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The correlation between quality of care and type of room in long-term care facilities in the Shenandoah Valley of the Commonwealth of Virginia

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The Correlation Between Quality of Care and Type of Room
In Long-Term Care Facilities in the Shenandoah Valley of the

Commonwealth of Virginia

An Honors College Project Presented to
the Faculty of the Undergraduate
College of Health and Behavioral Studies
James Madison University

by Hannah Elizabeth Twomey

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Accepted by the faculty of the Department of Health Professions and Health Sciences, James Madison University, in partial fulfillment of the requirements for the Honors College.

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PUBLIC PRESENTATION

This work is accepted for presentation, in part or in full at
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Abstract

The purpose of this study was to examine if there was a present correlation the quality of care a resident in a long-term care facility received and the type of room they resided in. The researcher conducted a quantitative, cross-sectional research study of direct care healthcare providers (n=77) in four long-term care facilities in the Shenandoah Valley of Virginia through the documentation of a paper survey. The survey questions were adapted from Nursing Home Survey on Patient Safety Culture and participants responded according to their personal habits regarding the quality of care they gave residents and feelings about their place of employment. Results showed no statistically significant conclusions between the quality of care a resident of a long-term care facility received and the type of room they resided in.

Chapter 1:

Introduction

My passion for the geriatric population was discovered after a professor my sophomore year of college assigned me to volunteer at a nursing home and rehabilitation facility. In the spring semester, my assignment required me to be a student volunteer in the activities department. Even with my limited healthcare experience and knowledge, it was quickly learned that long-term care facilities are overcrowded and understaffed. This observation was again confirmed when I began working as a Certified Nursing Assistant at a long-term care facility in January of 2017. I started working at a long-term care facility to gain clinical experience needed in order to apply to Physician Assistant school. Throughout my time at this facility, my experiences have ranged from caring for residents with a variety of needs ranging from just needing my supervision to total care residents with advanced stages of Alzheimer's.

Significance of the Study

This study focuses on the quality of care given to residents in four long-term care facilities located in the Shenandoah Valley and the type of room they reside in. The Shenandoah Valley encompasses Rockingham, Highland, Bath, Augusta, and Rockbridge counties of Virginia. In this area, the median age is 47.5 years old with the vast majority of citizens being of caucasian ethnicity. The median household income for this area was \$50,600 in 2016. (Regional Data Center) The elder population (65 years old and older) for the Shenandoah Valley was 77,202 as of March 2010 (U.S. Census Bureau, 2010). This study is significant because it is one of the first research studies that focuses on the quality of care given to elder residents based on the type of room they reside in. Previous studies have surveyed or interviewed the elderly who reside in these long-term care facilities. Asking the elder population is not only an ethical

concern, but can be seen as a source of fabricated data. Elders may respond how they believe the researcher wants them to, out of their kindness to the people around them or out of fear of retaliation. As the population of the human race steadily increases and advances in medicine allow the population to live well into their 80s and 90s, as a result the elder population is growing at an exponential rate with no end in sight.

Statement of the Problem

A gap in the literature is present in this area of the geriatric population specifically in long-term care facilities and their room placement. This study focuses on the quality of care given to residents in long-term care facilities and the type of room they reside in. This problem is extremely pertinent in today's society because of the exponential increase in the elder population and the decrease in the number of non-degree healthcare workers. "America's 65-and-over population is projected to nearly double over the next three decades, from 48 million to 88 million by 2050" (World's older population grows dramatically, 2016). The elder population is growing and the blue collar health care work force is decreasing dramatically (CNAs) as more of the millennial population are pursuing college degrees and not trade schools. As a result there are more residents and less staffing to take care of them. The staff is then burdened with multiple residents per room and a dozen rooms to care for (Maben, et al., 2002).

Research Hypotheses

My hypothesis is that residents in a double-room will receive a lesser quality of care than residents in a private room. I believe in this because health care providers will try to multitask while in a double room and not give their full attention to one resident (as would happen if the

resident were in a private room) but the provider would give half of their attention to one resident and half to the other resident.

Research Questions

Some questions being answered in this study are whether each resident in a long-term care facility receives the quality of care they deserve and whether the facility's staff has enough time and resources to provide each resident the best quality of care no matter their room type.

Another research question being asked is whether one facility provides an overall higher quality of care for the residents (according to the staff) vs another facility. All the facilities taking part in this study are located in the Shenandoah Valley of the Commonwealth of Virginia.

Chapter 2:

Review of the Literature

While completing individual annotated bibliographies, it became extremely clear that there were apparent gaps in this area of health research. The peer reviewed articles reviewed contained studies focusing on the quality of care in nursing home facilities via interviews and surveys taken by their elder inhabitants. Not only is gathering information from the elderly an ethical dilemma since they are a vulnerable population but the data is more subjected to be skewed. The elder might fear retaliation if they answer they survey with what they portray as undesirable answers, which contributes to skewed and biased data. This is why in order to conduct a study which surveys or includes elder participants extensive IRB reviewal is required. In this study, for the sake of time, the elder population was not surveyed however their caregivers were. Four of the journal articles chosen for reference in this study were conducted in countries other than the United States; which made the need for this study even more imperative.

If an elder is in a long-term care facility it is more than likely that they “require some form of staff assistance to achieve activities of daily living (ADLs) but staff promotion of residents’ autonomy, independence, and control is frequently absent.” (Taylor, 2014) The staff’s ability to help and give the highest quality of care to these residents with their ADLs depends on the amount of staff on duty, the number of residents each CNA, the resident’s skill level, and the experience of the CNA. The more staff on duty, the less elders each staff member will be responsible for and therefore the staff will be allowed to spend more time with each resident and give them the highest quality of care possible. However the staff to resident ratio is becoming a more and more relevant problem in the United States. As medicine advances which allows the population to successfully live into their 80s and 90s more people will be needing to use these

long-term care facilities. Also as a result of the expanded life expectancy of Americans, more people want to go to a college or university and receive a 4-year degree, which is leading to a workforce shortage in the skilled trades (CNAs). Because of this more and more elders are entering the long-term care facility needing care, and less and less skilled nursing assistants are being hired to care for them. Specifically, in the Shenandoah Valley, citizens receiving an associates degree or higher has increased 22% in the past ten years alone (U.S. Census Bureau, 2010). Which leads to the grand problem of throwing brand new care providers into the deep end of caring for ten or more residents without the necessary education or training on the ways of how to properly care for the elderly, simply because the facility does not have enough staff to cover their bases.

Making an Institution a Home

The history of homes dedicated for the health and rehabilitation of the elderly have been around since the 1850s, originating in Norway. In the 1950s, the nursing home developed around the medical model requiring care facilities to become more like a hospital than a home (Hauge & Heggen, 2008). However this brings up the problem of balance we still are fidgeting with today; where do we draw the line of having a place be more like a home or a sterile hospital facility? As one could imagine the transition from a life of white picket fences to nurses poking and prodding about vital signs four times per day would be a traumatic one. For the elder, home “is a powerful symbol of independence” (Hauge & Heggen, 2008). These elders have had control over their homes their whole lives and were raised in a time period when your home was something you were proud of. From my personal experience, the women seem especially bothered by this shift in domain. These women have been homemakers for as long as they can remember and when someone comes in and starts dictating what and where and when they can eat or bathe or

play or cook, one can imagine that tensions arise. When an elder enters a long-term care facility they basically forfeit any sense of independence they may have left inside them, which should not be the case.

Long-term care facilities have come miles in the past couple of years. Recent modifications have been incorporated to make “common living rooms and hallways more colorful and furnished like homes” (Hauge & Heggen, 2008). The halls are no longer tiled with stainless steel railings but carpeted with fine wooden accents, the dining rooms are decorated with table linens and centerpieces. However, most residents do not spend the majority of their time in the common areas of the facility but in their rooms. “It is actually in their private rooms that the residents have the opportunity to look at personal belongings, to control the space, to create an individual lifestyle, and to engage in private conversation with significant others” (Hauge & Heggen, 2008). Without the private space for the elders to control and feel fully themselves, their care will inevitably be lacking.

Spaced Out

If every patient had their ‘own space’, including a private bathroom and toilet, where personal care could take place away from other patients, resident morale and more importantly quality of care would inevitably skyrocket to a higher level. “A staff nurse said that she would ‘hate to go back to nursing patients behind curtains’ because it can be embarrassing when patients don’t make it to the toilet in time [. . .] now they have the dignity and privacy of being in their own room.” (Maben, Griffiths, Penfold, et al, 2015). With each patient having their own room they have the privacy they need and deserve in case of any accidents they also have the space for their own personal furniture, photos, and memorabilia. However living in a long-term care facility is most certainly more adept for a higher quality of life in the social sphere for

geriatric residents. “Research found that living alone is significantly associated with a lower quality of life while a stronger social network contributes a higher quality of life” (Bökberg, Ahlström, & Karlsson, 2017). This would be more true of women, who do make up the majority of long-term care facility residents due to their longer life span or widowed status. Older women feel the need for connections and will go out of their way to socialize and meet their neighbors in a long-term care facility, which will improve their quality of life no matter their room status. While men typically stay to themselves and not thrive off of social interaction with their peers.

Importance of Person to Person Care

It is no secret that most people dismiss CNAs as the bottom of barrel in the field of healthcare, since one can become a CNA only after a month-long class and virtually no clinical experience needed. The people that say this have obviously never seen the majority of them work. CNAs may be the only other human that elderly resident comes into contact with for hours or days on end. All CNAs must give their undivided attention to one resident at a time to make sure they are receiving the care and attention they need and deserve. With two residents located in one room, this is harder. They may have differing skill levels which results in the CNA needing to give more care to one resident over the other. This increased attention to one resident over the other may lead to jealousy among the residents and lashing out either to the CNA or their roommate.

As problematic as it is, the majority of resident families visit once a week at the most, if the resident even has any family left living. Changes in family structure and gender indiscriminate increased mobility within the workforce mean that many of the elders are separated from their families and other support networks for longer hours of the day and even

days on end. Loneliness and social isolation are consequences impacting on their happiness and well-being. (Sparrow and Sparrow, 2006). While residents can voluntarily participate in card games or checkers from the activities department, there is no touch or real in-depth conversation present there. An ideal CNA will become like a resident's family member; they should know their likes and dislikes as well as have a sense of their daily routine in an effort to make them as comfortable as possible as well as provide the highest quality of care. "Other opportunities for social interaction and continuing interaction with families should also be provided to enhance the sense of belonging and continuity and better adaptation among long-term care facility residents" (Chao, Lan, Tso, et al, 2008). A patient-centered facility should allow family members to come and visit as they please and not be restricted by visiting hours. If the resident is sick or simply lonely, the facility should pull out all the stops and allow the family member to stay as long as they please even if that means they must sleep in a recliner by the resident's bedside. An ideal CNA must know their residents' likes and dislikes as well as their daily routine. A CNA that goes above and beyond their job description knows all the things mentioned above and can have in-depth conversations with the residents while conducting care in an effort to make them feel valued and know that someone is there for them. The power of the human touch and interaction is unmatched and undeniable.

Chapter 3:

Methodology

In order to study the effects of the type of room residents in a long-term care facility reside in and the type of care they receive, an anonymous paper survey was conducted at numerous long-term care and rehabilitation facilities across the Shenandoah Valley. However before the study was allowed to be conducted, the research needed approval from JMU's Institutional Review Board (IRB). The study of "*The Correlation between Quality of Care and Type of Room in Long-Term Care Facilities in the Shenandoah Valley of the Commonwealth of Virginia*" was approved by the IRB on December 6, 2017 and given the protocol number of 18-0249. The study will be effective from December 6, 2017 through April 30, 2018.

Subject Recruitment and Participation

Subjects were recruited at long-term care facilities and preferably were involved with the physical care of the resident (CNAs). It was a requirement that all subjects be at least 18 years of age. Surveys were left in the break rooms of the long-term care facilities for participants to fill out at their discretion. Willing participants filled out their survey and then placed their responses in a manila envelope to ensure anonymity. The survey was comprised of 27 questions which consisted of participant demographics, participant feelings about the facility in which they work, teamwork, quality of care they provide, and resident feelings toward their roommate. A copy of the cover letter and survey taken by participants can be seen below (page 26).

Methods of Data Analysis

After all surveys were collected, the data was entered into a single drive on SPSS, where the data would be later analyzed. The researcher came up with a code on SPSS for the 27 questions included on the survey. An independent sample t-test, Pearson correlation, and Chi-

Square analysis were run to compare the results and determine if there was a significant value or correlation was present between the type of room a long-term care resident resides in and the quality of care they receive.

Limitations of the Study

There are several major limitations included in this study. The first limitation being that the researcher only surveyed long-term care facilities in the Shenandoah Valley which was a convenient sample. Results may have been different if the researcher reached out to health care providers in Northern Virginia.

An additional limitation was the participants' potential for social desirability. Studies show that individuals are more inclined to answer surveys in such a way that they are portrayed in a more positive light and seem like a better person. If one of these individuals participates in this survey, they may say they provide a higher quality of care than what is actually shown to be true. The researcher tried to limit the occurrence of a social desirability bias by providing participants with an anonymous survey. Thereby, with an anonymous survey participants should not be concerned that the results of the survey could be traced back to him or her.

A third limitation of the study was that the researcher used a small sample size which consisted of mostly women. Controlling for the majority of the women population would have required a much larger sample size since the majority of healthcare providers in the geriatric field are women.

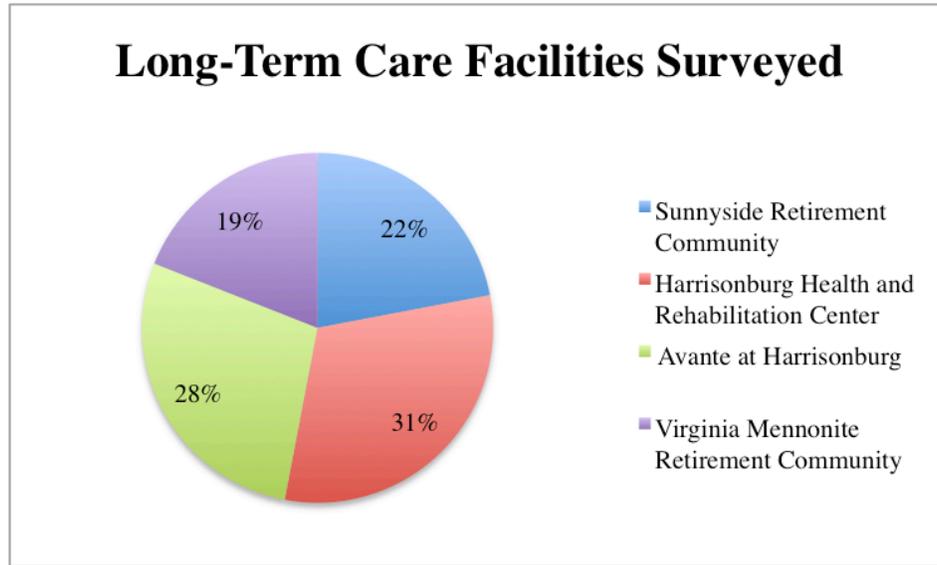
Chapter 4:

Results

Firstly, the results were filtered using SPSS into two groups: one group contained nurses, CNAs, and direct care staff that had direct contact with the residents and provided care for them the other group consisted of administrators, support staff, and those who did not have direct contact care with the residents. The groups that responded that they did not have direct care with residents (n=9) were disregarded because they did not have the credentials needed in order to have a valid say when asking about the quality of care given to residents of long-term care facilities. Healthcare professionals that worked directly with residents was the backbone of this survey and a necessity for the validity of this study.

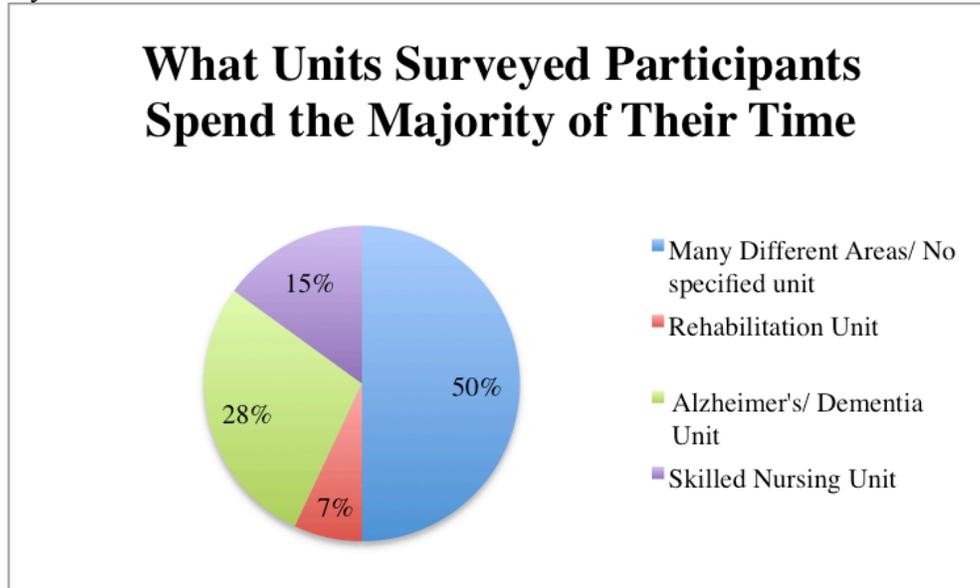
After running SPSS analysis on the 68 responses of workers that provided direct-care to residents, several trends were seen from the independent T-test, Chi square analysis and descriptive statistics that were run. The most predominant trend was that, although not significant, staff stated that they overall agree that they would be better able to care for their residents of each and every one had their own single room.

Figure 1. The percentage of survey participants that came from each of the four facilities surveyed.



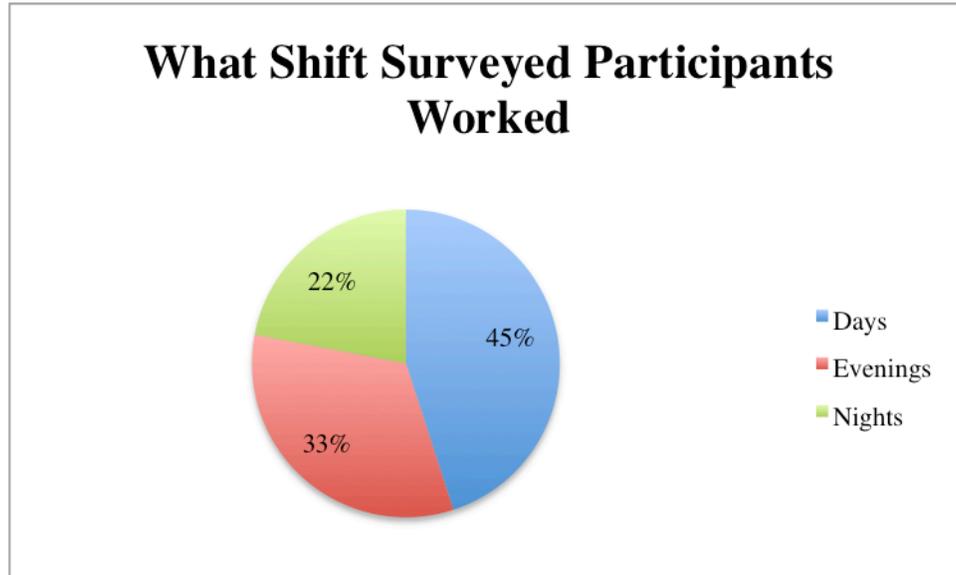
Question number two on the *Survey for Assessing Quality of Care Among Long-Term Care Residents with Differences in Room Type* asked the health care provider on which nursing home or rehabilitation facility they were employed under. Figure 1 breaks down the distribution of surveys taken by participants and each of their places of work. It was purposeful to make the proportion of all facilities somewhat even so there was no oversampling of some facilities and undersampling of others, as each facility is unique and has their own set of criteria and staff training and credentials.

Figure 2. The type of unit direct-care survey respondents stated that they work the majority of the time they are on the floor.



Question number seven on the *Survey for Assessing Quality of Care Among Long-Term Care Residents with Differences in Room Type* asked the health care provider on which type of unit they spent the majority of their time working. The majority stated (50%) that they did not have a consistent unit they were placed on but shuffled around to where they were most needed. The second most prevalent unit (28%) recorded was Alzheimer’s and Dementia Unit, followed by skilled nursing unit (15%) and lastly rehabilitation unit (7%).

Figure 3. The time of day that surveyed participants worked their eight hour shift at long-term care facilities



The majority of participants (45%) stated that they worked the day shift. A typical day shift runs from 7am to 3pm and contains two meals and the majority of therapies and activities for residents. The second most prevalent shift was evening shift (33%). Evening shift lasts from 3pm to 11pm and contains one meal. The least prevalent shift was night shift (22%). Night shift goes from 11pm to 7am when most of the residents are sleeping.

Table 1. Chi-Square analysis of how long participant has been healthcare provider and being able to provide better care if each resident had their own room

	Value	Degrees of Freedom	Asymptotic Significance
Pearson Chi-Square	20.918	20	.402

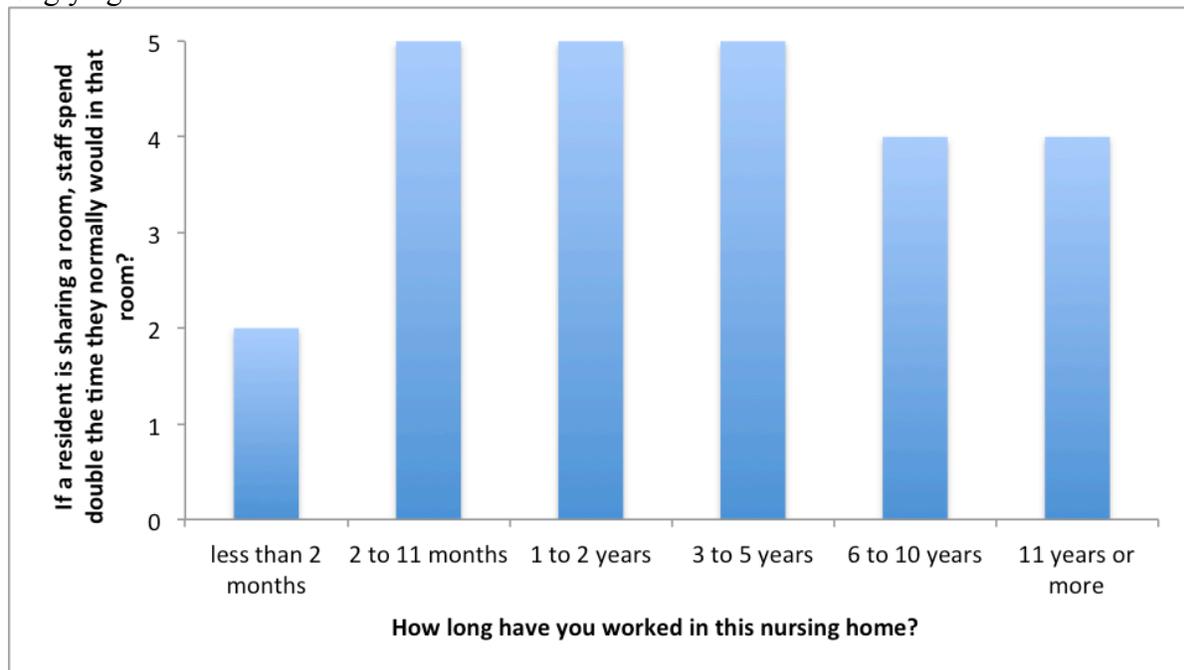
This Chi-square test, as seen above in table 1, was conducted when comparing how long the participant has been an on-patient healthcare provider (question #3) and the question that asked whether staff would be able to provide better care if each resident had their own room (question #26). The Pearson Chi-square test statistic value was 20.918 with 20 degrees of freedom which corresponded to a significance level of .402. This value was not significant at the alpha level of .05.

Table 2. Chi-Square analysis of what facility the care provider worked for and if the same quality of care was given for a resident in a single room compared to a resident in a double room.

	Value	Degrees of Freedom	Asymptotic Significance
Pearson Chi-Square	5.915	9	.74

This Chi-square test, seen in table 2, was conducted when comparing what facility the health care provider worked for (question #2) and the question that asked whether staff provide the same quality of care for someone who has their own room and someone who shares a room with a roommate (question #25). The Pearson Chi-square test statistic value was 20.918 with 20 degrees of freedom which corresponded to a significance level of .402. This value was not significant at the alpha level of .05.

Figure 4. Comparison of how long the provider has worked in the facility they are currently employed under and how much they agree that if a resident is sharing a room, staff spend double the time in that room. On the y-axis, 0= strongly disagree, 1= disagree, 2= neutral, 3= agree, 4= strongly agree.



For the healthcare providers that have been employed at their long-term care facility for less than two months, the vast majority stated that they are neutral about whether staff spend double the amount of time they normally would in that room, if the resident is sharing a room. For the healthcare providers that have been employed at their long-term care facility for two to eleven months, one to two years, and three to five years, the vast majority stated that they strongly agree with the statement that whether staff spend double the amount of time they normally would in that room, if the resident is sharing a room. For the healthcare providers that have been employed at their long-term care facility for six to ten years and eleven years or more, the overarching majority stated that they agree with the statement that whether staff spend double the amount of time they normally would in that room, if the resident is sharing a room.

Chapter 5:

Discussion

Overall, the trends in the data showed that there was not a significance in health care providers responses to the quality of care they give and the type of room a resident resides in. Participants, no matter how long they had been at a facility, what shift they worked, or what facility they worked in stated that they indiscriminately gave each resident, no matter their type of room, the highest quality of care.

In breaking down the results into more depth, figure 1 displays the four long-term care facilities that were surveyed for this study. It was intentional by the researcher to keep the percentage of surveys from each facility at a roughly even percentage. The approximate same percentage among the sampling of facilities controlled for oversampling and undersampling. It was also necessary to survey this many if not more than the facilities listed because each one has their own set of rules and credentials with slight differences in training of their staff as well as facility procedures such as using restraints, for example. Two of the facilities surveyed are a continuing care retirement communities while the other two are geared more so for long-term care and Alzheimer's patients.

Additionally, figure 2 displays what units that surveyed participants from all four long-term care facility locations spend the majority of their time when working on the floor. With the majority of healthcare providers responding that they have no specified unit they are consistently assigned to, this may have a severe impact on the quality of care residents of these facilities receive. With providers being shuffled around to wherever they are needed most, the residents do not always see a familiar face and are being cared for by someone who may not know their likes, dislikes, and daily routines. This not knowing on the resident's part may result in stress. This

question also did not clearly identify the difference between a skilled nursing unit and rehabilitation unit which may have caused some confusion in the participants taking the survey.

Furthermore, figure 3 is the pie graph corresponding to what shift the surveyed participants worked the majority of the time. Most of the participants responded that they worked the day shift. This is not surprising because day shift needs more people on that shift in order to get everything accomplished. Day shift includes resident baths, two meals, therapies, and the majority of activities for the day. Also day shift is a desirable shift, for employees as well. Evening shift was the second most popular shift. Night shift was the shift that was least likely to be worked by participants. On the average, there are less people employed on night shift because there is less on-patient work to be done.

Finally, figure 4 compares how long the healthcare provider has worked at their current facility and what degree to which they agree or disagree with the statement that staff spend double the amount of time they normally would in that room, if the resident is sharing a room. This question fails to account for the fact that a healthcare provider may have been working in the field for more than ten years but just switched to the facility they currently work at. There is no trend in the data shown in figure 4, so it can be determined that no matter how long that provider has worked in their current facility, it does not have an effect on whether they believe staff spend double their time in a room with two residents when compared to a single room.

Both the Chi-square tests for statistical significance showed that there was no statistical significance present. In table 1, the chi square value (.402) and the corresponding p-value were too high in order to determine statistical significance between how long the participant has been an on-patient healthcare provider and whether staff would be able to provide better care if each resident had their own room. The same trends can be seen in table 2. The chi square value (.74)

and corresponding p-value were too high to determine statistical significance among what facility the health care provider worked for and whether staff provide the same quality of care for someone who has their own room and someone who shares a room with a roommate. When analyzing these non-significant values, one must analyze them with a grain of salt because of the small sample size and the extreme likelihood of response bias among the respondents.

Suggestions for Further Research

If this same study were to be conducted again, additional questions would need to be added to the survey that explore additional facets to the quality of care a resident of a long-term care facility may receive. Some examples of these questions would ask the healthcare professional if their facility uses restraints, how often activities are available for the residents to get out of their room and socialize, and if the resident has extensive choices for meals or is it a set menu for everyone?

Possible implications for future research would include a more diverse population including a more even number of male and female participants at more facilities across the Shenandoah Valley. Also, a cross sectional study would be more beneficial to scientific community but also more costly and timely. A cross-sectional study is a type of observational study that analyzes data from a population, or a representative subset, at a specific point in time. Also, with more research experience it would be interesting to survey the elder population on their opinions on the quality of care they receive. This was not done in the present study because of ethical concerns. Another possible facet for future study would be including long-term care facilities in more urban communities outside the Shenandoah Valley, possibly in Northern Virginia. It would be fascinating to see if there are more discrepancies in care compared to rural communities vs. urban communities.

Conclusions

Overall, this study filled in the gap present in the scientific literature community between quality of care provided in long-term care facilities and the type of room a resident resides in. This study was imperative for the scientific literature community because it addresses the issue of a growing elderly population and the diminishing population of health care professionals. There is a lack of research performed on the care providers of elders in facilities. I believe there was not a significant finding because there was response bias present in the respondents. Even though the survey was completely anonymous, and the cover letter stated that the research was for an undergraduate student at James Madison University, participants have the innate desire to respond that they give the best care to each of their residents, even if this is far from the actual truth.

With over a year's experience in the field of healthcare, specifically long-term care, I believe that facilities need not spend their money on common areas and dining rooms and making them more home-like but spend their dollars giving every resident whether they are there for days or years their own personal space. It is also imperative that each healthcare provider spends one-on-one time with each resident and listens to their concerns or even simply has a conversation with them, as that may be the only human interaction they receive that day. It is a necessary component of life to be touched by a human and have a conversation. As the elder population continues to grow at an exponential rate, this increased human interaction with each resident will only become harder for the healthcare provider to accomplish. It is necessary to encourage the families of each resident to visit and visit often to raise the resident of the long-term care facility's quality of life. A family may be more inclined to visit if each resident had their own room.

Cover Letter

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Hannah Twomey from James Madison University. The purpose of this study is to identify discrepancies in the quality of care given to nursing home residents in a single person room vs a double person room in the Shenandoah Valley of the Commonwealth of Virginia. This study will contribute to the researcher's completion of her requirements for the honors college curriculum.

This study consists of a survey that will be administered to individual participants in various nursing home facilities throughout Harrisonburg and the Shenandoah Valley. You will be asked to provide answers to a series of questions related to the quality of care you give as a healthcare provider.

Time Required

Participation in this study will require 10 minutes of your time.

Risks

The investigators do not perceive more than minimal risks from your involvement in this study (that is, no risks beyond the risks associated with everyday life). The minimal risks may include being uncomfortable with disclosing personal information, but participants are protected by anonymity in this study.

Benefits

Potential benefits from participation in this study include a personal reflection of care given to residents of a nursing home and/or rehabilitation facility. The benefits of this study as a whole are to learn more about the quality of care given to residents and the elderly residing in a nursing home or rehabilitation facility. This research can be used to further develop potential programs to address care given to elderly in institutional settings and the training staff performing this care needs to be given.

Confidentiality

The results of this research will be presented at the James Madison University Honors College Symposium. While individual responses are obtained and recorded anonymously and kept in the strictest confidence, aggregate data will be presented representing averages or generalizations about the responses as a whole. No identifiable information will be collected from the participant and no identifiable responses will be presented in the final form of this study. All data will be stored in a secure location accessible only to the researcher. At the end of the study, all records will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind. However, once your responses have been submitted and anonymously recorded you will not be able to withdraw from the study.

Questions about the Study

If you have questions or concerns during the time of your participation in this study please contact:

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Questions about Your Rights as a Research Subject

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Giving of Consent

I have read this cover letter and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. I certify that I am at least 18 years of age.

Name of Researcher (Printed)

Name of Researcher (Signed)

Date

Name of Research Advisor (Printed)

Name of Research Advisor (Signed)

Date

This study has been approved by the IRB, protocol #18-0249 _____

Survey for Assessing Quality of Care Among Nursing Home Residents with Differences in Room Type

SURVEY ID # (for researcher use only) : _____

1. What is your job in this nursing home? (circle one)

- A) Administrator/Manager
- B) Physician (MD, DO)
- C) Other Provider (PA, NP, clinical nurse specialist)
- D) Licensed Nurse (LPN, RN, wound care nurse)
- E) Nursing Assistant/Aide (CNA, GNA, nursing aide student)
- F) Direct Care Staff (activities, dietician, pharmacist, therapist, chaplain, social worker)
- G) Administrative Support Staff (admissions, billing, HR, medical records, secretary)
- H) Support Staff (Transportation, security, maintenance, housekeeping, laundry, food service)

2. What nursing home or rehabilitation facility are you employed under?

- A) Sunnyside Retirement home
- B) Harrisonburg Health and Rehabilitation Center
- C) Avante at Harrisonburg
- D) Virginia Mennonite Retirement Community
- E) other _____

3. How long have you worked in this nursing home? (circle one)

- A) less than 2 months
- B) 2 to 11 months
- C) 1 to 2 years
- D) 3 to 5 years
- E) 6 to 10 years
- F) 11 years or more

4. How many hours per week do you usually work in this nursing home? (circle one)

- A) 15 or fewer hours per week
- B) 16 to 24 hours per week
- C) 25 to 40 hours per week
- D) more than 40 hours per week

5. When do you work most often? (circle one)

- A) Days
- B) Evenings
- C) Nights

6. In your job in this nursing home, do you work directly with residents most of the time? (circle one)

- A) YES, I work directly with residents most of the time
- B) NO, I do NOT work directly with residents most of the time

7. In this nursing home, where do you spend most of your time working? (circle one)

- A) Many different areas or units in this nursing home/no specific area or unit
- B) Alzheimer's/ Dementia Unit
- C) Rehab unit
- D) Skilled Nursing Unit

How much do you agree or disagree with the following statements?

8. Staff support one another in this nursing home...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

9. We have enough staff to handle the workload...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

10. Staff follow standard procedures to care for residents...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

11. Staff use shortcuts to get their work done faster...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

12. Staff have to hurry because they have too much work to do...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

13. When someone gets really busy in this nursing home, other staff help out...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

14. Staff are blamed when a resident is harmed...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

15. Staff have enough training on how to handle difficult residents...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

16. Staff are afraid to report their mistakes...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

17. To make work easier, staff often ignore procedures...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

18. Residents' needs are met during shift changes...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

19. If a resident is sharing a room, staff spend double the time they normally would in that room, since there are two residents...

- A) Strongly Disagree
- B) Disagree
- C) neutral
- D) Agree
- E) Strongly Agree

20. If a resident is sharing a room, staff tries to get them both up and dressed/ready for bed at the same time...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

21. Staff go back and forth (multitasking) between two residents when they share a room...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

22. Residents who share a room, complain more and are more difficult to provide care for...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

23. Staff uses a privacy curtain when giving care to residents in a double room (residents who share a room)...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

24. Residents with a roommate often complain of their roommate...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

25. Staff provide the same quality of care for someone who has their own room and someone who shares a room with a roommate...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

26. Staff would be able to give residents a higher quality of care if all residents had their own room...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

27. Overall, residents who have a roommate have a good relationship with them...

A) Strongly Disagree B)Disagree C) neutral D)Agree E) Strongly Agree

THANK YOU FOR COMPLETING THIS SURVEY! WE TRULY VALUE THE INFORMATION YOU HAVE PROVIDED. YOUR RESPONSES WILL CONTRIBUTE TO THE ANALYSES OF THE TEXTS AND SUGGEST NEW LINES OF APPROACH TO THE CORPUS DATA.

Definition of Terms

a. *Long term care* refers to a continuum of medical and social services designed to support the needs of people living with chronic health problems that affect their ability to perform everyday activities. (McCall, 2001)

b. *Certified nursing assistant* is someone who fulfill basic quality-of-life needs for patients of any age in residential nursing care facilities or outpatient clinics. Since nursing assistants have daily contact with patients, they are gatherers of vital information about the patients' conditions, which they must then transmit to their supervisors (Your Guide to Becoming A Medical Assistant, 2014)

c. *Single (private) room* a single person dwelling; A room that has one single bed.

d. *Semi-private room* is having some degree of privacy but not fully private, as a hospital room with fewer beds than a ward. (semiprivate, 2018); multiple beds in one room with a fabric curtain separating for privacy

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