this reason efforts was taken to provide protection for individuals participating in this study. Approval for this study was obtained from the committee for research on human subjects, North Texas State University. A copy of the informed consent form is in the appendix.
Procedure for Collection of Data

The first instrument dealt with previous experience with a medical facility. It is a simple one-question item designed to determine if the client has had previous experience with a health facility (see Appendix A). The resident indicated the number of times he had been admitted and received treatment in an in-patient health care facility. These terms are described in the section of definitions.

The next step involved a structured interview dealing with quality of the experience. The resident was asked to rate the most recent health care experience in terms of favorable, non-favorable (see Appendix B). At that time the questionnaire, "Factors Perceived as Favorable, Unfavorable Following A Health Care Experience" was administered (see Appendix C).

This questionnaire was based on research conducted by Walker and Restuccia. They developed a questionnaire to be used for patient satisfaction surveys. Items on the questionnaire were compared with an overall rating of the hospital stay as in the question, "Taking everything into account, how do you feel about the care and services you received during your hospital stay?" Pearson's product-moment correlation coefficient was used to determine the most important question. Only those items which had
Pearson's correlation coefficient equal to or greater than 0.3 were used in this questionnaire (10). This corresponds to a statement made by Doering. He said patients with previous hospital experience are more willing to be hospitalized than patients being admitted for the first time. Patients may, with accumulating experience, replace ideal expectations with practical expectations and be more easily satisfied (3). It is possible that these ideal expectations could also apply to nursing homes. Degree of satisfaction with hospital experience is important. Simpson conducted a two and one half year study regarding patient perception of care in the hospital. She found that the age group that perceived care the lowest was the oldest age group, especially in regard to discharge planning and teaching (8). This study was an attempt to determine if this perception effects adjustment to long term care.

The structured interview was conducted with the residents following selection of the sample. It involved administration of both "Quality of Health Care Experience Scale," and "Factors Perceived as Favorable or Unfavorable Following a Health Care Experience." It consisted of a one to one interview with the resident.

The second part of this study occurred at least one month following admission of the resident to the long term care facility. The Life Satisfaction Index (LSI-Z) was administered. This was also a one to one interview with the
resident. Privacy was provided by conducting the interview in the room of the resident. The resident was assured that confidentiality would be maintained. This was done to prohibit fear of reprisal.

The Life Satisfaction Index was originally developed by Neugarten, Havighurst, and Tobin and was published in 1961 (6). This instrument was developed to measure the following components: zest, resolution and fortitude, congruence between desired and achieved goals, positive self-concept and mood tone. From these components they developed two Indexes. Life Satisfaction Index A was composed of twenty items and Life Satisfaction Index B was composed of twelve items. The authors stated their efforts were only moderately successful in refining these instruments (6).

This instrument was later revised by Wylie and Tweete. It was tested for reliability by Wood and Sheafer and published by Wood, Wylie and Sheafer in 1966. This version is called Life Satisfaction Index Z (LSI-Z) (12). Wells and Grant referred to this instrument when they said, "The Life Satisfaction Index (LSI-Z), a thirteen item questionnaire is a shortened version of Neugarten, et al. and has been used extensively in research with the elderly population" (11, p.178).

In terms of reliability Wood, and others stated,

The thirteen statements were correlated with LSR for the full sample of 100; the resulting correlations ranged from .45 to .57. The correlation was .57 (this
validity coefficient is significant at the .01 level or beyond). The Kuder-Richardson Formula 20 'Coefficient Alpha' which computes on the average of all conceivable split halves was applied to the 100 LSI-Z scores. Test reliability was .79" (12, p. 467).

This instrument is found in Appendix D. The charts of these residents were also examined to determine if the resident had changed roommates more than once or if he or she had moved from one long-term care facility to another. If the answer is yes to either of these two criteria he or she was classified as having made an unsatisfactory adjustment. Roommate change which resulted from changes the client cannot control including death, illness or dismissal of his or her roommate or decisions made by those responsible for the care of the residents were not considered unsatisfactory adjustment. Chart examination also revealed the number of times a medical doctor was consulted regarding this resident.

In an attempt to identify factors which might skew the data demographic data were obtained from the charts of the residents. This included age, religion, sex, race, known ethnicity, and length of stay in the facility. The Health Attribution Test was also administered as a structured interview and conducted by the investigator.

The Health Attribution Test was developed by J. Lawlis and G.F. Lawlis to determine the degree to which an individual perceives his individual control over his health. The Health Attribution Test (HAT) was described by Drake.
He used this instrument when he conducted research for his dissertation. He stated,

The Health Attribution Test (HAT) was developed by Frank Lawlis and Jeanne Lawlis in 1980. The test is designed to assess the degree of attribution or personal control people have regarding their own health. . . . Using principles of locus of control, the HAT measures three areas. These areas are internal (how much responsibility they take for their own health), powerful others (the degree to which they abdicate control of their health to other people), and chance (the degree to which they feel that fate controls what happens to their health). Reliability was measured by test-retest method with an average coefficient of .81 and by a split-half method with a coefficient of .88 (4, p. 21).

A pilot study was conducted. Following approval from the resident and administration of the institution all five instruments were administered. The first one-question test was used. This was followed by the "Quality of Health Care Experience Scale." The questionnaire, "Factors Perceived as Favorable, Unfavorable Following A Health Care Experience," the Life-Satisfaction Index (LSI-Z), and the Health Attribution Test (HAT) were also administered. These are found in the Appendix.

Procedure for Analysis of Data

Procedure for Testing

Research question 1--- Will residents who have had more experience with an in-patient health facility show a higher degree of satisfactory adaptation to nursing home living?
Data were obtained from the first structured interview. The specific number of times the resident had been admitted to an in-patient facility was recorded. These were a range of numbers and were a continuous variable. Ferguson said, "A continuous variable is a variable that may take on any given value within a defined range of values. The possible values of this variable belong to a series" (5, p. 12). This was compared to the score on the Life Satisfaction Index which is also a continuous variable. Analysis was made using multiple regression.

A comparison was also made of the results obtained from the examination of charts. This revealed the number of times an individual had changed roommates as described in this chapter or changed to another health care facility. The number of times a medical doctor was consulted was also determined. These were also continuous variables.

**Procedure for Testing**

**Research question II**—Will residents who perceived their previous experience with the health care facility as favorable have a more successful degree of adaptation? Data for this question utilized the scale, "Quality of Health Care Experience." It was compared with the Life Satisfaction Index (LSI-2). These are continuous variables. Multiple regression was used for analysis.
Health Care Experience." The criteria for measurement of successful relocation or criterion variables were the number of times the client had changed rooms, the number of times he or she had contacted a medical doctor as revealed by chart examination, and the score on the LSI-Z. The significance of the multiple correlation was tested using an F ratio. The .05 level of significance was used.

Data obtained were categorized according to age, sex, race, ethnicity, religion, length of stay in the facility, and scores on the HAT. Multiple correlation was also used as analysis of this data. After all computations were made data were entered into figures for ease of reporting.

In this chapter the procedure for collection of data was presented. The selection of the population was described as well as the procedure for data collection. Five instruments were included and described. These included "Questionnaire to Determine Quantity of Health Care Experience, Quality of Health Care Experience Scale," and the questionnaire, "Factors Perceived as Favorable, Unfavorable Following a Health Care Experience," the Life Satisfaction Index (LSI-Z), and the Health Attribution Test (HAT). A copy of these instruments is included in the appendix. This information is discussed in terms of statistical analysis in Chapter IV. The analysis is presented by the use of multiple regression.
CHAPTER BIBLIOGRAPHY


CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Population

Previous chapters presented the introduction to the study, a survey of related literature, and the design and methodology of the study. This chapter is concerned with the presentation and analysis of data collected from fifty residents in the intermediate care facility section (as defined in the section on definitions) of a long term care facility.

Facilities used for the collection of data include the nursing home care unit of a Veterans Administration Hospital which has a bed capacity of 93 beds, Tioga Manor, with a bed capacity of 120, Camellia Gardens, with a capacity of 95, Heritage Manor North, with a total of 90 beds, and Heritage Manor South, which could accommodate 56 residents. Both Heritage Manor South and Camellia Gardens are located in the lower socioeconomic section of the community. The other facilities were primarily in a middle class neighborhood. Veterans Hospital served veterans from any economic class. Each of these facilities was located in the Alexandria Pineville area of Rapides Parish, Louisiana. A pilot study was performed in Heritage Manor #2, a 120 bed facility.
located across the street from a 300 bed hospital in a middle class neighborhood.

The Pilot Study

Prior to data collection a pilot study was completed. This was done to familiarize the investigator with the research process of this particular study and to allow her to become familiar with the measurement instruments. Performing the pilot study facilitated the achievement of these objectives.

Permission was obtained to conduct the pilot study in a nursing home in Alexandria, Louisiana. Thirteen residents were interviewed following obtaining written permission from each resident. The "Questionnaire to Determine Quantity of Health Facility Experience, Quality of Health Care Experience Scale, and Factors Perceived as Favorable, Unfavorable Following A Health Care Experience Scale" were administered. The Life Satisfaction Index (LSIZ) and Health Attribution Test (HAT) were also used.

As a result of this pilot study a few minor changes were made in the research process. In obtaining permission the statement "I want to ask you some questions" sometimes was mistaken as a test of cognitive knowledge. This was changed so that the investigator stated, "I need to ask your opinion." or, "I need you to help me by giving me some information." This method of obtaining information seemed
to be less threatening.

There was a need to clarify the question in the "Questionnaire to Determine Quantity of Health Facility Experience." The purpose of this question was to determine perception of health care experience prior to admission. Some residents had been admitted to the hospital after residing in the nursing home. For this reason the interviewer said, "This question concerns the time before you entered this nursing home. Therefore, answer this question, "Before you were admitted to this home, were you admitted to a hospital or rehabilitation facility? How many times?"

In using the "Quality of Health Care Experience Scale" the descriptors good experience or bad experience were added to the list of descriptors already included in the preface to Appendix B. The same descriptors were used in the questionnaire in Appendix C. A change was also made in recording responses in Appendix D and F. Instead of recording an X under the appropriate columns the investigator recorded A (Agree), D (Disagree) in Appendix D or SD (Strongly Disagree), DS (Disagree Somewhat) SID (Slightly Disagree), S1A (Slightly Agree, AS (Agree Somewhat) or SA (Strongly Agree). This made the responses easier to record and categorize. The decision was also made to include length of stay in the demographic data. No other
changes were found to be necessary in the research process, and efforts were made to proceed with data collection.

Data Collection

After initial approval was obtained from the administrator or his or her representative the investigator contacted the Director of Nursing or Head Nurse depending on the appropriate person in that particular facility. A list of 100 names of residents who met the criteria outlined in Chapter III, Selection of the Population was obtained. These names were listed in the order obtained from the Director of Nursing and were numbered. Using the procedure for using the table of random numbers as described by Borg and Gall (1) and referred to in Chapter III, randomized selection was used to obtain a sample of fifty. Written permission to participate in the study was obtained from the administrator or his representative and from the resident. The questionnaires were numbered and the permission sheet removed to protect confidentiality.

Each resident was interviewed separately and by the same investigator. Since the same person conducted the pilot study and all the interviews, no training was needed for this aspect of data collection. The pilot study served as training for administration of the questionnaires. "The Questionnaire to Determine Quantity of Health Facility Experience, Quality of Health Care Experience Scale, and
Factors Perceived as Favorable, Unfavorable Following a Health Care Experience Scale," were used. The Life Satisfaction Index Z (LSIZ), and Health Attribution Test (HAT) were also administered. Responses were tabulated and the LSIZ and the HAT were scored. This information was used for statistical analysis. The sample included individuals with many different characteristics.

Demographic Characteristics

Various factors sometimes influence the way an individual responds to changes in his or her environment. For this reason, it is important to determine if there is a relationship between these factors and the response of that individual to the research instrument. Demographic data regarding the sample are presented. Information regarding age, religion, sex, race, known ethnicity, and length of stay in the present facility are presented in the following figures. This is similar to a study by Killian who included age, sex, race, organic diagnosis, and length of stay in his study. (3) Knowledge of each of these categories of information helps provide a more complete understanding of characteristics of the sample.

Distribution of age is important in evaluating the responses obtained. Neugarten and Hogestal stated, "Age is a major dimension by which the individual organizes his life course and interprets his life experiences" (5, p. 35). For
this reason it is important to examine the age of the sample members. Age distribution is presented in Figure 1.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>105-92</td>
<td>XXXX</td>
</tr>
<tr>
<td>88-80</td>
<td>XXXXXXXXX</td>
</tr>
<tr>
<td>79-71</td>
<td>XXXXXXXXXXXXXXXXXX</td>
</tr>
<tr>
<td>69-60</td>
<td>XXXXXXXXXXXXXXXXXX</td>
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<tr>
<td>58-51</td>
<td>XXXX</td>
</tr>
<tr>
<td>48-39</td>
<td>XXXXXX</td>
</tr>
</tbody>
</table>

Fig. 1--Age distribution of residents in the sample

Examination of age reveals a wide age span. The age of members of the sample ranged from 39 to 105 years. Although this is a wide span the residents were somewhat evenly positioned along the age continuum. The largest percentage of residents were in the sixties and seventies. A smaller percentage occurred in the age 92 to 105 and in 39 to 48 and 51 to 58.

Religion is another factor that influences the way an individual responds to change. Consideration of this relationship is important. There were nine different religious groups represented in the sample. From the standpoint of religion this provided variety in the sample. However, it is noted that the distribution only included Protestants and Catholics. There were no non-Christian religions represented. These groups are represented in Figure 2.
Religion
Church of Christ  X
Presbyterian  X
Methodist  X
Nazarene  X
Pentacostal  XXXX
None  XXXX
Protestant  XXXXXXX
Catholic  XXXXXXXXXXXX
Baptist  XXXXXXXXXXXXXXXXXXXX

1  4  8  14  24
Number of Residents
Fig. 2—Religious preference of residents

Religious preference is not evenly divided.
Twenty-four out of the sample of 50 are Baptists. There is also a high percentage of Catholics. Both of these religious denominations are strong in Louisiana. The strength of these groups would influence the religious preference of the sample. Analysis was made of this relationship and is presented later in this chapter.

Information was obtained regarding sex of the residents. It is important to consider the relationship of sex to adaptation. Differentiation of the sex of the sample was done to provide data for analysis. This is presented in Figure 3.

Sex
Female  XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Male  XXXXXXXXXXXXXXXXXXXXXXXXXXXX

24  26
Number of Residents
Fig. 3—Sex of the residents
From the standpoint of sex an unusual sex ratio existed. There were only two more females than males. The sample was somewhat evenly divided. The relationship of sex to criterion variables is discussed later.

For purposes of analysis information was obtained regarding race and ethnicity. It was deemed desirable to determine the degree of relationship of those criteria and the criterion variables. This is presented in Figures 4 and 5.

Race
Black xxxxxxxx
White xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

8 42
Number of Residents

Fig. 4—Race of the residents

The vast majority of residents in this particular sample were white. Many did not know the ethnicity regarding their origin or nationality. Several made statements similar to, "I am just a good old American." Information is provided on those participants who did know their ethnic origin.

Ethnic
French XXXXXXXX
Italian XX
Czechoslovakian X

8 12
Number of Residents

Fig. 5—Known ethnicity of residents
The high percentage of French is characteristic of the population in Louisiana. Italian and Czechoslovakian groups were also represented. Other known ethnic groups were not present in this sample.

In order to facilitate analysis, information was obtained regarding length of stay in the facility in which the resident is currently residing. A wide variance existed in length of stay. There was a need to determine if the length of stay influenced the degree of successful adaptation to long-term care. This is represented in Figure 6.

<table>
<thead>
<tr>
<th>Months</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>168</td>
<td>X</td>
</tr>
<tr>
<td>144</td>
<td>X</td>
</tr>
<tr>
<td>132</td>
<td>X</td>
</tr>
<tr>
<td>120</td>
<td>XXX</td>
</tr>
<tr>
<td>96</td>
<td>X</td>
</tr>
<tr>
<td>72</td>
<td>X</td>
</tr>
<tr>
<td>60</td>
<td>XXXX</td>
</tr>
<tr>
<td>48</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>36</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>24</td>
<td>XXXXXX</td>
</tr>
<tr>
<td>12</td>
<td>XXXXXXXXXXXXXXXX</td>
</tr>
<tr>
<td>7-11</td>
<td>XX</td>
</tr>
<tr>
<td>2-6</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

Fig. 6—Length of stay of residents according to months

A difference existed from 2 months to 168 months (14 years). This was a large difference, although 15 of the 50 reported a length of stay of 12 months (1 year) and 6 reported 24 months (2 years). Analysis of this difference is presented in the next section of this chapter.
Analysis of Data

An analysis of data obtained from the instruments and other criteria measuring satisfactory adjustment as well as demographic data and questionnaires measuring quantity and quality of prior health care experience, was treated using multivariate statistics. Multivariate statistics refers to the class of statistical methods which is used in the analysis of data comprising more than two variables. Sometimes many variables are used (2). Analysis employed multiple regression.

The SAS computer program package was used utilizing the MUSIC operating system. This program was copyrighted in 1984 by the SAS Institute and was run under release of SAS at North Texas State University. For analysis utilizing Pearson product moment correlation coefficients a significance of 0.01 was identified as the acceptable level. All other comparisons utilized 0.05 as a significant level.

The purpose of this study was to examine measures of quantity (identified on data as ADMIT) and quality of previous experience with a health care facility (identified as L) as well as the ten-item questionnaire regarding specific factors in previous hospitalizations which are regarded as favorable, unfavorable (identified as Fl-10). These measures were compared with criteria which measure satisfactory adjustment to nursing home living. These were the score on the Life Satisfaction Scale
(identified on data as LSIZ), the number of times the resident changed rooms (identified as ROOMCHG), and the number of times a medical doctor was contacted regarding physical complaints or complications (identified as DOCVISIT). An additional correlation was done regarding demographic data and a measure of perceived control of health (the HAT). This was done to identify factors which may have served to confound the data because of a direct relationship to the results of the study.

Factor analysis was used in an attempt to determine if the number of items in the questionnaire, "Factors Perceived as Favorable, Unfavorable Following a Health Care Experience" were similar and could be combined. Factor analysis is a statistical method which is used in the analysis of tables of correlation coefficients. It reduces the variables to a smaller number of variables. The new variables are called factors (2). The factor analysis reduced the ten items to three factors. Information regarding the factor analysis is included in Table 1.

<table>
<thead>
<tr>
<th>Question</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>-0.0660</td>
<td>0.8380</td>
<td>-0.0702</td>
</tr>
<tr>
<td>F2</td>
<td>0.4279</td>
<td>0.5215</td>
<td>0.1202</td>
</tr>
</tbody>
</table>

TABLE 1

FACTOR ANALYSIS ON QUESTIONNAIRE ITEMS FACTORS PERCEIVED AS FAVORABLE, UNFAVORABLE FOLLOWING A HEALTH CARE EXPERIENCE
TABLE I—Continued

FACTOR ANALYSIS ON QUESTIONNAIRE ITEMS FACTORS PERCEIVED AS
FAVORABLE, UNFAVORABLE FOLLOWING A HEALTH CARE EXPERIENCE

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>F3</td>
<td>0.6657</td>
<td>-0.1290</td>
<td>-0.3680</td>
</tr>
<tr>
<td>F4</td>
<td>0.5969</td>
<td>0.1637</td>
<td>0.2200</td>
</tr>
<tr>
<td>F5</td>
<td>0.6649</td>
<td>-0.1212</td>
<td>-0.2417</td>
</tr>
<tr>
<td>F6</td>
<td>0.3830</td>
<td>-0.5436</td>
<td>0.4869</td>
</tr>
<tr>
<td>F7</td>
<td>0.1975</td>
<td>-0.2789</td>
<td>0.6501</td>
</tr>
<tr>
<td>F8</td>
<td>0.6150</td>
<td>-0.1959</td>
<td>0.2689</td>
</tr>
<tr>
<td>F9</td>
<td>0.2873</td>
<td>-0.0271</td>
<td>0.6830</td>
</tr>
<tr>
<td>F10</td>
<td>0.4401</td>
<td>0.6646</td>
<td>-0.1937</td>
</tr>
</tbody>
</table>

This factor analysis did not reveal any significance at the .05 level. For this reason the information obtained from factor analysis was not helpful. These items will be treated individually, since the factor analysis did not reveal significant categories.

Multiple correlation was performed comparing the criterion variables with the predictor variables. "Multiple regression and correlation involve the use of a correlation coefficient—the correlation coefficient may be used to predict or estimate a score on an unknown variable from a score on a known variable. . . . The multiple correlation coefficient is a measure of the efficacy of prediction for a particular sample" (2, p. 466, 471).

For purposes of this study the predictor variables were identified as the number of times the resident was admitted (ADMIT), the "Quality of Health Care Experience Scale,"
which is in the form of a Lickert scale and is identified as \((L)\), and the ten item questionnaire \((F1-10)\). These variables were the measures of quantity and quality of prior health care experience. This is comparable to a study described by Ferguson in which a measure of scholastic success was called a criterion variable. The scores on two psychological tests were called predictor variables (2, p. 466). The criterion variables in this study were measures of satisfactory adjustment to nursing home living. These included the score on the Life Satisfaction Index \((LSI)\), the number of times the resident changed rooms \((ROOMCHG)\), and the number of times a medical doctor was contacted regarding the resident \((DOCVISIT)\). The results of this analysis are presented in Tables II and III.

**TABLE II**

**ANALYSIS OF VARIANCE REGARDING PREDICTOR AND CRITERION VARIABLES**

<table>
<thead>
<tr>
<th>variable</th>
<th>source</th>
<th>DF</th>
<th>sum of squares</th>
<th>mean square</th>
<th>F</th>
<th>Prob &gt;F</th>
</tr>
</thead>
<tbody>
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<td>ADMIT</td>
<td>model</td>
<td>3</td>
<td>71.910</td>
<td>23.9702</td>
<td>1.803</td>
<td>.1599</td>
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<tr>
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<td>error</td>
<td>46</td>
<td>611.610</td>
<td>13.295</td>
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</tr>
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<td></td>
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<td>49</td>
<td>683.520</td>
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<td></td>
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<td>L</td>
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<tr>
<td></td>
<td>c total</td>
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<td></td>
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</tr>
<tr>
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<tr>
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TABLE II—Continued
ANALYSIS OF VARIANCE REGARDING PREDICTOR AND CRITERION VARIABLES

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<th></th>
<th>c total</th>
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<td>F3</td>
<td>model</td>
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<td>2.3288</td>
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<td>49.000</td>
</tr>
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<td>32.5000</td>
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<td>25.2800</td>
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<td>27.1200</td>
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<td>error</td>
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<td>26.0558</td>
</tr>
<tr>
<td></td>
<td>c total</td>
<td>49</td>
<td>26.5800</td>
</tr>
</tbody>
</table>

*significant at the .05 level
### TABLE III

**PARAMETER ESTIMATES REGARDING PREDICTOR AND CRITERION VARIABLES**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Df</th>
<th>Parameter Estimate</th>
<th>Standard Error</th>
<th>T For H0 Parameter =0</th>
<th>Prob&gt;T</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roomchg</td>
<td>1</td>
<td>-0.8661</td>
<td>0.4506</td>
<td>-1.922</td>
<td>0.0608</td>
</tr>
<tr>
<td>Docvisit</td>
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<td>0.1332</td>
<td>0.0946</td>
<td>1.407</td>
<td>0.1661</td>
</tr>
<tr>
<td>LSIZ</td>
<td>1</td>
<td>-0.0436</td>
<td>0.4757</td>
<td>-0.918</td>
<td>0.3634</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Roomchg</td>
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<td>0.1001</td>
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<td>1.176</td>
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<td></td>
</tr>
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<td>-1.220</td>
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</tr>
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<td></td>
<td></td>
</tr>
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<td>Docvisit</td>
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TABLE III—Continued
PARAMETER ESTIMATES REGARDING PREDICTOR AND CRITERION VARIABLES

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*Significant at the .05 level

This analysis did not show any significant results other than the relationship between factor eight of the ten-item questionnaire when compared to the criterion variable. Factor eight was the question, "How would you rate your overall medical care?" The comparison resulted in a significance of 0.0218. There was a probability >T of 0.0024 when it was compared to LSIZ. Additional analysis involving parameter estimates of variable F1-10 and criterion variables did not reveal any significant results. There were some relationships which came close to being significant. When analysis of variance was used to compare admit (the number of admissions to a health care facility)
to the criterion variables a significance of 0.1599 was found. Parameter estimates showed a relationship of 0.0608 between admit and roomchange and a significance of 0.1661 between admit and docvisit. Parameter estimates also showed a relationship between F3 and roomchange of 0.1933. F3 was the question, "How was the quality of food?" A relationship of 0.1858 existed between F4 and docvisit. F4 was the question, "How would you rate overall nursing care?" An additional relationship of 0.1001 was shown between F9 and roomchange. F9 was the question, "How would you rate Doctor's explanation?"

Additional analysis was done comparing the criterion variables with demographic data, length of stay, and raw scores on the Health Attribution Test (HAT). The reason for this comparison was to determine if these factors confounded or caused the data to be skewed in one way or the other. If any of these factors were significant the likelihood existed that significance would be given to prior health care when in fact the significance was related to one of these factors. Information relating to the comparison of these items is found in Tables IV and V.
### TABLE IV

ANALYSIS OF VARIANCE REGARDING CRITERION VARIABLES AND DEMOGRAPHIC DATA, LENGTH OF STAY, AND HAT SCORES

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There was no level of significance identified in this analysis. However, there were three relationships that are worthy of mention. Analysis of variance revealed a relationship of 0.1603 between sex and criterion variables,
0.1728 between religion and criterion variables, and 0.0729 when internal control was compared with the same variables. Analysis of variance is a statistical method for dividing the variation observed in experimental data into different parts. Each part is assigned to a known source, cause, or factor (2).

**TABLE V**

PARAMETER ESTIMATES REGARDING CRITERION VARIABLES AND LENGTH OF STAY, DEMOGRAPHIC DATA, AND HAT SCORES

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TABLE V--Continued
PARAMETER ESTIMATES REGARDING CRITERION VARIABLES AND LENGTH OF STAY, DEMOGRAPHIC DATA, AND HAT SCORES

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*Significant at the .05 level

This analysis revealed two relationships that reached a level of significance of .05 or greater. A comparison of the relationship of religion and roomchange revealed a probability of 0.0476 being greater than T and therefore not occurring by chance. A significant relationship was also found when comparing the raw score of internal control on the HAT test with the score on the LSIZ test. This relationship was 0.0436.

Although the .05 level was not obtained there were three relationships in this analysis that should be mentioned. Parameter estimates revealed a relationship of 0.1856 between docvisit and sex, 0.1333 between sex and LSIZ, and 0.1365 between race and roomchange. These relationships will be discussed in Chapter V.
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* Significant at the .05 level
The SAS computer analysis program also included Pearson correlation coefficients on selected items. Ferguson stated, "the statistic that describes the degree of relation between two variables is called a correlation coefficient." The most widely used measure of correlation is the Pearson product-moment correlation coefficient" (2, p. 108). A summary of this information is presented in Table VI. It is understood that in a table which includes a large number of items some significance will occur by chance. Therefore a significance of both 0.01 and 0.05 will be discussed. This correlation revealed some significant correlations. Correlations which were significant at the .01 level were age and admit (0.0064), admit and L (.0004), and internal and power (0.0081), F6 and F1 (0.0018), and F10 and F1 (0.0004). F6 was the question, "Were the nurses competent?". F1 was the question,"Were you satisfied with your admission process?". F10 was the question, "Was the frequency of your doctor's visits satisfactory?". Additional correlations were significant at the .05 level. These include roomchange and docvisit (0.0112), power and age (0.0380), admit and power (0.0234), F4 and L (0.0127), F 10 and stay (0.0203), admit and stay (0.0203), and F5 and internal (0.0441). F4 was the question, "Were you satisfied with your overall nursing care?". F5 was the question, "Was the clarity of nursing instruction
satisfactory?". Consideration will be given regarding the meaning of these correlations.

Other correlations which did not meet the criteria of a .05 level of significance but are considered important include stay and internal (0.1019), roomchange and admit (0.1603), internal and admit (0.0936), internal and L (0.1821), chance and internal (0.0565), F1 and L (0.1612), F1 and age (0.0789), and F2 and age (0.1741). F2 was the question, "Were you satisfied with the condition of your room?". Other relationships included power and L (0.1680), F4 and admit (0.1566), F7 and L (0.0824), F9 and admit (0.1896), F8 and L (0.1049), and F9 and roomchange (0.1311). F7 was the question, "Was the clarity of nursing instruction satisfactory?". F9 was the question, "Were the doctor's explanations satisfactory?". F8 was the question, "Were you satisfied with your overall medical care?".

Discussion

Analysis of data in this study reveals only minor areas of significance. A direct significant relationship between criterion and predictor variables was not verified. A significance at the .05 level was found in only one item on the ten-item questionnaire. This was opinion of overall medical care. A significance at the .05 level was shown when overall medical care was compared to the LSIZ score. In only two of the additional variables analyzed did a
significant relationship appear with the criterion variable. This was a comparison of religion and roomchange and a comparison of the measure in internal control and LSI2 score.

Pearson correlation coefficients were similar. Admit and L (0.004) were both predictor variables. This significance came from comparing two of the same type variables. The same thing is true with internal and power (0.0081). They are HAT scores. F6 and F1 are predictor variables (0.0018). F10 and F1 (0.0004) are also predictor variables. Roomchange and docvisit (0.0112) are both criterion variables. Power and age are demographic data and HAT scores (0.0380). F4 and L are predictor variables (0.0127). Other relationships included demographic data or HAT score and predictor variables. These included age and admit (0.0064), admit and power (0.0234), admit and stay (0.0203), and F10 and stay (0.0203). Analysis was done to determine if a relationship occurred between criterion and predictor variables or between demographic data or HAT scores and criterion variables. These comparisons were all within the same category.

Pearson correlations which were mentioned but did not reach the .05 level and included items in the same category are stay and internal (0.1019), chance and internal (0.0565), F1 and L (0.1612), F4 and admit (0.1565), F7 and L (0.0842), F9 and admit (0.1896), and F8 and L (0.1049). The
only relationship which compared a criterion variable with a predictor variable was roomchange and admit (0.1603). This relationship is discussed elsewhere. Comparisons between demographic data or HAT scores and predictor variables are internal and admit (0.0936), internal and L (0.1821), F1 and age (0.0789), F2 and age (0.1741), and power and L (0.1612). This comparison was not within the framework of this study.

The statistical analysis was performed to test three research questions. Research question I was: will residents who have had more experience with an in-patient facility show a higher degree of satisfactory adaptation to nursing home living? The number of times the resident had been admitted (ADMIT) was compared to the criterion variables. The criterion variables were the score on the Life Satisfaction Index (LSIZ), the number of times the resident changed rooms (ROOMCHG) and the number of times a medical doctor was consulted (DOCVISIT).

Analysis of variance of admit and criterion variables revealed a probability of 0.1599 >F. Parameter estimates comparing admit with roomchg revealed a probability of 0.0608 >T; when compared with docvisit a probability of 0.1661 >T; when compared with LSIZ a probability of 0.3634 >T. Although the .05 level was not achieved the probability with roomchg was very close and the relationship with docvisits worth mentioning. It is possible that the Life Satisfaction Index was not a good measure of successful
adjustment for this particular sample, or perhaps they did not understand the questions. Regardless of the cause the possibility of a relationship still should be considered.

Research question II was: will residents who perceived their previous experience with the health care facility as favorable have a more successful degree of adaptation? The score on the scale, "Quality of Health Care Experience" was compared with the same criterion variables. Analysis of variance comparing L with the criterion variables revealed a probability of 0.4424 >F.

Parameter estimates showed a relationship of 0.4030 >T when L was compared to roomchg, a relationship of 0.3961 >T, when compared to docvisit, and 0.2455 >T when compared to LSIZ. These results are not indicative that a causal relationship exists.

Research question III was: what are some factors clients identify as causing a health care experience to be perceived as favorable or unfavorable? The items on the questionnaire, "Factors Perceived as Favorable, Unfavorable Following a Health Care Experience" were compared with the same three criterion variables. Each item will be treated separately.

The first questionnaire item (F1) was the question, "Were you satisfied with your admission process?" Analysis of Variance of this item was a probability of 0.5634 >F. Parameter estimates resulted in 0.4679 when compared with
roomchg. 0.7710 when compared with docvisit, and 0.2287 >T when compared with LSIZ. This is not a significant relationship.

The second questionnaire item (F2) was the question, "Were you satisfied with the condition of your room?" Analysis of variance was performed. This revealed a probability of 0.7129 >F. Parameter estimates showed 0.8376 with roomchg, 0.3207 with docvisit, and 0.2287 >T with LSIZ. This is not significant.

The third questionnaire item (F3) was the question, "How was the quality of food?" Analysis of variance for this item was 0.5195 >F. Further analysis revealed 0.1933 when compared with roomchg, 0.3710 with docvisit and 0.6199 >T with LSIZ. Only roomchg was close to being significant.

The fourth questionnaire item (F4) was the question, "Were you satisfied with your overall nursing care?" This was also analyzed using analysis of variance. This revealed 0.5028> F. Further analysis resulted in 0.2956 when compared with roomchg, 0.1858 with docvisit, and 0.5556 >T with LSIZ>. The comparison with docvisit is possibly worthy of consideration.

The fifth questionnaire item (F5) was the question, "Was the clarity of nursing instruction satisfactory?" Comparison to the criterion variables resulted in 0.7961 >F by analysis of variance. Parameter estimate revealed 0.6768
for roomchg, 0.5014 for docvisit, and 0.9168 for LSIZ. None of these are significant.

The sixth questionnaire item (F6) was the question, "Were the nurses competent?" Analysis of variance showed 0.7726. Parameter estimate was 0.2773 for roomchg, 0.4971 for docvisit, and 0.9862 for LSIZ. None of these is significant.

The seventh question (F7) was the question, "Was the clarity of nursing instruction satisfactory?" This also was analyzed statistically. With analysis of variance a value of 0.5210 was obtained as being >F. Utilization of parameter estimates showed 0.8382 when compared with roomchg, 0.6463 on comparison with docvisit, and 0.2133 when compared with LSIZ. None of these is significant.

The eighth question (F8) was the only item of significance. This was the question, "How would you rate your overall medical care?" Analysis of variance was significant at 0.0218 >F. Parameter estimate was also significant in one area. Roomchg revealed a value of 0.6109, docvisit 0.6224, and LSIZ 0.0024.

The ninth question on the questionnaire was, "How would you rate your doctor's explanation?" The analysis of variance value was 0.4094 >F. Parameter estimate was 0.1001 for roomchg, 0.4344 for docvisit, and 0.7635 >T for LSIZ. Although a significance of .05 was not reached consideration could possibly be given to roomchg.
The last question in this questionnaire was, "Was the frequency of your doctor's visits satisfactory?" Analysis of variance revealed 0.8191. Parameter estimates on this item showed 0.3891 for roomchg, 0.9353 for docvisit, and 0.9207 >T for LSIZ. These levels are not significant.

Initial examination of this analysis seems to indicate that prior health care experience does not have a relationship to adaptation to long term care and therefore cannot be used as a predictor of successful adjustment. The research conducted with this particular sample does not substantiate a relationship. Further consideration of the data is needed. The questionnaire item F8--"How would you rate your overall medical care?" is a very general statement. It is very possible that residents who perceived overall medical care as satisfactory would also achieve a satisfactory adjustment to life changes and respond positively to questions regarding satisfaction with life.

Although it is understandable that a relationship between the other two variables might also be explained by the nature of the variables, consideration of these variables is desirable. It is possible that religion might influence the request to change rooms. Likewise a person who perceives himself as having a high degree of internal control over health might have a tendency to be more satisfied with his life in general. This similarity could account for the significance. However, the fact that some
degree of significance exists is a reason to examine this entire study more critically. Lack of a level of significance between predictor and criterion variables does not diminish consideration of the factors investigated. Duplication of this research with another sample might produce different results.

Each person relocating to long term care is a unique individual and therefore will react in his own way. Lack of significance in this study does not negate consideration that prior experience in a health care facility might in fact influence the degree of successful adaptation. Shamian, Clarfield and Mark found a lack of significance in the study they conducted regarding preparation for relocation (7). Other authors such as Hasselkus (2), and Pino and Rosica (6) have found positive results related to preparation for relocation. It is possible that the same situation might exist regarding prior experience in health care and relocation.

Explanation of the reaction of the individuals in this sample is comparable to the theoretical framework developed by Lieberman and Tobin which was referred to in the Review of Literature. They stated, "Old Age is accompanied by a sense of already having lived a lifetime. There is a task to maintain a consistent, coherent self and a sense of self-continuity, self-integrity and self identity" (4, p. 348). During the process of data collection, the importance
of the application of this theory was evident. The interviewer became cognizant of the fact that expression of a positive attitude toward life was not related to the degree of physical impairment or to environmental characteristics of the facility. Instead, there seemed to be an over-riding expression of self-acceptance that was present in those individuals who verbalized satisfaction with life and with their environment.
CHAPTER BIBLIOGRAPHY


CHAPTER V

SUMMARY OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS

Summary of Findings

The problems associated with successful relocation in long-term care have been recognized by many professional practitioners. This problem has been addressed many times in the literature. A review of the literature was conducted regarding status of the elderly, nursing education and gerontology, and a study of the effect of relocation, predictors of successful relocation, and interventions which facilitate successful relocation. Due to the increase in the percentage of the population over sixty-five years of age and the fact that it has been estimated that 25 per cent of the total population will spend some of their time in a nursing home, this subject is very relevant. Many nursing educators are focusing their attention on the quality and quantity of gerontologic content in nursing curricula. Relocation has been linked to increasing mortality and morbidity.

Predictors of successful relocation such as preparation for the move, involvement in decision making and inter-personal networks have been identified. There were no studies which investigated prior health care experience as a
possible predictor. This is one factor which could be identified early and thus facilitate selection of appropriate interventions. This study examined the relationship of prior health care experience and successful relocation.

The problem of this study was to identify and compare prior health care experiences and adjustment to relocation in a long-term care setting of selected current residents in nursing homes. The purposes of the study were the following:

1. To increase and strengthen curricular content in gerontologic nursing by investigating a factor which may influence the degree of successful adaptation to nursing home living.

   Investigation of this possible predictor of successful relocation added to content which may be included in the curriculum of schools of nursing.

   The fact that a probability level of 0.1599 was obtained was evidence that this factor should not receive much emphasis in nursing curricula. Other factors such as family support should be emphasized more.

2. To facilitate more effective methodology in teaching assessment of client problems in nursing education.

   Methodology in teaching assessment will be strengthened by the knowledge that perhaps this predictor is not as strong as could be assumed. Primary focus needs to
be placed on other criteria. A probability of 0.1599 is not strong enough to support this assessment parameter.

3. To identify selective criteria which may be used by health care professionals such as nurses, social workers, occupational therapists, and nursing home administrators who are involved in the admission of clients to long term care.

In performing intake assessments of clients prior to admission to a long term care facility perhaps less attention needs to be given to previous admissions in health care facilities. A significant level of 0.1599 is not strong enough to support placing extra emphasis on this criteria. Other selective criteria include such factors as preparation for the move and degree of perceived internal control.

4. To identify factors which will increase the quality of nursing assessment of client problems.

Other factors should be given primary emphasis in performing assessment and identification of client problems. Since the relationship of admit and criterion variables was 0.1599 other factors should be emphasized during the assessment process.

5. To examine the number and nature of previous admissions to a health care facility, in regard to the effect on successful relocation.

The number and nature of previous admissions were examined in relation to the effect on successful relocation.
The number was not found to be significant. The significance of the nature was 0.4424. This is not significant either. The emphasis on the importance of previous admissions is not advocated. More important is a means of helping the client maintain a sense of self-identity.

6. To determine if the perception of the client regarding quality of health care admissions has any relationship to successful relocation.

Perception of the client regarding quality of health care admissions was examined in regard to the effect on successful relocation. A level of significance was not achieved.

7. To identify selected factors which clients perceive as favorable or unfavorable regarding health care.

Selected factors regarding health care were examined in regard to the relationship of perception of the client regarding the degree in which that experience was favorable and the effect on successful relocation. Only one item on the ten factor questionnaire was found to be significant. The factor was the question, "How would you rate your overall medical care?" This received a significance level of 0.0218 and seemed to indicate that generally patients perceive their overall medical care favorably. Health care workers seem to be performing satisfactorily according to the opinion of this sample regarding this particular item.
The general overall perception seems to be satisfactory. General overall perception correlates significantly with satisfactory relocation.

To carry out the purpose of this study three research questions were studied. Research question one was: will residents who have had more experience with an in-patient facility show a higher degree of satisfactory adaptation to nursing home living? The specific number of times the resident had been admitted to an in-patient facility (ADMIT) was compared to the score on the Life Satisfaction Index (LSIZ), the number of times he changed rooms (ROOMCHG), and the number of times a medical doctor was contacted during the first year of admission (DOCVISIT). Multiple correlation was performed regarding these variables. There was no significant correlation at the .05 level. The resident was asked to identify the number of times he had been admitted to a health care facility. The Life Satisfaction Index is an instrument which was designed to measure zest, resolution and fortitude, congruence between desired and achieved goals, positive self concept and mood tone (9). It was administered by the investigator. Information regarding room changes and visits from the doctor was obtained from the charts. Even though the .05 level was not obtained some degree relationship does seem to exist between admit and roomchange and docvisits. The possibility of a relationship cannot be completely ignored.
The second research question was: will residents who perceived their previous experience with the health care facility as favorable have a more successful degree of adaptation? The total score on the "Quality Health Care Experience Scale" (L) was compared to LSIZ, ROOMCHG, and DOCVISIT. The tool "Quality Health Care Experience Scale" was developed similar to a likert scale. The resident was asked to rate the experience on a scale from very favorable to very unfavorable. Multiple correlation was performed on these variables. There was no significance found at the .05 level.

The third research question was: what are some factors clients identify as causing a health care experience to be perceived as favorable or unfavorable? The items on the ten item questionnaire, "Factors Perceived As Favorable or Unfavorable Following A Health Care Experience" (F1-10) were compared to LSIZ, ROOMCHG, AND DOCVISIT. This questionnaire was developed by Walker and Restuccia to determine patient satisfaction regarding hospital stay (11). Factor analysis was performed on the ten items in an attempt to reduce the number of categories. The factor analysis did not reveal any significance at the .05 level, therefore factor analysis was not helpful. Multiple correlation was performed on these variables. Only one item was found to be significant at the .05 level. This item was factor eight which was the question, "How would you rate your overall medical care?".
The level of significance was 0.0218 when compared with the LSIZ. Although the .05 level of significance was not reached analysis approached that level for the comparison of factor three—"How was the quality of food?" and roomchg, of factor four—"How would you rate your overall nursing care?" and docvisits, as well as Factor nine—"How would you rate doctor's explanations?" and roomchg.

Additional analysis was done to identify variables which might skew the data. A comparison was made of the criterion variables (ADMIT, L, and F1-10) and other data including demographic characteristics, length of stay, and raw scores on the Health Attribution Test (HAT). This instrument was designed by J. Lawlis and G. F. Lawlis to determine the degree of perceived control an individual has for his health. The relationship of religion and ROOMCHG was a probability of 0.0476. The relationship of internal control on the HAT test and LSIZ revealed a probability of 0.0436. There was no other significant relationship at the .05 level. Other relationships which did not reach the .05 level but are still considered important are sex and criterion variables, religion and criterion variables, and internal control and criterion variables. The same thing is true concerning sex and docvisits, sex and LSIZ, and race and roomchg.

The study was experimental in nature but because there was no control group, a representative design was
used and therefore the study was considered exploratory. Borg describes a representative design as being a process for planning experiments so that they reflect accurately the real life environment. An assumption is that the characteristics of the natural environment are complex and interrelated. The participants are effected in many different ways (2). It involved a complete factorial experiment. Ferguson defined a complete factorial experiment as "experiments in which the treatments are combinations of levels of two or more factors. All possible treatment combinations are studied" (4, p. 226). Analysis was performed using the multivariate form of non-parametric statistics.

Conclusion

The topic of relocation to long-term care is very important. This topic has been demonstrated to have a direct relationship with mortality rate. Examples of this are the studies by Lieberman (7), Lieberman and Tobin (8), Gray (5), Aldrick, Knight and Mendkoff (1), and Killian (6), as well as studies showing increasing morbidity by Thomas (10). Any situation which has been demonstrated to result in increasing mortality or morbidity merits the attention of scholars in that discipline. Research which is focused on identification of causality or predictors is needed.
Efforts have been made to identify possible predictors. Killian examined a number of variables including demographic data (6). Ebersole investigated age, health status, adequacy of living situations, preparation, stressors, family involvement and other factors (3). Wells and Grant identified inter-personal networks as being a salient factor in effective relocation (12). This study was an investigation of an additional factor as a possible predictor of successful relocation, prior experience in a health care facility.

The findings of this study seem to indicate that there is no relationship between quantity or quality of prior health care experience and successful adaptation to relocation in long-term care. A study in which no significant difference is found is useful. It is a stimulus for study and investigation. The findings in this study indicate that except for three areas there was so significant correlation between prior health care experience and successful relocation in long term care for this particular sample. Perhaps the conclusion can be drawn that less emphasis needs to be placed on this factor than other factors when admitting a patient. To make that assumption is somewhat premature. These findings show there is a need for further investigation in this area. There is a need for replication in various ways. Other factors regarding relocation need to be investigated. The entire topic of
relocation is a complex subject with many different factors and ramifications. In addition to replication, examination needs to be made of other predictors of successful relocation.

An examination of the results is helpful. Three areas of significance were identified. In comparing predictor and criterion variables one area was significant. The relationship of Factor eight on the questionnaire, "Factors Perceived as Helpful, Unhelpful Following a Health Care Experience" was found to have a significant relationship to the LSIZ score. Since this is the only measure of significance it seems that this gives support to the LSIZ as a measure of satisfaction. Factor eight, "How would you rate your overall medical care?" was in some ways similar to the measure of quality of health care experience, "How would you rate your previous medical care-favorable or unfavorable on a scale of one to five?" (L). It is interesting that one of these questions was significant and the other was not. Factor eight is a very general question. A level of significance regarding this one question could have been obtained very easily.

The other areas of significance were comparisons of demographic data or HAT scores with criterion variables. There was a significance between religion and roomchg. It could be assumed that religion might have either a positive or negative effect on the number of times an individual
changes rooms. Religion might cause a person to be more tolerant and accepting of others in trying to demonstrate a Christian attitude and therefore result in less room changes. On the other hand, religion might result in less tolerance and cause the resident to want to only room with a person who shares his religious beliefs and practices. The degree of significance might have been influenced by the fact that the demographic data revealed the two major religious denominations were Baptist and Catholic. Both of these denominations place a strong emphasis on external rather than internal control in regard to religious feeling.

The relationship between measure of internal control and LSIZ score is understandable. If a person feels that he is in control of himself, his destiny, and his health he is likely to be more satisfied with himself. If he is more satisfied with himself he usually is able to adjust to change in a more effective manner and would score higher on a life satisfaction scale. The fact that these two items were significant means there is a need to examine the data in terms of the possibility that these factors effected the outcome.

The acceptable level of significance was established at .05 before the study was started. This level will remain. On that basis there were no other significant relationships. In this particular sample there does not appear to be any significance between prior health care experience and
successful relocation to long term care. However it might be interesting to examine the data in terms of which relationships were almost significant. This might be especially helpful in determining other areas for recommended studies, or other areas that need to be investigated. Relationships involving two criterion variables, two predictor variables, two demographic data variables, or predictor variables and demographic data or HAT scores will not be included in this discussion.

There were some relationships which approached significance between predictor variables and criterion variables. Evaluation of admit revealed a significance of 0.1599 when compared to criterion variables and also approached significance in comparison with two of them individually--room change and docvisit. Therefore the number of admissions to a health care facility may have meaning even though a significance level was not reached in this study. It is recommended that this variable be investigated again in another study. Three items on the questionnaire were close to significance. F3--"How was the quality of the food?" when compared with roomchg, F4--"Were you satisfied with overall nursing care?" when compared with docvisit, and F9--"Were the doctor's explanations satisfactory?" when compared with roomchg. All of these relationships approached significance. Although each of these questions deal with different information it is
interesting that a significant level was almost reached. Perhaps this questionnaire needs to be studied again, or each of these items examined more closely.

Four of the demographic data factors reached an interesting level even though significance was not achieved. Sex received a close level in three areas—criterion variables, docvisits, and LSIZ. The comparison of religion and criterion variables was fairly close and race and roomchg received a good rating. The only HAT score that was close to being significant was internal control and criterion variables. It would be interesting to determine whether male or female participants were better satisfied. The relationship of religion and roomchg has been discussed earlier. It is understandable that race could influence roomchg. Either black or white residents might prefer to live with members of their own race. The relationship of internal control and satisfaction has also been discussed earlier. Although a level of significance was not reached with these items consideration should be given to the fact that these factors might have influenced the response of the resident on measures of satisfaction.

Lieberman’s later writings appear to be substantiated by this study. He addressed the need to understand the unique psychological characteristics of aging. He developed his strong belief in this theoretical framework after conducting numerous studies on the effect of relocation.
According to his theory the inner task to maintain a consistent self is of utmost importance. He stated, "The sense of self does not change—rather it is the utilization of strategies by the elderly to maintain this sense of selfhood" (7, p. 348). Each elderly individual has his or her own unique sense of selfhood. In order to maintain this an individual will select different strategies to be utilized at different times. The role of the health care worker or gerontologist is to help the elderly client select individual strategies and then give support and reinforcement as the residents utilizes these strategies to manipulate their environment.

The fact that no significance was found in this study reinforces the fact that the process of adaptation following relocation is very complex and individual. It is very difficult to identify one specific cause or one specific cause and effect relationship. In examining the three studies described in The Experience of Old Age, Lieberman states,

Relocation clearly constituted a stress for the elderly despite considerable variations in the conditions of the relocation. . . . The critical factor in the association between stressors and outcomes was found to be the management strategies that elderly persons use to contain and ward off the threatening implications of relocation. The most potent management strategy was the creation by aged persons of a view that they had mastery and control over their lives and the impending crises (7, p. 338-39).
One of the three areas which obtained a level of statistical significance in this study was the relationship between measure of internal control on the HAT test and the score on the LSIZ. Internal control was also in the group of "almost significant" variables when compared to all three predictor variables. During the process of data collection the investigator was impressed many times by the fact that physical limitations, characteristics of the relocation environment, or situations which necessitated the move did not seem to effect satisfaction. The clients who expressed satisfaction with the environment seemed to possess a characteristic of inner strength and self acceptance. Additional study certainly is warranted in this area. Identification of intervention strategies which may be utilized by the health professional to facilitate the process of maintaining a sense of internal control and achieving a sense of selfhood by the elderly client is essential.

Recommendations

The implications of this study are that there is no direct relationship between prior health care experience and successful adaptation to relocation in long-term care in regard to this particular sample. The exception to this is a significant relationship between overall perception of medical care, religion, and perception of internal control
over health and the criterion variables. Additional study needs to be done regarding these particular variables. Replication of this study is recommended. It is possible that if this study would be repeated with another sample and with different measurement techniques, more significant results might be obtained. Borg and Gall identified different types of replication. They stated, "Literal replication involves exact duplication of the sampling procedures, experimental conditions, measuring techniques, and methods of analysis of the first investigator. . . .

This can be used to evaluate whether a Type I error (rejection of the null hypothesis when it is correct) has occurred. In operational replication, duplication of just the sampling and experimental procedures is done. This is done to determine the effectiveness of a procedure. In order to perform constructive replication the replicator formulates his own methods of sampling measurement and data analysis to measure the same research question. This increases the validity of theoretical studies (2, p. 384).

It is recommended that any or all of these replications be performed regarding the relationship of prior health care experience and successful relocation. Studies which focus on the degree of internal control over health and the relationship to relocation are especially recommended. An interesting study would focus on the relationship of religion and adaptation to relocation in long term care. In
addition, studies need to be performed regarding other possible predictors of successful relocation.

There are implications for nursing education and nursing practice as a result of this study. This study seems to give credence to Lieberman's theory regarding the psychological characteristics of aging. This theory needs to be incorporated into the content of nursing courses relating to developmental stages of aging and psycho-social needs of the elderly. Inclusion of this content would facilitate a higher level of understanding of the needs of the aged individual. This theory can also be used as a framework for nursing practice. A gerontological nurse who understands the need of the elderly to maintain a state of integrity of self will incorporate this into her or his practice. Nursing interventions will then be selected to strengthen and reinforce utilization of individual strategies by each elderly resident. These interventions should be included in the nursing care plan for each resident.
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APPENDICES
Appendix A

QUESTIONNAIRE TO DETERMINE QUANTITY OF HEALTH FACILITY EXPERIENCE

Write in the bracket the answer to the following question:

1. I have been admitted to a hospital or rehabilitation facility in the last 10 years ( ) times
Appendix B

QUALITY OF HEALTH CARE EXPERIENCE SCALE

Categorize the last experience with a health facility according to the category on the accompanying scale which describes that experience. If your memory of that experience is generally viewed as pleasant, you would choose very favorable or category (5). If it is more pleasant than unpleasant you would choose favorable or category (4). If it is viewed as neither pleasant or unpleasant you would choose average or category (3). If your memories of that experience were more unpleasant than pleasant you would choose unfavorable or category (2). If your memories are completely unpleasant you would choose very unfavorable or category (1). If the resident has difficulty with the terms pleasant-unpleasant or favorable-unfavorable the other descriptors which may be used by the researcher include enjoyable-not enjoyable or my needs were met-my needs were not met. No other descriptors will be used to explain the question.

very unfavorable unfavorable average favorable very unfavorable

1. (1) (2) (3) (4) (5)
Appendix C

FACTORS PERCEIVED AS FAVORABLE, UNFAVORABLE FOLLOWING A HEALTH CARE EXPERIENCE

This questionnaire will utilize the same instructions and the same descriptors as the scale in Appendix B

1 = very unfavorable
2 = unfavorable
3 = average
4 = favorable
5 = very favorable

1. satisfaction with admission: 12345
2. condition of room: 12345
3. quality of food: 12345
4. nursing care (overall): 12345
5. concern of nurses: 12345
6. competency of nurses: 12345
7. clarity of nursing instruction: 12345
8. medical care (overall):
   1 2 3 4 5

9. doctors explanation:
   1 2 3 4 5

10. frequency Dr. visit:
    1 2 3 4 5
Appendix D

LIFE SATISFACTION INDEX Z

The researcher will give the following instructions: Here are some statements about life in general that people feel differently about. I will read each statement on the list to you. If you agree with it, tell me you agree. If you do not agree with a statement, say "I disagree". If you are not sure one way or the other, say "I do not know."

(Key: Score 2 points for each "right" answer—marked with X; 1 point for ? or no response)

AGREE  DISAGREE  ?

1. As I grow older things seem better than I thought they would be. X

2. I have gotten more of the break in life than most of the people I know. X

3. This is the dreariest time of my life. X

4. I am just as happy as when I was younger. X

5. These are the best years of my life. X

6. Most of the things I do are boring or monotonous X

7. The things I do are as interesting to me as they ever were. X

8. As I look back on my life, I am fairly well satisfied. X

9. I have made plans for things I’ll be doing a month or a year from now. X
10. When I think back over my life I didn't get most of the important things I wanted. X

11. Compared to other people, I get down in the dumps too often. X

12. I've gotten pretty much what I expected out of life. X

13. In spite of what people say, the lot of the average man is getting worse, not better. X

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Appendix E

PERMISSION TO PARTICIPATE IN STUDY

I ______________________________ agree to participate in the research study, A COMPARISON OF PRIOR HEALTH CARE EXPERIENCE TO SUCCESSFUL RELOCATION IN LONG-TERM CARE, conducted by Eugenia Tickle. It is my understanding that this consists of verbally answering questions from a questionnaire administered by her. I understand that my responses will be kept confidential. I also understand that I may withdraw from this study at any time. My participation in this study has no effect on the level of care I receive in this facility. My participation is completely voluntary.

signed.

_________________________
participant

_________________________
representative of the agency
Appendix F

HEALTH ATTRIBUTION TEST

SD = strongly disagree
DS = disagree somewhat
SLD = slightly disagree
SLA = slightly agree
AS = agree somewhat
SA = strongly agree

1. I can usually keep myself healthy by paying attention to what I eat.

2. When I get sick or hurt it is usually God's way of punishing me for my sins.

3. If I don't catch a cold or flu or have an accident once a year it is because I am very lucky.

4. If I were extremely sick, I might go to a faith healer.

5. Most diseases or accidents can happen to anybody at any time.

6. Thinking positive thoughts can help me get well and stay well.

7. If I keep my body in shape through exercise I can ward off much sickness.

8. If I breathe in cold germs, I'll almost always catch a cold.
9. If I could just understand how my body functioned, I could figure out how to get well and stay healthy.

10. I will still get sick or hurt if that is what is supposed to happen even if I set my mind to stay healthy.

11. Everyone should be responsible for their own health and not push the responsibility off on a doctor.

12. Sickness or accidents are a lesson in life and carry a message.

13. I believe little children can learn to be healthy if they are exposed to proper teachings.

14. Other countries who are our enemies are probably responsible for the high rate of disease here.

15. No matter what I do I will get sick or hurt sooner or later.

16. It always amazes me that people think they can control whether they’ll get sick or hurt or not.

17. Only medical doctors know how to treat illnesses.

18. Diet and nutrition have very little to do with health, people will get sick no matter what they do.

19. All the talk about nutrition and exercise is foolish; some people are just basically healthy and others aren’t.

20. Some people just seem to be accident prone.
21. I can usually tell when I am about to get sick, and with some care on my part I can avoid it.

22. My life is chiefly controlled by powerful others.

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