Order Number 1341998

A subjective assessment of quality of life by the older adult residing in a sheltered care environment

Allyn, Peggy Wetzel, M.S.

The University of Arizona, 1990

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

A SUBJECTIVE ASSESSMENT OF QUALITY OF LIFE BY THE OLDER ADULT RESIDING IN A SHELTERED CARE ENVIRONMENT

by

Peggy Wetzel Allyn

A Thesis Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF SCIENCE

In the Graduate College

THE UNIVERSITY OF ARIZONA

1 9 9 0

STATEMENT BY AUTHOR

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SIGNED: Peggy W. Allyn

APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

Jessie V. Perrin — September 7, 1990

Jessie V. Perrin
Associate Professor of Nursing

Date

ACKNOWLEDGEMENTS

I would like to thank Dr. Jessie Pergrin, my graduate advisor and thesis committee chairperson for her guidance, encouragement, and patience in supporting my efforts throughout graduate school. I would also like to thank the other members of my thesis committee, Dr. Beverly McCord and Dr. Alice Longman, for sharing their expertise, time, and support in the entire thesis project.

The support and consideration provided by those with whom I work on a daily basis made the graduate process proceed smoothly. They deserve a medal.

Lastly, and most importantly, I want to thank my husband Darwin Allyn. His love, encouragement, support, and gentle (sometimes) pushes, helped keep the momentum going that was necessary for the completion of this project and graduate school.

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ABSTRACT

A descriptive research design was utilized to identify the quality of life perceived by 46 male veterans, ages 55 to 75 years. They resided in a domiciliary.

The data analyses of the four quality of life subscale showed human dignity, the living environment, and health and medical care with more positive outcomes than activities of body and mind. The subjects also viewed their self-assessed health and self-assessed quality of life as positive.

The care of increasing numbers of aging veterans in institutional settings is a major responsibility and concern of the nursing profession. Nurses need to be cognizant of the perceptions veterans have regarding their quality of life. Only then can nurses develop appropriate care plans and interventions to enhance their quality of life. Nursing's goal is to assist the veteran to function at the highest level of which he is capable.

CHAPTER I

INTRODUCTION

Quality of life has been addressed by many authors in a variety of settings. Quality of life has probably not been viewed as such by individuals as they strive to meet the daily demands and challenges of life. As individuals progress along the continuum of life, change provides different challenges. Individuals attempt to meet these challenges in their efforts to maintain a lifestyle and quality of life acceptable to themselves. Achieving an acceptable life style and quality of life is a subjective assessment by the individual. Older adults requiring assistance in meeting their individual daily needs may find it necessary to adjust to a new environment such as a residential care home.

Since quality of life is a concern for older adults and for health care professionals involved with their care, it becomes necessary to identify concepts and variables impacting on quality of life in different populations and environments. The purpose of this study was to obtain from older adult veterans residing in a domiciliary, a subjective assessment of their quality of life based on the variables of human dignity, the living environment, health and medical care and activities of body and mind.

Background Information

Concerns related to quality of life of clients served by health care professionals have been addressed since the time of Florence Nightingale (Torres, 1985). Her concerns for the environment with which the patient interacted while in need of medical and nursing care, was the first step in addressing concerns of quality of life by the nursing profession. Burckhart (1985) stated that although the goal of enhancement of quality of life is apparent in nursing's philosophical statements, it has not been measured systematically in many of the populations nursing serves.

Quality of life has been addressed by health care professionals involved with the care of different population groups including: (a) elderly American Indians (Johnson, Cook, Foxhall, Kelleher, Kentopp & Mannlein (1986); (b) persons receiving continuous ambulatory peritoneal dialysis (Klein, 1985); (c) hearing-impaired older women (Magilvy, 1985); (d) elderly persons in cardiac rehabilitation (Packa, Branyon, Kinney, Khan, Kelley & Miers, 1989); and (e) persons with insulin dependent diabetes mellitus (Scheibmeir, 1986). The results suggest that attempts are being made in developing systematic measurements and identification of concepts relevant to quality of life.

A formal program, the Joint Commission for Accreditation of Health Organizations (JCAHO), reviews the quality of care provided by health care professionals in various settings (Moss, 1989). This program has in the past attempted to review the quality of care provided for clients in the various clinical settings by looking at the structure and process

of care being delivered. Now the focus is largely on the outcomes of care provided to the recipients of health care resources (Moss, 1989).

The individualization of patient care includes involving the recipients of health care and their significant others in the planning of care to meet the outcomes of care mutually identified, thus providing the recipients of health care the opportunity to maintain autonomy and control over their lives to the extent possible. Autonomy and control of one's life is considered basic to attaining the highest potential quality of life for all ages (Power & Craven, 1983).

One aspect of the review of outcomes is patient or member satisfaction with the services provided. This information is a subjective, cognitive assessment by the member using the health care resources.

Subjective assessment by the older adult began in the mid-1940s (Horley, 1984). Larson (1978) stated that a great deal of research has been done over the past 30 years on the life satisfaction, morale, and contentment of people over 60 years of age. Gould (1985) identified the need to "take a more deliberate look at living conditions" and to "study those elements which influence quality of life so that a more orderly approach can be taken toward making changes" (p. 1).

Statement of the Problem

Satisfaction with quality of life is a subjective assessment by all individuals. Their assessment is based on their ability to maintain a lifestyle that meets their perceived needs for a satisfactory quality of life. Older adults assess their satisfaction with quality of life as they perceive it from past experiences and as it relates

to their present circumstances. Satisfaction with quality of life within a facility is best determined by the residents of the facility. Therefore, veteran members living within a domiciliary can best identify the level of satisfaction with their quality of life within their present living environment.

This study addressed the following questions in an attempt to establish veterans' levels of satisfaction with their quality of life in the domiciliary, as it pertained to the variables of human dignity, the living environment, health and medical care, and activities of body and mind. The study questions posed were:

1. How do veterans rate their level of satisfaction pertaining to the concept of human dignity within their present living arrangements in the surveyed domiciliary?
2. How do veterans rate their level of satisfaction pertaining to the concept of the living environment within their present living arrangements in the surveyed domiciliary?
3. How do veterans rate their level of satisfaction pertaining to the concept of health and medical care within their present living arrangements in the surveyed domiciliary?
4. How do veterans rate their level of satisfaction pertaining to the concept of activities of body and mind within their present living environment in the surveyed domiciliary?
5. What is the quality of life-life satisfaction rating reflected by the total scores of the four subscales for the subjects?

6. Is there a relationship between the veteran's self-assessment of his health and his self-assessment of his quality of life?
7. How do veterans rate their quality of life overall, considering their personal situation?

Significance of the Problem

The older adult (age 65 years and over) comprised 11.3% of the total population in 1980. Approximately 5% or 1.3 million persons of the aging population resided in nursing homes (Lammers, 1983). Other groups of older adults resided in residential care homes and were not included in the reported data.

The veterans of armed services are a large population served by health care professionals. A federal agency was established in 1930 to provide care for these veterans. During 1984, this federal agency identified its major challenge as caring for the "rapidly aging veteran population". A report published by the Agency noted that veterans over age 65 would make up more than a quarter of the total veteran population by 1990. Veterans 65 years of age and older are expected to comprise over one-third of this population by the year 2000 (Caring for the Older Veteran, Preface, 1984).

The statistical data in 1988 estimated the total veteran population at 27,424,100 million (Figure 1). Of the estimated total veteran population, 6,240,450 million or 23% were age 65 years or older. These data closely align with the agency's projection that a quarter of the population would be 65 years of age or older by 1990. The veteran population statistics indicate a population of 16,607 veterans receiving

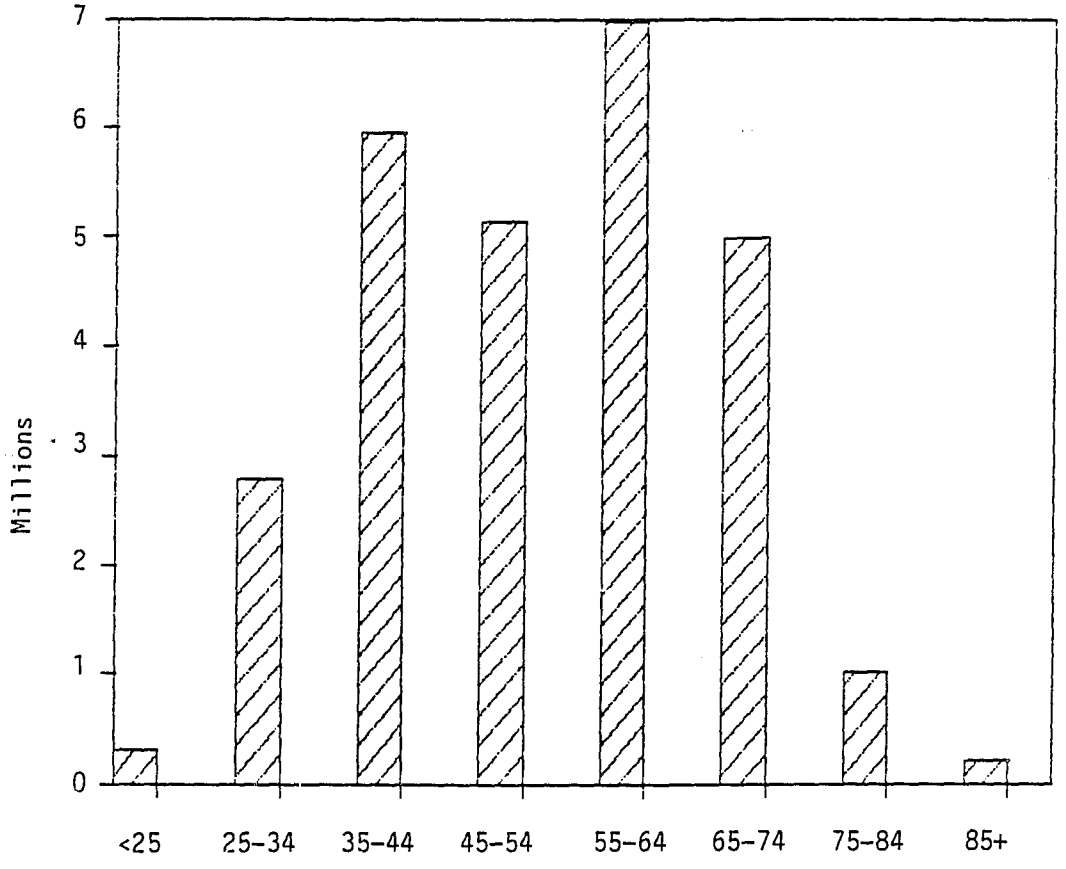

Figure 1. 1988 Veteran Population by Age Group

care in domiciliary facilities. This figure represents 0.06% of the total veteran population of 27,424,100 million noted earlier. Approximately 13% of the veteran population in domiciliary care facilities are 65 years of age or older. The group from 55 years of age or older comprised approximately 36% of the veteran population in domiciliary care facilities (Figure 2) (Summary of Medical Programs, 1988).

Purpose of the Study

The purpose of this study was to obtain a self-assessment of the quality of life of veterans residing in a domiciliary. The foci of the quality of life framework were the concepts of human dignity, the living environment, health and medical care, and activities of body and mind.

Definitions

Quality of life has been noted in the literature since the early 1960s with many definitions providing a framework for quality of life. For this study, the definition of quality of life is adopted from Calman (1987). The definitions for quality of life and the variables within the quality of life framework are as follows:

Quality of Life. Quality of Life is defined as satisfaction with activities of daily life, past experiences, future hopes, dreams and ambitions. Quality of life is affected by the impact of illness and treatment, changes over time, and can vary considerably under normal circumstances. The priorities and goals of individuals must be realistic and are expected to change or be modified with time, age and experience (Calman, 1987).

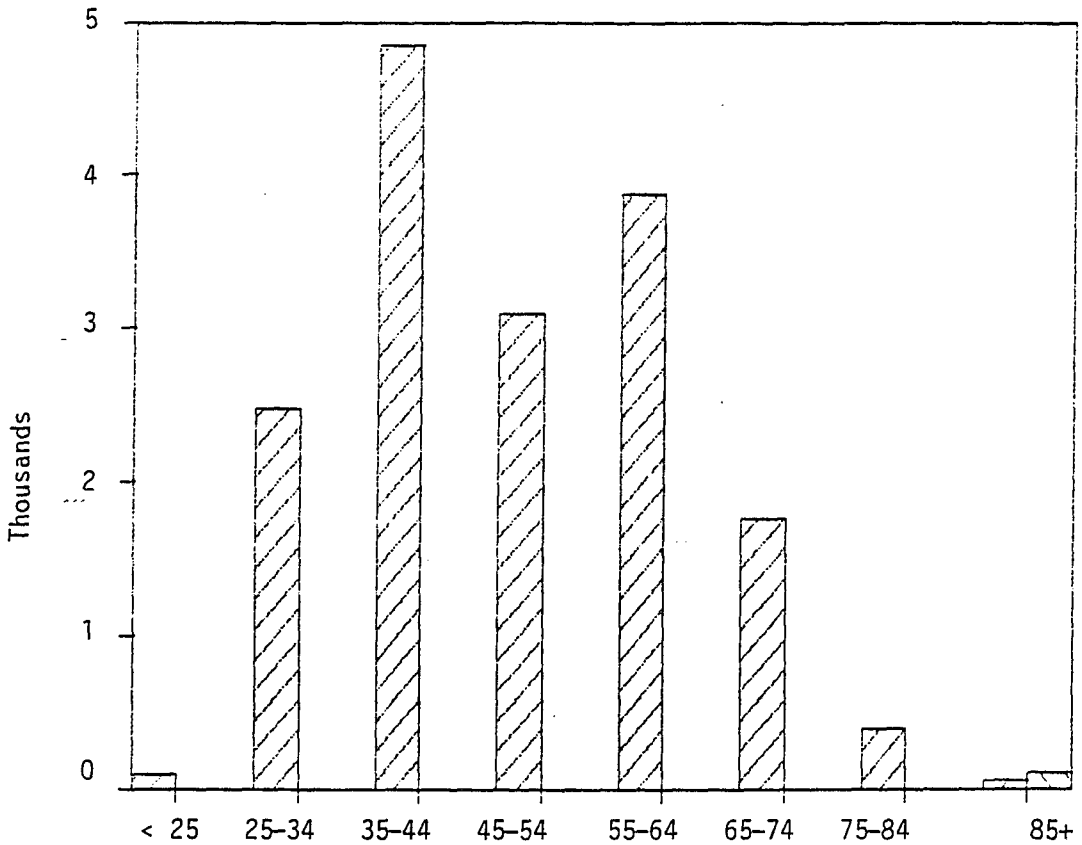

Figure 2. 1988 Domiciliary Population by Age Group

Human Dignity. Human Dignity is defined as containing such elements as freedom of choice, statement of rights, sensitivity of staff, and participation in policy setting and operations (Gould, 1985).

The Living Environment. The Living Environment is defined to include those factors which influence the comfort, privacy, safety and security of the living environment and availability of personal space (Gould, 1985).

Health and Medical Care. Health and Medical Care is defined as the appropriateness and adequacy of medical services, and the perception of competency and compassion of medical professionals (Gould, 1985).

Activities of Body and Mind. Activities of Body and Mind is defined as those activities or functions that affect the spirit and sense of well-being of the older adult. The factors considered are the extent to which the recreational, vocational and spiritual activities meet the individual's interests (Gould, 1985).

Quality of Life-Life Satisfaction. Quality of Life-Life Satisfaction is defined as the mean score of the total mean scores from the subscales of human dignity, the living environment, health and medical care, and activities of body and mind as measured by the Member Opinion Quality of Life Survey instrument.

Self-Assessed Quality of Life. Overall Quality of Life is defined as the veteran's self-assessment of his quality of life as it pertains to his present personal situation. This variable was measured by question 21 on the Demographic Data Form (Pearlman & Uhlmann, 1988).

Self-Assessed Health. Self-Assessed Health is defined as the veteran's self-assessment of his health at the present time, as it compares with other members of the home. It was measured by question 20 on the Demographic Data Form.

Study Limitations

One limitation for this study was the lack of information on the validity and reliability of the Member Opinion Quality of Life Survey instrument. The investigator of the original study did not analyze the inter-item correlations in the questionnaire sections (Task Group I - IV) to determine item relationships and validity, and the dependence or independence of the various quality of life variables.

Summary

Quality of life is a concern for older adults and health care professionals involved with their care. This concern leads to the need to identify concepts and variables impacting on quality of life in various environmental settings of the older adult.

The population of this investigation was older adult veterans residing in a domiciliary. The concept of quality of life was the framework for this investigation. The variables of human dignity, the living environment, health and medical care, and activities of body and mind were addressed within the quality of life framework.

CHAPTER II

CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

The literature review focused on the concept of quality of life, which includes the variables of human dignity, the living environment, health and medical care, and activities of body and mind. The variables were operationalized by using the Member Opinion Quality of Life Survey developed by Gould (1985). The conceptual framework of the study and a review of the related literature are also presented.

Conceptual Framework

The framework for this study is quality of life. The variables were human dignity, the living environment, health and medical care, and activities of body and mind. The conceptual framework for this study is found in Figure 3.

Quality of Life

The definition by Calman (1987) was the foundation for this study. The difficulty in defining quality of life is that highly subjective value judgments are involved and these transcend formulation (Dubos, 1976). Dubos (1976) described quality of life as "profound satisfaction from the activities of daily life" (p. 8). Calman (1987) developed the definition to address the quality of life of cancer patients. He defined quality of life as described and measured only in individual terms; it depends on the individual's past experiences and future hopes,

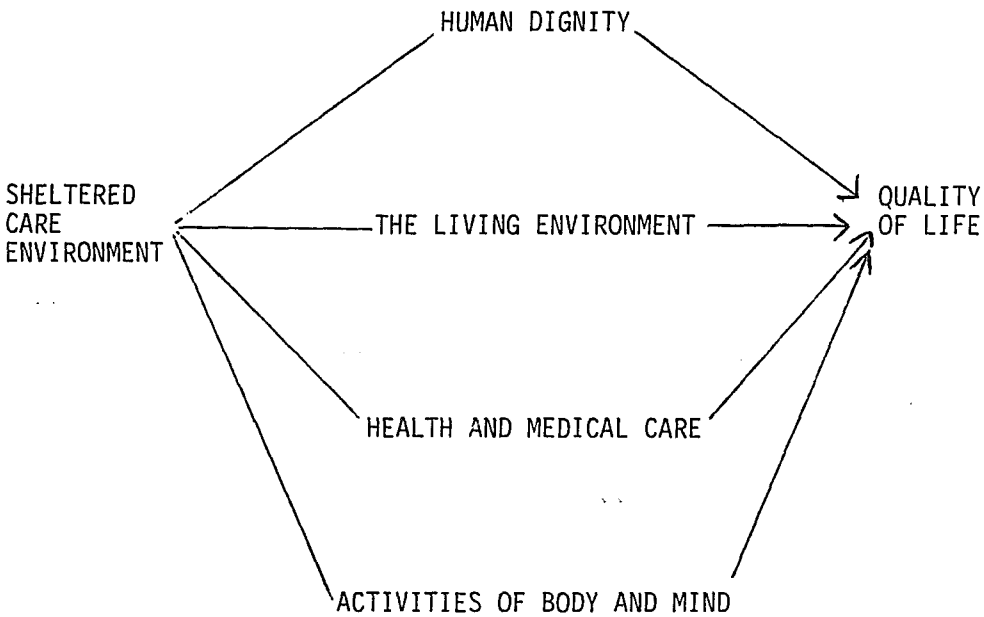

Figure 3. Conceptual Framework for Quality of Life Study

dreams, and ambitions; it must include all areas of life and experience; and takes into account the impact of illness and treatment. He stated "quality of life changes with time and under normal circumstances can vary considerably. Priorities of an individual must be realistic and therefore are expected to change with time and be modified by age and experience" (pp. 7-8). The implications derived from the definitions by Calman (1987) indicate that quality of life can only be described by the individual; must take into account many aspects of life; must be related to individual aims and goals; improvement is related to the ability to identify and achieve these goals; illness and treatment may modify these goals; goals must, in general, be realistic; actions are required to narrow the gap, either by meeting goals or by reducing expectations; and the gap between expectations and reality may be the driving force for some individuals (Calman, 1987).

Calman (1987) noted that his definition of the concept of quality of life is a task analysis or goal-oriented approach and fits into such current concepts as the nursing process and problem-oriented medical records. He recommended that efforts to modify the quality of life of individuals should be approached by using four steps: (1) assessment; (2) planning; (3) implementation of plan; and (4) evaluation. The framework for quality of life by Calman (1987) provides guidelines for the nursing profession in addressing quality of life with the patient population.

Health care professionals no longer focus on the isolated disease entity of individuals but take a more holistic approach in the care

planning of individuals. The holistic approach by health care professionals includes involving individuals and significant others in the decisions to be made regarding their care. This requires subjective assessments by individuals regarding their desires and/or goals and needs.

Putnam (1987) addressed the need to obtain subjective data from older adults by stating:

> Often it is a matter not of the actual presence or absence of abilities that threatens quality of life for seniors but rather of the meaning that they perceive to be attached to their lives (p. 67).

Pearlman and Uhlmann (1988) stated that "aspects of living in an institutionalized setting may affect quality of life" but that "the perceptions of nursing home residents specifically regarding their quality of life have not been systematically characterized" (p. 317). This study by Pearlman and Uhlmann (1988) compared the quality of life of 47 nursing home residents and 47 community residents in the northwest. The subjects' subjective perceptions of their quality of life were measured by a single item question developed by Pearlman and Uhlmann (1988). The subjects were to consider their personal situation and rate their quality of life using a 6-point Likert scale: 1 = "about as good as it can possibly be"; 2 = "good enough, no major complaints; 3 = "fair, good enough to manage"; 4 = "not so good, quality of life leaves much to be desired"; 5 = "not good at all, poor quality of life"; and 6 = "terrible, my quality of life is very bad" (p. 319). The pretests of this question demonstrated a two-week test-retest reliability of kappa = .94.

Quality of life has been addressed in the literature since the early 1960s. The concepts of quality of life and life satisfaction seemed to be intertwined. Other concepts such as happiness, morale, well-being and mental health were added to the list. Quality of life is not attainable without life satisfaction. Life satisfaction influences the attitude one has about his quality of life. Much of the literature speaks to quality of life by addressing life satisfaction. Clearly life satisfaction and quality of life must come from individuals' cognitive assessments of their degree of success in fulfilling their personal aspirations.

Earlier attempts at determining quality of life focused on statistics of economic measures, as they were easy to count. Campbell (1976) suggested these economic data did not represent the quality of the national life, but that a more sensitive set of measure was needed to provide a "fuller description of people's lives" (p. 118). Campbell (1976) and George (1986) supported the definition of life satisfaction as the global assessment of life quality as it is derived from the comparison of one's aspirations to the actual conditions of one's life. Although Calman (1987) did not define quality of life in this same manner, his definitions supported this approach.

George (1986) addressed life satisfaction in the older adult by incorporating the concept of mental health. She stated that positive mental health was part of the sense of satisfaction with life. Jahoda (1958) defined mental health as characterized by a distinctive configuration of psychosocial resources which included: (a) a feeling of self-worth; (b) a sense of competence; (c) a well-integrated ego that permits

a flexible approach to the environment, yet also controls destructive impulses; (d) a sense of comfort with one's relationship to the environment; and (3) the perception that one's life is meaningful.

George (1986) also found that life satisfaction had been used as a synonym for mental health. George (1986) and Larson (1978) supported this by stating that labels such as "subjective well-being" and "psychological well-being" typically were used interchangeably with the term life satisfaction. This definition of mental health clearly contains elements one would need to attain the quality of life for which one strives.

George (1986) suggested that life satisfaction was the result of adequate social and psychological resources, regardless of age, but the resources might vary in importance and direction of impact for persons in different stages of life. This strengthened the definition of quality of life by Calman (1987).

Previous surveys of older adults suggest that the vast majority of older adults are satisfied with their lives. No data are available from these studies, although George (1986) estimated the percentage of older adults satisfied with their lives was approximately 85%. George (1986) also indicated that sufficient data were lacking on the quality of life of the institutionalized older adult. Campbell, et al. (1976) compared young, middle-aged and older adults by measuring both life satisfaction and happiness.

A total of 2164 persons 18 years old and older and living in private households in 48 states were interviewed. One conclusion from this study indicated that old age was a period of relatively low levels

of happiness and high levels of satisfaction, whereas younger persons had higher levels of happiness and lower levels of satisfaction (Campbell, 1976). The implications of these results are that the older adult focused on being satisfied with life rather than the more transitory state of happiness. Campbell (1976) stated that researchers must stop using the word "happiness" indiscriminately to refer to any aspect of experience that is positive but should work on identifying the major dimensions of the experience of well-being. The basis for quality of life could then include the domains of well-being, positive mental health, and life satisfaction.

George (1986) viewed life satisfaction as involving evaluation along a good-bad continuum, with the evaluation primarily being based on cognitive assessments of the discrepancy between achievements and aspirations. She added that life satisfaction is a more long-term judgment, while happiness and mood are transitory. It is noted that Jahoda's (1958) definition of mental health did not address transitory items such as happiness or moods but rather used indicators of psychosocial resources. Life satisfaction can be considered a positive mental health indicator. Dissatisfaction with life cannot, however, be considered mental illness. Dissatisfaction is the difference between hopes and expectations of individuals and their present experiences.

George (1986) suggested two methods for reducing individuals' dissatisfaction with their quality of life that was supported by Calman (1987). These methods noted by George (1986) cannot be considered to stand alone. Intervention by health care professionals should draw

on both of these methods based on the status of the client. The methods are a goal directed behavior that brings achievements closer to desired conditions and a reduction in aspirations so they more closely match the actual conditions of existence. The two methods can be used within the framework of Calman's (1987) definition and recommendations for addressing quality of life.

Burckhardt (1985) cited studies that were done to determine specific domains of life that described quality of life for a group of randomly selected Americans. She provided no data, but stated the studies concluded that the specific domains could be categorized into five broad areas: (1) physical and material well-being; (2) relations with other people; (3) social, community and civic activities; (4) personal development and fulfillment; and (5) recreation. Much of the literature reviewed refered or alluded to these domains in many ways (Campbell, 1976; George, 1986; Horley, 1984; Larson, 1978; Markides & Martin, 1979). It can be concluded that these domains should be included in studies looking at quality of life and life satisfaction.

Quality of life was addressed in two different populations by Johnson et al. (1986) and Packa et al. (1989). One portion of the study by Johnson et al. (1986) addressed life satisfaction using the Life Satisfaction Index-Z Scale in 1969. Packa et al. (1989) addressed quality of life using the Cantril Self-Anchoring Scale.

Johnson et al. (1986), in their study of 58 native American Indians on two midwestern reservations, noted that 41% of the study subjects scored between 16-20 on life satisfaction. The scores on the

instrument (Life Satisfaction Index-Z Scale) ranged from 1 to 26. The median life satisfaction score was 18. These scores indicated a high level of life satisfaction for these subjects.

Packa et al. (1989) studied 51 elderly patients enrolled in nine cardiac rehabilitation programs. One focus of this study was a self-assessment of quality of life using the Cantril Self-Anchoring Scale (Cantril, 1965). This scale used a 10-rung ladder ranging from 0 (worse possible life imaginable) to 10 (best possible life imaginable) to rate quality of life. Quality of life was rated average ($\bar{X}$ = 5) prior to participation in cardiac rehabilitation; increased to $\bar{X}$ = 8 at the time of the interview; and was predicted to be $\bar{X}$ = 9 three months after program completion.

A quality of life study was conducted by Gould (1985) at a State Veterans Home in Northern California. The Member Opinion Quality of Life Survey was developed to measure the four variables of human dignity; the living environment; health and medical care; and activities of body and mind. Gould (1985) studied 121 male and female subjects, with an age range of 40 to 92 years and a mean age of 69 years. The residential settings at the Home included in the study were the domiciliaries, intermediate care areas, and the hospital.

The Member Opinion Quality of Life Survey (Gould, 1985) consisted of 109 items. The subscales of the survey were human dignity with 17 items, the living environment with 41 items, health and medical care with 25 items and activities of body and mind with 26 items. The response categories were 'strongly disagree'; 'moderately disagree';

'slightly disagree'; 'slightly agree'; 'moderately agree'; and 'strongly agree' with values assigned for each response ranging from 1 for 'strongly disagree' to 6 for 'strongly agree'. The possible range of scores was from 109 to 654 with higher scores reflecting increasingly higher levels of satisfaction.

The results of the study by Gould (1985) noted mean scores for the four subscales as: 3.4 for the human dignity subscale; 3.7 for the living environment subscale; 4.2 for the health and medical care subscale; and 3.5 for the activities of body and mind subscale. The overall quality of life-life satisfaction score was 3.7. This score was the mean of the totals of the four subscales.

Variables

The conceptual framework of quality of life contains four variables. The variables are human dignity, the living environment, health and medical care, and activities of body and mind.

Human Dignity

The variable of human dignity is defined as containing such elements as freedom of choice, statement of rights, sensitivity of staff, and participation in policy setting and operations (Gould, 1985). Dignity is enhanced when a person is able to maintain his individuality in making choices and has some measure of control over his activities of daily life.

This investigator found a dearth of information on human dignity as it applied to the older adult. Kahana (1973) did not directly refer

to dignity but addressed issues of the institutional environment that could be either humanizing or dehumanizing to the resident of the institutional environment. Kahana (1973) stated that older adults were not institutionalized until they could no longer cope with life in the community. She went on to say that humane treatment (within the institution) must not be just the absence of maltreatment, but an active attempt to restore the older person to his optimal level of functioning. This philosophy of rehabilitation should have a positive effect on the enhancement of human dignity.

Kahana (1973) approached human dignity by addressing humanistic psychology and human ecology. She stated that humanistic implies concentration on the distinctively human aspect of the individual, which includes the concepts of integration, goal setting, and self-actualization. Some of the practices Kahana (1973) identified as problems were related to protecting the well-being of the older person while disregarding their simplest wishes. These included providing well maintained and well supplied environments, yet being insensitive to apathy and an atmosphere of hopelessness; poorly paid and inexperienced nursing staff; crowded environments; addressing group needs while neglecting individual needs; frequent relocation within the facility; lack of dignity in dying; and protecting the individual to the extent he could not master his environment.

Meaningful choices were identified by Kahana (1973) as part of humane treatment. The opportunity to make choices in one's daily life can provide an environment that fosters human dignity. There have been

recent attempts to provide an environment that allows residents to participate in choices by having some form of representation or self-government by residents. The residents, with the support of the health care professionals, become part of the decision making process. The federal agency charged to provide health care to the veterans of the armed services has two documents, Patient's Bill of Rights (Appendix A) and Patient Responsibilities (Appendix B) that are significant to veterans using these services. These two documents provide guidelines that govern the staff and the veterans in maintaining a milieu that gives veterans choices and some measures of control over their lives.

The nursing profession's attempt to change the focus of care to meet each individual's needs is apparent in the article published by Alston, Dempsey, Franklin, McGonagle, Moore and Rowland (1989). The topics of relocation; individuality-treating people with dignity; care-giver attitude; and decision making and autonomy were addressed. Alston et al. (1989) supported the premise of treating older adults with dignity while supporting them in their activities of daily life.

The Living Environment

The variable, the living environment, included those factors which influenced the comfort, privacy, safety and security of the living environment, and availability of personal space (Gould, 1985). Pincus (1968) identified the need to develop a systematic method for analyzing the institutional environment for evaluating the effects of institutional and group living facilities of the older adult.

The significance of addressing the effects of the environment on the institutionalized older adult were also addressed by Harel (1981). Harel (1981) stated there was evidence that negative environmental features of environmental constraints adversely affected the psychological well-being of older people. There was also an indication that person-environment congruence and institutional environments that fostered resident autonomy, integration and personalized care, promoted high morale, life satisfaction and better adjustment (Harel, 1981; Kahana, Liang & Felton, 1980).

A conceptual framework was chosen by Harel (1981) to empirically test the importance of quality of care and congruence in determining residents' well-being in nursing homes and homes for the aged. The concepts were: (a) Permeability - continued ties with possessions, continued ties with people, and integration into surrounding environment; (b) Resident Domain - personal life space and personal responsibility; and (c) Need Gratifications Patterns - basic needs and social needs.

Fourteen nursing homes and homes for the aged in the Metropolitan Cleveland area which had self-care or intermediate care floors were included in Harel's study (1981). The author identified these floors as a limiting factor, decreasing the generalizability of the study. There were 125 subjects from 54 years to 97 years, with an average of 80 years. Two important findings of this study were the results of the data on personal responsibility and personal life space. Personal responsibility was defined as the degree to which residents cared for themselves, their possessions and their immediate environment. This

(personal responsibility) was significantly associated with life satisfaction (r = .18; p = $\leq$ .05). Personal life space was defined as the amount of privacy and space available for personal use and for keeping personal possessions. This (personal life space) was associated with life satisfaction at (r = .04; p = $\leq$ .05). Personal responsibility and personal life space were significantly associated with life satisfaction for this group of subjects who lived in this sheltered care environment. Harel (1981) summarized the results of the study by identifying the need to place greater emphasis on:

* providing residents with opportunities for continuing ties with preferred family members and friends;
* allowing residents to have more privacy and personal life space and more opportunities to exercise choices and personal responsibilities;
* providing residents with more opportunities for social involvement and social activities.

Health and Medical Care

The variable, health and medical care, assessed the appropriateness and adequacy of medical services, the perception of competency and the compassion of medical professionals (Gould, 1985). Poor health or the perception of poor health influenced individuals' ability to meet their perceived needs of daily living and influenced their level of satisfaction within their present environment.

A study by Markides and Martin (1979) was founded on the belief (based on their literature review) that the effects of other correlates

of life satisfaction were negligible when the variables of health status, socioeconomic status and activity were held constant. The hypotheses relevant in their study were: (a) activity was positively related to life satisfaction; and (b) health had a direct positive effect on life satisfaction and an indirect positive effect via activity. They proposed and applied a path analysis model of life satisfaction to data from interviews with 141 persons age 60 years and older. The subjects resided in four low-income census tracts in South San Antonio, TX.

The predictor variables examined in the study by Markides and Martin (1979) were self-reported health, income, education, and an activity index. The analyses were conducted separately for the two sexes. They found that health influenced life satisfaction not only directly but also indirectly by permitting or preventing individuals from engaging in essential life satisfying activities. Health (males, $\underline{r}$ = .296; females, $\underline{r}$ = .374) and activity (males, $\underline{r}$ = .385; females, $\underline{r}$ = .327) emerged as strong predictors of life satisfaction. Each of these relationships was statistically significant at $\underline{p} = \leq .05$. Health emerged as a stronger predictor of life satisfaction for females than for males, while activity was the stronger predictor of life satisfaction for males. These results supported the individualization of care planning and provided health care professionals with information to direct their approach toward care planning for older adults.

Huss, Buckwalter and Stolley (1988) designed a descriptive study to look at the relationship between residents of long-term care facilities and the nursing staff. This study also included residents'

perception of the nursing staff and the association of these perceptions to their life satisfaction. This study included interviews of 30 subjects in two intermediate care facilities in a midwestern city. The ages of the subjects ranged from 67 to 97 years, with a mean age of 85 years. Results of the study indicated that the correlation between life satisfaction and perception of the nursing staff was not statistically significant. The findings indicated that a positive view of the nursing staff was not related to life satisfaction. The statistically significant correlation in this study was between life satisfaction and perception of health status at $\underline{r} = .72$, $\underline{p} = \leq .001$.

Although no 'p' values were presented, the authors (Huss et al., 1988) indicated that the four independent variables had (using multiple regression analysis) a strong relationship to life satisfaction (Multiple $\underline{R} = .81$). They stated the independent perception of health status had the strongest relationship to life satisfaction, followed by the presence of a confidant, nurse/resident relationship, and activities of daily living.

The implication for nursing gained from this study was the importance of the perceived health status by the older adult. This can be supported by nursing in presenting the older adult with sufficient information on health maintenance measures, such as diet, exercise, medications, etc. (Huss et al., 1988). The presence of a confidant in this study, often proved to be a member of the nursing staff when other sources were absent. Again, a direction for nursing in planning care of the older adult was identified.

Activities of Body and Mind

The variable of activities of body and mind was defined as those activities or functions that affected the spirit and sense of well-being of the older adult (Gould, 1985). The factors considered were the extent to which the recreational, vocational, and spiritual activities met the individual's interests.

Riffle (1982) supported promoting activity as an approach to facilitating adaptation to aging changes. She stated that "for older persons, the ability to remain active affects not only health, but the quality of life, including the degree of independence they can assume in activities of daily living and the continuing ability to interact socially with family, friends, and community groups" (p. 455).

A study by Duellman, Barris and Kielhofner (1986) addressed organized activity and the adaptive status of nursing home residents. This study examined the relationship between opportunities to participate in organized activities and the effect on the elderly person's self-perception as an active person in the present and future environment. Duellman et al. (1986) stated that "elderly people who are unable to engage in successful interactions with the environment may eventually cease to have positive expectation for further interactions with the environment" (p. 618). This statement formed the underlying hypothesis for the study. The sample consisted of 44 subjects who met the study criteria. The subjects were 60 years of age or older, with a mean age of 77.5 years and a standard deviation of 9.5. The results showed a positive relationship between activity and future roles ($r = .51$, $p = \leq .001$) and between activity and present roles ($r = .56$, $p = \leq .001$).

Roles were defined as the components of habituation. The implications were that older adults who participated in organized activities within their environment would form and maintain a system (present and future roles) that supported the perception of themselves as actively involved with their environment.

As noted previously, Markides and Martin (1979) found activity to be a strong predictor of life satisfaction. The variable of income was included in the Markides and Martin (1979) study. It is of interest that they found that "income affects life satisfaction indirectly via activity with a strong effect in the case of males" (p. 91). They speculated that this may indicate that the kinds of activities the older male engaged in required the spending of more money than activities engaged in by older females. Recall that activity was a stronger predictor of life satisfaction for the older adult male than the female (Markides & Martin, 1979).

It should be noted that the study by Markides and Martin (1979) found activity a strong predictor of life satisfaction, while Huss et al.'s (1988) study findings did not support this. The conclusions may be affected by the residency of the populations studied. Markides and Martin (1979) selected a population residing in a community setting, while Huss et al. (1988) selected a population in a sheltered care setting. Perhaps the indication is that older adults in a sheltered care environment have adapted to a decrease in activity levels, thus changing their personal goals for life satisfaction.

Lemon, Bengston and Peterson (1972) addressed the activity theory of aging which is identified as being "implicit in gerontological literature" (p. 511). Their principal intent was to present a statement, formal and explicit, on the activity theory of aging. Lemon et al. (1972) stated that the presence of this theory is that there is a positive relationship between activity and life satisfaction and that the greater the role loss, the lower the life satisfaction.

Two theorems formulated for the Lemon et al. (1972) study were that, (a) the greater the activity, the greater one's life satisfaction; and (b) the greater the role loss, the lower the life satisfaction. The proposition was stated as the greater the frequency of activity, the greater one's life satisfaction was likely to be. The hypotheses applicable to this study were that informal, formal and solitary activity were directly associated with life satisfaction; informal activity was more highly associated with life satisfaction than formal activity; and formal activity was more highly associated with life satisfaction than informal activity.

Lemon et al. (1972) selected a sample of 411 subjects who were members of a retirement community. The results of the study supported only one of the hypotheses tested. The only relationship that was statistically significant at the $\underline{p} = \leq .05$ level was between informal activity with friends and life satisfaction. Informal activity included social interaction with relatives, friends, and neighbors. The authors of this study identified several possibilities for the failure of the data to support their hypotheses. These possibilities were: (a) the

nature and quality of the data (secondary data was used); (b) the definitions of activity were too global to differentiate; and (c) the sample was inadequate or inappropriate. Further testing of the activity theory of aging was supported by Lemon et al. (1972).

Summary

The literature was reviewed to determine the information available on the quality of life of the older adult living in a sheltered care environment. The concept of quality of life was chosen as the framework of this study. Variables included in the concept were quality of life, human dignity, the living environment, health and medical care, and activities of body and mind.

CHAPTER III

METHODOLOGY

Chapter Three includes the design of the study and the specifics of data collection methodology. The plan of data analysis is also included in this chapter.

Design

A descriptive research design was used to address the research questions on the quality of life perceived by older veterans residing in a domiciliary. The variables of human dignity, the living environment, health and medical care, and activities of body and mind were rated by the subjects using the survey instrument, Member Opinion Quality of Life Survey. Additional subject information included demographic data, recreational, religious and family/friends visitation. The subjects were also asked to rate their perceptions of their state of health and quality of life.

Setting

The agency selected for this study was a State Veterans Home in Northern California. This Agency has a veteran population of over 600 members residing in domiciliaries. Permission to conduct this study was granted from the Executive Committee of the State Veterans Home (Appendix C).

Sample

A randomly selected sample of 46 subjects residing in two domiciliary units who met the study criteria participated in the study. The study criteria were:

1. Male subjects 55 to 75 years of age.
2. Residents in the domiciliary for six months or longer.
3. Oriented to time, person and place.
4. Able to speak and understand English.
5. Able to hear the questions posed by the investigator.

The age criterion was selected to include the large population of veterans in the 55 to 64 year old group. The criterion for residency was selected to control for the potential difficulties related to relocation adjustments. The critera for cognitive skills, language, and hearing were selected as the participant had to respond to the questions on the survey instrument posed by the interviewer.

The sample was selected by first identifying subjects between 55 and 75 years of age who had resided at the home for six months or longer. These subjects were then ranked from lowest to highest by the last four digits of their social security numbers. Fifty subjects from each unit were identified. Each subject was sent a notice explaining the study. Twenty five subjects from Unit One and 21 subjects from Unit Two agreed to participate in the study. Each subject was given a one hour appointment time to meet with the investigator.

Protection of Human Subjects

This project was submitted to and approved by the Human Subjects Committee of the University of Arizona and the Research Committee at

the State Veterans Home in Northern California, prior to data collection. The subjects were asked to read the disclaimer and ask any questions they had about participating in the study. If subjects agreed to participate in the study, they were asked to sign the consent required by the State Veterans Home (Appendix D). The subjects were informed in the disclaimer/consent form that participation was voluntary; their identity would be anonymous and privacy maintained; and they could stop at any point without jeopardizing their membership, care, or way of life at the home. The subjects were also informed that they would incur no costs, nor receive any financial compensation for participating in the study.

Data Collection Instruments

Two instruments were used in this study to collect data. The first was the Member Opinion Quality of Life Survey. The second was the Demographic Data Form.

Member Opinion Quality of Life Survey Instrument

This instrument was developed by a task force at the State Veterans Home in Northern California beginning in 1983. The variables included in the concept of quality of life were identified from an extensive literature search. The variables of human dignity, the living environment, health and medical care, and activities of body and mind were selected for their relationship to the literature and the significance to the mission of the State Veterans Home. Four task force groups were formed to address variables of Human Dignity, the Living

Environment, Health and Medical Care, and Activities of Body and Mind (Appendix E). The task force groups ranged in size from 12 to 15 participants, and included both Home members and employees. The Home members on the task force had resided in the domiciliaries longer than six months, and the employees were senior members of the health care professional group.

The leader of each task force was a senior member of the health care professional group and was responsible for establishing meeting times, contacting task force members and running the meetings according to a standardized format identified as the Nominal Group Process. The groups met twice, for one to one and one half hours, and were to accomplish two tasks. They were charged to generate exhaustive lists of issues or ideas thought to be relevant to that variable they were responsible for and then to group similar items into broader, major categories, or priorities which were then rank ordered from the most to the least important (Gould, 1985).

The instrument items were constructed from this raw data, using a six point Satisfaction-Dissatisfaction scale ranging from most to least satisfaction. The subjects rated their satisfaction/dissatisfaction by agreement/disagreement and the degree of agreement/disagreement with each item on the survey instrument.

The survey statements were developed in rough form and returned to the task force groups for further suggestions. The statements were then finalized and pre-tested on a group of six members in different levels of care to determine its appropriateness and ease of use for the Veteran members. The pre-testing identified the need to make minor

changes in a few words in some statements as the definitions of these words were too complex for easy comprehension. The pre-test indicated the content and format of the questionnaire to be suitable and the time required to complete the instrument ranged from 30 minutes to one and one half hours (Gould, 1985).

Gould (1985) identified the Home members as best able to address the concerns of the veteran members of the facility. He also noted that the health care professionals involved with the task force groups were considered by the administrative group of the Home, to be highly knowledgeable about the care of older adults in long term care or sheltered care environments. This instrument was developed for use only within this facility.

The original survey instrument had 17 questions in Part I, Human Dignity; Part II, The Living Environment, had 41 questions; Part III, Health and Medical Care, had 25 questions; and Part IV, Activities of Body and Mind had 26 questions. The value of each item on the instrument ranged from one to six points, with satisfaction being six points and dissatisfaction being one point. Therefore, the higher the score the greater the satisfaction.

The statements on the instrument have both positive and negative directions. The response choices for the positive direction range from 6 = Strongly Agree to 1 = Strongly Disagree. The response choices for the negative direction ranged from 1 = Strongly Agree to 6 = Strongly Disagree. Thus, the subjects' disagreement on a negative statement

would get the same score as agreement on a positive statement. Higher scores reflected higher levels of satisfaction with decreasing score values indicated lower levels of satisfaction.

Part I of the survey instrument used in the study addressed the human dignity variable. The 17 items in this section had a possible range of scores of from 17 to 102 points.

Part II of the survey instrument addressed the variable of the living environment. This subscale had 28 items with nine possible range of scores from 28 to 168 points. Gould (1990) eliminated 13 items in this subscale because of changes made within the domiciliary since the original study was completed in 1985. The major change was the completion of new living quarters so that members now have semi-private accommodations and no more than two members are assigned to each room. Formerly there were some dormitory style rooms.

Part III of the survey instrument addressed the variable of health and medical care. Twenty-five items were included in this section with the possible range of scores from 25 to 150 points.

Part IV of the survey instrument addressed the variable of activities of body and mind. This subscale contained 26 items with a possible range of scores of from 26 to 156 points.

To obtain the quality of life-life satisfaction score, the scores from the four subscales were added together. The total of 96 items allowed a range of scores from 96 to 576.

Each item was scored either positive or negative; for example in the subscale human dignity, Item #1 is positive and Item #9 is

negative as shown in the Member Opinion Quality of Life Survey in Appendix E. The subjects' responses were one of six choices for each statement which were scored from 1 'strongly disagree' to 6 'strongly agree' for the positive statements and 6 'strongly disagree' to 1 'strongly agree' for the negative statements so that disagreement on a negative statement would get the same score as agreement on a positive statement.

The following statements were negatively scored:

Part I, Human Dignity: Question 9.

Part II, The Living Environment: Questions 11, 12, 13, 14, 15, 17, 18, 24, 25, 26, 27.

Part III, Health and Medical Care: Questions 1, 3, 4, 6, 10, 11, 12, 13, 14, 19, 20, 23.

Part IV, Activities of Body and Mind: Questions 1, 2, 3, 9, 10, 11, 16, 17, 18, 19, 25, 26.

Demographic Data Form

This form was developed by the investigator to collect the demographic information for each subject and collect data on each subject's participation in social and religious activities in the community and/or home. The Demographic Data Form concluded with two questions related to the subject's self-assessment of his health and his quality of life.

The question on self-assessment of the subject's health was developed by this investigator. The scores ranged from one to six points for the response options of: 1 = 'very bad'; 2 = 'poor'; 3 = 'fair'; 4 = 'okay'; 5 = 'good'; and 6 = 'excellent'. The higher range of scores

reflected more positive perceived health status outcomes by the subjects. This question was not pilot tested to determine its reliability or validity.

The question that asked for a self-assessment of the subject's quality of life was developed by Pearlman and Uhlmann (1988). Their scoring scale ranged from 1 = 'about as good as it can get', to 6 = 'terrible, my quality of life is very bad'. Their scoring range was reversed for this study as follows: 1 = 'terrible, my quality of life is very bad'; 2 = 'not good at all, poor quality of life'; 3 = 'not so good, quality of life leaves much to be desired'; 4 = 'fair, good enough to manage'; 5 = 'good enough, no major complaints'; and 6 = 'about as good as it can possibly be'. The change in the scoring for this study was done to have the same direction as the other instruments so that the higher the score, the higher the satisfaction. Pearlman and Uhlmann (1988) stated the pre-tests of this question demonstrated excellent two-week test-retest reliability (kappa = .94).

Data Collection Protocol

The data collection protocol was based on an adaptation of the Interviewer Instructions and Procedure format developed for use with the original instrument (Appendix F). The subjects were interviewed in a private office provided for the investigator within the domiciliary. The first two paragraphs of the instruction sheet were read to the subject (Appendix G). The subjects agreeing to participate were then asked to read the disclaimer and sign the consent form required by the State

Veterans Home. The subjects were then given a card with the six ratings listed, and asked to use the scale to rate each question.

Each question was read to the subject. This method was used at the request of the original investigator for future data comparisons. The subjects would then decide if they agreed or disagreed with the statement or question. The degree or level of agreement/disagreement was determined and then recorded on the answer sheet by the investigator.

The demographic data and the additional questions on health and quality of life were administered after the survey questions were completed. The demographic data were not obtained at the beginning of the interview as some of the items addressed might have provided the subjects with a perception of what was expected in their answers for the survey instrument. When all data were collected from each subject, the investigator terminated the interview process.

Data Analysis

Data were analyzed using the SPSS-X statistical software package. Descriptive statistics were used to describe the data in the Member Opinion Quality of Life Survey instrument and the Demographic Data Form (Munro, Visintainer & Page, 1986, p. 7). Frequencies and means were used to present the findings for all research questions. Pearson Moment Correlation Coefficient was run to determine the relationship between self-assessed health and self-assessed quality of life.

Summary

A descriptive research design was used to address the quality of life perceived by older adults residing in a domiciliary in Northern

California. The two questionnaires used were the Member Opinion Quality of Life Survey and the Demographic Data Form. The Member Opinion Quality of Life Survey was first used by Gould (1985) and again for this study. Forty-six subjects participated in this study. Data were analyzed using descriptive and correlational statistics.

CHAPTER IV

RESULTS OF DATA ANALYSES

The results of the data analyses related to the demographic characteristics of the sample and research questions are presented in Chapter Four. The results of the frequency distributions and correlational analysis for the research questions are also presented. The higher scores in the data analyses indicated more positive outcomes.

Characteristics of the Sample

A random sample of 49 male residents residing in two domiciliary units at the State Veterans Home were personally contacted by the investigator. Forty-six residents agreed to participate in the study.

The ages of the 46 subjects ranged from 55 to 75 years with a mean age of 67 years (S.D. = 5.2). As noted in Table 1, 16 (35%) subjects were 70 to 75 years of age; 13 (28%) subjects were 65 to 69 years of age; and 13 (28%) subjects were 60 to 64 years of age. Twenty three (51%) of the subjects were smokers.

The total group's length of stay in the domiciliary ranged from less than one year to 30 years. Seventeen (37%) subjects indicated a length of stay that ranged from one to three years. There were five (11%) subjects with a length of stay of less than one year and four (9%) subjects with a length of stay of 15 to 30 years (Table 2).

Table 1. Frequency Distribution of Subjects by Age (n=46)

Age Group	Subjects	
	No.	%
55 - 59	4	9
60 - 64	13	28
65 - 69	13	28
70 - 75	16	35
TOTAL	46	100

Table 2. Frequency Distribution by Subjects' Length of Stay in the Domiciliary (n=46)

Years in Domiciliary	Subjects	
	No.	%
< 1 year	5	11
1 to 3 years	17	37
> 3 years to 6 years	14	30
> 6 years to 9 years	6	13
15 to 30 years	4	9
TOTAL	46	100

The data identifying the group's length of stay in the section of the domiciliary where they were living at the time of this study are noted in Table 3. The length of stay ranged from less than one year to nine years. Twenty-five (55%) subjects had a range of length of stay in the present section from one to three years.

Activities in the Community

Twenty-five (54%) subjects stated they visited in the community with family and friends. The number of family visits per year by subjects ranged from one time per year to three times per week, with 15 (60%) subjects indicating visits that ranged from one to 11 times per year. One subject visited three times per week with his family.

Subjects' visits with friends ranged from one time per year to three times per week. Twelve (48%) subjects indicated they visited with friends from one to 11 times per year. Four subjects visited three times per week with their friends (Table 4).

Participation in social activities in the community was noted by 18 (39%) subjects. Of the 18 subjects who participated in community activities noted in Table 4, seven (39%) subjects participated in social activities from one to 11 times per year, while six (33%) subjects participated as often as one to three times per week.

Eight (17%) subjects participated in religious activities within the community. Two (25%) subjects indicated participation in religious activities as often as three times per week, while four (50%) subjects ranged from one to 11 times per year (Table 4).

Table 3. Frequency Distribution by Subjects' Length of Stay in Present Section (n=46)

Years in Present Section	Subjects No.	Subjects %
< 1 year	13	28
1 to 3 years	25	55
> 3 to 6 years	7	15
> 6 to 9 years	1	2
TOTAL	46	100

Table 4. Frequency Distribution of Subjects, Outside Visits with Family or Friends and Their Participation in Social/Religious Activities in the Community

Activities	Range of Scores Subjects No.	%
Visit with Family (n=25)	25	54.3
Times/year		
1 to 11 x/year	15	60
12 to 36 x/year	7	28
< 36 x/year*	3	12
Visit with Friends (n=25)	25	54.3
Times/year		
1 to 11 x/year	12	48
12 to 36 x/year	6	24
< 36 x/year*	7	28
Social Activities (n=18)	18	39.0
Times/year		
1 to 11 x/year	7	39
12 to 36 x/year	5	28
< 36 x/year*	6	33
Religious Activities (n=8)	8	17.0
Times/year		
1 to 11 x/year	4	50
12 to 36 x/year	2	25
< 36 x/year*	2	25

* 1 to 3 x/week

Activities at the Home

Twenty-two (48%) subjects visited with their families at the domiciliary, while 21 (46%) subjects indicated visits with friends. Visits with family by 12 (55%) subjects and visits with friends by 15 (71%) subjects ranged from one to 11 times per year (Table 5).

Participation in social activities at the domiciliary was indicated by 33 (72%) subjects. Fifteen (46%) subjects indicated participation in social activities from one to 11 times per year (Table 5).

Eleven (24%) subjects participated in religious activities at the domiciliary. There were three (27%) subjects, as noted in Table 5, that indicated participation in religious activities as often as three times per week, while two groups of four (37%) subjects each noted a range of one to 11 times per year and 12 to 36 times per year.

Self-Assessment of Health
and Quality of Life

There were two questions whereby subjects were asked for a self-assessment. One question (#20), asked them to assess their health as compared to other members of the home. The second question (#21) asked subjects to assess their quality of life as it pertained to their present personal situation.

Each resident had the option of six responses for the self-assessed health question. The response categories were 'very bad'; 'poor'; 'fair'; 'okay'; 'good'; and 'excellent' with values assigned for each response ranging from 1 for 'very bad' to 6 for 'excellent'. The higher scores reflected increasingly better health.

Table 5. Frequency Distribution of Subjects' Visits with Family/Friends and Participation in Social/Religious Activities Within the Domiciliary

Activities	Range of Scores Subjects No.	%
Visit with Family (n=22)	22	48
Times/year		
1 to 11 x/year	12	55
12 to 36 x/year	10	45
< 36 x/year*	0	0
Visit with Friends (n=21)	21	46
Times/year		
1 to 11 x/year	15	71
12 to 36 x/year	2	10
< 36 x/year*	4	19
Social Activities (n=33)	33	72
Times/year		
1 to 11 x/year	15	46
12 to 36 x/year	9	27
< 36 x/year*	9	27
Religious Activities (n=11)	11	24
Times/year		
1 to 11 x/year	4	37
12 to 36 x/year	4	37
< 36 x/year*	3	26

* 1 to 3 x/week

Each resident had the option of six responses for the self-assessed quality of life question. The response categories were 'terrible, my quality of life is very bad'; 'not good at all, poor quality of life'; 'not so good, quality of life leaves much to be desired'; 'fair, good enough to manage'; 'good enough, no major complaints'; and 'about as good as it can possibly be' with values assigned for each response ranging from one for 'terrible, my quality of life is very bad' to 6 for 'about as good as it can possibly be'. The higher scores reflected increasingly higher levels of satisfaction with his quality of life.

The results of subjects' self-assessment of their health found 31 (67%) subjects viewing their health as good or excellent. Only three (7%) subjects viewed their health as poor and no one stated their health was terrible (Table 6).

The subjects' self-assessment of their quality of life also noted 31 (67%) subjects viewed their quality of life as 'about as good as it can possibly be' or 'good enough, no major complaints'. Thirteen (28%) subjects assessed their quality of life to be 'fair, good enough to manage' (Table 7).

Research Questions

The Member Opinion Quality of Life Survey form was the instrument used to measure each subject's level of satisfaction with his quality of life in the domiciliary. The four subscales measured were human dignity, the living environment, health and medical care, and activities

Table 6. Frequency Distribution of Subjects' Self-Assessment of Their Health (n=46)

Self-Assessment	Subjects	
	No.	%
Very Bad	0	0
Poor	3	7
Fair	9	19
Okay	3	7
Good	18	39
Excellent	13	28
TOTAL	46	100

Table 7. Frequency Distribution of Subjects' Self-Assessment of Quality of Life (n=46)

Self-Assessment	Subjects No.	Subjects %
Terrible, my quality of life is very bad	0	0
Not good at all, poor quality of life	1	2
Not so good, quality of life leaves much to be desired	1	2
Fair, good enough to manage	13	28
Good enough, no major complaints	13	28
As good as it can possibly be	18	40
TOTAL	46	100

of body and mind. The quality of life-life satisfaction score is the sum of the scores of the four subscales. The analyses were based on the number of respondents per subscale that ranged from an n of 30 to 42.

Each resident had the option of six responses for each statement. The response categories were 'strongly disagree'; 'moderately disagree'; 'slightly disagree'; 'slightly agree'; 'moderately agree'; and 'strongly agree' with values assigned for each response ranging from 1 for 'strongly disagree' to 6 for 'strongly agree'. The scores ranged from 17 to 102 for the human dignity subscale; from 28 to 168 for the living environment subscale; from 25 to 150 for the health and medical care subscale; from 26 to 156 for the activities of body and mind subscale; and from 96 to 576 for the quality of life-life satisfaction scale. The higher scores reflected increasingly higher levels of satisfaction.

Study Question One

> How do veterans rate their level of satisfaction pertaining to the concept of human dignity within their present living arrangements in the surveyed domiciliary?

There were 17 items in the human dignity subscale. The range of scores for the 42 (91%) subjects who completed the scale was from 62 to 93 points. The mean satisfaction for the human dignity variable was 4.6 (S.D. = 0.5) (Table 8). The subscale is found in Appendix I.

Study Question Two

> How do veterans rate their level of satisfaction pertaining to the concept of the living environment within their present living arrangements in the surveyed domiciliary?

Table 8. Subjects' Mean Levels of Satisfaction for the Subscales Human Dignity, Living Environment, Health and Medical Care, and Activities of Body and Mind and Total Scale

Subscale	Subjects No.	Subjects %	Subscale Range of Scores	Subjects' Range of Scores	Mean Level of Satisfaction	S.D.
Human Dignity	42	91	17–102	62–93	4.6	0.5
Living Environment	32	70	28–168	89–144	4.3	0.5
Health and Medical Care	30	65	25–150	73–138	4.4	0.5
Activities of Body and Mind	30	65	26–156	43–127	3.4	0.7
TOTAL SCALE	30	65			4.2	0.3

There were 28 items in the living environment subscale. The range of scores for the 32 (70%) subjects who completed the scale was from 89 to 155 points. The mean satisfaction for the living environment variable was 4.3 (S.D. = 0.5) (Table 8). The subscale is found in Appendix I.

Study Question Three

> How do veterans rate their level of satisfaction pertaining to the concept of health and medical care within their present living arrangements in the surveyed domiciliary?

There were 25 items in the health and medical care subscale. The range of scores for the 30 (65%) subjects who completed the scale was from 73 to 138 points. The mean satisfaction for the health and medical care variable was 4.4 (S.D. = 0.5) (Table 8). The subscale is found in Appendix I.

Study Question Four

> How do veterans rate their level of satisfaction pertaining to the concept of activities of body and mind within their present living arrangements in the surveyed domiciliary?

There were 26 items in the activities of body and mind subscale. The range of scores for the 30 (65%) subjects who completed the scale was from 26 to 156 points. The mean satisfaction for the activities of body and mind variable was 3.4 (S.D. = 0.7) (Table 8). The subscale is found in Appendix I.

Study Question Five

> What is the quality of life-life satisfaction rating reflected by the total scores of the four subscales for the group of subjects?

The quality of life-life satisfaction score included the four subscales of human dignity, the living environment, health and medical care, and activities of body and mind. Only 30 (65%) subjects completed all items on the four subscales and were included in this analysis. The mean satisfaction for the total scale was 4.2 (S.D. = 0.3) (Table 8).

Study Question Six

> Is there a relationship between the veteran's self-assessment of his health and his self-assessment of his quality of life?

As noted in Table 9, 46 (100%) subjects responded to the self-assessed health and self-assessed quality of life questions. The subjects' self-assessment of their health resulted in a mean satisfaction of 4.6 (S.D. = 1.3). The mean satisfaction of the subjects' self-assessment of their quality of life was 5.0 (S.D. = 0.98).

Correlations were run to determine the relationships between the self-assessed health and self-assessed quality of life questions. The Pearson Product Moment correlation coefficient between self-assessed health and self-assessed quality of life was $\underline{r}$ = .0177 ($\underline{p}$ = .907) which was not significant.

Table 9. Subjects' Mean Scores on Self-Assessment of Health and Self-Assessment of Quality of Life Questions

Self-Assessment	Subjects		Mean Scores
	No.	%	
Health	46	100	4.6
Quality of Life	46	100	5.0

Study of Question Seven

> How do veterans rate their quality of life overall, considering their personal situation?

The results of the self-assessed quality of life question indicated that the total group of subjects had a mean of 5.0 (S.D. = 0.98) (Table 9).

Summary of Findings

The demographic characteristics of the sample and survey outcomes were described in this chapter using descriptive statistics. The mean age of the subjects was 67 years. Thirty-one (67%) subjects viewed their health as good or excellent and their quality of life as 'good enough, no major complaints' or 'about as good as it can possibly be'. The results of Study Questions one to four found the mean satisfaction for the human dignity subscale was 4.6; the living environment subscale was 4.3; the health and medical care was 4.4; and the activities of body and mind was 3.4. Study Question five noted a quality of life-life satisfaction mean satisfaction of 4.2. No statistically significant relationship was found between the subjects' (n=46) self-assessed health and self-assessed quality of life in Study Question six. The subjects' self-assessed quality of life had a mean of 5.0.

CHAPTER V

FINDINGS, CONCLUSIONS AND DISCUSSION

The findings related to the outcomes of the research questions and conclusions are addressed in Chapter Five. The implications of the study findings for nursing practice and recommendations for future studies are presented.

Findings

This study was based on a quality of life framework that included the variables of human dignity, the living environment, health and medical care, and activities of body and mind. The relationship between self-assessed health and self-assessed quality of life was compared. Comparisons of the results from this study and the scores from the original study (Gould, 1985) were done.

There were several differences between this study and the original study by Gould (1985). The population size of Gould's (1985) study was larger (n=121) and included both male and female subjects. The ages of the subjects in Gould's (1985) study ranged from 40 to 92 years, compared to an age range in this present study of from 55 to 75 years. Gould's (1985) study subjects were selected from all areas of the Home, that included the domiciliaries, the intermediate care annexes and the hospital, while this study only used two units in the domiciliary.

Research Questions

Human Dignity (Study Question one) addressed the elements of freedom of choice, statement of rights, sensitivity of staff, the veterans' participation in policy setting and operations. The findings of this study indicated the subjects' (n=42) mean satisfaction score for the human dignity subscale was $\bar{x}$ = 4.6, on a scale of 1 to 6, compared to Gould's (1985) findings on 121 subjects of $\bar{x}$ = 3.4. Gould (1985) noted that "human dignity elicited much more dissatisfaction than any of the other areas", yet this study found that the human dignity subscale elicited the highest satisfaction of the subscales.

Several factors are suggested as potentially influencing the differences between the results of these two studies. The most obvious is the possibility that the results of the Gould's (1985) study precipitated changes by those interacting with the veterans that improved their sense of dignity during the past five years. Turnover in both staff and veterans residing in the domiciliary are other factors.

The Living Environment subscale (Study Question two) addressed those factors that influenced the comfort, privacy, safety and security of the living environment, and the availability of personal space. The findings of this study indicated the subjects' (n=32) mean satisfaction score for the living environment subscale was $\bar{x}$ = 4.3, compared to Gould's (1985) study findings (n=121) of $\bar{x}$ = 3.7. The difference in these mean scores can perhaps be explained by the changes in the physical plant at the domiciliary. Dormitory style housing was used in some sections in 1985. Completed construction since 1985 now provides all

residents with semi-private (two residents per room) and private rooms. The possibility of changes in federal and state regulations since 1985 could also be a factor in improving the living environment and the residents' level of satisfaction with his living environment.

Harel (1981) noted personal responsibility and personal life space were significantly associated with life satisfaction. The increase noted between the mean satisfaction scores from this study and the original study, coupled with the change in the housing from dormitory to semi-private rooms supports the findings of Harel (1981).

The Health and Medical Care subscale (Study Question three) assessed the appropriateness and adequacy of medical services, the perception of competency, and the compassion of medical professionals. The results of this study indicated the subjects' (n=30) mean satisfaction score for the health and medical care subscale was $\bar{x} = 4.4$, compared to Gould's (1985) study finding of $\bar{x} = 4.2$. There is essentially no difference between the mean scores of these two studies. One possible way to explain this would be by looking at the turnover rate of the health care staff, which is not addressed in this study. Nor is the percent of the veterans who participated in both studies known.

The subscale for Study Question four, Activities of Body and Mind, was defined as those activities or functions that affected the spirit and sense of well-being of the older adult. The factors considered were the extent to which the recreational, vocational, and spiritual activities met the individual's interests. The comparison of the results of the two studies showed no difference in the mean satisfaction scores

of the subjects. The present study subjects' (n=30) mean score for the activities of body and mind subscale was $\bar{x}$ = 3.4, compared to Gould's (1985) findings (n=121) of $\bar{x}$ = 3.5.

Markides and Martin (1979) showed activity to be a strong predictor of life satisfaction, while Huss et al.'s (1988) study findings showed no relationship. However, Huss et al.'s (1988) population sample resided in a sheltered care environment while Markides and Martin's (1979) population lived in the community. Perhaps older adults in a sheltered care environment have adapted to a decrease in activity levels, thus changing their personal goals for life satisfaction.

The Quality of Life-Life Satisfaction score (Study Question five) is the combined score of the four subscales of human dignity, the living environment, health and medical care, and activities of body and mind (Table 8, p. 61). The subjects' (n=30) satisfaction score in this study was $\bar{x}$ = 4.2, while the original study (Gould, 1985) noted a mean satisfaction score of $\bar{x}$ = 3.7 was noted. These results indicated an increase in the overall satisfaction of the residents at the home. The change in this score was influenced by the increase in the mean satisfaction scores of both the human dignity subscale and the living environment subscale.

The mean satisfaction score of the subjects' Self-Assessed Health ($\bar{x}$ = 4.6) and Self-Assessed Quality of Life ($\bar{x}$ = 5.0) (Study Question six) indicated a high degree of satisfaction. The correlations did not support a relationship between self-assessed health and self-assessed quality of life ($\underline{r}$ = .0177, $\underline{p}$ = .907).

The relatively high scores of both self-assessed health ($\bar{x}$ = 4.6) and self-assessed quality of life ($\bar{x}$ = 5.0) support the findings of Huss et al. (1988), who noted a strong correlation between life satisfaction and perception of health. Sixty-seven percent of the subjects (n=31) in this study viewed their health as 'good' or 'excellent' and their quality of life as 'good enough, no major complaints' or 'about as good as it can possibly be'.

The study by Lemon et al. (1972) found informal activity, which included social interaction with relatives, friends, and neighbors to be important ($\underline{G}$ = .21, $\underline{p}$ = $\geq$ .05) to life satisfaction. Over half (54%) of the subjects (n=25) in this study visited with family and friends in the community and 48% of the subjects (n=22) in this study visited with family and friends at the home, perhaps another reason for the high scores by the subjects on both the self-assessed health and self-assessed quality of life questions.

Data Collection Instruments

The numbers of subjects responding to the 96 items on the Member Opinion Quality of Life Survey ranged from 30 (65%) to 42 (91%) subjects. The fact that all subjects did not respond to each statement suggests several possibilities for explanation. First, the unanswered statement regarded situations the subjects did not or had not experienced or services the subjects did not require or use. Secondly, the statement was not clear and the subjects chose not to request clarification. The third possibility could be that subjects' interpretations of the statements were different than that intended by the originators of the

statements. Lastly, there was no response category, such as 'not applicable', for the subjects' use that addressed the previous explanations.

Implications for Nursing

A rapidly aging population increased longevity of the aged, and escalating health care cost provides a challenge for health care professionals involved with guiding and providing care for this population. Approximately 5% of the elderly reside in nursing homes. The remainder of this population, it must be assumed, are residents of communities in their homes or various residential care settings.

Quality of life has rapidly gained importance as a focus for care planning of the elderly. Many health care professionals continue to seek a definition of quality of life, as well as concepts that impact on quality of life of this aging population. The only major area of consensus in addressing quality of life is that quality of life is a subjective assessment by each individual. This subjective assessment by each individual offers a difficult task in identifying mutually exclusive concepts related to a quality of life model. Future studies may indicate that mutually exclusive concepts are not possible in assessing quality of life of the elderly.

Information on the quality of life of the elderly residing in their homes and residential care homes is limited. The expectations of the elderly in maintaining an acceptable quality of life may change when they leave their home and enter a residential care home. Longitudinal studies beginning with the elderly residing in their homes is

necessary to address the many unanswered questions related to quality of life. The longevity of the aging population makes this possible.

Escalating health care costs have changed the focus of health care from the acute care setting to the ambulatory or home care setting. The role of the professional nurse has begun to move rapidly toward filling the gap between the acute care needs of the elderly and the attainment of self care by the elderly. The Gerontological Clinical Nurse Specialist provides an eclectric approach to providing care for the elderly.

The residents of the domiciliaries, within which this study took place, were receptive to the presence of this investigator. Each of the residents must be able to independently perform his activities of daily living to reside in these sections. These activities of daily living include personal hygiene, laundry, care of personal surroundings and going to the main dining room for meals.

This particular environment is conducive to providing a wealth of opportunities for a gerontological clinical nurse specialist to promote enhancement of the health and quality of life of the older adult. Many subjects in this study verbalized the desire to know more about their medical conditions, diet, exercise and social issues. Administration time for the Member Opinion Quality of Life Survey and Demographic Data Form ranged from 30 to 45 minutes. This investigator found that many subjects wished to remain to discuss various issues and the hour allocated for the interview process was used.

The low score of the activities of body and mind subscale was not expected as all subjects in this study were able to go to the dining room for their meals. The dining room was located approximately two blocks from the domiciliary. Residents unable to ambulate independently had supportive devices such as walkers, wheelchairs (motorized and non-motorized), scooters, and golf carts. The Home has many planned activities for the residents. Transportation to other sections of the Home for planned activities is readily available and appropriate for handicap needs. There is also transportation available for the residents to go to other towns for shopping. Many of the subjects in this study were employed at the Home in such areas as food service, transportation, and assistant section leaders. The fact that approximately 50% of the study subjects were employed by the Home was not known prior to data collection.

The lack of congruence between the results of the activities of body and mind subscale and what the investigator observed would suggest a review of the items on the Member Opinion Quality of Life Survey would be useful to determine their appropriateness for this variable. The activities the subjects stated they were involved in would lead one to have expected a higher mean score.

Although there was not a statistical significant relationship between self-assessed health and self-assessed quality of life, the mean scores suggest clinical significance. The lack of statistical significance no doubt is due to the one item questions and no degrees of of freedom. The single item questions on self-assessed health and self-assessed quality of life provides nursing and health care professionals

with a method for identifying subjects' perceptions of their health status and their perceptions of their quality of life. The knowledge of the subjects' perceptions of their health and quality of life gives direction for the nurse in the planning of care and problem solving issues important to the subject. The single item questions on self-assessed health and self-assessed quality of life readily lends itself to incorporation into nursing care plans as a problem identification mechanism. The availability of a tool, such as the Member Opinion Quality of Life Survey, to measure the specific areas of concern to individuals would then provide a foundation for multidisciplinary planning with individuals to their concerns.

Recommendations

The Member Opinion Quality of Life Survey would provide a mechanism for health care professionals to identify the specific areas of concern to subjects. The continued development and refinement of this survey instrument to meet acceptable reliability and validity criteria are recommended. Consideration in designing the survey to apply to all subjects in residential care settings would expand the generalizability of the instrument, specifically the older veteran.

Summary

The mean satisfaction scores were noted to have improved in the subscales of human dignity and the living environment from the original study by Gould in 1985. No differences were found between Gould's 1985 study and the present study in the mean satisfaction scores for the

health and medical care subscale and the activities of body and mind subscale.

The quality of life-life satisfaction score from this study was $\bar{x} = 4.2$, while the previous study by Gould (1985) was $\bar{x} = 3.7$, indicating an overall increase in the satisfaction. This was related to the increased satisfaction scores in the human dignity subscale and the living environment subscale.

The subjects' self-assessment of quality of life had a mean satisfaction of $\bar{x} = 5.0$, indicating a high degree of satisfaction with their quality of life. No statistically significant relationship was found between self-assessed health and self-assessed quality of health.

APPENDIX A

PATIENT'S BILL OF RIGHTS

MEMORANDUM 136-90-1
Attachment A

PATIENT'S BILL OF RIGHTS

1. The patient has the right to considerate and respectful care.

2. The patient has the right to know by name the physician responsible for coordinating his/her care. The patient has the right to talk with the physician and other health professionals and be informed of the diagnosis, outlook, proposed treatment, and all medically significant information. Such information should be explained in terms that are understandable. When it is not medically feasible or advisable to share the above information with the patient, it should be made available to the next of kin or guardian.

3. The patient has the right to refuse treatment and to be informed of the medical consequences of such action.

4. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential. Consent for the release of information to others must be obtained from the patient, if competent, or from the next of kin or guardian.

5. The patient has the right to expect that within its capacity, the hospital will make reasonable response to requests for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case.

6. The patient has the right to be advised of any proposal to engage in or perform research. The patient has the right to refuse to participate in such research projects.

7. The patient has the right to expect that discharge planning will begin early in hospitalization and will be included in the hospital plan to avoid prolonged or unnecessary stay.

8. The patient has the right to have the medical record updated as often as necessary.

9. The patient has the right to know what hospital rules and regulations apply to his/her conduct as a patient.

10. The patient has the right to spiritual assistance when requested.

APPENDIX B

PATIENT RESPONSIBILITIES

MEMORANDUM 136-90-1
Attachment B

PATIENT RESPONSIBILITIES

Complying with the following list of Patient Responsibilities is necessary to assure the highest quality care.

1. The patient is responsible to follow all of the Medical Center's safety rules and posted signs.

2. The patient is responsible to be considerate and respectful of all Medical Center personnel and other patients.

3. The patient is responsible to cooperate with the treatment staff. If he/she has questions or disagree with the treatment plan, he/she is responsible for discussing it with the treatment staff.

4. The patient is responsible to try to prevent any injury to himself/herself, other patients, visitors and staff members by his/her own actions.

5. The patient is responsible for the safekeeping of clothing, money and personal possessions he/she chooses to keep with him/her while in this facility. (Valuables and in excess of $5 cash should be deposited for safekeeping.)

6. The patient is responsible to keep all of his/her scheduled diagnostic or treatment appointments on time and to let the staff know when he/she leaves the ward.

7. The patient is responsible to avoid interfering with the treatment of other patients, particularly in emergency situations.

8. The patient is responsible to assist by alerting the staff when another patient is having any difficulty.

9. The patient is responsible to tell his/her visitors to be considerate of other patients and Medical Center personnel and to observe the visiting hours.

10. The patient is responsible to make sure he/she understands what medications must be taken following discharge from the Medical Center, and to know what follow-up appointments, if any, have been scheduled.

APPENDIX C

LETTERS OF APPROVAL

STATE OF CALIFORNIA

Memorandum

To : Research & Education Committee Members Date: July 10, 1990

From : Edward Gould, Ph.D., Chairman
Research & Education Committee
Veterans Home of California

Subject : FINAL APPROVAL STATUS FOR QUALITY OF LIFE STUDY

In response to my 7/3/90 memo to the Executive Committee requesting approval of this study, the following points were raised at its meeting on July 5, 1990 and would require resolution before approval could be granted:

1) Unanimous Research & Education Committee approval. This has now been accomplished with Dr. Calvelo's approval of the protocol following his return from vacation.

2) Evidence that this investigation is under close supervision and monitoring in all its phases by an on site Veterans Home Medical Staff member (Dr. Gould).

3) Veterans Home review of the study report in rough draft, and prior to any efforts to publish it, to ensure that issues of privacy/ confidentiality concerning members/institutional names or other identifying data are followed and for corrections and suggested changes in manuscript.

On 7/6/90 these provisions were agreed to by the investigator, Peggy Allyn and myself. Executive Committee members were re-contacted by phone by Dr. Sunseri, Chief Medical Officer, and voted to approve the study subject to the above provisions.

Edward Gould

Edward Gould, Ph.D., Chairman
Research & Education Committee

cc: Stephan G. Sunseri, M.D., C.M.O.
Steven L. Phillips, M.D., Chief Of Medicine
Roger Kirkman, Chief, Residential Care
Don Reetz, Deputy Administrator
Peggy Allyn, R.N.

EG/ck

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HOME OF CALIFORNIA
YOUNTVILLE, NAPA COUNTY, CALIFORNIA 94599
Telephone: (707) 944- 4777

September 25, 1989

Peggy Allyn
9461 E. Summer Trail
Tucson, Arizona 85749

Dear Ms. Allyn:

As per our telephone conversation in early September, this is to formally grant permission for you to use our Quality of Life Questionnaire developed here at the Veterans Home of California during our study of member satisfaction in 1984/85. Of course, you may alter or modify the questionnaire to best suit the particular needs and characteristics of the facilities you wish to study.

Though I haven't further developed or pursued our own quality of life studies here at the Home, I'm pleased you are considering our survey in your research thesis. Much hard work went into it from both residents and staff. Resident satisfaction in residential care facilities for the aged is surely an area of major importance now in Social Gerontology.

Much luck and success in your explorations of resident satisfaction with Quality of Life. If you have additional questions, let me know.

Sincerely,

Edward Gould

Edward Gould, Ph.D.
Staff Clinical Psychologist &
Chairman, Research & Education Committee

EG/ck

STATE OF CALIFORNIA

Memorandum

To : MEMBERS OF RESEARCH & EDUCATION COMMITTEE

Date: JUNE 7, 1990

EDWARD GOULD, Ph.D., CHAIRMAN
RESEARCH & EDUCATION COMMITTEE
From : Veterans Home of California

Subject : REPLICATION OF THE QUALITY OF LIFE STUDY AT THE VETERANS HOME

Peggy W. Allyn, a graduate student in the Department of Nursing at the University of Arizona, is requesting permission to do a replication study of our 1985 Quality of Life project for her MS Thesis. Her interest in quality of life from the residents' perspective goes back to September 1986 when she attended our applied clinical Geriatric Conference where the original Quality of Life study findings were reported. She wishes to duplicate, as closely as possible, the original investigation including use of original survey, instructions, consent procedures, and sampling methods. However, her sample will be smaller and limited to our residents within the Domiciliary level of care.

As in the first Quality of Life study, a random sample of members meeting her study criteria would be selected from residential care and asked if they would be interested in participating on a strictly voluntary basis. I have agreed to provide consultation and assistance as needed though Ms. Allyn, as chief investigator, will do all phases of data collection including interviewing. She will bring with her a trained assistant to help in interviewing and expects to complete data collection in approximately one week. Enclosed is her cover letter, brief research protocol, research instruments, and University of Arizona Human Research and Committee approval.

Please review the attached research protocol and return by June 22, 1990 with questions, comments, etc. and recommendation for approval/disapproval. Time is an important factor as Ms. Allyn wishes to begin data collection no later than the end of the first week of July.

Edward Gould

Edward Gould, Ph.D., Chairman
Research & Education Committee

cc: Stephan Sunseri, M.D., C.M.O.
Don Reetz, Deputy Administrator
Roger Kirkman, Chief, Residential Care Service
Peggy W. Allyn, R.N., B.S.
Geri W. Pyle, Chief, Nursing Service

EG/ck

College of Nursing

THE UNIVERSITY OF
ARIZONA
HEALTH SCIENCES CENTER

Tucson, Arizona 85721
(602) 626-6154

MEMORANDUM

TO: Peggy Wetzel Allyn

FROM: Carolyn Murdaugh, Ph.D., R.N., F.A.A.N.
Director of Clinical Research

DATE: June 5, 1990

SUBJECT: Human Subjects Review: "A Subjective Assessment of Quality of Life by Older Adults Residing in a Sheltered Care Environment"

Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Subcommittee and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research if you need access to it.

We wish you a valuable and stimulating experience with your research.

CM:dbr

APPENDIX D

SUBJECT CONSENT FORM

A SUBJECTIVE ASSESSMENT OF QUALITY OF LIFE BY OLDER ADULTS RESIDING IN A SHELTERED CARE ENVIRONMENT

The purpose of the study is to get your opinions and feelings about living here at the Home.

As a member of the State Veterans Home, residing in the domiciliaries, you are being asked to voluntarily give your opinion on the statements in this questionnaire. By responding to the questionnaire, you will be giving your consent to participate in the study. Your name is not on the questionnaire, and you may choose not to answer some or all of the questions, if you so desire. Whatever you decide, your care will not be affected in any way. Your questions will be answered and you may withdraw from the study at any time.

This study is comprised of a 97-item Member Opinion Quality of Life Survey, and a 19-item Demographic Data Form which will be given to you during the interview process. The Principle Investigator or Research Assistant will ask you questions on the survey. You will be asked to agree or disagree with the statement and then indicate how strongly you agree or disagree. Then you will be asked to answer the questions on the Demographic Data Form. The time needed to complete the two questionnaires is approximately one to one and one-half hours.

There are no known risks or benefits to the study participants. The only person to have access to your responses is the Principle Investigator. The report of the study will contain only combinations of the responses of all participants. Thank you for any consideration given this request.

Principle Investigator: Peggy W. Allyn, R.N., B.S.
Graduate Student
University of Arizona
College of Nursing

I agree to participate in this study:

Signature _____ Date _____

Subject ID Number _____ Unit _____

Project Sponsor: Edward Gould, Ph.D.
Clinical Psychologist
Holderman Hospital
State Veterans Home of California

APPENDIX E

QUALITY OF MEMBER LIFE TASK GROUPS

QUALITY OF MEMBER LIFE TASK GROUPS

TASK GROUP I - HUMAN DIGNITY

This Group will consider the factors that detract from or enhance human dignity. Elements such as freedom of choice (where possible), statement of rights, sensitivity of staff, participation in policy setting and operations, etc., are assessed so that specific improvement steps can be proposed and taken. By looking at those practices which tend to detract from human dignity we should be able to identify those actions which would restore or enhance human dignity in our setting.

TASK GROUP II - THE LIVING ENVIRONMENT

This Group will be concerned with those factors which influence the comfort, privacy, safety and security of the living environment irrespective of level of care. Consideration will be given to matters such as handicap access and accessories, availability of personal space, sense of security from theft or harm, cleanliness, pride.

TASK GROUP III - HEALTH AND MEDICAL CARE

This Group will assess and report on appropriateness and adequacy of medical services, perception of competency and compassion of medical professionals, degree to which human dignity is enhanced or diminished by medical practice, efforts to support failing faculties.

TASK GROUP IV - ACTIVITIES OF BODY AND MIND

This Group will examine those activities for functions which affect the spirit and sense of well-being of the member. They will consider the extent to which recreational, vocational and spiritual activities meet the individual interests of the members. They will evaluate the mobility opportunities for outside visits, frequency and ease of contact with available family, opportunity for meaningful work, etc. They will explore the causes of and seek solutions to social isolation.

(Gould, 1985)

APPENDIX F

MEMBER OPINION QUALITY OF LIFE SURVEY

INSTRUMENT AND DEMOGRAPHIC DATA FORM

ID #_____
UNIT #____
DATE_____

MEMBER OPINION
Quality of Life Survey

Part I - HUMAN DIGNITY	AA	A	a	d	D	DD
1. I would like to see older and younger members do more together.	6	5	4	3	2	1
2. Employees should make more effort to understand what its like to live here as a member.	6	5	4	3	2	1
3. If the Home had more involvement with outside community organizations or programs, there would be better acceptance and understanding from the community.	6	5	4	3	2	1
4. There are usually enough interesting and varied activities from which to choose.	6	5	4	3	2	1
5. My needs and wishes are usually taken into account before decisions or policies are made that affect my life.	6	5	4	3	2	1
6. There should be more ways for members and employees to socialize and get to know each other better.	6	5	4	3	2	1
7. I'd be happier if I had some kind of work to do now and then.	6	5	4	3	2	1
8. I would like more of a say in deciding on where I live here at the Home.	6	5	4	3	2	1
9. I feel ashamed to be here, even though as a veteran, I've earned my right to live here.	6	5	4	3	2	1
10. My spiritual and religious needs are being well met here.	6	5	4	3	2	1
11. I would like to see members show more sensitivity, compassion and respect for one another.	6	5	4	3	2	1
12. I would like to know more about my rights and and privileges as a member, and have a person wo can represent me when I think these rights are being denied.	6	5	4	3	2	1
13. I want to have more of a sense of family, home and pride in living here.	6	5	4	3	2	1
14. "Old-timer" members should have more contact with, and be more helpful to newer members.	6	5	4	3	2	1

MEMBER OPINION
Quality of Life Survey

Part I - HUMAN DIGNITY - PG. 2

		AA	A	a	d	D	DD
	When it comes to my financial affairs, home expenses and charges, I am....						
15.	Adequately informed.	6	5	4	3	2	1
16.	Treated in courteous, respectful ways.	6	5	4	3	2	1
17.	Treated as a responsible, capable adult.	6	5	4	3	2	1

MEMBER OPINION
Quality of Life Survey

Part II - THE LIVING ENVIRONMENT

1. There is enough shelf and storage space for all my personal effects.	6	5	4	3	2	1
2. Members and employees should have their own separate lounges.	6	5	4	3	2	1
3. There should be special lounges or areas set aside just for visits from family or friends.	6	5	4	3	2	1
4. I prefer eating in a dining room with other patients/ members to eating alone at my bed.	6	5	4	3	2	1
Meals here are usually....						
5. Good and plentiful	6	5	4	3	2	1
6. Served courteously and well.	6	5	4	3	2	1
7. Nutritous.	6	5	4	3	2	1
8. There ought to be a better division of social/ recreational activity spaces into smoking and non/smoking areas.	6	5	4	3	2	1
9. My personal living areas is attractively furnished, and clean enough.	6	5	4	3	2	1
10. Members who live close by keep their areas attractive, and clean enough.	6	5	4	3	2	1
11. There should be a better system for getting meals to members too sick to go to the dining room.	6	5	4	3	2	1
12. I would like to see the outdoor, patio areas better kept and furnished.	6	5	4	3	2	1
Younger members ought to have....						
13. Their own sections.	6	5	4	3	2	1
14. Their own social/recreational areas.	6	5	4	3	2	1
15. Having more privacy is one of my biggest concerns.	6	5	4	3	2	1

MEMBER OPINION
Quality of Life Survey

Part II - THE LIVING ENVIRONMENT - Pg. 2

	AA	A	a	d	D	DD
16. I think the Home is safe and well protected enough.	6	5	4	3	2	1
17. I find it too inconvenient to use the telephone.	6	5	4	3	2	1
18. Wider walks are needed to get around the Home more safely and easily.	6	5	4	3	2	1
Transportation/bus services here....						
19. Usually run often enough and on time.	6	5	4	3	2	1
20. Have enough shelters at bus stops.	6	5	4	3	2	1
21. Handle wheelchairs for disabled members adequately.	6	5	4	3	2	1
22. Have drivers who are courteous and drive safely.	6	5	4	3	2	1
23. Fire safety regulations, precautions, and procedures around the Home seem good enough.	6	5	4	3	2	1
24. More parking space is needed for members' cars, mopeds or motorcycles.	6	5	4	3	2	1
Better lighting, in good working order, would make the Home safer in the following areas....						
25. Outside areas - night lights	6	5	4	3	2	1
26. Recreational/social activity areas	6	5	4	3	2	1
27. Bathrooms and Hallways in Residences	6	5	4	3	2	1
28. Specially equipped bathrooms for handicapped are available in all areas commonly used by members.	6	5	4	3	2	1

MEMBER OPINION
Quality of Life Survey

art III - HEALTH AND MEDICAL CARE

1. Doctors or other health care staff here don't take me seriously and are not informative enough.	6	5	4	3	2	1
2. Most doctors and health care staff here are really responsible and care about me.	6	5	4	3	2	1
3. Health care staff sometimes don't respect my confidentiallity and privacy.	6	5	4	3	2	1
4. Sometimes I can't follow treatment recommendations because I don't understand my medication program.	6	5	4	3	2	1
5. If I were to become critically ill, my family and I would want special assistance and information to cope with death and dying.	6	5	4	3	2	1
6. The older I get, the less I'm likely to receive proper medical care.	6	5	4	3	2	1
7. As I get older, I feel I need more frequent medical check ups to help identify problems before they get worse.	6	5	4	3	2	1
8. I want to know more about my rights and choices as a patient when a treatment, drug or medical procedure is prescribed for me.	6	5	4	3	2	1
9. Drug side effects or other risks associated with medical procedures are usually well explained.	6	5	4	3	2	1
It takes too long too....						
10. Get medical or clinic appointments.	6	5	4	3	2	1
11. Pick up medications.	6	5	4	3	2	1
12. Be seen at appointment time.	6	5	4	3	2	1
13. I would have fewer health care problems if I had more satisfying, closer family relationships, friendships and social contacts.	6	5	4	3	2	1
14. If I disagree with doctors or other health care staff, I'm afraid my medical care or treatment may be adversely affected.	6	5	4	3	2	1

MEMBER OPINION
Quality of Life Survey

Part III - HEALTH AND MEDICAL CARE - Pg. 2

15. Restorative service staff (PT, OT, Speech and Audiology) and sensory aids (eyeglasses) are adequately available here.	6	5	4	3	2	1
16. I would like to know more about the qualifications and experience of medical/health care staff who see me.	6	5	4	3	2	1
Doctors, nurses or other health care staff should motivate members to know more about....						
17. Their medical or health problems.	6	5	4	3	2	1
18. Taking better care of themselves.	6	5	4	3	2	1
19. Health care staff here sometimes don't work together effectively to provide the best treatment, (i.e. coordinate appointment, referrals, medications, etc.)	6	5	4	3	2	1
20. When I question or object to medical or health care procedures/practices, I often don't know where to go, or what to do to obtain satisfaction.	6	5	4	3	2	1
21. Most health care staff and doctors here are well trained, knowledgable and competent.	6	5	4	3	2	1
22. Medical and health care staff usually dress well and behave in professional, courteous and pleasant ways.	6	5	4	3	2	1
23. Health care staff don't work closely enough with domiciliary or section leaders about my medical problems.	6	5	4	3	2	1
24. My feelings and opinions are usually taken into consideration before treatment is prescribed for me.	6	5	4	3	2	1
25. Dental services are good enough, and adequately available.	6	5	4	3	2	1

MEMBER OPINION
Quality of Life Survey

Part IV - ACTIVITIES OF BODY AND MIND

1. I would like more opportunities to participate in physical fitness activities, games, or sports.	6	5	4	3	2	1
2. Low member employee salary rates reduces morale and work productivity.	6	5	4	3	2	1
3. I would like to improve my own personal living area, and the way my section looks.	6	5	4	3	2	1
Members living together in various sections, get together in small groups on a regular basis, in order to....						
4. Socialize and develop friendships.	6	5	4	3	2	1
5. Work out problems in living together.	6	5	4	3	2	1
6. Support and help each other out with our problems.	6	5	4	3	2	1
7. There are times when I need spiritual/pastoral counseling or guidence.	6	5	4	3	2	1
8. I would like to participate in political advocacy groups for elders' rights (i.e. Grey Panthers).	6	5	4	3	2	1
9. I need to be more aware of how I look, and improve my grooming, dress, and personal hygeine.	6	5	4	3	2	1
10. I would like to see junior college or college level, adult education classes (i.e. art, history, or other fields of study) offered at the Home.	6	5	4	3	2	1
11. Member employees often don't have enough responsibility or authority to do a good job.	6	5	4	3	2	1
There are individual or group programs to help member in....						
12. Diet, eating and weight reduction	6	5	4	3	2	1
13. Stopping smoking	6	5	4	3	2	1
14. Coping with death, dying or incapacitating physical illness	6	5	4	3	2	1

MEMBER OPINION
Quality of Life Survey

Part IV - ACTIVITIES OF BODY AND MIND - Pg. 2

	AA	A	a	d	D	DD
15. Coping with sexual feelings or problems	6	5	4	3	2	1
16. I wish other members would make more effort to improve their personal hygeine, grooming and dress.	6	5	4	3	2	1
17. If I know more about diet and nutrition, I could develop better eating habits.	6	5	4	3	2	1
18. I would like to meet. and socialize more with other members having similar backgrounds and interests to my own.	6	5	4	3	2	1
19. Having vocational skill and job counseling services available would help me find some kind of meaningful work.	6	5	4	3	2	1
20. I have enough opportunities to express my affectionate/sexual feelings.	6	5	4	3	2	1
21. There are professional counselors and/or therapists available to help with some of my personal problems.	6	5	4	3	2	1
I have contact with....						
22. Foster Grandparent or Adopt-A-Vet program.	6	5	4	3	2	1
23. Visiting pet programs.	6	5	4	3	2	1
24. Other outside community program/activity. (Specify)_____	6	5	4	3	2	1
25. The Home should have more affiliations (ties) to outside community religious or spiritual organization/ activities.	6	5	4	3	2	1
26. I want more contact with my family, and then to be a greater part of my life at the Home.	6	5	4	3	2	1

ID #_____(1,2)
UNIT #_____(3,4)
DATE_____(5,6)

MEMBER OPINION
Quality of Life Survey

DEMOGRAPHIC DATA FORM

1. AGE, IN YEARS; _____(7,8)

2. SEX: MALE-1._____(9)
FEMALE-2._____

3. LENGTH OF STAY IN DOMICILIARY: YEARS-._____
MONTHS-._____(10,11,12)

4. LENGTH OF STAY IN PRESENT SECTION: YEARS-_____
MONTHS-._____(13,14,15)

5. SMOKER? YES-1._____(16)
NO-2._____

6. DO YOU EVER LEAVE THE HOME TO:
VISIT WITH FAMILY? YES-1._____(17)
NO-2._____

7. IF YES, HOW MANY TIMES,
WITH FAMILY X'S/YEAR_____(18.19)

8. DO YOU EVER LEAVE THE HOME TO:
VISIT WITH FRIENDS? YES-1._____(20)
NO-2._____

9. IF YES, HOW MANY TIMES?
WITH FRIENDS X'S/YEAR_____(21,22)

10. DO YOU EVER PARTICIPATE IN SOCIAL
ACTIVITIES IN THE COMMUNITY? YES-1._____(23)
NO-2._____

9. IF YES, HOW MANY TIMES? X'S/YEAR-1._____(25.26)

10. DO YOU EVER PARTICIPATE IN RELIGIOUS
ACTIVITIES IN THE COMMUNITY? YES-1._____(27)
NO-2._____

11. IF YES, HOW MANY TIMES? X'S/YEAR-1._____(28,29)

12. DO YOU EVER VISIT AT THE HOME:
WITH FAMILY? YES-1._____(30)
NO-2._____

13. IF YES, HOW MANY TIMES? X'S/YEAR_____(31,32)

14. DO YOU EVER VISIST AT THE HOME:
WITH FRIENDS? YES-1._____(33)
NO-2._____

15. IF YES, HOW MANY TIMES? X'S/YEAR-1._____(34,35)

16. DO YOU EVER PARTICIPATE IN SOCIAL ACTIVITIES AT THE HOME? YES-1._____(36)
NO-2._____

17. IF YES, HOW MANY TIMES? X'S/YEAR-1._____(37,38)

18. DO YOU EVER PARTICIPATE IN RELIGIOUS ACTIVITIES AT THE HOME? YES-1._____(39)
NO-2._____

19. IF YES, HOW MANY TIMES? X'S/YEAR-1._____(40,41)

ADDITIONAL SURVEY QUESTIONS:

20. HOW WOULD YOU RATE YOUR HEALTH AT THIS TIME, AS COMPARED WITH OTHER MEMBERS OF THE HOME? (43)

EXCELLENT 6._____
GOOD 5._____
OKAY 4._____
FAIR 3._____
POOR 2._____
VERY BAD 1._____

21. CONSIDERING YOUR PRESENT PERSONAL SITUATION, HOW WOULD YOU RATE YOUR QUALITY OF LIFE? (44)

ABOUT AS GOOD AS IT CAN POSSIBLY BE 6._____
GOOD ENOUGH, NO MAJOR COMPLAINTS 5._____
FAIR, GOOD ENOUGH TO MANAGE 4._____
NOT SO GOOD, QUALITY OF LIFE LEAVES MUCH TO BE DESIRED 3._____
NOT GOOD AT ALL, POOR QUALITY OF LIFE 2._____
TERRIBLE, MY QUALITY OF LIFE IS VERY BAD 1._____

APPENDIX G

INTERVIEWER INSTRUCTIONS AND PROCEDURES

INTERVIEWER INSTRUCTIONS AND PROCEDURES -- QUALITY OF LIFE INTERVIEWS

1. Select a name from list of member-subjects in research sample. Contact, and find, quiet, semi-private place (inside or outside) to introduce yourself and the Quality of Life project.

2. Read first two paragraphs of Instructions to potential member-subjects. Find out if he/she has been a resident of Home at least six months. Tell all potential subjects that the Interview will take about one hour, and that their participation is strictly voluntary; if they agree to participate, find out if this time is convenient. If not, re-schedule another time that is more convenient. Have all subjects who agree sign the consent letter that formally states their rights to privacy and to stop if they change their minds.

3. For members who decline to participate, politely end the interview, noting on survey form their reason for refusing. The interview may also be ended for those who don't meet the minimum six month residency requirement.

4. For all subjects who qualify and agree to participate, finish reading instructions about use of Agreement-Disagreement Scale. Provide them with special card that gives them enlarged version of scale to which they can refer during administration of Survey. Follow instructions that indicate what to do with member-subjects that have difficulty following directions.

5. Administer Quality of Life Survey itself. If subjects wishes (i.e., tires quickly, works very slowly) schedule another interview to complete. Read, and if necessary, explain each item to make sure subject understands. Be friendly, but do not engage in prolonged unnecessary conversation or social chit-chat that distracts, lengthens interview, or in any way influences his/her responses to survey statements. Finally, gently encourage subjects to discriminate regarding amount of agreement-disagreement by using different steps of scale.

6. When Quality of Life Survey has been completed, continue with the Subject Information Sheet. Part of the demographic information may be gained from the subjects records. Ask each question, recording answer. If the answers to Questions 1 - 6 are yes, continue by asking the subject to estimate the number of times they participate in the activity. Complete the process by asking the subject to rate his/her health and quality of life using the scale with each question.

7. When done, briefly summarize and write down any comments, opinions, etc., subjects may have about any aspect of interview or survey. Write down any pertinent comments you might have about how interview went. Indicate dates and times of interview(s), and sign.

APPENDIX H

MEMBER OPINION QUALITY OF LIFE

SURVEY INSTRUCTIONS

VETERANS HOME OF CALIFORNIA

Quality of Life
Member Opinion Survey

Instructions: (To be read to potential subjects)

I am interviewing members randomly selected from the members residing in the domiciliary, to get your opinions and feeling about life here. This information can enable us to make recommendations for changes or improvements around the Home that could help member achieve better, more satisfying lives. Your privacy and confidentiality will be strictly protected, and no names or identities of members will be used in the analysis and reporting of results.

I will be reading statements to you having to do with various aspects of life here at the Home. I'll also help you understand each one, and record your answers. There's no time limit or hurry, so we can take as much time as you want to finish. Also, there are no right or wrong answers - we are interested only in your true feelings, and opinions.

(Secure permission from subject to participate, or to decline participation at this point. Make sure he/she can comprehend instructions and meets criteria for inclusion in study.)

I will be asking you the extent to which you agree or disagree with each statement, using these six steps that work like this:

1. Strongly Disagree - (DD)
2. Moderately Disagree - (D)
3. Slightly Disagree - (d)
4. Slightly Agree - (a)
5. Moderately Agree - (A)
6. Strongly Agree - (AA)

For example, let's take the statement: "Children should be seen, but not heard". Would you agree or disagree with that? If subject disagrees, obtain degree/level of disagreement (DD, D, or d). If subject is able to understand, and select an appropriate response, say "Fine, that's exactly how to do it. For each statement, I'll be asking you to do the same thing, deciding on how much you agree or disagree with it".

For subjects that obviously cannot seem to understand, or respond appropriately, the interview may be tactfully ended at that point, and they will be dropped from the study. For subjects who do seem to understand and respond appropriately, proceed with the interview.

APPENDIX I

MEAN SCORES FOR EACH ITEM FOR THE SUBSCALES, HUMAN DIGNITY, THE LIVING ENVIRONMENT, HEALTH AND MEDICAL CARE, AND ACTIVITIES OF BODY AND MIND

Percent of Subjects' Responses and Subjects' Mean Score for Each Item for Human Dignity Subscale

Item	n	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Mean Score
1	45	44.4	26.7	11.1	6.7	11.1	----	4.9
2	45	68.9	6.7	6.7	6.7	11.1	----	5.2
3	46	45.7	26.1	13.0	6.5	4.3	4.3	4.9
4	46	56.5	23.9	2.2	2.2	10.9	4.3	5.0
5	46	28.3	21.7	13.0	8.7	4.3	23.9	3.9
6	45	46.7	24.4	13.3	8.9	4.4	2.2	4.9
7	46	28.3	10.9	8.7	6.5	6.5	39.1	3.3
8	45	35.6	6.7	15.6	8.9	8.9	24.4	3.8
9	46	65.2	10.9	2.2	2.2	10.9	8.7	4.9
10	45	15.6	----	----	6.7	11.1	66.7	2.0
11	46	78.3	10.9	6.5	---	4.3	----	5.6
12	46	50.0	15.2	8.7	6.5	4.3	15.2	4.5
13	46	39.1	21.7	4.3	8.7	----	26.1	4.1
14	46	54.3	13.0	8.7	8.7	4.3	10.9	4.7
15	46	73.9	8.7	4.3	2.2	6.5	4.3	5.3
16	46	84.8	8.7	2.2	2.2	2.2	2.2	5.7
17	46	73.9	13.0	4.3	2.2	2.2	4.3	5.4
TOTAL		52%	15%	7%	6%	6%	14%	4.6

Percent of Subjects' Responses and Subjects' Mean Scores for Each Item for Living Environment Subscale

Item	n	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Mean Score
1	45	42.2	13.3	2.2	6.7	17.8	17.8	4.0
2	46	28.3	15.2	13.0	8.7	10.9	23.9	3.7
3	46	58.7	10.9	6.5	2.2	4.3	17.4	4.7
4	46	89.1	6.5	----	----	----	4.3	5.7
5	46	30.4	21.7	8.7	4.3	15.2	19.6	3.9
6	46	56.5	19.6	13.0	4.3	4.3	2.2	5.1
7	46	47.8	26.1	4.3	2.2	2.2	17.4	4.6
8	46	54.3	10.9	6.5	4.3	2.2	21.7	4.5
9	46	87.0	4.3	2.2	2.2	----	4.3	5.6
10	46	60.9	13.0	10.9	2.2	4.3	8.7	5.0
11	44	38.6	11.4	9.1	4.5	11.4	25.0	3.9
12	45	31.1	13.3	22.2	4.4	2.2	26.7	3.9
13	46	15.2	8.7	13.0	8.7	13.0	41.3	2.8
14	46	17.4	8.7	8.7	6.5	13.0	45.7	2.7
15	46	37.0	8.7	4.3	6.5	8.7	34.8	3.5
16	46	76.1	13.0	4.3	2.2	2.2	2.2	5.5
17	46	67.4	8.7	6.5	4.3	2.2	10.9	5.0
18	46	13.0	6.5	4.3	15.2	8.7	52.2	2.4

Percent of Subjects' Responses and Subjects' Mean Scores for Each Item for Living Environment Subscale (Continued)

Item	n	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Mean Score
19	40	42.5	12.5	7.5	----	15.0	22.5	4.0
20	40	52.5	12.5	10.0	5.0	5.0	15.0	4.6
21	38	63.2	5.3	18.4	----	5.3	7.9	5.0
22	41	70.7	17.1	----	4.9	7.3	----	5.4
23	45	64.4	13.3	2.2	8.9	2.2	8.9	5.0
24	41	20.0	2.2	2.2	8.9	17.8	48.9	2.5
25	46	19.6	8.7	19.6	10.9	6.5	34.8	3.2
26	45	13.3	8.9	15.6	4.4	2.2	55.6	2.6
27	46	10.9	4.3	17.4	4.3	6.5	56.5	2.4
28	45	64.4	11.1	8.9	----	4.4	11.1	5.0
TOTAL		45%	11%	9%	5%	7%	23%	4.3

Percent of Subjects' Responses and Subjects' Mean Score for Each Item for Health and Medical Care Subscale

Item	n	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Mean Score
1	46	45.7	15.2	8.7	4.3	8.7	17.4	4.3
2	44	59.1	15.9	6.8	----	2.3	15.9	4.8
3	45	60.0	11.1	13.3	----	4.4	11.1	4.9
4	44	13.6	2.3	11.4	9.1	9.1	54.5	2.4
5	46	50.0	8.7	4.3	2.2	4.3	30.4	4.1
6	46	65.2	4.3	6.5	10.9	6.5	6.5	4.9
7	46	54.3	15.2	4.3	6.5	2.2	17.4	4.6
8	45	53.3	6.7	15.6	8.9	----	15.6	4.6
9	45	55.6	13.3	6.7	6.7	4.4	13.3	4.7
10	45	42.2	6.7	15.6	6.7	4.4	24.4	4.0
11	44	59.1	15.9	11.4	6.8	----	6.8	5.1
12	45	44.4	2.2	22.2	2.2	4.4	24.4	4.1
13	45	53.3	8.9	6.7	11.1	4.4	15.6	4.5
14	46	50.0	6.5	8.7	6.5	8.7	19.6	4.2
15	42	47.6	23.8	4.8	4.8	----	19.0	4.6
16	45	26.7	8.9	11.1	6.7	11.1	35.6	3.3
17	45	53.3	20.0	11.1	----	----	15.6	4.8

Percent of Subjects' Responses and Subjects' Mean Score for Each Item for Health and Medical Care Subscale (Continued)

Item	n	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Mean Score
18	45	53.3	17.8	8.9	4.4	4.4	11.1	4.8
19	46	34.8	4.3	4.3	10.9	13.0	32.6	3.4
20	44	27.3	6.8	2.3	9.1	6.8	47.7	3.0
21	43	67.4	9.3	4.7	7.0	4.7	7.0	5.1
22	46	43.0	17.4	10.9	2.2	2.2	4.3	5.2
23	38	47.4	7.9	15.8	----	7.9	21.1	4.2
24	46	50.0	23.9	4.3	2.2	4.3	15.2	4.7
25	42	71.4	16.7	4.8	----	2.4	4.8	5.4
TOTAL		50%	12%	9%	5%	5%	19%	4.4

Percent of Subjects' Responses and Subjects' Mean Score for Each Item for Activities of Body and Mind Subscale

Item	n	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Mean Score
1	46	47.8	----	10.9	13.0	6.5	21.7	4.0
2	45	33.3	4.4	6.7	2.2	8.9	44.4	3.2
3	45	31.1	6.7	4.4	8.9	13.3	35.6	3.3
4	46	45.7	13.0	10.9	6.5	2.2	21.7	4.3
5	46	32.6	6.5	8.7	8.7	13.0	30.4	3.5
6	46	30.4	8.7	8.7	10.9	13.0	28.3	3.5
7	44	13.6	9.1	15.9	15.9	4.5	40.9	2.9
8	45	20.0	11.1	11.1	4.4	----	53.3	2.9
9	46	34.8	8.7	2.2	13.0	10.9	30.4	3.5
10	46	19.6	4.3	6.5	10.9	19.6	39.1	2.8
11	43	20.9	4.7	14.0	16.3	4.7	39.5	3.0
12	45	53.3	11.1	8.9	4.4	2.2	20.0	4.5
13	42	52.5	11.9	----	2.4	4.8	28.6	4.2
14	39	46.2	10.3	5.1	5.1	7.7	25.6	4.1
15	41	9.3	12.2	2.4	7.3	7.3	41.5	3.2
16	46	0.9	2.2	2.2	10.9	19.6	54.3	2.1
17	46	39.1	2.2	4.3	6.5	10.9	37.0	3.4

Percent of Subjects' Responses and Subjects' Mean Score for Each Item for Activities of Body and Mind Subscale (Continued)

Item	n	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Mean Score
18	46	17.4	2.2	8.7	17.4	15.2	39.1	2.7
19	45	37.8	2.2	13.3	13.3	4.4	28.9	3.7
20	46	56.5	8.7	8.7	2.2	8.7	15.2	4.6
21	44	47.7	20.5	11.4	4.5	----	15.9	4.6
22	46	2.2	4.3	----	----	2.2	91.3	1.3
23	46	6.5	----	----	4.3	----	89.1	1.4
24	45	20.0	8.9	6.7	2.2	2.2	60.0	2.6
25	43	34.9	2.3	4.7	16.3	9.3	32.6	3.4
26	42	52.4	----	7.1	4.8	7.1	28.6	4.0
TOTAL		32%	7%	7%	8%	8%	38%	

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