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Social Work Perspectives of Quality in Nursing Homes Compared to
Minnesota Nursing Home Report Card and Nursing Home Compare

By

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The number of older adults requiring nursing home level of care continues to rise and is expected to continue as the baby boom generation ages. The quality of nursing home care has been a significant policy issue for several years, as poor quality of care continues to be an endemic problem in many of the U.S nursing homes. The Nursing Home Reform Act passed in 1987 was designed to set quality standards to improve nursing home care quality. In 1998 the Centers for Medicare and Medicaid responded by implementing Nursing Home Compare, which is a tool to inform consumers about nursing home quality. Social workers often play a key role in advocating for resident rights and ensuring residents' psychosocial needs are being met. Care quality can have a large impact on the overall wellbeing of a resident. The purpose of this study was to learn about nursing home social workers perspectives of what quality care is and if their perspectives are similar to quality indicators identified on the Minnesota Nursing Home Report Card and Nursing Home Compare. Eight nursing home social workers participated in individual semi-structured interviews answering fourteen questions regarding their perspectives of quality care in the nursing home setting. The participants' responses demonstrated similar quality care indicators compared to the Minnesota Nursing Home Report Card and Nursing Home Compare. Participants' responses evolved into themes regarding resident centered care and quality of life, quality indicators and lack of response, staffing ratios, retention and burnout, leadership and empowerment, awareness and use of report cards and informed consumers. Developing an understanding of indicators that contribute towards good quality care in the nursing home setting will allow social workers to advocate for residents to ensure they experience the highest achievable quality of life possible.

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Social Work Perspectives of Quality in Nursing Homes

In 2011 the older adult population, age 65 and older, numbered 41.1 million. Of the older adult population in 2011, 1.3 million lived in institutional settings, such as nursing homes (Administration on Aging, U.S Department of Health & Human Services, 2011). Nursing homes are defined as long-term care facilities that offer 24 hour room, board, and health care services, which include basic and skilled nursing care (Du Moulin, Van Haastregt & Hamers, 2010). The percentage of older adults residing in institutional settings increases dramatically with age, ranging from 1% for persons 65-74 years, to 3% for persons 75-84 years, and 11% for persons 85+ (Administration on Aging, U.S Department of Health & Human Services, 2011). As the nursing home population increases, concerns from patients, families and policymakers rise regarding the quality of care provided.

The quality of nursing home care has been a significant policy issue for several years, as poor quality of care continues to be an endemic problem in many of the U.S nursing homes. In 1970 Congress responded to persistent quality problems through the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987, also known as the Nursing Home Reform Act. The Nursing Home Reform Act raised minimum quality standards and strengthened federal and state oversight (Park & Stearns, 2009). To address concerns about poor quality in the nursing home setting, greater efforts were made by public accountability initiatives to provide consumers with information about the quality of care in nursing homes (Castle & Lowe, 2005).

Quality of care information that is standardized and released to the public is generally defined as a report card (Castle & Lowe, 2005). The information that is available on the report card is presumed to be beneficial to the consumers in assisting with identifying and choosing providers. The Centers for Medicare and Medicaid Services introduced a web-based nursing home report card initiative in October 1998 called, "Nursing Home Compare," to improve

consumer information (Grabowski & Town, 2011). The Nursing Home Compare reports data on various dimensions of quality, such as: size, ownership status, location, staffing and quality indicators (Grabowski & Town, 2011). The initial report cards in 1998 only reported on basic facility information and deficiency citations. In June 2000 staffing information was added, and in April 2002 quality measures were added. Quality measures have varied since the implementation of Nursing Home Compare. As of 2006 there were a total of 15 quality measures, which entailed specific areas of resident care and resident outcomes. Examples would include restraint use and pressure sores (Castle, 2009).

The goal of the Nursing Home Report Card is to educate consumers about the quality of care provided in the nursing home. Consumers who are unfamiliar with the complex array of nursing home terms and procedures may become confused and frustrated, which may affect their ability to comprehend the report card (Castle & Lowe, 2005). The definition of quality can also be different among consumers and various nursing home staff. Spilsbury et al. (2010) looked at structure, process and outcome to assess quality. Structure refers to the organizations ability to deliver care and services. Variables of an organizations structure include: staffing levels, ownership status and characteristics of residents. The interactions between the provider and consumer relate to the process, and the outcomes relate to the health status and conditions of the consumer (Spilsbury, Hewitt, Stirk & Bowman, 2010). Nursing home residents assess quality through two dimensions: quality of life and quality of care. Nursing home residents often look at quality of life as having choices and autonomy, whereas quality of care deals with technical aspects of care (Spilsbury, Hewitt, Stirk & Bowman, 2010).

The purpose of this study was to look more in depth regarding what quality means and how quality is defined through the use of the Minnesota Nursing Home Report Card and Nursing Home Compare Report Card. There is minimal research regarding the social workers perspective of quality in the nursing homes setting, therefore this study examines if social workers'

perspectives of quality care coincide with the Nursing Home Report Cards standards for quality care.

Literature Review

In order to better understand social workers' perspectives of what quality care is in the nursing home setting, consideration must be given to how quality is assessed and what factors contribute towards good or poor care quality. The literature review will discuss different measurements utilized in the nursing home setting to assess quality care. Ownership status, staffing ratios and leadership styles will also be reviewed to assess the impact on quality care. Lastly, the literature review will look at direct care staff perspectives of what quality care means to them.

Measurements

There are currently a variety of measurements utilized to assess quality of care in nursing homes. Measurements that are utilized to assess quality include the Minimum Data Set (MDS), Online Survey Certification and Reporting System (OSCAR), private or state nursing home report cards and the federal Nursing Home Compare (NHC). The Nursing Home Compare created by the Centers for Medicare and Medicaid Services is one of the most familiar tools.

Minimum Data Set (MDS). The MDS is a federal assessment instrument that all nursing homes are mandated to complete on their residents upon admission, quarterly, annually and if there is a significant change (Rante et al., 2009). The data that is derived from the MDS is collected by each state, as well as nationally. Data that is pulled from the MDS includes quality measures (QM) and quality indicators (QI). The quality indicators of the MDS look at potential quality problems, which can provide insight to nursing homes overall performance. Rante et al. (2009) found 12 QIs calculated from MDS data to review quality of care practices. The QIs included: falls, types of depression, depression without treatment, use of nine or more medications, bladder or bowel incontinence, urinary tract infection, weight loss, dehydration,

bedridden residents, decline in late-loss activities of daily living, daily physical restraints, and stage one to four pressure ulcers (Rante et al., 2009).

On-Line Survey and Certification Reporting System (OSCAR). About 96% of the state's nursing homes have data regarding their facilities characteristics and quality measures on OSCAR (Park & Stearns, 2009). OSCAR data is derived from state surveys for all federal Medicare and Medicaid certified facilities in the United States. The OSCAR data is utilized to assess nursing homes compliance with federal regulations and is determined to be the most comprehensive national source of facility level information on the operations and regulatory compliance of nursing homes (Park & Stearns, 2009).

Nursing Home Report Card. Quality report cards have played a key role in enhancing quality in the American Healthcare System. In addition to the Centers for Medicare and Medicaid Services, Nursing Home Compare, there are numerous private and state report cards. An example of the state report card is the Minnesota Nursing Home Report Card. The Minnesota Department of Health and the Minnesota Department of Human Services has worked collaboratively with the University of Minnesota to help consumers compare facilities based on seven quality measures (Minnesota Department of Human Services, 2013). The quality measures include: resident satisfaction and quality of life, quality indicators, hours of direct care, staff retention, use of temporary nursing staff, proportion of beds in single bedrooms, and state inspection results. The overall intent of the Minnesota Report Card is to provide information to consumers and to promote a high standard of quality in all nursing homes across the state (Minnesota Department of Human Services, 2013).

Castle and Lowe (2005) studied which states utilized nursing home report cards. They evaluated the information that was provided on the report card, as well as the usefulness of the information. At the time of their study they found 19 states to have report cards on the World

Wide Web (Castle & Lowe, 2005). The information that was provided, as well as the usefulness varied with no specific trends. Some states report cards focused more on quality measures, where as other states focused on deficiencies. Information provided on the state report cards may be helpful for consumers. However, it was found that the information didn't necessarily influence the consumers' decision (Castle & Lowe, 2005).

Nursing Home Compare. The hope of nursing home quality care information being published is that facilities will strive to get the best scores possible. Mukamel et al. (2008) examined associations between nursing homes' quality and publication of the Nursing Home Compare quality report card. The study evaluated nursing home responses regarding action taken as result of publication of the report card. Surveys were mailed to nursing home Administrators and their responses were merged with five quality measures (QM). The study focused on quality measures of activities of daily living, infections, pressure ulcers, restraints and pain frequency. Mukamel et al. (2008) found that the Nursing Home Compare quality report card led to improvement in some quality measure areas, but not all. They found the quality measures regarding restraints to show improvement, however pressure ulcers showed deterioration. Being that not all areas were improved, it was determined that quality report cards shouldn't be relied on solely as the only instrument to improve quality (Mukamel, Weimer, Spector, Ladd and Zinn, 2008).

Grabowski and Town (2011) conducted a similar study to Mukamel et al. (2008). Grabowski and Town's objective was to review the effectiveness of Nursing Home Quality Indicators (NHQI) with enhancing nursing home performance (2011). The findings suggested that introduction of the NHQI measures improved competitive markets reported quality in comparison to less competitive markets. Grabowski and Town (2011) indicated that report cards alone may not be sufficient to improve performance due to public reporting being less effective for facilities with greater market power.

The Nursing Home Compare report card was designed to provide information to consumers regarding quality measures. While the intent is to be informative, the question may arise about consumers' abilities to understand the data that is provided. Castle (2009) collected data from 4,754 family members of nursing home residents to determine if they utilized Nursing Home Compare, and if they were able to accurately interpret quality data. Castle (2009) found that 47% of the residents selected were admitted into nursing homes from the hospital. Castle noted that residents who admitted directly from the hospital were likely given little time to search for a nursing home, let alone time to evaluate Nursing Home Compare (2009). It was found that 12% of the families utilized Nursing Home Compare and another 18% received the information from someone else (Castle, 2009).

Overall, the findings showed that consumers understood the information on Nursing Home Compare. Castle (2009) states, "Simply having the Nursing Home Compare report card available does not mean that it will be used, nor does it mean that it can influence consumers in any meaningful way," (pg.205). Castle suggests hospital discharge planners play a central role in the use of Nursing Home Compare, however acknowledges that discharge planners may have a lack of awareness regarding Nursing Home Compare (Castle, 2009).

Ownership Status

When determining quality care in nursing homes it's important to be mindful of the context in which the nursing home operates. Contexts that attribute towards good or poor quality care may include: case mix, funding, home size, location and competitive market. Of the Medicare and Medicaid certified facilities in the United States 66% are classified as for profit status (O'Neill, Harrington, Kitchener & Saliba, 2003). Resources that facilities have are largely related to the funding sources they receive. Most care costs for residents are reimbursed through

Medicare, Medicaid and private pay at different rates. O'Neill et al. (2003) found several studies to indicate that as the percentage of Medicaid residents increased, measures of quality decreased.

O'Neill et al. (2003) study examined the relationship between profit and quality amongst for-profit and non-profit nursing homes. They utilized a tobit multivariate technique examining data from 1,098 California nursing homes California Office of State-wide Health Planning and Development, OSCAR and California licensing and statistical reports. There were a total of 377 nursing homes that received more than 20 deficiency citations. Of these nursing homes 349 were for-profit and 28 were non-profit. The study revealed that for-profit nursing homes in California had significantly lower quality of care than non-profit nursing homes (O'Neill, Harrington, Kitchener & Saliba, 2003). Comondore et al. (2009) conducted a similar study, which also found non-profit nursing homes to provide higher quality care than for-profit nursing homes.

Chesteen et al. (2005) and Grabowski and Hirth (2003) compared ownership status in examining quality. Chesteen et al. (2005) discussed how for-profit healthcare facilities face conflict between providing health welfare to residents and profits to investors, thus indicating that non-profit healthcare facilities provide higher quality services. Their study found non-profit nursing homes demonstrated higher quality processes. Of the higher quality processes, involvement of the Director of Nursing was not one of them. Areas where processes did score higher included patient focus and responsiveness (Chesteen, Helgheim, Randall & Wardell, 2005). Similarly, Grabowski and Hirth (2003) discussed that low quality in for-profit nursing homes could be attributed towards opportunistic behaviors. Their study found that non-profit nursing homes level of quality promised would be delivered (Grabowski & Hirth, 2003).

A different study conducted by Anderson et al. (2003) evaluated quality and efficiency amongst profit status and chain affiliation among Florida nursing homes. Since nursing home chains can share resources, it may allow them to run more efficiently than non-chains in terms of

lowering general and administrative expenses (Anderson, Weeks, Hobbs & Webb, 2003).

Anderson et al. (2003) reviewed several past studies, which showed for-profit nursing homes to be more efficient than non-profit nursing homes due to the incentives of profit through cost minimization. The (2003) study found for-profit and chain affiliated nursing homes to be more efficient than non-profit and non-affiliated nursing homes (Anderson, Weeks, Hobbs & Webb). In contrast, it was found that for-profit and chain affiliated nursing homes produced lower quality than non-profit and non-chain affiliated nursing homes (Anderson, Weeks, Hobbs & Webb, 2003).

A (2011) study by Grabowski et al. utilized Minimum Data Set information to evaluate ownership status and quality in the post-acute setting. Their study found patients in non-profit post-acute settings to have fewer 30 day hospitalizations, and better improvement in mobility, pain, and functioning (Grabowski et al., 2011). The studies included in this literature review indicate that although for-profit facilities may operate more efficiently, non-profit nursing homes provider better quality care. Another important aspect in assessing quality care in nursing homes is evaluating staffing ratios.

Staffing Ratios

The Nursing Home Reform Act of 1987 implemented national standards, which included standards regarding staffing. Bowlis (2011) states, “As part of the OBRA, nursing homes are required to have sufficient nursing staff to provide nursing and related services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident” (p.1497). The act requires a nurse be on staff 24 hours a day, a Registered Nurse (RN) on for at least eight hours per day and seven days a week, and the Director of Nursing must be a RN (Park & Stearns, 2009). All Medicare and Medicaid funded nursing homes are required to meet the staffing standards. The annual survey certification process monitors the compliance of nursing

homes. Nursing homes that are found to be in non-compliance are at risk of receiving deficiency citations, monetary penalties or denial of payment (Park & Stearns, 2009). Some studies have found that inadequate staffing is directly correlated to poor quality, whereas good staffing ratios lead to better processes and outcomes (Harrington, Olney, Carrillo & Kang, 2012).

Park and Stearns (2009) studied the effects of state minimum staffing standards on nursing home staffing and quality of care. Their study found that the standards increased staffing particularly in non-profit nursing homes that had staffing levels below or close to the new standards. Facilities that already had higher staffing levels did not show any increases in staffing. In fact, some of the higher staffed facilities decreased their staffing to mimic the standards (Park & Stearns, 2009). Park and Stearns (2009) found that the new staffing standards lead to reduced restraint use deficiencies, which leads to better quality care.

Similar to Park & Stearns (2009), Bowblis (2011) studied the effect of staffing ratios and quality. Bowblis (2011) discussed facilities that rely more on Medicaid have fewer financial resources due to Medicaid reimbursing at lower rates compared to Medicare. Therefore, due to minimum direct care staffing standards other areas of care quality may be altered. Bowblis (2011) assessed quality by evaluating OSCAR data in relation to care practice measure, outcome quality measures, and deficiency citations. The study found that minimum direct care staffing did change staffing levels and improved some areas of quality, but also lead to lower quality as result of care practices changing (Bowblis, 2011). While many studies find higher staffing to be associated with higher quality, it's important to evaluate the mix of staffing in relation to quality. Registered Nurses (RN), Licensed Practicing Nurses (LPN), and Certified Nursing Assistants (CNA) all have different skill sets that can impact care quality (Bowblis, 2011).

Havig et al. (2011) study evaluated staffing levels effect on quality by comparing the ratio of Registered Nurses to the ratio of unlicensed staff. Their study found that nursing homes

should minimize the use of unlicensed staff. They however did not find a significant relationship between Registered Nurse ratios impacting quality of care (Havig, Sogstad, Kjekshus & Romeron, 2011).

A 2012 study evaluated ten of the largest U.S. for-profit nursing home chains to compare staffing levels and deficiencies (Harrington, Olney, Carrillo & Taewoon, 2012). The study found that the top ten for-profit chains, in comparison to other ownership groups, had the worse staffing and deficiencies. It was also found that even though the top chains had higher acuity patients they were well below the national average for RN and total nurse staffing (Harrington, Olney, Carrillo & Taewoon, 2012). The top ten chains and for-profit facilities appear to be utilizing the management strategy of lower staffing levels to reduce labor costs. It has been found that lower staffing levels equate to poor resident outcomes and increased deficiencies (Harrington, Olney, Carrillo & Taewoon, 2012).

Schnelle et al. (2004) study compared different nursing homes staffing levels to quality of care. Data was collected through direct observations, resident and staff interviews, and chart reviews (Schnelle et al., 2004). The study found that higher staffed nursing homes had lower resident care loads resulting in the ability to provide better care. The study also indicated that nursing assistant staffing above 2.8 hours per resident per day is correlated with better quality (Schnelle et al., 2004).

Determining who all of the necessary staff are in the nursing home setting can create challenges in ensuring that the complex needs of the patients are being met. Spilsbury et al. (2011) evaluated the relationship between nursing home nurse staffing and its effects on quality care. The study revealed that when comparing quality indicators with nurse staffing, tentative evidence indicates total nurse and nursing assistant staffing positively attribute towards quality of care for residents (Spilsbury, Hewitt, Stirk & Bowman, 2011). The review of studies most often

demonstrates that appropriate staffing levels assists with patients receiving quality care. Another important factor that may affect quality of care in the nursing home setting is the leadership style of top management.

Leadership Style

Castle and Decker (2011) define leadership as, “how you relate to employees” (p.630). The leadership team in the nursing home setting typically consists of the Nursing Home Administrator (NHA) and the Director of Nursing (DON) (Castle & Decker, 2011). The 2011 study defined different leadership styles of the NHA and DON and compared the leadership styles effect on quality care (Castle & Decker, 2011).

To understand the results of this study it’s important to be aware of the leadership model they utilized. Castle and Decker (2011) utilized the bonoma-slevin leadership model because it allowed them to compare leadership styles with existing nursing home research. The bonoma-slevin leadership model categorizes leaders into four styles. The first style, consensus manager, encourages the employee to provide input to assist with team decisions. The second leadership style, consultative autocrat, requests input from employees, but make decisions on their own. The third leadership style, shareholder manager, does not communicate with employees about job expectations or decision making allowing employees to work with a high level of independence. Lastly, autocrat leadership style makes all decisions on their own and does not seek any input or advice from their employees (Castle & Decker, 2011).

Castle and Decker (2011) study determined that the leadership style, consensus manager, has a strong association with better quality. They also found that if both the NHA and DON worked with a consensus manager style it lead to significant better quality (Castle & Decker, 2011). Previous analyses showed that consensus manager styles contributed towards longer

tenure and lower staff turnover (Castle & Decker, 2011). Castle and Decker (2011) study shows that leadership style does in fact have an influence on quality.

Havig et al. (2011) conducted a similar study to assess leadership, staffing and quality of care in nursing homes. Their study examined the effects of ward leaders' task and relationship-oriented leadership styles, staffing ratios of licensed and unlicensed staff on three different measures of quality of care (Havig, Skogstad, Kjekshus & Romoren, 2011). Havig et al. (2011) define task-oriented styles as, comprising the behaviors of planning work activities, clarifying role objectives, and monitoring job operations and performance. The behaviors of supporting, developing and recognizing are described as relationship-oriented style (Havig, Skogstad, Kjekshus & Romoren, 2011). Their study concluded that active leadership, particularly task-oriented behavior, should be the focus of leaders. Leaders who demonstrate task behaviors of structure, coordination, clarifying staff roles and monitoring operations improves quality of care (Havig, Skogstad, Kjekshus & Romoren, 2011).

While NHA and DON leadership styles are shown to have an influence on quality care it is also important for them to develop other leaders within the organization. Enabling caregivers to make meaningful decisions is described by Dwight D. Eisenhower as, "pull the string, and it will follow wherever you wish. Push it, and it will go nowhere at all" (Castle & Decker, 2011, p.641). The next section will focus on direct care staff perspectives of quality care in the nursing home setting.

Direct Care Staff Perspective of Quality Care

The majority of hands-on care that nursing home residents receive is from direct care workers. Not only do direct care workers assist with activities of daily living, they also deal with emotional and psychological issues the resident may be facing during care interactions (Chung, 2012). Direct care workers play an integral role in assisting new residents with adjusting to the

nursing home setting. Chung (2012) discussed how several previous studies examined the association between staffing level and quality of care signifying that more nursing assistant hours lead to higher quality care. Chung (2012) study explored direct care workers conceptualization of good care, and assessed potential external factors that may attribute towards their view.

Chung (2012) study interviewed 21 direct care workers in Los Angeles area nursing homes. Chung (2012) found that some participants had heard the word quality from their nursing home administrator and nurses, but were unable to define what quality meant. For the purpose of the 2012 study Chung changed the verbiage to reflect good care. The majority of nursing assistants' defined good care based on outcomes of residents such as, resident cleanliness, happiness and comfort (Chung, 2012). One of Chung's participants defined good care as, "Good care is reflected by clean mouth, face, nail, hair..every part of the body needs to be clean. Also good clothes, good presentation, sitting up good...are examples of good care" (2012, p.249). Multiple nursing assistants' reported they felt good about their job when they received positive comments about the residents they have helped (Chung, 2012).

Chung (2009) study evaluated beliefs and assumptions held by nursing assistants in the nursing home setting. More than 90% of direct care residents receive in nursing homes are provided by nursing assistants, who often are one of the few sources of social interaction for residents (Chung, 2009). Chung found that nursing assistants' generally viewed residents as dependent, and classified them based on how much assistance they needed such as stating, "they're total care" (2009, p.723). Chung also found that nursing assistants viewed residents as losing their dignity when moving into the nursing home and relying on others for help (2009). Chung (2009) concluded that roles held by nursing assistants and how they interact with residents' influences quality of care in the nursing home.

Conclusion

The literature reviewed in this study demonstrates how quality care is assessed through the use of the Nursing Home Compare and Nursing Home Report Cards. Factors found that attribute towards good or poor quality care include: ownership status, staffing ratios and leadership styles. The literature review finds that direct staffs' views regarding quality care are defined differently than Nursing Home Compare or leaderships definitions. Castle (2009) discussed the importance of discharge planners playing an integral role in informing consumers through the use of Nursing Home Compare; however, indicated discharge planners may not be familiar with Nursing Home Compare. This statement holds some truth as very little research was found regarding nursing home social workers' perspectives of quality care or awareness of state report cards or Nursing Home Compare. Social workers often play a key role in advocating for resident rights and ensuring residents' psychosocial needs are being met. Care quality can have a large impact on the overall wellbeing of a resident. The purpose of this study was to learn about nursing home social workers' perspectives of what quality care is and if their perspectives are similar to quality indicators identified on the Minnesota Nursing Home Report Card and Nursing Home Compare.

Conceptual Framework

The conceptual framework for this study includes consideration for factors that attribute towards either good or poor quality care in the nursing home setting. This study also considers the quality standards set forth by the Centers for Medicare and Medicaid as identified through the use of Nursing Home Compare and Minnesota Nursing Home Report Card.

Nursing Home Compare was established in 1998 as an initiative to improve consumer information (Grabowski & Town, 2011). Past research has shown a significant relationship between care quality and the context in how a nursing home operates. The literature review identifies factors that can affect care quality as resident case-mix, funding, home size, location and the competitive environment (O'Neill, Harrington, Kitchener & Saliba, 2003). Being that nursing home care quality can be affected by a myriad of factors, and Nursing Home Compare and the Minnesota State Report Card is devised to educate consumers, Systems Theory and Empowerment Models were utilized to guide this research study.

Systems Theory

Systems Theory looks at how the individual can be impacted by their environment. In relation to this study, quality was evaluated by assessing perspectives of nursing home social workers perceptions of quality care. The Systems Theory framework evaluates sub systems that can affect the individual.

The resident is considered to be the individual in this study. A larger sub system that governs the nursing home is the Centers for Medicare and Medicaid (CMS). The Centers for Medicare and Medicaid mandate nursing home regulatory compliance on both the federal and state level. Nursing homes that are found to be out of compliance are at risk of receiving monetary penalties, citations or denial of payment. Sub systems included in this study that can attribute towards good or poor care quality include: ownership status, staffing ratios, leadership

styles of top management, funding, quality indicators, and geographic location. One of the objectives of this study was to assess if social workers identify the included sub systems as factors that attribute towards good or poor quality care.

Empowerment

The Empowerment Model was utilized in this study in relation to the development of Nursing Home Compare and state report cards equipping consumers with quality information to empower them to make informed decisions regarding their healthcare. An Empowerment Perspective incorporates an integrative approach looking at the personal, interpersonal, and political factors (Richardson & Barusch, 2006). As people become older the likelihood that they'll require nursing home level of care increases.

Empowerment practice for this study can raise older adult's awareness regarding nursing home quality. Grabowski and Town (2011) discuss the impact lack of consumer information has on improving quality outcomes. They state, "If consumers have difficulty assessing quality, then it diminishes the incentive for firms to invest in improving quality" (Grabowski & Town, 2011, pg. 1,698). The incentive to publish report card data and make it more accessible to consumers will in turn generate positive motivations for providers to invest in quality improvement (Mukamel et al., 2008). This research study is helpful in that it discusses nursing home social workers' awareness of Nursing Home Compare and the Minnesota Nursing Home Report Card with how they utilize these report cards in their work, as well as other resources to empower consumers to make informed decisions regarding their healthcare.

Methods

Research Design

The purpose of this study was to examine social workers' perspectives of what quality care is in the nursing home setting and to evaluate if their ideas of quality coincide with the Minnesota Nursing Home Report Card and Nursing Home Compare quality standards. An exploratory qualitative study design was utilized by conducting semi-structured interviews that allowed participants to answer questions regarding what their idea of quality care is and what factors contribute towards good or poor care quality. This study also helped identify nursing home social workers' awareness of the Minnesota Nursing Home Report Card and Nursing Home Compare, and evaluated how they utilize the information in their practice to inform consumers.

Sample

This study consisted of interviewing social workers who currently work in the nursing home setting within the Minneapolis and St. Paul metro area. Participants were identified through the use of the Care Options Network Senior Care Guide Book. This book includes a directory of skilled nursing facility options in the metro and surrounding areas. Four participants in each of the Minneapolis and St. Paul regions were randomly selected from Care Options. Participants were not selected from the same chain affiliation. Social workers were contacted individually via phone with the use of a phone script (see Appendix A) regarding interest in participating in this study.

A total of eight nursing home social workers were interviewed. Four social workers from the Minneapolis region and four social workers from the St. Paul region participated in this study. All of the participants were the Director of Social Services with their experience ranging from 3-28 years. Of the eight participants two worked in for-profit facilities and six worked in non-profit facilities. All of the participants were Licensed Social Workers (LSW) with the exception of one

participant being a Licensed Graduate Social Worker (LGSW) (see Table 1). The roles of the participants in their respective facility were fairly similar. All of the participants have the responsibility of overseeing their departments, as well as carrying a case load. Several of the participants discussed their role in policy implementation and being a part of their facilities quality assurance committee.

Table 1

Participant and Facility Demographics

Gender	Degree	Experience	Ownership Status	Bed Occupancy	Private Rooms
Female	LSW	28 Years	Non-Profit	157	22.70%
Female	LSW	25 Years	Non-Profit	268	44%
Female	LGSW	3 Years	For-Profit	75	7.20%
Female	LSW	25 Years	Non-Profit	138	87%
Female	LSW	22 Years	Non-Profit	108	91.30%
Female	LSW	14 Years	Non-Profit	237	70.50%
Female	LSW	13 Years	Non-Profit	125	31.20%
Female	LSW	13 Years	For-Profit	131	23.60%

Protection of Human Subjects

Prior to conducting research for this study, the process and methods of this study was reviewed and approved by the St. Catherine University Institutional Review Board to safeguard participants from any potential harm. An informed consent form (see Appendix B) was presented to participants explaining the purpose of the study, why the individual was selected, the procedures that would be taking place and how the information from the interview would be used, risks and benefits, issues of confidentiality, and the voluntary nature of the study. The consent form was reviewed with the participant prior to conducting the study. Participants who agreed to be a part of the study signed the consent form, and received a copy for their records. Participants were made aware they could withdraw from the study at any time. The records of this study were kept confidential. Research records, audio recordings, consent forms, transcripts and notes were

kept in a locked file in a secured area, and electronic copies of the transcripts were password protected. Audio recordings, consent forms, notes, and transcripts with any identifying information of participants will be destroyed no later than July 1, 2014.

Data Collection

This study utilized a qualitative semi-structured interview. The researcher met with the participants at the time and location of their choice to complete the interviews. All interviews were audio-recorded and lasted between 10-15 minutes. The facility ownership status, occupancy and ratio of private rooms to semi-private rooms was obtained from the Care Options Network Senior Care Guidebook and Nursing Home Compare (see table 1). Participants were asked fourteen open ended questions (see Appendix C) with additional exploratory questions asked as needed. The questions for this study were developed from the findings in the literature review. Questions involved the social worker's perception regarding quality, leadership involvement, staffing ratios and knowledge about Minnesota Nursing Home Report Card and Nursing Home Compare, as well as their thoughts about how the aging baby boom population will impact nursing home quality and care.

Data Analysis

Interviews with participants were audio recorded and transcribed. The transcriptions were analyzed by using an inductive approach to find common words, themes and subthemes. Manifest analysis was utilized to count common words or themes found in the transcriptions and latent analysis was utilized to understand the meaning of the words and themes found. The content from this analysis is reported in the results section and further analyzed in the discussion section of this study.

Results

There were a variety of themes that were found from the participants' responses regarding factors that contribute towards good or poor quality care in the nursing home setting. One of the common definitions of good quality care that was identified by all of the participants revolved around providing resident centered care to enhance the resident's quality of life. Other common themes that were found included factors such as, staffing ratios, retention and burn out. All of the participants identified leadership as an integral component to empower direct care staff, which in turn leads towards happier residents. The knowledge and use of the Minnesota Nursing Home Report Card and Nursing Home Compare varied among participants, but the use of various tools and resources were fairly similar. Participants identified consumers as being more informed and having higher expectations for future care. The findings will be further described in themes in relation to the participants' responses to better understand social workers' perspectives of quality in the nursing home setting.

Resident Centered Care and Quality of Life

All of the participants in one way or another identified good quality care as providing resident centered care. Resident centered care meaning providing individualized attention to that specific resident to what their wants and needs are and ensuring that they are being heard (see Table 2). One of the participants described individualized attention not only as providing the resident with their basic needs, but going above and beyond by assisting with makeup application and ensuring residents wear clothing of their choice. Other factors that were discussed by two of the participants in relation to good quality care included the importance of being on time, addressing needs and concerns promptly, and cleanliness of the facility.

Table 2

Resident Centered Care and Quality of Life

Theme	Participant Responses
Resident Centered Care	<i>"I believe that it [good quality] has to be resident, that everything that we do needs to be resident centered and that decisions are being made and when training is being provided to staff, that it's always from the resident point of view."</i>
and Quality of Life	<i>"I think good quality of care is, I always say... happy resident, happy families, happy survey, happy staff is good quality care."</i>
	<i>"When you provide individualized attention and detail to that person's daily routine and having knowledge of who that person is and what's important to them." "That resident's feel they're being heard and that their issues, questions, concerns are being responded to."</i>
	<i>"Always having the resident's quality of life in mind."</i>

Quality Indicators and Lack of Response

When participants were asked to describe what poor quality care meant to them many of the participants indicated it was the opposite of their responses they identified with good quality care (see Table 3). Two of the participants described poor quality of care in relation to quality measure indicators, particularly facility acquired wounds. One of the participants described poor quality care as, *"When decisions are more profit driven or even sometimes when the focus is so much on regulations, that they lose sight of our customers."*

Many of the participants referenced poor quality in relation to lack of responses, not only in addressing concerns, but also in addressing the resident's needs and call lights. One of the participants described an example of poor quality care in relation to a nurse who did not respond to the needs of a resident when a family member requested their loved one be changed due to having an incontinent episode. The nurse responded to the family member by informing them that

the resident would have to wait until the nursing assistants were done assisting other residents. In this particular situation the nurse should have helped the resident opposed to making them wait.

Table 3

Quality Indicators and Lack of Responses

Theme	Participant Responses
Quality Indicators	<i>“Poor quality of care is, where I think, obviously that’s kind of sometimes where the quality measures come in, if people are suffering from facility acquired wounds, that’s certainly an indication, potentially, that people are not getting the bedside care that they should be getting.”</i>
and	
Lack of Responses	<i>“When people are feeling that they’re expressing questions and concerns and there not being heard.”</i>
	<i>“Un-cleanliness, unhappy people, unhappy staff, unhappy residents, unhappy family, poor survey and staffing challenges lead to poor quality.”</i>
	<i>“If they [residents and families] don’t feel like they have someone they can talk to.”</i>
	<i>“Communication Breakdown.”</i>

Staffing Ratios, Retention and Burnout

Another core theme found to have an effect on care quality relates to staffing ratios, retention and burnout. Seven out of the eight participants identified having appropriate staffing ratios to be important in order to provide quality care. The participant who didn’t identify staffing ratios as a primary factor reflected:

I do think its [staffing ratios] one part of the equation, but there are times when you have staff, where you’ve got staff on the floor and they’re working short because they’re a good team, they can still get it done, they still get it done. To me, it goes more to... I think more importantly than staff ratios is the longevity of the staff. The team being able to work together as a team.

Another participant also identified the quality of the staff being as equally important as the staffing ratios. All of the participants agreed that retention of staff is crucial to provide quality

care (see Table 4). Several of the participants identified staff retention with job satisfaction and lack of staff retention towards burn out.

Table 4

Participant Responses Regarding Staff Ratios, Retention and Burnout

Staff Ratios	Retention	Burnout
<i>“Well, it [staffing ratios] obviously affects, yah know, people can only do so much in one day and if there aren’t enough staff to provide that care, it’s going, you know, the care will suffer.”</i>	<i>“If staff are happy, if they feel they have incentives enough to come and want to work, and they feel they have flexibility, you know, that they’re cared for and that they can make decisions, than they’re going to be happier, and then that’s going to go back to the resident.”</i>	<i>“It [staffing ratios] certainly does, because it’s stressful work. I think maintaining reasonable ratios helps maintain... retain staff and reduce burnout, provides better customer service and therefore better quality.”</i>
<i>“When I started out it was, um... a different type of client, people were much more independent then they are now, because people come much sicker to the nursing home, so you need to have a higher quality or higher care ratio.”</i>	<i>“If you don’t have enough staff then it’s very hard to provide good quality care, because everything just takes longer and people get frustrated. Both residents and the staff get upset. It’s hard for the staff to stay motivated when they’re, yah know, they’re running ragged and it gets very difficult to do that for days at a time.”</i>	<i>“If staff feels overworked or that they are doing this [resident care] for us [facility] not the resident than that can lead to burnout.”</i> <i>“The higher the ratios the better for staff, because they’re not going to have staff burn out and staff can get to know each of the residents individually and be preventative with their care.”</i> <i>“If front line staff are expected to do more than they can, it’s going to hurt morale and be more challenging to work as a team.”</i>

Leadership and Empowerment

Leadership, defined as Nursing Home Administrator and Director of Nursing, were described by the participants’ as playing a key role in motivating and empowering the staff. Common themes that developed around leadership entailed being present and supporting the have better job satisfaction, which will lead to better care and outcomes for the residents.

Table 5

Leadership and Empowerment

Theme	Participant Responses
Leadership	<i>“Leadership is absolutely paramount and what I mean by that is we have to set the standard, we have to set the expectations, we have to promote and empower a culture where customer service is expected.”</i>
And	
Empowerment	<i>“I think that those people [leadership] are in a position of establishing a philosophy and help to create an environment that is resident and customer focused for customer service focused and supporting the staff, to um...maintain regulation...maintain that resident focus, and serving, serving people...providing quality care in conjunction with the regulations.”</i>
	<i>“Their [NHA & DON) leadership, shown towards others, is a good way of modeling how we should be treating our residents. So, if you have poor leadership you’re going to see poor quality of care towards our residents, and good leadership then shows that we have good quality of care towards our residents.”</i>
	<i>“If you have good leadership and they empower their staff, then you will have good care. I think that oversight and getting out on the floors and being heavily involved with the everyday runnings of the facility is good.”</i>

Awareness and Use of Report Cards

The participants had varying levels of awareness regarding the Minnesota Nursing Home Report Card and Nursing Home Compare. All but one participant was able to describe a time when they had utilized either report card. Of the seven that responded, three of the participants identified reviewing their facilities report card results during their quality assurance meeting and four identified reviewing the report card to see how their facilities ranked. One participant described her use of the report cards as, *“I tend to look at it periodically to see what people in the community might be seeing or what our customers might be seeing.”* Another participant described her use of the report cards as:

We use it at quality assurance, we meet monthly and look at the report card, um... the quality indicators and how we can get smiley faces and improve, um.... Areas where we need to work on, so... we look at that a lot.

Commonly, all of the participants who stated they've used either report card identified that their facilities use it as a marker to assess areas they need to work on to improve their report card score.

When the participants were asked what their thoughts were regarding the report cards five of the eight participants emphasized that either report is one tool for consumers and shouldn't be relied on solely to make a decision regarding a nursing home. One participant commented:

It's a place for people to start when they're looking for services. What concerns me about it, actually about both of them, is that they um.. you have to put in context and you have to have information to know how to do that, and I don't think an average person, like when you look at ratings for anything, if you don't know what the measurements are and what it means and how they arrive at it, it doesn't necessarily tell you everything. It's not always accurate.

Several of the participants discussed the importance of the consumer touring the nursing home prior if they're able to do so. One participant stated, "*It's one tool that is used to give a picture, but always come in and tour a facility. Things happen with surveys and different issues that can lower your standard on the internet.*" Another participant stated:

I think it's a good tool for consumers that don't know anything about nursing homes, and that's exactly what it is, it's just one tool. I think if you're looking for a nursing home you have to tour and check it out because each of those things can be different based on what you see.

Two of the participants discussed how there are sections of the report card that are out of the facilities control, which will always lead to lower scores in those areas. An example included talking about how some facilities have several semi-private rooms and how the facilities need to keep them in order to sustain, so they'll never score high in that area. Another participant discussed that some facilities have niches, such as providing wound care. In this situation a facility will likely receive a lower score in relation to quality indicators, because they're going to have a higher number of residents requiring wound care.

When the participants were asked if a client or family member had ever brought up either report in their decision to choose a nursing home six out of eight participants said they had. One of the six participants reflected:

Yes, they[consumers] have yep [discussed report card scores], hmm... hmm. There's family members who have also referenced the Minnesota Department of Health. Um.. like survey results as well, and we have those displayed in a public area, um.. and I guess to me when they do bring that up, I feel like that's an opportunity for us to say, well here's our side of the story. Let's explain this a little bit more and then that way we can hopefully address and reassure them what the specifics are.

Another participant shared a similar statement discussing that she welcomes the consumer to bring up her facilities report card score, so she can explain what they did to correct the situation.

One of the two participants who hadn't experienced a consumer bringing up a report card responded:

No...pretty much residents placed at our facility is because the hospital has placed them here and often times they've never considered a nursing home before in their lives, so their just placed here and if they don't like they go back home.

Tools and Resources. The majority of the participants indicated that both report cards can be considered a tool for consumers when selecting a nursing home, although only one of the participants identified with providing consumers with this tool in their role of providing resources to families. Common tools or resources that the participants all identified with using when providing resources included: The Senior Linkage Line, Care Options Senior Care Guidebook, homecare agencies, consulting with the county and using the internet.

Informed Consumers

All of the participants described consumers as being more informed than in the past in relation to pursuing nursing home care. When participants were asked about how the aging baby boom population will impact nursing home quality and care there were several responses describing the baby boom generation as having higher expectations and wanting more, but not necessarily wanting to pay for it. One participant responded:

I believe that the baby boomers will impact quality and care, because I think that there's increasing demands, and terms of what they expect from nursing homes, they expect more amenities, they expect more services in terms of what they get for what they pay for, they're more informed consumers, so the nursing home industry as a whole is going to have to make a lot of changes in terms of what we provide and what's the standard out there.

This participant went on to discuss how nursing homes will likely need to have all private rooms and private bathrooms to accommodate this generation. Another participant made a similar comment regarding the esthetics of the nursing home:

I do think that expectations will be higher, which isn't a bad thing. I don't think it's a bad thing. I also think it's going to have an impact on the layout of the facility or even the rooms-designs. People... everybody's going to want a private room. They're going to expect, not to be waited on hand and foot, but they're going to expect a very high quality of care.

Several of the participants mentioned that consumers today have more options than they've ever had in the past allowing them to stay at home longer. One participant referenced that future nursing home residents will likely admit when they're much older and more chronically ill.

Discussion

The results from this exploratory study show strong support that social worker perspectives' of quality care in the nursing home setting does compare to quality standards identified in the Minnesota Nursing Home Report Card and Nursing Home Compare. The participants' perspectives do not completely coincide with all factors on one report card over the other. The main quality identified related to resident centered care and quality of life, which is a component of the Minnesota Nursing Home Report Card (Minnesota Department of Human Services, 2013). The participants stressed the importance that residents feel that they are being heard, that they're able to make choices and most importantly ensuring that their psychosocial needs are being met. When participants identified factors associated with poor quality of care, two of the participants discussed the Nursing Home Compare quality indicator of facility acquired wounds, which was found as an indicator of poor quality care in the literature review (Mukamel et al., 2008; Rantz et al., 2009; Flynn et al., 2010). Rantz et al. (2009) described the twelve most influential quality indicators to effect quality of care practices, which included stage 1-4 pressure ulcers.

All of the participants we're in agreement that adequate staffing ratios and staffing retention plays is an important factor in being able to provide good quality care. Staffing ratios for nursing homes are reflected on Nursing Home Compare and staffing retention is reflected on the Minnesota Nursing Home Report Card. Previous studies have shown that appropriate staffing levels can reduce the care loads, which allows for staff to provide better care than understaffed nursing homes (Schnelle et al., 2004; Park & Stearns, 2009; Bowblis, 2011; Harrington et al., 2012; Spilsbury et al., 2011). Two of the participants in this study did highlight that the quality of the staff is equally as important as the staffing ratios. The theme identified in this study based on participant responses regarding staffing ratios and retention showed that if there is inadequate staffing ratios and lack of retention it leads to staff burn out. One participant reflected:

The higher the ratios the better for staff, because they're not going to have staff burn out and staff can get to know each of the residents individually and be preventative with their care.

Although, the role of leadership in the nursing home is not benchmarked as a quality indicator in either report card all of the participants did agree that leadership, defined as Nursing Home Administrator and Director of Nursing, plays an integral role in supporting direct care staff. When leadership is present and supportive of their staff it creates a positive environment, which in turn leads to better quality care. Two studies identified in the literature review demonstrated the impact leadership has on increasing quality of care (Havig et al., 2011; Castle & Decker, 2011). Castle's study showed that the leadership style consensus manager, defined as allowing employees to give input before making decisions and encouraging team decisions, positively impacted quality of care (2011). The participants identified similar attributes in leadership styles indicating that leaders should be involved, visible, and supportive allowing for staff to have feelings of empowerment.

Another focus of this study was to assess social workers awareness and use of either report card. Castle (2009) noted that there may be a lack of awareness or use from discharge planners regarding either report card. This study showed that seven out of eight participants were familiar with both report cards, however only one participant suggested that they used the report card as a tool for consumers when selecting a nursing home. All participants who were aware of either report card were strong to suggest that report cards should be used as one tool for consumers when looking for nursing home placement. The participants recommended consumers tour nursing homes of interest and use local resources such as: The Senior Linkage Line, Care Options Senior Care Guidebook and local county and state offices.

Two studies identified in the literature review evaluated the report cards implementation having an effect on facilities striving to enhance their performance (Grabowski & Town, 2011; Mukamel et al., 2008). Seven out of eight participants identified using data on either report card

to evaluate their facilities scores. Three of the participants discussed reviewing their report card score at monthly quality assurance meetings to evaluate areas for improvement. This study shows that report card data does have an influence on facilities evaluating and using the data to improve care quality.

Findings from this study show that social workers' perspectives of quality care can be compared to the indicators identified on the Minnesota Nursing Home Report Card and Nursing Home Compare. The quality indicators that the participants identified with in relation to the Minnesota Nursing Home Report card include: resident satisfaction and quality of life and staff retention. The quality indicators that the participants identified with in relation to Nursing Home Compare included: staff ratios and the quality indicator regarding pressure ulcers. Providing individualized resident centered care was the highest ranked factor attributing towards good quality care from the participants' perspectives. Participants also agreed that leadership, which is not a report card indicator, plays a role in facilities providing good quality care.

Implications for Social Work Practice

It's important for social workers in the nursing home setting to be aware of the intentions of Nursing Home Compare and the Minnesota Nursing Home Report Card. The purpose of both report cards is to inform consumers about quality indicators in the nursing home setting, as well as to have facilities strive to improve care quality. Social workers need to understand the history of poor quality care in the nursing home setting in order to effectively advocate for current nursing home residents.

Social workers play a key role in the nursing home setting to ensure that a resident's needs are being met, so they can have the highest achievable quality of life possible. This research study allows for social workers to be aware of the importance of addressing questions, concerns and treating resident's individually. It also allows social workers to be aware of the

importance of not only advocating for resident rights, but also advocating for direct care staff. The study shows the positive impact direct care staff can have on quality of care if they are supported and working in an environment where they're allowed to be a part of team decisions. Inadequate staffing ratios and lack of retention leads to staff burn out; therefore, social workers can play a key role in supporting direct care staff by providing education regarding self-care, as well as advocating for appropriate staff ratios. Being that nursing homes set their standards based on federal and state guidelines mandated by the Centers for Medicare and Medicaid Services social workers need to be aware of the policies and procedures that have a direct impact on quality of care.

Implications for Policy

Policies implemented on the state and federal level directly impact the care that is provided in U.S nursing homes. The quality of nursing home care has been a significant policy issue for several years, as poor quality of care continues to be an endemic problem in many of the U.S nursing homes. The passage of the Nursing Home Reform Act in 1987 has paved the way to raise minimum quality standards and strengthen federal and state oversight (Park & Stearns, 2009). Even with the advancements that have been made to nursing home quality, there is still room to improve. This research study shows the positive impact appropriate staffing ratios has on increasing retention, reducing staff burn out and providing good care quality. Good care quality meaning providing resident centered care that is specific to each resident.

In order to impact staffing ratios and retention advocacy needs to start on the state and federal level. State and federal policies set the staffing standards and reimbursement rates through Medicare and Medicaid. There are a couple of important factors to consider in relation to staff ratios and retention in the nursing home setting. The first factor is to ensure that staff feels they are supported and not overworked. The second factor is ensuring that direct care staff is paid

adequately. Our elders who reside in nursing homes deserve to be treated with dignity and respect so they can experience the best quality of life possible; therefore, nursing home professionals should advocate on a federal and state level for staffing standards and reimbursement rates to be increased.

Implications for Research

The results from this exploratory study show that social work perspectives' of quality care in the nursing home setting does compare to quality standards identified in the Minnesota Nursing Home Report Card and Nursing Home Compare. The indicator the social workers' identified with the most was resident satisfaction and quality of life. Being that there is minimal research regarding social work perspectives of quality care in the nursing home setting further research is needed to fully understand their perspectives.

Strengths and Limitations

Strengths of this study include the qualitative nature, which allowed for deeper meaning from nursing home social workers who have direct experience working with residents in the nursing home to assess their perspective of quality care. Nursing home social workers are generally an integral part of the care team to ensure a resident's psychosocial needs are being met, which often is affected by their care quality. Limitations of this study include the lack of past research regarding social work perspectives of quality in the nursing home setting to cross compare with the participants' perspectives. The findings of this qualitative study provided deeper meaning; however, the results cannot be generalized to solely answer the research question due to participant size and demographic location they're selected from. This study assessed Minneapolis and St. Paul metro area social work perspectives' and did not encompass rural area nursing home social work perspectives.

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Appendix A

Phone Script

Hi, my name is Nicole Leasure. I'm a graduate student at the University of St. Thomas and St. Catherine University working towards my master's degree in social work. I'm contacting you because I'm working on a clinical research study to evaluate social work perspectives of quality in nursing homes compared to the Minnesota Nursing Home Report Card and Nursing Home Compare. My study is under the supervision of my research chair Rajean P. Moone. I'm utilizing a qualitative design for this study. The interview will consist of open ended questions which will take approximately 60 minutes to complete. The interview can be conducted in a confidential area of your choice. The interview will be audio recorded for transcription purposes. All information obtained will be kept confidential and secured. If you're interested I can provide you with the consent form to review and I will answer any questions you may have.

Appendix B

CONSENT FORM
ST. CATHERINE UNIVERSITY/UNIVERSITY OF ST. THOMAS
SCHOOL OF SOCIAL WORK

Social Worker Perspectives of Quality in Nursing Homes

I am conducting a study about social workers perspectives of quality in nursing homes. I invite you to participate in this research. You were selected as a possible participant because you are a social work professional who works in a nursing home in the Minneapolis/St. Paul Metro. Approximately eight nursing home social workers will be interviewed for this study. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Nicole Leasure, a graduate student at the School of Social Work, College of St. Catherine/University of St. Thomas and chaired by Rajean P. Moone, Ph.D.

Background Information:

The purpose of this study is to assess if social workers perspectives of quality in the nursing home setting are similar to quality indicators identified by Nursing Home Compare and Minnesota Nursing Home Report Card. Nursing Home Compare was established in 1998 by the Centers for Medicare and Medicaid Services to improve consumer information regarding nursing home quality. The Nursing Home Compare reports data on various dimensions of quality, such as; size, ownership status, location, staffing and quality indicators. Similarly, Minnesota Nursing Home Report Card reports on quality measures including; resident satisfaction and quality of life, quality indicators, hours of direct care, staff retention, use of temporary nursing staff, proportion of beds in single bedrooms, and state inspection results.

Procedures:

If you agree to be in this study, I will ask you to participate in a face to face qualitative interview that will be audio-taped. The interview will include fourteen questions regarding your perspectives of quality in the nursing home and factors that may contribute towards either good or poor care quality. The interview will take approximately 60 minutes and will occur in a public confidential setting of your choice.

Risks and Benefits of Being in the Study:

Due to the discussion regarding different factors that may attribute towards good or poor care quality you may feel uncomfortable answering some of the questions if it relates to your facility. You are free to stop the interview at any point. There are no direct benefits for participation in this research.

Confidentiality:

The records of this study will be kept confidential. Research records, audio recordings, consent forms, transcripts and notes will be kept in a locked file in a secured area of my home. I will also keep the electronic copy of the transcript in a password protected file on my computer. I will delete any identifying information from the transcript. Audio recordings, consent forms, notes, and transcripts with any identifying information of participants will be destroyed no later than July 1, 2014.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be utilized.

Contacts and Questions

My name is Nicole Leasure. You may ask any questions you have now. If you have questions later, you may contact me at 612-868-6192. You may also contact the Chair, Rajean P. Moone, Ph.D., at 651-235-0346, as well as John Schmitt, IRB Chair, with the University of St. Catherine Institutional Review Board at 651-690-7739 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix C

Participant Interview Questions

1. How long have you worked as a social worker? What is your licensure/education level?
2. How long have you worked specifically in the nursing home setting, have you worked at other skilled nursing facilities?
3. What are your roles as a social worker in the nursing home setting at this particular facility?
4. How would you define good quality care in the nursing home setting?
5. How would you define poor quality care in the nursing home setting?
6. How does leadership, defined as nursing home administrators or directors of nursing, contribute to good or poor quality care?
7. How does staffing ratios contribute towards good or poor quality care?
8. How does staffing retention contribute towards good or poor quality care?
9. Can you describe a time when you utilized the Nursing Home Compare or the Minnesota Nursing Home Report Card?
10. What are your thoughts about Nursing Home Compare?
11. What are your thoughts about the Minnesota Nursing Home Report Card?
12. Has a client or family member ever brought up either report card in their decision to select a nursing home?
13. As a social worker what resources or knowledge do you provide residents and/or families with should they be looking at alternative nursing facility options or community resources?
14. What are your thoughts on the impact the aging population will have on nursing home quality and care?