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A STUDY TO DETERMINE THE CONTINUING PROFESSIONAL EDUCATION NEEDS OF NURSING HOME SURVEYORS

By

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ABSTRACT

A STUDY TO DETERMINE THE CONTINUING PROFESSIONAL EDUCATION NEEDS OF NURSING HOME SURVEYORS

By

Grace A. Kerlin

This study was developed to examine the continuing professional education (CPE) needs of nursing home surveyors. It was intended to address the variations in the way surveyors evaluate the care given in nursing homes. A three-part survey instrument was administered to eighty-two (82) surveyors in a mid-western state. It included professional background information (PDI), self-perceived needs and interests in CPE, preferred methods for presentation of educational material and twenty-five (25) true/false questions relating to issues concerning older persons. The three sections of the survey questionnaire were correlated to determine significant relationships between the independent variables (nine items in the PDI) and the dependent variables (CPE needs and score on the true/false questions).

The four major research questions were:

1. What are the areas and levels of need for continuing professional education among the nursing home surveyors by discipline, on each of the items on the continuing education needs and interests assessment?

2. What are the relationships between surveyor scores on the gerontology knowledge instrument and their perceived needs for continuing education?

3. What are the primary factors that influence a surveyor's judgement relative to the criteria they use in making judgements?

4. How can uniformity in surveyor judgement during the nursing home certification process be improved?

Data from the CPE needs assessment indicates a fairly high need for CPE in drug use, legal issues of surveying, and diversional activity for lower functioning residents. Higher educational preparation had a significant positive correlation with higher interest in CPE and with more need for CPE.

The Gerontology Knowledge Instrument (GKI) questions yielded a mean of 18.55 on twenty-three questions. There was a strong positive correlation between age and previous professional work experience and score on the GKI.

Recommendations based on study findings include changes in the selection and orientation of new surveyors and reorganizing in-service education to allow greater individual choice. It would be reasonable to expect nursing home surveyors to eventually attain the status of aging specialist practitioner. In the interim, the status of aging generalist practitioner should be the minimum standard for new nursing home surveyors.

DEDICATION

To my family, for their patience and encouragement that served as a constant source of motivation for the successful completion of my degree.

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Finally, gratitude is expressed to the survey respondents, whose overwhelming cooperation made this study possible.

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Introduction

The care given to residents of nursing homes and other long-term care facilities has historically been a matter of public concern. Since the Civil War, the care of the elderly has undergone radical changes both in the provision and funding of care and in the way quality of care is measured and regulated. Because of such changes, it has become evident that the individuals who judge the care in long-term care facilities must possess state-of-the-art knowledge of the care and conditions of the aged if their decisions are to be fair and accurate. The provision of appropriate continuing education is a function of the Health Department, the entity responsible for the licensing and certification of nursing homes and other long-term care facilities throughout the state.

Background

The present nursing home industry originated from various types of facilities that were common in the late 19th and early 20th centuries. State mental hospitals, county poorhouses, private boarding houses and ethnic and

religious homes provided the bulk of the care for the homeless or aged in that era. Until the Great Depression of the 1930s, local governments supported each county poorhouse or almshouse. Because those homes had a reputation for poor living conditions, reformers appealed to lawmakers and worked to have them closed (Waldman, in Vogel & Palmer, 1983). The passage of the Social Security Act in 1935 was responsible for their eventual disappearance. The Old Age Assistance portion of the Social Security Act dispensed monthly payments directly to the aged to be used for nursing home care (Waldman, in Vogel & Palmer, 1983). That change marked the beginning of nursing home care as a business, as competition to attract residents with their government subsidies began.

State licensure of nursing homes began in the 1930s to ensure that minimal capacity of the facilities to provide nursing care was available. Although state licensure inspections were based primarily on structural aspects rather than direct observation of care, few nursing homes met health and safety and nursing care standards.

From 1936 until the 1950s, as the proprietary nursing homes were expanding in the absence of effective government regulations, reports of abuse and inadequate care attracted public attention and prompted government action. In 1959, a special senate subcommittee was formed to address problems of older people requiring care outside the home (Institute of Medicine, 1986, Appendix A). The committee reported that

substandard care was indeed being provided by poorly trained nursing home personnel and that many states were not enforcing existing regulations. Those regulations that were enforced were not consistent among the states and some states were reluctant to close the homes without alternative placements for the residents. The study also reported that few states had adequate staff to survey the nursing homes and that the qualifications of state surveyors varied greatly.

The Medicare and Medicaid legislation in 1965 expanded funding to nursing homes and, at the same time, gave the department of Health, Education and Welfare (HEW) the authority to set standards for homes receiving federal funds (Institute of Medicine, 1986, Appendix A). Facilities already licensed by the state and wishing to participate in the funding program for providing care to Medicare and Medicaid residents now had to be certified. Federal regulations were promulgated that facilities were required to meet in order to obtain certification. As with existing state licensure rules, the federal regulations were based primarily on structure and process rather than the actual effects of the care the facilities provided.

In the state under study, the Department of Public Health (DPH) is the agency responsible for monitoring the quality of care in long-term care facilities. Teams of surveyors visit each facility at least once a year and report their findings. During the mid 1970s, increased

federal funding made it possible to increase hiring and begin adding other health care disciplines to survey teams. The multidisciplinary teams were composed of one or more registered nurses, a dietitian and a sanitarian or health care analyst. Most of their tasks on-site in the facilities consisted of reviewing records and providing consultative services. The team method, while adding more knowledge and expertise, still focused primarily on policies and procedures in the nursing homes.

Throughout the country, even facilities that passed their survey, continued to provide substandard care. In 1983, Congress again responded to public pressure to address the conditions in nursing homes. The Health Care Financing Administration (HCFA) commissioned the Institute of Medicine to do a recommendation study for the purpose of improving the regulatory process and, ultimately, the quality of care in long-term care facilities. The result of that comprehensive study was the foundation of the Omnibus Budget Reconciliation Act of 1987 (OBRA).

Recommendations for improving the quality of care in nursing homes centered on the survey process, facility staff training, assessment of residents' conditions and planning appropriate care. A basic tenet of the OBRA regulations is resident outcome, the result of care provided by the facility. Facilities reimbursed by Medicare and Medicaid are now required to focus on the quality of life of their residents. "Quality of life" includes not only the

resident's medical condition, but also the social and physical environment. Nursing homes are now held accountable for helping all residents to reach and maintain their highest practicable level of physical, mental and psychosocial functioning.

In addition to mandating a higher quality of care, OBRA will eventually provide a mechanism to issue financial penalties and other remedies to facilities that fail to comply with minimum care requirements. Currently, HCFA has the authority to withhold certification from long-term care facilities found to be substantially out of compliance with OBRA regulations, making them ineligible to receive federal funding.

Since OBRA took effect in October, 1990, the DPH has added social workers to the survey teams to strengthen the evaluative focus on psychosocial aspects of care in nursing homes. Currently, survey teams surveying each home comprise one or more registered nurses, a social worker and either a dietician, pharmacist or sanitarian. The responsibilities of the dietician, pharmacist and sanitarian are included in the job description of the "other discipline (OD)." The position responsibilities cross lines of professional disciplines and require the health professional to evaluate factors normally outside their area of expertise. The DPH also has a separate "complaint team" for the purpose of making timely investigations of complaints from nursing home residents or their families. This team comprises registered

nurses, social workers and sanitarians. Only one person from the team visits the nursing home to either validate or negate a complaint.

All surveyors are required to scrutinize the care provided in facilities and determine its effect on the residents, including both positive and negative effects. When negative care outcomes are observed, the surveyors must look further and investigate clinical records, as well as interview residents and staff members to determine the cause of such outcomes. In applying the nursing process, and in a way similar to the Orem theory of self-care (Matteson & McConnell, 1980), the facilities are expected to assess each resident's ability to perform self-care and plan their care accordingly (self-care is the practice of activities that a person initiates independently to maintain life, health and well-being). Nursing home personnel use an assessment instrument called the Minimum Data Set (MDS). It is a set of standardized screening and assessment elements that trigger resident conditions requiring additional assessment that follows specified protocols.

After assessing the abilities of a resident, the facility staff use the assessment information to plan care that meets and supports the resident's deficits as necessary, but is withdrawn as resident performance improves. The amount of assistance given varies according to the level of dependence. As the resident's needs and condition change, the care is revised to support resident

strengths and increase independence. The accuracy of assessment, planning and implementation of care in conjunction with ongoing evaluation of care, is all included in the tasks the surveyors perform to evaluate the facility's performance.

When on-site for a survey at a facility, survey team members visit all residents of the nursing home before selecting a sample of the residents to be studied in-depth. Surveys are usually carried out over one to four days. During that time emphasis is placed on the assessment of resident conditions, the comprehensiveness of plans for their care and the outcomes of that care. Concurrently, the physical environment is evaluated, and the qualifications of staff are reviewed. Dietary services and clinical files of residents who were discharged, or who expired, are studied as well.

To date, as nursing homes have been evaluated on their ability to provide care that maintains maximum wellness in the presence of disabilities, it has become more evident that there are variations in judging the quality of care and other issues among surveyors and also among survey teams. If the OBRA goals of quality care and living experiences are to be met, surveyors must continually strive to improve the accuracy of their evaluations and lessen the variation in judging care.

To improve the uniformity of surveyor performance, The Health Care Finance Administration (HCFA) has designed a

series of seven specific tasks that surveyors are to perform to ensure optimum collection of data (State Operations Manual, 1992).

Task One: Off-site Survey Preparation

The team member assigned as coordinator for a survey reviews the file on the facility. Of special note is information on changes in key personnel, deficiencies found on previous visits, abuse reports, complaint investigations and other pertinent information. Team members agree on assignments and plan the most efficient way to survey the facility.

Task Two: Entrance Conference/On-site Preparatory Activities

Upon arrival at the nursing home, the team coordinator informs the facility administrator about the survey and answers any questions from facility personnel. The facility is provided with signs announcing the survey to residents and visitors and offering to meet with any of them on a private basis. The local Ombudsman is contacted and invited to be present at the exit conference on the last day of the survey.

Task Three: Orientation Tour

Some or all of the members of the survey team tour different locations of the facility with a facility employee. The surveyors introduce themselves to the residents while observing the quality of care, quality of

life and any resident's rights problems. Problem areas include poor grooming, agitation, dehydration, poor positioning, inactivity and poor staff-resident interactions. Names of residents who would be likely candidates to be included on the sample would be noted.

Task Four: Resident Sampling

A case-mix stratified sample of residents is selected to be studied in-depth. The four categories of the case-mix are:

1. Category A--interviewable residents who require only light care.

2. Category B--interviewable residents who are more dependent and require heavier care.

3. Category C--non-interviewable residents who require only light care.

4. Category D--non-interviewable residents who require extensive or total care.

Included in the four categories are residents with special needs or conditions, such as pressure sores, underweight, physical or chemical restraints, feeding tubes, contractures, mental retardation and mental illness and residents who request to be interviewed.

Task Five: Information Gathering

Information is obtained by interviewing staff, residents and families, by observation of procedures and routines, and by reviewing the clinical files of residents.

The team meets on a daily basis to share the findings and concerns indicated by the following:

Environmental quality assessment. The surveyors observe physical features such as proper lighting, sanitation, adaption to residents' needs, safety, kitchen sanitation and home-like environment of residents' rooms.

Quality of care assessment. The residents are observed for negative outcomes (contractures, pressure sores, passivity, fear, etc.) or lack of positive outcomes, and possible causes are investigated. The depth and accuracy of assessment of resident conditions and needs is reviewed and compared to how care is planned and actually delivered to residents. The dining room atmosphere and adequacy of diets also are noted.

Closed record review. At least five records of residents no longer at the facility are reviewed to determine appropriateness of care and planning for discharge.

Residents' rights assessment. Residents and families are interviewed to determine their satisfaction with meals, daily routines, roommates, finances, privacy, involvement in care, and handling of grievances.

Dietary services assessment. The quality of food, appropriateness of diets, adequacy of the staff's knowledge and cleanliness of kitchen and equipment is evaluated.

Medication pass. Facility staff nurses are observed as they administer medication to residents. Emphasis is on actual medication errors and practices that foster them.

Task Six: Information Analysis and Decision-Making

The survey team meets to merge their findings and determine if negative outcomes are of sufficient frequency and severity to warrant citations. Guidelines in determining citations to be issued are given on a scope/severity matrix (see Figure 1).

Violations of regulations that occur rarely (position A) and are likely to cause little harm would probably not be cited and are included in the "comment" area of the matrix. Surveyors would discuss those findings with the facility administrative staff and depend on them to rectify the problematic issues. Violations occurring as a pattern (position B) in the facility and of potential harm would be citable, as would a serious violation occurring only once (position C) and resulting in actual or potential harm.

Task Seven: Exit Conference

Facility personnel, the local Ombudsman and interested residents meet with the surveyors, and survey findings are conveyed to them. A detailed, written report of the findings is sent to the facility within ten days. The facility is then required to respond with a plan of correction acceptable to MDPH. A follow-up visit will be made if level A or level B deficiencies have been found.

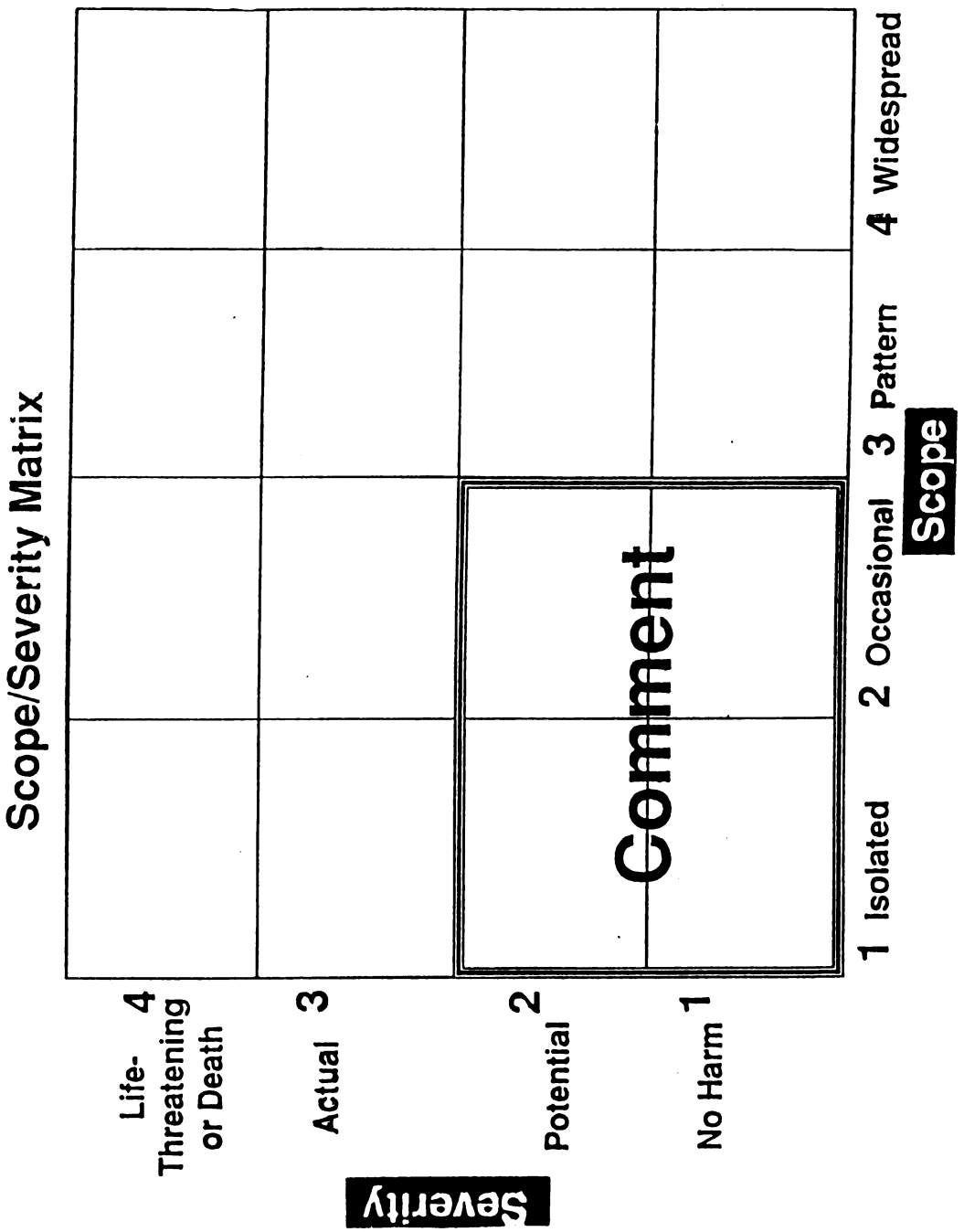

Figure 1. Scope and Severity of Citations

Prior to OBRA, the instrument used to collect data by the surveyors in nursing homes was the Patient Care and Services (PaCS) survey instrument. Deficiencies in care provided by nursing homes were delineated by the level of seriousness. The most serious violations were termed "Conditions" of participation in the certification program. Less serious violations were termed "Standards." The intent of the PaCS instrument was to move away from judging care based on facility structure and move toward judging the actual delivery of care and outcomes of it. It was intended to give the surveyors concrete guidelines in citing deficiencies by the level of seriousness. The instrument did not substantially improve the consistency of citations because there were still no definitive criteria for surveyors to use when citing serious deficiencies, but left them to "unguided surveyor judgment" (Institute of Medicine, 1986).

The most recent survey instrument developed for use in OBRA surveys of nursing homes still separates the regulations into a hierarchy, relabeled as "A" and "B" levels. A major change from the PaCS instrument is that more extensive interpretive guidelines for OBRA regulations are available for each regulation. The purpose of the guidelines is to assist the surveyors in forming conclusions about the quality of life and quality of care for residents in nursing homes and to rely less on individual opinions. Figure 2 offers an example of a level B regulation and

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F240-A	§483.15 Quality of life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.	
F241	(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	Interpretive Guidelines: §483.15(a) "Dignity" means that in their interactions with residents, staff carry out activities which assist the resident to maintain and enhance his/her self-worth. For example: o Grooming residents as they wish to be groomed (e.g., hair combed, beards shaved/trimmed, nails clean and clipped); o Assisting residents to dress in their own clothes appropriate to the time of day and individual preferences; o Promoting resident independence and dignity in dining (such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware, dining room conducive to pleasant dining, aides not yelling); o Respecting resident's private space and property (e.g., not changing radio or television station without resident's permission); o Respecting resident's social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with a name of the resident's choice); and o Focusing on residents as individuals when they talk to them. For sampled residents, use the Resident Assessment Instrument (RAI) and comprehensive care plan to consider the resident's former life style and personal choices made while in the facility to obtain a picture of characteristic resident behaviors. Residents have a right to participate in care and treatment. This includes, to the extent practicable, working with the facility to set up daily schedules. Such activities are appropriate for care conferences. Survey Procedures and Probes: §483.15(a) Observe staff-resident interaction. Do staff show respect for residents? When staff interact with a resident, do staff pay attention to the resident as an individual? Do staff notice the resident? Do staff act toward the resident as if he or she is the only person with whom they are relating? In group activities, do staff focus attention on the group of residents? Or, do staff appear distracted when they interact with residents? For example, do staff talk with each other while doing a "task" for a resident(s) as if she/he were not present? Does the physical contact between staff and residents support residents' independent functioning and psychosocial well-being? (See also, 42 CFR 483.15(e), Accommodation of Needs.)

Figure 2. "A" and "B" Models

accompanying interpretive guidelines (State Operations Manual, 1992).

Assessing quality of care may be performed by evaluating the structure, process and outcome of care (Vogel, 1983). Structure refers to the plant and the staff capacity to provide care; process is how the care is delivered; and outcome is the change in status or condition. Traditionally, structure was used as a measurement tool because it was the easiest to observe. Most difficult to evaluate were the outcomes of care because of the complexity of resident conditions.

Although residents of nursing homes are likely to have chronic diseases, functional disabilities, and/or deterioration in mental faculties, such conditions are not inevitable consequences of aging. Older people can be helped to make independent choices regarding health and lifestyles while maintaining dignity and self-esteem. It is essential that nursing home surveyors be well-grounded in gerontology and geriatrics if they are to effectively evaluate institutional care and the degree of success facilities have had in helping each resident to reach the highest practicable level of function.

The surveyors employed by the DPH are professionals in the health field, and the majority have Master's Degrees. Although some may have experience in gerontology and geriatrics, the lack of such experience or formal training does not preclude a potential surveyor from a position.

Once hired, surveyors undergo an orientation program varying in length according to their past experience but averaging from two to three months. After the orientation period and additional field experience, surveyors attend a one-week, HCFA-sponsored training course. Surveyors from all regions of the country are gathered together to receive a standardized training for the surveyor role that also serves to reinforce their orientation training.

As with orientation, CPE for surveyors currently employed by DPH focuses primarily on interpretation and application of federal and state laws concerning long-term care facilities. The day-long sessions are held once a month and are presented in a lecture format. Although a portion of each session is allotted to issues in professional education, it is presumed that all surveyors have a basic knowledge of normal aging and of disease processes in the aged. Research in both gerontology and geriatrics has expanded since the 1950s and has enhanced our understanding of the aged as well as providing new guidelines for their care. Because of the emphasis on appropriate care for the aged, it is vital that the people concerned with regulating nursing homes be knowledgeable in the field of aging.

Statement of the Problem

Variations among nursing home surveyors as they judge the quality of care in long-term care facilities pose a

problem during nursing home surveys. During a survey, specific aspects of care may be considered seriously deficient by one surveyor, while at the same time seen as satisfactory by a colleague. The varying pattern in which surveyors issue citations for deficiencies regarding resident care can be frustrating to facility personnel as well as to surveyors. While differences among survey team members remain unresolved, nursing home groups are beginning to take political and legal action as a result of what they perceive as disparities in surveyor judgment. Areas addressed by the study are the levels of gerontologic knowledge of surveyors and their perceived needs and interests in continuing professional education (CPE). Surveyors have full schedules that include traveling and frequent overnight stays. Planning effective and efficient educational interventions to lessen surveyor variations can be a difficult task.

Purpose of Study

This study investigates the needs and interests of nursing home surveyors regarding content, methodology and timing of continuing professional education (CPE). More specifically, it focuses on gerontological knowledge of surveyors in order to allow the staff-development team to formulate CPE plans that could be used in future orientation and in-service programs. Individualized CPE programs could facilitate staff competency, improve surveyor satisfaction

with their performance and also serve to enhance the careers of the staff development team if more effective training is accomplished. Concurrently, surveyor competence and improved care in nursing homes would place the state in a leadership role in the effort to achieve OBRA goals for nursing homes after nearly sixty years of reform efforts.

Major Research Questions of the Study:

The four major research questions of the study are as follows:

1. What are the areas and levels of need for continuing professional education among the nursing home surveyors by discipline, on each of the items on the continuing education needs and interests assessment?

2. What are the relationships between surveyor scores on the gerontology knowledge instrument and their perceived needs for continuing education?

3. What are the primary factors that influence a surveyor's judgment relative to the criteria they use in making judgments?

4. How can uniformity in surveyor judgment during the nursing home certification process be improved?

Limitations of the Study

The study surveyed only nursing home surveyors and complaint team surveyors employed by the Department of Public Health in a specific midwestern state. No attempt

will be made to study the interpersonal dynamics of the survey team members, how surveyors rationalize their decisions or the effect of bureaucracy on the judgment of surveyors. Rather, the study investigates the needs and interests of surveyors regarding content, methodology and timing of CPE. It also focuses on their gerontological knowledge.

CHAPTER TWO

Review of the Literature

Lifelong learning is no longer a choice for professionals, but a necessity if they are to experience productive work lives that impact positively on their professional roles. The number of adults who take part in continuing education has grown as new information and technology is made available. However, literature discussing continuing professional education (CPE) for nursing home surveyors is sparse. A study on nursing home "inspectors" in England noted "a most striking aspect" of nurses' educational background was that most had not completed a basic course in geriatric nursing. However, the nurses in the study indicated their major educational need was study of the law rather than material covering care of the aged (Bennett, 1987). In studying the continuing professional education (CPE) needs of nursing home surveyors, it is helpful first to discuss theories of motivation that offer explanations why adults seek out or take part in continuing education activities.

Theories of Adult Education

Theorists have speculated on the motivations of adult learners. Maslow developed a comprehensive view of human behavior. He believed that once physiological and sociological needs were satisfied, the more pressing motivating factors for additional education were those of self-actualization. Also, that some of the characteristics present in self-actualized persons could increase learning, such as being problem-centered, autonomous and possessing a stronger sense of ethics (Darkenwald & Merriam, 1982).

The term "androgogy" was first used in 1833 by Andrew Kapp in Germany as he referred to Plato's theory of education (Allman & Mackie, 1983). In this country, the term was first used by Malcom Knowles (Knowles, 1970) and was defined by him as "the art and science of helping adults learn." Knowles set forth four assumptions that separated adult learning from that of children:

1. With maturity, the learner becomes more self-directed.

2. Maturity and experience become a resource for learning.

3. With maturity, readiness to learn is more oriented toward social roles.

4. The adult learner becomes less subject-centered and more problem-centered.

Like Knowles, Houle found that goal-oriented adults seek information for future application (as in school

curriculums) rather than seeking information that is applicable to their immediate interests and needs (Houle, 1963). Houle identified three categories of adult learners that varied in their educational objectives:

1. Goal-oriented--the educational experience is pursued for a specific objective (a problem).

2. Activity-oriented--the stated objectives of the learning activity may have no connection with the learner's purpose (i.e., fellowship).

3. Learning-oriented--seek knowledge for its own sake.

Houle believed that the need or interest in a topic was an important motivator for the goal-oriented adult learn

Allan Tough (1971) studied the adult's deliberate learning efforts and concluded that about 70% of all learning projects are self-planned and usually for practical reasons. Many of the learning projects involve the learner's daily work either when entering a new position or striving for a promotion, or simply as maintenance of the necessary skills and knowledge to retain competence. Tough focused on self-planned learning and its popularity due to several factors, including the belief that the adult learner may have a more accurate sense of what they need in educational topics, methods, the time needed to learn the material and individual learning idiosyncracies.

The force-field analysis model by Miller (1967) attempted to explain positive and negative forces affecting participation by adults in education. Its purpose was to

delineate the force of the positive and negative factors as they affect motivation, as well as subjecting them to analysis for purposes of modifying elements where possible.

Rubenson (in Cross, 1981) delved further into motivation for continuing education with the expectancy-valence model. The expectancy aspect includes expectations of personal success and the positive consequences of the learning activity. If either is zero, there will be no motivation to take part in learning activities. The valence considers the learner's affect (positive, negative or indifferent) depending on the values put on the consequences of participation. One of the central features of the model is the learner's perception and interpretation of the environment. The model includes the effects of the hierarchial structures and values of reference groups. Cross (1981) organized writings on adult education theory and practice from several theorists and developed the chain-of-response (COR) model explaining motivation for learning based on several variables affecting participation in educational activities.

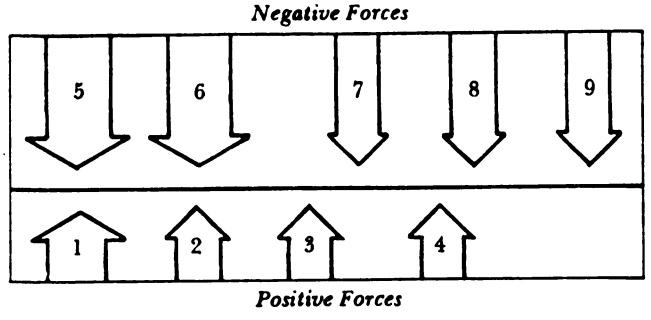

Figure 3. Miller's Positive/Negative Forces

The COR model incorporates four categories of barriers to adult learning participation (Darkenwald & Merriam, 1982): situational, institutional, informational and psychosocial. Situational barriers can be characterized by time constraints, institutional barriers by lack of choice or time, informational barriers by lack of awareness of CPE programs and psychosocial barriers by attitudes such as lack of interest or lack of belief that CPE would be helpful. Using the model to visualize and identify the barriers in the professional's work setting offers insight regarding unspoken reasons for nonparticipation, and determines areas for intervention.

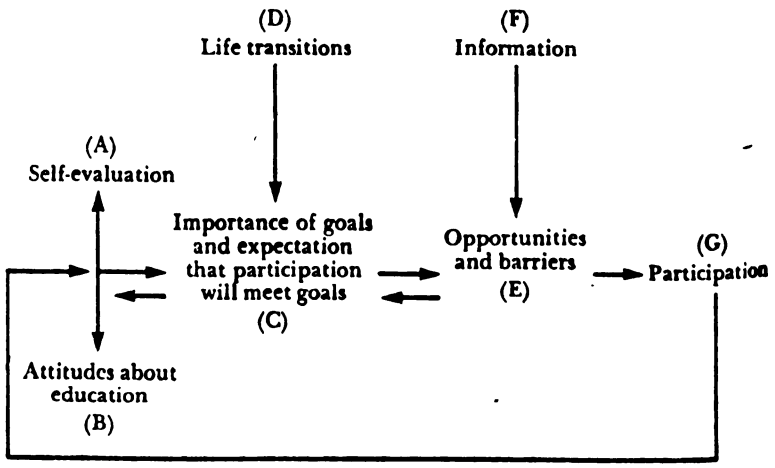

Figure 4. Chain-of-Response (COR) Model for Understanding Participating in Adult Learning Activities

A proponent of continuing education for professionals, Houle observed that professionals set high standards for themselves and that the nature of their work requires them

to remain current with new theories and practices. Changes in work roles within a profession (similar to changes experienced by nursing home surveyors) may occur frequently during the career of professionals without provision for learning the new role (Houle, 1980).

Kolb (1974) studied the problem-solving process as it is manifested in four types of learning styles (concrete experience, reflective observation, abstract conceptualization and active experimentation). He contends that while individuals may use all four styles, they develop a tendency to emphasize one in particular. Writing in Chickering's "The Modern American College," (Kolb, 1985), Kolb described his observation of some students in the college engineering program having difficulty with the subject material. The difficulty often resulted in confusion and loss of energy. He eventually concluded that the problem was a result of a "mismatch" between personal learning styles and the learning demands of a specific discipline, finally stating that persons develop distinct cognitive styles (Kolb, 1985) over their lifetimes that determine their predominant learning style and that specific professional disciplines may attract students of similar learning styles.

Adding to work on learning styles, Rancourt (Noble & Rancourt, 1991) has developed a model for ways of knowing, seeking to answer some of the causes of intradisciplinary

conflict within nursing based on knowledge-accessing modes. He describes these three distinct modes of knowing:

1. Empirical mode--use of senses and inductive reasoning.

2. Noetic mode--use of intuitive feelings and abductive reasoning.

3. Rational mode--use of defined standards or rules and deductive reasoning.

Although, as noted by Kolb, members of different professional disciplines tend to use the same modes, Noble's study found that nurses of different educational backgrounds differed in the predominance and flexibility of their use of the three modes. Because the knowledge processing ability affects problem-solving, interpersonal relations and perspectives of nursing practice, it also affects work roles and advancement possibilities. Understanding the learning modes of professionals helps to clarify the reasons for conflict that result from problems and issues seen from different perspectives by health team members.

Gerontology

Gerontology is the study of the aged as affected by social, political and related social aspects of aging (Cox, 1984). Geriatrics is a branch of medicine that deals with the problems and diseases of old age (Cox, 1984). Understanding the aging process and the associated changes,

losses and diseases is a part of the challenge for nursing home surveyors and others who work with older people.

Gerontology programs in colleges have grown since the passage of the Older Americans Act in 1965 although not all yet offer instruction in gerontology (Peterson, 1986). A study by the Association for Gerontology in Higher Education in 1988 stated:

> Gerontology instruction on every campus is a viable objective for the future, and when it is achieved, it will provide the basis for eradicating the stereotypes and misinformation about aging and older people...in order to achieve gerontological literacy, and to assure that our society will seek justice and dignity for our older citizens (in Verderber & Kick, 1990, p. 360).

Clark notes that gerontology and geriatrics are necessarily multidisciplinary if we are to fully understand the different experiences of aging and meet the needs of older persons (Clark, 1991). Peterson delineates categories of gerontology students into four groups, including the general practitioner in an existing profession and the aging specialist in existing professions. The general practitioner requires a sensitivity to the aged and knowledge of differences between normal and pathological aging. The aging specialist must know the interaction of physical, mental and social components, be able to adapt professional skills to the needs of the aged and be able to apply interventions as well as consult on treatments for the aged (Peterson & Wendt, 1990). A study of Public Health

Inspectors in Canada (Fulton & Sutherland, 1991, p. 10) concluded, although speaking of general public health issues, that the inspectors needed to be "more specialized and better educated to meet the environmental and societal needs of the future." The current thinking is that the inspectors should at least be generalists, if not specialists, in public health issues. A report from the Institute of Medicine and National Research Council supports the Canadian study with comments that lack of specifically trained geritricians or gerontic nurses to help residents cope with diseases and changes of aging may contribute to physical deterioration (Rabin, 1985).

In our youth-oriented culture the presence of misconceptions and stereotypes about old age among the people providing services to the aged may not be conducive to helping the older person adjust to the aging process. A study with college students as subjects included reading vignettes about people of different ages, both old and young. The vignettes described examples of long- and short-term memory failure. Pictures of the subjects accompanied the articles. The college students judged the older participants to have more mental difficulties and have need of professional evaluation, while younger subjects with memory difficulties were excused as lacking in attention or by judging that the task was too difficult (Erber & Rothburg, 1991). Medical residents in family practice specialty were surveyed using the Palmore facts on aging

quiz. They did poorly on the quiz and also demonstrated a low preference for working with older patients (Senger, O'Brien & Barker, 1985).

Weiner and Kayser-Jones (1989) have studied the functional organization of nursing homes and propose that as federal nursing home regulations have been interpreted and implemented, they result in an adversarial situation culminating in defensive work, an institution-protective avoidance strategy that contrasts with the therapeutic role with which they are charged. While the study emphasizes the defensive posture of the nursing facilities, it also points to one of the major underlying problems: that of staff not adequately trained to care for geriatric residents. Weiner and Kayser-Jones feel improved care could be given with better assessment, monitoring, planning care and evaluation, all part of the basic components of the nursing process.

Before the implementation of the OBRA survey process in 1990, Spector investigated specific characteristics of nursing home residents that affect outcomes of their care (Spector & Takada, 1991). He paid special attention to links between structure and process on outcomes, particularly on mortality, functional decline and functional improvement. The study results suggest that functional decline is associated with higher rates of catheter usage, poor skin care and low participation in organized therapeutic activities. Improvement in functional ability is re-lated to a greater number of registered nurses and

less staff turnover, as well as receiving citations from nursing home surveyors for care deficits.

Timko (Timko & Moos, 1991) describes the social climate of long-term care facilities for the aged, proposing that social climates in facilities, like people, can be friendly or not, and therefore affect resident outcomes. Facilities that promoted increased independence, allowed less regimentation and encouraged resident-staff interaction and resident input resulted in improved psychological well-being for residents and generally improved functional status. Earlier, Solomon discussed learned-helplessness of the aged in health care settings (Solomon, 1982). Learned-helplessness refers to the downward cycle accompanying the older person's perception of lack of control over his or her life, resulting in apathy and helpless behavior. The sense of loss of control was due to stereotypes of providers, such as the aged being dependent, requiring more bedside nursing care, having limited interests, possessing negative personality traits and being asexual and meddlesome. Implications of Solomon's findings are that education providing factual knowledge of normative aging results in improved relationships between the older person and caregivers while improving coping abilities of the aged.

Variables related to caregivers' behaviors with the aged who were cognitively impaired were studied to determine the factors that influence caregiver-resident interactions (Burgener & Shimer, 1993). Education and knowledge of

dementia was positively related to positive caregiver behaviors. Conversely, a study done in Sweden on elderly females living in a long-term care setting demonstrated that caregivers possessed insufficient knowledge of the physiology of aging. That lack of knowledge was demonstrated to cause the residents to suffer unnecessarily because of improperly administered personal hygiene care by ill-prepared caregivers (Lindell & Olsson, 1989).

Normal changes of aging, while not pathologic, occur at different rates for different people and may be perceived to be signs of illness if they become more noticeable during periods of disease conditions (Ebersole & Hess, 1985). Changes in all systems of the body occur that affect functional ability and consequently the physical, mental, social and environmental spheres of the older person's life. The aged and their caregivers can be educated about normal and abnormal aging factors to better equip them to monitor changes and conditions and make informed decisions about care and treatment.

Schilke reports the need for exercise throughout the life span, extending to later years. Benefits of exercise include positive effects on the cardiopulmonary system, as well as the musculoskeletal and immune systems. The nervous system benefits from improved oxygen consumption, and elderly persons conditioned by regular exercise tend to perform better on tests of psychomotor function and intelligence (Schilke, 1991). Even if the older person is

unable to exercise, caregivers' attention to positioning and seating can have profound effects on outcomes. Plautz reminds readers of the judgments society makes based on appearances. The older nursing home resident slumped in an ill-fitting chair gives the impression of dependence and cognitive impairment. In a sample of seventy-five (75) residents, the average resident did not fit the dimensions of the standard wheelchairs and geri-chairs used in facilities, increasing the likelihood of poor posture, restraint use, skin breakdown and psychosocial decline (Plautz & Timen, 1992).

The environment of congregate living centers for the aged is receiving more attention in the literature as another way of promoting increased function in aged residents. Living areas are preferably designed both to produce a homelike environment and to supply support for physical impairments (Marcu, 1991). Hiatt, an environmental psychologist and gerontologist, envisions a time when, at a staff meeting to plan care for the nursing home resident, an advocate for the physical and social environment plays as prominent a role as the medical and therapeutic staff. Hiatt points to research evidence that poor lighting may play a role in mental deterioration; that there may be a connection between uncontrollable noise and stress in older people; that bathing facilities not adapted to self-care lead to loss of functional ability; and that greater privacy may lead to greater social involvement (Hiatt, 1982). Moos

and Lemke discuss a model that provides a conceptual framework for assessing the environment of older people. It considers all influential factors and residents' reactions to them (1985, p. 867). The model allows for evaluation of interactions between resident and environment so that suitable adaptations can be put into place. The authors cite Lawton's studies on personal competence of older people and their reactions to environmental stresses. The less competent the older person, the less the person is able to cope with wide ranges in environment, and either the person or the environment could be changed to enhance functioning.

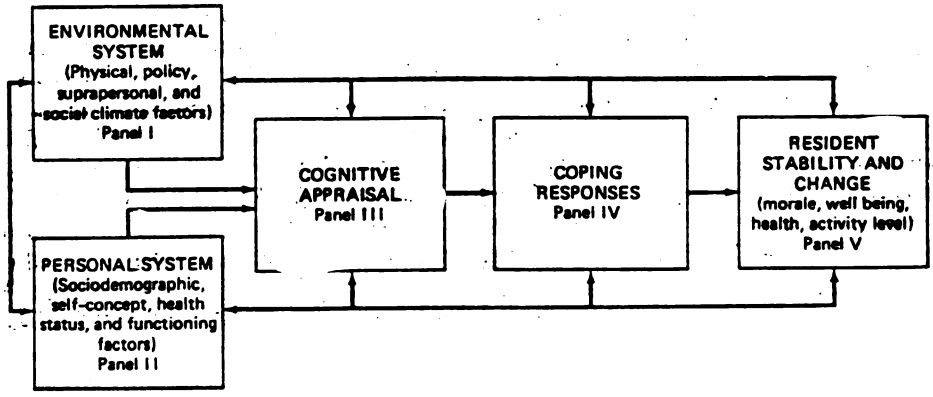

Figure 5. Moos and Lemke's Environmental Model

Continuing Professional Education

As offerings in CPE for health professionals become more prolific to keep up with new research and technology, their influence on practice is becoming an issue. Since most CPE is associated with formal programs, the education may not necessarily be associated with improved performance

(Houle, 1984) Much of the information received in CPE sessions is memory-based and applicable to some future need. Warmuth notes that nursing is a process that is complex, ongoing and requires judgment. As such, CPE cannot provide one answer for all situations, but can assist in providing the basis for answers in some situations (Warmuth, 1987).

Manning (1990) notes that, although useful, formal CPE programs do not always serve the need for specific knowledge in practice situations or when the need for knowledge is immediate. In his research on CPE, he found physicians read several professional journals and attended two or three major conferences yearly. One of their most useful sources of CPE however was access to electronic data banks of the National Library of Medicine. Manning suggests that collection of more data to determine "on-the-spot" informational needs by health professionals could lead to improved information sources available in short and specific blocks that are easily retrievable.

Nurse educators at one nursing college studied the benefits of a computerized decision support system, a software package that gives a concise description of a clinical condition including bibliographies, decision-support guidelines and evaluative essay questions to test independent learning (Lappe, Dixon, Lazure, Nilsson, Thielen & Norris, 1990). Although developed as a support mechanism for instructional preparation activities, such a system could be adapted for field use by health professionals.

Other research on CPE concerns computer-assisted instruction (CAI) to update dietary, medical and nursing staff at a large geriatric facility on drug-nutrient interactions (Mangus & Roe, 1991). The authors conclude that the method was useful in part because of easy access to reference materials, thus little change in staff routine was needed.

Cevero worked on evaluation of CPE (Cevero, Rottet & Dimmock, 1986)) investigating different factors that may impact on effectiveness of the programs. A model was developed using four sets of independent variables to explain differences in behavior change in individuals after CPE programs:

1. characteristics of the CPE program,
2. characteristics of the individual professional,
3. characteristics of the proposed behavioral changes, and
4. characteristics of the social system in which the professional operates (Cevero, 1985).

Cevero notes that processes in the design and implementation of CPE programs must be identified and related to program outcomes. He emphasizes that the social system where the behavior change from CPE is to take place is an equally important force to consider.

Models

A model is the framework that clarifies concepts and depicts relationships and problem areas. A model presented here was originally designed for nursing education in a hospital setting but is adaptable to demonstrate similar stages of career development for nursing home surveyors. Sovie's (1983) theoretical model to demonstrate stages of professional development for hospital nurses defines three levels of career development. The model provides more depth and opportunity for individualization in planning continuing education programs, and delineates successive steps in career advancement.

Sovie believes that if hospitals planned and implemented systematic continuing education, professional nurses would be attracted to, and retained by, such programs. They would feel valued, recognized and more likely to advance professionally. Her ideas were based on Maslow's hierarchy of needs (Cross, 1982) that states lower needs (to be competent and gain approval and recognition) must be at least partially satisfied before the individual is motivated to satisfy higher needs (self-actualization as at the professional maturation level of the model). Historically, job competency is reached by the trial and error method of learning, by observing the modeling of colleagues, reading and other alternatives. Once competency is attained, continuing education served to maintain acceptable performance.

Sovie's three-stage model (1982) is concerned with specific career changes and is useful for planning continuing education targeted to the appropriate stages. Use of the three stages gives recognition to the fact that career advancement is possible and intimates the benefits for the institution as a result of focused staff development. The original three stages of Sovie's model are:

1. Professional identification--orientation and in-service education.

2. Professional maturation--staff development for career development.

3. Professional mastery - individual research and leadership.

Beeler (1990) also is concerned with optimum staff development, and faces the problem of integrating nurses into their required roles from three levels of training: two-year associate's degree programs, three-year diploma programs and four-year bachelor level programs (Beeler, 1990). Tailoring professional career development to the individual was determined to be the most efficient and effective path to follow. Realizing that nurses need the time and opportunity to learn what is expected of them, Beeler builds on Sovie's model by inserting a foundation level into the model that focuses on nurses newly hired into the organization and further describes the remaining levels:

1. Professional awareness--The individual is becoming knowledgeable of what is expected by the organization, peers and the profession. Development of skills is the major focus.

2. Professional identification--The individual is becoming proficient in prioritizing and responding to situations based on previous experience and on the institutional guidelines. The individual becomes more independent in practice, identifies patterns and begins to participate in unit-based activities.

3. Professional maturation--The individual is characterized by a sense of self-confidence in practice with subsequent initiation of information-sharing. Sharing may take the form of committee involvement, serving as a consultant or being active at the local or state level of a professional organization.

4. Professional mastery--The individual is recognized by others for expertise within and outside of the profession. Research and involvement in professional issues at the national level are an integral part of this stage.

Houle noted that practitioners moving into specialized areas of their profession must still qualify for the new position and that such transitions do not have uniform methods to assure adequate preparation for the new role (Houle, 1984). In an effort to facilitate the transition of health care professionals into the role of nursing home surveyors, Beeler`s model could be adapted as a diagnostic

needs assessment model for the orientation and continuing education of surveyors.

Stake's model (1973) addresses the needs for CPE by providing a framework for planning, implementation and evaluation of educational offerings. Stake believed that informal evaluation made without specified and objective criteria was largely ineffective and did not take all factors into account. Means of measuring desired outcomes and specifying both minutiae and global criteria were necessary if planning education and evaluating the results was to be effective. The Stake model has been successfully adapted to continuing education programs for nurses, both for planning and for evaluation (Cowell, Kahn & Bahrawy, 1992).

Figure 6. Stake's Countenance Model

The model's design allows for varying depths of description and evaluation as well as a means for accepting learner input. Provision to monitor the relationships between antecedents to learning, the transactions occurring

during the learning process and the outcomes are depicted in the vertical column of both the descriptive and judgment matrices. The horizontal elements provide a method to evaluate the effectiveness of the learning by comparing what was intended and planned, to what was observed as outcomes. The descriptive and judgment matrices may be used alone or in combination.

Adult learning precepts include the recognition of learner characteristics that affect learner motivation and readiness to learn, and the adult learner's need to take an active part in the learning process (Knowles, 1960). Stake's model facilitates the use of adult learning principles by providing both an opportunity to describe learner characteristics (antecedents) and a mechanism for learner input and feedback (transactions). With surveyor consistency as a desired outcome of CPE, the model is useful for both formative (descriptive matrix) and summative (judgment matrix) evaluation.

As program planning progressed, more specificity would be possible. Investigation of variables from the surveyors' education and work experience as related to surveyor judgment would facilitate designing individualized orientation and continuing education programs to attain the desired outcome of consistency in surveyor judgments and reporting.

Summary

At issue is the variance of nursing home surveyors as they evaluate the care in various facilities. Research questions target surveyors' perceived needs and interests in CPE as correlated with professional background characteristics and a score on a gerontology knowledge instrument.

Nursing home surveyors are in a unique position, called on to evaluate the professional performance of other health professionals in a work setting that they may have never experienced themselves. The need for surveyors to possess current professional skills and knowledge is evident in that evaluator role.

Adult education theorists postulate that adults are most likely to seek continuing education to solve a problem or need and are best suited to know what they need to learn. As the workplace knowledge expands, so must CPE and those who provide it. In the case of this study, CPE is concerned both with updating knowledge in each specific professional discipline and in gerontology and geriatrics.

Gerontology and geriatrics, which encompass all aspects of the nursing home environment, are multidisciplinary and rapidly changing as the research progresses. Factors that the surveyor may not have experienced in previous educational or work settings could have a major impact on the physical, mental and psychosocial health in long-term care facilities.

Obtaining CPE that is timely, applicable, accurate and easily available is a challenge for the surveyor as well as the staff-development team responsible for the surveyor's orientation and training. As important as providing the CPE is the evaluation of those offerings for their efficacy for each surveyor. Models offered by Sovie and Stake provide a framework both for educational interventions for specific needs at appropriate levels and also for mediating the antecedents to educational presentations and evaluating the results.

CHAPTER THREE

Research Design

Conceptual Framework

The conceptual framework for this study is based on works of Malcom Knowles (1970), Cyril Houle (1963) and Allan Tough (1971). Knowles' postulation that adults are best able to determine their own learning needs, and Houle's and Tough's theories of adults' reasons for participation in continuing education opportunities provided the foundation for the questions asked in this study. According to the three theorists, the primary reasons adults seek out educational opportunities is the desire to use or apply the knowledge, primarily for use in solving a problem.

To relate theories of motivation for adult education to the study, it was assumed that:

1. Nursing home surveyors are aware of the problematic situations which result when there are variations between them as they judge the performance of nursing homes and decide if citations are warranted.

2. Surveyors are aware of the need to possess up-to-date knowledge in order to perform the evaluative aspect of their role effectively.

3. Given the opportunity to choose continuing professional education (CPE) topics and the presentation methods, surveyors would respond to the survey instrument in order to indicate their CPE needs and their interests in the CPE topics, as well as to perform well on the gerontology knowledge instrument (GKI) that was developed for this study.

This descriptive study focused on the self-assessed needs and interests in CPE for nursing home surveyors in a midwestern state. Additionally, a twenty-five (25) item GKI was used for the purpose of identifying any correlation between scores on the GKI, characteristics in the professional development information (PDI) of surveyors and their self-reported needs and interests in CPE. The data collected from respondents could assist the staff development team to focus on CPE issues perceived as most needed by surveyors and expand options for teaching methods that link theory and practice of adult education principles.

Major Research Questions

Four major research questions were proposed as the basis of the study:

1. What are the areas and levels of need for continuing professional education among nursing home surveyors by discipline?

2. What are the relationships between surveyor scores on a gerontology knowledge instrument and surveyors' perceived needs for continuing education?

3. What are the primary factors that influence a surveyor's judgment relative to criteria used in making judgments?

4. How can uniformity in surveyor judgment during the nursing home certification process be improved?

Study Population

The population for the study was the entire staff of eighty-two (82) surveyors employed by the Health Department of a midwestern state. Their role is to survey nursing homes either for certification/licensure purposes or to investigate complaints of substandard care by residents or their families. The population also included four nurses who form the staff-development team.

Survey Instrument

The survey instrument was developed by the researcher and consisted of three parts:

Part one: Professional development information (PDI)--Nine variables measured on nominal and ordinal measurement scales were collected to obtain an educational and work experience profile of the surveyors: professional discipline, number of years employed in the profession, length of time as a surveyor, educational degrees, gender,

age, attendance at HCFA classes, gerontology classes within the past two years and work experience with the aged.

Part two: Needs and interests assessment--The second part of the instrument was adapted from an unpublished dissertation (Keller, 1981), and contained fifteen (15) ordinal scale items that address surveyor choices of topics for continuing education, level of interest in those topics and preferred methods for presentation of the educational material. Additional topics were possible with the open-ended questions provided in each area.

Part three: Gerontology knowledge instrument (GKI)--The third element of the instrument was a twenty-five-item true/false list of gerontology knowledge questions. Each item was related to one or more needs of nursing home residents: choice-independence needs, social needs, physical needs, and environmental factors. The true/false items were developed by the researcher with the aid of advisory committee members. The intended use is as a diagnostic tool when new surveyors are hired. Use in this study correlated surveyor scores with variables in part one and part two of the instrument.

Methodology

It became necessary to construct a knowledge instrument to include items relevant to the survey tasks, items that pertain to characteristics and needs of the aged that surveyors are required to know if they are to fulfill their

role effectively. The questions elicit knowledge of the physical, psychosocial, cognitive and environmental needs of nursing home residents. The knowledge needed to answer these questions correctly also correlates with the regulations (F tags) in the state operations manual, the manual containing the Federal rules that guide the survey process in nursing homes.

The reliability of a test instrument is the degree to which a test consistently obtains similar responses over time (Gay, 1987). It can be measured from one administration of a test. Rationale equivalency reliability determines how well all items on a test relate to all other items, and to the total test. To measure the internal consistency of the GKI, the Kuder-Richardson 20 formula was applied, resulting in an alpha of .5807. Although a correlation coefficient of .90 would be very acceptable for a test, new tests usually produce lower coefficients. The more heterogeneous a group, the higher the reliability of a test (Mehrens & Lehmann, 1991). In comparing formal education, experience and lack of CPE in gerontology and geriatrics, the surveyors would be considered a heterogeneous group.

A pilot study was done with nursing home surveyors employed in a nearby state to test items on part two and part three of the survey instrument (needs and interests assessment and GKI). Thirty-eight responses were received (43%). Questions on the GKI with the most errors were

reviewed for clarity and appropriateness. Subsequent changes in the instrument included: one new item was added to the needs assessment (documentation updates) and one item was deleted (physiological aspects of aging to be replaced by physical assessment of the older person). Also, eight (8) questions on the gerontology knowledge instrument that had no errors were either reworded or replaced with similar ones in order to better capture the knowledge content of the surveyors. In conducting the pilot study, the researcher was attempting to determine the appropriateness of the CPE topics listed, the level of interest in the CPE topics, suggestions from the open-ended questions and the spread of scores from the GKI.

When revisions to the survey instrument were complete, the three-part survey instrument and a cover letter requesting voluntary participation was placed in a sealed envelope that included a stamped, return envelope. The cover letter included an assurance of anonymity and acknowledgment that participation was voluntary.

The majority of the instruments were handed out by the researcher at a surveyor staff meeting on March 22, 1993. Instruments for surveyors not present at the staff meeting were given to their colleagues for hand delivery within the following week. The cover letter requested the return of the questionnaire by April 30, 1993. A combination thank-you/reminder card was mailed to each surveyor team April 9,

1993. Of the eighty-two (82) instruments handed out, a total of sixty-eight (68) or 83 percent were returned.

Data Analysis

Data analysis on the returned survey instruments proceeded by using frequency distributions to describe the professional characteristics of the respondents by professional discipline, years employed in their profession, length of time as a surveyor, educational degrees and post-graduate training, attendance at HCFA classes, gerontology classes within the past two years, work experience with aged people, gender and age.

The second section addressed surveyor needs and interests in CPE and preferred methods and times for educational presentations. Fifteen CPE topics were listed with an additional space provided for suggested topics. The listed topics included:

1. aging and mental health,
2. nutrition and aging,
3. normal and abnormal aging patterns,
4. spiritual aspects of aging,
5. drug use and alternatives,
6. maintaining mobility in old age,
7. medical terminology,
8. physical assessment of the older person,
9. sexuality and aging,

10. diversional activities for lower functioning residents,

11. psychosocial aspects of aging,

12. death, dying and bereavement,

13. environmental factors that affect older people,

14. legal aspects of surveying, and

15. documentation updates.

The last item was an open-ended question asking for additional suggestions. Huntington's Chorea, renal failure and Parkinson's disease were listed on the instrument as examples. A column to select level of interest was provided next to each of the proposed topics and ranked.

To determine the level of perceived needs and interests for each of the proposed CPE topics, a five-point Likert-type scale was used with "5" signifying "high need," "4" being "fairly high need," "3" being "don't know/not sure," "2" being "fairly low need" and "1" signifying "no need." The corresponding level of interest columns used the same five-point scale.

The topics were ranked in order of frequency selection with the mean score for each category calculated for the whole population and also for each professional discipline, their preferred methods for presentation of the educational material and, finally, the frequency with which the material should be presented.

To facilitate analysis, the professional disciplines of dietitians, pharmacists and sanitarians were grouped

together and designated as the "other discipline" or OD. Commonly only one of those three disciplines is present on a survey. Therefore, they are required to perform the survey tasks of the other two disciplines. The responses of the OD group totaled thirteen (13) surveyors.

Open-ended questions were analyzed according to the method of content analysis. Those questions collected additional surveyor preferences pertaining to topics for CPE and methods and times of presentation of educational material.

Following selection of the CPE topics, opportunities were given for surveyors to select preferred methods of CPE presentations, both for group and individual educational presentations. They also were invited to list their preferred frequency for CPE. Open-ended questions for each area were provided for additional surveyor input. The same five-point scale was used as in the needs/interest component. The GKI scores were correlated with PDI and the perceived needs and interests for CPE. While correlations demonstrate the strength of the relationship between two variables, it does not explain cause and effect (Mehrens, et al., 1991). The Pearson product moment correlation was utilized for analysis of the survey data. Significance of correlation coefficients was guided both by computing the alpha level and by considering the characteristics of the population and the response rate. Assistance with the organization and analysis of data was received from the

Office of Research Consultation at Michigan State University.

In response to the four major research questions of the study, the following statistical methods were applied to interpret study findings:

Question #1

What are the areas and levels of need for CPE among nursing home surveyors by discipline?

The CPE topics were ranked according to surveyor preference by frequency, group means and also by the means of the five professional disciplines.

Question #2

What are the relationships between surveyor scores on a gerontology knowledge quiz and their perceived needs for continuing professional education?

A correlational analysis between the GKI scores and perceived needs and interests in topics on the CPE needs/interest assessment list was performed.

Question #3

What are the primary factors that influence a surveyor's judgment relative to criteria used in making judgments?

Correlational relationships between PDI, the needs/interests CPE assessment and the GKI scores were studied to determine what relationships may be most

influential to surveyors as they form their opinions and conclusions on conditions in nursing homes.

Question #4

How can uniformity in surveyor judgment during the nursing home certification process be improved?

The correlations performed for Question #2 were analyzed as well as the surveyors' preferred times and methods of presentation for educational offerings and reported interest in those offerings. Surveyor interest in CPE was also correlated with the GKI results. The researcher makes the assumption that significant correlations would be part of the basic factors that influence surveyor judgment and therefore could be addressed through focused CPE.

Summary

This chapter described the study as based on theories in adult education by Knowles, Houle and Tough as they applied to a unique group of health care personnel with specific educational needs.

A three-part survey instrument was developed that included sections on professional characteristics of surveyors, self-assessed CPE needs and a true/false gerontology knowledge instrument. The instrument was piloted at the health department of a nearby state by thirty-eight (38) nurse surveyors. Following revision of the instrument, it was administered to the total population

of eighty-two (82) nursing home surveyors in the health department of a midwestern state. The returned instruments (83%) were analyzed using the SPSS statistical package at Michigan State University. The data analysis is presented in Chapter Four.

CHAPTER FOUR

Analysis of Data

Overview

This chapter summarizes and analyzes the responses of sixty-eight (68) of the eighty-two (82) nursing home surveyors employed by the Health Department of a midwestern state. The instrument used for this descriptive study was divided into three areas: professional development information (PDI) of nursing home surveyors, a needs and interests assessment for continuing professional education (CPE) and a twenty-five (25) item true/false gerontology knowledge instrument (GKI). All three parts of the survey instrument were intended to answer the four major research questions of the study:

1. What are the areas and levels of need for continuing professional education among nursing home surveyors by discipline?

2. What are the relationships between surveyor scores on a gerontology knowledge instrument and their perceived needs for continuing education?

3. What are the primary factors that influence a surveyor's judgment relative to criteria used in making judgments?

4. How can uniformity in surveyor judgment during the nursing home certification process be improved?

Response by Professional Discipline

Measures of central tendency were used to determine the areas and levels of need for CPE. Correlational tests using the product moment correlation coefficient (Pearson's r) were performed to identify relationships between surveyor scores on the GKI, their perceived needs and interests in CPE and items from the PDI. Relationships between scores of three professional disciplines (nursing, social work and other disciplines) were tested with t-tests. Content-analysis was used for open-ended questions. Variables used to answer the four major research questions were the nine items in the PDI, the fifteen items of the needs/interests assessment and the scores on the GKI.

Demographic Information

The universe of the study was small; a total of eighty-two (82) that included forty-nine (49) registered nurses, eighteen (18) social workers, five (5)registered dietitians, eight (8) environmental sanitarians and two (2) pharmacists. There were twelve (12) vacant positions at the time of the study. The small sample (N=68) may not produce statistically significant correlations, but would still yield important relationships. The response rate of sixty-eight (68) out of eighty-two (82) allows a high degree of confidence that the data is true of the total population and

that the fourteen (14) non-respondents would not differ significantly from the respondents. For purposes of studying correlations between scores and CPE needs, the surveyors were divided into three primary groups: nurses, social workers and OD (other discipline) to include the dietitians, pharmacists and sanitarians.

The survey instrument was explained by the researcher and distributed during a surveyor staff meeting on March 22, 1993. Surveyors not present at the meeting were given their sealed envelope containing the survey instrument by a team member who had been present at the meeting. Of the eighty-two (82) instruments distributed, sixty-eight (68) were returned by April 30, 1993, for a return rate of 83%.

Professional Development Characteristics (PDI)

In Table 1 through Table 6, the nursing home surveyors are described by characteristics reported in the professional development information section of the survey instrument; discipline, years employed in their profession, years spent as a surveyor, educational preparation, continuing education courses, work experience with the aged, gender and age.

Table 1 and Table 2 display responses to the survey instrument by professional discipline, gender and age. Eighty-four percent (84%) of the nurses returned survey instruments to make up 61 percent of the total responses. At least 78 percent of each discipline responded. Fifty-one

(76%) were females. Twenty-six (39%) reported their age as 51 or older with fourteen (21%) in the 41- to 45-year age bracket. One respondent did not report their age.

Table 1. Response Rate to Survey by Professional Disciplines.

Professional Discipline	Total Population	Response	Percent of Responses
Nurses (RN)	49	41	61%
Social Workers (SW)	18	14	21%
Sanitarians (RS)	8	7	9%
Dietitians (RD)	5	4	6%
Pharmacists (Ph)	2	2	100%

Table 2. Response Rate to Survey by Gender and Age Range.

Gender	Frequency	Percent of Response
Male	16	24%
Female	51	76%
Age		
0 - 35	7	10%
36 - 40	6	9%
41 - 45	14	21%
46 - 50	13	19%
51 and over	26	39%

Most of the surveyors, fifty-eight (87%), had worked in their profession for ten years or more. The majority, twenty-seven (41%), had been employed as a surveyor between one and two years, while sixteen (24%) had worked in that position between three and four years. Table 3 describes

surveyors by years employed in their profession and length of time as a surveyor.

Table 3. Years of Professional Experience and Length of Time as a Surveyor.

Characteristic	Frequency	Percent of Total
Years in profession:		
6 - 9 years	9	13%
10 + years	58	87%
Time as surveyor:		
under 12 months	6	9%
1 - 2 years	27	41%
3 - 4 years	16	24%
5 - 9 years	9	13%
10 + years	9	13%

Educational Preparation

A total of thirty-one (63%) of the nurses reported having a Master's Degree with twenty-three (47%) in nursing and eight (16%) in another subject area. Seven had some type of post-graduate certification. All fourteen of the social workers had a Master's Degree in Social Work with two having post-graduate certification. Three of seven sanitarians had a Master's Degree, one in environmental health and two in other content areas. Two had post-graduate certifications. All four dietitians possessed a Master's Degree, three in nutrition and one in another area. Three had post-graduate certification. One of the two pharmacists had a Master's Degree.

Table 4. Educational Preparation of Nursing Home Surveyors.

Professional Discipline	Pop.	Specialty Master's	Other Master's	Post-grad. Cert.
RN	41	47%	16%	17%
SW	14	100%		14%
RS	8	14%	29%	43%
RD	4	75%	25%	75%
Ph	2	50%		50%

Work Experience with the Aged

When asked the length and type of work settings that involved working with older people before becoming a surveyor, other than hospital experience, the majority had not worked in nursing homes or community health agencies with the aged. Table 5 describes respondents by length and type of work experience involving older people. The respondents also were placed into three groups according to their major role function during long-term care surveys: nurses, social workers, and OD (other discipline). The OD consists of the dietitians, pharmacists and sanitarians. Although the three disciplines have their own areas of professional expertise and responsibility, on most surveys only one surveyor from the OD category is assigned. Consequently, the discipline assigned to the survey is responsible for specific survey tasks assigned to the OD.

Table 5. Type and Duration of Work Experience with the Aged by Nursing Home Surveyors.

Length of Time	**Total**	**RN**	**MSW**	**OD**	**Percent**
	N=68	N=41	N=14	N=13	100%
Nursing homes:					
No experience	39	21	9	9	57%
1 - 3 years	4	2	0	2	6%
4 - 6 years	10	8	2	0	15%
7 - 9 years	8	4	2	2	12%
10 or more years	7	6	1	0	10%
Hospital:					
No experience	30	14	9	7	44%
4 - 6 years	5	3	2	1	7%
7 - 9 years	12	7	3	2	18%
10 or more years	21	17	1	3	31%
Community mental health:					
No experience	57	36	9	12	84%
1 - 3 years	1	0	1	0	1.5%
4 - 6 years	4	2	1	1	4.5%
7 - 9 years	2	1	1	0	3%
10 or more years	4	2	2	0	6%
Other experience (open-end question):					
No experience	40	25	8	7	59%
1 - 3 years	2	2	0	0	3%
4 - 6 years	4	1	2	1	6%
7 - 9 years	5	4	0	1	7%
10 or more years	17	9	4	4	25%

Continuing Professional Education

Surveyors reported that sixty-three (94%) had attended the HCFA basic surveyor orientation class but that only half, thirty-five (52%), had been present at the regional conference in Chicago in 1992. Most respondents had not attended courses with gerontological content in the past two years. However, those who attended courses attended for ten (10) or more hours in one or more of the three major categories (physiological aspects of aging, psychosocial aspects of aging and mental health issues in aging).

Reported Needs and Interests

The needs and interest assessment section presented fifteen (15) choices of topics for continuing education programs and fourteen (14) choices of presentation methods and preferred timing of the sessions. Opportunities to add additional preferences for each area were provided by using open-ended questions. To collect self-assessed needs and interest, a Likert-type, five-point scale was used. Ratings ranged from "1" (no need/interest) to "5" (high need/interest).

Tables 7 and 8 list the CPE topics ranked in order of perceived need and interest by the surveyors. The top five topics were ranked highest both in need and interest: legal issues, drug use, diversional activities for lower functioning residents, aging and mental health and maintaining mobility in old age. Similarly, the lowest

Table 6. Nursing Home Surveyors' Gerontological Continuing Education Within the Past Two Years.

	Total	RN	MSW	OD	Percent
	N=68	N=41	N=14	N=13	100%
Attendance at HCFA surveyor orientation classes:					
Yes	64	39	13	12	94%
No	4	2	1	1	6%
Attendance at regional conference:					
Yes	35	18	8	9	51.5%
No	33	23	6	4	48.5%
CPE within the last 2 years:					
Physiological aspects of aging:					
No courses	54	33	13	8	79%
1 - 3 hours	2	0	1	1	3%
4 - 6 hours	4	3	0	1	6%
7 - 9 hours	2	1	0	1	3%
10 or more hours	6	4	0	2	9%
Psychosocial aspects of aging:					
No courses	51	31	10	10	75%
1 - 3 hours	2	0	2	0	3%
4 - 6 hours	2	1	0	1	3%
7 - 9 hours	6	2	2	2	9%
10 or more hours	7	7	0	0	10%
Mental health aspects of aging:					
No courses	52	30	10	12	77%
1 - 3 hours	2	0	2	0	3%
4 - 6 hours	3	2	0	1	4%
7 - 9 hours	5	4	1	0	7%
10 or more hours	6	5	1	0	9%

Table 7. CPE Needs Reported by Nursing Home Surveyors.

Rank	S.D.	Overall Mean	RN	MSW	RS	RD	Ph
1. Drug use	.90	4.13	4.27	4.21	3.33	3.50	4.40
2. Legal issues	.96	4.10	4.02	4.14	4.29	4.50	4.00
3. Diversional	.88	4.08	4.03	4.43	3.83	3.75	4.00
4. Aging/mental health	.95	3.94	3.80	4.43	3.83	4.00	3.50
5. Mobility	.86	3.91	3.88	3.93	3.83	4.25	4.00
6. Nutrition	1.13	3.85	3.73	4.07	4.00	4.00	4.00
7. Normal/abnormal	1.02	3.74	3.73	4.07	3.33	4.00	2.50
8. Psychosocial	.94	3.73	3.61	4.21	3.67	3.25	4.00
9. Environment	.98	3.65	3.39	3.93	4.43	3.75	4.00
10. Documentation	1.18	3.52	3.49	3.43	4.00	3.00	4.50
11. Physical assess.	1.27	3.32	3.39	2.86	3.43	3.75	4.00
12. Death/dying	1.11	3.31	3.10	4.00	3.50	3.25	2.50
13. Spirituality	1.04	3.33	3.20	3.86	3.50	3.25	2.00
14. Sexuality	1.09	3.08	3.12	3.43	2.83	2.00	2.50
15. Medical term.	1.40	2.68	2.17	3.43	3.29	3.50	4.00

Table 8. CPE Interests Reported by Nursing Home Surveyors.

Rank	S.D.	Overall Mean	RN	MSW	RS	RD	Ph
1. Drug use	.91	4.23	4.38	4.36	3.20	3.50	4.50
2. Aging/mental health	.80	4.23	4.13	4.79	4.00	3.75	4.00
3. Diversional	.89	4.14	4.17	4.57	3.80	2.50	4.50
4. Legal aspects	1.00	4.03	3.93	4.21	4.17	4.00	4.50
5. Mobility	.91	4.03	4.13	3.93	4.00	3.25	4.50
6. Psychosocial	.97	3.95	3.78	4.86	3.80	2.50	4.50
7. Normal/abnormal	.97	3.91	3.97	4.14	3.40	4.00	2.00
8. Nutrition	1.09	3.85	3.77	3.71	3.83	5.00	4.00
9. Environment	1.07	3.75	3.59	3.79	4.67	3.50	4.50
10. Physical assess.	1.26	3.53	3.65	2.86	3.83	3.75	4.50
11. Death/dying	1.17	3.49	3.33	4.36	3.40	2.50	3.00
12. Spirituality	1.11	3.48	3.40	3.86	3.40	3.75	2.00
13. Sexuality	1.05	3.28	3.33	3.57	2.60	2.75	3.00
14. Documentation	1.29	3.25	3.25	3.21	3.20	3.00	4.00
15. Medical term.	1.34	2.65	2.13	3.36	3.33	3.50	4.50

ranked topics were ranked low both in need and interest: physical assessment of the older person; death, dying and bereavement; spirituality of aging; sexuality and aging; and medical terminology. Reported needs and interests in CPE were correlated to determine the strength of the association between them. All fifteen (15) items demonstrated significant positive correlations.

Forty-three percent (43%) (29) of the respondents reported additional preferences for CPE in the open-ended question. The topics listed on the instrument to serve as examples for the respondents were listed as choices a total of thirty-four (34) times. In addition, CPE was requested for cerebrovascular accidents, Lou Gehrig's disease, multiple sclerosis, seizure disorders, pain management, care of residents on mechanical ventilator and assessment and nursing rehabilitation. There were nine (9) requests for information on dementia and the associated difficult behaviors including counseling approaches. One request was for "specific and practical suggestions" to use in addressing agitated residents.

Suggested topics less related to disease states included evaluating care of younger residents in nursing homes, residents rights and resident dignity, coping with losses, quality improvement and helping residents to reach their highest practicable level of function. Also suggested was information on alternative care settings.

Surveyors also used the open-ended question to suggest more CPE on performing survey tasks. They included learning what other surveyors expect from nursing homes, what responsibility the facility has for maintaining mobility of residents, how to complete assignments efficiently and how to cite deficient care in nursing homes appropriately. One respondent was interested in learning more about the survey task areas covered by the other disciplines and another wanted information on the "career ladder" for surveyors.

There were four (4) other requests for team-building assistance. One respondent suggested a standard course similar to that of police training schools so that all surveyors would start with the same information and thereby allow room for professional growth rather than "just surviving week to week." The other suggestions were for methods of negotiation with teammates, understanding teammates and "surveyor professionalism."

Pharmacists displayed the most interest in CPE by ranking eleven (11) of the fifteen (15) suggested topics as fairly high interest or higher. They listed only two (2) topics as of fairly low interest: normal/abnormal aspects of aging and spiritual aspects of aging.

Social workers reported seven (7) topics in CPE as of fairly high interest which matched their fairly high need for eight (8) CPE topics, except for having less interest for CPE in nutrition and aging.

Nurses ranked four (4) CPE topics as fairly high interest and only one (1) as fairly low interest, that of medical terminology. Dietitians reported two (2) CPE topics as fairly high interest and one (1) as high interest--that of nutrition and aging. Sanitarians ranked only two (2) of the CPE topics as a fairly high interest--legal issues and environmental factors that affect older people.

Preferred Methods for Presentation

Responding to the category describing presentation methods of educational material for group purposes, respondents preferred a combination of lecture and discussion. Teleconferences were least preferred. The most popular method for individual CPE was interactive video except with nurses, who preferred either synopsized journal articles or individual reading.

Responses to the open-ended questions for presentation methods of CPE material included seminars, individualized instruction, hands-on instruction, brainstorming and cracker-barrel presentations. Eight (8) respondents preferred that presentation methods allow some type of interactive discussion and four (4) requested that the material be presented by experts, regardless of what method was used. Another surveyor said the time for the presentation was the most important. Three respondents requested flexible time to allow them to pursue a graduate degree and to take a gerontology course at the college.

Preferred Times for Presentations

The present schedule for staff/in-service meetings (one day per month) was the preferred choice for all five disciplines, but they also wanted office or library time to read professional journals, see CPE videos, access to more reference materials and more time to "digest" CPE material. They wanted to choose the professional conferences they could attend and to network with colleagues. Two respondents wanted specific time to meet with other colleagues of their own professional discipline either every month or at least every three (3) months. One surveyor requested that CPE time be "sacred" and not taken away when work load was heavy.

Table 9. Methods Preferred by Surveyors for Group Educational Presentations.

	GROUP					
Method	**Mean**	**RN**	**MSW**	**RS**	**RD**	**Ph**
	N=68	N=41	N=14	N=7	N=4	N=2
				OD		
1. Lecture followed by small group discussion	3.94	3.88	4.07	4.00		
2. Panel discussions	3.39	3.33	3.46	3.46		
3. Lecture	3.33	3.44	2.62	3.75		
4. Teleconferences	2.48	2.77	2.00	2.08		
5. Other						

Table 10. Methods Preferred by Surveyors for Individual Educational Presentations.

	MEANS			
	Group	**RN**	**MSW**	**OD**
1. Interactive video	3.70	3.73	3.36	4.00
2. Synopsized journal articl	3.73	3.80	3.29	4.0
3. Individual reading	3.55	3.80	3.14	3.58
4. Study-guides	3.37	3.40	3.07	3.62
5. Computer-assisted instruction	3.23	3.36	3.07	3.00
6. Other				

Table 11. Surveyor-Reported Preferred Times for Presentations.

Time	**Group Means**	**RN**	**MSW**	**OD**
1. One day a month	3.98	3.84	4.14	4.30
2. One-half day/twice a month	3.02	3.08	2.54	3.40
3. One week/every 6 months	2.47	2.37	2.92	2.27
4. Two hours/week	2.40	2.31	2.54	2.60
5. Two weeks/once a year	1.84	1.88	1.92	1.60

Gerontology Knowledge Instrument Responses

The GKI questions were ranked according to those with the highest rate of errors. The range of correct answers was eight to twenty-three. Question 12 and Question 17 were answered incorrectly by fifty-one (51) of the sixty-seven (67) (76%) respondents (one respondent did not answer any of the questions). Question 8 and Question 17 were removed from the final score when they were found to correlate negatively with the total score. It should be noted that

questions 12 and 17 were answered incorrectly by 75% of the respondents. Comments from the respondents indicated they may not have understood the definition of the term "psychomotor" in question 12. Also, the term "lowered brain function" in question 17 was confusing. Table 12 depicts the mean and standard deviation for the group and for the three professional disciplines on each item.

Correlations

Correlational analysis was used to determine the strength of relationships between the GKI score and the CPE needs/interests assessment to address research Question #2 pertaining to relationships between surveyor CPE needs and GKI scores. The Pearson's r technique was used to test relationships. Correlations were considered to have magnitude defined as small at .10, medium at .30, and large at .50 (Cohen, 1977). Degrees of importance of these correlations do not depend solely on the strength of correlation, but also on what relationship is being studied. Due to the fact that a large number of the population responded to this survey, the question of statistical significance is not as important as in studies with a lower response rate.

Table 12. Incorrect Responses to GKI Questionnaire by Nursing Home Surveyors.

GKI Questions		Freq.	%	Mean	S.D.
1. (12) Psychomotor performance in all persons is permanently affected in later life. (true)		51	75%	.24	.43
	RN	34	83%	.17	.38
	MSW	10	71%	.29	.47
	OD	7	54%	.42	.51
(17) Lowered brain function in the elderly may affect reasoning flexibility. (false)		51	75%	.24	.43
	RN	35	85%	.15	.36
	MSW	6	43%	.57	.51
	OD	10	77%	.17	.39
2. (2) Older people are set in their ways and tend to hold tenaciously to old patterns of living. (false)		39	57%	.418	.497
	RN	26	63%	.37	.487
	MSW	5	36%	.64	.496
	OD	8	62%	.33	.491
3. (6) The use of warm, contrasting colors yellow, orange, red) make it easier for older persons to function in their environment. (true)		23	34%	.657	.478
	RN	15	37%	.64	.487
	MSW	4	29%	.71	.469
	OD	4	31%	.67	.491
4. (22) As people age, the variations among the elderly become less pronounced than among younger age groups. (false)		16	24%	.761	.430
	RN	10	24%	.76	.434
	MSW	2	14%	.86	3.63
	OD	4	31%	.67	.491
5. (7) People over age 65 tend to live in the past. (false)		15	22%	.776	.420
	RN	8	20%	.81	.401
	MSW	2	14%	.86	.363
	OD	5	39%	.58	.514

Table 12 (cont'd).

GKI Questions		Freq.	%	Mean	S.D.
(9) Older persons, unable to feed themselves should be fed in reclining chairs, sitting at a 45-degree angle. (false)		15	22%	.776	.420
	RN	8	20%	.81	.401
	MSW	3	21%	.79	.425
	OD	4	31%	.67	.491
6. (21) Most elderly people are very sensitive to others' reactions to them. (true)		14	21%	.79	.409
	RN	4	10%	.90	.3
	MSW	6	43%	.57	.513
	OD	4	31%	.67	.491
(18) Loss of memory and decreased learning ability occur as a result of old age. (false)		14	21%	.791	.410
	RN	6	15%	.85	.357
	MSW	5	36%	.64	.496
	OD	3	23%	.75	.452
7. (4) Elderly people experiencing the sundown syndrome actually have improved capacity for clear thinking in the late afternoon and evening. (false)		13	19%	.806	.398
	RN	6	15%	.85	.357
	MSW	4	29%	.71	.469
	OD	3	23%	.75	.452
(25) Diningroom chairs, rather than wheelchairs, are generally better for residents to sit in at mealtimes. (true)		13	19%	.806	.398
	RN	6	15%	.85	.357
	MSW	5	36%	.64	.496
	OD	2	15%	.83	.389
8. (19) In adjusting to stress, it is inappropriate for older adults to use denial as an adaptive or coping technique. (false)		11	16%	.836	.373
	RN	2	5%	.95	.219
	MSW	2	14%	.86	.363
	OD	7	54%	.42	.514

Table 12 (cont'd).

GKI Questions		Freq.	%	Mean	S.D.
9. (23) Generally, older people need higher levels of illumination to perform tasks of daily living. (true)		10	15%	.851	.359
	RN	6	15%	.85	.357
	MSW	3	21%	.79	.425
	OD	1	8%	.92	.288
10. (20) Lowered social and spatial environment result when older people experience a decrease of cues due to sensory loss. (true)		9	13%	.86	.343
	RN	5	12%	.88	.331
	MSW	3	21%	.79	.425
	OD	1	8%	.92	.288
11. (1) Lowered body temperatures can cause death in the older adult without his/her ever feeling cold. (true)		8	12%	.88	.327
	RN	4	10%	.90	.300
	MSW	2	14%	.86	.363
	OD	2	15%	.83	.389
12. (16) Emotional illness can be caused by hearing loss. (true)		7	10%	.896	.571
	RN	3	7%	.93	.264
	MSW	3	21%	.79	.425
	OD	1	8%	.92	.288
13. (3) Intelligence is not decreased in later life. (true)		6	9%	.910	.288
	RN	2	5%	.95	.219
	MSW	3	21%	.79	.425
	OD	1	8%	.92	.288
(5) One of the risk factors for suicide among the elderly is loss of mobility. (true)		6	9%	.91	.288
	RN	3	7%	.93	.264
	MSW	2	14%	.86	.363
	OD	1	8%	.92	.288

Table 12 (cont'd).

GKI Questions		Freq.	%	Mean	S.D.
(11) Morale in old age is not influenced by some of the same factors that affect morale in younger persons such as socioeconomic status and health status. (false)		6	9%	.91	.288
	RN	4	10%	.90	.300
	MSW	1	7%	.93	.266
	OD	1	8%	.92	.288
14. (10) A sudden behavioral change can signal a life-threatening condition. (true)		4	6%	.94	.238
	RN	1	2%	.98	.154
	MSW	3	21%	.79	.425
	OD	0	0	1.00	0
(13) Older people with less than average body weight will experience increased plasma and tissue concentration of drugs if the "normal adult dose" is used. (true)		4	6%	.94	.238
	RN	2	5%	.95	.219
	MSW	1	7%	.93	.266
	OD	1	8%	.92	.288
15. (14) Cataract surgery is unsuccessful in older adults 95% of the time. (false)		4	6%	.94	.238
	RN	2	5%	.95	.219
	MSW	1	7%	.93	.266
	OD	1	8%	.92	.288
(15) There is a direct relationship between high levels of activity and a high degree of morale. (true)		4	6%	.940	.239
	RN	40	98%	.98	.154
	MSW	13	93%	.93	.266
	OD	11	85%	.92	.288
16. (8) Taste and smell are rarely affected by aging. (false)		2	3%	.97	.170
	RN	2	5%	.95	.219
	MSW	0	0%	1	0
	OD	0	0%	1	0

Table 13. Results of Correlations between Surveyor-Reported CPE and Professional Discipline.

CPE Needs	Group Score	RN	MSW	OD
1. Aging/mental health	-.1705	-.1550	.2067	-.6619*
2. Nutrition and aging	.0236	-.1976	.6211*	-.2085
3. Normal/abnormal aging	-.0542	.1090	.0268	-.6999*
4. Spiritual aspects	-.1452	.1819	-.3853	-.5302
5. Drug use/alternatives	.1877	-.0448	.8277**	-.4483
6. Maintaining mobility	-.0990	-.1274	.4753	-.5619
7. Medical terminology	-.2332	-.1372	.2040	-.5400
8. Physical assessment	.1248	.0631	.4875	-.2320
9. Sexuality and aging	.0120	.1647	-.0750	-.3899
10. Diversional activities	.1078	.2562	.3784	-.6990*
11. Psychosocial aspects	-.0497	-.0096	.1789	-.6110*
12. Death/dying	-.2225	.0158	-.1430	-.8295**
13. Environmental factors	.0642	.1808	.4079	-.1899
14. Legal aspects	-.1652	-.0757	.0159	-.6777*
15. Documentation updates	-.3169**	-.3274*	-.3474	-.3328

Nurses reflected the group mean with a significant negative correlation (-.3274*) between the need for documentation updates and scores on the gerontology knowledge instrument. A small but not significant positive relationship (.2562) was noted between need for CPE on diversional activities for the lower functioning residents and the score.

Correlations of data on social workers yielded significant positive correlations between CPE needs in nutrition (.6211* [* = alpha .05]) and score and between CPE needs in drug use (.8244**[** = alpha .01]) and the score.

That group also had a significant negative correlation between need for documentation updates and score. Based on the decision to consider correlations of .20 and above important even if not designated as significant, social workers had six (6) other important positive correlations with CPE needs and score: aging and mental health, mobility, medical terminology, sexuality, diversional activities and environmental factors. An important negative correlation was noted for CPE need on spiritual aspects and score.

The OD group which included seven (7) sanitarians, four (4) dietitians and two (2) pharmacists also had a small but not significant negative correlation (-.3328) between need for documentation updates and score. The other fourteen (14) CPE needs were negatively correlated with the score on the gerontology knowledge instrument, six (6) of them with significant negative correlations: aging/mental health, normal/abnormal aging, diversional activities, psychosocial aspects, death/dying and legal aspects of surveying. All other CPE topics except the need for CPE on environmental factors were correlated higher than .20.

Correlations were performed between the three sections of the survey instrument (scores and professional background characteristics, scores and needs/interest assessment for CPE and between professional background characteristics and needs/interest in CPE) with the following results:

1. Significant positive correlations were found between higher educational degrees and interest in CPE which had a significant positive correlation with a higher need for CPE.

2. Higher scores on the GKI were significantly positively correlated with higher educational degrees for the nurses (.3736*). No significant differences in scores between professional groups was found using t-tests.

3. Age for all surveyors was significantly correlated (.2720*) with higher educational degrees.

4. There was a small positive correlation between age (.2390) and professional (.2374) experience and score. Relationships between CPE needs, CPE interests and GKI questions were found to have significant positive correlations which strengthened the reliability of the instrument.

Table 14. Correlations between Highest Education Degree of Surveyors and Self-Reported Interest and Need for CPE.

Correlations for highest educational degree:			
	Ed. Degree	**CPE Interest**	**CPE Need**
Ed. degree	1.0000	.3409**	.1946
CPE interest	.3409**	1.0000	.6269**
CPE need	.1946	.6269**	1.0000
Correlations between highest educational degree, age and score:			
	Ed. Degree	**Age**	**Score**
Ed. degree	1.0000	.2720*	.1950
Age	.2720	1.0000	.2390
Score	.1950	.2390	1.0000
Correlations between previous work experience in the professional discipline, age and score:			
	Prev. Exp.	**Age**	**Score**
Prev. Exp.	1.0000	.5359**	.2374
Age	.5939**	1.0000	.2374
Score	.2374	.2390	1.0000

To answer research Question #4: How can uniformity in surveyor judgment during the nursing home certification process be improved?

Significant correlations found between the three parts of the survey instrument and responses from the open-ended questions from part two of the instrument were analyzed to detect patterns and concentrations of surveyor responses. Findings and conclusions are presented in Chapter Five.

CHAPTER FIVE

Conclusions

Overview

This final chapter presents and analyzes the findings from the three-part survey research instrument. The results are used as the basis for discussing implications of the study and making recommendations for further research. The stated purpose of the study was to investigate self-perceived needs and interests of surveyors regarding content, methodology and timing for continuing professional education (CPE). Emphasis was placed on findings of a Gerontology Knowledge Instrument (GKI), intended for use as a starting point to determine how variations among surveyors may be reduced. Specifically the study addressed four major research questions:

1. What are the areas and levels of need for continuing professional education among nursing home surveyors by discipline?

2. What are the relationships between surveyor scores on a Gerontology Knowledge Instrument and their perceived needs and interests for continuing professional education?

3. What are the primary factors that influence a surveyor's judgment relative to criteria used in making

4. How can uniformity in surveyor judgment during the nursing home certification process be improved?

It was assumed that attention to self-assessed needs and interests of surveyors for CPE and their preferred methods and times for presentation of educational material would be a logical starting place to study the problem of variations in surveyors' judgment as they evaluate the care given in nursing homes. As adults tend to select learning projects based on immediate problems or needs that require specific knowledge or skills (Tough, 1975), it would follow that nursing home surveyors would best know their specific knowledge needs to perform their work role effectively. The complexities of performing the surveyor's role are demonstrated as integrated into a model by Sovie (Sovie, 1983), a theoretical model that then demonstrates stages of professional development and required tasks. The model provides depth and targets opportunities for planning individualized CPE programs as well as delineating successive steps in career advancement, as follows:

1. Professional awareness--New surveyors become know ledgeable of their role as the representative of a state agency and how to interpret and apply federal and state regulations. They become aware of new knowledge to be mastered, and form working relationships with other professionals both within and outside of their own discipline.

2. Professional identification--Surveyors become more aware of nursing home environments and identify deficiencies more easily. They learn to document findings in effective ways and communicate their findings in a professional manner. They work to refine relationships with survey team members.

3. Professional maturation--Surveyors are more efficient in noting and collecting information about deficiencies found in nursing homes and giving assistance to facility staff. They may serve on in-house committees to develop new policies, and may participate in informational seminars sponsored by the Health Department.

4. Professional mastery--The surveyor may qualify for managerial or training positions within the Department and may participate in discussion of long-term care issues at the national level.

Surveyors have the burden of learning and applying federal and state laws in addition to applying their profes sional knowledge in the varying situations found in nursing homes. Additionally, many are experiencing the unique environment of a bureaucratic organization for the first time. Houle (Houle, 1984) noted that practitioners moving into specialized areas of their profession must still qualify for the new position and that such transitions do not have uniform methods to assure adequate preparation for the new role. By using the Sovie model, appropriate educational interventions could be anticipated and targeted

where needed in the professional development stage based on the self-assessed needs of the surveyors. For instance, surveyors' preferences for more information about difficult behaviors of residents in nursing homes and especially for "specifics" may indicate the need for a more holistic view of the aged person. Surveyors lacking a strong gerontological knowledge base may not recognize inappropriate assessment and care of untoward behaviors in aging individuals.

The high response rate by surveyors both by discipline, as well as by the overall response rate of 83 percent, demonstrates a highly motivated group. They may have perceived their cooperation in the study as a concrete step in making their needs and interests known to administrative personnel in an acceptable and effective manner. Partial results of the study will be shared with administrative personnel in the Health Department as agreed to when permission for the study was granted. This may lead to problem-solving activity as the Department contends with the surveyor variation issue and develops future educational programs and educational funding budgets.

Findings from the Professional Development Instrument (PDI)

Most of the respondents (87%) had worked in their professional discipline for over ten years with 13 percent having six to nine years of experience. This result could be expected since a requirement for employment as a surveyor

is work experience, although a minimum time is not specified. The previous work experience is expected to have honed professional skills and judgment, enabling the surveyor to function in a field-type environment that has no direct supervision.

Forty-one percent (41%) of the surveyors reported their length of employment as a surveyor as one to two years. Twenty-four percent (24%) had been employed three to four years. Before the implementation of OBRA in October, 1990, the Department began hiring more professionals to train as surveyors to meet the projected increase in workload. In order to handle the rapid influx of new personnel, in Janu ary of 1990 a staff-development person was designated to initiate an in-depth orientation program and begin regular staff-in-service meetings.

Surveyors were primarily female with nurses making up 81% of the population. The most common age group was fifty-one (51) and over, making up 40% of the response. Hiring requirements and preferences for professionals with previous work experience and a Master`s Degree would make it likely that the population would be older. As stated above, study results describe a positive relationship between age, professional experience and score. Other possible explanations for the primarily older age group could be non-discriminatory hiring practices by the state employer, attractive retirement benefits and a growing interest in the well-being of the aged population.

Seventy-eight percent (78%) of the respondents possessed a Master's Degree. A graduate degree is required for social work surveyors and is preferred for all other disciplines. Those who meet that qualification will be hired before applicants with undergraduate degrees. The extensive amount of over-night travel has historically limited the amount of would-be surveyors interested in the position. Consequently, the applicant pool is often made up of professionals with Bachelor's Degrees only. The pay scale and opportunities for advancement are also linked to employees with graduate degrees.

The majority of surveyors reported no CPE within the past two years related to three areas of aging: physiological, psychosocial and mental health. Only 43% had work experience in nursing homes before becoming a surveyor. Although a higher percentage (57%) had worked in hospitals, work experience that provided opportunities to learn the characteristics of aging was weak.

Most surveyors had attended the HCFA surveyor basic orientation course (94%). The Chicago regional conference was less well-attended with slightly over half (52%) attending.

Summary and Conclusions of PDI. The typical surveyor is female, over fifty-one (51) years of age, possesses a Master's Degree, has worked in the professional discipline

over ten years and has been employed as a surveyor between one (1) and two (2) years. They have had no CPE in gerontology and geriatrics in the past two years, with the exception of information provided by the Health Department, and their work experience with the aged is limited to hospital work experience. They have attended both the HCFA basic surveyor training course and the Chicago regional conference. The lack of CPE in gerontology within the past two years other than what was offered by the Health Department requires additional study. Surveyor comments suggested it may be attributed to lack of time and choice.

To take advantage of the study findings of positive correlations between age, professional experience and possession of a Master's Degree (for nurses), hiring guidelines may need to be refined to increase the likelihood that professionals sensitive to and knowledgeable about changes of aging are given preference when position openings are filled. Recruitment efforts may need to include investigation of the travel and time spent away from home by surveyors to find ways of limiting it and making the position more attractive to prospective employees.

Findings from Needs and Interests Assessment

Study findings from the needs and interests in CPE assessment to address research Question #1: What are the areas and levels of need for CPE among nursing home surveyors by discipline?

Recognizing that many factors influence surveyor preferences and motivation for CPE, this study was restricted to analysis of what surveyors perceived as their CPE needs, their interests in it and how it could best be presented to them.

The five topics judged to be top priority by the surveyors were:

1. Drug use and alternatives,
2. Legal aspects of surveying,
3. Diversional activities for lower functioning residents,
4. Aging and mental health, and
5. Maintaining mobility in old age.

Surveyors selected four topics having a major impact on nursing home residents and their quality of life. The remaining topic ranked among the five most important pertained to legal issues.

Pharmacokinetics affect all systems of the body with the effects of psychoactive drugs being especially challenging to investigate. The use of psychotropic drugs has been emphasized in OBRA regulations as a chemical restraint and therefore an undesirable adjunct to therapy. New research and new drugs increase the difficulties surveyors have in keeping pace with medicine regimens for nursing home residents and increase their need for drug updates.

Concerns with legal aspects are reflected in all actions and decisions of surveyors during the survey process as they interpret and apply state and federal laws. When surveyors begin orientation, the legal aspects are stressed since the basic role of surveyors is to determine if federal and state laws are being followed. All five disciplines are affected by legal issues and realize that their interpretation of regulations can result in unwelcome legal proceedings. This was ranked as a "high" or "fairly high" need by all five professional disciplines.

Diversional activities for lower-functioning residents ranked third. It is a difficult area to evaluate during a survey, a task made more difficult by not having an activity therapy professional available as a team member or as a consultant. Current practice is to have the social worker take primary responsibility for evaluating the facility's activity program. Two responses to the open-ended question requested more CPE on evaluating activities for nursing home residents and, specifically, how to help residents reach their highest level of autonomy. Inclusion in the top five most important CPE topics signifies the importance of the subject to surveyors as well as the difficulty they have in evaluating it in nursing homes.

Aging and mental health ranked fourth. Residents suffering from delirium, dementia and depression present particular challenges to caregivers as well as to surveyors evaluating that care. Historically, one of the major forms

of treatment of dementia has been psychoactive drugs, which often caused additional problems. The responses to the open-ended questions included at least twenty-four (24) suggestions for more information on diseases affecting the mental status of residents and on interventions to be used with residents exhibiting difficult behaviors. In particular, surveyors wanted "specific and practical" suggestions. Those comments demonstrate a more narrow focus of the problem and may be indicative of a lack of depth of gerontological knowledge. A more holistic understanding of the aged person would enable the surveyor to detect the antecedants and contributing factors of difficult behavior in nursing homes and determine the appropriateness of care.

The fifth most needed topic for CPE was maintaining mobility in old age. Mobility is affected by dementia, drugs and diversional activities, and also related to many physiological and mental changes. Surveyors recognize that mobility can mean the difference between independence and increased quality of life versus dependence and lack of motivation. The effects of exercise impact both physical and mental functional status (Schilke, 1991).

The five middle ranked topics were:

6. Nutrition and aging,
7. Psychosocial aspects of aging,
8. Environmental factors that affect older people,
9. Normal and abnormal aging patterns, and

10. Documentation updates.

While nutrition ranked sixth overall, it was ranked as of more importance by dietitians, pharmacists, sanitarians and social workers than nurses. Pharmacists are concerned with the interactions between food and drugs as they evaluate the medication regime of residents. Additionally, when working as the OD on a survey, the pharmacists and the sanitarians are required to observe dining areas during meals, as well as the food preparation before the meals. Social workers are not required to evaluate nutritional aspects of resident care, but they do become aware of food issues when conducting resident interviews.

The first five topics listed as ranked in level of importance to the respondents (drug use, legal issues, diversional activity, aging and mental health and mobility) all impact on the psychosocial domain and may reflect the surveyors' need for more specific information than the topic listed simply as psychosocial aspects of aging which ranked seventh. Open-ended question responses indicated more education was needed to address losses of aging, dignity of residents and counseling techniques for the aged. The responses reflect surveyor insight into some of the issues that promote powerlessness in nursing home residents.

Environmental factors affecting residents in nursing homes was ranked as eighth. Sanitarians and pharmacists ranked it as a fairly important issue. These two disciplines are responsible for the environmental portion in

the absence of a sanitarian on a survey site. Nurses ranked it low, suggesting a lack of knowledge of how environmental factors impact the older resident. Variations in environmental factors such as noise, room temperature and lighting may occur in the presence of nurse surveyors and would need to be recognized and evaluated for detrimental effects on residents. Hiatt (1982) suggests that the environment is so important that it should be considered as another member of the caregiver team.

Normal and abnormal aspects of aging ranked ninth. Components of aging patterns are integrated in topics already listed. The low rank may reflect the surveyors' role of focusing on identifiable problems rather than having a holistic view of the older person. Open-ended question gathered responses indicating a need to know more about specific disease states as well as managing pain in the older resident and caring for residents on mechanical respirators in the nursing home.

The need for documentation updates ranked number ten. Only pharmacists and sanitarians considered it a fairly important need. This could be due to a lack of previous need to record work tasks and outcomes. The other three disciplines learn the effective use of documentation early in their training as they describe the care they have given and the effects of it.

The last five topics that were ranked lowest (physical assessment, death/dying, spiritual aspects, sexuality and

medical terminology) may reflect practical and philosophical aspects of CPE needs as perceived by surveyors.

Physical assessment needs were ranked number eleven. Only pharmacists considered it "fairly important." Since it is not uncommon for physical and mental symptoms to be caused by adverse reactions to drug therapy, physiologic reactions to drugs would be of interest to pharmacists. Nurses did not consider physical assessment as an important need although it is the first phase in the nursing process and necessary in establishing a data base. Responses to the open-ended question revealed the need to assess the dysphagic resident and plan rehabilitation based on the assessment, and learn more about rehabilitation principles leading to residents achieving their highest practicable level of function. All rehabilitation is based on careful assessment to determine appropriate nursing interventions. Although ranked as a low need for CPE in physical assessment, all disciplines indicated a higher interest in it.

Death, dying and bereavement, ranked number twelve and was considered more important by social workers, sanitarians and dietitians than by nurses. Cox (1984,) refers to the strain on a social group caused by the death of one of its members. The fear of death and the tendency to isolate persons who are dying would seem to be an anxiety-causing factor in nursing home residents. As nurses are responsible for determining if the facility has accurately and

completely addressed all resident needs, nurse surveyors may be missing an important component of the residents' psychosocial well-being. Changing societal attitudes toward death-with-dignity, the right-to-die and euthansia require surveyor awareness of the implications both long-term and for current residents of nursing homes.

Spiritual aspects of aging ranked number thirteen of fifteen choices and was not considered as a fairly high need by any of the five disciplines. It seems inconsistent that spiritual aspects are apparently considered detached from aging and mental health, the CPE topic that was ranked in fourth place. Malinowski (in Cox, 1984) believes that religious beliefs are one of the major factors that reduce the fear of death. In a way similar to death and dying issues, surveyors may be missing important clues to the psychosocial well-being and mental health of residents if they do not appreciate the significance of spirituality as experienced by residents.

Sexuality and aging ranked fourteenth. Little research is available on normal sexual activity and aging. A common care issue in nursing homes concerns residents suffering from Alzheimer's disease who no longer understand social constraints and may trigger staff overreaction to their sexual activity. Identification of institutional philosophy and their management of sexually aggressive residents would be a function of the nurses or social work surveyors who may not have adequate training to recognize and evaluate

problems. There are stringent time constraints when surveyors are performing survey tasks, therefore, issues concerning sexuality may not be recognized in the time allowed for resident interviews and care plan reviews.

Medical terminology ranked last, as expected, but was included to give surveyors an opportunity to designate it as a need if their professional training did not emphasize it. Only pharmacists considered it a fairly high need.

Additional topics CPE collected from the open-ended questions concerned survey protocol and team interpersonal relations. Survey protocol needs related to their recognition of variations that occur between surveyors (i.e., how to cite F tags appropriately according to OBRA regulations, "What do others expect?," how to complete survey tasks accurately). The statement that surveyors should undergo "basic surveyor training," much like policemen take, so that all "surveyors learn the same things" further demonstrates their concern with surveyor variations. One respondent connected ill-prepared surveyors with higher job stress.

Surveyors also attach significance to team relations by stating their need for CPE includes helping them to under stand teammates, increasing surveyor proficiency in observation and listening skills and learning the art of negotiation as part of team building. By listing team concerns as part of needs for CPE, surveyors indicate a

realization that dysfunctional team dynamics can interfere with team consensus and contribute to variations.

Preferences for Presentation Methods and Times

Surveyors indicated a preference for the opportunity to discuss CPE topics during or after CPE presentations. The top ranked presentational method was lecture followed by small group discussions (mean 3.94), followed by panel discussions (mean 3.39). Surveyors recognize the advantage of strengthening learning by having more time to assimilate the new subject matter while discussing it and asking questions. Many open-ended question responses included suggestions for discussion-type methods such as study-groups, small group workshops and group outings to get hands-on experience. Four respondents specified the need to have "experts" present the material regardless of what presentational method was used. Those comments signify a need for state-of-the-art information, the need for surveyors to choose their own CPE and the need to address different learning styles. There may be a need to update surveyors' knowledge and experience with a variety of presentation modes including computer-assisted instruction and teleconferences. The mean age of surveyors (age 51) is likely to represent adult learners who have not had the opportunity to participate in newer instructional methods or have experienced frustration when those methods were presented by inexperienced or unprepared instructors.

Improvements in organization, quality and content of newer technologies may promote more favorable attitudes toward the less popular presentation methods.

Open-ended question responses for individual learning methods included availability of more reference materials, time to use the reference materials, networking with colleagues, one-to-one instruction, and flexible work scheduling to allow them to pursue a graduate degree and to take gerontology courses. The suggestions are similar to those already given by recognizing the need to have current references and time to discuss work matters with colleagues.

Timing for CPE presentations continued to reflect the need for either more frequent in-service opportunities or for more concentrated presentations at less frequent intervals. Surveyors wanted more time to consult library references, read journal articles or see videos in the office. Two respondents suggested that specific disciplines meet together either one-half day a month or at least once every quarter.

Summary and Conclusions for Research Question #1

What are the areas and levels of need for CPE among the nursing home surveyors by discipline, on each of the items on the CPE needs and interests assessment?

Surveyors wanted information on drug therapy, legal issues, mobility, aging and mental health and therapeutic diversional activities therapy. It is an encouraging

indication that nursing home surveyors are viewing residents of long-term care facilities with a more holistic view versus a narrow clinical picture. Less encouraging is that topics having a major impact on the physical, mental and psychosocial function of the older person ranked in the lowest half of the list (environment, death/dying, spirituality, sexuality and normal and abnormal aging). The choice of the top five issues may be indicative of a generalist's view of aging while the topics in the second half of the list would fit in the aging specialist's knowledge base. Assuming that the low priority was due to lack of knowledge of their importance, it seems necessary to provide CPE on normal and abnormal aging as a way of increasing awareness of surveyors' educational needs in gerontology and geriatrics.

Surveyors also reported a need for CPE that includes team dynamics and time to interact with colleagues to compare work styles. They place a high value time on set aside for CPE and they want the CPE material to be presented by experts in the subject.

Surveyor responses indicating their need for more opportunity for discussion with colleagues and CPE presenters, their wish for adequate time for group and individual CPE and for opportunities to pursue advanced degrees and gerontology training are a road map for staff-development. None of the suggestions need to result in

costly changes; the primary need is careful assessment, planning and evaluation of CPE interventions.

Findings from Correlations Between Needs and Interests and Gerontology Knowledge Instrument

Research Question #2: What are the relationships between surveyor scores on a Gerontology Knowledge Instrument and their perceived needs for continuing education?

In the correlation tests for the entire group of respondents, there was only one significant relationship found between scores on the Gerontology Knowledge Instrument and the list of perceived needs for CPE. That was a negative correlation between the need for documentation updates and the score: the higher the need for documentation updates, the lower the score. Lack of knowledge of the complexities of gerontology and geriatrics could result in a lower score on the GKI and be reflected in difficulty documenting survey findings. Only the OD group demonstrated all negative correlations between score and needs for CPE; six of the correlations were statistically significant. The findings suggest that group felt a need for new knowledge based on their experience with the GKI. Nurses and social workers had fewer negative correlations suggesting they may not be aware of weak gerontological knowledge areas.

Summary and Conclusions for Research Question #2

There were small to statistically significant negative correlations between the need for documentation updates and GKI score for all professional disciplines. The negative relationship may reflect that documentation improves with practice and experience which would tend to increase gerontological knowledge. It appears necessary to facilitate more aging education for nursing home surveyors both during orientation sessions and also in CPE programs. Previous work experience with the aged and education in gerontology should be a major consideration when recruiting new surveyors.

Study Findings Related to Research Question #3

Research Question #3: What are the primary factors that influence a surveyor's judgment relative to criteria used in making judgments?

Surveyors, primarily nurses, possessing a Master's Degree achieved a higher score on the GKI. No other item on the PDI showed a significant relationship with the needs and interests assessment and the GKI score. Respondents demonstrated a high interest in CPE and a strong correlation between their interests and needs for CPE. They felt it necessary to interact with colleagues to share experiences, to discuss problem-solving issues, and to have experts in the topic area discuss CPE material.

Cevero's (1985) research indicated that social systems may be the most powerful factor affecting CPE's effectiveness but yet it is often overlooked. Based on surveyor comments to open-ended questions regarding team dynamics, issues and problems resulting from team interactions may be a major factor affecting surveyor judgment of nursing home care and deserving of equal attention with CPE on specific professional issues.

Cultivation of stated interests to achieve excellence in professional performance provides an advantage to the staff development team both for program planning and for promoting professional growth of nursing home surveyors. Surveyors need to know how their interpretation of OBRA regulations fits with that of their colleagues. CPE programs based on input by surveyors should be provided in formats that allow time for surveyor interaction between themselves and with the "experts" presenting the material. Surveyor input would include the need for information on survey protocol practices and on team building issues. Presentations need to be geared to the experience level of the surveyors, neither too basic for experienced surveyors nor too advanced for new personnel.

That surveyors expressed need for CPE from "experts" provides an opportunity to be innovative by making it possible for the surveyors themselves to be the experts in areas of their choice. It could solve the problem of not having state-of-the-art CPE readily available in practice

situations while opening a path to professional self-fulfillment and allowing surveyors more choice over their work role.

Study Findings Related to Research Question #4

Research Question #4: How can uniformity in surveyor judgment during the nursing home certification process be improved?

Primary findings of the study indicate that surveyors have a high interest in CPE and that they want to receive the CPE material from experts in the particular subjects presented. They also want consistent opportunities for discussion both with colleagues and with CPE presenters. Nurse surveyors with Master's Degrees tended to score higher on the GKI. Open-ended questions found a concern for team dynamics as it affected surveyor performance.

The researcher postulates that initial surveyor training is more important than later in-service training. Initial training influences the new surveyor's perception and understanding of the organization's culture and expectations before exposure to survey team dynamics and the values and attitudes of seasoned surveyors.

A comprehensive plan of CPE for surveyors would begin with the hiring process. Efforts to hire professionals with a Master's Degree, especially those with an educational background and work experience in gerontology and geriatrics, would be beneficial. Before beginning

orientation, new hires would be given a GKI-type of quiz as a diagnostic function. Orientation materials adapted to specific needs and learning styles could also be offered.

Some authors distinguish learning style from learning preference as the learning preference being the choice of one learning situation over another. They conclude that if given the opportunity to choose between various teaching methodologies, learners will select those methods which fit their learning preference (Loesch & Foley, 1988). Using preferred learning styles of nursing home surveyors would communicate educational material in a more personal way and assist the learner to perceive the environment as supportive to their learning activities.

Ongoing CPE offerings could still be offered on a one-day-a-month basis with the time carefully guarded so that other work tasks did not take precedence. Evaluation forms for the sessions could be revised to elicit more thoughtful and constructive feedback in a way that supports surveyor responsibility for input.

The concern by surveyors that CPE material be from experts could be addressed by allowing the surveyors to become the experts. Aspects of the older nursing home resident could be subdivided into body systems (circulatory, nervous, endocrine, etc.) and geropsychiatric conditions. Surveyors could be given a choice for an area of specialization and assigned to a type of quality circle for that specialty. Quality circles are designed to solve a

problem or perform some specialized function and can be a mechanism for change (Ammentorp, Gossett & Euchner Poe, 1991). The quality circles would be charged with developing CPE modules to include orientation for new surveyors as well as ongoing CPE for a particular condition as it related to the F tags in the OBRA regulations.

Each circle would choose their own appropriate outside seminars, workshops and print materials required to remain current with the latest research information. The staff development team would still be responsible for facilitating the dissemination of information as provided by the surveyor-experts. Long-term goals of that practice should lead to research and publication activities that would serve as guidelines for surveyors in other states.

Practices of providing CPE that influence the quality and consistency of services provided by nursing home surveyors can be individualized and continually evaluated by use of a model that provides avenues to control the educational process and change it as necessary. Stake's model (1967) emphasizes the educational component of CPE in the planning, implementation and evaluation of class offerings. The model facilitates the use of adult learning principles by providing for learner input in planning and feedback. Antecedents, transactions and outcomes demonstrate the flow of the program. Intents, observations, standards and judgments provide evaluation according to

	Descriptive Matrix		Judgment Matrix	
	Intents	Observations	Standards	Judgments
C	Antecedents (planning efforts)			
O N T I N G E N	Education in geron/geriatrics Experience Perceived need for continuing education HCFA guidelines Time/travel limitations	Review survey reports Analysis of learner self-reported needs Integration with HCFA materials	Progress consistent with HCFA standards Surveyor input supported	Surveyor reports more consistent Improved care in facilities and improved attitude of the public
C	Transactions (learning process)			
Y	Teaching methodologies Surveyors set goals and evaluate programs	Utilize principles of adult education	Analysis of continuing education and possible revisions	Observed satisfaction of surveyors and facilities
	Outcomes (performances)			
	New surveyors become aging generalists and progress to aging specialists New hiring guidelines	HCFA adapts program to national level less variation in surveyor citations	A state model for continuing education program	Improved image of the state health department Facilities maintain higher standards
	CONGRUENCE			

Figure 6. Stake's Model Applied to Surveyors' CPE

elements outside of learner evaluations (i.e., consistency of survey reports).

Since consistency of surveyor performance is the de sired outcome of CPE programs, Stake's model provides a framework for both formative (description matrix) and summative (judgment matrix) evaluation of in-service programs. The model facilitates program adjustment to achieve learner satisfaction and overall program objectives as well as possibly explaining outcomes of current in-service programs. Surveyors' suggestions to receive CPE of their choice, and that includes a discussion format and attention to team dynamic issues, would easily fit into Stake's model and be useful for continuous evaluation of programs, surveyor satisfaction, and surveyor performance.

Recommendations

1. The Health Department should expect and facilitate the process of surveyors becoming aging specialists in their discipline. Aging specialists in an existing profession are knowledgeable about the physical, mental and psychosocial aspects of aging and are able to apply appropriate interventions and consult with general practitioners on treatment for older persons (Peterson & Wendt, 1990). See Appendix E for course outline.

2. The Health Department should institute an orientation program on aging education that enables new surveyors to become aging practitioners in their discipline

as described by Peterson (1990): Aware of the differences between normal and abnormal aging and of appropriate referrals for older persons. Because conditions of aging are not the exclusive domain of any of the professional disciplines, a basic knowledge of gerontology and geriatrics would provide a commonality among surveyors. The shared knowledge would be a positive factor in reducing variations among surveyors. See Appendix E for course outline.

3. Future CPE initiatives should be restructured to be surveyor-driven with CPE and adequate time allotted as a priority goal. While improvements are important for the structured programs, ways must also be found to improve on-the-job learning opportunities.

4. CPE planners should take advantage of the interest for CPE and the expertise of surveyors to allow them to become experts in an area of their choice, allowing them to choose the methods and materials they need to achieve that goal. The surveyor-experts could be provided with basic information teaching/learning principles to help them develop useable information.

5. Budget allottments and limitations could be made known so that surveyors could plan their outside educational opportunities to attain maximum benefit from available funds and augument them by personal contributions if desired.

6. The Health Department should develop a system for collecting surveyor CPE needs and provide timely feedback.

7. It would be important to examine the survey team interactions and determine how surveyors and administrative personnel would describe a "good surveyor."

8. Consideration should be given to hiring an activity therapist to act as a resource and consultant for surveyors.

9. A study should be done to determine approximate time frames for completion of survey tasks. The information would be useful both for scheduling and for evaluation of staff performance.

Research Recommendations

1. Study the social system within which the surveyors operate. Specifically:

a. team dynamics (including communication patterns and leadership styles),

b. value placed on CPE by administrative personnel, and

c. rewards for attainment of CPE by surveyors (more in-put into CPE programs, wage increases, administrative leave for CPE).

2. Longitudinal studies after targeted CPE should be done to determine if lack of knowledge about specific aspects of aging (spirituality, sexuality and death and dying) produces less perceived need and interest in a topic.

3. The surveyors' attitudes toward the aged should be studied from the time they take the position, after initial training and continued at specified intervals to learn how they are affected by CPE and working with the aged.

4. Determine if a predictable career ladder exists in a state system for nursing home surveyors, and if surveyor "experts" would be fostered and supported in the bureaucratic system.

5. Develop a valid process to evaluate surveyor performance that will identify problems and effect corrective action through use of adult education principles.

6. Study the interdisciplinary nature of survey teams to develop a conceptual framework for CPE that will help the professional disciplines work together for more accurate evaluation of nursing home care.

APPENDICES

APPENDIX A

PROFESSIONAL DEVELOPMENT INFORMATION

APPENDIX A

Section I: Professional Development Information

The following questions are intended to provide information helpful in planning orientation and staff development programs.

1. Please indicate your professional discipline.

a. _____ dietitian
b. _____ social worker
c. _____ pharmacist
d. _____ sanitarian
e. _____ nurse

2. How many years have you been employed in your profession?

a. _____ 1 - 2 years
b. _____ 3 - 5 years
c. _____ 6 - 9 years
d. _____ over 10 years

3. Please indicate how long you have been a nursing home surveyor?

a. _____ less than 12 months
b. _____ 1 - 2 years
c. _____ 3 - 4 years
d. _____ 5 - 9 years
e. _____ over 10 years

4. Please indicate the educational degrees you have earned and the major area of study for each.

	Degree	Major area of study (nursing, dietetics, etc.)
a.	_____ associate	_____
b.	_____ diploma (nsng)	_____
c.	_____ bachelor	_____
d.	_____ master	_____
e.	_____ post-graduate or certification	_____

5. Check the HCFA sponsored classes you have attended.

a. _____ Basic surveyor training in Baltimore

b. _____ Region five conference in Chicago 1991

6. Please indicate any gerontology courses or seminars you have taken in the last 2 years other than the training provided by the health department or HCFA.

	Main Topic of Course	Approximate no. of hours
a.	Physiological issues as related to aging	_____
b.	Psychosocial topics related to aging	_____
c.	Mental health issues of aging	_____

7. Please indicate the general type and length of experience you have had working with older people before you became a surveyor.

	Type of experience	months/years (approximate)
a.	____ nursing home	_____
b.	____ hospital	_____
c.	____ community mental health	_____
d.	____ other (please specify) _____ _____ _____	_____

8. What is your gender? Male____ Female____

9. Please indicate your age.

___20-29 ____30-35 ____36-40 ____41-45

___46-50 ____51 and over

APPENDIX B

NEEDS AND INTERESTS ASSESSMENT FOR CPE

APPENDIX B

Section II: Continuing education needs assessment

The following questions measure YOUR assessment of continuing professional education topics that are necessary to your work. Please circle the numbers in the "level of need" and "level of interest" columns that BEST correspond to your educational needs and interests.

5 = high need/interest
4 = fairly high need/interest
3 = don't know/not sure
2 = fairly low need/interest
1 = no need/interest

A. Topics in continuing education related to aspects of aging.	Level of need					Level of interest				
	High Need				No Need	High Interest				Low Interest
1. Aging and mental health	5	4	3	2	1	5	4	3	2	1
2. Nutrition and aging	5	4	3	2	1	5	4	3	2	1
3. Normal and abnormal aging patterns	5	4	3	2	1	5	4	3	2	1
4. Spiritual aspects of aging	5	4	3	2	1	5	4	3	2	1
5. Drug use and alternatives	5	4	3	2	1	5	4	3	2	1
6. Maintaining mobility in old age	5	4	3	2	1	5	4	3	2	1
7. Medical terminology	5	4	3	2	1	5	4	3	2	1
8. Physical assessment of the older person	5	4	3	2	1	5	4	3	2	1
9. Sexuality and aging	5	4	3	2	1	5	4	3	2	1
10. Diversional activities for lower functioning residents	5	4	3	2	1	5	4	3	2	1
11. Psychosocial aspects of aging	5	4	3	2	1	5	4	3	2	1
12. Death, dying and bereavement	5	4	3	2	1	5	4	3	2	1
13. Environmental factors that affect older people	5	4	3	2	1	5	4	3	2	1

14.	Legal aspects of surveying	5	4	3	2	1	5	4	3	2	1
15.	Documentation updates	5	4	3	2	1	5	4	3	2	1

16. Other suggestion (renal failure, Parkinson Disease, Huntington`s Chorea, etc.) Please specify.

_____

_____

_____

B. Please circle the appropriate number in the "level of preference" column that BEST matches your preferences for the presentation of educational material.

Method of presentation	Level of preference				
	Most Preferred				Least Preferred
1. For group presentations					
a. teleconferences	5	4	3	2	1
b. panel discussions	5	4	3	2	1
c. lecture followed by small group discussions of lecture material	5	4	3	2	1
d. lectures	5	4	3	2	1
e. other (please specify) _____ _____ _____ _____					
2. For individual learning					
a. computer assisted instruction	5	4	3	2	1
b. individual reading instruction	5	4	3	2	1
c. synopsized articles from professional journals	5	4	3	2	1
d. study-guides (similar to the HCFA drug review)	5	4	3	2	1
e. videos	5	4	3	2	1
f. other (please specify) _____ _____ _____					

3. Please indicate your preferred times for presentation of continuing education material and rank each option in the right hand column.

	Most Preferred				Least Preferred
a. two hours a week	5	4	3	2	1
b. one week every 6 months	5	4	3	2	1
c. one half day twice a month	5	4	3	2	1
d. one full day a month	5	4	3	2	1

e. two weeks once a year 5 4 3 2 1

f. other suggestions
(please be specific)

_____

_____

_____

_____

APPENDIX C

GERONTOLOGY KNOWLEDGE INSTRUMENT

APPENDIX C

Section III: Changes in Aging

Please answer true or false to the following questions to the best of your ability. As in the previous section, information obtained will be useful in making necessary revisions in the orientation and continuing education programs.

1. ____ Lowered body temperature can cause death in the older adult without his/her ever feeling cold.

2. ____ Older people are set in their ways and tend to hold tenaciously to old patterns of living.

3. ____ Intelligence is not decreased in later life.

4. ____ Elderly people experiencing the sundown syndrome actually have improved capacity for clear thinking in the late afternoon and evening.

5. ____ One of the risk factors for suicide among the elderly is loss of mobility.

6. ____ The use of warm, contrasting colors (yellow, orange, red) make it easier for older persons to function in their environment.

7. ____ People over age 65 tend to live in the past.

8. ____ Taste and smell are rarely affected by aging.

9. ____ Older persons, unable to feed themselves should be fed in reclining chairs, sitting at a 45 degree angle.

10. ____ A sudden behavioral change in the older person can signal a life-threatening condition.

11. ____ Morale in old age is not influenced by some of the same factors that affect morale in younger persons such as socioeconomic status and health status.

12. ____ Lowered brain function in the elderly may affect reasoning flexibility.

13. ____ Older people with less than average body weight will experience increased plasma and tissue concentration of drugs if the "normal adult dose" is used.

14. ____ Cataract surgery is unsuccessful in older adults 95% of the time.

15. ____ There is a direct relationship between high levels of activity and a high degree of morale.

16. ____ Emotional illness can be caused by hearing loss.

17. ____ Psychomotor performance in all persons is permanently affected in later life.

18. ____ Loss of memory and decreased learning ability occur as a result of old age.

19. ____ In adjusting to stress, it is inappropriate for older adults to use denial as an adaptive or coping technique.

20. ____ Lowered social and spatial environment result when older people experience a decrease of cues due to sensory loss.

21. ____ Most elderly people are very sensitive to others' reactions to them.

22. ____ As people age, the variations among the elderly become less pronounced than among younger age groups.

23. ____ Generally, older people need higher levels of illumination to perform tasks of daily living.

24. ____ The "gag" reflex in the aged is stronger than in a young person.

25. ____ Dining room chairs, rather than wheelchairs, are generally better for residents to sit in at mealtimes.

APPENDIX D

CORRESPONDENCE

APPENDIX D

Correspondence

Letter to request voluntary participation:

Dear _____:

Enclosed is a survey for a study at Michigan State University entitled "Continuing Professional Education for Nursing Home Surveyors."

The purpose of the study is to determine what topics surveyors feel are most important for their continuing professional education, how they would prefer such material be presented, and how orientation and in-service programs could be tailored to meet individual learning needs. The findings could be helpful in designing future education programs that make the most efficient use of your limited time.

Your participation is important. Please take a few minutes to complete and return the survey by (two weeks). You will be helping in the study of a very important issue. Your answers will remain anonymous.

You indicate your voluntary agreement to participate by completing and returning this questionnaire.

Thank you for your interest and professional cooperation.

Sincerely,

Grace Kerlin
MDPH Surveyor
Lansing Office

APPENDIX E

COURSE OUTLINES FOR AGING SPECIALIST AND AGING GENERALIST

APPENDIX E

COURSE OUTLINE

Title: Nursing Home Surveyor as an Aging Specialist

Definition: The nursing home surveyor as an aging specialist is defined as a practitioner knowledgeable about the physical, mental and psychosocial aspects of aging, is able to apply their professional skills to care of the aged and understands appropriate interventions and evaluation of care.

Purpose: The course is designed to be presented in modules and will qualify experienced nursing home surveyors as aging specialists. Content includes state-of-the art assessment of pathological changes and conditions that potentiate physical and mental disease. Focus is on interventions and evaluation within the framework of comprehensive, holistic health care. The application of appropriate F tags is emphasized.

Goals of Coursse:

1. To update surveyor knowledge related to physical and mental diseases that afflict nursing home residents.

2. To increase awareness of spirituality, sexuality and ethical issues related to the older person in an institution.
3. To recognize the potential to restore function or maximize remaining function of elderly residents.
4. To maintain consistency among nursing home surveyors.

Course Objectives: Upon completion of the course the nursing home surveyor will be able to:

1. Recognize inadequate physical, mental and psychosocial assessment of residents.
2. Determine therapeutic or toxic effects of both prescribed and over-the-counter drugs on residents, as well as drug interactions with food.
3. Analyze the results of laboratory tests and relate them to the resident's condition and planned care.
4. Describe the effects of aging on intelligence and understand coping methods used by older people.
5. Describe the difference between depression, dementia and delerium and list the appropriate treatment for each.
6. Discuss the ethical issues associated with residents in nursing homes and how their rights are supported.
7. Identify sexual issues related to institutionalized persons and appropriate interventions.

8. Identify effective and adequate rehabilitation techniques.
9. Recognize adequate nutritional assessments and provision of proper diets including issues related to parental and enteral therapy.
10. Identify aberrant practices by nursing home staff that promote and support disability.

Evaluation:

1. Understanding of material as demonstrated by consistency in the application of F tags during surveys.
2. Identifying examples of both appropriate and inappropriate use of specific F tags during in-service sessions.
3. Positive comments from nursing home administrative personnel regarding surveyor consistency.
4. Positive comments from surveyors expressing satisfaction with staff-development efforts.

Content of Modules:

1. Effects of aging on body systems versus disease states.
   a) history and assessment
   b) appropriate interventions
   c) associated F tags 272, 273, 275, 276, 280
2. Pharmacology

a) pharmacodynamics

b) pharmacokinetics

c) food and drug interactions

d) associated F tags 190, 285, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351

3. Laboratory values

a) reference intervals

b) relation to infection and disease

c) relation to nutritional assessment

d) associated F tag 274

4. Intelligence

a) crystallized and fluid intelligence

b) information processing

c) problem-solving

d) adaption and creativity

5. Depression, dementia and delerium

a) assessment

b) reversible and irreversible causes

c) perceptual alterations

d) treatment approaches

e) associated F tags 177, 222, 257, 263, 265, 273, 275, 279, 284, 304, 305, 315, 325, 326, 347, 348, 349

6. Ethical issues

a) resident and family education

b) advance directives

c) care of dying residents

d) associated F tags 158, 174

7. Sexuality

a) need for touch

b) effects of chronic illness

c) behaviors in nursing homes

d) associated F tags 189, 279

8. Rehabilitation

a) expectations of resident, family, nursing home staff and nursing home surveyors

b) mobility

c) incontinence

d) environment

e) associated F tags 272, 275, 276, 279, 283, 310, 311, 312, 313, 315, 321, 322, 323, 324, 329

9. Nutrition

a) age-related physiological issues

b) psychosocial factors

c) assessment

d) parenteral and enteral nutrition

e) dehydration

f) environmental factors

g) food serving

f) associated F tags 241, 265, 274, 277, 281, 314, 327, 331, 332, 333, 335, 360-375.

10. Special issues in aging

a) safety

b) excess disability

c) learned helplessness

d) sleep disorders

e) infections

f) associated F tags 221, 223, 241, 329

Notes:

1. The definition of the nursing home surveyor as an aging specialist is adapted from Peterson, D. & Wendt, P., 1990. Gerontology Instruction: Different models for different results. Educational Gerontology, 16, 359-372.

2. The specific numbers assigned to F tags were in effect 10-9-93 and are subject to change. F tags that are more general and could apply to many conditions listed in the course outline are F tags 253, 272, 295 and 309.

COURSE OUTLINE

Title: Nursing Home Surveyor as an Aging Generalist

Definition: The nursing home surveyor as an aging generalist is defined as a practitioner with a sensitivity to the aged, awareness of normal and abnormal aging manifestations and knowledge of basic supporative actions.

Purpose: The course is an overview of gerontology presented in modules for new nursing home surveyors. It is intended to provide a basic awareness of the changes associated with aging and qualify new surveyors as aging generalists. The content focus is on manifestations of changes with aging and adaptions that will promote physical, mental and psychosocial health in nursing home settings. Emphasis is on relating deficits in nursing home care to appropriate F tags.

Goals of Course:

1. To refute negative stereotypes and replace them with factual results.
2. To increase awareness that aging is a natural process eased by individual planning and supporative actions of nursing home staff.
3. To become knowledgeable of the physical and sensory deficits of older persons and thereby

encourage positive adaptive behavior in older individuals.

4. To achieve consistency among nursing home surveyors.

Course Objectives: Upon completion of the course the nursing home surveyor will be able to:

1. Demonstrate knowledge of psychosocial theories of aging and how they may be manifested in nursing home residents.
2. Give examples of ageism in society and in nursing home settings.
3. Recognize the diversity among older persons and the need for individualized care.
4. Identify problemmatic practices related to communication with residents.
5. Recognize lack of provision of sufficient choices and opportunities for physical and mental activity.
6. Observe nursing home staffs' response to residents' spiritual needs and issues related to death and dying.
7. Identify signs of drug toxicity.
8. Make accurate observations of negative environmental factors that impede maximum independence and function.

9. Demonstrate understanding of application of F tags that contain general guidelines versus F tags directed to specific conditions.

Evaluation:

1. Understanding of material as demonstrated in class discussions relating problems to appropriate F tags.
2. Collection of observations gathered on orientation surveys.
3. Identifying examples of ageism in daily newspapers, greeting cards and daily conversation.
4. By a passing grade on the surveyor-competency test

Content of Modules:

1. Stereotypes and ageism
   a) heterogenicity
   b) attitudes of nursing home staff, residents and surveyors
   c) cultural and environmental influences
2. Theories of aging
   a) activity
   b) disengagement
   c) continuity
3. Communication with aging individuals
   a) sensory changes
   b) inpact of environment

c) family influences

d) associated F tags 241, 263, 276, 315, 318

4. Age-related changes

a) physical...changes in body systems

b) mental...stress, losses, self-concept

5. Environmental issues

a) physical environment...supporting function, privacy, autonomy

b) social environment...individuality, choices, lifestyle habits

c) associated F tags 176, 187, 188, 191, 242, 244, 246, 253, 260, 263, 264, 265, 470

6. Pharmacology

a) purpose of drug therapy

b) signs and symptoms of toxicity

7. Spiritual aspects

a) religiosity

b) staff attitudes

c) referrals

d) associated F tags 252, 279

8. Death and dying

a) attitudes of staff, residents and surveyors

b) effects of death on nursing home peers

c) associated F tags 279, 325, 326

9. Activity

a) deconditioning

b) dependency

c) exercise programs

d) associated F tags 182, 255, 282, 310, 323, 324

10. General F tags

a) F tags 253, 272, 295, 309

Notes:

1. The course outline was adapted from course material presented by Sister Mary Honora Kroger Ph.D, Professor Emeritus, Michigan State University.

2. The specific numbers assigned to F tags were in effect as of 10-9-93 and are subject to change. F tags that are more general and could apply to many conditions listed in the course content are F tags 253, 272, 295 and 309.

APPENDIX F

GLOSSARY

APPENDIX E

GLOSSARY

Activities of daily living (ADL): Basic activities that include eating, bathing, dressing, transferring from bed to chair, bowel and bladder control and ambulation.

Aged: Persons aged 65 and over.

Case-mix: The combination of diagnoses, medical care, and social care needs present in the population of a health care facility.

Certification for Medicare and/or Medicaid: A determination made by the state survey agency to the federal Medicare and/or state Medicaid agency regarding the compliance of a provider with federal regulations.

Complaint visit: A visit made by the state survey agency to a health care facility in response to a complaint made about the facility to the state agency.

Deficiency: The designation a surveyor makes on finding a facility out of compliance with Conditions and Standards of Participation.

Gerontology: The study of the process of aging and common problems of the aged.

Gerontology Knowledge Instrument (GKI): The third section of the survey instrument, a twenty-five (25) item

set of true/false questions covering general areas of knowledge on older people.

Geriatrics: The area of health care dealing with the diagnosis and treatment of diseases affecting older adults.

Health Care Financing Administration (HCFA): The Medicare and Medicaid administration branch of the Department of Health and Human Services.

Long-term care facility: Any nursing home, or similar institution licensed by the state and eligible for participation in Medicare and/or Medicaid.

Ombudsman: A representative of the Michigan Long-Term Care Ombudsman Program who investigates and resolves complaints on behalf of residents or families of residents in long-term care facilities.

Professional Development Information (PDI): The first section of the survey instrument designed to elicit information on age, gender, education, professional work experience and continuing education.

Survey: The process of inspecting a health care facility for compliance with state licensing regulations and/or Federal certification requirements.

Surveyor: A health care professional employed by the Michigan Department of Public Health (MDPH) for the purpose of inspecting (surveying) the care given in long-term care facilities.

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