Perceptions of Quality of Life and Agreement Among Residents, Staff, and Leadership in Nursing Homes

Dr. Kevin Hansen, Dr. Jennifer Johns-Artisensi, Dr. Doug Olson, Nathaniel Berg, and Kelsea Parker

Health Care Administration Program
University of Wisconsin – Eau Claire

Disclosure of Commercial Interests

- Drs. Hansen, Johns-Artisensi, and Olson are faculty members at the University of Wisconsin – Eau Claire Health Care Administration program. Mr. Berg and Ms. Parker are current students in the same program.
- Dr. Hansen serves on three committees for ACHCA, and works with AHCA/NHCA on their Silver Examiner development process.
- Dr. Hansen consults on the development of the new NABQSC, a Quality Star scoring system sponsored by ACHCA and NCAL.
- Dr. Olson consults with Pathway Health Services, Lake Hiawatha, MN.
- Dr. Johns-Artisensi works with the National Association of Long Term Care Administrator boards (NAB) as the Continuing Education Committee Co-chair.

Background

- Quality of life is defined in unique ways by different stakeholders.
- Differences in perceived QoL from residents, certified nursing assistants (CNAs), activity directors, social workers, nursing home administrators (NHAs).
- Research has shown perceptions of resident quality of life by staff cannot reliably replace resident perceived quality of life (Kane et al., 2005).
- Individually influenced (resident), not structural-based (facility).
- Quality of life, 5-Star ratings, and Artifacts of Culture Change.
- Nursing homes can influence quality of life by adjusting policies, practices, and their environments (Kane, 2003).
- Criticism of 5-Star ratings = more QoC rather than QoL.
- ACC tool is designed to measure consumer-centered change (Bowman and Schoeneman, 2004).
Background

- Associations between programs and practices
- Internal quality improvements and external quality assessments
- Studies involving the relationship of stakeholder agreement and quality ratings have not been reported
- Also, the relationships between perceived quality of life and facility quality ratings (i.e., 5-Star ratings from CMS, Artifacts of Culture Change scores from the CMS tool) have not been studied.

Study objectives

- Recognize key factors various stakeholders – residents, CNAs, activity directors, social workers, and NHAs – identify as contributing to “good” quality of life
- Identify common themes within stakeholder groups and compare similarities and differences between groups
- Explore the relationship between perceived quality of life from different stakeholders and facility’s various measures of quality

Rationale and hypotheses

Qualitative
- Accurately defining quality of life and sense of purpose
- Identifying categorical agreements between and within five (5) stakeholder groups

Quantitative
- Exploring the relationship between perceived quality of life and facility quality ratings
- Does stakeholder agreement correlate to 5-Star ratings from CMS?
- Are Artifacts of Culture Change total scores correlated to resident-rated quality of life?
- Can stakeholders’ perceptions of resident quality of life be used to predict facility’s CMS 5-Star rating?
Methodology

- Gathering data
  - Survey tool sent online to UWEC practicum sites
  - Qualtrics
- Sample demographics (N = 46)
  - 48% of sites were faith-based
  - 67% belonged to chain membership
  - 55% were non-profit or government-owned
  - Majority of respondents (66%) were female
- Respondents:
  - 138 each of residents and CNAs
  - 46 each of social workers, activity directors, and NHAs

Quantitative
  - Interviews with stakeholders, overall 5-Star rating, Artifacts of Culture Change scores
  - Measures of quality of life
    - Calculated quality score (QS) per building via Likert ratings
    - "Likelihood to recommend" rating
    - Quality of life rating
  - Tools (Excel and SPSS)
  - Analyses
    - Descriptives
    - Interrater reliability (Cronbach’s alpha) for agreement
    - Correlations (Pearson and Spearman)
    - Regressions

Qualitative
  - Defining “good” quality of life (QoL)
    - Do residents have good quality of life?
    - Contributors and detractors to QoL
  - Defining sense of purpose (SoP)
    - Do residents have a sense of purpose?
    - Contributors and detractors to SoP
  - Categorizing comments
    - Commonality and differences between/within stakeholder groups
  - Tools (Microsoft Excel and WordItOut)
### Results (Qualitative)

- Staff/resident relationships, autonomy and respect, and activities
- Quality of life vs. sense of purpose
- Quality of care
- Stakeholder perspectives
- Themes emerged
  - Contributory service to the community and emotional well-being
- Routines
  - Perceived as both negative and positive
  - Importance of tailoring routines to preferences

#### Results (Qualitative) – Quality of Life

<table>
<thead>
<tr>
<th>First</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
<th>Fifth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>Staff and Resident Relationships</td>
<td>Autonomy and Respect</td>
<td>Sense of Community</td>
<td>Food and Drink</td>
</tr>
<tr>
<td>CNAs</td>
<td>Activities</td>
<td>Staff and Resident Relationships</td>
<td>Autonomy and Respect</td>
<td>Sense of Community</td>
</tr>
<tr>
<td>ADs</td>
<td>Quality of Care</td>
<td>Staff and Resident Relationships</td>
<td>Autonomy and Respect</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>SWs</td>
<td>Staff and Resident Relationships</td>
<td>Quality of Care</td>
<td>Activities</td>
<td>Comfortability and environment</td>
</tr>
<tr>
<td>NHAs</td>
<td>Staff and Resident Relationships</td>
<td>Quality of Care</td>
<td>Activities</td>
<td>Comfortability and environment</td>
</tr>
</tbody>
</table>

#### Results (Qualitative) – Sense of Purpose

<table>
<thead>
<tr>
<th>First</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
<th>Fifth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>Sense of Community</td>
<td>Activities</td>
<td>Staff and Resident Relationships</td>
<td>Autonomy and Respect</td>
</tr>
<tr>
<td>CNAs</td>
<td>Activities</td>
<td>Autonomy and Respect</td>
<td>Quality of Life</td>
<td>Staff and Resident Relationships</td>
</tr>
<tr>
<td>ADs</td>
<td>Activities</td>
<td>Sense of Community</td>
<td>Autonomy and Respect</td>
<td>Staff and Resident Relationships</td>
</tr>
<tr>
<td>SWs</td>
<td>Activities</td>
<td>Quality of Care</td>
<td>Autonomy and Respect</td>
<td>Staff and Resident Relationships</td>
</tr>
<tr>
<td>NHAs</td>
<td>Activities</td>
<td>Sense of Community</td>
<td>Autonomy and Respect</td>
<td>Contributory service to the community</td>
</tr>
</tbody>
</table>
Results (Quantitative)

- Nursing homes with high levels of agreement
  \( n = 17 \) or 35.4%
- No correlation found between a site's 5-Star rating and the Calculated Quality Score (QS)
- Agreement about low quality didn't change this
- Inflated/deflated scores with smaller sample size
- Artifacts of Culture Change (ACC) scores and alignment with resident QoL
- Predictive: Higher ACC = Higher QoL scores
- Stakeholder QS and overall 5-Star rating
- Only resident and CNA scores (QS) predicted a 3-star rating or less
- No correlation
- Profit status and resident QS scores
- Profit status and overall 5-Star ratings

Results (Quantitative)

Facility QoL Ratings as a Function of Facility QS

As the calculated QS score increased, so did resident self-reports of QoL, validating the study’s proxy measure.

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Residents</th>
<th>CNAs</th>
<th>ADs</th>
<th>SWs</th>
<th>NHAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>3.17</td>
<td>3.17</td>
<td>3.17</td>
<td>3.17</td>
<td>4.13</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>4.13</td>
<td>4.12</td>
<td>4.13</td>
<td>4.13</td>
<td>4.13</td>
</tr>
</tbody>
</table>

*As the calculated QS score increased, so did resident self-reports of QoL, validating the study’s proxy measure.
Conclusions

• Across the board, nursing home leadership (NHAs, social workers, and activities directors) rated quality significantly higher than residents.

• Residents are often the ultimate determiners of quality, however.

• CNAs may be the best proxies for resident preferences and evaluations of care and quality, where residents are unable to communicate directly.

• NHAs should communicate more with residents and CNAs, as these two stakeholder groups more aligned with each other, but were well aligned with what leadership thought was important to residents.

Conclusions

• Importance of staff/resident relationships to QoL.

• Residents also valued peer relationships and a sense of belonging within their care community.

• NHAs should work to create a culture that cultivates these relationships.

• Nursing home leadership members who work on feedback of resident care; they rated staff/resident relationships important.

• Higher resident-centered care within the ACC resulted in higher resident QoL.

• Impact of resident QoL with new survey process.

• Study results affirmed other research that resident-centered care contributes to a higher QoL.

• Importance of nursing home administrative leadership roles.

Acknowledgements

• Health Care Administration Program Practicum Students/Sites.

• Center for Health Administration and Aging Services Excellence (CHAASE)

• University of Wisconsin – Eau Claire Office of Research and Sponsored Program.

• University of Wisconsin – Bay Campus Learning and Technology Services.