LAKEHEAD UNIVERSITY

PRIMARY NURSING AS A POTENTIALLY HUMANIZING INNOVATION IN NURSING HOME CARE

BY

LINDA PISCO ©

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF ARTS

DEPARTMENT OF SOCIOLOGY

THUNDER BAY, ONTARIO

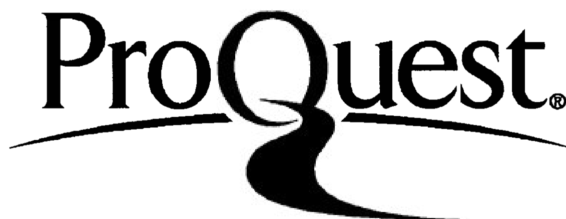
FALL, 1990

ProQuest Number: 10611351

All rights reserved

INFORMATION TO ALL USERS
The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript
and there are missing pages, these will be noted. Also, if material had to be removed,
a note will indicate the deletion.



ProQuest 10611351

Published by ProQuest LLC (2017). Copyright of the Dissertation is held by the Author.

All rights reserved.
This work is protected against unauthorized copying under Title 17, United States Code
Microform Edition © ProQuest LLC.

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

National Library of Canada

Bibliothèque nationale du Canada

Canadian Theses Service

Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-63189-9

Canada

Abstract

In four months of observation at Stafford House, an attempt was made to discover whether or not residents were receiving "humanized" care and if so, if this humanization was a result of, or was enhanced by, the implementation of the primary nursing method. After a tortuous analysis of field notes, what became clear was that there was no obvious pattern of humanization. Although there were numerous examples of humanizing resident care (i.e. shared decision making, freedom of action, etc.) there were just as many instances of dehumanization. The lack of a clear pattern was disturbing and frustrating. If primary nursing was a structural attempt to humanize patient care, and if it was being implemented by all nursing staff, and with all residents, why wasn't there a clear pattern emerging? Instead, repeated analyses of field notes revealed a seeming randomness of humanization.

This finding may appear to indicate that primary nursing is not an innovation which humanizes health care. That is not necessarily the case. This thesis puts forth the argument that theoretically primary nursing can be a humanizing intervention within the parameters outlined by Howard (1975). The reason for its lack of success at Stafford House would appear to be a result of a number of factors. External constraints (ie inadequate funding, government regulation etc.) were combined with a faulty, and unrealistic interpretation of what primary nursing is and how it can be operationalized. Individual actors are forced to act within an organizationally and individually imposed structure which is itself dehumanizing.

ACKNOWLEDGEMENTS

This thesis would not have been possible without the assistance of many individuals. I would like to thank the Administration of Stafford House for allowing me entry into their nursing home and for encouraging research. The Director of Nursing was especially supportive of the research project and contributed immensely by giving of her time in extensive interviews and by giving continual support and encouragement to me while I conducted research. The staff (primary nurses, health care aids, and recreation staff) were invaluable. They allowed me to "shadow" them in their day to day work and put up with my numerous questions. As well, I wish to thank the nursing home residents who welcomed me into their "home", answered my questions and voiced their ideas and concerns.

The completion of this thesis is due in large part to the continued support, patience and encouragement of my advisor, Dr. J. D. Stafford. I thank you for your guidance throughout this project. Dr. C. H. Nelson acted as committee member and her enthusiasm and suggestions regarding participant observation were appreciated. Dr. J. Aronson served as external examiner and provided valuable comments and suggestions.

TABLE OF CONTENTS

PAGE

CHAPTER ONE - INTRODUCTION AND LITERATURE REVIEW

1.1	Introduction	1
1.2	Demand for Institutional Care	4
1.3	Positive and Negative Aspects of Institutional Care	6
1.4	Humanization	9
1.5	Nursing Modality as an Element of Humanized Health Care	12
1.6	Humanized Primary Nursing Using a Mixed Staff Approach	15

CHAPTER TWO - METHODOLOGY

2.1	The Research Setting	21
2.2	Participant Observation as Research Methodology	22
2.3	Entry and Data Collection	24

CHAPTER THREE - DATA ANALYSIS

3.1	Philosophy of Primary Nursing at Stafford House	30
3.2	Nursing Staff Patterns at Stafford House	33
3.3	The Structure of Nursing Activities	35
3.4	Differential Valuation of Team Members	39
3.5	Food Service as an Example of Dehumanization	44
3.6	Resident Care Conferences: A Potential Humanizing Process Goes Unrealized	48
3.7	Summary and Discussion	51

CHAPTER FOUR - CONCLUSION AND RECOMMENDATIONS

4.1	Conclusion	53
4.2	Recommendations	56

END NOTES 57

REFERENCES 61

APPENDICES 66

LIST OF FIGURES

		PAGE
FIGURE 1	Primary Nursing Using a Team Approach	16

CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

1.1 INTRODUCTION

Canada's population is aging and with this aging comes an increase in the demand for institutional care. Extensive research has focused on both positive and negative aspects of institutionalization and methods of improving the quality of institutional care. (Goffman, 1961; Swain and Harrison, 1979; Myles, 1979; Penning and Chappell, 1980; Clough, 1981). While there is much debate over what constitutes "quality care" increasingly researchers are focusing on those approaches that address the psycho-social needs, or humanization needs, of residents of long term care facilities (Kahana, 1973; Kalson, 1976; Brearly, 1977; Bowker, 1982). One of the most clearly articulated concepts of humanization is Howard's (1975) examination of humanization and dehumanization in health care. Howard proposes eight conditions necessary for the humanization of health care (See Literature Review Section). This research used Howard's concepts to evaluate the humanizing potential of one particular model of nursing delivery (primary nursing) in a long term care setting.

The research problem was developed from a four month participant-observation study in one Ontario nursing home. This particular nursing home (Stafford House) had implemented a number of innovations in long term care delivery - building design, nursing method etc. - in an attempt to improve the quality of care. Some of these innovations were being suggested as models for others to follow (New Democratic Party, 1984) in spite of the fact that none of these innovations had been evaluated in terms of their efficacy.

Horn and Griesel (1980, p. 114) argue that innovative roles and programs must become the rule rather than isolated examples. This is debatable. As Mangen and Peterson (1984,p. 6)

pointed out, there is a recognition that social innovations may yield undesirable consequences. Before we, as a society, commit scarce resources (money, staff, space, etc.) to programs it is imperative that we evaluate the impact of those programs. Many innovations may "appear" to be humanizing. However, as Bowker (1982, p. 5) states in his study of four nursing homes, "...the label affixed to a given program department was not a dependable indicator of the humanizing social-interaction content of the program." The purpose of this research was to evaluate one innovation - primary nursing - as it was being implemented at Stafford Nursing Home. Was this innovation humanizing?

Evaluation is more than determining the degree to which a planned program achieves the desired objective (Goldbert and Connelly, 1982, p. 12). Evaluation research attempts to assess the conceptualization and design, implementation and utility of social intervention programs (Rossi and Freeman, 1982). As stated earlier, it is important to evaluate innovations because they are almost be definition experimental. They are an attempt to produce change. Evaluation is an effort to determine the effects of innovation, to document as carefully as possible what transpired (Lehman, 1975, p. 492).

To this end evaluation of primary nursing at Stafford house was done using a qualitative approach. "Qualitative methodology refers to those research strategies such as participant-observation...which allow the researcher to obtain first hand knowledge about the empirical world in questions" (Filstead, 1970, p. 6). Earlier quantitative approaches to program evaluation equated evaluation with verification of specific program effects (Broadhead, 1980). Later researchers realized that programs could have many effects (some of them unsuspected) and therefore evaluation had to focus on discovery rather than verification (Reichardt and Cook, 1979). Because qualitative methods emphasize discovery their use in program evaluation has been gaining support.

Broadhead (1980, p. 25) gives three arguments for the use of a qualitative approach to program evaluation. Firstly, it is largely non-reactive with the program being evaluated. Secondly, it would bring into relief much of the distrust and anxiety that arise during program evaluation. And finally, it "...would direct evaluators to the multiplicity of goals, processes, problems and consequences of any given program."

This research adds to the long term care and nursing theory literature by applying Howard's concept of humanization to a particular model of nursing. Humanization is operationalized in terms directly applicable to the implementation of primary nursing. This operationalization identifies particular actors and defines specific role behaviours that are necessary for a humanizing practise of primary nursing.

The data analysis indicates that primary nursing, in this instance, was not a humanizing innovation. The reason for it's lack of success at Stafford House would appear to be the result of a number of actors. External constraints (ie. inadequate funding, government regulation, etc.) were combined with a faulty, and unrealistic interpretation of what primary nursing is and how it can be operationalized. Individual actors were forced to act within an organizationally and individually imposed structure (the specific operationalization of primary nursing) which itself is dehumanizing. The implementation of a dehumanizing structure does not encourage humanizing practise.

The research findings indicate the importance of evaluating program innovations., Primary nursing does hold the potential for humanizing health care within the parameters outlined by Howard (1975). But the potential, if it is to be realized, requires specific philosophical and structural support and particular role behaviours from the various actors.

1.2 DEMAND FOR INSTITUTIONAL CARE

Canada's population is aging. The 65+ segment of the population will increase from 9.7% of total population in 1981 to a projected 11.5% in 2001 and to an even higher 19.5% in 2051 (Denton and Spencer, 1980). This aging of our population will not necessarily provoke a crisis,[1] social or economic, in our society. However, it will have important implications for services such as education, pensions, and of particular import to this paper, health care.

The impact on health care becomes more apparent when examining the internal characteristics of the 65+ group. Land and Shelton (1982) estimate that between 1976 and 2031 the (65-74) group will increase by 184% or 2.3 million persons, the (75-84) group will increase by 245.2% or 1.4 million persons and the (85+) group will increase by 238.2% or .4 million persons! The dramatic increase in the older segment of the 65+ population is of special import. It is this group that is more vulnerable to social and functional disabilities requiring long term care (Brody, 1977, p. 18). Members of this group often have a chronic illness and require nursing care. These individuals are most often widowed women. Their children, if they have any, are often in late middle age themselves and may be physically unable to provide the necessary nursing care. Family members may also be limited in their ability to provide assistance due to geographic location or job responsibilities (Brearly, 1977, p. 5). Community support services are often limited and as a result there is,

> no real alternative to institutionalization when the service needs of an older individual have reached a scope and complexity that can no longer be economically or logistically served in the community itself (Gaynes, 1973, p. 279).

The rates of institutionalization are a highly debated topic. Some researchers cite rates as low as 4-5% (Brody, 1977). Palmore (1976) using the Duke Longitudinal Study estimated that the chances of the aged being institutionalized is as high as one in four. Spasoff and Kraus (1978)

estimate rates of institutionalization in Canada from a low of 10% for the population 65+ to a high of 38% for the population 85+.[2]

Despite debates over the precise rates of institutionalization all researchers are in agreement that the demand for long term beds is increasing. Part of the increase in demand for institutional care is artificially created by availability of government funds for the provision of this type of care and the lack of funding for community based alternatives.[3] In spite of this artificially created demand there is a real increasing need for institutionalized care due to the dramatic increase in the number of frail older persons. In providing these services it is important to "... identify for whom long-term care is appropriate and to determine the nature of services and the qualities of the environments that would maximize their well being" (Brody, 1977, p. 22). This concern with the quality of institutional life becomes even more critical when one realizes that institutionalization is often very lengthy. Brody (1979, p. 46) found that "nearly 1/3 of the residents of nursing homes live in those facilities for 1 to 3 years, and an additional 1/3 do so for 3 or more years."

1.3 POSITIVE AND NEGATIVE ASPECTS OF INSTITUTIONAL CARE

Institutionalization is often perceived in very negative terms. Goffman (1961) described institutions in terms of their totality. He defined a total institution as

> a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable length of time together lead an enclosed, formally administered round of life.

Life in a total institution is regimented and controlled. Goffman included nursing homes in his definition of total institutions. Swain and Harrison (1979) used Goffman's model in their study of an Australian nursing home and concluded that negative behaviour of residents (dependency, apathy etc.) could be traced to the institutional structuring of the dependent role. They felt that "no program which perpetuates the institutional model in terms of staff-inmate interaction can provide a genuine solution" (p. 282) to the development of this dependency. Dudley and Hillery (1977) found that residents in homes for the aged had the highest score on alienation and conditional freedom as compared to other institutions. Thomas (1981) concluded that larger institutions resulted in dependency of residents, and a decrease in the personal dignity and abilities of residents. He attributed this to unsuitable building design, rigid routines and distancing between staff and residents. Brody (1977) found that for many resident institutionalization was a negative experience. Staff often found it easier to do things for the resident than to have residents do things for themselves. Drugs and restraints were often used and diets were rigidly controlled. And finally, Clough (1981) found that residents in many institutions maintained little control over their lives and that privacy was minimal.

In spite of these negative features Clough emphasizes that it is also necessary to look at positive aspects of institutionalization otherwise we will be guilty of perpetuating what he terms the "myth of the evil institution" (1981, p. 47). He offers a typology of old age institutions which incorporate the degree of control of lifestyle by the resident with the model of aging (activity,

disengagement, socio-environmental) which characterizes the institution. Penning and Chappell (1980) also conclude that institutions may be good or bad. They suggest a multi-dimensional approach which emphasizes personal independence and informal social interaction as the best predictors of "perceived well being" of institutionalized elderly. Myles (1979) found that institutionalized elderly have higher levels of social interaction and greater satisfaction from social relationships than the elderly in the larger community.

Following a review of the literature, Kart and Manard (1976, p. 254) concluded that "quality" old age institutions were non-proprietary, relatively small in size, wealthy in resources, sociable and had a staff with positive attitudes towards residents. Thomas (1981) felt that quality of life in nursing homes was dependent on variables such as staff attitudes towards residents and the extent and flexibility of rules and routines. Eustis and Patten (1984) put forward the following measures of effectiveness of long-term care - freedom of choice, perceived freedom, control, social integration and socialization. Brody (1979) found that the residents improved when they went to institutions that

> encouraged control over his or her life to the fullest extent possible, fostered personalization (offered privacy and respect), did not foster dependency but encouraged the individual to do for himself, fostered community integration (access to the outside world) encouraged social interaction and self expression... (p. 48)

Despite variations in definition of what constitutes quality care, what is clear in almost all research is that improvements in institutional care must be based on a recognition of the psycho-social needs of residents. An individual who requires assistance in meeting his basic health and safety needs does not cease being a "human" being with very real social or "human" needs. To this end gerontological literature and nursing home reform have begun to focus on ways to improve the quality of institutional life by attempting to meet the humanization needs (autonomy, shared decision making, social interaction etc.) of residents (Geiger, 1975; Moss, 1976; LaMonica, 1979;

Nicholson, 1979; Turner and Mapa, 1979; Penning and Chappell, 1980; Clough, 1981; Bowker, 1982; Boling, 1983).

1.4 HUMANIZATION

Humanization is a fairly new concept in the analysis of nursing home care. In 1973, Kahana stated that there were few studies of the quality of life in nursing homes along humanistic lines. However she pointed out that ..."there is a reawakening (sic) concern for the distinctively human and individual problems of the institutionalized person, above and beyond the technical quality of services" (Kahana, 1973, p. 282). She did not define humanization but stated that it included the concepts of integration, goal setting and self-actualization. Humanization required consideration of the individual needs of the resident, the need to involve the resident in creating a human environment, and the importance of staff and volunteers in the humanization of nursing home care.

Kahana's concern with humanization has been pursued by other researchers. Brearly (1977, p. 32) felt that residents needed decision making opportunities (to achieve personal integrity through feelings of control and self direction), opportunities for choice, independence, treatment with respect and dignity and finally, privacy.

Kalson (1976) examined humanization in his study of volunteer service by nursing home residents to others as a way of improving the quality of social interaction and counter-acting the loss of esteem in old age. He argued that a great deal of the loss experienced by the institutionalized aged was related to the fact that they are in an almost totally dependent role. He felt that the opportunity to give was crucial to a feeling of usefulness and a positive self-concept.

Dudley and Hillery (1977) emphasized the need to consider the structural characteristics of institutional living arrangements which lead to their residents' feelings of alienation and deprivation of freedom or dehumanization. This consideration is implicit in the recommendations

of Swain and Harrison (1979). These recommendations included flexible routines, provision of individual privacy and autonomy for residents, and consideration of residents as individuals.

Research on humanization of nursing homes has also included their physical design. Hiatt (1978) pointed out that recent approaches to humanizing geriatric institutions involved designing a "homelike" atmosphere. The physical design of the building could also provide residents with more control over their own lives - sinks at wheelchair level, doors light enough to be opened by residents (Hiatt-Snyder, 1978).

In this research the concept "humanization" is based on Howard's (1975) conceptual view of humanization and de-humanization in health care. She proposed eight conditions necessary for the humanization of health care. "Increasing values on these eight dimensions increases humanization of nursing home residents, and decreasing values on these dimensions decreases their humanization" (Bowker, 1982, p. 2). These eight dimensions are:

1. Inherent worth. Human beings are objects of value, to themselves if not to others...if persons are forced to prove their worth they are not accepted prima facie as fully human. The concept of inherent worth blends with notions of equality.

2. Irreplaceability. We are unique and irreplaceable. When people are stereotyped and treated in commonalities rather than differences dehumanization can logically follow.

3. Holistic selves. At any given moment the sum total of a person's experience influences that person's feelings, attitudes and actions. The patient's "whole" may be so fragmented that his or her problems become exclusive concerns of multiple practitioners who do not even communicate with one another.

4. Freedom of Action. Humanized relationships are predicated on freedom of choice...Humanized persons have considerable control over their destinies. They are not merely objects of action.

5. Status Equality. Humanized relations involve equals on some level. If either sees his or her total self as superior or inferior to the other, the interaction cannot be fully humanizing because participation of "lesser persons" destroys its human-to-human quality.

6. Shared decision making and responsibility...all patients...have a right and perhaps a duty to participate as much as possible in decisions about their care. Analogously, professionals and semi-professionals whose lives are increasingly controlled by large institutions are struggling for decision making power...If patients share in decision making about their care, they are essentially partners of providers and thus, in a way, their equals.

7. Empathy. Humans have the ability to sympathize (sic) and identify with others...if practitioners avoid seeing the world from the vantage point of their patients, they cannot as readily understand the needs of those patients and appropriately respond to them as unique human beings.

8. Positive affect...Person-to-person interactions are most likely to involve emotional commitments because reciprocity and empathy can occur. (Howard, 1975, pp. 73-84).

This conceptual view of humanization was used by Bowker (1982) in his study of four nursing homes in the U.S. His research which used resident humanization as the dependent variable "suggested a causal chain running from medical-model treatment dominance through institutional totality to resident dehumanization." (Bowker, 1982, p. 79).

1.5 NURSING MODALITY AS AN ELEMENT OF HUMANIZED HEALTH CARE

Any attempt to humanize nursing home environments must, of necessity, examine the provision of nursing services. The nursing department is usually the largest and most powerful group in a nursing home (Bowker, 1982) and nursing staff most often are the ones with most direct contact with residents on a day-to-day basis. What they do and how they do it are critical elements in providing humanistic nursing care (Campbell, 1985; Sparkes, 1982; Singer-Edelson and Lyons, 1985; Johnston, 1987).

With the increasing awareness of the psycho-social aspects of nursing care some modalities of nursing (i.e. functional and team methods)[4] are coming under criticism. It is argued (Daeffler, 1975; Campbell, 1985) that these approaches to care do not allow for continuity of patient care. With most methods staff are task rather than patient oriented. Work becomes focused on instrumental activities (examining, diagnosing, treating) rather than expressive activities (explaining, reassuring, accepting (Daeffler, 1975). Staff may not work with the same patient from one shift to another resulting in fragmentation of service delivery. As well, the gap between nurse and patient increases. The nurse is increasingly responsible for administration and co-ordination and only limited skilled nursing activities (i.e. dispensing medications) while the nurses aides have primary responsibility for bedside, one to one contact with the patient.

Primary nursing seeks to address these problems and was first designed and utilized in Minnesota in the late 1960's (Ciske, 1968; Manthey and Kramir, 1970; Marram et al, 1970; Felton, 1975).

> Primary nursing is a system of nursing whereby each nurse is totally accountable for the care she delivers. This means she is responsible for a group of clients 24 hours a day, seven days a week... Each time she works she is assigned her group of primary clients and even when not working, her nursing care plan is followed. She uses various channels (i.e. kardexes, communication books, and notes) to communicate the care plan she has developed. (Raab, 1984, p. 23)

The nurse is a primary nurse for the patients assigned to her and an associate nurse when she cares for a patient whose primary nurse is off duty (Daeffler, 1975, p. 22). One advantage of primary nursing is the increase in contact between the patient and one nurse. This should result in better continuity of care as compared to other methods of nursing and "the presence of the same nurse on a day-to-day basis... facilitates a sense of trust and a feeling of freedom on the part of the patient to express feelings and concerns..." (Daeffler, 1975, p. 23).

The other advantage of primary nursing is in terms of accountability and responsibility for patient care. As a nursing method, Manthey (1988, p. 55) argues that the key to primary nursing is not so much who delivers the care but that the primary nurse's decisions are carried out by others in her absence - and that she is responsible for those decisions.

Although these two benefits are not mutually exclusive, the priority given to them determines how primary nursing is implemented. In emphasizing the contact between nurse and patient, primary nursing has been operationalized as in all R.N. staff with each nurse responsible for the total care[5] (i.e. medications, baths, bed making etc.) of a small number (i.e. 4-8) of patients. While working, the nurse may be acting as the primary nurse for those patients who's care plan she has designed and for which she is responsible, or she may be acting as an associate nurse - still carrying out direct patient care but following the care plan drawn up by another nurse. They key here is increased contact of nurses with patients.

However, one of the original designers of primary nursing, Manthey (1988), states that it is a myth that primary nursing requires an all R.N. staff. Because she emphasizes the element of responsibility, she argues that primary nursing can be operationalized using a combination of R.N.'s and aides. The primary nurse then designs and is responsible for the car of her patients but the direct care itself can be delegated to others - even when the primary nurse is present. If this staffing pattern is to work, then primary nurses must become managers with good team

building skills and communication skills. Other members of the team (associate nurses, R.N.A.'s etc.) must not only follow the care plan she has designed but regularly communicate information to her regarding her patients (i.e. physical changes, personal problems etc.).

Although primary nursing, using either approach, has been practised in various settings its use in long term care facilities is limited. Campbell (1985) argues that this is due primarily to the interpretation of primary nursing as meaning an all R.N. staff and this approach is not economically feasible in a long term setting. Government reimbursement rates are lower for long term care as compared to acute care. As well, because the physical needs of long term patients do not require such a high level of skilled nursing care[6], their needs could be met using lower salaried staff (health care aides, R.N.A.'s under the direction of a registered nurse. Campbell's study showed that this mixed staff approach in long term care can be effective in providing "individualized nursing care which will maximize human potential" (Campbell, 1985, p. 12).

1.6 HUMANIZED PRIMARY NURSING USING A MIXED STAFF APPROACH

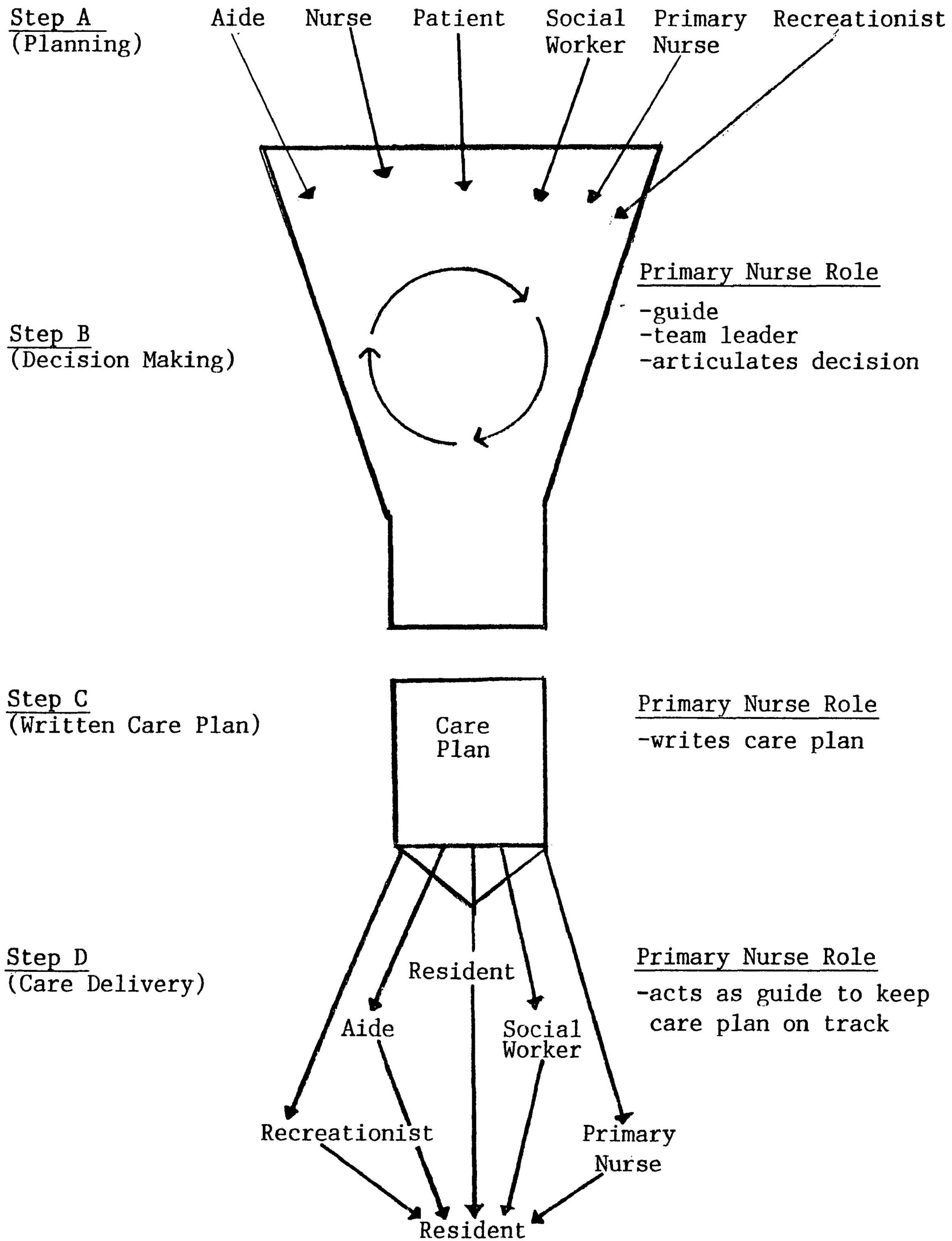
The humanizing potential of primary nursing using a "mixed staff" approach depends on an accurate understanding of the philosophical underpinnings and practical considerations that are necessary to make this method successful. The key is the interpretation, internalization and practise of the roles that the various actors (nurse, resident, health care aide etc.) play. (See Figure 1).

As Manthey (1988) says, the primary nurse in a "mixed staff" approach MUST become a manager. The skills that are most important in this role are her team building, communication and problem solving skills. Her patient care skills are equally important but they are played not by the primary nurse but by the nurse in her parallel role of "unit nurse."

The initial step, A (See Figure 1) in providing "humanized" primary nursing has to be a recognition that all participants patient, health care aide, recreationist, family member and nurse (in her dual roles of "unit nurse" and "primary nurse") - are equals. Each one has particular expertise or knowledge - based on skills, training, or familiarity with the resident - which must be taken into account and be recognized as "worthwhile." This legitimation of equality of all the participants in the care planning is a reflection of the inherent worth of each individual. This is important to the patient who will then receive the care, not as an "object" but as a "subject" who has been involved in the care planning. It is also critical for participants such as aides. As Howard (1975) points out, "for those on the bottom of the professional totem pole, being viewed as inherently worthy is vital to humanized treatment from patients as well as from colleagues" (p. 74).

The "unit nurse" actor at Step A is equal to all other actors. If in this role she is considered more important than the other actors and attempts to impose her perspective she then becomes a dehumanizing influence. The relationship of team members is no longer based on status

Figure 1. Primary Nursing Using a Team Approach



equality and "the interaction cannot be fully humanizing because participation of "lesser persons" destroys its human to human quality." (Howard, 1975, p. 78).

At Step A, the nurse in her role as "primary nurse" must act as a manager. This is where her team building and communication skills are important. She is responsible for gaining the participation of the other members of the team. Each member, because of the particular relationship s/he has with the patient, has particular knowledge of that person. If that knowledge is not shared it will be impossible to see or treat that person in a holistic manner. The result will be a fragmented approach and treatment of individual problems rather than treatment of individuals (Howard, 1975).

At Step B, the "primary nurse" also has specific responsibilities. By facilitating communication among team members, she takes the first step in developing shared understanding. By providing feedback to participants, and encouraging or teaching others to do the same, she begins the process of empathetic understanding - a key element in humanization. Empathy - the capacity to participate in anothers' ideas or feelings - displays an understanding of the world from the vantage point of the other. Without this, practitioners "... cannot readily understand the needs of (those) patients, and appropriately respond to them as unique human beings" (Howard, 1975, p. 85). Ideally, members of the team would develop this empathy not only to the patient, but the patient to the team members and team members to each other.

At Step B, case planning and problem solving is done using a team approach. The "primary nurse" acts as discussion leader - directing the process, keeping participants on track, sharing expertise, using her problem solving skills and summarizing decisions. The "primary nurse" articulates the group decision via a written care plan (Step C) tailored to the individual needs of the patient.

It is important that when the nurse acts in her role as "primary nurse" she does not sacrifice the important element of equality of participants. Others must not see her in a "superior" and themselves in "inferior" roles. She also must not see herself as superior, or act as superior, otherwise the process will become dehumanizing not only to her staff but to herself because of the reciprocity of action. To paraphrase Howard (1975) those who participate in dehumanizing interactions become dehumanized themselves in the process.

This does not mean that decisions are always arrived at by concensus. There may be times when team members disagree or when the "primary nurse" must impose her decision on others. The "primary nurse" as leader, in Step C, must accept responsibility and accountability for the care plan developed and so is the final arbiter. However, because this action is legitimized by her role as leader, the element of equality of members is not sacrificed. She has made the decision she thinks best based on the input of all participants.

Participation by team members in the decision making process should lead to ownership and support of the care plan and as a result continuity of care. The patient receives this care as "subject" because s/he has been involved in the decision making process. As well, as recipient of care, the patient should have the option of opting out of, or asking for modifications in, the care plan. Professional responsibility would require the "primary nurse" to inform the patient of the potential consequences (i.e. side effects, prognosis, etc.) but the final decision should be that of the patient.

In carrying out the care plan (Step D), the nurse acts in two roles. As "primary nurse" her job is to ensure continuity of care via other team members and to modify the care plan in light of new information. The nurse as "unit nurse," like all team members, will be guided in her actions by the care plan and is responsible for communicating (via communications books, shift reports, etc.) any new information that should be considered in the ongoing development of the care plan. All

team members in their interactions with the patient should be able to more easily empathize with the patient because of shared knowledge.

By emphasizing, and practising, the ideals of equality and individuality, team members become persons as well as role players (nurse, patient, etc.). This "person"alization is important in removing the "affective neutrality (which) is a defining characteristic of professionalism" (Howard, 1975, p.83). Following this, the door is open to person-to-person interactions which involve emotional commitments (positive or negative) from both persons.

The care plan and it's influence on all the team members is not static - once Stage D is reached the cycle begins again (A-B-C-D-A-B....), albeit in a less formal manner. Changes in the patients' needs which require modifications to the care plan may call for a formal case conference with participation of all team members. Minor changes can be made using routine channels of communication (i.e. kardex, chart notes, etc.).

This team approach is also to be used in the day-to-day management of the unit and as well in problem solving situations. The success depends in large part on the ongoing development of the team by the nurse in her role as "primary nurse."

As well as the humanization of behaviours of various role players, the successful implementation of a "team approach" to primary nursing requires a staffing structure which will support the "primary nurse" roles of manager and team leader. If these roles are to be carried out successfully they must be given priority over the role of primary nurse delivering direct patient care. This responsibility and also the responsibility for administrative, clerical, and social work tasks can be delegated if necessary, to other team members. In Felton's (1975) study the recognition and necessary priorization of these roles was accomplished by a staffing pattern which included: the primary nurse as team leader and manager; a unit nurse delivering skilled patient care, a ward clerk who carried out the ward clerical duties and administrative nursing support.

This arrangement allowed the primary nurse the necessary time to carry out her role as manager and team leader successfully.

At Stafford House primary nursing had been implemented using a mixed staff approach. The purpose of this research was to discover how primary nursing was operationalized and whether or not it was a humanizing innovation.

CHAPTER TWO

METHODOLOGY

2.1 THE RESEARCH SETTING

Stafford House is a 108 bed, non-profit, church sponsored nursing home. The nursing home delivers primarily extended care [7] to its residents. There are 8 single rooms, 20 two-bed rooms and 20 three-bed rooms. The daily charge varies accordingly. "In each case the Ontario government pays the extended care benefits and the resident is responsible for paying the remainder" (Forbes et al, 1987, p. 29).

The nursing home is located in a semi-residential area and it occupies the second and third floors of a modern complex. Each room has a four piece bath. In addition, there is centralized handicapped bathing facilities. There is a small lounge (i.e. sun room) in each single room and between triple and double rooms. Dining areas with an adjacent kitchenette, are located on each floor as are lounges, recreation areas and small laundry rooms.

The main floor and basement area of the building house administration offices, a dentist's office, beauty salon, chapel and a wide variety of therapeutic and support services. Most of the services are available to, and utilized by, community members as well as by resident of Stafford House.

Attached to the community complex is a 180 unit apartment building. The design (i.e. mix of services) was used to promote interaction of all age groups in an attempt to avoid the development of an "old age ghetto."[8]

2.2 PARTICIPANT OBSERVATION AS RESEARCH METHODOLOGY

The choice of participant observation as a methodology was primarily determined by the research topic. How was primary nursing operationalized and as an innovation, was it a humanizing intervention?

The nursing modality employed (primary nursing) was identified preliminarily to the study as being an innovative approach to nursing home care. The use of participant observation would allow the researcher an opportunity to understand how this innovation worked and how it affected the day-to-day lives of residents. At the same time the methodology would allow the researcher to be open to other aspects of care delivery which may or may not be supportive of humanization.

The usefulness of participant observation as a methodology in the study of aging and institutionalization is well known. Goffman's (1961) classic study of mental institutions used participant observation in an attempt to learn about the subjectively experienced world of the hospital inmate. Henry (1963) used participant observation to study dehumanizing environments as they affect the aged patient. His study along with those of Gubrium (1975), Swain and Harrison (1979), Clough (1981), and Sparkes (1982) have shown the value of participant observation in analyzing the social structure of nursing homes. The use of participant observation to study humanization has been recommended implicitly (Kahana, 1973) and explicitly (Bowker, 1982).

This methodology allows the researcher to get first hand knowledge about the area in question - you see behaviour as it is, not as it is reported. An extended presence in the field also allows research (overt or covert) of delicate areas - private as well as public behaviour may become accessible. Some respondents may become "...informants who instruct the investigator in the intricacies of their personal and social worlds" (Filstead, 1970, p. 343). This information can then be cross-checked with other sources. Participant observation also allows the researcher flexibility.

Research questions can be reformulated in the light of new, unanticipated information and research categories can be modified to suit the environment (McCall and Simons, 1969; Wiseman, 1970; Filstead, 1979).

The validity of other research tools in studies of the elderly has been questioned. Measures of life-satisfaction as an indicator of the impact of long term care may be invalid since this variable can be affected by other aspects of the older person's life. Mangen and Peterson (1984, p. 83) have also criticized the exclusive use of interviews or questionnaires to measure program performance. They stated that these tools were unreliable. Reporting error tends to be high because some elderly respondents may fear that negative feedback will result in the demise of the program being evaluated. As well, research instruments must be usable with persons who are physically handicapped and not test-wise. "Ideally measures of long-term care outcome would be process oriented and would measure what happens over a period of time." (Eustis and Patten, 1984, p. 223).

I am not arguing for the general adoption of participant observation as a methodology. There are particular difficulties in using this approach.[9] The method is very time consuming - to conduct the research and to do the data analysis. The researcher has little opportunity to pre-plan activities or to control action of subjects. The researchers' presence may change behaviour of subjects and finally because the research is not controlled or standardized, findings cannot be generalized to other settings. In spite of these difficulties participant - observation was judged to be the methodology best suited to the research question.

2.3 ENTRY AND DATA COLLECTION

A great deal of time and effort was spent on gaining entry into Stafford House. It was recognized that this successful entry is a precondition for doing research because validity of observations are directly related to the receptiveness of research subjects to the researcher (Johnson, 1975).

Stafford House had been the site for university based student research in the past. Appointments with the home's business administrator and director of nursing were held to discuss the tentative area of research and to identify the organizational requirements in terms of entry and data gathering. Both administrators were supportive and asked that a written proposal be drawn up identifying the specific area of research and the methodology to be employed. This was done and the proposal was subsequently presented to an administration meeting which was attended by the nursing administrator, all primary nurses and the head of the activity department. The researcher was present to answer questions, clarify issues and to note areas of concern. This committee approved of the research as presented.

It was proposed that participant observation research be conducted with the researcher acting in a student/volunteer role. This role was selected for two reasons. Because volunteers and students were routinely placed in the home, it was possible to assume the role without too much expenditure of time and effort. As well, the role allowed observations that were relevant to the research topic (Mayntz and Huebner, 1976, p. 98). Following the suggestion of a professor, an initial trial period of observation (6 periods - 3 hours each) was conducted. This gave reassurance that the role was a feasible one.

At the commencement of research I attended a resident council meeting where I explained my research and the role that was to be taken. No objections (or even questions) were raised. During my research I also introduced myself and explained my role to individual residents.

As a volunteer I was able to work with a number of staff. My initial placement was with recreation staff where I worked with the recreationists. I assisted with recreational activities, portered residents, took part in exercise classes etc. I was able to observe residents in day-to-day recreational activities and to serve interaction of staff and residents. This first "role" also taught me quite quickly the danger of becoming too much of a "participant" and not enough of an "observer". My early notes repeatedly mention the skimpiness of my observations. As a result I made a concerted effort to give priority to my observations and recordings.

Although my field entry and placement with recreation staff was reasonably easy it did present certain problems. After two weeks or working with the recreation staff I began to feel that nursing staff were not too enthusiastic about my being there. No one from nursing ever said hello to me, welcomed me or invited me to coffee -- despite the fact that they had approved of my research! I started dreading going to the home.[10] Was this a group "freeze out?" I discussed this with the recreation supervisor who pointed out that the two departments (recreation and nursing) did not have the best of relationships and that nursing staff may have felt I was a "rec" volunteer. I didn't want to be labelled as such and to have my chances of observing nursing staff eliminated. The next day I visited each floor and asked if I could attend a shift change during the next week to re-introduce myself and to explain my role.

After attending these meetings and explaining my role, I was not welcomed with open arms. In spite of my explanations nursing staff did not seem to know what to do with me. I had to ask the nurses to assign me to someone. Initial placement was with the health care aides but the aides, unlike recreation staff, were not accustomed to volunteer help and really didn't understand why I was there.

As we were making beds I explained to the first aide, A, what I was doing...
A "Yeah, you have to work someplace to really know what it's like."
A little while later A introduced me to H, another health care aide.
A "This is Linda. She's ... What are you?" I went on to explain.
When we were done and went for coffee she thanked me.
A "It's nice to have an extra set of hands."

Initially, I tried to show the health care aides how I could help them (making beds, helping with baths, toileting residents etc.). I had 6 years of hospital experience and this proved to be an invaluable "bridge" in getting to know the nursing staff. I feel the fact that I was able to help them and not just sit and watch or get in their way had a great deal to do with my being accepted so quickly.

When I saw the aide A the next day (she came looking for me'.) she said
A "Oh you'll help me again, eh? We have the same rooms to do."

Although entry was difficult I very quickly was privy to "backstage" information.

While helping a nurse, C, make beds the 3rd day we discussed the financial situation of Stafford House
C "Sometimes I wish they'd let this place go to the government and we'd get more funding. I know it's a good idea and everything but...the care depends on who the primary nurse is..."[11]

Later the same day I was having coffee in the staff lounge. there were two health care aides, one activity person, a volunteer and myself. One health care aide, C, was transferring to midnights.

C "I'll avoid all this administration hassle. No one to bother me."

This is not to say that there was complete trust of me or understanding of my role.

At breakfast the same day two health care aides were sitting with residents and were eating toast.
HCA (to me) "You must think that all we do is eat here. We run around so much we have to have something to eat or we'll collapse."

I found out later that administration had directed staff NOT to eat food that was prepared for residents. This directive was followed by only a handful of staff. The fact that the aide had

explained her behaviour may have been due to a distrust of what I would do with information I acquired.

Within a week I felt more comfortable working on the units. Nursing staff welcomed me and called me by name. As I became more confident I approached nurses and health care aides on my own and asked if I could work with them. No one refused and most seemed happy to have help with what was often a heavy workload. I rotated days so that I was on each floor 2 days a week on a regular basis. Initially, (first 3 weeks) I tried to be there at times when I knew that extra help was needed (i.e. breakfast time) so that staff would see me as a benefit rather than a liability.

By the second week working with nursing staff I felt that nursing staff trusted me enough to be quite open.

> C, a health care aide had invited me for a coffee.
> Two other aides were present. There was general chit chat - weather, kids etc. but also some grumbling about changes and no communication.
> C "That's 'cause Miss Muffett is on."
> Me "Who's that?"
> C "G" (a nurse), They just tell us what to do and expect to get it done. We know what has to be done and do it at our own pace."

I worked with nursing staff in both an observer and a participant-observer role. While working with primary nurses my role was primarily observer. I watched what they did on a day-to-day basis. This was done on a formal basis - by following them around and observing them while they did their day's work. On a casual basis, I observed the nurses while I was making notes at the nursing desk, at coffee breaks, while working with other staff etc.

With auxiliary nursing staff (health care aides) I primarily utilized a participant as observer role. After explaining my role I asked for permission work with them (no one who was approached refused) and then assisted them in doing their daily work (making beds, portering, bathing, etc.). I also observed them more casually - again while making notes, at staff meetings, while I was visiting with residents, etc.

My role with residents was explained both at resident council and one-to-one with individual residents as a student/volunteer. Most residents chose to see me as either a volunteer - and asked me to visit with them (i.e. repot plants, read, etc.) or a staff member - asking me to toilet them, asking for information regarding services, etc., or calling me nurse.[12]

The participant-observation role of student/volunteer proved, after initial difficulties, to be a very useful one. I was able to obtain a wide variety of views of the life on one nursing home and to come to an understanding (albeit a limited one) of how that nursing home works (Wideman, 1978).

In total 300 hours of participant observation was carried out over a 3 month period. On a daily basis, research time varied from 2 to 8 hours. Observations were recorded on a daily basis and usually after 15-30 minutes of observation. Notes were made either at the nursing desk or in the staff meeting room adjacent to the nursing desk. These notes were fleshed out either at the end of the day for before the next period of observation.

Curiously enough few people seemed to be interested in what I was doing. Occasionally a staff member would ask what I was writing and I'd tell them something like "I have to make notes of what I see or I'll forget right away." On two occasions I was asked to show a staff member (the one I had just observed) my notes. I did this and they just read them through and left. Observations were made on all days of the week, and on the day and evening shifts but never on the midnight shift.

As well as observations of day-to-day life, data was gathered from the following sources:

a) attendance at two resident council meetings;

b) attendance at two staff meetings;

c) attendance at one resident care conference;

d) thirty five tape recorded shift reports;

e) two formal interviews (6 hours in total) with the nursing administrator;

f) minutes from resident council meetings for the last year.

These additional sources of information proved valuable in two ways. They either substantiated or enriched my observations or they pointed out issues that were not readily apparent to my field observations and helped to direct me in my observations.[13]

CHAPTER THREE

DATA ANALYSIS

3.1 PHILOSOPHY OF PRIMARY NURSING AT STAFFORD HOUSE

Primary nursing was selected as the model of nursing practise for Stafford House because it was thought to meet the needs of "residents"[14] in a holistic manner. In discussions with the Director of Nursing (D.O.N.) their model of nursing was described as "modified primary nursing". (Personal interview, June, 1985). She described the benefits of this approach. For the resident "it improved continuity of care" and allowed them "to get to know one person well" (elements of the 1:1 primary nursing). For the nurse it allowed for "better planning and accountability" (elements of the 1:1 and team approach to primary nursing). Because of the expense of an all R.N. staff, and the lack of funding the "modified" approach was implemented by using a mixed staff of primary nurses and health care aides (an element of the team approach).

The D.O.N. emphasized the philosophical priority of the nurse/resident (1:1) relationship in the implementation of primary nursing at Stafford House. The emphasis she and the organization placed on this relationship was made explicit when she described the importance of the length of time that was necessary to make primary nursing successful. She stated the optimal length of time for the resident/nurse relationship to be 18-24 months. It took approximately 8 months for the nurse to develop a relationship with the resident. An assignment of longer than 18-24 months resulted in burn-out, repetitive behaviour and a lack of enthusiasm on the part of the primary nurse.

The fact that at no time did the D.O.N. discuss or even mention the importance of teamwork or the role of primary nurse as manager in the implementation of primary nursing is an implicit

indicator of the lack of priority given these aspects (philosophically and practically) - in spite of the fact that Manthey (1988) emphasizes the importance of these elements in a "team approach" to primary nursing.

The nurses also defined the important feature of primary nursing at the 1:1 relationship with "their" residents.

> Me "What do you think of primary nursing? Is it a good thing?"
> N.E. (nurse) "Oh yeah. You get to know one resident really well and they get to know you. You know all about them - money, health, family etc. If we did it the other (sic) way different people would be looking after different things and I might never get to know about them."

This nurse and other nurses when describing primary nursing always talked about their relationship with that resident not about their role as manager or co-ordinator of team care - this role was NEVER mentioned.

A second characteristic of the 1:1 (patient: primary nurse) relationship is the role of the primary nurse as a direct care giver in meeting the total needs of the patient. At Stafford House the primary nurse was expected to deliver many aspects of resident care - dispense medications, change dressings, etc. Those areas that she either delegated (bed and body work to health care aides) or did not have responsibility for (i.e. recreation) appeared to be undervalued by the organization and by the primary nurses. This undervaluation (to be discussed later) is dehumanizing itself and severely limited the humanizing potential of primary nursing as practised at Stafford House.

The D.O.N. and the nurses defined the personal nurse/resident relationship as being the key to primary nursing. The D.O.N. saw some problem with this: "...(the nurse) may get too possessive of her residents...burnout...give lots of (her)self and this was exhausting." To counteract this the primary nurses were assigned "management functions". This was seen as "something different to

do" and was defined as attendance at a "once a month management meeting". (Personal Interview, June, 1985).

Management clearly was not identified as a priority. Nurses were selected for their support of the philosophy of primary nursing as a 1:1 relationship and not for their skills as a manager or team leader. Each nurse I talked to had little, if any, training in leadership skills and while I was conducting research no skill development in this area took place. As a result, the few times teamwork approach was used, it had minimal success. Staff participation was limited. Issues were seldom clearly defined. There was no clear structure to the meetings. Decisions (if they were made) were usually not group decisions and often now followed through.

I asked one of the health care aides about floor meetings.

> G "I don't go. They always talk about the same things - coffee, lunch, coffee, lunch. I have more important things to do than waste my time like that. They bring things up and talk a lot but never get anything resolved. At X (another nursing home) we had a heavier workload but you were part of the team."

The lack of emphasis given to the role of primary nurse as manager was also reflected in the structural organization of the nursing staff roles and responsibilities.

3.2 NURSING STAFF PATTERNS AT STAFFORD HOUSE

Stafford House provides accommodation for up to 108 residents at any one time, with 54 residents on each floor. Each floor for administrative purposes is divided into two units, north and south. For the day (7:30-3:30) and evening (3:30-11:30) shifts each unit was staffed by one registered nurse and 2-3 health care aides. These staff were assigned to particular units on a semi-permanent basis but rotated between days and evenings. As a result the same two nurses and health care aides worked continuously on each unit.[15]

In keeping with the primary nursing model each nurse was assigned responsibility for the nursing care of individual residents. As a result each nurse usually acted as a primary nurse for 12-14 residents[16] whose primary nurse was not working that shift. As the primary nurse she was responsible for the care of her residents. Before admission she would visit the potential resident and do a social and physical assessment (see Appendix I) to determine their suitability for placement on her unit.[17] If the person was to be admitted, the primary nurse was responsible for informing other staff and for completing the necessary documentation. She welcomed her new resident to the nursing home, gave him/her a tour and was responsible for designing a care plan for that resident. Communication concerning the resident with family members, doctors, etc. was her responsibility. When the primary nurse was not working her responsibility was delegated to her associate nurse on the alternate shift. This associate was expected to follow the care plan designed by the primary nurse and to communicate specific problems, concerns, changes, etc. back to the primary nurse. Any major issues or decisions (i.e. medications, diets, medical tests, family problems etc.) regarding the resident care plan were to be handled by the primary nurse.

The health care aides were the other members of the nursing department. They also were assigned to specific units and to particular residents on those units - under the supervision of the nurse on duty. Like the nurses, the health care aides worked alternating day and evening shifts,

but unlike the nurses, they also worked weekends. During her shift the health care aide was responsible for the majority of the direct patient care. She was responsible for seeing that residents were awakened, washed, dressed, toileted, portered, etc. The health care aides were also responsible for serving meals in the dining room.

3.3 THE STRUCTURE OF NURSING ACTIVITIES

An understanding of the roles the nurses and the health care aides was developed by observing them over a 4 month period. Each staff member worked an eight hour shift. A typical shift was organized around a framework of activities that were predetermined and consumed a certain amount of time.

Health care aides had their time structured as follows:

Day Shift (7:30-3:30)

7:30-7:45 - Listen to evening report and get duty assignment
9:30-9:45 - Coffee Break
12:30 - 1:00 - Lunch
2:30 - 2:45 - Coffee Break

Total amount of structured time: $1\frac{1}{4}$ hours.

Evening Shift (3:30 -11:30)

3:30 - 3:45 - Listen to report and get duty assignment
5:30 - 6:00 - Supper
9:00 - 9:15 - Coffee Break

Total amount of structured time: 1 hour.

Other than this 1 - $1\frac{1}{4}$ hours of structured time health care aides were usually in contact with residents. This 6 - 6¾ hours was divided up between approximately 13 residents so on an average, aides spent about 30 minutes per day with each resident. This time was spent primarily in delivery of direct patient care - bathing, dressing, portering, feeding, etc.

Nurses also worked around a framework of structured activities.

Day Shift (7:30 - 3:30)

7:30 - 7:45	- Listen to evening report and assign duties to health care aides
8:30 - 9:30	- Prepare and dispense medications for up to 27 residents
9:30 - 9:45	- Coffee Break
11:30 - 12:30	- Prepare and dispense medications
12:30 - 1:00	- Lunch Break
2:30 - 2:45	- Coffee Break
3:15 - 3:30	- Record shift end report

Total amount of structured time: 3.5 hours.

Evening Shift (3:30 - 11:30)

3:30 - 3:45	- Listen to day report and assign duties to health care aides
4:30 - 5:30	- Prepare and dispense medications
5:30 - 6:00	- Supper Break
9:00 - 9:15	- Coffee Break
11:15 - 11:30	- Record shift end report

Total amount of structured time: 2.25 hours.

All of these activities took up a major segment of the nurses' time and involved very little, if any, resident contact. Where resident contact did take place (i.e. dispensing medications) this was usually done in a routine way at meal times. A large medication cart was brought into the dining room and medications were given to residents as they ate.

The observation of primary nurses at work allowed me an understanding of how they defined and attempted to practise primary nursing. Because of limited time and a large patient/nurse ratio, nursing practise was determined foremost by external and internal structural priorities (medical care, documentation, clerical requirements etc.) and only secondly by their belief in primary nursing as a 1:1 relationship. Little emphasis was placed on team development or communication. The amount of time spent at various roles reflects this.

As described earlier the nurse had to operate around structural requirements which consumed a large segment of her time. The balance of time left in her shift ($4\frac{1}{2}$ - $5\frac{1}{4}$ hours) was divided up between a number of areas. Because of the lack of a ward clerk the nurse was responsible for a large amount of clerical work (necessary but with little potential for humanizing resident care). Answering phones, filling requisitions, completing forms, making appointment, making travel arrangements etc. - all consumed at least $1\frac{1}{2}$ hours each shift (it was often much longer). At a maximum then the nurse had between 3 and 3¾ hours (6.6 - 8.3 minutes per resident) to accomplish her other tasks - including acting as primary nurse to her 13-14 residents. These tasks were priorized again according to structural requirements. Skilled nursing care (footcare, dressing changes etc.) for the 27 residents she was responsible for during that shift consumed a large amount of time as did the necessary charting and documentation. As unit nurse she was required to liaise with other professionals (doctors, physiotherapists etc.) who visited or called the unit when she was on duty. Other time consuming responsibilities included management responsibilities (i.e. supervising and directing health care aides, doing job evaluations etc.), acting as a committee member, attending management meetings once a month, and acting as a student supervisor for placements from the local college and university.

In the little time that was left, the nurse was to act as a primary nurse for her individual residents. This role, described earlier, if it is to be successful as a 1:1 relationship requires TIME spent in patient/resident interaction. This element of time is usually reflected in a low patient/nurse ration. The priorization of nursing responsibilities at Stafford House did not allow the nurse spend time with her residents. Therefore primary nursing based on the 1:1 model had little potential for success.

The structure of nurses' time also did not support the practise of primary nursing as a team approach. Although the primary nurse did have a structured responsibility for management this

was ranked below other responsibilities (i.e. delivering medications and skilled nursing care, clerical work and acting as primary nurse to her residents) in terms of the amount of time allocated to it. Management was practised by nurses primarily in terms of work allocation, staff supervision and job evaluation. The responsibility for developing teamwork via humanizing communication or group problem solving was either not recognized or was given low priority by the organization and by the nurses (see earlier chapter). This low priority was also reflected in the fact that group problem solving and team communication (via case conferences) were an exception rather than the rule. In the four months of research I saw only one case conference and one attempt at group problem solving. Each was the result of a "crisis" situation and not a usual event. Staff meetings were held twice while I was present. Not only was a team approach rarely used, when it was used it was not carried out in a humanizing manner. This will be shown to reflect the under-valuation of some team members and the lack of practise of the necessary leadership skills on the part of the primary nurses.

3.4 DIFFERENTIAL VALUATION OF TEAM MEMBERS

In describing the modified primary nursing approach the D.O.N. emphasized the importance of the (1:1) nurse/patient relationship. She indicated the importance of the time element in this relationship by describing the lengthy (18-24) mos.) period required to make this modality work. However, organizationally there was little valuation of the one relationship which was structurally organized to allow extended 1:1 contact - the patient/health care aide relationship. When asked about the role of the health care aide, the D.O.N. stated they were responsible for activities of daily living. They needed specific health care training (3 mos.) and they had to like older people. She did not feel that it was necessary to assign the health care aide to one unit for a long period of time as was done with the nurses.

> "... the job is not as complex (as that of the primary nurse) and therefore does not have to be long term. They can't accomplish as much as the nurses" (Interview, June, 1985).

This statement indicates an unequal valuation of team members.[18] Nurses were perceived as having a more valuable role than health care aides. This was reflected in dehumanizing organizational behaviour. Two examples will be given.

a) Assignment and Re-assignment of Resident Care

Primary nurses at Stafford House were assigned to units on a semi-permanent basis. As stated earlier, the D.O.N. thought 18-24 mos. as the ideal length of patient/nurse match up. She described the first time the nurses were to be re-assigned. (Personal interview, June, 1985). The nurses had gone on a two day "retreat" to discuss the move. "It was a difficult decision but in the end it was a group decision and the group supported it." This process is an example of shared decision making - a key element of humanization. Input from all members (nurses) was encouraged and as a result the final decision, although costly, was a shared decision which

resulted in group support of the outcome. The fact that they were seen as equal members in the decision making process reflects the ideal of status equality.

The assignment of health care aides was carried out quite differently. Not only was the length of the assignment defined as unimportant but the method of reassignment was accomplished in a less than humanizing manner.

Health care aide B described a reassignment of health care aides at Stafford House.

> B "About a year ago P (D.O.N.) wanted the health care aides to transfer floors. She didn't ask us - just said they were going to change. P always supports the nurses and not the health care aides."

This issue of reassignment also came up at a meeting I attended. Health care aides had been working on their respective units and were due to change in one month. The primary nurses and health care aides debated the merits of reassignment. Some aides wanted shorter assignment and some a longer one. In the end the planned reassignment (to take place in one month) was postponed for 4 months, in effect supporting a longer patient/health care aide assignment. There was no clear indication of support for this decision and even though health care aides had participated in the discussion, there was not a feeling of ownership in the decision by all aides.

> Three days after the floor meeting, I asked T (health care aide) about the proposed reassignment. She wasn't in agreement with the decision and didn't feel that she had been listened to: T "... it's too long. They should listen to us because a happy staff does a better job. Not that we'd do anything to hurt them but you know..."

This aide recognized, as did Howard (1975), that the participation in a dehumanizing interaction (where she did not feel she was listened to) may result in dehumanized care.

b) <u>Nurse/Health Care Aide Communication</u>

Health care aides delivered the majority of care to residents at Stafford House and spent the most time with them of all staff. Because of this, the aides developed an intimacy with, and personal knowledge of, the resident that could be a key in "person"alizing health care. However, this intimate awareness of the resident was rarely communicated to the nurse. Most communication concerned instrumental activities such as bath assignments, toileting, urinary output etc. The nurse rarely probed for deeper information and the aide rarely volunteered this information. There was no recognition that, "... the direct care personnel are the ones with whom the resident is in contact most of the time and... their intimate observations are necessary..." (Brody, 1977, p. 48) in the development of comprehensive treatment plans.

The majority of information nurses communicated to the health care aides was also instrumental in nature. Important information that would help the health care aide "humanize" her care giving was often not shared with her.

> While I was in the conference room with <u>K</u> (a nurse) discussing my research <u>B</u> (a health care aide) came in.
> <u>B</u> "T's been crying for three days now. She wants ___ to visit her. Do you think you should call her?"
> <u>K</u> "She was here just a couple of days ago. But I'll try and call her and let her know. She's living far out in the country now and it's pretty hard to get here."
> <u>B</u> "Oh, I didn't know that."

At times the lack of communication was clearly a result of the health care aides' perception that they were not valued members of the team.

> <u>T</u> (a health care aide) - who became a key informant often talked with me about this.
> <u>T</u> "There's a lack of teamwork here. Especially on ___ end with job sharing. If you have questions about their residents you have to wait for their days on. We (aides) tell each other things before we tell the R.N.'s."

Health care aides did not feel they were valued as members of the team and this was demoralizing to them.

> Health care aide, R, and I were sitting in the staff lounge having coffee. R was complaining about her work.
> R "This job gets to you."
> Me "Do you mean you get burned out from working with residents?"
> R "No, that's not it. The residents are nice. It's administration. They keep changing things around."
> Me "Who?"
> R "It's the nurses. They never ask the health care aides for their opinions."

The lack of communication also affected the continuity of care.

> One day I was in the dining room and Mrs. O. asked me to get her wheelchair from her room. I brought it to the dining room. A health care aide G was there.
> G "Mrs. O. is supposed to walk to her room. The nurses hit the roof if you put her in a chair. But it's okay. Go ahead and do it."

G very clearly felt little ownership in the care plan the nurses had designed for Mrs. O.

The lack of valuation of other care givers was also reflected in organizational structure and practise. There was no social worker on staff. This was the result initially of an external determinant - limited funding. The internal allocation of limited funds via staffing reflected the priority given to medical versus socio-emotional needs of the residents. The belief on the part of the D.O.N. and nurses that primary nurses could practise social work reveals a lack of understanding and lack of valuation of the expertise required to practise these skills successfully.

Although recreation staff were present at Stafford House their budget allocation and the lack of support for recreational programs appeared to reflect a devaluation of those team members vis-a-vis the nursing staff. Not only did recreation and nursing department "not get along" (see notes on Entry) recreation needs were often defined as less important than medical/nursing needs of residents.

The lack of valuation of other team members limited their participation in the planning and delivery of resident care. This was coupled with a definition of primary nursing as a 1:1

relationship where the care giving role of the nurse was emphasized and the role of team leader or manager was given little support or practise. As a result when teamwork or problem solving were attempted the outcome was not particularly successful. Two examples will be given.

3.5 FOOD SERVICE AS AN EXAMPLE OF DEHUMANIZATION

An analysis of the resident council minutes from the last year revealed a repeating pattern of complaints about the food. "Lack of choice, poor service, lack of choice, poor service..." The same two items were repeated almost every meeting.

Early in my fieldwork I attended a resident council meeting. The home administrator was present and gave a short presentation about the financial difficulties the home was encountering. Following her presentation she moved to the back of the room and the dietician who had been invited to attend began to speak about the food service. As the dietician started speaking the home administrator started to leave.

> Resident
> "This may be the most important thing and now you're leaving?"
> Administrator
> "Oh, I'm, sure I can get this from someone else."

The administrator, in spite of her voiced concern for residents, acted in a dehumanizing manner by negating the importance residents placed on the issue of food. She defined the financial situation as important and stayed to listen to residents and answer questions about this issue. She did not stay to listen to residents comments concerning the issue they felt was most important - food.

The issue of food arose again, when I first discussed my research with one resident. She defined food as a humanizing element.

> I explained to Mrs. N. that I was trying to identify aspects of humanization in patient care. I tried to explain this concept.
> Mrs. N.
> "Oh that's good. We don't have any say about what goes on here. Especially the food - there's no choice."
>
> Other residents expressed similar concern regarding the food service.
>
> I was at the nursing desk making notes when one of the residents Mrs. L. came over. She had been reading the menu that was posted on the wall.

Mrs. L.
"There's things that are crossed off. Sometimes there is no second choice. And when you ask the girls what's second choice they shrug their shoulders and say they don't know."

All of these examples show that to the residents the food service was a problem. The fact that it had not been effectively dealt with indicates a weakness in the problem solving process, and a lack of valuation of residents - the concern they felt most strongly about was not given priority by the administrator or the staff.

During the time I was doing my fieldwork I often helped serve meals. Some problems in the service were apparent. By law, there were always supposed to be two choices of entree. Sometimes there was no second choice. Health care aides were responsible for serving the meals to residents and were supposed to ask resident what their choice was. This was often not done. Service was to rotate. On odd days one end of the dining room was to be served first. On even days service was to start at the opposite end. This also was often not done. Many times while meals were being served a nurse would tell a health care aide to rotate service. This was often not done. The topic of meal service also came up in conversations with nurses.

While at coffee with two nurses the topic of rotation of food service arose.
E I don't know how many times those health care aides have to be told about this..."
This was the topic of conversation for about five minutes but there was no decision made as to how to deal with it.

About mid-way into my research there was a structured attempt to deal with the issue of food service. Although the issue directly concerned the health care aides (they were responsible for serving the food) and residents, it was the nurses and dietician who finally defined food service as a problem which required a solution. They attempted to solve the problem via a meeting with the aides.

I was at the nursing desk making notes and overheard two nurses talking.
C "R (dietician) would like to talk to the health care aides about service of meals. She wanted an hour but I told her that would be impossible."

The meeting was arranged but communication to the health care aides regarding the meeting was disorganized. A notice had been put up on the bulletin board about the meeting however many health care aides didn't seem to be aware of it.

The day of the meeting I was in the staff lounge with a nurse, N, and health care aide, C. Another nurse, O, poked her head in the door.
O (nurse) "The time of that meeting is changed to 11:00 from 11:30."
C (health care aide) "What meeting is that?"
N (nurse) "it's between B (dietician) and health care aides to talk about food service..."
(She did not clearly state the reason for the meeting.)

The meeting was held with 6 health care aides, 1 nurse (acting D.O.N.), the dietician and myself present. I took very detailed notes and an analysis of these was very revealing.

1) No residents were present - and they were key actors!
2) No health care aide seemed to know why the meeting was called.
3) The dietician in spite of the fact that she asked for the meeting never clearly identified the problem or reason for calling the meeting. In fact at one point when one of the aides asked her, "What's wrong with the service?" Her response was "I'm not saying there's anything wrong."
4) Although health care aides served the meals they were supervised in their work by the primary nurses. However, no nurses (except the acting D.O.N.) attended.
5) No minutes were taken.
6) The meeting ended because the time was up. No final statement or decision regarding action was made.

The dietician and the acting D.O.N. appeared to identify the problem as being primarily the way the meal was served (speed, choice, social interaction etc.) The aides for the most part identified conditions (other job responsibilities i.e. toileting, resident behaviour, lack of staff etc.) which did not allow them to serve the meal in a pleasant manner. Neither side provided feedback to reflect an understanding of what the other side said.

Following this meeting there was no discernable change in food service. This is not surprising. Not only was there no clear decision made as to how to change the food service but aides did not define their behaviour as the key to improving service.

> "It is generally accepted that changes in routine only work when staff understand and accept the reasons for the change. The challenge lies in understanding and paying attention to the individual human processes that are entailed in bringing about change." (Singer-Edelson and Lyons, 1985, p.5).

It is this challenge which is the responsibility of the primary nurse as leader. However, she needs the necessary time and skills to meet the challenge. External determinants and the structure and philosophy of primary nursing as practised at Stafford House did not allow for either.

3.6 RESIDENT CARE CONFERENCES: A POTENTIAL HUMANIZING PROCESS GOES UNREALIZED

Resident care conferences were an unusual occurrence at Stafford House. One was arranged during the four months of research. This conference was the result of a perceived crisis by nursing staff and involved one resident, (L), who was being unco-operative with staff. He refused to wash or get out of bed. He insulted staff and regularly complained about the service. He refused a suggestion of psychiatric counselling. Almost all staff (health care aides, nurses, recreationists) indicated at one time or another that they did not want to work with him. But he was a resident and interaction could not be avoided. (A previous care conference had been held to address similar problems involving the care of this same resident).

Participants in the conference included most staff - nurses, health care aides, recreation staff, one pastoral care staff member, a social work student and housekeeper. The resident was not present and had not been invited. Participation of staff was quite high. Each shared differing information regarding their knowledge of the resident and suggestions for improving care delivery.

Recreationist
"Sometimes you can rationalize with him, if you confront him and explain how you feel."

Aide
"Maybe because I know him I can confront him."

Primary Nurse (PN)
"I don't think anyone has had more time and attention than L."

Nurse (N)
"Do you think medication needs any kind of review?...I think he's better on Monday when he's been off medications..."

PN
"I'll talk to Dr. K. about that..."

Recreationist
"His tutoring...if that's the thing that's going to help his self esteem, that should be built on. It came from him. He's happy with it."

PN
"I'll phone ____ again about this (tutoring) and maybe something can be done."

Discussion included resident's anger, staff responses to the display of anger, care options, the resident's response to his health situation, changed eating habits, his marital situation etc. Generally there was a high degree of participation by all staff and each was able to share particular "person"alizing information about the resident. The primary nurse and other nurse did not dominate the discussion and information from all staff appeared to be attended to equally. This recognition of the inherent worth of participants, was humanizing to all participants and may have been the reason for the high level of participation. It was not humanizing to the resident who was not present. He would still receive the care as "object" rather than as "subject" who had been involved in the care planning. An empathetic understanding of the resident was expressed.

Nurse
"He doesn't like to be around handicapped people. It may be from his culture where it's thought people should be locked away..."

Social Work Student
"We have to realize that all this anger is in him..."

Generally then, (except for the absence of a key actor - the resident) the first step in the team approach to primary nursing appeared to have been practised in a humanizing manner. The concepts of inherent worth, status equality and empathy were evident.

The second and third steps in the process (Step B & Step C) were not carried out quite so effectively. The primary nurse did not assume the leadership roles required. As a team member, she did not dehumanize the process by dominating the group but she failed to act in the key role of team leader. She did not direct the process, practise any organized problem solving skills or summarize the input of participants. She also failed to clearly articulate the group decision. In fact, at the end of the meeting it was not clear exactly what plan was to be followed (who was going to do what). Without this clear articulation and communication of a care plan, the delivery

of care could not be consistent.

The planning and enactment of the care plan lost it's potential for humanization because of 1) lack of participation of the resident 2) lack of a concrete plan of action to be followed by all members of the care team and, 3) the lack of regularity of care conferences. Caring and participation by team members are not enough. They must be supported and encouraged by regular, concrete care planning (a primary nurse responsibility).

> To involve the care giving staff in decision making about delivery of individualized personal care many institutions have developed...regular weekly team meetings (which) should include both morning and afternoon nursing staff, activity staff, social workers, and nursing supervisors...(this requires) leadership to ensure that the dominant input comes, not from the professional staff in attendance, but from the direct care staff (Singer-Edelson and Lyons, 1985, p. 211).

Without this structure no legitimate evaluation of progress, or lack of it, can be made. As a result the resident care is a haphazard affair rather than being a structured, humanizing process with particular resident needs being identified and addressed in a holistic manner.

This example of the practise of resident care conferences is important. It shows the interest and participation of team members in the development of resident care. They very much wanted to meet resident needs. This interest and participation could form the basis for the humanization of primary nursing using the team approach but it would need support, primarily in terms of leadership and the development of team work on the part of the primary nurse.

Without this role of team leader, members of the care team will only participate in care planning and decision making on an ad hoc basis. This makes systemic humanization of resident care impossible. It is the primary nurse, as leader, who must take responsibility for developing practise on her unit which reflects the humanizing principles of inherent worth, status equality, shared decision making etc. This practise does not occur by itself.

3.7 SUMMARY AND DISCUSSION

The humanization of patient care at Stafford House was not systemic in nature and could not be attributed to the implementation of primary nursing. The lack of humanization resulting from this innovation may be traced to a number of factors. Although it has not been the focus of this research, the humanizing potential of primary nursing was severely limited by external constraints (funding levels, documentary requirements etc.) imposed on the organization. (See Conclusion). These external factors were combined with and/or resulted in, an organizational and individual interpretation and practise of primary nursing which did not allow the humanizing potential of this nursing method to be realized.

As described earlier, primary nursing can be practised in two ways. In primary nursing practised as a 1:1 relationship a variety of roles (skilled care giver, care planner, etc.) may be practised successfully by the primary nurse. The key though, is a small enough patient/primary nurse ratio to allow extended contact between patient and the primary nurse. This extended contact is the key to humanizing the care giving. Primary nursing practised as a "team approach" is a n:n relationship. Multiple practitioners (primary nurse, health care aides, social workers etc.) deliver care to multiple patients. The primary nurse acts as team leader and has ultimate responsibility and accountability for that care. The humanization of this care giving can no longer be based on extended 1:1 contact which allows each actor to see the other as a whole person. This knowledge of the wholeness of individuals, and the practise that results, is dependent on good communication and humanized relationships among team members who individually are aware of various parts of the patient's "whole."

Primary nursing as practised at Stafford House was an unsuccessful hybrid of both approaches. The organization (and individuals) philosophically defined primary nursing as a 1:1 relationship. Staffing reflected primary nursing as a team approach. The delivery of care (i.e. role

responsibilities) was based on both models. As a result, the organizational structure and practise of primary nursing in terms of staff numbers, role responsibilities and role behaviours did not support either model.

CHAPTER FOUR

CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

Primary nursing is a potentially humanizing innovation. In the institution examined, the potential was not realized. The lack of success can be traced to a number of factors.

Initially the organization was constrained in its implementation of primary nursing by available funds - an external factor. The optimal choice of the Director of Nursing would have been an all nurse staff with a low nurse/patient ratio where nurses would have enough time to practise primary nursing as a 1:1 relationship. As an alternative "modified primary nursing" using a mixed staff approach was selected as the nursing method to implement.

Although the implementation that was used was described as a team approach to primary nursing there was little support for this practise. The requirements (external and internal) to make this approach successful were not present. Three key ingredients were missing. - adequate staffing, priorization of the role of primary nurse as team leader and equal valuation of team members.

The initial difficulty in providing adequate staff to operate effectively can be traced to the lack of sufficient funds. Funding for nursing homes (as for most health care) comes primarily from government. The last twenty years have been a period of financial restraint directed "...by government towards health and social services where "efficiency", by definition, means cutting nursing labour costs" (Campbell, 1984(b), p. 28).

The direction of these cost cutting measures requires critical examination rather than quiet acceptance. The financial and social resources necessary to provide adequate staffing levels to

"humanize" nursing care are available. However, the social institutions and structures (and the belief systems of the individuals who act within those structures) do not define the allocation of those resources to the aged as a priority. A closer examination of these funding allocations using a political economy approach would "...help to develop an understanding of the character and significance of variations in the treatment of the aged and to relate these to the broader systemic trends" (Estes et al, 1984, p.27). This critical examination is a key to any systemic humanization of services to the aged.

Another factor undermining the successful implementation of primary nursing using a team approach was the low priority given to the role of primary nurse as team leader. Structural determinants of primary nurse time usage (documentation was a clear time consumer) did not allow her the time necessary to practise the role of leader.

Campbell (1984a) describes in detail the difficulties nurses encounter in abiding by the documentary requirements governing nursing practise. These requirements are imposed by administration, government regulation and the nurses' own professional organization. Not only does the completion of documentation take time away from other roles (i.e. team leader, care giver, etc.) it results in "the loss of nurse's control over their daily practise" (p. 181). This in itself is dehumanizing.

The role of primary nurse as team leader was undermined in other ways as well. The organization and primary nurses interpreted and attempted to practise primary nursing as a 1:1 relationship and little emphasis was placed on the role of team leader (i.e. in terms of skill development, job responsibilities, etc.).

Finally, the humanization of primary nursing using a mixed staff approach requires an equal valuation and participation of all team members. This was not done at Stafford House. Many key members were either undervalued (health care aides, recreationists) or absent (social worker).

There was no organizational structure to allow team members equal participation in care planning and delivery. All of these factors contributed to the lack of humanization resulting from the implementation of primary nursing at Stafford House.

The successful implementation of primary nursing, if it is to be humanizing in its practise, must have the necessary support from government (in terms of funding and regulation), from the organization (in terms of philosophy and role responsibilities), and from the individual (in terms of philosophy and action). All of these must reflect a priority placed on the role of person or human rather than on the role of patient.

4.2 RECOMMENDATIONS

Recognizing the limitations of this research, it is recommended that before primary nursing is implemented there needs to be a clear understanding of what primary nursing is and how it is to be practised - either as a 1:1 relationship or as an n:n relationship. The organization must support one or the other - by philosophy, by staffing and by the priorization and allocation of role responsibilities of various actors. The difficulty in implementing either approach is the lack of adequate funding to provide the necessary staff.

a) The delivery of primary nursing emphasizing the 1:1 relationship should be based on a small (6:1, 8:1) patient/nurse ratio with the nurse delivering the majority of nursing care - both skilled and unskilled. Even using this method, the nurse and the organization should recognize the legitimacy of other professions in the delivery of humanized health care. Skills such as social work require as much training as that of nursing. An attempt to practise these without the necessary background will often result in failure.

b) Primary nursing using a team approach requires a definition of the key role of primary nurse as that of manager or team leader. The organization and the nurse must support and develop the skills necessary for the primary nurse to carry out this role effectively. The health care aide must be defined as a key member of the team and be actively involved in care planning and delivery. The organization must also help the health care aide to develop the necessary skills to carry out her work in a humanizing manner. This team approach to primary nursing requires the routine recognition and valuation of all team members in delivering humanized health care. This can be done via regular meetings of all team members to discuss care planning, problem solving and routine unit management.

END NOTES

1. The fear of an economic crisis arising from such a dramatic increase in the 65+ population can be tempered somewhat when it is realized that the overall dependency rate (youth and elderly combined) will be the same in 2031 as it was in 1976 (Denton and Spencer, 1980).

2. Not only is there a variation in rates of institutionalization by age but rates also vary from country to country. Schwenger and Cross (1980, p.251) estimate that Canada's rate of institutionalization of 8.4% (65+) was a great deal higher than England and Wales at 5.1% or the United States at 6.3%. Canada's notoriety for having such a high rate is disputed by other researchers (Forbes et al, 1987). What is clear is that in all industrialized countries the demand for long term beds is increasing.

3. The influence that government funding has on rates of institutionalization becomes apparent when comparing Britain with one of the lowest rates, to Canada, with one of the highest rates. Historically, Britain has had a comprehensive health care program which provides government funding for a continuum of care which encourages and supports individuals to stay out of institutions as long as possible. Contrast this with Canada where the structure of funding for health care encourages institutionalization. Government financially subsidizes institutionalized care extensively while providing minimal funding to program that would keep the individual at home. As a result, individuals are often inappropriately placed in long-term care facilities. (Forbes et al 1987; Schwenger and Cross, 1980).

4. These methods of nursing are described by Gordon and Stryker (1983, p. 153).

   The Case Method

   The case method of nursing assignment is based on one nurse having complete responsibility for the nursing care of a group of residents. For example, the public health nurse has a "case load". A variation of the case method is commonly called "total patient care". In this method of assignment, one nurse would have responsibility for a group of residents for an eight-hour period.

   The Functional Method

   This method of nursing assignment is an efficiency-oriented division or work by duties. Each staff member is assigned a cross-section of unit activities. With this method, a nurse may never assume complete responsibility for any one resident; thus, the nurse cannot be expected to know or co-ordinate total nursing needs of the resident.

The Team Method

This is another efficiency model. Through this approach individuals with different preparations, experience and status work together with a leader to provide nursing care, to identify and to solve problems of a specific group of residents. In either the team or functional methods, one nurse may give medications to an entire groups of residents.

Mini-Team Nursing (modular method)

This method emphasizes care being carried out by one or two nursing personnel assigned to a relatively small group of residents. Experienced nurses function as module leaders, either working with a nursing assistant of LPN in caring for a larger group. In effect, modular nursing breaks the nursing team into smaller team units.

Primary Nursing

This system is based on the philosophy which emphasizes returning the professional nurse to the resident and his family in a direct care giving system. Within this method one nurse is identified as a "primary nurse" for a specific number of residents on a continuing basis. For those nurses who wish to upgrade their professional level of practice, primary nursing offers the potential for greater job satisfaction than the fragmented approach offered by other models.

5. In the original conceptualization of primary nursing as a 1:1 relationship (Ciske, 1968; Ciske, 1984) the primary nurse was never identified as responsible for meeting all patient needs. There was still recognition that many patient needs require the expertise of other care givers who have specific skills or training that the primary nurse does not possess.

6. This argument is based on the inherent assumption that the patients' physical needs should determine the type of nursing care required - skilled or unskilled, R.N. or aide. Implicit in this is the idea that the patients' social or emotional needs can be met by either and this does not require any special training.

7. Extended care is defined as:
Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24-hour basis with medical and professional nursing supervision and provision for meeting psychosocial needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

8. The physical design of the building itself had a number of innovations which contributed to the humanization of residents but these features, although they were important, were not evaluated in this paper.

9. If a researcher has not used participant observation previously, many of the difficulties may not be apparent until she is immersed in the methodology, while in the field. In conducting this research I ran the gamut of emotions from frustration, depression, and despair, often wondering if I should give up the research or if ever I would find out what I was looking for. Data analysis presents similar and even more difficulties. In spite of this I feel confident that the experience is a good one.

   1) As a learning experience - I now understand the methodology (it's strengths and weaknesses) much better.
   2) The methodology allowed me insights into the operation of a nursing home that I never had before.
   3) As well, the methodology did in fact allow me to identify particular features which affect the humanization of nursing home care that I had not considered prior to my research. These features would not have been revealed if I had a predetermined set of categories.

10. This was my first period of frustration and despair. In a discussion with my thesis advisor, he helped by pointing out that these feelings were not unique (even though the methodology texts neglect to mention this). A recent article he had read had described in detail the very real tears one researcher had while doing participant observation.

11. At the time of this research the home was in a financial crisis. A mortgage payment on the complex was coming due and the organization was not able to pay it and at the same time it was operating at a deficit. This presented definite stresses to the organization and staff.

12. This identification as a staff member is not so difficult to understand when one realizes that none of the staff, except dietary, wore uniforms.

13. I was also given access to resident charts at the nursing station. I began to gather data from them but found that, because of time, it was not feasible for me to use this rich source of information.

14. The use of the term resident was a deliberate move on the part of administration to humanize care. Defining the person as resident rather than patient was an attempt to communicate to others (staff, family, resident) that Stafford House was a home and not a hospital and that emphasis was on wellness versus the sick role.

Another attempt to humanize the relationship between staff and residents was the lack of staff uniforms (except for dietary staff). Just as the label "patient" conveys a particular message in terms of behaviour, so too, a uniform conveys a message. The person in uniform is initially identified in their role as "nurse" or "health care aide" rather than as a person. In doing this the uniform may give a message of superior power of staff vis-a-vis the resident (Personal Interview June, 1985).

Another humanizing practise was the presentation by most staff of a number of skits for the residents at Stafford House. This entertainment night was done twice a year. The purpose was humanizing - an attempt to level the hierarchy of relationships between staff and residents. However it was based on the recognition that indeed there was a dehumanizing power structure in place with the staff in a superior position and the residents in an inferior one.

> One of the nurses, O, described the Christmas performance.
> O "The order givers were being made fun of and I think they (the residents) enjoyed that."

15. On one unit 4 nurses were assigned. This was due to a job-sharing trial that was in place and as a result 2 persons shared one job.

16. The two job sharing R.N.'s had primary responsibility for 6-7 residents.

17. This assessment was in addition to the assessment done by the local placement co-ordinator service which was responsible for determining the level of care (i.e. old age home, nursing home, chronic care hospital) required by someone applying for long term care and for preparing waiting lists. When applying for long term care an individual could indicate the particular institution s/he wished to be admitted to. If that person fell within the care requirements governing admission to that institution s/he would then be placed on a waiting list for admission.

18. There were numerous other examples of the differential valuation of team members. Early in my research I interviewed two social work students who were on placement at Stafford House. While discussing the difficulties of "fitting in" to Stafford House (see Section on Entry) they both mentioned the differences in staff (nurse/health care aide) interaction on the two floors. On one floor the nurses and health care aides rarely sat together and the student felt she was always walking a fence - unable to get too chummy with either group in case the other ostracised her. I experienced a very similar situation. In fact one nurse was nicknamed "Miss Muffett" because of her superior manner. Singer-Edelson and Lyons (1985) recognized the dehumanizing potential of this type of practise.

    "Aside from their relatively low pay, the status of the care team can be undermined in its own eyes through the subtle messages contained by whether the charge nurse and R.N.'s sit with them at coffee breaks and meal times" (p. 213).

REFERENCES

Boling, Edwin T. 1983 — Nursing Home Management: A Humanistic Approach. Springfield: Charles C. Thomas.

Bowker, Lee 1982 — Humanizing Institutions for the Aged. Lexington: Lexington Books.

Brealy, C. Paul 1977 — Residential Work With the Elderly. Boston: Routledge and Kegan Paul.

Broadhead, Robert S. 1980 — "Qualitative Analysis in Evaluation Research: Problems and Promises of an Interactionist Approach," Symbolic Interaction, Spring, Vol. 3, No. 1, pp. 23-40.

Brody, Elaine 1977 — Long-Term Care of Older People: A Practical Guide. New York: Human Sciences Press.

Brody, Elaine 1979 — "Long-Term Care of the Aged: Premises and Prospects," Health and Social Work, Feb., Vol. 4, No. 1, pp. 29-56.

Campbell, Marie 1984(a) — Information Systems and Management of Hospital Nursing: A Study in Social Organization of Knowledge. Toronto: Ontario Institute for Studies in Education.

Campbell, Marie 1984(b) — "Organizational Settings Define Nursing: Let's Change the Definition," The Canadian Nurse, Sept. 1984, pp. 26-28.

Campbell, Susan Divine 1985 — "Primary Nursing: It Works in a Long-Term Care Setting," Journal of Gerontological Nursing, Vol. 11, No. 12, pp. 12-16.

Ciske, K.L. 1968 — Primary Nursing: What Is It and What Difference Does It Make? Chicago: American Hospital Association.

Ciske, K.L. 1984 — "Primary Nursing: An Organization That Promotes Professional Practise," Journal of Nursing Practise, Jan.-Feb., Vol. 4, pp. 28-31.

Clough, Robert 1981 — Old Age Homes. London: George Allen and Unwin Ltd.

Cook, Thomas A. and Charles S. Reichardt, (eds.) 1979 — Qualitative and Quantitative Methods in Evaluation Research. Beverly Hills: Sage Publications.

Daeffler, Reidum Juvkam 1975 — "Patients' Perception of Care Under Team and Primary Nursing," Journal of Nursing Administration, March-April, pp. 20-26.

Estes, Carrol L. and James Swan and Lenore E. Gerard 1984 — "Dominant and Competing Paradigms in Gerontology: Towards a Political Economy of Aging," in M. Minkler and C. L. Estes, (eds.), Readings in the Political Economy of Aging. Farmingdale, N.Y.: Baywood Publishing Co.

Eustis, Nancy N. and Sharon K. Patten 1984 — "The Effectiveness of Long-Term Care," in D.J. Mangen and W. A. Peterson, (eds.), Research Instruments in Social Gerontology: Health, Program Evaluation and Demography. Minneapolis: University of Minnesota Press.

Felton, Geraldine 1975 — "Increasing the Quality of Nursing Care by Introducing the Concept of Primary Nursing: A Model Project," Nursing Research, Jan.-Feb., Vol. 24, No. 1.

Filstead, William J. 1970 — Qualitative Methodology: Firsthand Involvement with the Social World. Chicago: Markham Publishing Co.

Filstead, William 1979 — "Qualitative Methods: A Needed Perspective in Evaluation Research," in Thomas D. Cook and Charles S. Reichardt, (eds.), Qualitative and Quantitative Methods in Evaluation Research. Beverly Hills: Sage Publications.

Gaynes, Neil L. 1973 — "A Logic to Long-Term Care," The Gerontologist, Autumn, Part 1, pp. 277-282.

Geiger, H. Jack 1975 — "The Causes of Dehumanization in Health Care and Prospects for Humanization" in J. Howard and A. Strauss, (eds.), Humanizing Health Care. New York: Wiley.

Goffman, Erving 1961 — Asylums. Chicago: Aldine Publishing Co.

Goldberg, Matilda E. and Naomi Connelly 1982 — The Effectiveness of Social Care for the Elderly. London: Heinemann Educational Books.

Gordon, G.K. and Ruth Stryker, (eds.) 1988 — Creative Long-Term Care Administration. Springfield: Charles C. Thomas.

Gubrium, Jaber F. 1975 — Living and Dying at Murray Manor. New York: St. Martin's Press.

Henry, Jules 1963 — Culture Against Man. New York: Random House.

Hiatt, Lorraine 1978 — "Architecture for the Aged: Design for Living," Inland Architect, Nov.-Dec.

Hiatt-Snyder, Lorraine 1978 — "Environmental Changes for Socialization," Journal of Nursing Administration, Vol. 8, No. 1, pp. 44-50.

Horn, Linda and Elma Griesel 1977 — Nursing Homes: A Citizens' Action Guide. Boston: Beacon Press.

Howard, J. 1975 — "Humanization and Dehumanization of Health Care," in J. Howard and A. Strauss, (eds.), Humanizing Health Care. New York: Wiley.

Johnson, John M. 1975 — Doing Field Research. New York: The Free Press.

Johnston, C.A. 1987 — "Primary Nursing Model: Fosters Staff's Autonomy and Accountability," Dimensions, June, pp. 30-36.

Kahana, Eva 1973 — "The Humane Treatment of Old People in Institutions," The Gerontologist, Autumn, Vol. 13, No. 3, pp. 282-289.

Kalson, Leon 1976 — "M.A.S.H.: A Program of Social Interaction Between Institutionalized Aged and Adult Mentally Retarded Persons," The Gerontologist August, Vol. 16, No. 4, pp. 340-348.

Kart, Cary S. and Barbara B. Manard 1976 — "Quality of Care in Old Age Institutions," The Gerontologist, June, Vol. 16, No. 3, pp. 250-56.

La Monica, Elaine Lynne 1979 — The Nursing Process: A Humanistic Perspective Menlo Park: Addison - Wesley.

Lang, Cathy and Carol Shelton 1982 — The Directory: Programs for Senior Citizens Across Canada. Toronto: Canadian Pensioners Concerned Inc.

Lehman, Stanley 1975 — "Psychology, Ecology and Community: A Setting for Evaluative Research," in Elmer Struenning and Marcia Guttentag, (eds.), Handbook of Evaluation Research. Beverly Hills: Sage Publications.

Leininger, M.M. 1985 — Qualitative Research Methods in Nursing. Orlando: Grune and Stratton Inc.

Liebow, Elliot
1967
Tally's Corner: A Study of Negro Street Corner Men. Boston: Little, Crown and Co.

Mangen, D.E. and
W. A. Peterson (eds.)
1984
Research Instruments in Social Gerontology: Health, Program Evaluation and Demography. Minneapolis: University of Minnesota Press.

Manthey, M. and
M. Kramir
1970
"A Dialogue on Primary Nursing," Nursing Forum, Vol. 9, No. 4, pp. 356-380.

Manthey, Marie
1988
"Myths That Threaten," Nursing Management, Vol. 19, No. 6, pp. 54-55.

Marram, Gwen and Olivia Bevis and Margaret W. Schlegel
1979
Primary Nursing: A Model of Individualized Care. Toronto: Mosby.

McCall, George J. and
J.L. Simmons, (eds.)
1969
Issues in Participant Observation: A Text and Reader. Reading: Addison-Wesley Pub. Co.

Moss, W. (ed.)
1976
Humanistic Perspectives on Aging: An Annotated Bibliography and Essay. Ann Arbor: University of Michigan - Wayne State University.

Myles, John
1979
"Institutionalization and Disengagement Among the Elderly," Canadian Review of Sociology and Anthropology, Vol. 16, No. 2, pp. 171-82.

Myles, John
1980
"Institutionalizing the Elderly: A Critical Assessment of the Sociology of Total Institutions," pp. 257-268 in Victor E. Marshall, Aging in Canada: Social Perspectives. Don Mills: Fitzhenry & Whiteside.

New Democratic Party
1984
Aging with Dignity, Report of the NDP Caucus Task Force Caring for Seniors. Toronto: Ontario New Democratic Party Caucus.

Nicholson, Clara H.
1979
"Personalized Care in the Nursing Home: Problems and Practice," Paper Presented at the Annual Meeting of the Gerontological Society.

Palmore, Erdman
1976
"Total Chance of Institutionalization Among the Aged," The Gerontologist, Vol. 16, No. 6, pp. 504-507.

Penning, Margaret and
Neena Chappell
1980
"A Reformulation of Basic Assumptions About Institutions for the Elderly," in Victor Marshall, Aging in Canada: Social Perspectives. Don Mills Fitzhenry & Whiteside.

Raab, Diana M.
1984
"Quality Nursing - A Primary Advantage," Health Care, Sept., pp. 23-24.

Reichardt, Charles and Thomas D. Cook
1979
"Beyond Qualitative Versus Quantitative Methods," in Thomas D. Cook and Charles Reichardt, (eds.), Qualitative and Quantitative Methods in Evaluation Research. Beverly Hills: Sage Publications.

Rossi, Peter H. and Howard E. Freeman
1982
Evaluation: A Systematic Approach (2nd ed.) Beverly Hills: Sage Publications.

Schwenger, Cope and John Cross
1980
"Institutional Care and Institutionalization of the Elderly in Canada," in Victor Marshall, (ed.), Aging in Canada: Social Perspectives. Don Mills: Fitzhenry & Whiteside.

Singer-Edelsen, J. and W. Lyons
1985
Institutional Care of the Mentally Impaired: Elderly. New York: Van Nostrand Reinhold Co.

Sparks, Geoffry
1982
"Participant Observation in a Hospice," in Rex Taylor & Anne Gilmore (eds.), Current Trends in British Gerontology. Hampshire: Gower Publishing Co.

Spasoff, Robert A. and Arthur S. Kraus
1978
"A Longitudinal Study of Elderly Residents of Long-Stay Institutions," The Gerontologist, Vol. 18, No. 3, pp. 281-292.

Swain, Cherry and A. Harrison
1979
"The Nursing Home as a Total Institution," Australian Journal of Social Issues, Vol. 14, No. 4, pp. 274-284.

Thomas, Neil
1981
"Design Management and Resident Dependency in Old People's Homes," in M. Goldberg and N. Connelly, (eds.), Evaluative Research in Care. London: Heinemann Educational Books.

Turner, Gerald D. and Joseph Mapa
1979
Humanizing Hospital Care. Toronto: McGraw-Hill Ryerson.

Wiseman, Aron
1970
Field Projects for Sociology Students. Cambridge: Schenkman Publishing Company.

Application for Type 1, 2 or 3 Care

(Please read before completing the form)

Purpose of Form

1. To establish eligibility for Extended Care benefits.
2. To serve as an application form for admission to all long-term care facilities.
3. To provide information for the professional staff of the receiving facility.
4. To replace the multiplicity of existing forms.

Criteria For Eligibility for Extended Care (Type 2) Benefits

1. Currently insured with OHIP.
2. Residence in the Province of Ontario for 12 months immediately preceding the date of application for Extended Care benefits.
3. Need for continuing medical supervision and skilled nursing care.
4. If applicant is not admitted to a facility within 6 months, a new application form must be submitted.

Instructions

For Extended Care (Type 2)

1. Complete assessment form (see reverse side for Guide For Completing Section B).
2. Forward Page 1 to: Ontario Extended Care Program
5th floor, 880 Bay Street
Toronto, Ontario M7A 2C2.
3. The remainder of the form (Pages 2, 3 and 4) is to be sent directly to the facility to which application is being made.

For Residential Care (Type 1) or Chronic Care (Type 3)

1. Discard Page 1 (this page is for Extended Care eligibility only).
2. Starting at Page 2, complete remainder of the form.
3. The remainder of the form (Pages 2, 3 and 4) is to be sent directly to the facility to which application is being made.

Guide for Completing Section B (Pages 1 and 2)

This form measures the **degree of staff assistance** (i.e. time) required in DAILY activities/functions. Whatever the applicant's condition or problems, indicate to what extent staff must assist in EACH activity/function listed.

Check only 1 box in each of the 13 categories. Choose the box which BEST describes the degree of staff assistance (i.e. time) currently required by the applicant. If the applicant's condition fluctuates, consider the average degree of staff assistance required.

Please treat each category independently. For example, do not consider transfer when completing the section on locomotion.

A space for comments has been provided.

In section B the term "aspects" includes one or more of the following items under each activity/function.

Eating: e.g. cut/slice/mash food (e.g. meat, dessert, vegetables), place utensils, position assistive devices, etc.

Dressing: e.g. select clothes, fasten clothes, put on socks/stockings, put on slacks, tie shoes, put on prosthesis, etc.

Grooming: e.g. brush hair, teeth/denture care, shave, nail care, make-up, clean eye glasses, etc.

Bathing: e.g. transfer to tub, wash back, wash feet, dry hair, wash face, hands etc.

Mental Retardation

Assistance required because of limited mental ability should be considered when completing all categories, in particular orientation and socio-emotional support.

Blindness/Deafness

Make note of specific visual or hearing difficulties under comments. The degree of staff assistance required as a result of these problems should be included when completing all categories.

Prostheses, Braces and Other Special Devices

Make a note of devices used under comments. Assistance in putting on these devices, e.g. hearing aid, leg prostheses, etc. should be included as one aspect of dressing. When completing other categories, consider assistance required once prosthesis is applied.

Locomotion/Ambulation

If applicant is bedridden, check total assistance.

Communication

If a language (translation) problem is the ONLY communication difficulty, check box "no assistance". Indicate the language difficulty under comments.

Medication

If medication is given only once/twice a week, check the first box "none or occasional p.r.n.".

Ministry of Health
Ontario

Application for Type 1, 2 or 3 Care

(EXTENDED CARE INSURED SERVICE)

Please print or type

SECTION A

Applicant's Surname	Given Name	Initials	Date of Birth (day / month / year)	Age	Se

OHIP Number	Surname of Insurance Holder	Initials	Applicant's relationship to Insurance Holder
			1 ☐ Holder 2 ☐ Spouse 3 ☐ Child 4 ☐ Dependent Over age 2

Is applicant receiving social assistance?	Present Location:	If Applicable		
☐ Yes ☐ No	1 ☐ Nursing Home 2 ☐ Psychiatric bed. 3 ☐ Home for the Aged 4 ☐ Acute bed 5 ☐ Home 6 ☐ Chronic bed 7 ☐ Other	Licence or Registration Number of Present Facility	H.S.C. Applicant ☐ Yes ☐ No	H.S.C. Resident

Drug Benefit Number	Other Insurance *(please specify)*	Social Insurance Number

Permanent address of Applicant	Telephone No. where applicant or responsible person can be contacted

Address where Eligibility Certificate should be mailed

☐ As above ☐ Other *(Please specify)*

Has applicant been an Ontario resident for the 12 months immediately preceding date of application?	I agree that application be made	Date
☑ Yes ☐ No	*(Signature of Applicant or Representative)*	

SECTION B

Degree of Staff Assistance in Daily Activities/Functions *(To be completed by physician or designate)*
In each of the following sections, check the box which best describes the usual degree of Staff Assistance required in that daily activ or function.

EATING	DRESSING	GROOMING (mouth, hair care, etc.)	BATHING (tub/shower/sponge, include trans)
☐ No assistance	☐ No assistance	☐ No assistance	☐ No assistance
☑ Assistance with one or two aspects of eating or supervision	☑ Assistance with one or two aspects of dressing or supervision	☑ Assistance with one or two aspects of grooming or supervision	☐ Assistance with one or two aspects of bathing or supervision
☐ Assistance with several aspects of eating	☐ Assistance with several aspects of dressing	☐ Assistance with several aspects of grooming	☐ Assistance with several aspects of bathing
☐ Total assistance	☐ Total assistance	☐ Total assistance	☑ Total assistance

SKIN CARE	BLADDER CONTROL	BOWEL CONTROL	TRANSFER/POSITIONI (bed/chair/wheelchair, toilet
☑ Routine/preventive care-skin intact	☑ No assistance	☐ No assistance	☑ No assistance
☐ Routine plus special treatment-one or two small areas involved	☐ Needs reminding only	☑ Needs reminding only	☐ One staff needed for transfers/ positionings
☐ Routine plus special treatment-large and/or many areas of skin broken	☐ Needs regular toileting/ catheter care/occasional incontinence	☐ Needs regular toileting/ colostomy care/occasional incontinence	☐ Two or more staff needed transfers/positionings
	☐ Needs frequent attention-incontinent	☐ Needs total care e.g. frequent incontinence or enemas	

LOCOMOTION/ AMBULATION	ORIENTATION (time/place/person)	COMMUNICATION (perceiving/understanding/responding) Not language difficulty	SOCIO-EMOTIONAL SUPPORT
☐ No assistance even if crutches, canes, walker, wheelchair, etc. used	☐ No assistance-well oriented	☑ No assistance-communicates with ease	☐ Routine support, e.g. encouragement, discussion fears/worries
☑ Assistance in negotiating specific problem locations e.g. ramps, stairs, corners, etc.	☑ Some assistance/reminding, e.g. finding way, knowing time of day, etc. poor judgement.	☐ Some difficulty (input or output may need to be repeated or written)	☑ Some intervention for mild behavioural problems e.g. depressed, noisy, resistive times, etc.
☐ Considerable assistance with locomotion/ambulation	☐ Considerable supervision/ assistance e.g. wanders, difficulty following directions, etc.	☐ Moderately severe difficulty (use of pictures, objects, gesture required)	☐ Considerable intervention-persistently disruptive, host destructive, etc.
☐ Total assistance		☐ Severe difficulty (almost no comprehension of input and/ or no comprehensible output)	

Person providing information: ______

Comments: ______

Diagnosis — Primary: ______

MEDICATION (oral, drops, suppositories, laxatives, etc.)

☐ None or occasional p.r.n. (including injections)
☐ One or two medications once or twice daily (no injections)
☑ Several medications three times or more daily (no injections)
☐ I.M. or S.C. only

Applicant's Surname | Given Name

SECTION C

General Information: *(To be completed by physician or designate)*

State of Consciousness: ☐ Conscious ☐ Semi-Conscious ☐ Unconscious

Physical Abnormality: ☐ Yes ☐ No Describe

Pain: ☐ Mild ☐ Moderate ☐ Severe Describe

Oedema: ☐ Peripheral ☐ Other Describe

Skin: ☐ Abrasions ☐ Rash ☐ Bruises ☐ Ulcerations ☐ Pressure sores ☐ Other Describe

Appetite: ☐ Good ☐ Fair ☐ Poor

Nutrition: ☐ Well nourished ☐ Under nourished ☐ Overweight Height Weight

Other: ☐ Prosthesis ☐ Brace ☐ Splint ☐ Dentures ☐ Eyeglasses ☐ Contact Lenses ☐ Hearing Aid

☐ Pacemaker ☐ Other Describe

Social Information:

Name of next of kin/responsible person | Telephone Number

Address

Present Marital Status ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Other

Type of Accomodation: ☐ Owns home ☐ Rents Home ☐ Boards ☐ Rents Apartment

Living Arrangements: ☐ Lives with others ☐ Lives alone

Financial Assistance Required: ☐ Yes ☐ No Describe

Preferences: ☐ Smoker ☐ Non-Smoker ☐ Alcohol *(specify)* Religion

Language:

Previous Occupation:

Interests *(please specify)*

Other Social Information

Social Emergency Admission *(specify)*

SECTION D

Professional Service Needs *(check and specify) (To be completed by physician or designate)*

☐ **Nursing**
- Dressing
- Tubefeeding
- Intravenous feeding
- Tracheostomy care
- Irrigations
- Indwelling Catheter
- Oxygen
- Other Techniques

☐ **Nutrition**
- Special diet

☐ **Laboratory Tests**
- Type
- Frequency

☐ **Radiology**

☐ **Physiotherapy**

☐ **Occupational Therapy**

☐ **Speech Therapy**

☐ **Social Work**

☐ **Community Support Services** *(indicate under comments)*

☐ **Other**

Present Medication

Drug	Date Prescribed	Dosage	Frequency	Route

Comments *(Sections C and D)*