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A select exploration of induced dependency in nursing home residents

Sharron, Amy Beth, M.S.

The University of Arizona, 1993

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A SELECT EXPLORATION OF INDUCED DEPENDENCY

IN NURSING HOMES RESIDENTS

by

Amy Beth Sharron

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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

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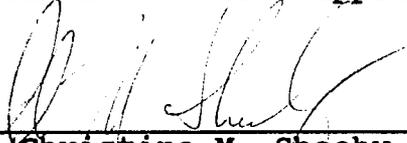
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ABSTRACT

The purpose of this study was to investigate the relationship among autonomy, control over nursing practice, and selected sociodemographic characteristics of nursing staff, the degree of institutional bureaucratization, and quality of resident care in two nursing homes.

A significant difference was found in the IRA/Keogh benefit for both RNs and LPNs. Significant positive relationships were found between autonomy and control over nursing practice; years since completion of basic education and age of the nurse; and total benefits the nurse received and their salary. A significant difference between RNs and LPNs was found in their sense of autonomy, with RNs scoring higher than LPNs. An inverse relationship was identified between the institution's bureaucracy and the variables autonomy and control over nursing practice.

No significant differences were found between the nursing homes with regard to urinary incontinence and the level of nursing autonomy, control over nursing practice, and degree of institutional bureaucratization.

Chapter I
INTRODUCTION

The demand for nursing home care is rising and, in the next several decades, is anticipated to increase dramatically. Recent studies indicate that those who became 65 years old in 1990 will require some nursing home care before they die; half will need a year or more and almost one-third will need at least five years of care (Kemper & Murtaugh, 1991). In the nursing home setting, nursing is regarded as the basic unit of care (American Nurses' Association (ANA), 1986a). As such, resident care is greatly affected by the presence of adequate numbers of nurses who can assess, plan, implement, and evaluate the residents' care (ANA; McKibbin, 1990). Thus, nursing homes need to place more importance on the retention and support of qualified professional nurses trained in geriatrics (Institute of Medicine (IOM), 1986) to ensure that appropriate care can be provided to these people.

In this chapter, the background of the study, purpose of the study, problem statement, research questions, operational definitions, and significance of the study are presented.

Background

Over the next several decades, the number of persons in the United States who are over 65 years of age is expected to increase, especially in the years from 1990 to 2030 (Taeuber, 1992). The 1990 United States census indicated that there are 31.1 million elderly people 65 years or older, 18 million of whom are aged 65 to 74, 10 million aged 75 to 84, and 3 million are 85 years or older (Taeuber). Elderly persons 65 to 74 years of age are considered to be in "early old age", those over age 75 are considered to be in "advanced old age" and those over age 84 are the "old-old" and the most frail (Butler & Lewis, 1977). It is specifically these frail "old-old" elders who are most likely to be in need of extended nursing home care. In addition, the number of elderly requiring nursing home care during the course of any one year is expected to increase 76% over the next 30 years and associated costs are expected to increase from \$42 billion in 1988 to over \$120 billion in 2018 and \$350 billion in 2048 (Alwin, 1991a).

Therefore, the quality of care that these residents receive in the nursing home environment is an important consideration to be studied; one that cannot be compared with quality in other settings. "The attributes of quality in nursing homes are very different from those in acute medical care settings such as hospitals" (IOM, 1986, p. 45).

The differences stem from: (1) the characteristics of residents living in the homes; (2) the care needs of these residents; (3) the circumstances and settings where their care is provided; (4) the expected outcomes of the residents; and (5) the fact that for many, the nursing home is their permanent home and not a temporary placement for medical treatment (IOM).

In terms of care needs, older people typically need nursing home placement due to increasing difficulties with functional and/or cognitive abilities rather than medical diagnosis or the number of chronic illnesses they possess (Mezey & Lynaugh, 1989; Rowe, 1985; Williams, 1983). Limitations in functional abilities may interfere with independent self-care activities such as nutrition and hydration, hygiene, dressing, ambulation, and toileting. One of the objectives of nursing should be to assist residents in gaining and maintaining their optimal level of functioning. However, there is evidence that nursing staff actually induce dependency (Avorn & Langer, 1982; Baltes, Honn, Barton, Orzech & Lago, 1983; Langer, 1979; Pawlson, Goodwin & Keith, 1986; Sharlin & Polansky, 1972) rather than encourage independence in some residents.

To diminish this problem, it has been shown that an important aspect of promoting functional improvement among residents and achieving quality care, is the presence of

adequate numbers of qualified nursing staff (IOM, 1986). Yet, nursing homes across the nation have experienced both shortages of nursing staff and difficulty in retaining those whom they have been able to recruit (Atchley, 1991; Bergman, Eckerling, Golander, Sharon & Tomer, 1984; Cotler & Kane, 1988). Many factors contribute to the retention problems in nursing homes including poor salaries and inadequate fringe benefits (Cotler & Kane; Koizumi, 1991; Migdail, 1991). Although to date there is little research specific to nursing homes, there is evidence that autonomy and control over nursing practice are important to nurses (Gerber, Murdaugh, Verran & Milton, 1990) and that bureaucracy tends to interfere with this process (Hall, 1968a).

As previously stated, the nursing home setting varies greatly from acute care settings in terms of patient needs. These differences are also reflected in the nursing staff. Statistically, nursing homes have many fewer registered nurses (RNs) than acute care settings and a larger RN to patient ratio (Jones, Bonito, Gower & Williams, 1987). In the nursing home setting, the registered nurse spends the majority of time on administrative duties (Jones et al.), while the bulk of direct patient care, 80-90%, is provided by nursing assistants (ANA, 1986b; IOM, 1986).

In terms of sociodemographic characteristics, registered nurses employed in nursing homes tend to be

older, generally 15 years post graduation from nursing school, and approximately 40% work only part-time (Jones et al., 1987). The usual educational preparation of 40-60% of the RNs is a nursing diploma from a hospital-based program (Jones et al.; McKibbin, 1990). Nursing retention rates vary, but are highest for diploma graduates and lowest among associate degree nurses (ADNs) (Jones et al.). Licensed practical nurses (LPNs) constitute the majority of nurses in long-term care facilities (Alwin, 1991b).

Additionally, autonomy and control over nursing practice may be different for nursing home nurses than for nurses employed in the acute care setting. In nursing homes, RNs are responsible for evaluating and making decisions related to treatments and to other care needs of the residents (Cotler & Kane, 1988; Watson, 1991). Nurses think they have the major responsibility regarding planning, scheduling, and delivering services to the residents (Deckard, Hicks & Rountree, 1986). An explanation for this felt independence is the fact that there are few other health professionals involved in the everyday care of the residents (Aiken, 1990). This suggests that this setting could or should have the potential for being a very attractive practice setting for nurses (Aiken).

However, although nurses in the nursing home setting think they have great independence in their practice (i.e.,

autonomy and control over nursing practice), regulatory requirements of the nursing home institution may interfere with their exercise of autonomy and control over nursing practice. Nursing homes are highly regulated and this, combined with large patient to staff ratios, may create a highly bureaucratized atmosphere (Sheehy, 1992). In a study by Hall (1968a), it was found that increased institutional bureaucratization threatens professional autonomy. Policy makers often reduce the complex problems of nursing homes to simple issues of staffing and training, rather than to the totality of the institution (Tellis-Nayak & Tellis-Nayak, 1989). As a result, regulations and guidelines increase and may become the focus of care (Sheehy).

Another problem lies in the lack of research focusing on the effects of professional preparation on quality of care. "One of the difficulties in convincing policy makers of the need for more professional nurses trained in gerontology is the lack of research data showing that professional staffing improves quality of care" (Harrington, 1987, p. 209). Thus, in the nursing home setting, the relationship between quality of care, the presence of adequate numbers of professionally trained nurses, and their felt autonomy and control over nursing practice needs to be further investigated.

Purpose of the Study

The purpose of this study was to explore the relationship among (1) autonomy, control over nursing practice, and selected sociodemographic characteristics of nursing staff, (2) the degree of institutional bureaucratization, and (3) the quality of resident care in nursing homes.

Problem Statement

The problem investigated in this study was: what is the relationship among autonomy, control over nursing practice, and selected sociodemographic characteristics of nursing staff, degree of institutional bureaucratization, and quality of resident care in nursing homes? The data used in the present study are part of a larger, funded study, "The Contextual Environment of Nursing Homes" (Sheehy, 1992).

Research Questions

1. Are there differences in the sociodemographic characteristics of RNs and LPNs between the two nursing homes with regard to their age, type of educational preparation (for RNs only), years since completion of basic education, benefits and salary in nursing homes?

2. What are the relationships among autonomy, control over nursing practice, age, years since completion of basic education, total benefits and salary in the two nursing homes and do any differences exist between RNs and LPNs in these variables?

3. What are the relationships among autonomy, control over nursing practice, the degree of institutional bureaucratization, and the quality of resident care in nursing homes as measured by one indicator of induced dependency (i.e., urinary incontinence) in nursing homes?

Definition of Terms

For the purpose of this study, the following definitions were used:

Induced Dependency: Theoretical- induced dependency was originally described by (Kuypers & Bengston, 1984) as (1) the loss of existing adaptive capacities, and (2) learned behaviors of helplessness and dependency. Induced dependency is frequently evidenced as residents' inability or reduced ability to perform self care activities, for example, ambulation and toileting (Kuypers & Bengston; Avorn & Langer, 1982).

Operational- assessed by one measure of induced dependency: This includes nursing home residents who are incontinent of urine at the time of the investigation, but did not have incontinence problems prior to the nursing home admission. This also entails an absence of evidence of a systematic assessment and a plan of care for toileting as well as efforts to manage and evaluate continence alternatives (Sheehy, 1992).

Autonomy in Nursing Practice: Theoretical- the feeling that the professional should be able to make their own decisions without external pressures (Hall 1968a).

Operational- measured by the Occupational Inventory Scale (Hall, 1963, 1968a, 1968b) which measures perceived independence in job performance and aspects of professionalism.

Control Over Nursing Practice: Theoretical- one's freedom to evaluate and modify nursing practices to influence others and the environment, to make individual decisions related to patient care, and to work with others in the delivery of that care (Gerber, Murdaugh, Verran & Milton, 1990; Gerber, McNamara, Verran, Murdaugh & Milton, 1990; Hinshaw & Atwood, 1986; Verran, Murdaugh, Gerber & Milton, 1988).

Operational- measured by the Control Over Nursing Practice Scale (Gerber, Murdaugh, Verran, & Milton).

Bureaucratization: Theoretical- a series of dimensions on a continuum of organizational descriptors which are characteristically cited as attributes of rigid adherence (Hall, 1963).

Operational- measured by the Organizational Inventory Scale (Hall).

Significance of the Study

In the United States in 1990, there were 6.9 million people aged 80 years old or older; these statistics are expected to grow to possibly more than 25 million individuals by the year 2050 (Taeuber, 1992). At the present time, nursing homes are nearly 90% occupied with elderly residents (National Institute of Aging (NIA), 1987) from this population. More than 40% of these residents are 85 years or older and many have serious cognitive impairments which require increased care. As can be expected, these nursing home figures are certain to increase as the population continues to age in the future, further burdening the supposition that nursing home care in the United States is less than sufficient (Penchansky & Taubenhaus, 1965; Sheehy, 1992).

Paralleling this increase in the elderly population is the need for an increase in nurses to care for these individuals. However, there is a tremendous problem in

finding and retaining adequate qualified nurses to work in nursing homes and, obviously, the potential solution to this dilemma demands a creative, multidimensional approach (Cotler & Kane, 1988). Only about 6.6% of employed RNs are currently working in nursing homes or extended care facilities (McKibbin, 1990) while the nursing shortage in nursing homes is 18.9%, almost twice that of the shortage in hospitals (Koizumi, 1990; McKibbin). Over one-third of nursing homes report severe shortages and nearly one of every five RN positions is unfilled (Atchley, 1991; McKibbin). Recent estimates are that 88% of nursing homes need more nursing staff, 34% need more RNs and 8% need more LPNs (Mohler, 1991).

In nursing homes, the presence of qualified, professional nurses is regarded as a major factor in maintaining quality care (IOM, 1986; Mezey & Lynaugh, 1989; Tellis-Nayak, 1988). Unlike acute care settings where care is provided by numerous disciplines, nursing homes are predominately a nurse managed setting where the majority of care is provided by nursing and nursing related support services. According to Watson (1991), the role of the long-term care (LTC) nurse has changed over the years and is evolving into a challenging environment that requires exceptional clinical and management skills. Because of these changes, the LTC nurse has also experienced a greater

sense of accomplishment and autonomy, has acquired improved decision making abilities, and has demonstrated better use of learned skills and talents (Watson).

Quality care is important in all areas but especially in nursing homes due largely to the fact that this setting is generally the permanent residence for these elders. In order to assess this quality of life and care of nursing home patients, several factors need to be taken into consideration. These include the motivation, attitudes, and qualifications of nursing home management, as well as a well trained and supervised staff (IOM, 1986). For the most part, insufficient numbers of nurses providing minimum care needs, poor working conditions, inadequate training of staff, and low wages contribute to poor quality of care (IOM; National Citizens' Coalition for Nursing Home Reform (NCCHHR), 1985). Significant strides need to be made to elevate the quality of care in today's nursing homes through further research studies (Kane, 1981). In fact, a difficulty in convincing policy makers for more professional nurses is the very lack of research that demonstrates an improvement in quality of care and in life outcomes due to this professional staffing (Harrington, 1987).

Summary

Due to the increasing elderly population in the United States, the need for sufficient nursing home care is also expected to rise to meet the specific care requirements and functional abilities of these individuals. As the primary care provider in the nursing home setting, the presence of qualified professional nurses is essential in providing this adequate care. Yet, instead of promoting functional independence (i.e., urinary continence), the results of research indicate that long-term care nurses may actually assist in inducing dependency in some nursing home residents. By examining the relationship between autonomy, control over nursing practice, and the degree of institutional bureaucratization as measured by one indicator of induced dependence, that of urinary incontinence, a solution to the issue of increased dependency may be found. This knowledge can then be clinically applied to effect an improvement in the quality of care of nursing home residents.

Chapter II

REVIEW OF THE LITERATURE

Introduction

In chapter two, the conceptual model of Induced Dependency (Kuypers & Bengston, 1984) is described. In addition, the related concepts of Learned Helplessness (Seligman, 1975) and Litwak's (1985) theory of formal organizations and informal primary groups will also be elaborated upon. Following the presentation of the model and concepts, the literature review is presented and organized according to the integrated conceptual model of all three as applied by the investigator.

Conceptual Models

Induced dependency (Kuypers & Bengston, 1973) is a phenomenon in which "... an individual's sense of self, his ability to mediate between self and society, and his orientation to personal mastery are functions of the kinds of social labeling and valuing that he experiences in aging" (p. 182). Although induced dependency can be manifested in all age groups, the elderly are particularly susceptible due to their increased dependence on social labeling. This is largely attributable to the nature of social reorganization in later life (e.g., role loss, loss of normative guidance,

and lack of reference groups) and to the associated negative stereotyping (Kuypers & Bengston). In terms of social reorganization, the most likely consequence for the elder is the development of a basically negative cycle of events where self, social attitudes and behaviors develop into a label of incompetence (Kuypers & Bengston). In the nursing home setting, incompetence becomes obvious in behaviors such as (1) wheelchair use by residents capable of walking and (2) diapering to manage urinary incontinence rather than the evaluation and implementation of an individualized plan of care.

Induced dependency is part of a larger process known as the social-breakdown syndrome (SBS) (Kuypers & Bengston, 1973). As originally introduced, the SBS was delineated by Gruenberg and Zusman (1964) as a seven stage development of negative psychological functioning. Kuypers and Bengston (1984) have reduced these to six stages: (1) precondition of susceptibility to vulnerability; (2) dependence on external labeling; (3) social labeling as incompetent; (4) induced dependency; (5) atrophy of previous skills; and (6) internalization and self-labeling as incompetent (Figure 1). The SBS is influenced by the way in which: (1) an individual's competence interacts with social and environmental conditions; (2) the person's sense of self is related to what has been taught by the outside world;

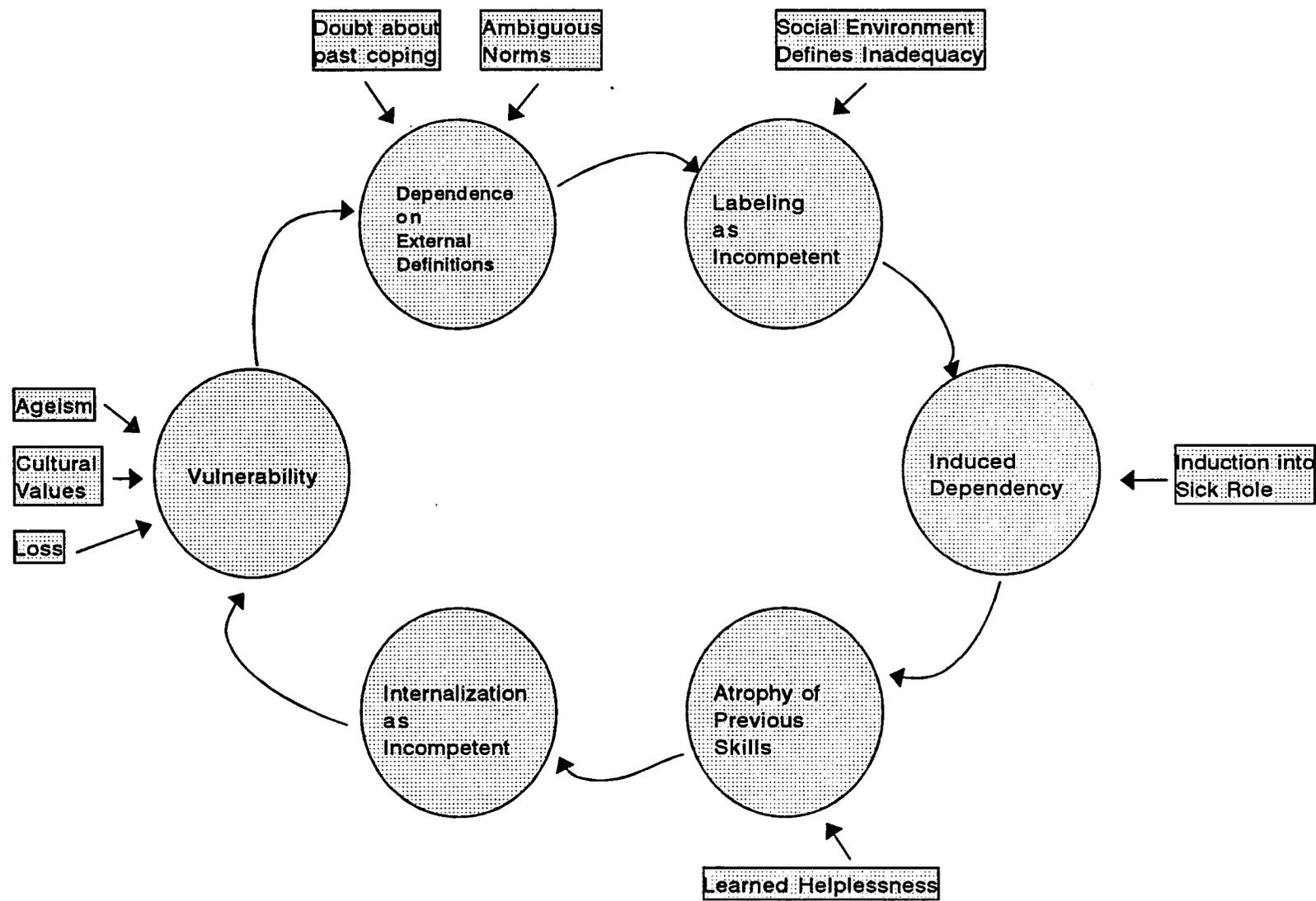


Figure 1 Social Breakdown in old age:A vicious cycle of induced incompetence (Kuypers & Bengston, 1984, p.17)

(3) the person's survival skills will either strengthen or weaken a new situation; and (4) the way in which the environmental feedback strengthens or weakens existing perspectives and adaptive capacities of the person (Kuypers & Bengston). Lastly, the SBS emphasizes that a repeating negative cycle develops and that, without intervention, this cycle may be resistant to change (Kuypers & Bengston).

Because it is largely surrounded by multiple negative attitudes in today's society, aging may lead to vulnerability, the most important first step in the negative cycle (Kuypers & Bengston, 1984). Many changes that occur in later life also may increase the elder's vulnerability such as widowhood, retirement, loss of income, onset of diseases, decrease in mobility, and realization that death is imminent (Kuypers & Bengston). Another area of importance to consider is the absence of acceptable society defined 'norms,' designed specifically for elders in their old age. Havinghurst and Albrecht (1953) found that behaviors approved for elders reflected the values of the local culture and apply to all adults, not specifically to the elderly. Older people are cognizant of age appropriate behaviors, yet there is little definition of behavior expectations for them to follow during their later years in life (Neugarten, Moore, & Lowe, 1965). This lack of definition can promote confusion in determining which

behaviors are considered appropriate, and as a result, the elder may tend to withdraw so as not to be viewed negatively (Kuypers & Bengston, 1973).

In addition, many other factors may promote vulnerability, including having a history of feeling powerless and possessing ineffective skills to cope with and resolve life's challenges, being socially isolated and lacking social networks, and finally, reacting to the degree to which a crisis is fundamental to the individual's values and hopes (Kuypers & Bengston, 1984). For the purpose of this investigation, the crisis and area of vulnerability are reflected in the need for nursing home placement. However, while placement in a long-term care facility may initiate the SBS cycle, it is not automatic that every elder in this circumstance begins the cycle nor experiences the complete chain of events (Kuypers & Bengston).

Whatever the catalyst, vulnerability causes the initiation of the cycle and the progression to the next step in the SBS process: the dependence on external definitions. Dependence on these societal definitions is the direct result of the decrease in the elder's ability to utilize previously appropriate internal frames of reference in their present situation, mostly due to a lack of self-confidence (Kuypers & Bengston, 1973). Therefore, they must use these currently available external definitions which, in fact, are

sometimes not appropriate. More importantly, if the reference the elder utilizes is appropriate (positive), the cycle stops and if inappropriate (negative), the cycle continues to step three, social labeling as incompetent (Kuypers & Bengston).

For the elder population, labeling as incompetent is perceived through society's negative stereotyping of aging in terms of direct or indirect messages which inform elders of their uselessness, obsolescence, inadequacy, lack of value, and incompetence (Kuypers & Bengston, 1973). The degree and amount to which these messages are conveyed and adopted as true by the elders lead to a self-view of incompetence, uselessness and worthlessness, and to a change in role (Kuypers & Bengston). "The remaining steps in the SBS follow this initial pattern of susceptibility, dependence, and negative social labeling" (Kuypers & Bengston, p. 189) and lead to the next areas in the cycle: induced dependency and atrophy of previous skills. In this study, these two areas will be considered as one and the main focus of the investigation.

Basically, when individuals perceive their fate as hopeless (i.e., nothing changes regardless of one's actions), their typical response is to give up, leading to induced dependency and atrophy of previous skills (Kuypers & Bengston, 1984). For elders, this implies their induction

into the 'sick role,' where new behaviors and skills appropriate for survival in this negative role are learned (Kuypers & Bengston, 1973). Simultaneously, their previous social and functional skills atrophy because they are no longer needed in this new situation.

Learned helplessness (Seligman, 1975) is a related concept which also contributes to an understanding of the phenomenon, but will not be elaborated upon. Seligman's initial work with both animal and human subjects consisted of studies with controlled stimuli that the subjects were unable to alter. Upon obtaining control over the same stimuli, the subjects still behaved as if they were unable to control their environment, even when these perceptions were false (Avorn & Langer, 1982). These findings closely resemble the behaviors of induced dependency in nursing home residents who lose control over their functional capabilities (i.e., urinary continence) as a result of inadequate assessment and interventions to compensate in more appropriate and resident 'control centered' ways.

The final step in the SBS cycle is internalization and self-labeling as incompetent whereby the elderly believe in their own incompetence. By confirming this false reality, the negative cycle is completed thus increasing the elders' vulnerability (the first step) for the next crisis situation that they may encounter (Kuypers & Bengston, 1984).

In conceptualizing the phenomenon of induced dependency among nursing home residents, it is helpful to understand the environment in which these induced (i.e., dependent) behaviors occur. Litwak (1985) suggests that there are both formal organizations (nursing homes) and informal primary groups (families, friends, neighbors) that provide specific services to the elderly. Both groups differ in the manner in which they respond to the elder's care needs: the formal organization is characterized by segmented, impersonal ties and a focus on economic issues while the primary group reflects a need to establish permanent ties and to provide services, not based on financial rewards, but out of affection, respect, and/or a sense of duty (Litwak). In a typical scenario, a conflict arises between the formal organization and primary group due to their contradictory structures and abilities to achieve the same desired outcome: quality care of the elderly (Litwak) (Figure 2).

Therefore, it is essential for the achievement of the goals of the formal organization that primary groups and formal organizations reach some type of middle ground in the form of task matching (Litwak, 1985). Since different aspects of the desired outcome are best handled by either formal organizations or primary groups, Litwak indicates that specific tasks should be matched to the group to which they are best suited. Formal organizations can most

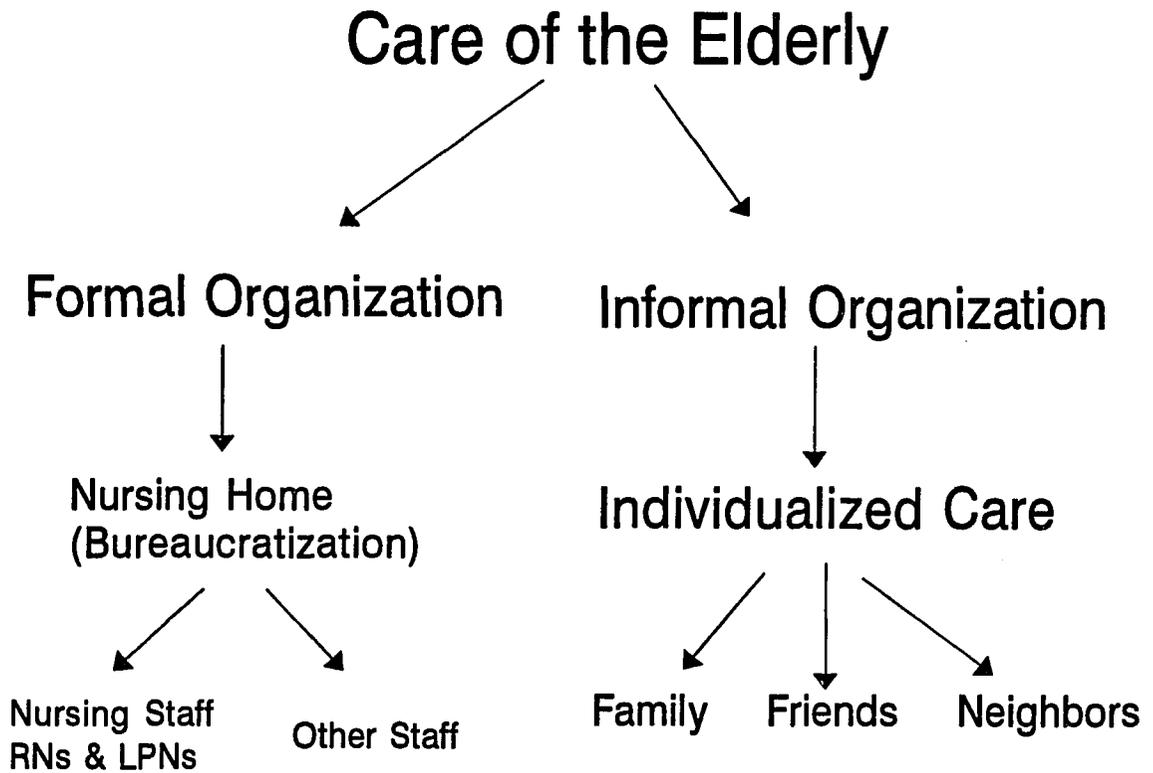


Figure 2 Litwak's Formal and Primary Organizations (1985) Modified

efficiently manage the technical tasks that require technical experts and special training while primary groups can assist with activities of daily living and other non-uniform tasks such as shopping, driving the car, and preparing favorite foods (Litwak).

As the formal organization, the major function of the nursing home is to replace services that are generally provided by the family or primary group of the residents (Litwak, 1985). To achieve this goal, the nursing home must either change its structure to be more like that of the primary group or routinize and make predictable the primary group's tasks, thus taking advantage of the formal organization's division of labor, rules and regulations, hierarchies, sense of efficiency, and staff economic incentives (Litwak). The nursing home further tries to achieve these goals by increasing the predictability of work through the establishment of care routines for the nursing staff (Litwak). For example, the formal organization elicits efficiency and eliminates the individuality of meals by serving one type of meal to all residents, in the same seat, and at the same time of day (Litwak). In addition, nursing homes increase predictability and control in residents with varying degrees of incontinence by routinely placing diapers on every individual and changing them on a set schedule (Litwak).

When a patient in a nursing home requires a service that cannot be easily routinized, over time that specific task becomes generally overlooked by the staff (Litwak, 1985). This is usually not the result of intentional neglect on the part of the staff, but stems from time constraints: individualizing services to satisfy each resident's idiosyncracies would mean not completing routine tasks that must be accomplished during each shift (Litwak). Thus, this loss of personalization (i.e., non-uniform tasks) is a consequence of the dynamics between the formal organization's bureaucracy and its effects over the nursing staff. In conclusion, this can only be prevented by more assistance from the primary group or by changing the structure of the formal organization (Litwak).

In this investigation, these three models will be integrated with regard to quality of care as reflected by one example of induced dependency (i.e., urinary incontinence), resulting from nurses' autonomy and control over nursing practice, and the degree of nursing home bureaucratization (Figure 3).

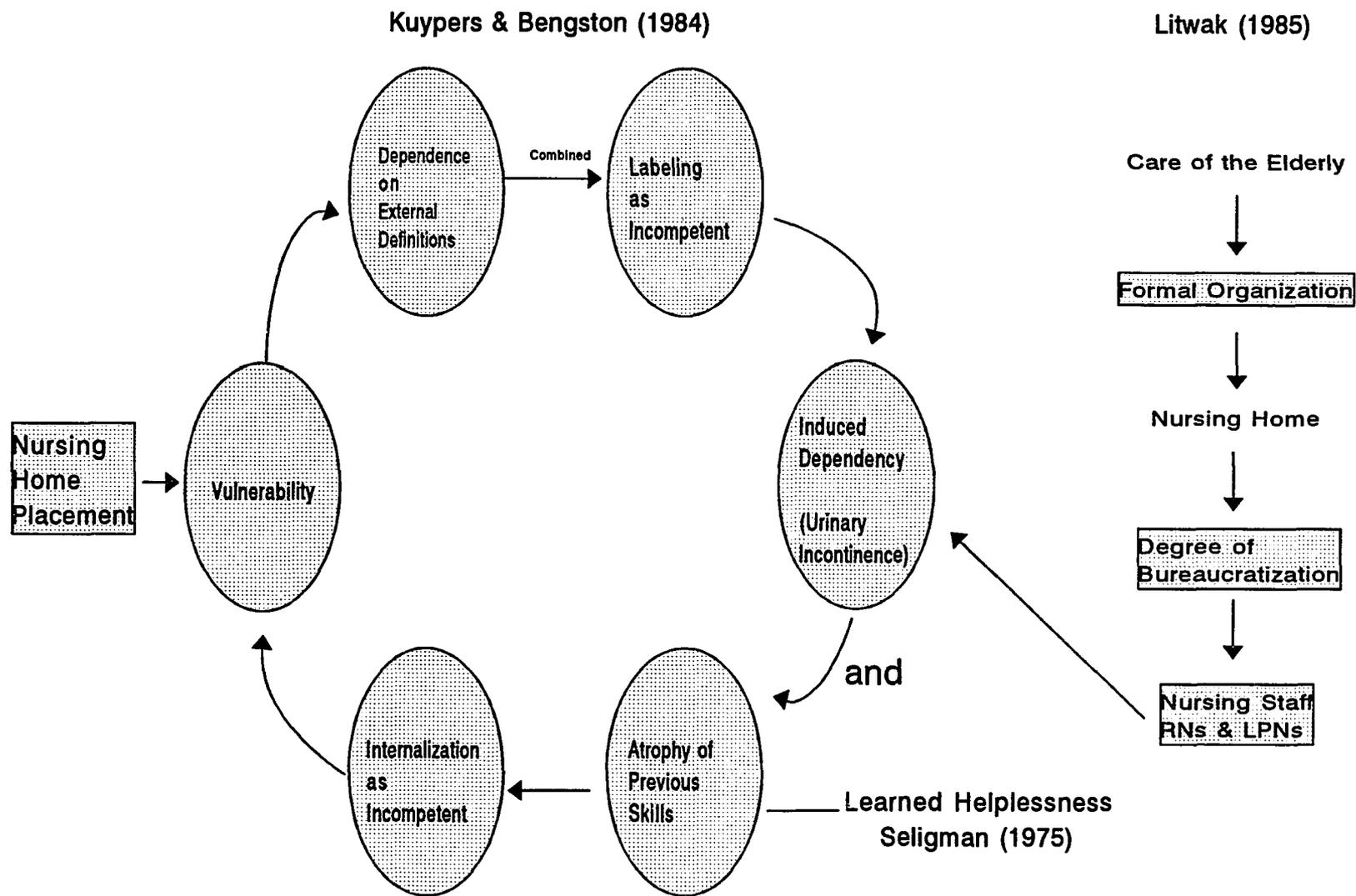


Figure 3 Integrated Conceptual Model for the Study - (Adapted from Kuypers & Bengston, 1984)

Summary of Models

The conceptual models of Induced Dependency (Kuypers & Bengston, 1984) and the related concepts of Learned Helplessness (Seligman, 1975) and Litwak's (1985) theory of formal organizations and informal primary groups have been presented. Thus, the literature review is presented and organized according to the integrated model of all three as applied by the investigator.

Literature Review

For the purpose of the current investigation, only induced dependency, bureaucratization and nurses' sense of autonomy and control over nursing practice was explored in depth. Supporting literature, however, encompasses expanded portions of the model (Figure 3).

Vulnerability

As the elderly population increases, so will the need for their eventual placement in long-term care facilities. Recent studies indicate that those who turned 65 in 1990 will require some nursing home care before they die; half will need a year or more and almost one third will need at least five years of care (Kemper & Murtaugh, 1991).

In their later years, most elderly persons desire to remain active and healthy while attempting to resist

becoming dependent and helpless because nursing home placement is most commonly perceived as a sign of rejection by their familiar world (Jasin, 1981). Although dependency constitutes a part of all life stages, it is particularly difficult for the elderly to disguise and is viewed by society as a less than acceptable trait in this age group (Goldfarb, 1969).

Dependence on External Labeling & Labeling as Incompetent

Being elderly in some cultures is an honor that carries an air of respect, but in American culture, society destroys status-giving roles and functions for the aging without providing satisfactory replacements (Gresham, 1976). Society continues to convey false stereotyping of the elderly as people who: (1) think and move slowly; (2) are not able to think like before; (3) are unable to learn new things and would not wish to do so if able; and (4) are entering their second childhood instead of moving forward (Dolinsky, 1984). These attitudes are so ingrained in our culture that everyone over the age of 65 is considered elderly regardless of their health, status, race or sex (Dolinsky). In fact, a majority of our elders have accepted these negative beliefs that society has created (Gresham).

Induced Dependency, Atrophy of Previous Skills, and Learned Helplessness

The phenomenon of induced dependency (Kuypers & Bengston, 1984) reduces the residents' abilities to perform care activities for themselves and can lead to depression (Avorn & Langer, 1982). Induced dependency is the direct result of the interaction between the individual and the social and physical environment (Matteson & McConnell, 1988) rather than disease or the aging process (Avorn & Langer).

In the nursing home, induced dependency is used to explain patients' loss of independence (i.e., atrophy of their previous skills) which is most likely unnecessary and possibly the consequence of staff convenience, lack of attention or patient planning needs. For some residents, the circumstances of group residence and the presence of staff help contribute to the development of dependent situations that resemble hotel living, including reliance on hotel-like personnel to perform basic functions that were previously performed independently (Lipman & Slater, 1977). This loss of independence is usually associated with the aging process, when in fact, it is the perceptions of helplessness toward the elders that is most often the cause of dependent behaviors (Avorn & Langer, 1982).

To explain the residents' induced dependency and atrophy of previous skills, it is necessary to explore what

factors precipitate this loss of independence. Steele (1986) conducted a qualitative study of ($N = 7$) residents in nursing homes and described a process of entrapment that included five concepts: physical disengagement, interpersonal detachment, frustration, despair, and resistance. In the stage of physical disengagement, the route toward despair most frequently begins with changes in the individual's physical functions and abilities to perform daily tasks (Steele). With regard to interpersonal detachment, the lack of sufficient staff time for the residents was not elaborated upon beyond general statements expressing a perceived lack of time on the part of the staff (Steele).

In addition to the explanation provided by Steele (1986), Sommer and Osmond (1961) identified 'symptoms' present in long-term mental hospital patients; two of which may also be applied to the experiences of nursing home residents. These applicable 'symptoms' are de-individuation and disculturation (Sommer & Osmond). 'De-individuation' is characterized by a reduced capacity for independent thought and action, as reflected by a virtual incapacity for spontaneous activity, increased dependence, increased acceptance of and reliance on the institution, a desire to remain in the institution and to return quickly if discharged, and an inability to make even small decisions

(Sommer & Osmond). 'Disculturation' reflects the individual's acquisition of institutional values, language and attitudes, a decrease in the importance of social needs, an increase in the importance of such physical needs as eating and sleeping, and greater prominence of everyday immediate problems over the people left behind (Sommer & Osmond). It was also found that the deindividuation experience was evidenced by an increased physical reliance on others and the loss of status upon entering the facility, a result that parallels the elder's experience upon entering the long-term care facility (Sommer & Osmond).

In the nursing home environment, an area of induced dependency is that of wheelchair usage in mainly ambulatory patients. The use of wheelchairs by cognitively intact, ambulatory residents is viewed as a self-initiated choice, yet the study found that 52% of residents using wheelchairs began using them after their nursing home admission for one reason or another (Pawlson, Goodwin, & Keith, 1986). Upon chart review, there was little documentation indicating the reason that a wheelchair was being utilized (Pawlson, Goodwin, & Keith). Interview data showed the majority of the residents began using the wheelchair after a specific accident, while for another 18%, the move to the nursing home itself was the major event related to using a wheelchair (Pawlson, Goodwin, & Keith). When questioned,

the residents stated that staff either encouraged or were neutral toward their wheelchair usage; the majority also thought that using the wheelchair increased their independence and sense of well-being (Pawlson, Goodwin & Keith).

Another area of induced dependency is that of feeding the institutionalized elderly. According to Rogers and Snow (1982), the staff preferred to sit and feed one resident rather than to walk around the dining room and assist patients only when help was needed. Similarly, if residents did not take extended periods of time to feed themselves, they were left alone, but if self-feeding was taking too much time, they were fed by a staff member (Roger & Snow). Efficiency was also demonstrated by the use of pureed food when residents needed assistance in cutting their food (Roger & Snow).

Furthermore, another factor which contributes to residents' induced dependency is the influence of nursing staff attitudes and behavior. Previous studies have shown that residents' dependent behavior is directly related and frequently maintained by the nursing home staff (Avorn & Langer, 1982). According to Gresham (1976), nursing staff are well aware of the power that they have over the residents in 'encouraging' them to conform to their wishes. Also, the residents are aware of their dependencies and

abide by the staff wishes out of fear of losing what contact and other basic needs that they are currently being given (Gresham).

Godlove, Dunn and Wright (1980) reported that almost half of the nursing staff preferred taking care of more dependent residents, especially the physically dependent. To explain this preference, the staff reported that: (1) they found the care of these residents easier; (2) they could do what they wanted; (3) the residents were more grateful; (4) they could advocate more for these residents; and (5) they could easily manage these patients (Godlove et al.). According to Dolinsky (1984), older people are often infantilized or treated as children by the nursing staff through remarks such as "good girl" and through the denial of even the smallest decisions concerning the residents' own personal care such as bed time. As a result of such infantilization, patients permit their activities of daily living to be performed by others regardless of whether they are able to achieve them for themselves. Dolinsky attributes this to the staff's need to mother, to protect or to be expedient.

In addition to staff preferences, communication and behavior of nursing staff contribute or reinforce induced dependency in residents. Cohler and Shapiro (1964) found that staff talked more to the patients who were dependent

and helpless. An explanation to account for this increase in communication may involve: (1) certain patient traits that may encourage staff response, such as an attitude of receptive acceptance rather than rejection, like that of the more active patients who maintain a facade of independence; (2) the infantile and helpless appearance of the patients which may elicit a less anxious staff response; and (3) the perceived dissimilarity that reduces the possibility of staff members making an unconscious identification with patients (Cohler & Shapiro).

In their study of nursing homes, Baltes, Honn, Barton, Orzech and Lago (1983) found that: (1) the staff showed more supportive behavior for residents who needed dependent personal maintenance in the form of self-care (e.g., toileting) than for the residents who were independent in personal maintenance; (2) the staff failed to respond to residents' independent behaviors; (3) the dependent characteristics exhibited by the residents affected the behaviors other people had in response to the residents; and (4) the length of institutionalization of the resident did not influence the findings. Unlike the theory of learned helplessness of Seligman (1975), these findings suggest that dependency, even as a consequence of a lack of control, can be important; i.e., residents engaging in dependent

behaviors can set the occasion for a contingency to occur thereby controlling their own environment (Baltes et al.).

Moreover, those patients who received more communication from staff were also found to be more dependent, which could possibly explain the dependency inducing behavior that the nursing staff projects in order to confirm their own self-concept as helpful and nurturing (Doherty, 1971). For the most part, resident contact with the nursing staff is largely related to physical care (Bowers, 1988; Harrington, 1987; Laird, 1979; Savishinsky, 1991; Woods & Britton, 1985; Wright, 1988). As a result, these physical tasks are more understandable and amenable in evidencing clear outcomes than the subtle socio-emotional and supportive tasks (Lipman, Slater & Harris, 1979). Thus, nursing home relationships are characterized by staff dominance; the staff possesses the power to determine many of the residents' daily living activities (Lipman, Slater & Harris).

Finally, the quantity of interaction is not the only relevant consideration; quality is equally important. Butler and Lewis (1973) stated that many of these interactions are authoritarian in nature and result in the infantilization of the residents. According to Avorn and Langer (1982), this infantilization and overly intrusive help in self-care can lead to learned helplessness with

further disability for the resident. Storlie (1982) agrees with the infantilization of residents that occurs in nursing homes and mentions the lack of decision making for residents, the presence of rules, the incidence of showers being given to those residents preferring baths, and the insistence that residents eat in the dining room as examples of this process.

The Formal Organization and Its Degree of Bureaucratization

Bureaucratization can be observed in formal organizations (i.e., nursing homes) through the emphasis on the efficiency and regimentation of care. Unfortunately, an obvious consequence of this bureaucratic focus is that this system lacks patient individuality; small but important tasks related to aesthetics (e.g., bathing at the residents' requested time) are not routinely accomplished.

An example of this routinization and its negative impact on nursing home patients can be found in Carobeth Laird's (1979) memoirs of her firsthand experiences as a nursing home resident. Laird details the effect of efficiency and bureaucratization in nursing homes and the impact that this has on the residents. According to Laird, rules abound in areas such as staff insistence that patients not lie down once beds were made, staff indication of patient bath times and staff decisions that patients use the

bedpan as a means of lessening the time that would be necessary to assist patients to the bathroom. As a result of such regimentation, Laird describes her feelings of loss of control. In response to being forced to use the bedpan, for example, Laird's reaction was first one of conflict, then timidity, then a terrible sense of helplessness, feeling that she would become a bedridden patient in this particular facility rather than regaining her strength from an illness, which was the reason behind her nursing home admission.

Savishinsky (1991) provides yet another example of how this routinization negatively affects residents. When interviewed, one resident's family spoke of their father's need to be walked several times a day and mentioned that, although the staff stated that this man was being walked regularly, the father in fact indicated that this was not the case (Savishinsky). When confronted, the staff quickly blamed the man's mental state, although the family indicated that there was nothing wrong with his mind and showed their willingness to walk their father if this could not be accomplished by the nursing home staff (Savishinsky). Fortunately, in this case there were family members (i.e., a primary group) that could intervene to help to minimize the time constraints that bureaucratization places on the

realization of patient care and to maintain this patient's independence by satisfying his individual care need.

In addition to the negative effect felt by nursing home residents, nursing home nurses themselves report extreme frustration with bureaucracy (i.e., regulations and paperwork) (Cotler & Kane, 1988; Jones et al., 1987; Savishinsky, 1991), and feel powerlessness in their ability to humanize the institution (Schwartz, 1974). As care providers, the nurses not only fit into the nursing home's daily routine, they are that routine, causing many nurses to feel that they have lost touch with the basic language of caring (Savishinsky).

There is evidence that the type of organizational activity may be highly related to the degree of bureaucratization (Hall, 1963). Litwak proposes that, although the role of nursing homes is to take on the care usually provided by the primary groups, these formal organizations are ineffective in managing tasks that are unpredictable, have many contingencies and are not standardized (Litwak). In fact, the majority of the caregiving activities that take place in nursing homes must be capable of being routinized and therefore, those tasks which cannot be structured are gradually eliminated (e.g., diapering incontinent residents instead of having individualized toileting program) (Litwak).

In addition to adversely impacting resident care, bureaucratization also affects the retention of nursing staff in the nursing home setting. According to Savishinsky (1991), nurses in this bureaucratized system thought that bureaucracy itself led to a lack of respect in the treatment that they received. Nurses were frequently publicly reprimanded by superiors and, upon complaining about these instances to administrators, little was done due to time constraints and more pressing matters (Savishinsky).

Among the staffs' reasons for leaving their employ, nursing home administrators cited: (1) the degree of impersonality or bureaucratization in the home; (2) the institution's emphasis on efficiency, not the welfare of residents; (3) the pressure from regulatory agencies; (4) the lack of autonomy over their own work; and (5) the discrepancy between what they expected and the reality of the situation (Rubin & Shuttlesworth, 1986).

Select Sociodemographics of Registered Nurses and Licensed Practical Nurses and Their Implications

To meet the standards recommended by geriatric and long-term care experts, it is estimated that an additional 35,000 RNs and 27,000 LPNs are needed to fill vacancies in the nation's nursing homes (Aldrich, 1991). Nurses employed in nursing homes tend to be older than nurses working in hospital, generally having graduated from nursing school 15

years or more ago (Cotler & Kane, 1988; Jones et al., 1987). The highest level of education for 40-60% of the RNs is a diploma (Cotler & Kane; Jones et al.; McKibbin, 1990). Nursing home nurses have the lowest professional status, and the setting has become the reentry level for nurses who have not been active (Cotler & Kane; Jones et al.; McKibbin). According to Knopf (1983), there is evidence that 10-15 years after graduation, all graduates (i.e., diploma, associate, baccalaureate) tend to be increasingly employed by nursing homes; yet for all programs, the percentage of nurses seeking nursing home employment one year after graduation is still small.

In a study of four nursing homes by Sheehy (1992), it was found that most RNs were approximately 20 years post RN graduation and in their mid to late forties in age. Educationally, nearly 50% had a diploma degree while the other half an Associate Degree, with only 7 nurses having obtained a baccalaureate degree (Sheehy). Similar findings were reported for the LPNs, who were approximately 16 years post LPN schooling and in their mid to late forties (Sheehy).

With regard to their treatment of the elderly, Jaeger and Simmons (1970) found that a considerable amount of nursing personnel, especially aides and LPNs, thought that their patients are and should be treated as though they were

children. Upon examining such factors as age and level of education, Gillis (1973) found that there was no significant correlation between the age of the nursing personnel and a positive attitude toward the aged. Registered nurses with bachelor degrees (BS) were less positive towards the elderly than LPNs, although there was no significant difference in the nurses' positive attitudes the longer that they worked with this specific age group (Gillis).

In terms of patient care, a survey of 19,070 nursing homes revealed that nearly 40% provided less than six minutes of RN time per patient per day, about 60% had nursing staff composed of less than 10% RNs, and half employed no RNs at all (Jones et al., 1987). Approximately 50% of the nursing homes had a physician available at scheduled times and only 30% had a physician on an on call status (Jones et al.). Thus, unlicensed personnel provides 80-90% of the care while professional nurse time is spent in supervisory and administrative duties (Jones et al.). Although the majority of RNs are employed as staff nurses, 33% report administration and supervision as their primary role, followed by charting (Jones et al.). Therefore, as a result of the constraints that bureaucratic demands (i.e., paperwork and supervision) place on them, registered nurses are almost never directly involved in the delivery of personal care to patients (Jones et al.).

In addition to its effects on direct patient care as judged by the perceptions of both the patients and the nurses themselves, bureaucratization in the nursing home setting is also a major factor in nurse attrition. However, another cause of the retention problem stems from the fact that nurses employed in nursing homes are paid up to one-third less than nurses working in hospitals (Aldrich, 1991; Alwin, 1991b; Atchley, 1991; Jones et al., 1987; National Citizens' Coalition for Nursing Home Reform (NCCNHR), 1985). Unless salaries can be made more comparable to hospital salaries, nurses will continue to be uninterested in careers in long-term care facilities, forcing the homes to rely on LPNs who hold one-year degrees (Alwin). Statistically, nursing home salaries have increased somewhat between 1990 and 1991, with the median salary for all levels of nursing increasing by the following: directors of nursing, increased 9.6% to \$32,890; nursing supervisors, up 21.8% to \$31,600; head nurses, up 9.6% to \$29,120; RNs, up 34% to \$12.96 per hour; and LPNs, up 11.1% to \$9.92 per hour (Koizumi, 1991). Registered nurses in nursing homes are paid about \$4,000 less than RNs working in hospitals, (Alwin, 1991b; Atchley, 1991; Jones et al., 1987; NCCNHR) and have fewer fringe benefits such as vacation, health, sick leave benefits, and pensions (Cotler & Kane, 1988). These inadequacies result in less experienced LPNs filling

most of these positions (Alwin). As can be predicted, vacancies are minimal in nursing homes that pay RN wages similar to those of hospital RNs (McKibbin, 1990).

According to Jones et al. (1987), in addition to salary, an important factor in the retention of nursing home nurses is the benefit package (i.e., hospitalization and dental coverage, vacation and retirement plans). They also conclude that the following should be included: (1) holiday pay, bonuses and merit based raises (Jones et al.). In many nursing homes, these are usually inadequate and contribute to higher retention problems and vacancy rates among nursing personnel. A recent study by the census bureau of 6,182 health workers revealed that more than one-fifth (20.5%) of nursing home employees have no health insurance, as compared to 6% of personnel employed in physicians' offices (Migdail, 1991). In conclusion, once the level of compensation and recognition of a career ladder in long-term care settings exists, a substantial impact on retention of nurses will be achieved and in turn the quality of care will be better (Friedland, 1992).

In the state of Arizona, the following salaries for nursing home nurses apply: (1) directors of nursing average \$35,222 with a minimum of \$26,000 and a maximum of \$53,800 annually; (2) charge nurses (RNs) average \$13.58 with the minimum being \$11.46 and the maximum being \$20.01 per hour;

(3) staff nurses (RNs) average \$12.65 with a minimum of \$10.97 and a maximum of \$17.85 per hour; (4) charge nurses (LPNs) average \$10.58 with a minimum of \$8.25 and a maximum of \$17.00 per hour; and (5) staff nurses (LPNs) average \$9.61 with a minimum of \$7.56 and a maximum of \$16.32 per hour (Arizona Association of Homes for the Aging (AAHA), 1991). Approximately half of the homes offer no retirement plan, no disability plan, and no dental insurance (AAHA).

Autonomy and Control Over Nursing Practice

Professionalism is the general term used to encompass both control over nursing practice and autonomy, two phenomena which are important in the delivery of care and which have been the focus of a number of nursing studies over the years (Gerber et al., 1990). According to Gerber et al., control over nursing practice is defined as "... one's perceived freedom to evaluate and modify nursing practices, to make autonomous decisions related to a patient's care, and to influence the work environment and staffing at the unit level of organization" (p.1). Autonomy is conceptualized by each nurse on an individual basis (Gerber et al.).

Ethridge (1987) indicated that, in order for nursing to achieve a status of professionalism, nurses must be recognized as having and being able to manage

responsibility, authority, and autonomy in their practice. Furthermore, control over nursing practice and autonomy have been shown to be important to nurses' satisfaction and to quality outcomes in a number of studies (Ethridge; Hinshaw, et al., 1987; Mueller & McClosky, 1990). According to White (1980), nurses in long-term care facilities practice with a great deal more autonomy, responsibility, and authority than nurses in any other setting. This may be due in part to the fact that professional nurses in acute-care settings are influenced by powerful formal organizations which place little consideration on their autonomy (Donley, 1992).

However, the majority of the research relating to control over nursing practice and autonomy to date has been conducted in acute care hospitals. There are, for example, several studies in the literature that examine the autonomy of professional nurses and their accountability. Hall, Alfano, Rifkin, and Levin (1975) found that nursing autonomy can be associated with decreased lengths of patient stay, more discharges to the patients' home, lower overall costs, and fewer rehospitalizations. In addition, a study by Maas and Specht (1990) reported positive clinical outcomes and higher nurse satisfaction after a professional practice model was instituted at their place of employment.

Also relevant to the discussion of autonomy is the gap between the clinical authority of nurses and their

responsibility for patient care (Prescott & Dennis, 1985). In the hospital setting, for example, nurses are directly responsible for the performance of a wide variety of duties, yet they think that tension exists between their responsibility for care and their lack of autonomy in clinical decision making (Prescott & Dennis). Most professionals think that they would be more motivated by a goal of quality care rather than by the need to maintain the hierarchical structure's goal (Donley, 1992).

In their study of personnel in Israeli geriatric facilities, Bergman, Eckerling, Golander, Sharon and Tomer (1984) indicated that: (1) the fulfillment of job expectations was slightly higher among LPNs than RNs, due to increased autonomy and status in this setting; (2) RNs and LPNs placed great value on the ability to use their knowledge, skills and special attributes; (3) most RNs felt they had autonomy and an influence in decision making; LPNs did also, but to a lesser extent; and (4) half of the management nurses were LPNs, a status they could not achieve in an acute care setting.

White (1980) asked nurses in long-term care facilities to identify the positive and negative attributes of their jobs. Among the positive factors were: (1) greater autonomy in decisions regarding delivery of care to their patients; (2) closer relationships with residents and families; (3)

more opportunities to use professional and administrative skills without alienating themselves from direct patient care; (4) increased time to talk to and to understand patients; (5) opportunities for assisting in the development and for seeing the results of well-planned team care plans; (6) chances to utilize a wide variety of skills, including teaching; and (7) less organization bureaucracy than hospitals (White). On the negative side were the stress and close contact with death and dying, communication difficulties with residents, the emotional commitment as a family surrogate, and the difficulty in separating work from their personal life (White).

Although its principal purpose was to provide guidelines for quality care for nursing homes residents, the national nursing home reform law passed in 1987 indirectly supports the need for professional nurses who maintain autonomy and control over their nursing practice in the nursing home setting. In short, this law parallels what geriatric nurses have been saying and practicing for many years: "... the systematic practice of nursing grounded in the logic of the nursing process makes a difference in patient outcomes" (Beyers, 1991, p.21). Professional nurses can be the principal player in the successful implementation of these reform requirements (Holder, 1991) while further developing their professional role. For example, according

to the reform law, quality care depends on a comprehensive accurate assessment conducted by a RN, including specific ADL's areas such as nutrition, drug therapy, and urinary incontinence (Holder). Regulations such as this, which specify the importance of the professional nurse, provide crucial support to nursing personnel in their pursuit of adequate qualified staff (Holder), thereby increasing their autonomy and control over nursing practice. Furthermore, the needs of residents cannot be met without professional nurses to provide this area of leadership and these invaluable services (Holder).

Along with such rewards as salary and benefits, professional opportunities, control, responsibility and decision making have also been found to be important to nurses (Mueller & McCloskey, 1990). Task complexity, the degree to which an employee's skills and strengths are used, participation in patient care and the fit between the individual and the work environment are also related to overall employee well-being in the facility (French, Caplan & Van Harrison, 1982). In addition, the nursing profession needs to be more attentive to the concerns of nurses in long-term care settings as well as cognizant of the need for more research in this area in order that quality of care will improve (Haight & Bahr, 1991).

Urinary Incontinence

Urinary incontinence problems increase with age and, based on recent projections for the growing elderly population, the statistics for those who suffer from such a problem are only expected to intensify in the future (Yu, Johnson, Kaltreider, Hu, Brannon & Ory, 1991). Urinary incontinence in the elderly, a major reason for nursing home placement, results in enormous costs which are estimated to be \$10 billion annually in total direct health care costs (National Citizens Coalition for Nursing Home Reform (NCCNHR), March/April 1992)). More specifically, the cost of urinary incontinence directly to nursing homes is estimated to be \$2 billion per year, a figure which comprises 10% of total nursing home costs (Hu, Igou, Kaltreider, Yu, Rohner, Dennis, et al., 1989). According to Cella (1988), nursing homes need approximately two full-time staff members per day to care for these incontinent patients. Yet, while at least half of the residents in nursing homes have bladder incontinence problems, only 4.24% of these people are receiving any form of a bladder retraining program (NCCNHR).

According to the Health Care Financing Administration (1993), the total number of nursing home residents in the United States (in facilities certified to participate in Medicare/Medicaid programs) is currently 1,490,451 people.

Of the total nursing home population, 723,622 are incontinent of urine and only 67,906 of these people are receiving any form of bladder training (Health Care Financing Administration).

In addition to being embarrassing and stressful to nursing home residents, urinary incontinence has also been shown to affect the nursing staff who work with these patients. Yu et al. (1991) found that nursing home personnel experienced such feelings as frustration, discouragement, depression, and irritation when dealing with incontinent patients. Additionally, nursing staff stated that the displeasure associated with working in the presence of urine odor was one of the reasons for their decision to leave a particular position (Cotler, & Kane, 1988; Schwartz, 1974).

Summary

The review of the literature was organized according to the investigator's integrated model for the study. It included the developed topics of induced dependency, the degree of bureaucratization of the formal organization, the select sociodemographics of RNs and LPNs employed in the nursing home setting, these nurses' perceptions of autonomy and control over their nursing practice, and the issue of induced dependency as related to urinary incontinence.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study was to explore the relationship among (1) autonomy, control over nursing practice and selected sociodemographic characteristics of nursing staff, (2) the degree of institutional bureaucratization, and (3) the quality of resident care in nursing homes. The study was organized according to the integrated conceptual models of Kuypers and Bengston (1984), Seligman (1975) and Litwak (1985) as applied by the investigator. Throughout this chapter, the methodological aspects for the study are addressed, including the research design, the setting and study sample, protection of human rights, data collection procedures, instrumentation, and methods of data analysis.

Research Design

This study is a secondary analysis of data collected for the funded study, "The Contextual Environment of Nursing Homes" (Sheehy, 1992). In the study, a cross-sectional descriptive design was used. Data were collected from two freestanding community nursing homes.

Sample and Setting

For the purpose of this investigation, the study sample consisted of RNs and LPNs from two Southern Arizona nursing homes under the ownership of national chains. The first nursing home had a total of 312 beds; 208 skilled beds, 32 intermediate beds, 20 personal care beds, 22 special care beds for Alzheimer's patients, and 30 Medicare-certified beds. The second nursing home had a total of 240 beds of which 158 were skilled, 40 intermediate, and 42 Medicare-certified; 40 beds are allotted for the protective dementia unit. All participants were enrolled as a convenience sample. The study sample consisted of 15 RNs and 31 LPNs who were identified from employee lists provided by the Director of Nursing of each facility.

Protection of Human Subjects

Approval was obtained from the Human Subjects Committee of the University of Arizona (Appendix A) and the College of Nursing Human Subjects Committee (Appendix B). The data used in this study are from a larger funded project: "The Contextual Environment of Nursing Homes" (Sheehy, 1992). A disclaimer rather than a consent form preceded the instruments contained in the questionnaire. Coded identification numbers were used to ensure confidentiality of the respondents.

Variables and Instruments

Staff Characteristics

The following are the sociodemographic characteristics used in the study:

Category of Nursing Personnel: RN or LPN

Age: the nurse's actual age in years

Educational Level: the type of educational preparation for each nurse (RN) in practice and the highest degree achieved

Years Since Completion of Basic Education: the number of years of (active) professional practice for RNs and LPNs

Salary: the dollar amount of annual wages paid to the nursing home employee for their services

Employee Benefits: the employee's individual selection of fringe benefits

Autonomy

Autonomy was operationalized using concepts from Hall's (1963, 1968a, 1968b) Occupational Inventory, which relates to the employees' perceived sense of independence in their job performance and in the aspects of professionalism. The scale is a Likert-type with a five-point rating scale from "Strongly Agree" to "Strongly Disagree." Hall developed the instrument from viewed characteristics of a profession examined by Wilensky and Caplow (1966), including status as a full-time occupation, the presence and utilization of a

training model, the formation and involvement in professional associations, and a code of ethics. Hall's original instrument contained five subscales that measured: (1) the use of the professional organization as a major reference; (2) the belief in service to the public; (3) belief in self-regulation; (4) sense of calling to the field; and (5) a feeling of autonomy at work. These attitudes reflect how practitioners view their work in reference to the professional organization, their belief system and their ability to make their own decisions (Hall, 1968b). In this study, only two of Hall's subscales are utilized; those of belief in self-regulation and a feeling of autonomy at work.

The split-half reliabilities was reported to be .80 or higher for each of the subscales after applying a Spearman-Brown correction (Hall 1968a, 1968b). The data supported the validity of the scales; for example, chi-square tests of statistical independence indicated a strong relationship ($p < .001$ for all analyses) between level of professionalism as measured by the scale and professional behaviors (e.g., attendance at professional meetings, membership in professional organizations, and presence of certification or a license) (Hall, 1968a, 1968b). High scores reflect and indicate a highly professional sense of orientation. Results from the study "The Contextual Environment of

Nursing Homes" showed that the internal consistency reliability was $\alpha = 0.81$ for the subscale of autonomy (Sheehy, 1992).

Control Over Nursing Practice

Control Over Nursing Practice was operationalized with concepts from the Control over Nursing Practice Scale from Hinshaw and Atwood, 1986; Verran, Murdaugh, Gerber and Milton, 1988; Gerber, Murdaugh, Verran and Milton, 1990; Gerber, McNamara, Verran, Murdaugh and Milton, 1990. This scale was designed to reflect one's freedom to evaluate and modify nursing practices, to influence others and the environment, and to work with others in the delivery of care (Gerber et al.). The scale as developed by Gerber et al. (1991) consists of 21 items with a reported internal consistency of .89 as measured by Cronbach's alpha. An evaluation of internal consistency using factor analysis indicated a single factor accounted for 28% of the variance in the scale. Results from the study "The Contextual Environment of Nursing Homes" showed that the internal consistency reliability was $\alpha = 0.95$ for the subscale when used in the initial study (Sheehy, 1992).

Bureaucratization

Bureaucratization was operationalized using concepts from Hall's (1963) Organizational Inventory. The scale is a series of dimensions on a continuum of organizational description which are characteristically cited as attributes of rigid adherence (Hall). In this study, these were measured by the following three subscales: (1) hierarchy of authority, (2) division of labor based upon functional specialization, and (3) rules which govern rights and duties of employees (Hall). Participants rate the extent to which they perceive that the statements apply to their organizational setting on a five-point Likert-type scale ranging from "Strongly Agree" to "Strongly Disagree." The instrument was based on Max Weber's notion of increasing standardization, reliance on rules rather than individual judgement, and impersonality of interpersonal relations characteristic of the modern post industrial era. In the ideal setting of a bureaucracy, all dimensions would be present to a very high degree. Hall reported split-half reliabilities for his subscales to be in the range of .80 to .90. A higher score indicates a greater degree of bureaucracy possessed by the institutions. The relationship between professionalization and bureaucratization is generally assumed to be inverse (Blau, Heydebrand, & Stauffer, 1966). From the funded study "The Contextual

Environment of Nursing Homes," the construct validity was demonstrated by using factor analysis with Principal Components extraction, explaining 62% of the variance (Sheehy, 1992). The results showed the internal consistency reliability was $\alpha = 0.81$ and that inverse relationships were found between the scale and measures of professionalism (Sheehy).

Data Collection

Administrative personnel at the nursing home initially introduced the study to the nursing staff to assist in recruiting nurses at meetings and/or change of shift reports. Next, the subjects were recruited face-to-face by either the principal investigator or several graduate research assistants and were asked to participate voluntarily in the study. Subjects represented all three shifts, 7am-3pm, 3pm-11pm and 11pm-7am.

The data collectors were trained in the administration of the questionnaires and data collection protocol to insure uniformity of the procedure. Staff nurses, RNs and LPNs, individually completed the questionnaire at his or her convenience after receiving instructions from the data collectors. The questionnaire was either handed directly to the data collector or left in a questionnaire box located at each nurses' station for later retrieval by a data collector.

Data Analysis

Data were analyzed based on the following research questions:

1. Are there differences in the sociodemographic characteristics of RNs and LPNs between the two nursing homes with regard to their age, type of educational preparation (for RNS only), years since completion of basic education, benefits and salary in nursing homes?

To answer research question one, a One-Way Analyses of Variance (ANOVAs) was used for age, years since completion of basic education, total benefits, and salary for both RNs and LPNs. Next, chi-square test of statistical independence was conducted to evaluate relationships between type of educational preparation and benefits. Finally, the question was analyzed using measures of central tendency and dispersion (e.g., mean, median, mode, frequency distribution, and standard deviation).

2. What are the relationships among autonomy, control over nursing practice, age, years since completion of basic education, total benefits and salary in the two nursing homes and do any differences exist between RNs and LPNs in these variables?

To answer research question two, Pearson's Product Moment Correlations and One-Way ANOVAs were used to analyze the data.

3. What are the relationships among autonomy, control over nursing practice, degree of institutional bureaucratization, and quality of resident care in nursing homes as measured by one indicator of induced dependency (i.e., urinary incontinence) in nursing homes?

To answer research question three, Pearson's Product Moment Correlations and One-Way ANOVAs were used to analyze the data.

Summary

The methodology for this study was fully elaborated on in this chapter, including the design, sample and setting, protection of human subjects, variables, methods of data collection, and the plan for data analysis. The instruments utilized for data collection were the Occupational Inventory for studying nurses' sense of autonomy, the Control Over Nursing Practice Scale for control issues and the Organizational Inventory for identifying the amount of bureaucratization.

CHAPTER IV
RESULTS OF DATA ANALYSIS

Introduction

Statistical tests were conducted to answer the research questions proposed in chapter three. The results of these tests are presented in the following section.

Results Related to Research Questions

Research Question 1: Are there differences in the sociodemographic characteristics of RNs and LPNs between the two nursing homes with regard to their age, type of educational preparation (for RNs only), years since completion of basic education, benefits and salary in nursing homes?

In this study, the convenience sample resulted in a total of 46 responses from 15 RNs and 31 LPNs employed in two different nursing home facilities. A chi-square test of statistical independence showed no significant difference between the proportion of RNs and LPNs employed between the two nursing homes nor between the number of nurses employed full-time and part-time. In facility one, the staff consisted of 9 RNs and 15 LPNs (38% and 62% of the staff

respectively), while at facility two, the staff consisted of 6 RNs and 16 LPNs (27% and 73%).

In terms of the nurses' age, the responses indicated that: six LPNs, but none of the RNs, were between 20-29 years of age; five RNs and four LPNs were between 30-39 years; 5 RNs and 11 LPNs were between 40-49 years; and four RNs and seven LPNs were in the 50+ age category. A One-Way ANOVA comparing the mean ages for RNs and LPNs ($N=42$) showed no significant differences in age; the mean age of RNs was 45.9 years ($n=14$, $SD=12$), while the mean age of LPNs was 41.4 years ($n=28$, $SD=11$) for both nursing homes combined. Four nurses did not complete this question.

In addition, when comparing the two homes there were no significant differences in terms of the nurses' age between the RNs and LPNs. The results in age differences between the RNs of nursing home one and nursing home two are as follows: there were no RNs in either home who were between 20-29 years of age; three RNs in home one and two RNs in home two were between 30-39 years; two RNs in home one and three RNs in home two were between 40-49 years; and three RNs in home one and only one RN in home two were in the 50+ age category.

The results in age differences for the LPNs of the two nursing homes are as follows: there were two LPNs in home one and four LPNs in home two between 20-29 years of age;

two LPNs in both homes were between 30-39 years; four LPNs in home one and seven LPNs in home two were between 40-49 years; and four LPNs in home one and three LPNs in home two were in the 50+ age category.

Educational preparation of the RN nursing staff ($n=15$) resulted in the following divisions: five RNs were prepared at the associate degree level; four completed a baccalaureate degree in nursing; one held a master's in nursing; and five were diploma graduates. In nursing home one, there were three RNs prepared at the associate's degree level; two completed a baccalaureate degree; one held a masters in nursing; and three were diploma graduates. In nursing home two, there were two RNs prepared at the associate degree level; two at the baccalaureate level; none held a master's in nursing; and two had a nursing diploma.

Among the RNs ($n=13$), the number of years since completion of basic education included four who completed their basic education 0-5 years prior to this investigation and nine who left school 10 or more years ago. For the LPNs ($n=25$), four finished school 0-5 years prior to completing the questionnaire, five completed their basic education 5-10 prior, and 16 received their training 10 or more years ago. Eight respondents did not indicate the number of years since completion of basic education. Analysis by a One-Way ANOVA showed no significant difference in the mean number of years

since completion of basic education between RNs and LPNs ($N=38$, RN: $M=20.8$ years, $SD=16$; LPNs: $M=17.3$ years, $SD=11$).

In addition, when comparing the two nursing homes there were no significant differences between the RNs and LPNs in the number of years since completion of basic education. The RNs responded as follows: there were three RNs in nursing home one and one RN in nursing home two who completed their basic education 0-5 years prior to this investigation; there were no RNs in either home who finished school 5-10 years ago; and five RNs in home one and four RNs in home two who left school 10 or more years ago.

The LPNs responded to the question: years since completion of basic education, as follows: there were three LPNs in home one and one LPN in home two who completed their basic education 0-5 years prior to this investigation; there were three LPNs in home one and two LPNs in home two who finished school 5-10 years ago; and seven LPNs in home one and nine LPNs in home two who left school 10 or more years ago.

The next area addressed was that of employment benefits for the nurses. Both Chi-square tests of statistical independence and One-Way ANOVA showed that there were no significant differences in the total number of benefits between RNs and LPNs. On the average, the total number of benefits chosen were 3.6 by RNs and 3.2 by LPNs. In

addition, when comparing the two nursing homes there were no significant differences between the RNs and LPNs in the total number of benefits chosen. The RNs in nursing home one chose an average of 3.6 benefits, while the RNs in nursing home two chose 3.7 benefits. The LPNs in nursing home one chose an average of 2.4 benefits, while the LPNs in nursing home two chose 3.9 benefits.

When differences between RNs and LPNs were computed for each individual benefit, all benefits lacked significant differences. However, for the IRA/Keogh benefit, the difference approached significance between RNs and LPNs ($N=26$, $X^2=3.32$, $df=1$, $p=.068$). The missing respondents for each category of benefits were as follows: sick time (two RNs, five LPNs); vacation (one RN, five LPNs); holidays (two RNs, four LPNs); health insurance (three RNs, five LPNs); continuing education (2 RNs, 14 LPNs); tuition reimbursement (2 RNs, 15 LPNs); IRA/Keogh (4 RNs, 16 LPNs); and pension (3 RNs, 13 LPNs).

In addition, when comparing the two nursing homes there were no significant differences between the RNs and LPNs in the benefit category of IRA/Keogh. In nursing home one, there were two RNs who received the benefit and four RNs who did not receive the benefit. While in nursing home two, there were three RNs who received the benefit and two RNs who did not receive the benefit. In nursing home one, there

were no LPNs who received the benefit and eight LPNs who did not receive the benefit. In nursing home two, there were two LPNs who received the benefit and five who did not receive the benefit.

Since benefits frequently depend on status as a full-time employee, the aforementioned analyses were recomputed for full-time RNs and LPNs. There were no significant differences in the number of benefits between the two homes for both RNs and LPNs ($N=31$). Among the full-time employees, there was a statistically significant difference between RNs ($n=8$) and LPNs ($n=23$) again in the IRA/Keogh benefit ($X^2=5.60$, $df=1$, $p=.02$).

The last area addressed in research question one focused on the yearly salary earned by RNs and LPNs in the two nursing homes. It was found that the RNs' ($n=12$) annual income, \$31,885.00, was significantly greater than the LPNs' ($n=20$) income at \$18,740.00 ($p=.00$). The RNs average salary was \$32,103.34 in nursing home one, while in nursing home two the RNs average salary was \$31,666.67. For the LPNs, the average salary was \$18,550.00 in nursing home one, while in nursing home two the LPNs average salary was \$18,866.67.

Research Question 2: What are the relationships among autonomy, control over nursing practice, age, years since completion of basic education, total benefits and salary in the two nursing homes and do any differences exist between RNs and LPNs in these variables?

For this question, Pearson's Product Moment Correlations were used to analyze the data available from the two nursing homes ($N=40$). A statistically significant positive relationship was found between: (1) autonomy and control over nursing practice ($r=.55$, $N=38$, $p<.01$); (2) years since completion of basic education and age of the nurse ($r=.76$, $N=35$, $p<.01$); and (3) total benefits the nurse received and their salary ($r=.49$, $N=32$, $p<.01$). No significant relationships were found among the other variables.

Since full-time versus part-time work can be expected to influence the variables such as salary and the total number of benefits, the correlations were recomputed for the full-time employees ($N=27$) in both nursing homes. Four positive significant relationships were established; three of which were again those between autonomy and control over nursing practice ($r=.61$, $N=26$, $p<.01$), years since completion of basic education and age ($r=.67$, $N=23$, $p=.01$), and total number of benefits and salary ($r=.46$, $N=22$,

$p=.03$). The additional significant relationship was found between total number of benefits received and age of the nurse ($r=.41$, $N=29$, $p=.03$).

Next, a One-Way ANOVA was used to analyze whether there was a significant difference between RNs and LPNs with regard to the variables of autonomy ($N=40$), control over nursing practice ($N=40$), age ($N=42$), years since completion of basic education ($N=38$), and the total number of benefits ($N=46$). There was a statistically significant difference between RNs and LPNs in their sense of autonomy ($df(1,38)=9.78$, $p<.01$) with registered nurses scoring higher than LPNs (RN: $n=12$, $M=28.5$, $SD=4.33$; LPN: $n=28$, $M=23.11$, $SD=5.24$). No significant differences were found between RNs and LPNs nor between the two nursing homes for the variables of control over nursing practice, age, years since completion of basic education, and total benefits.

Research Question 3: What are the relationships among autonomy, control over nursing practice, the degree of institutional bureaucratization, and the quality of resident care in nursing homes as measured by one indicator of induced dependency (i.e., urinary incontinence) in nursing homes?

For this question, Pearson's Product Moment Correlations were used to analyze the data available from the two nursing homes ($N=41$). A statistically significant positive relationship was found between nursing autonomy and control over nursing practice ($r=.55$, $N=38$, $p<.01$). As the nurses' perceived sense of autonomy increased, so did their sense of control over nursing practice.

In addition, an inverse relationship was identified between the institution's bureaucracy and the variables of autonomy and control over nursing practice. As the nursing staff (RNs and LPNs) scored the organization as being more highly bureaucratized, their scores of perceived sense of autonomy decreased ($r=-.66$, $N=39$, $p<.01$). Also, the higher the organization was scored on bureaucracy, the lower the nurses scored their perceived control over nursing practice ($r=-.59$, $N=38$, $p<.01$).

The correlations were again analyzed taking into account the full-time status of the nursing employees ($N=26$). A significant relationship was found between the nurses autonomy and control over nursing practice ($r=.61$, $p<.01$). Inverse relationships were again found between institutional bureaucratization and autonomy ($r=-.68$, $p<.01$) and control over nursing practice ($r=-.75$, $p<.01$).

A One-Way ANOVA (using incontinence rate to group the homes) was used to analyze the level of nursing

autonomy, control over nursing practice, and degree of bureaucratization. The definition for measuring induced dependency (i.e., urinary incontinence) in nursing home residents was as follows: Nursing home residents who are incontinent of urine at the time of the investigation, but did not have incontinence problems prior to the nursing home admission. This also entails an absence of evidence of a systematic assessment and a plan of care for toileting as well as efforts to manage and evaluate continence alternatives (Sheehy, 1992).

In the area of nursing autonomy ($N=40$), no significant difference was found between the two nursing homes on the basis of this variable. Although no significance was found, the data did reveal that nursing autonomy was slightly higher in the first nursing home than in the second home ($\underline{M}=25.4$, $\underline{SD}=6.30$; $\underline{M}=24.1$, $\underline{SD}=4.83$ respectively).

Closely related to nursing autonomy is the concept of control over nursing practice ($N=40$). A One-Way ANOVA showed no significant difference between the nurses' control over their practice and the urinary incontinence rate of the two nursing homes. Although no significant difference was found, nursing home one exhibited a slightly higher level of control over nursing practice than nursing home two ($\underline{M}=107.4$, $\underline{SD}=25.10$; $\underline{M}=95.1$, $\underline{SD}=22.00$ respectively).

Lastly, the concept of institutional bureaucratization was analyzed ($N=41$). Again, a One-Way ANOVA was utilized and no significant difference was found in the level of institutional bureaucratization among the nursing homes with regard to urinary incontinence of the residents. Bureaucratization was shown to be slightly higher in nursing home two, where there was a higher level of urinary incontinence, than in the first nursing home ($M=40.2$, $SD=12.20$; $M=45.2$, $SD=11.36$ respectively).

Summary

The results of the data analysis were presented in this chapter. Chi-square tests of statistical independence, One-Way ANOVAs, and measures of central tendency and dispersion were used to analyze the sociodemographic characteristics of the nursing staff in research question one. In question two, correlations and One-Way ANOVAs were utilized to analyze the relationships between autonomy, control over nursing practice, age, years since completion of basic education, total benefits, and salary. In addition, the effect of these factors on quality of care as measured by the indicator of induced dependency (i.e., urinary incontinence) was analyzed by One-Way ANOVAs in research question three. The significant differences and relationships were revealed throughout this chapter and are

elaborated upon in chapter five with regard to the findings and their implications for nursing practice.

CHAPTER V
DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

Introduction

In this chapter, the findings related to the research questions are addressed. Limitations of the study, implications, and recommendations for nursing research are presented.

Discussion of the Findings

The investigation resulted in a total sample of 46 responses from nurses (15 RNs and 31 LPNs) employed in the two different nursing homes utilized in this study. This 2:1 ratio of LPNs to RNs in the two facilities is in agreement with the findings in the current literature that there are twice as many LPNs than RNs employed in nursing homes (Alwin, 1991b; Jones et al., 1987).

In terms of the nurses' age, no significant differences were found between the RNs and LPNs, but 27 out of the 42 nurses who responded to the questionnaire were 40 years old or greater. According to the literature, nurses employed in nursing homes tend to be older which is consistent with the findings of this study (Jones et al., 1987; Sheehy, 1992).

In addition, no significant differences were found between RNs and LPNs concerning years since completion of

basic nursing education. However, the majority of RN nurses in both nursing homes (10 out of 15) held either an associate degree or a diploma. This is consistent with the literature which indicates that the highest level of education for 40-60% of RNs is a diploma (Cotler & Kane, 1988; Jones et al., 1987; McKibbin, 1990).

Furthermore, the majority of both RNs and LPNs had been out of school at least 10 or more years (25 out of 38). In this area, this study approximated but did not match the findings in the current literature that nurses employed in the nursing home setting have generally graduated from nursing school 15 or more years ago (Cotler & Kane, 1988; Jones et al., 1987). The discrepancy between the results of this study and the literature could stem from the small sample size of this study.

With regard to the variable of benefits, an approach toward significance was found between the RNs and LPNs only in the category of the IRA/Keogh benefit. Among the RNs and LPNs in both nursing homes, three times as many nurses did not receive this benefit as those who did. For RNs, it was evenly divided between those who did and did not receive this benefit and for LPNs, five times as many did not receive this benefit as did.

Moreover, since benefits frequently depend on status as a full-time employee, analyses were recomputed for full-time

status yielding a significant relationship once again between the RNs and the LPNs only in the category of IRA/Keogh. According to the literature, the lack of comprehensive benefit packages and poor salaries are contributing factors to high vacancy rates and retention problems among nursing staff (AAHA, 1991; Jones et al., 1987; Migdail, 1991). However, the lack of significance for the benefits variable could also be the result of such factors as the decision not to select or participate in certain benefit programs or the availability of particular benefits from other sources (i.e., a spouse's place of employment).

In the area of average yearly salary for RNs and LPNs in both nursing homes, it was found that the RNs' mean annual income was \$31,885.00 and the LPNs' was \$18,740.00. Contrary to the figures available in the literature, these annual incomes are several thousand dollars above the national and state averages (AAHA, 1991; Koizumi, 1991). Once again, the small sample size may be a contributing factor to this variation in incomes. In addition, this finding could simply indicate that the nursing staff in these two nursing homes are receiving better than the average salaries.

The next two significant relationships were found between (1) years since completion of basic education and

age of the nurse, and (2) the total benefits the nurse received and his or her salary. This is most probably due to the fact that the nurses' increased age leads to an increase in length of nursing career and higher seniority which, in turn, may influence the total benefits package that they receive.

A statistically significant relationship was also found between autonomy and control over nursing practice for the nurses in both the nursing homes used in this study. The literature reflects that professionalism is a general term used to encompass both control over nursing practice and autonomy. As well as the statistical relationship between the two variables, both of these terms have been shown to be very important to nurses in their delivery of adequate health care (Gerber et al., 1990). In addition, the literature indicated that in order for nursing to achieve a status of professionalism, nurses must be recognized as having responsibility and being able to manage responsibility, authority, and autonomy in their practice (Ethridge, 1987). According to the results of this study, the nurses indicated that they believed they did have autonomy and control over their nursing practice. However, RNs experienced greater autonomy and control over their nursing practice than LPNs.

A significant difference was found between RNs and LPNs for the variable of sense of nursing autonomy, with RNs scoring higher than LPNs in this area. This increased sense of autonomy for RNs may be related to the fact that registered nurses are responsible for a greater variety of duties than LPNs, even though LPNs in LTC facilities can obtain positions they could not achieve in other settings. This finding is consistent with the literature in that RNs thought they had autonomy and an influence in decision making, LPNs did also, but to a lesser extent (Bergman et al., 1984).

It was also found that as the nurses' sense of autonomy increased, so did their sense of control over nursing practice without regard to their status as an RN or an LPN. Registered nurses and LPNs place great value on the ability to use their knowledge, skills and special attributes, which in turn, leads to whether or not they feel they have autonomy and control over their nursing practice (Bergman et al., 1984). Although little research has been conducted in LTC facilities, the literature does indicate that the nurses in nursing homes have reported a greater sense of autonomy and control over nursing practice than in any other setting (White, 1980). This significant relationship was not affected by nurses' full- or part-time status.

In addition, an inverse relationship was identified between the institution's bureaucracy and the variables of autonomy and control over nursing practice. As the nursing staff (RNs and LPNs) scored the organization as being more highly bureaucratized, their scores of perceived sense of autonomy decreased. The same conclusion was reached for the variable of control over nursing practice, i.e., the higher the organization was scored on bureaucracy, the lower the nurses scored their perceived control over nursing practice. These results are consistent with the findings in the literature that nurses are frustrated with the bureaucracy system and its impact on their practice (Cotler & Kane, 1988; Rubin & Shuttlesworth, 1986; Savishinsky, 1991). Most professionals think that they would be more motivated by a goal of quality of care rather than by the need to maintain the hierarchical structure's goal (Donley, 1992).

This result is also consistent with the literature in that as care providers, the nurses not only fit into the nursing home's daily routine, they are that routine, causing many nurses to feel that they have lost touch with the basic language of caring (Savishinsky, 1991). In addition to impacting the nursing staff, bureaucratization can also adversely impact resident care.

No significant differences were found between urinary incontinence and the level of nursing autonomy, control over

nursing practice, or degree of institutional bureaucratization in the two nursing homes. Although no significant differences were found, the data did reveal that autonomy and control over nursing practice were slightly higher in nursing home one than nursing home two. However, the level of bureaucratization was shown to be slightly higher in nursing home two where there was a higher level of urinary incontinence than in nursing home one.

In spite of the fact that no significant relationships were found between urinary incontinence, level of nursing autonomy, control over nursing practice, and degree of institutional bureaucratization, the aforementioned differences between the two nursing homes suggested some trend between these variables and further research is needed. This is consistent with findings in the literature that nurses' autonomy and control over nursing practice may be affected by the institution's degree of bureaucratization and in turn affect the residents by inducing dependency (Hall, 1963; Rubin & Shuttlesworth, 1986; Savishinsky, 1991).

Also these results begin to suggest, which is consistent with the literature and the national nursing home reform law passed in 1987, that there is a need in the nursing home setting for professional nurses who maintain autonomy and control over their nursing practice to assist

in providing quality care for the residents (Holder, 1991). Professional nurses can be the principal players in successful implementation of these reform requirements (Holder) while further developing their professional role and providing quality care to the residents in the nursing home. Furthermore, the needs of the residents cannot be met without professional nurses to provide this area of leadership and these invaluable services to the residents (Holder).

Although not conclusive, the research provided no inferential support for a relationship between professionalism and quality of care as measured by one indicator of induced dependency (i.e., urinary incontinence) with the proposed conceptual models of Kuypers and Bengston (1984) and the related concepts of Litwak (1985).

The results of the study found that as nurses' perceived sense of autonomy increased, so did their sense of control over nursing practice. In addition, as they scored the institution higher in its level of bureaucracy, their level of nursing autonomy and control over nursing practice decreased. However, no significant relationships were detected in the data relating to urinary incontinence and the level of nursing autonomy, control over nursing practice, or the degree of institutional bureaucratization to support the literature (Kuypers & Bengston, 1984; Litwak,

1985). This is probably due to the small population utilized in this study. Bureaucratization, autonomy and control over nursing practice may also be related to turnover rates which was not a variable addressed in this thesis.

Limitations

The small sample size of this investigation limits the conclusions that can be drawn from the resulting information. In addition, the utilization of a convenience rather than a random sample could have introduced some bias into the sample group. Furthermore, this particular study only addressed one indicator of quality care and focused on only two of the four nursing homes included in the funded project, "The Contextual Environment of Nursing Homes" (Sheehy, 1992). Another limitation of the study is that no conclusive data supported the conceptual model therefore, the model needs to be revised in the future and tested again. Finally, there were several questions that the staff chose not to answer, which resulted in some missing data.

Implications for Nursing Practice and Research

Further research is needed to determine conclusively to what extent institutional bureaucratization influences the nursing staff with regard to their autonomy and control over

nursing practice and results in inducing dependency in nursing home residents (i.e., urinary incontinence).

Other areas that need to be examined through adequate research are the effects of the professional preparation of the nursing staff on the quality of care of the residents and the effects that these have on the staff and the residents that they care for. Furthermore, the relationship between quality of care, the presence of adequate numbers of professionally trained nurses, and their felt autonomy and control over nursing practice need to be more thoroughly investigated.

In the nursing home, residents' care requirements should be adjusted to accommodate for individual preferences and needs; the amount of time that nurses spend with patients should be based on the residents' personal choices and needs rather than on time limits for uniform services imposed by the formal organization's bureaucracy. In addition, the formal institutions could become more effective in managing nonuniform (primary group) services by reducing the strict guidelines and making allowances so that these services could be provided if wanted and/or needed by the residents. Primary and formal organizations have complimentary goals (i.e., adequate elder care) and a mutual solution needs to be reached (Litwak, 1985).

Furthermore, recommendations to improve quality of care to the patients also should include such provisions as providing staff with basic training in professional and interpersonal skills, assisting the nursing staff in the development of more positive attitudes towards the residents, offering better wages and benefits, fostering increased support from supervisors, and improving the staffing of nurses (NCCNHR, 1985).

Lastly, the nursing profession needs to be more attentive to the concerns of nurses in long-term care settings as well as cognizant of the need for more research in this area in order to improve the quality of care that the nursing home residents receive (Haight & Bahr, 1991). These changes cannot be accomplished without further research in this area to support these earlier findings.

Summary

The purpose of this investigation was to explore the relationship among autonomy, control over nursing practice, and selected sociodemographic characteristics of nursing staff, the degree of institutional bureaucratization, and the quality of resident care in nursing homes.

A significant difference was found for both RNs and LPNs in the variable of the IRA/Keogh benefit, regardless of their full-time or part-time status. Also, statistically

significant relationships were found between (1) autonomy and control over nursing practice; (2) years since completion of basic education and age of the nurse; and (3) total benefits the nurse received and their salary. A statistically significant difference between RNs and LPNs was found in their sense of autonomy, with RNs scoring higher than LPNs. A significant relationship was found between nursing autonomy and control over nursing practice, which indicated that as nurses' perceived sense of autonomy increased, so did their sense of control over nursing practice. In addition, an inverse relationship was identified between the institution's bureaucracy and the variables of autonomy and control over nursing practice.

No significant differences were found between the two nursing homes with regard to urinary incontinence and the level of nursing autonomy, control over nursing practice, and degree of institutional bureaucratization.

The relationship between quality of care, the presence of adequate numbers of professionally trained nurses, and their felt autonomy and control over nursing practice needs to be more thoroughly investigated.

**APPENDIX A:
HUMAN SUBJECTS APPROVAL FOR
FUNDED STUDY
HUMAN SUBJECTS COMMITTEE**

THE UNIVERSITY OF
ARIZONA
HEALTH SCIENCES CENTER

1690 N. Warren (Bldg. 526H)
Tucson, Arizona 85724
(602) 626-6721 or 626-7575

Human Subject Committee

June 2, 1992

Christine Sheehy, D.P.A., R.N.
College of Nursing
Arizona Health Sciences Center

RE: THE CONTEXTUAL ENVIRONMENT OF NURSING HOMES

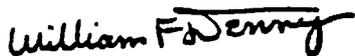
Dear Dr. Sheehy:

We have received documents concerning your above cited project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b) (2)] exempt this type of research from review by our Committee.

Please be advised that approval for this project and the requirement of a subject's consent form is to be determined by your department.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely yours,



William F. Denny, M.D.
Chairman
Human Subjects Committee

WFD:rs

cc: Departmental/College Review Committee

**APPENDIX B:
HUMAN SUBJECTS APPROVAL FOR
CURRENT STUDY**

College of Nursing

Tucson, Arizona 85721
(602) 626-6154

March 23, 1993

Amy Sharron
College of Nursing
University of Arizona
Tucson, Arizona 85721

Dear Ms. Sharron:

Your request to complete a secondary data analysis of the data collected by Dr. Christine Sheehy has been approved by the Office of Nursing Research.

We wish you success with your research.

Sincerely,

Leanna J. Crosby, DNSc, RN
Director of Intramural & Laboratory Research

LJC/ms

APPENDIX C:
ORGANIZATIONAL INVENTORY SCALE

ORGANIZATIONAL INVENTORY SCALE

Instructions:

Circle the number that most closely indicates how you feel about each statement. The *left* set of numbers indicates degree of *disagreement*. The *right* set of numbers indicates degree of *agreement*. The *center* number (which is 3) means "undecided". Please use it as little as possible. The more strongly you feel about the statement, the further from the center you should circle, with disagreement to the left and agreement to the right.

		Disagree					Agree				
		1	2	3	4	5	1	2	3	4	5
1.	Rules and regulations are a big part of this nursing care facility.	1	2	3	4	5					
2.	Even small matters have to be referred to someone higher up for a final answer.	1	2	3	4	5					
3.	One thing I like around here is the variety of work I get to do.	1	2	3	4	5					
4.	I have to check with a supervisor, administrator or someone in charge before I do almost anything.	1	2	3	4	5					
5.	My job has something different happening from day to day.	1	2	3	4	5					
6.	Employees are repeatedly reminded to follow rules and regulations.	1	2	3	4	5					
7.	I usually find my job here to be monotonous.	1	2	3	4	5					
8.	Employees are constantly being checked upon for rule and regulatory violations.	1	2	3	4	5					
9.	It seems as though there is a rule or regulation for everything here.	1	2	3	4	5					
10.	There can be little action until a supervisor, administrator or someone in charge approves a decision.	1	2	3	4	5					
11.	Only an administrator, persons in supervisory positions or someone in charge can decide how a job is to be done.	1	2	3	4	5					
12.	There is something new and different to do almost every day.	1	2	3	4	5					
13.	No two days are ever the same in this job.	1	2	3	4	5					
14.	People here feel that they are constantly being watched to see that they obey all the rules.	1	2	3	4	5					
15.	Any decision I make has to have the approval of an administrator, a supervisor or someone in charge.	1	2	3	4	5					

APPENDIX D:
CONTROL OVER NURSING PRACTICE SCALE

CONTROL OVER NURSING PRACTICE SCALE

Instructions:

Circle the number that most closely indicates how you feel about each statement. The *left* set of numbers indicates degree of *disagreement*. The *right* set of numbers indicates degree of *agreement*. The *center* number (which is 4) means "undecided". Please use it as little as possible. The more strongly you feel about the statement, the further from the center you should circle, with disagreement to the left and agreement to the right.

		Disagree			Agree			
1.	I am free to consult with others when solving complex care problems.	1	2	3	4	5	6	7
2.	I am free to evaluate current nursing policies and procedures.	1	2	3	4	5	6	7
3.	I am free to evaluate the outcomes of nursing care.	1	2	3	4	5	6	7
4.	I am free to influence standards of nursing practice in this facility.	1	2	3	4	5	6	7
5.	I am free to modify or adapt patient care procedures and protocols.	1	2	3	4	5	6	7
6.	I am free to implement my nursing care in an efficient manner.	1	2	3	4	5	6	7
7.	I am free to provide holistic, resident-centered care.	1	2	3	4	5	6	7
8.	I am free to practice clinical skills to the best of my ability.	1	2	3	4	5	6	7
9.	I am free to analyze problems critically.	1	2	3	4	5	6	7
10.	I am free to plan strategies to meet my own developmental needs.	1	2	3	4	5	6	7
11.	I am free to plan care with other members of the health care team such as physicians, dietitians, and therapists.	1	2	3	4	5	6	7
12.	I am free to act on my own decisions related to care-giving.	1	2	3	4	5	6	7
13.	I am free to be creative in the delivery of nursing care.	1	2	3	4	5	6	7
14.	I am free to introduce new nursing practices and procedures.	1	2	3	4	5	6	7
15.	I am free to identify problems in the delivery of nursing care.	1	2	3	4	5	6	7
16.	I am free to coordinate care between residents and health care services outside the facility.	1	2	3	4	5	6	7
17.	I am free to adjust nursing care plans to meet residents' changing needs.	1	2	3	4	5	6	7
18.	I am free to negotiate my time off duty.	1	2	3	4	5	6	7
19.	I am free to exert the authority needed to fulfill my job responsibilities.	1	2	3	4	5	6	7
20.	I am free to ask for assistance from other staff members when needed.	1	2	3	4	5	6	7
21.	I am free to utilize research findings to improve my nursing practice.	1	2	3	4	5	6	7

APPENDIX E:
OCCUPATIONAL INVENTORY SCALE

OCCUPATIONAL INVENTORY SCALE

Instructions:

Circle the number that most closely indicates how you feel about each statement. The *left* set of numbers indicates degree of *disagreement*. The *right* set of numbers indicates degree of *agreement*. The *center* number (which is 3) means "undecided". Please use it as little as possible. The more strongly you feel about the statement, the further from the center you should circle, with disagreement to the left and agreement to the right.

		Disagree					Agree				
		1	2	3	4	5	1	2	3	4	5
1.	I make my own decisions in regard to what is to be done in my work.	1	2	3	4	5					
2.	I don't have much opportunity to exercise my own judgment.	1	2	3	4	5					
3.	I know that my own judgment on a matter is the final judgment.	1	2	3	4	5					
4.	When problems arise at work, there is little opportunity to use your own intellect.	1	2	3	4	5					
5.	There is little autonomy in my work.	1	2	3	4	5					
6.	My decisions are subject to review.	1	2	3	4	5					
7.	I am my own boss in almost every work-related situation.	1	2	3	4	5					
8.	Most of my decisions are reviewed by other people.	1	2	3	4	5					
9.	Nurses here have a pretty good idea about each other's competence.	1	2	3	4	5					
10.	There really aren't any penalties here for nurses who violate nursing standards.	1	2	3	4	5					
11.	A problem in nursing here is that no one really knows what his/her colleagues are doing.	1	2	3	4	5					
12.	Violators of nursing standards face fairly severe penalties here.	1	2	3	4	5					
13.	There is not much opportunity to judge how other nurses here do their work.	1	2	3	4	5					
14.	My nurse colleagues here pretty well know how well we all do in our work.	1	2	3	4	5					

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