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BENCH MARKS OF THE STATUS PASSAGE OF ELDERLY PERSONS FROM INSTITUTIONALIZED TO NON-INSTITUTIONALIZED STATUS

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Benchmarks of the Status Passage of Elderly Persons from Institutionalized to Non-institutionalized Status

By Elizabeth Grace Nichols

ABSTRACT

For the elderly person in the extended care facility, movement home may necessitate a change in life style. It will necessitate a movement to a new status, that of non-institutionalized, or non-hospitalized, status. To explore the anticipation of this status passage, the following research question was developed: What are the similarities and dissimilarities in the content and timing of the status passage benchmarks, in the passage from institutionalized to non-institutionalized status, as reported by the nursing staff and the older patients on one extended care facility? Content was defined as the event that was perceived and reported or identified as a benchmark by the interviewee. Timing was defined as the point at which the subject perceived the stated benchmark. Writings from the areas of (1) the extended care facility, (2) discharge of the geriatric patient, and (3) status passage theory formed the background and conceptual framework for the study.

A series of semi-structured interviews was conducted with twelve elderly patients on one extended care facility.

Each patient specified a nurse to be interviewed to complete the interview sequence. A total of twenty-six interviews was completed. The interview data and field notes were examined for the timing and content aspects of the reported benchmarks. These properties were then compared with those from previous interviews. From this comparison, categories emerged and were revised. Data collection was continued until categories ceased to appear with any regularity.

The content categories that developed were: mobility, progress toward normalcy, reduction of pain, eating, sleeping, change of interest, change of attitude, development of confidence in the patient, and indicators of regression. These benchmarks were related to the tasks the patient, or nurse, felt were necessary for the patient's discharge. The patient related goals that were functional in nature; the nursing staff related goals that reflected the professional goal of the extended care facility, rehabilitation of the patient.

Patient-reported benchmarks referred to both the acute and the extended care settings. Those occurring in the acute care setting were dramatic physiological changes associated with a discrete time reference. Those occurring in the extended care setting came from a variety of content areas and were seldom associated with a discrete time reference. Nurses reported benchmarks occurring in the extended care setting only. These had no discrete time reference.

The staff member or patient perspective of the home situation affected the goals set and the benchmarks reported. The patient related home as a positive place; the staff member was more cautious in her assessment. Three distinct rehabilitation styles were noted: initiators, assumers, and acceptors. These styles affected the patient's ability to report benchmarks.

The patient benchmarks could be divided into the general themes of survival and mastery. The staff benchmarks were mastery in nature.

The patient derived his benchmarks from a variety of sources. These sources were grouped into three interacting dyads: (1) illness concerns--other concerns (the life area); (2) goals--home (the home area); and (3) rehabilitation style--health care team (the hospital area). The product of each of the dyads then combined with those of the other dyads to determine the tasks to be accomplished prior to discharge. The nursing staff derived their benchmarks from the tasks to be accomplished; however, these tasks were drawn directly from the goals for the patient. The goals were derived from a number of sources, the primary influence being the professional goal of the nursing unit.

The time perspective for the rehabilitative process was, for most of the patients, a continuous open-ended frame. Time cues were derived mainly from the health care team's statements. The nurse developed her time perspective from the health care team and her previous experience rather than from the patient's experience. The nurse's temporal perspective, as with the benchmarking perspective, was drawn from the hospital area; the patient's was drawn from all three areas: hospital, home, and life.

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Knowledge and understanding are life's faithful companions who will never prove untrue to you. For knowledge is your crown, and understanding your staff; and when they are with you, you can possess no greater treasures.

--Kahlil Gibran
<u>The Voice of the Master</u>

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CHAPTER I

INTRODUCTION

> The tree of my heart is heavy with fruit. Come ye hungry souls, gather it, eat and be satisfied. My spirit overflows with aged wine. Come, oh ye thirsty hearts, drink and quench your thirst.
>
> --Kahlil Gibran[1]

So spake Almuhtada, the spokesman of the Master. And so is the field of nursing heavy with fruit, awaiting the searching minds of nurses. But the search into nursing does not stop when facts are learned; the facts must be developed into theories. These theories then form the basis for the emerging science of nursing. Several authors have presented theoretical frameworks on which to base the practice of nursing; for example, Martha Rogers' holistic theory of nursing, Dagmar Brodt's synergistic theory of nursing, and the adaptation theory posed by Sister Callista Roy.[2] Any

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[1] The Voice of the Master (New York: Citadel Press, 1958), p. 30.

[2] Martha Rogers, "Some Comments on the Theoretical Basis of Nursing Practice," Nursing Science, I (April-May, 1963), 11; Dagmar Brodt, "A Synergistic Theory of Nursing," American Journal of Nursing, LXIX (August, 1969), 1674; Sister Callista Roy, "Adaptation: A Conceptual Framework for Nursing," Nursing Outlook, XVIII (March, 1970), 42.

one of these theories may be selected to form the basis for hypothesis testing, or for nursing actions.

Another approach to the development of nursing theory is the inductive or grounded theory approach. A nursing situation is examined in its natural setting. These qualitative data are then examined for relationships and explanations out of which will emerge theoretical notions that account for much of the relevant data.[1] Until recently, nurse researchers developed theoretical frameworks based on theory borrowed from other disciplines, then tested their applicability to the field of nursing. For nursing to develop nursing theory, both the logico-deductive and the grounded theory approaches are necessary. One complements, rather than excludes the other. The study reported here seeks to develop a grounded theory, that is, the researcher gathers the fruit already available, examines it, describes its properties and explores relationships between these properties.

The Research Problem

Geriatric nursing is concerned with the assessment of nursing needs of older people, planning and implementing nursing care to meet these needs, and evaluating the effectiveness of such care to achieve and maintain a level of

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[1] Barney G. Glaser and Anselm L. Strauss, The Discovery of Grounded Theory (Chicago: Aldine Publishing Co., 1967), p. 30.

wellness consistent with the limitations imposed by the aging process.[1] In this definition, nursing acknowledges the uniqueness of the needs and the care of the elderly patient. And, as the Committee for Standards of Geriatric Care stated, it is the responsibility of nurses to further test and develop the standards of care that follow from this definition.[2]

Just as the definition of geriatric nursing, and even nursing itself, is changing, so is the setting in which it is practiced. The care of elderly persons has undergone some radical changes in the last two decades.[3] The White House Conference on Aging and the advent of Social Security legislation have brought the care of the elderly into national view. With the advent of Medicare came a new type of health care facility, the extended care facility. Here patients receive continued skilled nursing care under medical supervision. The patient no longer requires the intensive level of care offered in the acute care setting. From this

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[1] "Standards for Geriatric Nursing Practice," <u>American Journal of Nursing</u>, LXX (September, 1970), 1894.

[2] <u>Ibid</u>.

[3] For a discussion of the history and advances of the care of the elderly, see Raymond Harris, "Advances in Medical Care of the Elderly," <u>Hospital Progress</u>, L (April, 1969), 60, and Jacob Gold and Saul Kauffman, "Development of Care of Elderly: Tracing the History of Institutional Facilities," <u>The Gerontologist</u>, Part 1 (Winter, 1970), p. 262.

facility the patient moves to other care settings or to home, based on his abilities, needs, and desires. It is the movement of the elderly patient from the extended care facility that became of interest to the researcher, and it is the anticipation of that movement that is the focus of this study.

One of the stages of illness described by Suchman and Lederer is the recovery or rehabilitative stage during which the patient should move from being in the dependent patient role to looking outward and concerning himself with the consequences of his illness and his return to society.[1] The care offered in the extended care facility focuses on the rehabilitation of the patient, thus assuming that he is in the process of developing, or is ready to develop, this outward orientation. Development of such an orientation, as well as the concentration of elderly persons in the facility, makes the extended care facility an ideal setting for examining aspects of the transition of the elderly person from an institution to his home.

For an elderly person illness may necessitate a change in his life style, even though he returns home; for

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[1] Edward Suchman, "Stages of Illness and Medical Care," Journal of Health and Human Behavior, VI (Fall, 1965), 114; Henry Lederer, "How the Sick View Their World," Social Interaction and Patient Care, ed. by Skipper (Philadelphia: J. B. Lippincott Co., 1965), p. 155.

example, a stroke patient may no longer be able to walk unaided, or a heart patient may have to sell his house if he cannot negotiate the stairs to the front door. Whether or not a change in the patient's life style will be necessary, both the patient and the nursing staff make assessments of the patient's progress toward discharge. This progress may be divided into two major areas: the physiological progress and the psychological or ideational progress. The concept of anticipatory socialization, presented in reference to upward social mobility, states that persons rehearse new roles in order to learn the values and norms of the group they strive to join.[1] That is, they prepare ideationally for the coming status passage. Physiological progress may be measured against preset criteria and by observable measures. Ideational progress cannot be so assessed. If it can be determined what the patient perceives as important indicators of his progress, then this ideational change can be explored and possibly assessed. The importance of events or occurrences is dependent upon the individual's own perception of that event, and the influence of those about him.

The nurse in the extended care facility has the opportunity to greatly influence the patient for two reasons:

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[1] Robert K. Merton, Social Theory and Social Structure (New York: The Free Press, 1957), p. 265.

(1) the patient usually spends a longer period of time in the extended care facility than in the acute care setting, and (2) the emphasis in this facility is on nursing care rather than on medical care.

One component of the nursing care in the extended care facility is the preparation of the patient for a transition to a less controlled living situation, preparation that requires a planned program. Development of such a program is essentially an educational problem and so should be based on educational principles; two concepts important to any such program are those of goal congruence and learner readiness. It is important for the educator, here the nurse, to know not just the goals and the priorities she sets, but also those of the learner, in this case the patient. The goal of the participant influences not only what to teach, but also when to teach it, that is, it may affect patient readiness, a crucial factor in any learning situation. At this time it is not known if there is a common understanding of both patient and professional goals on which to base discharge programs. It is important to gain this knowledge to ensure that patients are appropriately prepared to make the transition to the home situation.

The study reported in this paper was designed to discover what differences, if any, exist between the perceptions of the staff member and the patient concerning the patient's progress toward discharge. Concentration is on the aspects of content (what the person says) and timing (when it occurred).

Statement of the Problem

Movement from the extended care facility may be viewed as a status passage, that is, the movement from the status of being in the hospital (institutionalized) to that of being at home (non-institutionalized). As the patient progresses through this transitional phase, he notices benchmarks, or indicators of progress. These benchmarks form the cues that tell the patient (or nurse) where he is in reference to the successful completion of the status passage. For example, a visit from the discharge planner may suggest to the patient that his discharge is assured and imminent; that he is close to completion of the passage. The benchmarks selected as indicators of movement in the status passage are dependent upon those things of importance to the passagee. Importance, in turn, is dependent upon the individual's perception of his situation and the factors he sees as crucial to that situation.[1] It is not known if the

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[1] Dr. Stanley King developed a theoretical framework from the social sciences which he then applied to disease and its interpretation, the persons who treat disease, and the setting in which disease is treated. In this discussion he examined the effects of various psychosocial and cultural factors on the perception of illness, and its treatment. See Stanley H. King, <u>Perceptions of Illness and Medical Practice</u> (New York: Russell Sage Foundation, 1963).

nurse and the elderly patient have the same perceptions and goals relating to the patient's preparation for discharge, that is, if they have the same definition of importance. Whiting suggests that the setting in which the nursing care occurs and the process of professionalization that occurs during the education of the nurse create a unique core of values that influence the nurse's perception of the nurse-patient situation.[13] The patient has not experienced this socialization process, nor is he as immersed in the goals and philosophy of the hospital-based extended care facility as is the nurse.

To explore this area of possible conflict, the following problem statement was developed: What are the similarities and dissimilarities in the content and timing of the status passage benchmarks, in the passage from institutionalized to non-institutionalized status, as reported by the nursing staff and the older patients in one extended care facility?

Definitions

Status Passage Benchmark: an indicator of the change in the individual's progress from one status to another. In

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[1] Frank Whiting, "Needs, Values, Perceptions and the Nurse-Patient Relationship," *Journal of Clinical Psychology*, XV (April, 1959), 149. For a detailed account of the process of the socialization of the nursing student, see Virginia Olesen and Elvi Whittaker, *The Silent Dialogue* (San Francisco: Jossey-Bass, Inc., 1968).

this study it is the passage from institutionalized status to non-institutionalized status. A benchmark is the point of perceived change which may occur at any time in the hospital career of the patient. The relative importance and meaning of an event to the individual will affect its selection as a benchmark, and the time at which it is perceived.

Content: an event that is perceived and reported or identified as a benchmark by the interviewee. For example, in the statement "I think I really felt I would go home the day I walked down the stairs in the physiotherapy department," the content of the benchmark is the act of walking down the stairs. The content of the benchmark reported in the following statement is the capability of the individual: "You know, yesterday I said to myself, 'You can fix dinner, all you need is a chair nearby to sit on.' Since then I figure I can manage at home O.K."

Timing: the point at which the subject perceived the stated benchmark. Timing may be related as a specific hour and day, or in relation to specific events. For example, Saturday morning, or right after the sutures were removed.

Older Patient: a person, sixty-five years of age or over, who is a patient in an extended care facility. The specific criteria for patient selection in this study will further define the older patients to be interviewed.

Extended Care Facility: a health care facility that provides intermediary, rehabilitative care for the post-acute hospital patient who no longer needs intensive hospital care but still requires continued skilled nursing care.[1]

Nursing Staff: the registered nurses (excluding supervisory personnel), licensed vocational nurses and nursing assistants (aides) who are staff members of the extended care facility.

Discharge: leaving the hospital, with the physician's approval, to go to the patient's or a significant other's home, that is, the patient may go to the home of his children, his spouse, or relative, or a close friend, as well as to his own home.

Institutionalized Status: residency in an extended care facility.

Non-institutionalized Status: discharged from the extended care facility to the patient's own home or that of a significant other.

Assumptions

Basic to the study are the following assumptions:

1. The patient's discharge home is important to both the patient and the nurse. Home is the private house or apartment of the patient or of a person who is important to the patient.

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[1] Charlotte Isler, "New Specialty: Nursing in the Extended Care Facility," R.N. (June, 1968), p. 31.

2. During the rehabilitation period the individual no longer conserves his energies only for survival and physical maintenance, but is able to look outward and concern himself with leaving the hospital setting.[1] This change of energy expenditure will then permit the patient to discuss his experiences during the pre-discharge period.

3. Discharge from a care institution is a status passage.

Limitations

The study was conducted in one extended care facility, thereby limiting the population from which the sample could be drawn, and so limiting the generalizability of the findings. In order to protect the patient from physical or psychological harm, the nursing staff was requested to assess the potential effects of interviewing on the patient. This screening effect further reduced, although minimally, the available population, and so the generalizability of the study results.

In order to obtain the patient's or staff member's perspective of this status passage, the data were restricted to interview data. Interview data represented the informant's perception of the truth and the data he wished

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[1] Lederer, p. 155.

to share with the interviewer.[1] Becker and Geer suggest that a combination of participant observation and interviewing is a more accurate method of data collection.[2] Economy of time in relation to the desired data dictated the use of the interview in this study. Interviews were conducted until the categories emerging from the data became repetitious. Such a method relied on the data for the termination point of data collection. It is possible that with continued interviewing, more categories may have emerged; however, the likelihood of this was not great.

Review of Related Literature

The literature pertinent to the problem for study is discussed in three sections: the extended care facility, the discharge of the geriatric patient, and status passage.

The Extended Care Facility

This section focuses on the development of the extended care facility and the patient care aspect of this level of medical and nursing care.

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[1] John P. Dean and William F. Whyte, "How Do You Know the Informant Is Telling the Truth?" Issues in Participant Observation, ed. by McCall and Simmons (Reading, Mass.: Addison-Wesley Publishing Co., 1969), p. 105; Howard S. Becker and Blanche Geer, "Participant Observation and Interviewing: A Comparison," Issues in Participant Observation, p. 326.

[2] Becker and Geer, p. 322.

<u>Development of the extended care facility</u>. Public Law 89-97 (Medicare) formally established a new level of health care facility: the extended care facility. At that time the definitions of, and criteria for, care in this facility were not clearly understood by either the patients or the health care personnel. Under the initial Medicare legislation many hospitals were reimbursed for custodial care under the extended care benefits. Other financial components of the Medicare legislation, such as override payments to the sponsoring hospital, also contributed to the desirability of an extended care unit in the general hospital. To counter the phenomenal rise in the cost of the Medicare program, the Social Security Administration redeveloped the standards for extended care coverage and further defined the concept of extended care.[1] These new standards and definitions resulted in many patients no longer being eligible for extended care benefits, causing the census in many of the facilities, which had been built in anticipation of a continued and increasing clientele, to drop markedly. In response, some general hospitals then attempted to convert the extended care facility beds to acute care beds; many re-examined the financial aspects and feasibility of the hospital-based extended care facility; and others

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[1] Leon W. Hisle, "The Hospital-Based Extended Care Unit Can Work," <u>Nursing Homes</u>, XXI (February, 1972), 12.

encouraged the private health insurance companies to include extended care coverage in the basic policy. In 1971, again in response to rising program costs, the Social Security Administration called for improvement of controls over the extent of care provided Medicare patients.

> The Congress intended that the program would cover high quality convalescent and rehabilitative care in an extended care facility, where medically appropriate, as an alternative to inpatient hospital care.[1]

Utilization review committees were requested to examine the continued needs of the patient for extended care coverage before approving these requests. Dressler, following a survey of the operation of utilization review committees in Connecticut, suggested these committees could assist in better utilization of extended care facility services by developing innovative means of assessment of the patient's care needs.[2] Most committees based their assessment of need on a review of the patient chart.

This brief overview of the development of the extended care facility suggests that the development of this facility has been prompted and molded by financial concerns,

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[1] Social Security Administration, Report to the Congress: Improved Controls Needed over Extent of Care Provided by Hospitals and Other Facilities to Medicare Patients (Washington: Department of Health, Education, and Welfare, July 30, 1971).

[2] Forrest G. Dressler, Patient Care Assessment in Extended Health Care Facilities (New Haven: Connecticut Health Services Research Series, 1971).

and insurance benefit coverage more than the theoretical and ideological bases of convalescent care.

Senator Frank Moss, in a paper discussing the implications of Medicare benefits for the hospital and nursing home, noted that the concept of extended care was intended to fit into the progressive patient care philosophy while providing needed services to the elderly (and other) persons in the areas of nursing care and rehabilitation.[1] Today elderly persons remain the majority of extended care facility patients, despite the applicability of extended care to persons in all age groups.[2] As recently as 1972 Le Roy Deabler stated that 30-40 percent of patients of any particular short-term hospital could be treated more appropriately at a less intensive level of care, such as the extended care facility.[3]

Patient care in the extended care facility. The literature reviewed in this section pertains to the patient care function of the extended care facility. A study on the effects of skilled nursing care on geriatric patients in

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[1] Senator Frank E. Moss, "E.C.F. Benefits under Medicare: Implications for Hospitals and Nursing Homes," Hospitals, J.A.H.A., XLI (January 16, 1967), 41.

[2] Robert C. Straight, Craig A. Duncan, and L. J. Danehy, "Fiscal Viability in E.C.F. Program," Hospitals, J.A.H.A., XLVII (February 1, 1973), 99.

[3] Le Roy Deabler, "Regional Planning for Effective Services in Extended Care Facilities," American Journal of Public Health, LXII (June, 1972), 877.

three long-term care facilities is included since it focused on the role of the nurse in the care of geriatric patients. That study took place before the passage of the Medicare legislation, so could indeed have included patients who might otherwise have been candidates for extended care services.

Dornblaser and Rising reported the results of a two-year evaluation of an activities of daily living (A.D.L.) program conducted with geriatric patients in Greenfield, Massachusetts.[1] The success of the program was measured on the basis of improvements in thirty-two self-care abilities, social functioning, and psychological health. Patients in the A.D.L. program were compared with similar patients in a nearby nursing home. Both groups of patients were examined for their self-care abilities by an independent rehabilitation team; their psychosocial characteristics were evaluated by graduate students under the supervision of University of Massachusetts sociologists and psychologists. This testing was done prior to the A.D.L. program, upon completion of the program, and three months after discharge. (The two groups showed similar levels of self-care abilities and social adjustment prior to treatment.)

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[1] B. M. Dornblaser and E. J. Rising, "Hospital Based Extended Care, Part 1: Conducting an A.D.L. Rehabilitation Program," Hospitals, J.A.H.A., XLII (May 16, 1968), 68.

A total of 143 patients experienced this A.D.L. program during the two-year evaluative phase. The program employed a team approach to rehabilitation with the patient's private physician acting as the team leader. The team included a physiotherapist, an occupational therapist, a medical social worker, a speech and hearing therapist, and a recreational therapist. The nurse was not acknowledged as a part of the rehabilitation team.

The experimental group demonstrated statistically significant gains in 53 percent of the thirty-two self-care activities three months after discharge. They also demonstrated statistically significant gains in the social adjustment measurements. The control group did not show such changes. The tools used to assess the psychosocial characteristics and the methods of administration of these tools and of the self-care assessment tools were not discussed, other than to indicate they had been administered by independent parties.

Dornblaser and Piedmont evaluated the psychosocial elements of patient care in the study discussed above.[1] The psychosocial characteristics of the A.D.L. unit staff of the experimental unit were compared with those of the control unit. The experimental group was found to be significantly

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[1] B. M. Dornblaser and E. P. Piedmont, "Hospital Based Extended Care, Part 2: A Social Model of Extended Care," <u>Hospitals</u>, <u>J.A.H.A.</u>, XLII (June 1, 1968), 103.

less authoritarian, less rigid, and less distant from their patients than their counterparts in the control group. The authors felt the characteristics of the unit staff created an atmosphere that promoted the improvement of the self-care abilities in the experimental group of patients.

Motivation and rehabilitation of the patient in an extended care facility do not complete the responsibilities of the unit.[1] Effective placement upon discharge is a vital function of an extended care facility which is based on a social, rather than a medical, model. Dornblaser and Piedmont found that patients who had participated in the A.D.L. program and were then discharged to some custodial institutions were labeled by the staff of those institutions as "too demanding," and "unrealistic" in their expectations.[2] These patients had difficulty maintaining the gains they had made in self-care activities and social awareness while in the experimental unit.

The authors also examined the sociological characteristics of the patients who readily accepted treatment and demonstrated the most improvement psychologically, sociologically, and physiologically. A similar analysis was done on those patients who did not readily accept treatment. The results showed that the patient whose value structure was

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[1] Dornblaser and Piedmont, p. 106.

[2] *Ibid.*, p. 104.

closest to that of the physicians, nurses, and others administering treatment, and who were externally oriented to "placate" such sources of power, were more apt to accept treatment and benefit from it. They did find, however, that the internally oriented patients (that is, those patients who believe that what happens is directly related to their own actions) who did accept treatment improved more and maintained their gains longer than did the externally oriented group of patients.[1]

Charlotte Isler saw the opportunity for nurses to specialize in the care of patients in the extended care facility. In 1968 she stated that there were nearly 4,000 extended care facilities that employed 25,000 to 30,000 nurses.[2] The majority of these facilities were not hospital-based facilities, but rather were nursing or convalescent homes that met the requirements established for certification as extended care facilities. A survey made in 1967 revealed that 3,000 of the 3,865 extended care facilities in the United States of America at that time were also licensed as nursing homes.[3]

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[1] Dornblaser and Piedmont, p. 110.

[2] Isler, p. 30.

[3] Samuel Levey and Sheldon Lubow, "Survey of Long Term and Extended Care Facilities," Nursing Homes (May, 1968), p. 27.

Miller discussed the role of the nurse in the non-hospital-based extended care facility as he defined skilled nursing care.[1] He stated the nurse must be able to assess changes in the patient's physical condition, manage the patient's drugs, manage the psychosocial aspects of patient care, counsel the patient's family, become the leader of the health care team, be skillful in nursing techniques, involved in inservice training of herself and other staff members, and be active in nursing research.

A five-year, federally funded training project is presently in process in the San Francisco Bay Area to develop the role of the clinical specialist in the extended care facility, and to develop a curriculum to prepare nurses for this clinical specialty.[2] This project is jointly sponsored by the University of California and the Ralph K. Davies Medical Center in San Francisco.

Research has been conducted on the effects of the nurse on patients in long-term facilities.[3] Weiss conducted his study to determine the effects of skilled nursing care

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[1] Michael B. Miller, "A Physician Views Skilled Nursing Care," Journal of Nursing Administration, III (January-February, 1973), 20-29.

[2] Nursing in Extended Care: The Expanded Role, a Project funded by the U.S. Department of Health, Education, and Welfare, Division of Nursing, Project Grants Section, Nursing Education Branch, #D10 NU 00788-01.

[3] James M. Weiss, Nurses, Patients, and Social Systems (Columbia: University of Missouri Press, 1968).

on a sample of geriatric patients in three long-term institutions. The nurse was involved in active participation with the patient, primarily verbal communication and secondarily in non-verbal communications involving such functions as bedmaking or feeding. The nurse, acting as a participant observer, spent ninety minutes a day, three times a week for six weeks with the experimental group, and twenty minutes a day observing the control group. The experimental nurse dictated her observations as soon as she left the patient. The nurse observing the control group of patients made concurrent observations and dictation. The observations were then coded for statistical treatment.

The nursing treatment was replicated in three diverse settings, all of which were long-term institutions. Weiss found that the experimental group sharply increased the amount of time the older patients spent in interactional involvement with the nurse, even when allowance was made for the additional time spent by the nurse with the patient in the experimental setting. The experimental patient's ability to orient himself in relation to biosocial functions such as care and maintenance, housekeeping and recreation was also increased. The research group noted that the setting in which the replications were carried out affected the results. The social and physical setting of the institution determined what interactional patterns were permitted or encouraged in that institution.

Discharge of the Geriatric Patient

Freeman states that the elderly require more care, more precise care, pose greater risks and usually have greater need for direction.[1] Preparedness for discharge may become a critical factor in the care of the elderly patient. In this section literature relating to the movement of the geriatric patient from the hospital to the home is reviewed. Few studies have been done on the movement from the extended care facility; however, a number have been conducted in other settings and on times other than the pre-discharge period. For that reason, the studies discussed here deal with the general area of discharge, rather than the specific area of discharge from the extended care facility.

Brocklehurst and Shergold interviewed two hundred elderly patients discharged from an acute hospital to their own homes or to old people's homes to determine what happened to these people.[1] The majority of these patients were in the hospital for medical reasons (71%), 26 percent were there for medical and social reasons, and 3 percent for social reasons. Of the two hundred patients discharged, 20 percent were

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[1] J. C. Brocklehurst and Margaret Shergold, "Old People Leaving Hospital," Gerontologia Clinica, XI, No. 2 (1969), 115.

readmitted within one year. Of the 149 patients who came to the hospital from private homes, 140 returned home on discharge. There was no evaluation or discussion of the appropriateness of these placements or of the preparation for these discharges.

In an attempt to determine the correct post-discharge placement for elderly patients, Seth and Alvarez organized a fourteen-bed minimal care ward at a geriatric hospital in England.[1] The objectives of this demonstration project were to give the elderly patients practice in the activities of daily living and to alleviate a staffing shortage being experienced in the hospital at that time. A small nursing staff was placed on the unit to supervise the patient activities and to ensure the continued safety of the patients. Forms were devised for the nursing staff to use in making daily assessments of the patients. These assessments included evaluation of the patient's level of anxiety, depression, and loneliness, as well as the patient's ability to handle the activities of personal hygiene and daily living. The patients followed a daily routine similar to that in a home situation with the exception of cooking the meals. The food was prepared in the hospital kitchen; the patients served it

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[1] H. K. Seth and A. S. Alvarez, "Experimental Minimal Care Ward in a Geriatric Unit," Gerontologia Clinica, XI, No. 2 (1969), 216.

and cleaned up after the meals. The average patient stay on this minimal care unit was eight weeks.

The authors reported that the patients "liked" the unit for it was similar to a home situation. A few of the patients were confused and anxious in the beginning of the study; however, the authors concluded that once the patient was oriented to the unit the environment stimulated greater confidence in the patient, decreased the time of the patient's recovery, and promoted his independent existence. It also permitted the staff to assess the patient's capabilities in a more natural setting than the normal hospital ward.

Another study conducted in Great Britain was aimed at improving the post-discharge services available through the National Health Service.[1] This study was not restricted to elderly patients. The researcher interviewed 533 National Health Service patients discharged from two groups of non-teaching hospitals. The patients were interviewed two and ten weeks after their discharge. Some of the findings were significant to the study reported here in that they dealt with the pre-discharge period rather than the post-discharge period. The interviewers found that many patients had been

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[1] Muriel Skeet, Home from Hospital, prepared for the Dan Mason Nursing Research Committee of the National Florence Nightingale Memorial Committee of Great Britain and Northern Ireland, n.d.

upset at the short notice they received of their discharge, even though many times the staff could have predicted this discharge before the actual order was given. They found a need for two-way communication between the hospital authorities and the patients. Such communication, they felt, should include information about the patient's home situation. Many patients relied heavily on neighbors and family upon returning home, emphasizing the need of the hospital staff to be aware of the home situation in order to prepare the patient and his family for functioning in that home.

Kelman and Muller followed fifty-seven chronically ill patients for three years after their discharge from acute care or extended care facilities.[1] During this time the authors examined the variety of health care services used by these patients. There were fifty-seven rehospitalizations during the study period; forty-four of these were for medical treatment, of which one-half were the result of acute events, such as a cerebrovascular accident. The patients who returned to the chronic care setting did so for four reasons: (1) there was a need for increased physical nursing care; (2) there were increased behavioral or social difficulties; (3) there was a change in the social environment itself; and (4) there had been an inadequate match of

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[1] Howard R. Kelman and Jonas Muller, "The Role of the Hospital in the Care of the Ambulatory Chronically Ill and Disabled Patient after Discharge," American Journal of Public Health, LVII (January, 1967), 107.

the discharge living arrangement with the patient's needs. The authors also noted that the patient or the family usually requested the return to the chronic care setting. For the majority of the patients, the hospital emerged as the central source of continuing basic medical care as well as serving as a resource for resolution of medical or social crises that threatened the continued community residency of the individual.

Holy Cross Hospital in Chicago initiated a discharge planning service in the acute care setting for patients who were sixty-five and over, utilizing the hospital social service department and a nurse coordinator.[1] The purpose of this project was to create a more effective use of the hospital facilities by having the social service department initiate planning for the discharge of the patient upon his admission to the hospital. Questionnaires were administered to the patients upon admission to the hospital. The patients assessed as needing assistance were visited by a member of the social service department staff as soon as was possible. If the patient required other than informational and financial assistance, he was referred to the nurse coordinator for these needs. The patients used the discharge planning service as an informational resource once they had

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[1] Regina Kulys, "Discharge Planning," Hospitals, J.A.H.A., XLIV (May 1, 1970).

returned to the community.

The concept of a discharge planning service has been further developed by the Regional Medical Programs in California. R.M.P. Area 1 conducted a project to develop discharge planning as a nursing function in six San Francisco Bay Area hospitals.[1] Each nurse discharge planner developed her own role within the sponsoring hospital. The services of the discharge planner were available to all units of the general hospital and its nursing staff. Following the termination of this project, four of the six participating hospitals continued this service as a part of the hospital functioning and assumed the cost of the discharge planner.

Status Passage

In 1971 Glaser and Strauss published a formal theory of status passage as a basis for the social existence of human beings.[2] Life, they proposed, was a series of movements from one status to another. Passages could be regulated, scheduled, unregulated, or unscheduled. The shape of the passage could be reversible or nonreversible. As a status passage occurs over time, the direction need not be in a straight line, but may curve backward temporarily,

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[1] Final Report, Alameda-Contra Costa County Project Rehabilitation and Continuity of Care Program, Area 1, Regional Medical Programs, n.d. (Mimeographed.)

[2] Barney Glaser and Anselm L. Strauss, _Status Passage: A Formal Theory_ (Atherton: Aldine Publishing Co., 1971).

such as with the rehabilitation patient who has a set-back and then proceeds on to recovery. The temporal aspect of the passage deals with rate, scheduling, transitional statuses, and coordination of the passage.

A number of sociological studies, examining a variety of status passages, were done prior to the publication of this formal theory of status passage. Five of these are discussed here.

Roth, a tuberculosis patient himself, described the extended recovery period of the patient with severe tuberculosis.[1] During the course of his own treatment in two different tuberculosis hospitals, he observed and recorded the progress of the patients in these hospitals. Following discharge from the hospital, he spent two years as a participant observer in two other tuberculosis hospitals. From his data he was able to develop some general notions of timetable setting, especially in the tuberculosis hospital. The tuberculosis patient, he discovered, conceived of his treatment as a matter of putting in time; for example, he had six months "to go" or he had three weeks until the next review conference. The patient did not view his progress in terms of the changes in his lung condition.

Roth found the patient watched to see what happened to most of the other patients; for example, how long it was

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[1] Julius Roth, <u>Timetables</u> (Indianapolis: Bobbs-Merrill Co., 1963).

between admission and the granting of a pass, or how long the patient usually stayed in the hospital. The patient then assessed his own progress against this yardstick. He found that the patient privileges were important in themselves, but also important in their symbolic value, for they were signs that the treatment was progressing.

If the old benchmarks were withdrawn, say because of a new ward administrator, or a change in the treatment of the disease, and no new benchmarks replaced them, either by official policy or patient observation, the patient then made an innacurate estimate of his hospital timetable.

The physician, Roth noted, also set timetables, which he then used as the basis for judging the progress of the patient. The actual timetable of the treatment, Roth concluded, was the result of the interaction of the explicit and the implicit bargaining done by the patient and the physician: the patient continually pressed to have his treatment speeded up, the physician wished to keep the patient in the treatment facility until he was assured of the inactivity of the disease process.

In this setting, benchmark delineation and timetable setting were group efforts. Patients talked to one another, compared among themselves, and determined a timetable norm. Benchmarks were often set by the administration of the hospital, such as the requirement of having three negative sputum cultures prior to discharge. The patients also developed their own indicators of progress, such as noting that movement to a new ward heralded discharge.

Fred Davis also emphasized the recovery phase of an illness, paralytic polio in children.[1] Again the temporal aspect of the passage was crucial. The recovery from this disease was prolonged, the ultimate extent of the recovery unknown. He observed that the very policies of the hospital, such as allowing parents to visit only twice a week, worked toward changing the definition of time held by the child and his family.[2] This lengthening of the child's time perspective allowed him to work on short-term goals, rather than thinking in terms of returning quickly to his pre-illness way of life.

M. Davis interviewed multiple sclerosis patients to determine the effects the disease had on their lives and to find out how they handled the progressive, downward trajectory of the disease.[3] Maintaining a normal appearance for as long as possible was most important to these patients, a

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[1] Fred Davis, Passage through Crisis: Polio Victims and Their Families (Indianapolis: Bobbs-Merrill Co., 1963).

[2] Fred Davis, "Definitions of Time and Recovery in Paralytic Polio," American Journal of Sociology, LXI (May, 1965), 582.

[3] Marcella Z. Davis, "Transition to a Devalued Status: The Case of Multiple Sclerosis" (unpublished D.N.S. dissertation, San Francisco, June, 1970).

phenomenon the author called "passing." Passing lengthened the transitional status for these patients, but did not alter its inevitability.

Glaser and Strauss, as a part of a study on death and dying, examined the temporal aspects of dying as a non-scheduled status passage.[1] The temporal cues, they stated, had many reference points. For example, the progression of the disease as compared to the patient's actual progression, the physician's expectations as compared with the actual time (of dying), and the work schedules of the health care staff. They noted that the physical cues to the movement through this transitional status were fairly easy to read, the temporal ones were not.

A study dealing with one aspect of the status passage of elderly persons from a rehabilitation unit was reported by Eddy.[2] The rites of passage through a rehabilitation unit were observed during a two-year field study of two fifty-bed wards devoted to the intensive rehabilitation of the physically handicapped.[3] The median age of the

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[1] Barney G. Glaser and Anselm L. Strauss, "Temporal Aspects of Dying as a Non-Scheduled Status Passage," American Journal of Sociology, LXXI, No. 1 (1965), 48.

[2] Elizabeth Eddy, "Rites of Passage in a Total Institution," Human Organization, XXIII (Spring, 1964), 67.

[3] Julius Roth and Elizabeth Eddy, Rehabilitation for the Unwanted (New York: Atherton, 1967).

patients in this study was sixty years. In this institution for indigent persons, movement onto the rehabilitation ward was seen as an upward move in social status, for it promised movement back into the world of the useful and wanted; movement back to the "home" or custodial side of the institution resulted in a reduced social status. Transitions in the passage through this rehabilitation ward were frequently based on the physical independence of the patient. The rehabilitation team was committed to the ideal image of rehabilitation rather than the realities of the patient's life, producing activity that was unrelated to the patient's life needs. Movement out of the unit was almost always sudden, and usually was movement to the "home" side of the facility. The return of the patient to the custodial setting rather than the realization of the promised movement out of the hospital into society prompted the author to term the tasks required of the patient on the rehabiliation ward "false rites of passage."

Kemper discussed the importance of reference groups to socialization and achievement. He stated there were three types of reference groups that work together to foster achievement striving: normative, comparison, and audience.[1] Lack of one of these groups may result in impairment of the

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[1] Theodore D. Kemper, "Reference Groups, Socialization and Achievement," American Sociological Review, XXXIII (February, 1968), 32.

individual's ability or desire to achieve. Merton suggested a further factor in upward social mobility, that of anticipatory socialization.[1] Anticipatory socialization is a mechanism whereby the individual learns the norms and values of the group he desires to join. This process is an internal one during which the person assimilates these values and rehearses, conceptually, his new role.

An important factor in the selection or desirability of the new status, if a selection procedure is operant, is the individual's perception of that status. Shibutani discussed the role of reference groups in shaping the perspective of the individual.[2] Perspective is the organized view of the world through which one perceives the environment. The organization of an individual's perceptual experience depends in part upon what is anticipated and what is taken for granted.[3] Reference groups help organize the individual's world and so create a selective aspect of perception.

Wolff in a volume devoted to psychological, physiological and sociological aspects of aging suggests that the aging process and society's values and expectations in

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[1] Merton, p. 265.

[2] Tamotsu Shibutani, "Reference Groups as Perspectives," American Journal of Sociology, LX (1955), 652.

[3] Ibid.

relation to aging combine to effect the perceptions of the aged person.[1]

The theories and conclusions of these persons who have studied the fields of reference group theory and the sociological aspects of perception as determinants of social movement are similar to some of the properties Glaser and Strauss presented in their theory of status passage: the desirability of the passage, the duration of the passage, and the regularization of the passage.[2]

Summary

The grounded theory approach to nursing research requires that the nursing situation be studied in its natural setting. Qualitative data are developed from this observation and examined for relationships. Out of these relationships emerge theoretical notions. This approach to theory development was applied to the movement of the geriatric patient from the extended care facility to the home. Home was defined as the private residence or apartment of the patient or of a person important to the patient.

To ascertain both the patient and the nursing perspective of this status passage, the following research

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[1] Kurt Wolff, *The Biological, Sociological, and Psychological Aspects of Aging* (Springfield, Ill.: Charles C. Thomas, 1959).

[2] Glaser and Strauss, *Status Passage*, p. 3.

question was developed: What are the similarities and dissimilarities in the timing and content of the status passage benchmarks, in the passage from institutionalized to non-institutionalized status, as reported by the nursing staff and the older patient in one extended care facility? Status passage benchmarks were defined as indicators of change in the status passage from institutionalized to non-institutionalized status.

Literature forming the conceptual framework and the background of the study was discussed under the classifications of (1) the extended care facility, (2) discharge of the geriatric patient, and (3) status passage. Little research has been published on the pre-discharge period, or on the role and effect of the nurse in the extended care setting.

In order to obtain data that are relevant to the research question and that will produce answers to that question, the appropriate method of data collection and analysis must be used. Chapter II is a discussion of the research strategy employed to pursue this research problem.

CHAPTER II

RESEARCH STRATEGY

This chapter contains a discussion of the processes of data collection and analysis. The discussion is divided into the following sections: the pilot phase of the study, the study setting, sample selection, the interviews, and data handling.

Kerlinger defines strategy as the methods used to gather and analyze the data.[1] These methods must be consistent with the statement of the research problem, in this study an exploration and comparison of two perspectives of patient progress. To search for what is, and to discern whether relationships exist among phenomena, the researcher must examine the situation in its natural setting; he must be able to seize opportunities and follow them to a fruitful end. He must be able to raise additional questions and seek answers to develop a complete picture of his study subject. Field research offers this freedom, for the researcher may develop and refine his discovery techniques as the data and the situation require.

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[1] Fred Kerlinger, Foundations of Behavioral Research (New York: Holt, Rinehart and Winston, 1964), p. 275.

Schatzman states:

> . . . he [the field researcher] understands that a method of inquiry is adequate when its operations are logically consistent with the questions being asked; when it adapts to the special characteristic of the thing or event being examined; and when its operations provide information, evidence, and even simply perspective that bear upon the questions being posed.[1]

Field research not only promotes descriptive discovery but leads to the development of grounded theory, that is, a theory that is evolved from the relationships in the data. The general classification of field research sets the limits for the researcher, but does not delineate the primary method of data collection. This, as noted in the quote from Schatzman, evolves from the research question. For this study, the semi-structured interview was selected as the most appropriate tool for data collection.

Pilot Phase of the Study

Prior to initiation of the study, the investigator spent several months doing participant observation and interviewing of patients in two hospital-based extended care facilities, neither of which was used for the study reported here. The pilot phase led to a refinement of the question for study, and to development of the initial interview

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[1] Leonard Schatzman and Anselm L. Strauss, Field Research: Strategies for a Natural Sociology (Englewood Cliffs: Prentice-Hall, 1973), p. 7.

schedule. It also served as the basis for several of the methodological decisions in the research study itself, such as the type of interview to be conducted and the initial scheduling of patient and staff interviews. The researcher's experience of negotiating entrée to these facilities, and the problems encountered in conducting interviews proved to be of great value in promoting the subsequent research.

The Study Setting

For the field researcher, negotiating entrée to a study setting is crucial. The tone set during the initial contacts with the institution will affect the entire course of the study, for the field researcher is dependent upon the generosity of the institution and the cooperation of the study subjects for his data. Consent to conduct the research study in the chosen facility was obtained by submitting the research protocol to the hospital research committee. At this time the hospital was requested to specify additional requirements, or modifications in the protocol; there were no changes requested, and permission was granted to proceed. Equally as important as the official consent was entrée to the study setting, for this was where the researcher would be interviewing, questioning, and observing. The research was to involve the nursing staff of the unit as well as the patients, making negotiations on the unit even more crucial, for without the cooperation of the nursing staff little accurate data would be collected. The first contact with the unit was through the clinical specialist who served the extended care facility. This person, it was soon discovered, was a major influence on the functioning of the unit, and so a critical person to the success of the research. It was her support and assistance that facilitated the successful conduct of the study.

Prior to interviewing, it was necessary to determine how much information could, and should, be shared with the various levels of personnel within the hospital. An informational guide was constructed and submitted to the hospital administration so that all persons concerned with the study would receive the maximum information about the study, yet potential interviewees would not receive information that would affect their responses. A meeting was held with the unit staff to share this information on a personal basis, to answer questions, and to familiarize the staff with the researcher.

The Participating Extended Care Facility

The extended care facility selected to participate in the study was a hospital-based facility in the San Francisco Bay Area. The unit was licensed apart from the hospital, but shared the hospital facilities and resources. Hospital-based extended care facilities represent the minority of extended care facilities in the United States; however, as the idea of extended care is seen as relevant for care of patients other than elderly persons more of these facilities are being developed. Longest states that the physical proximity of the extended care facility and the hospital has the effect of spreading the available talents and skills, another logical reason for developing hospital-based extended care facilities.[1] Because this study was designed to explore the ideas of patients who were going home, the rehabilitative aspect of the care setting was important. In the pilot work, it was found that many of the patients in the hospital-based extended care facility anticipated discharge home, and did indeed go home. This observation was further reinforced by the discharge statistics kept by the participating facility: during the six months prior to the study, over one-half of the patients went directly home.

The two hundred bed hospital at which the facility was based was known by both the local community and the health care community for its excellence of care and innovations in the delivery of care. The hospital was located in a middle-class suburban neighborhood. In selecting the facility, the researcher attempted to select an "average"

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[1] Beaufort Longest, "Affiliation Agreements between Hospitals and Extended Care Facilities," Nursing Homes, XIX (November, 1970), 16.

facility. This, however, proved impossible, for each hospital-based facility had some distinguishing characteristic that could affect the outcome of the study. One facility was participating in a federally funded project to develop the clinical specialist role, two were primarily rehabilitation units, and one served an exclusively upper-class neighborhood. For this reason the researcher approached the hospital that was reputed to be research-oriented and, it seemed, no more or less unique than any other of the hospital-based extended care facilities. It was also hoped that on this unit there would be patients with a variety of experiential and cultural backgrounds, for the community served by the hospital was a mixed one. This would enable the researcher to interview a range of persons, within the limits specified by the guidelines for sample selection.

The extended care facility, which had been operating for nine months prior to the initiation of the study, temporarily occupied one wing on an upper floor of an old section of the hospital. It was to move into a new building once construction was completed. The age of the physical structure produced a dark and depressing environment: the windows were small, the rooms small, and the paint old and dark. One patient noted: "and here in this old part of the hospital, it is dark, there are no carpets and it is so noisy."

Unit functioning. Although the functioning of the unit was not being studied, some knowledge of the structure and function of the research setting is basic to an understanding of the data. The extended care facility had no head nurse; rather this function was shared by the team leaders and the ward clerk. The clinical specialist, who had been hired to assist in developing the facility, assumed some supervisorial functions although she felt her role was that of a clinical practitioner and attempted to keep this her primary focus. This person was a major force in determining the course and length of the patient's stay in the extended care facility, and the post-hospital situation of the patient, as is suggested by two examples from the field notes:

> Mr. Young was experiencing some transient disorientation, so I called the doctor and told him. I really did not feel good about him going tomorrow. Now he will stay a few more days.

and

> Mr. X. wants to die, his physician wants to put him in a long-term care institution, but I can't see him going anywhere but home. He has the potential. . . . We'll see.

She also made the recommendations for admission to the extended care facility and participated in the Utilization Review Committee meetings.[1] The unit staff nurses used her as a reference, resource, and a role model; thus she

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[1] The utilization review committee is a hospital committee charged with the assessment of the continued eligibility of the patients for Medicare coverage.

influenced what care and what kind of care was given on the unit.

Even though there was a basic team structure operant on the unit, this was not always the pattern:

> We do team nursing or direct care as we have the staff. If we have an aide who must be supervised then we do team nursing, otherwise we do direct care. We really let it hang loose.

The nurses on the unit experienced a good deal of freedom concerning the care and progress of the patients. One nurse described it this way: "Here the physicians really let us do a lot of things on our own. In fact, some of them just say write the order, and I'll sign it." The nurses interviewed stated they felt this freedom was appropriate because of the kind of care these patients needed, that is, nursing and rehabilitative care that was based on nursing assessments of the patients.

Unit patient population. The extended care facility from which the sample was drawn served patients other than those anticipating discharge home, although the latter group represented the majority of the extended care facility patients: during the six-month period prior to the initiation of the study, 104 of the 181 patients had been discharged to their homes.[1] The percentage of this group

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[1] These and all statistics pertaining to the extended care facility are drawn from the statistics kept by the unit clerk in a folder on the nursing unit.

that was seventy to seventy-nine years of age was not known, as age was not a statistic kept by the unit. The requirements for admission to the unit were that the patient be referred by his physician and that he would benefit from this type of care. Such requirements created no restriction on diagnosis, resulting in a variety of presenting illnesses. There was no restriction on age, resulting in a varied age group. The average census over the six-month period prior to the study was 15.96 patients per day; however, the unit was running close to its capacity of twenty-three during the course of the study. The average length of stay of the patients on the unit was 15.3 days.

Unit nursing staff. The nursing staff on the unit was composed of ten registered nurses, four licensed vocational nurses, and one nursing assistant. A clinical specialist worked closely with the unit, but was not one of the unit staff. The staff members included a variety of cultural and ethnic backgrounds, as did the patients: French-Canadian, Filipino, and black- and white-American. All the nurses on the unit had requested placement with the extended care facility, and several had been on the unit since it had opened some nine months before the start of the study.

Sample Selection

Criteria were developed for inclusion in both the patient sample and the nursing staff sample. These are discussed on the following pages.

Patient Sample Selection

The following criteria were set for the selection of patient subjects:

1. The patient must be a candidate for discharge home. This criterion was derived from the definition of discharge: going to the patient's, or a significant other's, home. Home was expanded to include more than the patient's own home, for many persons of this age group do not live in their own homes, but, rather, have a place in another person's home or may go to such a substitute home for a convalescent period following discharge.

2. Patient subjects must be between the ages of seventy and seventy-nine, inclusive. A finite age group was selected in order to limit the effects of age variation on the data reported, and so accentuate any variations in the data due to perceptual differences. Of elderly persons in the extended care facilities studied during the pilot phase of the project, this age group was the most common. The exclusion of the patients between sixty-five and sixty-nine was made in an attempt to minimize the effect that recent retirement may have had on the individual.

3. The patient had to communicate in English with the researcher. This requirement eliminated aphasic patients as well as non-English-speaking persons.

4. The patient had to demonstrate that he was oriented to time and self by indicating his correct name and the length of time he had been in the hospital. This determination was made at the outset of the interview. These factors were selected as crucial components of the patient's awareness since they were the basic concepts to be researched.

During the five-month course of the study, twenty-nine persons aged seventy to seventy-nine were patients on the unit. Thirteen of these patients were either candidates for long-term or intermediate care facilities or presented receptive or expressive aphasia and did not meet the criteria for sample selection. Two of the remaining sixteen patients refused to participate, and two were discharged before any interviews could be done, resulting in a total of twelve patient-staff interview sequences. The number of interviews with each patient ranged from one to six. For each patient interviewed, a member of the nursing staff, designated by the patient, was also interviewed. The patient sample, then, included all those eligible patients who were on the unit during the course of the study, with the exception of the four patients mentioned above.

Patient Sample Characteristics

The sample interviewed consisted of eight women and four men. (See Figure 1 for patient characteristics.) Five women and one man were widowed; two women and three men had living spouses. One woman was single. Only one patient disclaimed any close relatives; several patients had sons, daughters, grandchildren, or other close relatives nearby. All the patients received visitors.

The age of the patients ranged from seventy-one to seventy-nine; the median age for both men and women was seventy-six. The sample included a variety of cultural and ethnic backgrounds: Russian, Danish, Scottish, black-American, and white-American.

The educational and occupational backgrounds were also quite diverse: one gentleman was a retired university professor, one woman an astrologer, another a retired domestic. Of the total sample, only the astrologer was still active in her profession, but her activities had been greatly curtailed. All the patients were receiving Medicare coverage, usually supplemented by another form of hospital insurance. None of the patients was receiving Medicaid or other social assistance program benefits, a situation in keeping with the social setting of the hospital, a middle-class neighborhood. The time the subjects remained in the extended care facility varied from three to twenty-eight days.

Name*	Age	Sex	Marital Status	Diagnosis**	Length of Stay on E.C.F. (days)
Isabel Adams	76	F	W	Gastric carcinoma	12
Frances Crown	79	F	W	Fracture right hip with open reduction with Hagie pin	13
Anne Coolidge	78	F	S	Left carotid endarterectomy	17
John Cooper	71	M	M	C.V.A. with left hemiplegia	7
Ingrid Newman	75	F	M	Metastatic cancer	5
Zeta Long	78	F	W	C.V.A. with right hemiparesis	28
Oscar French	77	M	M	Peptic esophagitis and diabetes mellitus	28
Ulysses Young	76	M	M	Cervical laminectomy C-5,6,7, T-1	18
Yvonne Oxford	76	F	W	Old pacemaker, sore right knee, C.V.A. with right paresis, right heminopsie	4
Mary Thomas	75	F	W	Post acute heart failure, diabetes mellitus	9
Brian Zork	77	M	W	Congestive heart failure	17
Fanny Miller	72	F	M	Fractured pelvis with angina pectoris	3

Fig. 1. Patient Characteristics

*All names are fictitious. Two randomly selected code letters appeared on each patient consent form. These letters were used as the patient's initials. Fictitious names were developed from these initials.

**Diagnosis as listed on the admitting form and/or the physician's history and physical examination form.

The patients presented a range of admitting diagnoses including cerebral vascular accident, congestive heart failure, post-carotid endarterectomy, diabetes, metastatic cancer, and post-cervical laminectomy. Many patients had multiple diseases, a common situation in elderly patients, or those with long-term illnesses.[1]

Nursing Staff Sample Selection

The members of the nursing staff to be interviewed were selected by the patients interviewed. Each patient was requested to designate a nurse whom the researcher would interview around the same topics that were discussed with the patient. This method of staff selection was used in order to interview the staff member who seemed most significant in the eyes of the patient. This person would be in a position to influence the patient's perception of his progress and so the development of the benchmarks.

To minimize any effects that feelings of dependency on the unit staff may have had on the data received from the patients, and to promote the selection of a specific nurse, the timing of the staff interview and the anonymity of the information received from the patient were made explicit to the patient. Despite this, some patients had difficulty in specifying a nurse for interview, as is illustrated in this

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[1] Jeanne Blumberg, Nursing Care of the Long-Term Patient (New York: Springer Publishing Co., 1971), p. 9.

example from the interview with one of the patient subjects: "They are all so good. I don't think I could say one over the other. I don't think I could hardly name one."

Nursing Staff Sample Characteristics

Five registered nurses and one aide were interviewed. Three of the registered nurses and the aide were from the day shift personnel; one registered nurse was a member of the evening staff, and one was the clinical specialist. (See Figure 2 for nursing staff characteristics.) Several of the other staff members were consulted in conjunction with selection of patient subjects; however, the staff members designated for interview remained a small and consistent number of nurses.

The nurses interviewed came from as varied backgrounds as did the patients. One nurse was a recent two-year graduate from a local junior college school of nursing, another was an experienced graduate from a foreign hospital school of nursing. The aide, a middle-aged woman, had left the dietary department to enter the nurse aide course in the hospital affiliated with this extended care facility. After working in the acute care setting for two years, she had recently transferred to the extended care facility. One of the registered nurses and the nurse's aide had taken a course in rehabilitation at a nearby rehabilitation center.

Name*	Age Group	Nursing Position	E.C.F. Experience	Basic Education (Nursing)
Carole Carpenter	20-29	R.N. day shift	12 months	Assoc. degree
Donna Yester	30-39	R.N. day shift	2 months	Hospital School of Nursing
Amy York	30-39	R.N. day shift	5 months	Baccalaureate
June Royal	40-49	Nurses' Aide day shift	5 months	Nursing Aide Course
Ruth Hoffman	30-39	R.N. Clinical Specialist	10 years	Hospital School of Nursing
Greta Queen	30-39	R.N. evening shift	8 months	Hospital School of Nursing

Fig. 2. Nursing Staff Sample Characteristics

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*All names are fictitious. Two randomly selected code letters appeared on each consent form. These letters were used as the nurse's initials. Fictitious names were developed from these initials.

The other staff members had not. The clinical specialist had a great deal of experience in rehabilitation, in particular with stroke patients.

These persons all indicated they were concerned with more than the physical care of the patient; however, the nurses admitted that physical care took precedence when faced with limited time and resources and a surplus of patient and unit demands. The physical care required by the patients going home was less than that required by the more dependent patients, resulting in a seemingly unequal amount of time allocated to this group of patients. Donna Yester, R.N., described the situation this way:

> Our goal here is to have the patients doing as much for themselves as they can. . . . Then there are the demands of the other patients, so that when a patient is independent, we cannot spend as much time with them.

A common complaint of these nurses was that many of the patients on the unit required so much physical care that they had little time left to work with the less dependent patients, that is, those persons who would be going home.

The Interviews

Prior to the start of the study, interview guides were developed for the patient and staff interviews. These guides were developed from questions and concerns that were voiced by patients or staff members during the pilot work.

Because each patient and each extended care facility is unique, it was expected that these interview guides would be further modified. This was indeed true. As new areas of concern or interest became apparent they were included in subsequent interviews. Continual examination of the interviews yielded a number of particularly fruitful questions. These formed the core of the interviews. The interviews were semi-structured to facilitate a free flow of discussion and to allow the development and exploration of any new ideas. The interviews were tape-recorded unless the subjects refused to permit this; only two patients refused, no staff member did. Each patient and staff consent form was marked with two randomly selected letters. These letters formed the initials of the fictitious names used in this research report.

Patient Interviews

Initially interviews were done twice: once when the patient was perceived as a candidate for discharge to his home and again the day prior to his actual discharge. During the pilot phase of the study both patients and staff received approximately one week's notice prior to discharge. The two-interview schedule was based on this anticipatory period. In the extended care facility selected for study the expected disposition of the patient was obtained upon admission of the patient, thus creating a less uniform duration of the anticipatory period. The time that both the patient and the staff member anticipated discharge was often much longer than a week, thus calling for a change in the patient interview schedule. To maintain continuity with the elderly patient during this variable time and to develop rapport with some of the more reticent patients, more frequent visits were made, the actual number and length of the interviews varying with the length of hospitalization and the tolerance of the patient. Studies done by Gilbert and Levee and by Talland suggest the ability of persons to recall events and associations, especially those newly formed associations, is markedly decreased in old age.[1] It was these newly formed associations that were the benchmarks. Frequent interviews, then, reduced the chance of the patient omitting a benchmark and so increased the likelihood of obtaining complete data. The actual number of interviews with the patient did not influence the quality or even the quantity of the data gathered; for example, one patient offered more data in one one-hour interview than did two others in repeated interviews.

Williams and Wirth found that persons in their late sixties and seventies are struggling with the disengagement process and at this time are reluctant to having their lives

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[1] Jeanne G. Gilbert and Raymond Levee, "Patterns of Declining Memory," Journal of Gerontology, XXVI, No. 1 (1971), 70. George Talland, "Age and the Span of Immediate Recall," Human Aging and Behavior, ed. by George Talland (New York: Academic Press, 1968), p. 93.

probed.[1] Development of a trusting relationship eased some of this tension and allowed the patient to share his experiences with the interviewer. An aspect of field research discussed by Wax is that of reciprocity.[2] The field researcher is, of necessity, a part of the research. That is, as the subject contributes to the research, so the researcher contributes to the subject. This idea is basic to interviewing the aged and a nursing staff. The frequent visits and short interviews with the patient helped develop this reciprocity, as did frequent contacts and consultations with the unit staff.

Interviewing the Aged

Burnside discussed three areas requiring early assessment if an interview with an elderly person is to be fruitful. These areas were (1) distance, both physical and psychological; (2) hearing ability; and (3) comprehension ability.[3] The interviewer must remain alert for signs of misunderstanding during the interview, for these may suggest an impairment not noticed initially. An example from the

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[1] Richard H. Williams and Claudine G. Wirth, Lives Through the Years (New York: Atherton Press, 1965).

[2] Rosalie Wax, "Field Methods and Techniques: Reciprocity as a Field Technique," Human Organization, II (Fall, 1952), 34.

[3] Irene Burnside, "Interviewing the Aged," an Occasional Paper in Nursing Research, University of California, San Francisco.

interviews conducted during the course of the study will help clarify this point.

Mrs. Miller was sitting in her bed when the interviewer entered. The interviewer introduced herself, asked if she could sit down, and upon receiving this permission began to explain the purpose of the visit.[1] At first Mrs. Miller smiled and agreed, then began to ask that a number of statements be repeated. The researcher obliged, speaking more distinctly and a little louder. The patient did not favor either ear, yet she did not seem to hear what was said. The researcher moved closer to the bed to facilitate the conversation. This seemed to help as Mrs. Miller requested fewer repetitions and seemed to understand the purpose of the interview. She agreed to participate and to be tape-recorded. She then reached up and pulled two cotton balls from her ears. "My room partner keeps her television so loud that I just have to use these," she said. A most productive interview followed. In this case, the assessment of a hearing difficulty and the persistence of the interviewer resulted in some excellent data.

Several of the patients seemed to have difficulty understanding the purpose of the interviews. This was, in part, a result of the amount of information they had to

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[1] All patient names and nursing staff names are fictitious. See Fig. 1, note (*) for an explanation of the derivation of these names.

receive in order to give an informed consent. Informed consent requires that the individual understand what he is being asked to do and that he know both the possible benefits and harms that may result from his participation.

Often it is worth spending a little extra time with a patient, although at first he seems to be unsuitable for interviewing, for he may not understand the purpose of the interview. Panicucci et al. found improved communication if the pace of the communication was set by the patient, not the interviewer.[1] Giving the patient additional time allowed him to integrate the information and respond to the situation. Reusch's concept of overloading was important when interviewing the elderly, for just as too rapid presentation of stimuli can inhibit communication, so can an excess volume of stimuli.[2] The inhibitory effect of an excess volume of verbal data was most apparent during the consent-obtaining portion of the interview. The patients frequently asked for clarification of the purpose of the interviews, even after several interviews, or after completion of the final interview. For example, one patient consented to participate, saying she understood, yet at the close of the

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[1] C. Panicucci, et al., "Expanded Speech and Self-Pacing in Communication with the Aged," American Nurses' Association Clinical Sessions, Papers (New York: Appleton-Century-Crofts, 1968), p. 98.

[2] Jurgen Reusch, Therapeutic Communication (New York: W. W. Norton and Co., 1961), pp. 265-67.

final interview she stated, "Once I knew what you wanted, then it was all right." This patient, it was later learned, had also sought explanations and assurances from the nursing staff concerning her participation in the study. It was the volume of information that had interfered with the patient's understanding rather than the rapidity of the presentation. Some patients experienced no trouble in assimilating the purpose of the interviews, and the implications of participation in the study. For both the patients who had difficulty understanding the purpose of the interviews and those who had no trouble with this aspect of the interview, frequent interviews permitted clarification and free-flowing discussion without physically or mentally exhausting the patient.

The pacing and the content of the interview are important, but they must be geared to the elderly person's ability to assimilate. Diminished receptive senses in the elderly require that the interviewer be conscious of the location of light sources, colors, and conversational distances. The interviewer wore bright lipstick and sat with the light on her face to allow the patient to augment his hearing with lip reading if necessary. It was also important to sit close enough to enter the patient's hearing and visual range. Physical contact such as hand-holding or touching assured some patients of the sincerity of the researcher, and allowed her to enter the patient's perceptual and territorial world.

Staff Interviews

The interview with the designated nurse was conducted after the specific patient had been discharged. This time was selected for two reasons: (1) to allow the staff member to recount the patient's progress in its entirety, and (2) to minimize any hesitancy on the part of the patient to share data with the interviewer. Tagliacozzo states that patients often experience feelings of powerlessness and dependency and that these feelings affect the patient's freedom to express his needs, other than those he perceives to be critical to his welfare.[1] The patient, she feels, will make efforts to avoid deviations from what he perceives to be acceptable behavior.[2] Interviewing the nurse after the patient's discharge removed the threat of disclosures by the researcher that the patient might feel would compromise his situation on the unit, or his progress through the program for his rehabilitation.

The nurse was interviewed at a time and place that was convenient to her. While there was only one formal interview for each series of patient interviews, data on the

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[1] Daisy Tagliacozzo, "The Nurse from the Patient's Point of View," Social Interaction and Patient Care, ed. by Skipper and Leonard (Philadelphia: J. B. Lippincott Co., 1965), p. 219.

[2] Ibid.

progress of the patient were often acquired during visits to the unit for patient interviews and during consultation with the staff to determine potential patient interviewees.

When conducting the interviews it was important to use shared language. It was also important to avoid assumed meanings when using this shared language. When a nurse interviews nurses, meanings become crucial, for while the language is shared and much of the jargon is familiar, the actual meaning may not be shared. To assume a meaning may very well alter the data being given. To avoid this, the researcher attempted to obtain the interviewee's definition of any such words used in response to the questioning.

Data Handling

The tape-recorded interviews were transcribed and the tapes held for future reference. Observations and comments made and discussions held during the visits to the extended care facility were also tape-recorded and later transcribed. The typewritten notes then became the principal source of data. As each interview was completed, it was examined for benchmarks or for areas needing further exploration or clarification. The benchmarks gleaned from the interview were compared with those reported by previous patients and staff members, or by the same patient in previous interviews. From this constant comparison and analysis, categories of benchmarks were developed. Again, the categories were examined and compared to discern similarities and differences between the categories themselves and between the persons or groups of persons reporting the benchmarks that comprised the category.

As theoretical notions developed, memos were written to correlate these notions with the data. The data, then, became the governor not only of the categorization of the benchmarks, but also of the theoretical ideas that were considered. The data were also an indicator of the completeness of the data, and thus indicated when to seek new areas of data as well as when to terminate the interviews. Data collection and analysis, then, were done concurrently. A more detailed analysis was made following termination of the researcher's involvement in the clinical setting. Access to the clinical setting remained open throughout the course of the analysis so that further interviews or observations could be done as was necessary.

Summary

A series of semi-structured interviews was conducted with the elderly patients and nursing staff of one extended care facility to determine differences and similarities in the timing and content of the status passage benchmarks reported by these two groups of people.

Twelve patient-staff interview sequences were done. The patients were those persons seventy to seventy-nine years of age who were candidates for discharge to their homes. Each patient designated the nurse to be interviewed to complete the interview sequence. The interview guides were modified during the course of the study to incorporate new ideas and concerns as they arose. Content and timing categories were developed from the interview data concurrent with the data collection. These categories were constantly compared and revised. Data collection was terminated when new categories ceased to appear with any regularity. A discussion of the categories of benchmarks based on the content component is the focus of Chapter III. Chapter IV deals with the timing component.

CHAPTER III

CONTENT CATEGORIES OF BENCHMARKS

The status passage benchmarks elicited in this study were the indicators of change in the progress of the patient toward non-institutional status. To achieve this change in status, both the patient and the staff member set goals that they felt would result in such a change; these goals included both long- and short-term goals. The benchmarks reported by both the patient and the nurse related to these goals. In this chapter is a discussion of the goals reported by both the patient and the nurse, followed by a presentation and discussion of the benchmark categories as determined by the content component. Both nurse-reported and patient-reported benchmarks are discussed in each content category.

Goal Setting

Attainment of the highest degree of independence possible was a universal goal held by the nursing staff for all patients. Independent functioning was reported to be the main requisite for discharge, that is, for leaving institutionalized status. The key to such independence lay in mobility, for which there was a standard progression of skills called progressive ambulation.[1] Movement in this program was based on the development of progressively complex skills, creating a number of intermediary steps or objectives. Attainment by the patient of any one of these steps was reported by the nurse as a benchmark of progress toward the goal of independence. For example, the nurse's goal for Frances Crown was to have her develop as much independence as possible. The goal was then individualized to "walking a few steps with a walker." To accomplish this, Mrs. Crown had to attend physiotherapy, which became a nursing objective, so that, on questioning, the nurse related her primary objective as that of having the patient attend physiotherapy. Once accomplished, this became a benchmark of the progress to the goal of walking with a walker.

It is important to note in this discussion that the mental capabilities of the patient were predetermined by the sample selection. The patient had to be alert and oriented to be admitted to the sample. For this reason, this study does not include this important facet of independent functioning.

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[1] Progressive ambulation was a graded progression of activities moving from bed rest to completely independent ambulation by the patient. The steps followed on this extended care facility were: standups, transferring, walking with an appliance and assistance, walking with an appliance without assistance, walking without appliance but with assistance, independent ambulatory functioning.

The base line from which the staff developed their objectives and assessed the progress of each patient was determined upon admission to the unit. At this time, the nurse made an assessment of the patient's ambulatory and cognitive abilities. Failure of the patient to progress as anticipated created frustrations for both patient and staff member as reflected in the following statements:

by a staff member:

> "Then she began to have the chest pain so we had to stop her going to physiotherapy until that ceased. She needed to be pushed, but it's not easy with someone like that."

by a patient:

> ". . . but I never can seem to do it right, and the therapist would scream at me, and I would do it wrong again."

Patients reported a broader variety of goals than did the nursing staff, goals which were functional in nature. For example, the patient desired to learn to walk again so that he could garden, or so that he could do the marketing, or in order to manage a household. Two patients wanted to go home so that they could eat, and one wished to go home so that she would not be a burden on her children. The skills that had to be accomplished in order to achieve the measure of independence necessary for realization of these goals were related by the patient as means to the end, rather than as the objectives reported by the nursing staff.

The use of an appliance such as a walker was referred to in a matter-of-fact way by the patients; for example, "Of course, I'll have to use a walker to get about." However, the patient did specify accomplishments in the use of these appliances as benchmarks of his progress. For example, Anne Coolidge was most excited when she was able to walk looking ahead rather than down at the walker and her feet.

A goal not specified by the patient, but apparent from the benchmarks he reported, was his return to normalcy. Such a goal was not functional in the same manner as was walking to garden or keep house, yet such a goal seemed to provide the patient with the incentive to continue working with a paralyzed limb or on a difficult exercise. One patient expressed it thus: "I want that leg to be normal again. . . . I'll keep working with it."

Content Categories

The crucial components of the benchmarks that were identified from the data were the content and the timing. Following is a presentation and discussion, with examples, of the different categories of benchmarks as determined by the content component of the benchmark. Chapter IV will present and discuss the categories as determined by the timing component of the benchmarks.

The _content_ of the benchmark refers to the event that was perceived and reported, or identified as a benchmark by the interviewee. Examples of the content of a benchmark are:

> "See, today I can pick up a pencil." (The content of the benchmark is the ability to pick up the pencil.)

and

> "I woke up in the morning, the headache was gone." (Here the content of the benchmark was the absence of the headache.)

The content areas delineated were mobility, progress toward normalcy, reduction of pain, eating, sleeping, change of interest, change of attitude, development of confidence, and indicators of regression. Each of the categories will be discussed separately; however, both patient-reported and nurse-reported benchmarks will be discussed in each category.

Mobility

Mobility refers to the ability of the patient to move by himself. This was the category of benchmarks most frequently reported by both the staff and the patients. As discussed in the section on patient and staff goals, independent ambulation was the prime indicator used by the nursing staff to assess the patient's ability to function independently. It was not surprising, then, to find this the most common group of benchmarks.

To the patient, mobility represented a functional capacity. For the patient to engage in the activities he apparently valued, or felt were necessary, he had to develop a certain degree of independent ambulation. The degree of ambulation necessary depended upon the activities to be undertaken and the assistance available in the home. For example, Anne Coolidge, returning to a house with a live-in housekeeper, was in the process of sorting out the treasures accumulated over many years when she entered the hospital for surgery. She was returning to this unfinished task and related her abilities to that: "I can walk up stairs well enough to go up once a day. That will allow me to go on with my task." Brian Zork, returning to a home alone, planned on returning to his garden and assessed his abilities in relation to that goal: "I'll be able to do the planting, at least."

Many times the patients were to be discharged with an appliance to aid their ambulation. Learning the use of the appliance necessary to achieve the final level of mobility was not a goal in itself; rather it was one of the means to the major functional goal. Appliances were incorporated as a part of the patient: "I can walk. . . . I'll use a walker, of course." While mobility generally meant independence, it did have other connotations. To one patient it meant non-invalid status; to another it was a source of personal pride.

Within the category of mobility were five subgroups.

1. Benchmarks that dealt with the physical skill of walking, such as: "Today I walked twice around the room," or "I am walking in therapy now." The majority of the mobility benchmarks reported by both patients and nursing staff dealt with this aspect of mobility.

2. Benchmarks that dealt with the development of stamina and its effect on the individual's mobility. For example, "I am feeling stronger, I can walk better," and "After a while she would say, 'Why don't we go for a walk when you are ready?'"

3. Benchmarks that dealt with the use of an appliance. For example, "She walks well with a walker," or "She is learning to use a cane." The majority of patients who specified benchmarks relating to ambulating selected events that indicated ambulation with an appliance was quite acceptable for discharge home. For example, Frances Crown said, "Today I walked on the ward [with a walker]. I walked quite a ways." And Yvonne Oxford said, "I am walking with a walker, and I am starting to use a cane." It seemed that the mobility they needed would be achieved in this manner.

4. Benchmarks that dealt with the refinement of ambulatory skills. Some of the patients reported benchmarks that dealt with refinement of the basic ambulatory skill. For example, Anne Coolidge noted events that suggested to her that she would regain her former graceful walk: "Yesterday I walked without looking at the floor." And Zeta Long wanted to walk with a single-footed cane rather than with a walker or a platform cane. For these persons ambulating in itself did not seem to be sufficient, but was, to them, representative of themselves. Anne Coolidge voiced it this way: "I suppose it is a little vanity. . . . This is a matter of pride in one's physical endowment." The manner of ambulating rather than the fact of ambulating was important for this group of patients.

The nursing staff called refinement of skill "polishing" and used this term to denote safety and competence rather than style as expressed by the patients.

5. Benchmarks dealing with other forms of mobility. Some patients on the unit were not able to move by themselves and as they developed this capacity they related benchmarks that indicated a concern with developing ability in this area. For example, Anne Coolidge related the first time she was able to move her legs unaided: "This morning I felt that my legs . . . that I could move them around under myself; I could sit up. . . . You see I've never been able to do this."

Progress Toward Normalcy

The next most frequently cited benchmarks were those that dealt with the patient's progress toward normalcy. Normalcy was defined, by the patient, as being able to participate in the activities that he associated with his home environment. For some patients this meant an improvement over their pre-hospitalized state, such as for those who had been admitted for elective surgery; for others, such as the stroke patient, it meant a return to as near the pre-hospitalized state as was possible. Such a definition included activities ranging from "doing nothing, my daughter does everything" to being able to manage a household and a variety of outside activities with little or no restriction. It also resulted in a variety of benchmarks ranging from physiological changes directly resulting from medical treatment to those dealing with the activities of daily living such as dressing, showering, or using the bathroom.

Many of the benchmarks in this category dealt with physiological phenomena such as reduction in edema, shortness of breath, the return of movement and sensation in an affected area, the return of lateral eyesight and the return of memory. These improvements reduced the handicaps and restrictions the patient was experiencing in his life style. For example, Zeta Long noticed the increasing ability to control her right arm and leg, and Brian Zork reported a dramatic reduction of edema and concurrent relief of dyspnea.

Accomplishments in activities of daily living offered proof to the patient that he was regaining the abilities that were a part of a normal life style. Few of the patients expressed an expected change in life style. Some did indicate that they expected a curtailment of activity, but only for a limited time; then they anticipated a return to what they defined as a normal life. Yvonne Oxford expressed it this way: "My life is all I have. No, I'll have to stop everything, at least for a while." And Mary Thomas said, "When I am better . . . then I can make up for all the time I couldn't do anything."

The physiological factors such as a reduction of edema resulted in a normally functioning body, alleviating the necessity for the patient to accept a changed body image. Activity factors, similarly, indicated the return of a normal life style and reduced the need for accepting a new life style image.

The nursing staff did not report these benchmarks as part of the patient's progress toward normalcy. Some of the nurses did note physiological changes, but reported them as indicators of the effectiveness of a medical or nursing intervention rather than as a return toward the patient's normal state. With the exception of the clinical specialist, the nurse did not report the patient's ability to undertake activities of daily living as benchmarks. Many of the patients were not physically capable of returning to the pre-hospital state and the nurse was aware of this. The goal of the nurse, as stated earlier, was the development of "as much independence as possible," or working toward a condition "as normal as possible," or a "stable condition," not a return to normalcy. The nurse did not share the patients' definition of normalcy, nor, it seemed, did she share her assessment of the recovery potential of the patient with the patient, possibly because this was not really known. Progress toward the nurse's goal was assessed by the patients' ambulatory capabilities and in a small part by their intellectual abilities. To the patient, return to normalcy was an attainable goal, or at least one to be worked toward. To the nurse, normalcy carried many qualifiers and presented a truly long-term goal; thus it did not offer a realistic goal toward which she could direct her efforts.

Reduction of Pain

Both the nurse and the patient stated the reduction of pain was a benchmark in the progress toward wellness. Reduction of pain allowed the patient to accomplish other activities critical to recovery and discharge, such as eating, sleeping, and walking. The absence of pain also resulted in a mood change on the part of the patient. For example, Anne Coolidge described the absence of pain and its effect on her mood: "I woke up in the morning, the headache is gone. I feel great. I feel almost lighter. In spirit."

For one patient the reduction of pain was closely related to the diagnosis of her illness and the acceptance of a doubtful prognosis. This woman entered the hospital for diagnosis and subsequent treatment of a metastatic cancer that had rendered her lame from the pain. She associated the decrease in pain to finding its cause and to the effectiveness of the radiation treatment.

Frances Crown reported the advent of pain as a step backward:

> "I have been going to therapy. . . . They won't take me any more. It gives me a heart seizure. . . . Oh, a pain. Pain. A sharp pain."

The nurse viewed the advent of her pain somewhat differently:

> "Like some of her symptoms were because she did not want to go home. But then when one has chest pain, with a history of severe heart disease, well, you just don't play around with that."

This was the only group of benchmarks that suggested a discrimination according to diagnosis. None of the stroke patients cited pain reduction as a benchmark. The patient who did use this as an indicator of progress had undergone surgery or, as with Mary Thomas, an arthritic, had a painful chronic disease that was incidental to his hospitalization.

It is of interest that improvement in a problem not under treatment, as with the arthritis, was noted by the patient as a step toward release from the hospital. For both patient and staff member, pain reduction indicated progress; the advent of pain, regression or a potential for regression. Not all patients identified this benchmark.

Eating

Several of the patients and one staff member related the ability of the patient to eat as a benchmark in his progress. The context and the individual definition of "ability to eat" fell into two groups. The first group dealt with the ability to eat and retain the food. Isabel Adams is an example of a patient who reported such a benchmark. She stated, "Last week I ate one spoonful, this week maybe two." Another patient, on the unit for esophageal dilatations, was also concerned with being able to eat. He, like the other patient, saw the ability to eat as the means to gaining weight and strength and so to go home.

Benchmarks relating to the technique of eating comprised the second group. The patient whose progress included this group of benchmarks was developing the coordination required to move an eating utensil from the plate to his mouth. Such an accomplishment allowed the patient greater independence and personal pride as well as contributing to an improved appetite as expressed in the following interview excerpts.

> "Her appetite picked up when she learned to feed herself with her left hand. Because, you see, when you feed someone they feel they should not eat as much, to give you as much time as possible free from them, because she [Zeta Long] was concerned with us spending so much time with her."

> "The first few days I didn't want anyone to see me eat, because my spoon, my soup spoon would go any way. I would have to direct it to my mouth. Aim it."

> "I have finally mastered a cup of tea."

For each patient and staff member, improved eating habits, from whatever basis, represented a step toward independence. For the patient, eating was a basic function that he was then able to undertake for himself. It was also a function that had been the responsibility of the nurse and was now assumed by the patient, thus relieving the nurse of a time-consuming task. Managing one's own food, then, increased patient confidence and well-being and also reduced the physical workload of the staff.

Sleeping

Getting a good night's sleep heralded a step ahead for several of the patients. For some of the patients the simple fact of sleeping well was a benchmark, but for one patient it was the advent of confidence in his ability to sleep that was the important factor. With the exception of one person, the patient attributed his inability to sleep to the unfamiliar and overstimulating hospital environment. The one exception was a patient with metastatic cancer, who related her sleeplessness to her pain and anxiety level. The nurse did not report benchmarks that fell into this category.

Changing Interests--Widening Horizons

As the patients progressed toward discharge some of them noted a widening of their interests. Two patients noted they were now reading the paper rather than merely glancing at the headlines, or having no interest in the news at all.

The wife of one patient noted a change in the questions her husband asked. She stated he suddenly began to ask questions about their house and family and listened to the answers. Formerly he had not indicated an interest in hearing about these matters. Three patients mentioned the advent of the desire to get dressed and to walk outside their rooms.

The patient did not note this group of benchmarks as being of much importance; rather these were changes that were assimilated in quite a matter-of-fact manner.

The nurse did not note any of these changes. The fact that a patient was allowed, or wished, to go to the sun roof depended upon the patient's physical tolerance rather than on the patient's widening interests. It was not noted when the patient began to express interest in leaving his room for walking or watching television (there was a color television in the day room) or mingling with other patients. The nurse did note how far the patient wandered and how long he stayed up, but did not note the locational changes as evidence of changes in interest.

Change of Attitude

This was a group of benchmarks frequently reported by the staff. The nurse stated that the development of a positive attitude toward the activities required for rehabilitation was most important. In fact, it was prerequisite to success in this area. The staff stated such a development often heralded the acceptance by the patient of responsibility for his own rehabilitation. The patient then worked at his exercises himself as well as with the physiotherapist or the nurse.

Some attitudinal changes were more subtle, such as noting that one patient bickered with her roommate or another joked with the staff when feeling better. For one patient, the nurse noted a gradual lifting of depression. These benchmarks were less common than were those denoting a development of a positive attitude; however, they did indicate, quite accurately, the feeling and physiological status of the patient.

Development of a positive attitude presented not just a benchmark but also a goal for the nurse. One nurse expressed it this way: "You have to get them to want to do it. . . . It is really most important for them to think that what you want to do is really their own idea."

Ulysses Young reported the transfer of responsibility as a major benchmark. His physician told him he could leave when he, the patient, felt he was ready. Following this announcement, the patient and his wife began to assess his abilities against those he would need to function in the home setting. They then set a discharge goal.

The benchmarks in this group augmented the moving of the patient to a less dependent state from both a patient and a staff perspective. Assumption of responsibility also affected how the staff viewed the patient. A patient who did assume responsibility for doing exercises of his affected extremities, or who assumed other responsibilities formerly assumed by the nursing staff, was described as "persistent," "independent," and "self-sufficient."

Development of Confidence

This group of benchmarks deals with the development of confidence in the patient's abilities and potential. For the patient this development marked a turning point in his rehabilitation. With the development of confidence the patient was more willing and able to extend himself and to attempt tasks that had previously seemed beyond his abilities.

For the nursing staff there were two levels of confidence: confidence in the abilities of the patient (for example, "I would trust her with a walker") and the development of the patient's confidence in himself (for example, "You have to sell the patient on the idea of doing it and that he can do it"). Development of confidence, then, not only allowed the patient to attempt new tasks, but the confidence the staff had in the patient's abilities influenced when the patient was allowed to try new skills.

The appearance of others' confidence in his abilities generated a similar feeling in the patient. Ulysses Young describes how he developed confidence: "I figured if they feel that way about you, why shouldn't I feel that way?" and Zeta Long described her reliance on her feelings of confidence in her skills as follows: "I am going tomorrow. The most important thing is to remember that I'll be all right at home." Confidence, then, yielded a spiral phenomenon. The development of the patient's confidence led to new abilities which led to confidence in the patient on the part of others, which then increased the patient's confidence in himself.

Benchmarks Indicating Regression

Not all of the patients moved unerringly toward discharge; indeed, indicators of regression were noted by some of the patients and staff members. The nursing staff related regressive steps as frustrations in their attempt to attain the goal of relative independence on the part of the patient, for example, the nurse's reaction to Frances Crown's chest pains that resulted in the cancellation of her physiotherapy:

> ". . . then she began to have chest pain, so we had to stop her going to P.T. She needed to be pushed, but that's not easy with someone like that. . . . I think once she gets home she will slip back to where she was before she came."

The patient did not allow the observed regressions to threaten his stated goals. To remove this threat the regressions were held in abeyance until the rehabilitative process was completed, often a long-term proposition for the patient. The regressive step could then be integrated into the total hospital experience and placed in its proper perspective. For example, Anne Coolidge, in discussing a regressive step, stated, "I am going to wait before I make a judgment on my progress like that."

Following are some examples of benchmarks indicating regressions to the patients: John Cooper had anticipated receiving an overnight pass, but because of Medicare regulations which he did not understand this pass was modified to two day passes. He expressed his feelings this way:

> "Yes, I saw it as a step backward. After I had been told that I could go then a few days later to be told that it had to be restricted."

Another patient related walking with a wider stance was a step backward:

> "At the moment I think walking with a wider gait is a step backward."

This technique of walking facilitated this patient's ambulatory capacities and so, in fact, moved her along the ambulatory continuum.

It was the meaning of the event to the patient or nurse that resulted in its being perceived as regressive rather than progressive. This meaning was more closely tied to the patient's perception of himself than to his progress along the ambulatory continuum.

Differences between the Patient and the Nurse

The patient's progress was based on his ambulatory abilities: abilities that were used by the nurse as indicators of the patient's independent functioning. The patient's benchmarks reflected his own goals and needs, which were frequently different from those of the nursing staff. The nursing staff worked toward a series of short-term goals, the patient toward one long-term goal. The nursing goals were restricted to activities to be accomplished in the hospital; the patient did not express this restriction.

When the patient and staff member defined differing goals and so tasks to be accomplished, there was a potential for frustration on the part of both patient and nurse. For example, Brian Zork concentrated on the resolution of grief and the advent of a new role outside the hospital; the nurse concentrated on his physiological status and assumption of new dietary patterns. This patient's nurse expressed concern that he had not learned and would not follow the health care teaching. Another patient, Frances Crown, was concerned with obtaining a live-in housekeeper, the nurse with developing her ambulatory capacities. Until the patient saw a solution to his problem he was unable to deal effectively with other aspects of his care.

Some of the goals, although different, were complementary. For example, the short-term nursing objective of using a walker complemented the patient's long-term goal of walking enough to cook dinner.

The benchmarks indicating regression offered some of the most striking differences in perception between the staff member and the patient. Oscar French stated he went backwards following each esophageal dilatation because he lost weight; the nurse stated he progressed each time because his eating improved. The development of a wider stance when walking was a step backward to Anne Coolidge; to the staff it meant better balance and so an improvement in her functioning.

Sources of Benchmark Content

It is apparent that the patient and staff member drew their benchmarks from a variety of sources. The most common source was the patient's physical abilities. Which abilities were critical, and the level of competence required in these abilities, depended upon the goals of the individual. The benchmarks related by both the patient and the nurse reflected tasks and attitudes that were useful to him. For the patient these tasks related to his home situation and his long-term goals. For the nursing staff these tasks related to the independent functioning of the patient, the goal of the nursing staff.

For both groups, the benchmarks reflected the tasks at hand; these tasks, however, were not always perceived to be identical. For the patient who was struggling with other than rehabilitative tasks, the goals and benchmarks reflected this concern rather than the rehabilitation. For example, Brian Zork was resolving his grief over the death of his wife. His goal and the benchmarks stemmed from this concern rather than his presenting illness.

The patient also used comments by the physicians, nurses, and physiotherapists to help delineate important accomplishments. However, three patients stated they did not feel the unit nurses influenced them in the selection, assessment, or attainment of their goals. Of these, one patient viewed the nurse as a person whose job it was to help her when she needed it, but not to influence her, for that was not, she felt, the role of the nurse. The other two patients did not see the nurse participating in their attempts to relearn walking, so excluded her as an influential person. No one excluded the physician or the physiotherapist as a source of benchmarks.

The comments made by the health care team did not always offer the patient a meaningful frame of reference on which to base his self-assessments. Ulysses Young struggled with the ambiguity of words used to describe his progress. For example:

> "That's the bad part of it, the physician and the surgeon, they say you're improved. They don't say you're on the way to being well, they just say you're somewhat improved. Now that's . . . uh . . . I don't know. I am damned with fake praise."

The nursing staff benchmarks came from direct observation of the patient as he progressed (or regressed) on the progressive ambulatory continuum. Some benchmarks were derived from the physician's orders for the patient. These benchmarks related to the ambulatory capacities of the patient; for example, increased time in physiotherapy or increased time up in a chair. The physiotherapist had little direct influence on the nurses' selection of benchmarks. While it was largely through the physiotherapy department's efforts that the patients developed many of the ambulatory capacities, the nurse stated she really did not have much direct communication with that department to provide her with a source of benchmarks. The patient, she stated, progressed through a standard set of tasks, so there was little that needed to be reported.

The unit staff relied on the evaluations and planning of the clinical specialist. During the course of data collection, the clinical specialist had a two-week vacation. During this time when the researcher asked for evaluations of patients, the staff members repeatedly said, "Well, it is hard to say, because the clinical specialist usually knows that."

The nursing staff related the intermediate steps to the overall goal, such as doing standups in preparation for walking. The patient did not make these connections. For example, none of the patients who desired so strongly to learn to write again associated the specific accomplishments of hand exercises with the development of writing skills. Normalcy, to the patient, seemed to have many attributes, such as eating, walking, sleeping, reading, and writing. The progress toward this state was a monofilament rope, rather than a multifilament one. The benchmarks cited were indicators of this progress.

Summary

This chapter discussed the content aspect of the benchmarks related by the patient and staff member of the extended care facility. The content of the benchmarks was determined by the tasks each nurse or patient faced during the patient's hospitalization. These tasks were, in turn, dependent upon the individual's goals. The nursing staff goal was universal, that of having the patient obtain as "much independence as possible" which when translated into tasks meant those that developed the patient's ambulatory capacities. The patient had more individual goals, most of which were dependent upon independent ambulation. Some patients were undergoing life tasks that were not directly related to their present illness. For these persons, acceptable resolution of these tasks was prerequisite to facing and dealing with tasks specifically pertaining to their illnesses. The benchmarks reflected these goals and concerns.

The content component of the benchmarks was discussed under the categories of mobility, progress toward normalcy, reduction of pain, eating, sleeping, change of interest, change of attitude, development of confidence in the patient, and indicators of regression. Benchmarks pertaining to mobility were those most frequently reported by both patients and nurses.

Some patients noted regressive as well as progressive benchmarks. The staff nurse also noted regressive benchmarks but these were not always those noted by the patient. In fact, a benchmark considered regressive by the patient was frequently considered progressive by the staff nurse. Benchmarks noted as regressive by the patient were indicators of personal attributes; those noted by the staff were indicators of ambulatory functioning.

The patient and staff member used a variety of sources from which to draw benchmark content. The most common source was the individual goal set by the person. The nursing staff goal was drawn from the professional goal of the nursing unit, the patient goal from his own needs and desires.

CHAPTER IV

TIMING CATEGORIES OF BENCHMARKS

The second component of benchmarking to be examined was the timing of the benchmarks. The timing was the point at which the subject perceived the stated benchmark. Timing was related as a specific hour or day, or in relation to specific events. Examples of the reported timing of benchmarks are: "Well, Sunday morning I began to feel my right leg and arm again" and "She was feeling so much better after [a thoracentesis]." Following is a presentation, with examples, of the categorization of the temporal component of the benchmarks reported by the patient and the nurse. This is followed by a discussion of the sources of cues used by these persons to make time determinations, and the patient and staff member definitions of the time of the status passage.

Timing Categories

In grouping the benchmarks according to the temporal component, there were significantly fewer categories than when using content as the classifier. Two major groups related to the setting in which the event occurred: the acute care setting and the extended care setting. Within these major categories the timing was either discrete or continuous.

Benchmarks in the Acute Care Setting

All of the patients interviewed came to the extended care facility from an acute hospital setting. With the exception of one patient, all came from the hospital at which the extended care facility participating in the study was based. Several patients reported benchmarks that had occurred during their acute stay; for example, Anne Coolidge reported moving from the intensive care unit and getting to sleep; Ingrid Newman also reported that getting to sleep had occurred in the acute care setting. Some of the more dramatic physiological changes occurred during the first few days of hospitalization when the patient was in the acute care unit. For example, Brian Zork reported his most dramatic change occurred three days after admission: "I woke up one morning and pretty near hollered, 'Hey, my legs,' 'cause I seen everything was down. . . . In three days!"

Reduction of pain was also a benchmark that was associated with the acute setting as it was for Anne Coolidge, whose headaches eased shortly after surgery. One stroke patient reported the beginning of the return of sensation in her arm and leg while on the acute unit; the other stroke patients did not relate occurrences in the acute setting. The benchmarks, then, that occurred in the acute setting were physiological in nature and quite dramatic in character.

The nursing staff did not report any benchmarks that had occurred in the acute setting. This may have been due in part to the emphasis of the interviews on occurrences in the extended care setting, but also in part to the reported lack of, or incorrect, information passed on to the extended care facility staff by the acute care staff. Carole Carpenter, R.N., described it as follows:

> "Well, we get very little information from the acute setting, and often it is all wrong. Like they say the patient can't do anything, and we get them and they can't because they have never had to do anything."

Benchmarks in the Extended Care Setting

The benchmarks that occurred in the extended care facility covered a broader range than the physiological basis that was noted in the acute setting. These benchmarks also tended to be more subtle occurrences, that is, the patient did not note when they had occurred; rather he seemed to assume such occurrences as part of a gradual progression.

There were some dramatic physiological changes occurring in the extended care facility, and these were related to specific timings. For example, Mary Thomas' breathing improved and her apprehension decreased markedly following a thoracentesis, and the nurse reported a definite improvement in Oscar French's eating following an esophageal dilatation. Several patients specified the day of the interview as a particularly significant day as they had "done well" in physiotherapy or on the ward.

More commonly the benchmarks reported by the patient and staff member as having occurred in the extended care setting were related to the development of ambulatory skills and the activities of daily living. Both of these groups of activities are based on progressive, overlapping skills and so it was not surprising that neither the patient nor the staff member could relate when something had happened, even though he could state what had indeed happened.

Discrete Timing

As stated previously, some of the benchmarks were associated with specific timings. This timing was generally associated with a significant occurrence in the hospital routine; for example, a benchmark occurred three days after admission, or after a treatment, rather than on a specific day or date. The benchmarks that were noted in such a manner were the more dramatic occurrences, physiological or psychological. For example, Brian Zork described the suddenness of relief of shortness of breath and reduction of edema and an improvement in his general feeling state:

> "You know that, I woke up one morning, and I said to myself, I felt like I was able to lick my weight in wildcats. Then I looked down to see if my legs would hold me and they was way down . . . you can imagine I was happy. . . . That was after three days."

The patient was more able to give discrete time associations than was the staff member.

Continuous Timing

Both the nurse and the patient found that they were unable to make a time designation for the majority of the reported benchmarks. The patient related his progress as slow and usually upward. Many times the accomplishment of one activity was blended into the progress toward the next, obliterating any time structure to the past accomplishments. Several patients, on looking back at a change, responded in a manner such as Brian Zork when he acknowledged dressing was a relatively new skill: "Oh, yes, well I have been wearing them [clothes] for the past couple of days." Other patients expressed the difficulty in delineating a time in a manner similar to Zeta Long, who said, "Everything is gradual. There is no time that I can do it. It is slow. It is gradual." One staff nurse described it this way: "Little by little she was gaining strength. . . . It is gradual. Day by day she was doing better, and you could see it."

Sources of Timing Cues

During the initial interview, the patient was asked to project the criterion he felt was necessary for discharge and to project a time frame for his hospitalization. Few patients were able, or willing, to do this. The patient stated he would stay as long as the physician felt necessary, or as long as policies for Medicare coverage would let him stay. The patient who did project a time frame used very elaborate and, it turned out, inaccurate means of arriving at his estimate. Generally, as the time of discharge grew closer the patient's assessment of his capabilities and of the time frame of his hospitalization became similar to the nurse's assessment of the same factors.

Each patient interviewed initially assigned the responsibility for determining the date of discharge to his physician or other controlling person in the hospital. The patient who later tried to regain this responsibility did so by attempting to influence the physician's assessment of the patient's own progress. This was usually done through additional effort at physiotherapy. Ulysses Young described it this way:

> "Well, I have to convince the doctor that I will be able to do the things at home, and so I have to do well in physiotherapy and tell the doctor how well I am doing, and convince both the therapists and the doctor that I am ready to go."

Some patients based their assessments of progress on previous experiences in the health care field. Two such persons were Yvonne Oxford, who had been a nurses' aide at one time, and John Cooper, a retired physician. John Cooper's wife had suffered a stroke several years before. He selected parts of her rehabilitation as comparable to his, and incorporated these factors into the basis for his self-assessment. The major factors in this man's assessment, however, were the statements made by the health care team concerning his progress. Mr. Cooper explains it best himself:

> "I am a doctor, you know, and I've taken care of people with strokes, and so have dealt in this sort of thing, and so know in favorable cases that patients go home in 6-8 weeks. Well I had my stroke in the end of January, that gives me February and March. That first of all, is a general sort of thing. Some make more rapid progress, but still that is sort of a wide guide. Then I have had a chance during the five weeks to evaluate my progress, also to listen to what the doctors and nurses seem to think about my progress and to combine those two things together with the general thing. The doctors and nurses seem to think my progress is far more rapid than the average. And all have expressed the thought that I might be able to go home soon. Now soon to one person means in the next ten minutes, but to others it is the next few days, and to others several weeks and some several months. So that soon business is not very accurate. But still, if some had said you'll be able to go home in a few months, then it's be a way of figuring it out too. . . . And all of this combined to somehow to come to the feeling that I would be able to go in two or three weeks, and I was aiming at the middle of the month."

Critical to this man's assessment was the definition of the word soon, a word he had difficulty translating into a meaningful time frame. His assessment that soon meant two to three weeks was very inaccurate for he was discharged the next day.

For the patient who relied upon the health care team for the major clues as to his time of discharge, such a vague word offered little tangible evidence of when that would be. Some of the patients liked this. Mary Thomas did not want to know when she was to go until the day of departure, for she said then she would not be anxious about going, nor would she be impatient for the time to arrive. This woman was going to a protective environment where her daughter-in-law cared for her and where she had no personal responsibilities or need to make plans. The majority of the patients, however, did have to make plans for their return home. Some had to arrange for domestic help, families had to coordinate their plans and transportation arrangements had to be made. For several of these patients, who had been in the hospital for extended periods, time was needed for termination of nurse-patient relationships.

The unwillingness, or inability, of many of the patients to project an expected length of stay reduced the possibility of their projecting an unattainable time limit. The patient often related his progress as slow, but steady. Such a view does not predict an end. However, the patient was conscious of the limitations placed on his hospitalization by Medicare. Anne Coolidge expected to stay "as long as they [Medicare] will let me."

It seemed that while the patient was able to predict goals he was unable to predict an expected time for accomplishment, and similarly he was more able to recall what had occurred than when it had occurred.

The nurse also used a variety of cues to project the length of the patient's stay. Initially such a projection was based on the assessment of the patient made by the clinical specialist in conjunction with the physician's referral of the patient to the extended care facility. As the patient progressed on the unit, the nurse incorporated the physical and mental progress of the patient and the assessment of the patient by the utilization review committee into her assessment of the patient.[1]

In the description of the patient and of the expected time frame of hospitalization, the nurse used a number of ambiguous terms. These terms were frequently undefinable by the nurse. For example, on discharge Mr. Cooper was described as _stable_. _Stable_, the nurse explained, could mean that the patient had good balance, or that he had attained a positive (undefined) level of ambulatory skill and was not improving. For this patient _stable_ included both meanings.

Soon was a word commonly used in projecting a time of discharge. This word generally indicated the staff member assessed the patient as being capable of functioning in his home, but that the physician had not indicated the actual date of discharge. In actual time, _soon_ stretched from one day to three weeks.

The vagueness of these words is both useful and frustrating to the health care personnel as well as to the

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[1] The utilization review committee is a hospital committee that is charged with assessing the needs and eligibility of patients for Medicare coverage in the extended care facility.

patient. On a unit such as this where the progress of the patient is anticipated, but not assured, and where the patient's ultimate capabilities are frequently in doubt, such nebulous concepts provide the health care team with the vocabulary to encourage the patient without building excessive expectations. These words also provide sources of uncertainty and gaps in plans and expectations between the patient and the health team members and even between health team members themselves. Such gaps are sources of frustration for, and lack of preparation by, the patient, family, and nursing staff. For example, Carole Carpenter, R.N., described such a gap:

> "Yes, I was here in the morning when they said Utilization Review kicked him out, and he left later that evening. It was quite a hurried affair, because they wouldn't cover him any more. . . . We usually have some idea that U.R. is watching them closely, so the physician makes plans and we can plan for his discharge."

Status Passage Defined

Institutionalized status was defined, for the purpose of this study, as residency in the extended care facility. Non-institutionalized status was defined as having been discharged from the extended care facility to the home of the patient or significant other. The patient and nurse had also developed definitions for the timing of this status change. As the patient talked of progressing toward discharge, he spoke in terms of being at home, or going home.

He did not speak in terms of leaving the hospital. As previously noted, the patient allowed the physician to determine the discharge date, yet even when this was set, and the order written, the patient did not note this as a major benchmark. There was a change in the patient's mood following announcement of a discharge date, a change similar to that noted when one achieves a long-sought prize but has not yet received it, a mood that is both relieved and at the same time anxious in anticipation of the event, its consequences, and the fear that it might not really happen. An excerpt from notes of the pre-discharge interview with Zeta Long indicates her feelings at this time:

> Z.L. states she is gradually getting more excited about going home, although she did not give any appearance of this as we talked. Tomorrow, she says, she will probably get nervous, because things at home are quite different from those in the hospital, and she is not sure just how much she will be able to do, or will be allowed to do at home. "The most important thing is to remember that I will be all right at home, and we'll work from there," she says.

Another characteristic of this time between the setting of a discharge date and the actual leaving of the unit was a "breath-holding" phenomenon. While the patient expressed some anticipation and excitement, it was a controlled excitement. For several of the patients, the actual discharge had been preceded by one or more false alarms. That is, either the physician or the patient had determined a discharge date which was then cancelled, or altered.

Tentative discharge dates were sometimes taken to be definite dates, and alteration of these dates proved disappointing to the patients.

This flexibility and frequent extension of the hospitalization increased the patient's uncertainty as to when he would go home, and resulted in the "breath-holding." For the patient, then, assurance that he was indeed discharged was his arrival at home. This was then projected as the final benchmark that would indicate to him that he had achieved non-institutionalized status.

The nurse's definition of this change in status was the same as the definition used for this study. While discharge plans included assuring whatever continuity of care was necessary, the responbility for the care was transferred to the referral agency, the family, or the patient when the patient left the extended care facility.

Summary

Benchmarks related by the patient occurred in both the acute care and the extended care settings. The benchmarks occurring in the acute care setting were dramatic, physiological changes. They were associated with a specific time. The benchmarks occurring in the extended care facility were less dramatic and were the result of a gradual progression. These benchmarks were based on a wider variety of occurrences than those occurring in the acute care setting. These benchmarks also lacked the definitive time frame of those occurring in the acute care setting.

Benchmarks described by the nursing staff occurred solely in the extended care setting. They had no discrete time frame. It seemed that both the patient and staff member were able to define what had happened more accurately than when it had happened.

The patient and staff member used a variety of sources to draw the temporal cues from which they developed a time frame for the patient's hospitalization. The patient relied heavily on the comments made by the health care team; he modified these with ideas arising from his experience, his goals, and his perception of his illness and his home situation. The nurse developed her cues from a variety of professional sources such as the physician, the clinical specialist, and the utilization review committee.

The time of anticipated status change differed between patient and staff member. While the staff member perceived the change occurring upon discharge of the patient, the patient waited for his arrival at home to signal this change.

Chapters III and IV dealt with the content and timing components of the benchmarks and the similarities and differences in this area between the patient and staff member. The following chapters will deal with broader themes that emerged from the data. The next chapter is devoted to the meaning of home to the patient and staff member and to the rehabilitation styles of the patients and the effects of these factors on the benchmarking process.

CHAPTER V

FACTORS INFLUENCING SELECTION OF BENCHMARKS

Bearing upon the selection of benchmarks were the patient and staff perceptions of home. The meaning of the house and the situation of being at home were defined differently by the patients and the staff members. Another factor that influenced benchmark selection was the rehabilitation style of the patient. This chapter deals with these two aspects of the benchmarking process.

Being at Home

To be admitted to the interview sample, a patient had to be a candidate for discharge home. A broad definition of home was developed for the study that indicated only that home must be a private residence or apartment of the patient or a significant other. As the interviewing progressed, it became increasingly apparent that home had a variety of meanings to both the patient and the staff member. To the patient, arrival at home offered both a goal and a benchmark. Initially this event was projected as a goal, then as its attainment became a certainty the event was projected as a benchmark. It was as if being at home would afford the patient tangible proof that he had indeed successfully made the transition to non-institutionalized status.

It was also apparent that home meant more than being at home, or an improvement in the physical health of the patient. The patient projected "home" as a resource in itself, as well as a place with resources. When asked to discuss this further, the patient had great difficulty in articulating his feelings about his home. A typical explanation was that of Yvonne Oxford, who said, "Just the sound of the word 'home' has a special meaning to it."

Zeta Long suggested that there were fewer pressures on the individual at home when she decided to wait until getting home to learn to write so that she could work at her own speed. She later modified this idea of fewer pressures to different pressures, as on the eve of her discharge she stated:

> "Things at home are quite different than in the hospital. I am not sure just how much I will be able to do, or will be allowed to do."

Ulysses Young and his wife attributed the special meaning of home to the familarity of the setting. Fanny Miller stated it was the investment of time, money, and energy that made it a special place. Isabel Adams summed up these descriptions when she described an apartment her children were building for her: "It is a special place. A very, very separate place for me." In this description is a sense of belonging and possessing, of independence, and of self-determination.

Each of the patients realized they had to continue to do exercises at home, yet there he would be able to do them in a meaningful context: walking would become functional rather than merely "twice around the ring" in the physiotherapy department.

At home there were frequently family members who were particularly supportive of the patient; persons who encouraged the patient to come home and who expressed the confidence that whatever problems arose could, and would, be worked out without too much difficulty. This, of course, was not always a realistic expectation, as has been observed during portions of the pilot phase of the project. The present study, however, did not deal with the actual adjustment to the home, but rather with the anticipation of this adjustment, so the veracity of these ideas was neither confirmed nor denied.

For this group of patients, the home was frequently the center of their lives, as well as a place of personal investment. Many of the patients talked of their gardens, and their plans for planting, pruning, and upkeep, as younger people talk of their children. Two persons, each of whom was considering giving up his house as he felt it was getting to be too much to maintain alone, expressed regret and sorrow at having to do this. Anne Coolidge was preparing her home for sale, and as a part of this was giving away many of the sentimental items that had been saved over the years. It was, she said, like giving away parts of herself. Brian Zork was also contemplating selling his house, for it was too large and empty for him alone. "But," he said, "if I sold it, then I'd have nothing, and besides that, I'd have to pay out rent which is robbery." His house, then, represented a measure of financial security as well as a place with a great deal of personal investment, and a large number of memories of the life he and his wife had had together until her death, some three months earlier. Rather than sell this last vestige of his former way of life, he sought acceptable alternatives such as having a sister-in-law come to live with him. It was interesting to note that while this man was reluctant to divest himself of his home, he saw no reason why his sister-in-law, also the sole occupant and owner of a house, would not sell her home and move in with him.

Home, then, was more than the place of residence; it was a source of independence, of purpose, of self-definition, and of belonging. It was a place of familiarity and also of relaxation, a place to sort out one's problems and a place to gain strength. As Anne Coolidge said, it was like a part of oneself.

The nurse had a different definition of home. While she agreed tentatively that home was a positive place since it offered the patient a supportive environment, and that going home was a positive step for the patient, she viewed the home as a potential hazard. Carole Carpenter enumerated some of the hazards, or unknowns, that she considered when a patient was to go home:

> "Planning for discharge doesn't just mean who is going to be there and what's going to happen. I mean, are there stairs, are they going to have to walk up the stairs? You have to think of them cooking at home, bathing . . ."

Ruth Hoffman stated that both the patient and the home had to be prepared. Preparation of the patient involved the development of ambulatory skills; preparation of the home involved measurement of doorways to see if appliances would pass through, assessment of the physical layout of the home, and the making of such changes as were necessary. It also involved the determination of the necessity for, and availability of, nursing or housekeeping assistance for the patient. The staff nurse stated the clinical specialist usually did this assessment; she contributed to it, but did not have the primary responsiblity for it. The clinical specialist made such assessments through patient and family interviews and, if necessary, with the assistance of a home visit by a local public health nurse.

An important variable in the home was the patient's family. In the case of Zeta Long, the family was described as a very positive force in her rehabilitation:

> "And not only that the family took such participation. And they visited every day. And given that kind of situation there is no doubt that the patient succeeds. . . . I think it is a great thing for the patient to go home somewhere that they are wanted. And people are anxious to see them back where they belong."

For John Cooper, the family was not seen to be as definitely positive. Mr. Cooper's wife had suffered a stroke some years prior to Mr. Cooper's stroke, and her activities were now somewhat limited. She was also reported to have inappropriate behavior at times, which was interpreted by the unit nurses as a hazard to Mr. Cooper's physical safety.

The nurse's assessment of the home was a more cautious one than was the patient's. Donna Yester, R.N., felt that home was a positive factor, provided the patient was prepared to enter that environment. She recognized that the patient did not see the potential hazards, rather that he dwelt on the positive aspects of the home. "To the patient," she said, "it is like a new medicine." Something new, and full of promise, with a tradition of being secure and comforting.

Rehabilitation Styles

The study was not designed to assess the ways in which the patient handled the rehabilitation process; however, this factor seemed to affect the kinds of benchmarks reported and the ability of the patient to report them. Each patient approached the tasks he felt necessary to his discharge in a manner that was unique to him. As it was possible to group the benchmarks, it was also possible to group the patients according to their style of handling their rehabilitation process. The rehabilitation process was defined as those tasks _related to the illness_ of the patient that were perceived as necessary for discharge by patient or staff member; for example, arranging for a housekeeper, or walking up and down stairs. It must be noted that style is a prevailing mode, not an absolute, and that classifications of a patient's style into any one of these categories is based on the data available from the present study, rather than from data designed for the purpose of classification of style. The three categories of rehabilitation styles were initiators, assumers, and acceptors. Each category will be discussed separately.

Initiators

The patient who was classified in this group did not wait for the health care team to indicate goals or tasks to be accomplished prior to discharge. He set his own illness-related tasks and goals and determined how best to achieve these goals. For example, Yvonne Oxford determined her own discharge date, her own discharge criteria, and began doing range of motion exercises to achieve that end before the health care team set these parameters for her confinement. Ingrid Newman also developed her own goals and criteria for discharge and prepared for her post-discharge needs before the nurse was even aware of these needs. Zeta Long also initiated exercises and set functional criteria for her discharge without assistance from the nursing staff. These persons seemed to be able to assess their disabilities and/or illness-related needs and initiate action in response to them. These patients were termed "independent" by the nursing staff; the patients related specific benchmarks of their progress toward their goals. For example, Zeta Long: "Today I walked in P.T. with a single cane"; and Ingrid Newman: "I am taking less pain pills. . . . I don't have as severe pain even when I need them."

Assumers

The "assumer" patient did not initiate such a responsibility, but when a member of the health care team suggested that the patient could be a determinant in his discharge date, the patient grasped the opportunity. For example, Ulysses Young's doctor stated the patient could go home when he [the patient] thought he was ready. Following this announcement, Mr. Young set a discharge goal, and said:

> "Well, I have to convince the doctor that I will be able to do the things at home, and so I have to do well in physio and tell the doctor how well I am doing, and convince both the doctor and the therapist that I am ready to go."

Fanny Miller also assumed the responsibility for progressing in physiotherapy when this was suggested to her. This group represented a small number of the sample.

Acceptors

The third category of rehabilitation style was the acceptors. This patient did as the health care team or family instructed him to do. He did not initiate exercises or other tasks required for discharge, although he did comply with the regime designated for him. Within this category of patient behavior were two subcategories: patients who had a low level of available energy and patients whose major concern was not the presenting illness. Following are examples of this category of rehabilitative style.

Mary Thomas was a patient with a low level of available energy. She was almost totally incapacitated by arthritic feet, fragile diabetes, and congestive heart failure. She had, at the time of the interview, relinquished all decision-making and environmental control to her family. She, as she said, took things as they came. Her doctor's criterion for her discharge, she thought, was for her to be able to do without oxygen, but if this was not possible then her daughter-in-law would arrange to have the oxygen equipment at home. While in the hospital she complied with the medication and activity regime set by the health care team. She did not anticipate a discharge date; she did not want to know when she would go home until the day of departure.

Frances Crown was another patient with little energy. She seemed totally overwhelmed by the situation in which she found herself, and felt herself at the mercy of the health care team. She had no specific goal associated with her return home and set no criteria of her own for discharge. Instead she accepted that set by the physician--finding a live-in housekeeper.

Brian Zork also accepted the tasks and goals set by the physician and nursing staff in relation to his presenting illness. He was described by the nurse as a good and cooperative patient. He did everything he was told to do, and took his medications as prescribed. The interviews with the patient indicated his primary concern was resolving the grief associated with his wife's death and his movement to a new life style. In this case it was the preoccupation with a non-illness-related concern that led to his accepting the criteria of others.

Effect of Rehabilitation Style on Benchmarks

The ability to specify benchmarks was markedly reduced in the patient who accepted the tasks and goals set by others. Frances Crown was able to note only one benchmark, that of walking a few steps; Mary Thomas noted the relief of her dyspnea following a thoracentesis, and Brian Zork noted reduction in edema. Oscar French noted a regressive step, that of weight loss following each esophageal dilatation. The patient who lacked the energy to deal with his situation was unable to specify much progress, nor could he project anything but general goals, such as Frances Crown's goal of returning to her home. The benchmarks reported by these patients were based on physiological changes.

The patient who initiated goals and activities, however, expressed many benchmarks. He noted physiological changes, stamina changes, increased mobility, and changes in feeling and mood. This person was actively working on his disabilities and was able to specify the points of progress and, in some cases, to project benchmarks.

The patient who assumed responsibility when it was offered him was also able to specify benchmarks of his progress. Because only two patients fell into this group, it was not possible to determine a relationship between their style and the kind and number of benchmarks noted. Ulysses Young's primary concern was with his survival as a person; until this was resolved he was unable to specify illness-related goals or benchmarks. The resolution of this other concern was associated with the assumption of responsibility for his progress. At that point, he was able to delineate illness-related goals and benchmarks. Fanny Miller, the other patient who assumed a similar responsibility, related few benchmarks. However, her reason for hospitalization was a fractured pelvis, which was treated with five days of bed rest. She did not experience the incapacities or pain that most of the other patients did.

Summary

This chapter dealt with the two separate concepts that affected the ability of the patient and the staff member to specify benchmarks. These concepts were home and rehabilitation style. Home had a variety of meanings to the patient, all of which were positive. Home was seen as a resource in itself, and as a place containing resources. The nurse viewed the home and the home situation differently. She agreed that there were many beneficial attributes to both the home situation and the home itself; however, she also perceived the home to be a place of potential hazard. This uncertainty to the home then helped shape the tasks she felt the patient must accomplish prior to discharge.

The rehabilitation style of the patient affected the benchmarking ability of the patient. The patient who initiated goals and activities relating to his illness was able to relate a number and variety of benchmarks. This person had a relatively high level of available energy.

Some patients assumed responsibility for their progress after the health care team had set goals and tasks for them. At this juncture these patients took a more active role in their rehabilitation. At this point they were able to specify benchmarks. The patient who accepted the criteria of the health care team--that is, he let others assume the decision-making and caring roles--was unable to specify many benchmarks. Those that he did note were based on physiological changes. Some of these persons had a comparatively low level of available energy; others were dealing with overwhelming, non-illness-related tasks.

Two major themes suggested by the data were survival and mastery. It is to these two themes we now turn.

CHAPTER VI

SURVIVAL AND MASTERY

On examining the data, it became apparent that there were two major classes of benchmarks, those that pertained to survival and those that pertained to mastery. Benchmarks classified as survival benchmarks indicated to the patient the answers to the questions: "Am I going to live?" and "Will I, as an individual, make it?" Mastery benchmarks indicated the answers to the questions: "What skills do I need to live?" and "How am I going to make it?" These major categories of benchmarks will be discussed in this chapter. Both nurse-reported and patient-reported benchmarks are included in this discussion.

Survival

Benchmarks pertaining to survival fell into two groups, those dealing with the biological survival (Will I live?) and those dealing with the survival of the self (Will I, as an individual, make it?). These groups will be discussed separately.

Biological Survival

Several of the patients interviewed were faced with, or had been faced with, situations that placed their biological survival in danger. Examples of such threats were metastatic cancer, acute cerebrovascular accident, and major surgery. Benchmarks related by a patient facing such a threat dealt primarily with events or occurrences that indicated a movement ahead on the physiological continuum toward wellness. Some examples follow.

Isabel Adams, recovering from a gastrectomy for carcinoma,was concerned with being able to eat: "Last week I ate one spoonful, this week, maybe two." For some persons, as with Anne Coolidge, the manner of speaking denoted the importance and the survival nature of the benchmark more than the actual words. For example: "*Finally*, I got to sleep. Then things began really moving, to improve." In recounting her inability to sleep while in the intensive care unit, Miss Coolidge's voice expressed the fear and doubt of recovery that the sleeplessness had produced.

Few survival-oriented benchmarks were related by the nurse. One of these was the comment by Carole Carpenter, R.N., with regard to Mrs. Adams' state on the day of her discharge: "I told the doctor, 'She's having pain and not tolerating food. I don't think this woman can go home.'" Another example is the statement in reference to the radiation treatment Mrs. Newman was having to combat metastatic cancer:

"Her treatment was finished." Neither of these examples of nurse-related benchmarks suggests the concern for survival that the patient expressed. Both of these benchmarks were reported as the state of the patient on discharge or, in the case of Mrs. Adams, the reason she was not discharged at that time. This benchmark was actually given as an example of the nurse's influence on the time of a patient's discharge, rather than as an indicator of the patient's progression or regression. For both of these patients, the nurse was aware of the poor prognosis. This knowledge probably affected the assessment of these patients, for the question of their survival had been answered; the only question that remained was how long they would survive.

Survival of the Self

The benchmarks related by some patients indicated a concern with survival of themselves as individuals. The source of this threat was not necessarily the reason for the patient's hospitalization; it did, however, affect the ability of the patient to handle his illness tasks. The patient faced with a threat to his individuality related benchmarks that indicated this concern, not his illness, if indeed he could relate *any* benchmarks.

One widower had nursed his wife for many years, caring for her by himself until her recent death removed him from this nurturing role. This caring role had curtailed his outside activities and interests. He was now faced with resolving his grief, developing new interests, and developing a new life style. A few months following his wife's death he was hospitalized for congestive heart failure. During this hospitalization he had experienced a dramatic reduction in edema and shortness of breath, and so an improvement in his ambulatory capabilities as well as his physiological status. A limited number of benchmarks this man related dealt with the physiological changes that occurred in the acute setting. The major concerns he voiced, and most of the benchmarks he projected, suggested his major concern was movement to a new, non-caring role, rather than with his movement out of the hospital. Such changes were seen as necessary if he was to maintain his personal integrity.

Mr. Young also perceived a threat to his integrity. This threat, however, was a result of his presenting illness. A man who had previously overcome difficulties through persistence and acceptance, he was now faced with a situation that seemed totally regressive and insurmountable. The early interviews with this man were filled with the assurances by the patient to himself that he had indeed been successful. The benchmarks he related pertained to the effectiveness of his former life style; for example: "I never did rebel against the supervision that was afforded me. I took it in stride and progressed."

Two patients expressed fear that they would be sent to a nursing home. One of these patients was greatly relieved when she finally was convinced that this was not the purpose of the interview. The second patient had mistaken the investigator for a nurse who would live in, thus preventing her from being sent to a nursing home. Both of these patients saw a move to a nursing home as a threat to themselves as persons, a move they intended to avoid if at all possible.

None of the nurses mentioned benchmarks that indicated a concern with the patient's individuality. The clinical specialist related a situation involving a patient, not in the sample, that indicated this concept was considered on the unit. The situation described, however, was a source of frustration for the nurse, the physician, and the patient, for the nurse did not feel the staff was able to assist the patient with his problem. In fact, she was not convinced that this was indeed the patient's real concern.

Mastery

Many of the benchmarks related by the patient dealt with the development of skills he saw as necessary to master his post-discharge environment. Examples of such skills were walking up and down stairs, writing, and developing the stamina to manage a household. Mrs. Long described the process of regaining these normally taken-for-granted skills as follows: "It is like being a child and learning to do all these things again." The majority of the benchmarks reported by the nursing staff came under this grouping. The benchmarks in the major category of mastery may be divided in a similar manner to those in the survival category: biological mastery and mastery related to the self-concept. Each category will be discussed separately.

Biological Mastery

Benchmarks in this group gave indication of the achievement of, or progress toward, mastering illness-related handicaps. Mastery of these handicaps would result in development of the skills the patient would need to return to live in his home. Many of the benchmarks reported by the patients who had suffered cerebrovascular accidents were of this group. The patient's primary concern, it seemed, was overcoming his disabilities to the level that he could manage in his home environment. The home, as was discussed earlier, helped to set the requirements this person felt necessary for discharge. A person who was going home to a family frequently set lower limits for himself than did one who was to be going home alone, or with only temporary or part-time assistance. There were, of course, exceptions to this trend. Zeta Long, who was going to live with her daughter, wanted to master walking with a single-footed cane, rather than walking with a platform cane or a walker, both acceptable means of ambulation for many of the patients.

Anne Coolidge, a patient whose recovery from a carotid endarterectomy was complicated by a marked weakness and lack of muscle control of the right extremities, was concerned with mastering several skills. The most striking descriptions related to mastering the technique of eating:

> "At first I didn't want anyone to see me eat, because my spoon would go any way. I would have to direct it to my mouth. Aim it."

And later,

> "I have finally mastered a cup of tea!"

Relearning to write, or to maintain a train of thought necessary to write a letter, was a skill with which several of the patients struggled. Anne Coolidge wanted to write to sign checks to pay her special nurses, rather than have her family handle this. John Cooper wanted to be able to write letters again, as did Yvonne Oxford. Zeta Long was content to leave the development of this skill to a later time when she was home and could progress at her own speed; she was, however, concerned with development of this skill.

Ambulating independently to the point of being able to do some light gardening was frequently cited by the patient as one of his goals and anticipatory benchmarks were cited by the patient to reflect this goal. For example, this projection by Ulysses Young:

> "So a point of real concern at the present time is to regain my ability to walk, to exercise, to do the ordinary homely chores around the house. I can't hardly stand the thought of not being able to get out and do some gardening."

And

> "Now I have only the planting to do, and I can do that."

These activities were not necessary for the survival of the patient, but rather for him to return to a position of being in control of himself and his environment--a mastery orientation.

The nursing staff related many mastery benchmarks. The yardstick for progress along the progressive ambulation continuum required mastery of skills. As a patient mastered the skills of walking with a walker or with a cane, that benchmark was noted.

Some of the nurse's goals, and so benchmarks, related to the learning of specific dietary or health care teachings; for example, the nurse noted the degree of mastery of knowledge of Oscar French: "He knew all about his diabetic teaching. He could tell you back." In regard to teaching Mary Thomas' family how to use the oxygen equipment she would need at home, the nurse commented: "Her daughter was going to take care of the oxygen. I showed her how to use it. She asked some good questions." The staff's concern was with the mastery of this knowledge. Not one of the patients reported such a benchmark, or indicated concern with health care teaching.

Mastery Related to Self-Concept

Some of the mastery type benchmarks were directly related to the development or reassessment of the patient's self-concept. The skills denoted by these benchmarks were not necessary for functioning in the home environment, but were skills that the patient felt were particular characteristics that were identified not just with him, but as him. Anne Coolidge related several such benchmarks. She wanted to walk gracefully, as she had before the surgery, and selected skills that indicated progress toward this goal. She also was diligently practicing her handwriting in an attempt to regain a flowing style. Both of these attributes allowed her to return to her former graceful self. She was not prepared to accept a new self-definition that included a less graceful person, as is evidenced by her response to a suggestion by the physiotherapist that she consider the possibility of having residual handicaps:

> "I think that maybe I have not quite accepted the fact that this isn't . . . I still feel that perhaps the efforts that I am making, that the muscles . . . You see they tested my muscles and apparently my muscles are pretty good. And I have a feeling that perhaps I am going to wait before I make a judgment."

The benchmarks reported in this group resulted from mastery of illness-related disabilities, disabilities that affected the patient's self-image. The nurse did not report benchmarks that fell into this category.

Movement from Survival to Mastery

Not all the patients related benchmarks that fell exclusively in either the survival or the mastery groupings. Several patients made a transition from a survival orientation to a mastery one. Anne Coolidge moved from concern with survival to being concerned with such mastery skills as graceful walking and handwriting. John Cooper also moved from concern over the probability of physiological survival to the development of mastery skills such as handwriting and unassisted walking. Neither of these patients made this transition until he had assured himself he would survive. Anne Coolidge's statement about finally getting to sleep not only noted a survival benchmark, but also the movement from survival to mastery orientation: "And I finally got a good night's sleep. Then things began to move. To improve." And John Cooper spoke of his concern with his survival, and the shift in his focus since coming to the extended care facility:

> "Of course, the mortality rate for those having simultaneous myocardial infarction and c.v.a. is very high, so I'm lucky I'm here at all, but now I figure I'll be here a month or so . . . I need the physiotherapy."

Ulysses Young also moved toward the mastery emphasis; however, throughout his stay on the extended care facility, he remained concerned with the maintenance of his personal integrity. Both Anne Coolidge and Ulysses Young had entered the hospital for elective surgery and anticipated improvement over their pre-hospitalized states. They were, however, faced post-operatively with not just a decrease in their physiological and psychological abilities, but also with a critical period when their lives were in jeopardy. The expectations and realizations of these patients were quite different. Both persons found themselves faced with relearning skills that had previously been a part of their personal repertoire, skills they had not anticipated having to relearn. It was necessary for them to adjust to an unanticipated situation before they could cope with the illness (or recovery) tasks presented. Once survival was assured, both persons were able to approach the mastery tasks, Miss Coolidge more so than Mr. Young. Both patients did exhibit movement along the survival-mastery continuum.

Some patients did not change their perspective; rather, they remained either in the mastery or the survival sphere. Isabel Adams and Ingrid Newman centered their concerns on developing abilities that promoted their biological survival. Other patients related only mastery-related benchmarks. There seemed to be no doubt as to their survival, or this doubt had been resolved and the patient had progressed to the task of developing his skills to meet the needs of his environment.

Because of the limited number of benchmarks dealing with the survival aspect of the patient's progress as reported by the nursing staff, there was no discernible movement of the patient along the survival-mastery continuum reflected in the nurse-reported benchmarks.

The patient moved along the survival-mastery continuum at his own pace, relatively unaffected by the efforts of the nursing staff. The survival concerns of the patient were frequently more dominant during the time the patient was in the acute care setting, although they did carry over into the extended care facility. The extended care facility's nursing staff concentrated on the mastery aspects of the patient's progress.

Survival of the self was, for some patients, an overwhelming concern, whether it was the resolution of conflicts involved in facing a totally new life situation or acquiring the self-assurance that the individual was not losing his mental capacities, as one example indicated. No one of the patients experiencing concerns with aspects of his survival, biological or in relation to self-concept, was able to effectively deal with the mastery requirements, or concerns that the nursing staff expressed, until he had resolved the survival issue to his satisfaction. The examples of benchmarks related by Mr. Young, Mr. Zork, and Miss Coolidge attest to this observation.

The fact that the nursing staff did not relate any survival-oriented benchmarks, despite the overwhelming concern for this aspect by some of the patients, creates an area for conflict of goals and activities. For example, the concern of Mr. French was to be able to eat and gain weight. The nurse wanted him to master the knowledge and skill necessary to administer insulin. Another such example is that of Brian Zork. As he struggled with the advent of a new role, the nurse was concerned that he would not follow a new dietary regime. If the nurses are able to assess the survival concerns of the patient they may then be able to assist the patient to resolve these concerns more rapidly and to approach the mastery tasks more effectively.

Summary

The benchmarks and concerns of the patient fell into two major categories, survival-oriented benchmarks and mastery-oriented benchmarks. Each of these categories was further subdivided into groups dealing with biological and personal concerns. The benchmarks related by the nursing staff were almost totally related to biological mastery.

Some patients did move along the survival-mastery continuum; those patients who expressed survival tasks had to resolve these to their satisfaction before they could move on to the mastery-oriented tasks. The survival-oriented benchmarks did not necessarily deal with the presenting illness, mastery-oriented benchmarks did.

The preceding chapters have dealt with the content and timing of the benchmarks, the general ideas of survival and mastery, and the concepts of home and rehabilitation style. These factors may be related to develop a theory of benchmarking as it pertains to this group of elderly patients and their nursing staff. These factors, as well as the theory developed from them, have implications for the professional practice of nursing and the development of further nursing knowledge. The next chapter deals with this aspect of the research process.

CHAPTER VII

A THEORY OF BENCHMARKING, IMPLICATIONS FOR NURSING, SUGGESTIONS FOR FURTHER RESEARCH

From data gathered in the clinical setting can emerge theory that furthers both the science and the practice of nursing. Such a theory would be grounded in data, that is, it would be based on the relationships emerging from data collected. Such a theory would explain the data obtained as well as provide a guide to action for those persons working in the area covered by the theory. This level of grounded theory is substantive theory. Substantive theory is generated by comparative analysis between or among groups within the same substantive area.[1]

To develop a theory of benchmarking as it pertains to the movement of the elderly person from the extended care facility, it is necessary to examine the relationships between the factors that influenced the selection of events as benchmarks, and to examine the relationships between the factors that influenced the temporal definitions of progress

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[1] Barney G. Glaser and Anselm L. Strauss, The Discovery of Grounded Theory (Chicago: Aldine Publishing Co., 1967), p. 33.

and status passage. The presentation of the theory developed in this chapter will be discussional rather than propositional.

This chapter is divided into three sections: a theory of benchmarking, implications for nursing, and suggestions for further research.

A Theory of Benchmarking

The process resulting in the selection of the content of the benchmark and the time frame of that benchmark is discussed in this section. The discussion is divided into the areas of content derivation, both patient and nurse, and time derivation, both patient and nurse.

The content of the benchmark, both patient-reported and nurse-reported, related directly to the tasks selected by either the nurse or the patient as prerequisite to the patient's discharge. The patient and the nurse did not always select the same tasks, nor were the factors that influenced the tasks identical. In the discussion that follows, the patient content derivation and the staff content derivation are handled separately.

Patient Content Derivation

The specific benchmarks reported by the patient related directly to the tasks he felt were necessary for him to function in his home. Several factors influenced the tasks the patient selected; they were: the goals the patient set, his perception of home, his illness concerns, his other concerns, his rehabilitation style, and the comments made by the health care team. These six factors may be grouped into three interacting dyads. These dyads are: illness concerns/other concerns, goals/home, rehabilitation style/ other persons. It is the interaction within and between these dyads that determines what tasks are crucial, in the eyes of the patient, to his progress. The interaction within each of these dyads will be discussed separately; the interaction between these dyads will be discussed later.

Illness concerns/other concerns. As discussed in Chapter V, the illness was not always the major concern of the patient. When there was another major concern, or life task, such as grieving, this affected the kinds of benchmarks reported and the ability of the patient to report benchmarks. A patient with an overriding concern not related to his illness remained detached from the illness-related tasks until he had resolved his other concern. He related few benchmarks. The patient who was primarily concerned with aspects of his present illness reported benchmarks that reflected such a concern. One patient, who was initially concerned with a non-illness problem, was able to move on to dealing with his illness once he had resolved the question of his personal survival. The functional influence from this dyad is a combination of the illness concerns and other concerns; the character of this influence is determined by the strength of the dominance of one of the interacting factors.

Goals/home. The patient's perception of his home situation influenced the goal he set for himself, and it is likely that the goals set by the patient colored his view of the home. For example, the reluctance of Anne Coolidge to leave the hospital may have been due, in part, to the fact that she was returning to a task for which she had little enthusiasm, giving up her home. The influence of the home on the patient's goal was obvious, for each patient stated his goal in terms of functioning in that home setting.

Rehabilitation styles/health care team. The rehabilitation style of the patient, that is, the way in which he handled the illness-related tasks perceived as necessary to his discharge, combined with his perception of the roles of the members of the health care team to yield a third major influence on the selection of tasks to be accomplished. The patient who initiated his own goals and actions indicated the health care team had little influence on the tasks and benchmarks he selected. The patient who accepted the goals set by the health care team was obviously influenced by these persons. Exactly which member, or combination of members, of the health care team exerted the most influence was dependent upon the patient's perception of that person and his role in the patient's rehabilitation. The scarcity of data about the third rehabilitation style, the assumers, prevents conclusions from being drawn in relation to their perception of the roles of the health care workers. These persons were influenced by the health care team in their initial goal setting and task selecting processes.

Interaction between the dyads. Each dyad is representative of a larger area that influences the patient during the course of his hospitalization. These areas are: home, life, and hospital. The discussion here reflects the effects of these areas on the patient in the extended care facility. The home area pertains to the patient's perception of his home and all that his home represents to him; for example, security, family, or wellness. The life area deals with those tasks, illness or non-illness, that the patient faces during the course of his hospitalization; the hospital area represents the influence of the institutional aspect of the patient's disease process; for example, the influence of the physician or the nurse. There is, of course, overlap between these areas of influence. Figure 3 shows the relationships within and between the three dyads and the larger areas of influence.

----- Line of derivation

——— Line of interaction

→ Direction of action (if unidirectional)

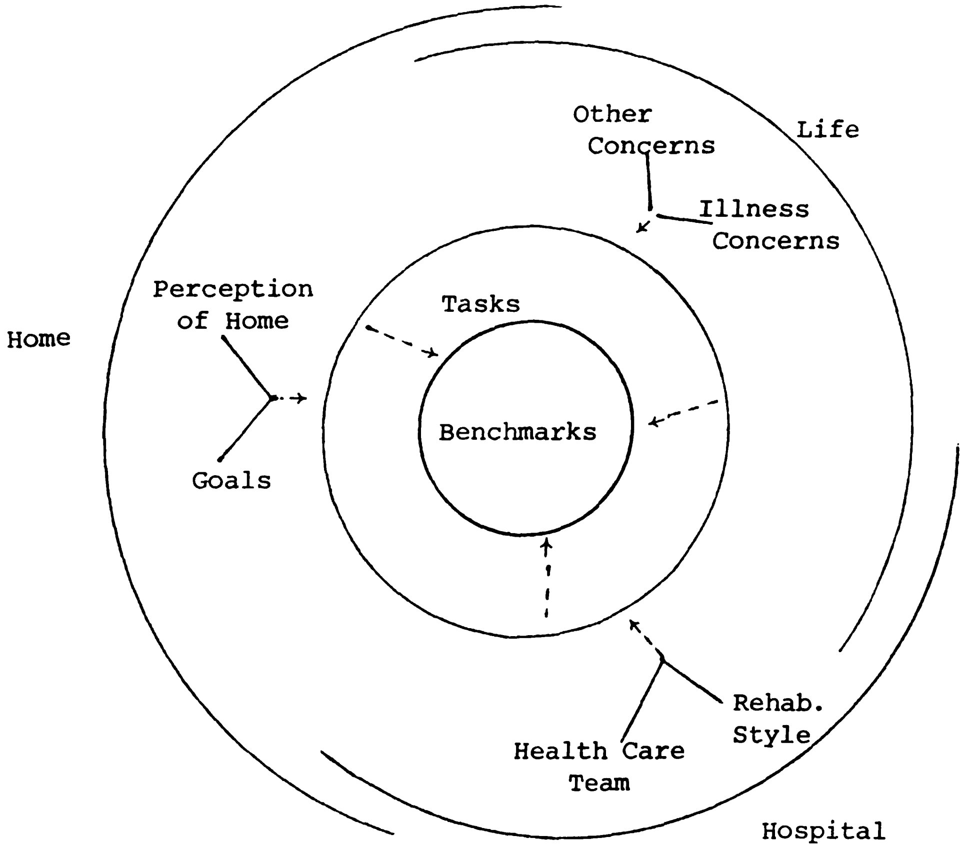

Fig. 3. Derivation of the content of the patient-reported benchmarks

The sources of the benchmarks reported by the patient indicated a weakness in the area of overlap between the hospital area and the home area, as evidenced by the lack of influence of the health care team on the goals set by many of the patients. The tasks perceived as requisite to the patient's discharge are selected as a result of interaction among the dyads. The benchmarks are directly related to the selected tasks.

Staff Content Derivation

As with the patient content derivation, the content of the staff-reported benchmarks was determined by the tasks the patient had to accomplish prior to discharge. These tasks were derived from the goals set for the patient by the nurse. A variety of factors combined to determine the goals set for the patient. The most influential factor was the care philosophy of the unit, that is, the professional goal of the nursing staff. The nurse's knowledge of the patient's home environment and his specific illness then modified the general goal. The desires and assessments of other members of the health care team were also an influencing factor. Occasionally the nurse was aware of non-illness-related concerns of the patient. This latter influence was not apparent with regard to any of the patient subjects, but was cited by the clinical specialist in a discussion of a patient not eligible for inclusion in the sample. The goal, then, was a preset, general goal that was modified by additional data concerning the patient's situation. The tasks required to meet this goal were also predefined; they formed the progressive ambulation continuum. The modification of goal was usually in respect to how far along this continuum the patient was expected to move. The benchmarks indicated which goal-oriented tasks had been completed.

Figure 4 shows the content derivation of the nurse-reported benchmarks. Again, as in the content derivation of the patient-reported benchmarks, the three major areas of influence provide a broad basis for the content derivation. In the staff content derivation there is less interaction between the three larger areas of home, life, and hospital. These gaps are the areas of poor communication that resulted in the unshared goals and plans of the patient and nurse subjects in the participating extended care facility.

Instead of the dyads operant in the patient content derivation, there are a number of factors directly influencing the selection of the nursing goals for the patient. These factors influence the goals set for the patient, not the tasks to be accomplished, as was the case in the patient content derivation. The patient's own goals did not influence the nurse's goal setting. The influences on the nurse's selection of benchmark content were derived primarily from

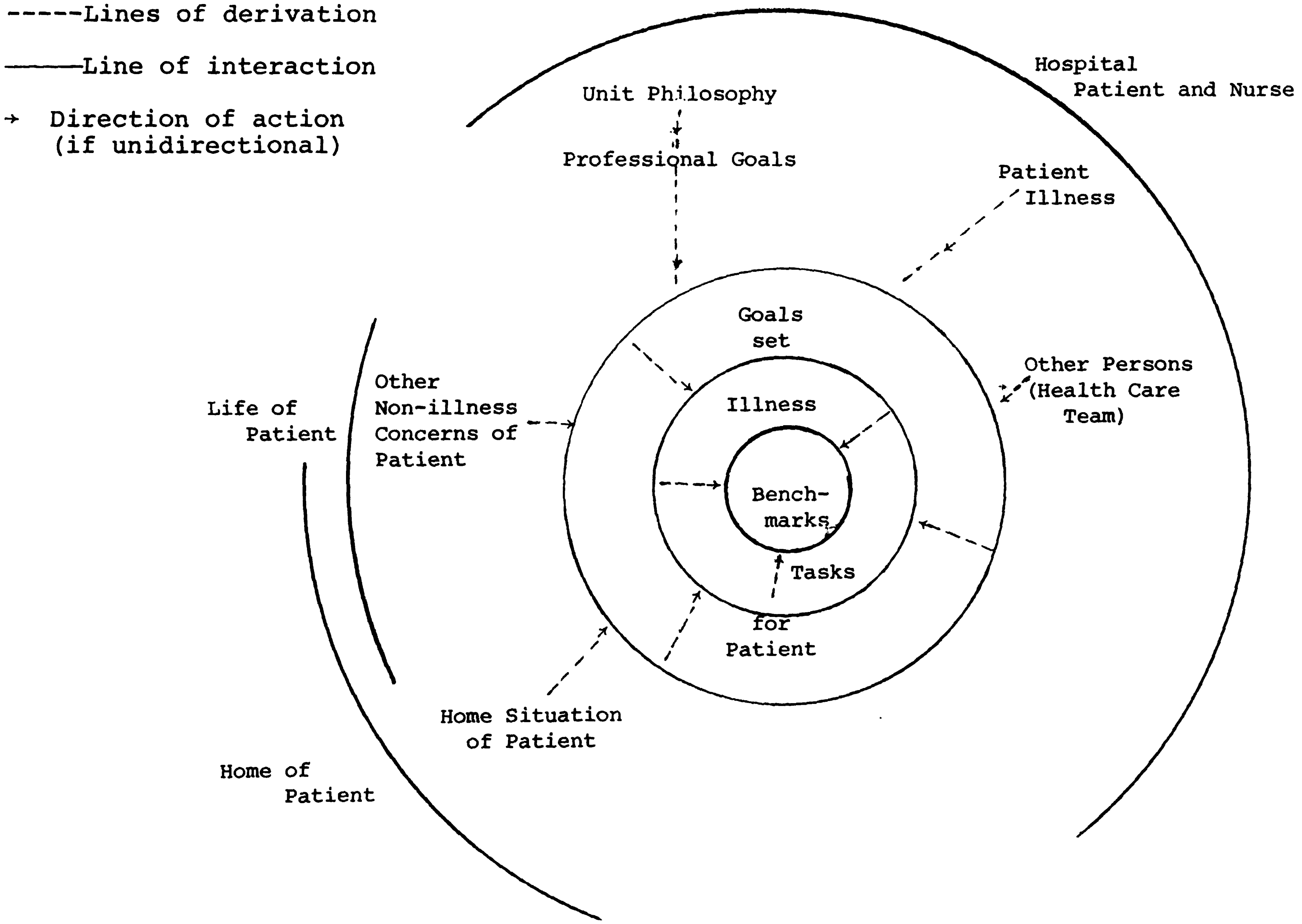

Fig. 4. Derivation of the Content of the Nurse-Reported Benchmarks

the professional, or hospital, area, with minor influence from the home and life areas of the patient.

If a Venn diagram is constructed to show the overlap of the life, home, and hospital areas, the derivation of benchmarks by both the patient and nurse can be illustrated. It is obvious that the life and home areas are defined in relation to the patient, and that knowledge of these must be sought by the nurse. For this reason, they are labeled "patient life" and "patient home." The hospital area, however, is shared by the patient and the nurse. The nurse and patient definitions and expectations of this hospital area may differ, yet the influence of this area is common to both benchmark derivations. The patient benchmarks arise from the intersection of all three areas, the nurse benchmarks from the hospital area. Figure 5 is the Venn diagram of this situation.

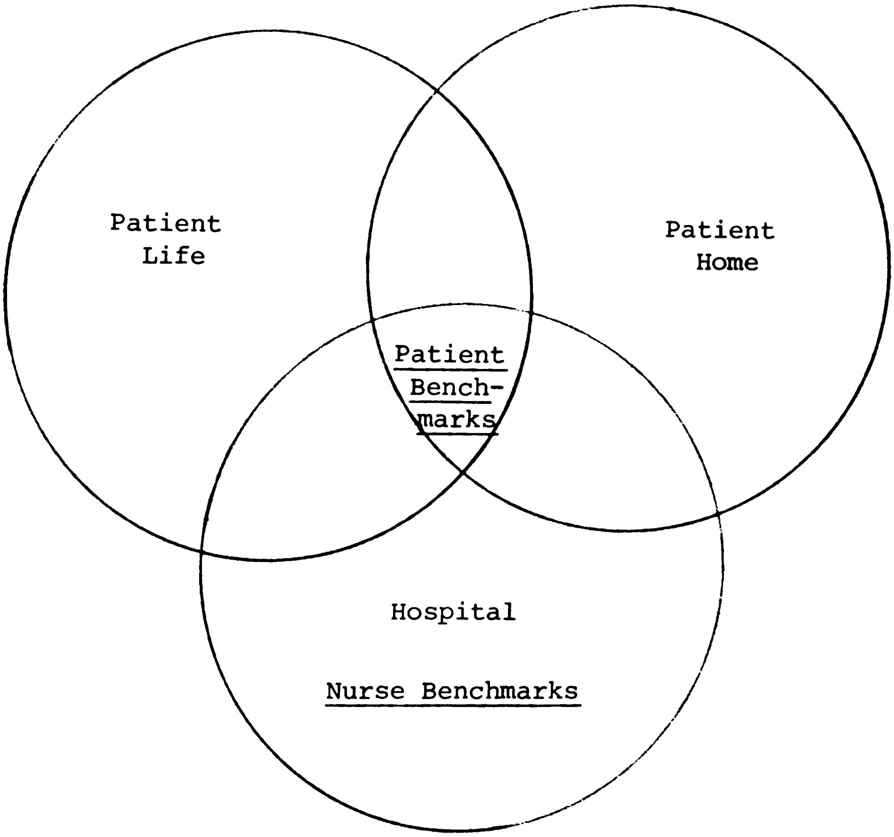

Fig. 5. Interactional derivation of content of patient-reported and nurse-reported benchmarks

Patient Time Derivation

The time perspective was not well delineated by the patient. For most of the benchmarks, there was no discrete time reference. The rate and extent of recovery for many of the extended care facility patients was not known, as it was not known for the families and children involved in Davis' study of the effects of paralytic polio.[1] The comments and reports of the health care staff in reference to the recovery aspect of the polio patients and the functioning of that facility caused the children and their parents to change their time perspective to accommodate a long-term and uncertain rehabilitation process. The extended care facility patients, while facing a similarly uncertain recovery process, were not in an institution geared to long-term care; in fact, the need for long-term care is a reason for discharge from an extended care facility. The length of stay was over-anticipated by at least two patients, suggesting they, rather than the health care team, had developed a lengthened time perspective.

Wallach and Green examined the subjectively perceived time references of healthy young adults with those of healthy persons over sixty-five.[2] The median age of the elderly

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[1] Fred Davis, "Definitions of Time and Recovery in Paralytic Polio Convalescence," American Journal of Sociology, LXI (May, 1965), 582.

[2] Michael Wallach and Leonard Green, "On Age and the Subjective Speed of Time," Middle Age and Aging, ed. by Neugarten (Chicago: University of Chicago Press, 1968), p. 485.

group was 71.4 years, an age similar to that of the study sample. The age range of the young adults was 18-20 years. The authors concluded that subjectively perceived time is shorter in the elderly than in the younger persons, and that this is related to the value of time. Elderly persons have less time remaining, therefore see time as more valuable, and as moving more quickly. For an elderly person who is afflicted with an illness from which recovery rate and extent are in doubt, there arises a conflict. On the one hand, time is of great value to the patient and so is perceived to be short, whereas on the other hand, the patient must assume a lengthened time perspective in order to work toward the rehabilitation goals.

The patients were trying to construct a time frame, and drew from a number of sources in this attempt. The sources noted were the patient's own goals, his rehabilitation style, the statements made by the health care team, the patient's perception of his home situation, the patient's perception of his illness, and the patient's previous experiences in similar situations. The comments of the health care team were the source that seemed to be that most commonly used by the patient. Figure 6 is the model of this aspect of benchmarking.

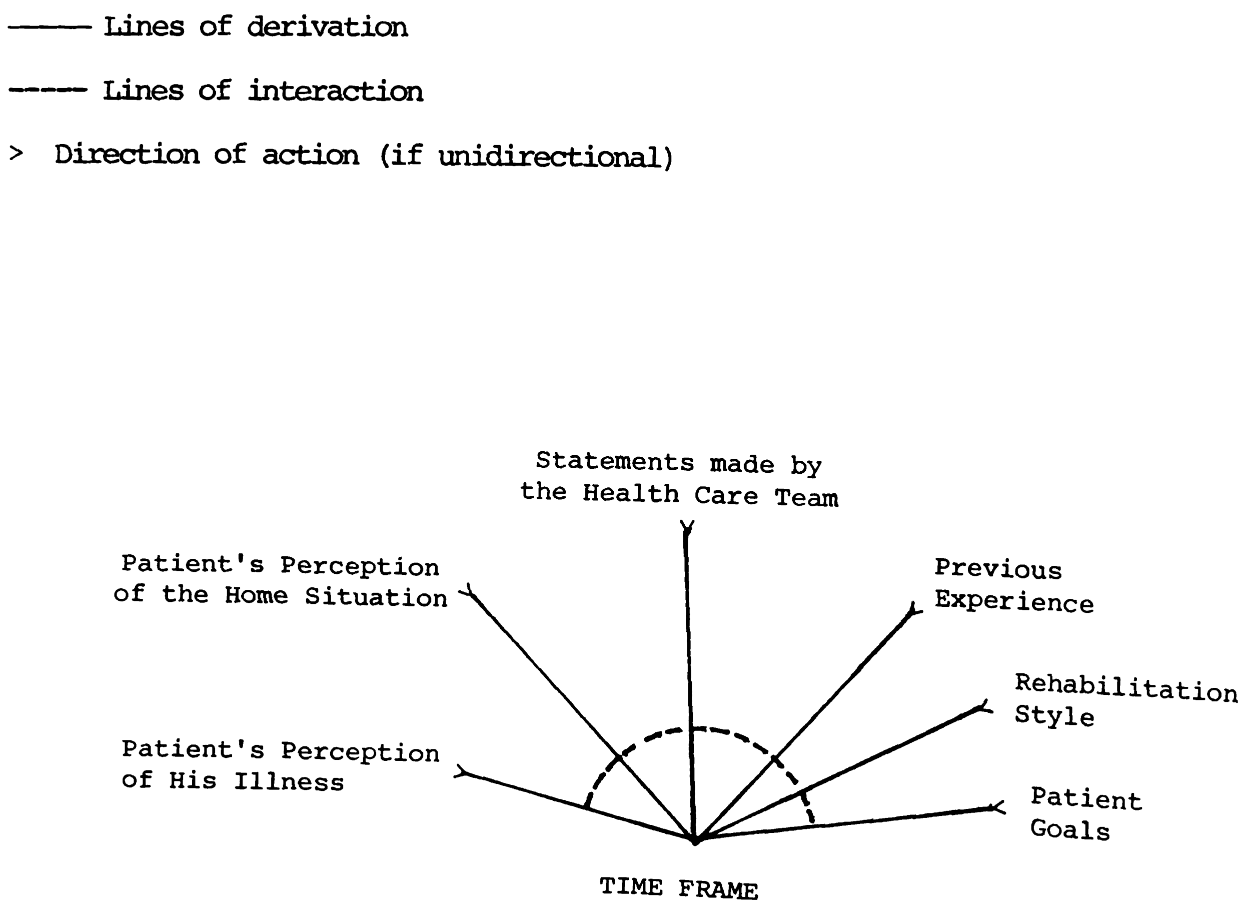

Fig. 6. Derivation of the temporal component of the Patient Benchmarks

The actual time of an event was not usually known by the patient, suggesting that the patient was operating in an open-ended time frame, or at least within a frame that offered few commonly known points of reference. Unlike the tuberculosis patients studied by Roth,[1] or the polio patients studied by Davis,[2] the sequence of events for the extended care facility patient was not well-known to the patient. Even though patients such as John Cooper and Anne Coolidge had recently experienced similar situations from which they could draw a tentative time schedule, they selected not to do this because, they said, "It is too different this time." Both of these patients did make comparisons with their previous experience; however, this influence was minor in comparison with that of the other influencing factors. Unlike the patient in the Roth and Davis studies, the extended care facility patient did not see himself following a common sequence of events leading to his discharge. In fact, this patient was following a common path, progressive ambulation. Because of the different patient perceptions of recovery needs, the extended care facility patient was not able to compare his progress with that of his roommates or with that of the other patients on the unit. Nor was the extended care facility patient on the

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[1] Julius Roth, Timetables (Indianapolis: Bobbs-Merrill Co., 1963).

[2] Davis, "Definitions of Time and Recovery."

unit for the long-term stay associated with either the tuberculosis or the polio patient. The time reference for the extended care facility patient had to be constructed by the individual patient rather than by the group of patients.

Staff Time Derivation

The time frame constructed by the staff member had opportunity for more discrete parameters, for the nurse dealt with the patient in the hospital for a finite, but unspecified, period of time. Within this time she also was faced with the uncertainty as to the rate and outcome of the rehabilitation process. As with the patients, the actual time of occurrence of the events within this frame was unclear. The sequence of events was predetermined by the professional goal for the patient, but the time allowed for each step was not set, nor was a time associated with the attainment of each step.

Glaser and Strauss, in their discussion of the temporal aspects of dying, found the reference points for the temporal cues as to the position of the patient in that status passage were: the progression of the disease compared with the patient's actual movement, the physician's expectations compared with the actual time involved and the work schedules of the health care persons.[1] Even with these reference points

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[1] Glaser and Strauss, "Temporal Aspects of Dying as a Non-Scheduled Status Passage," p. 49.

the temporal cues remained rather indeterminate, as they were in the extended care facility.

The nurse developed the parameters of the time frame from a variety of sources. These sources reflected the different range of references she had available to her in comparison with those the patient had available; references were professional rather than personal, as they were for the patient. These sources were: the utilization review committee, the assessments by the clinical specialist and the physician, the nurse's own assessment, the confidence of the nurse in the patient's abilities, and the nurse's knowledge of the home situation. Again, there is an apparent lack of the patient's perspective in the nursing derivation.

The model of time determination is similar to that of the patient, although the influencing factors are not identical. The specific illness for which the patient was hospitalized was not an influencing factor. The nurse did not seem to compare one patient with another, although it would seem almost impossible for them not to do this.

A model of the time derivation made by the nursing staff member is shown in Figure 7.

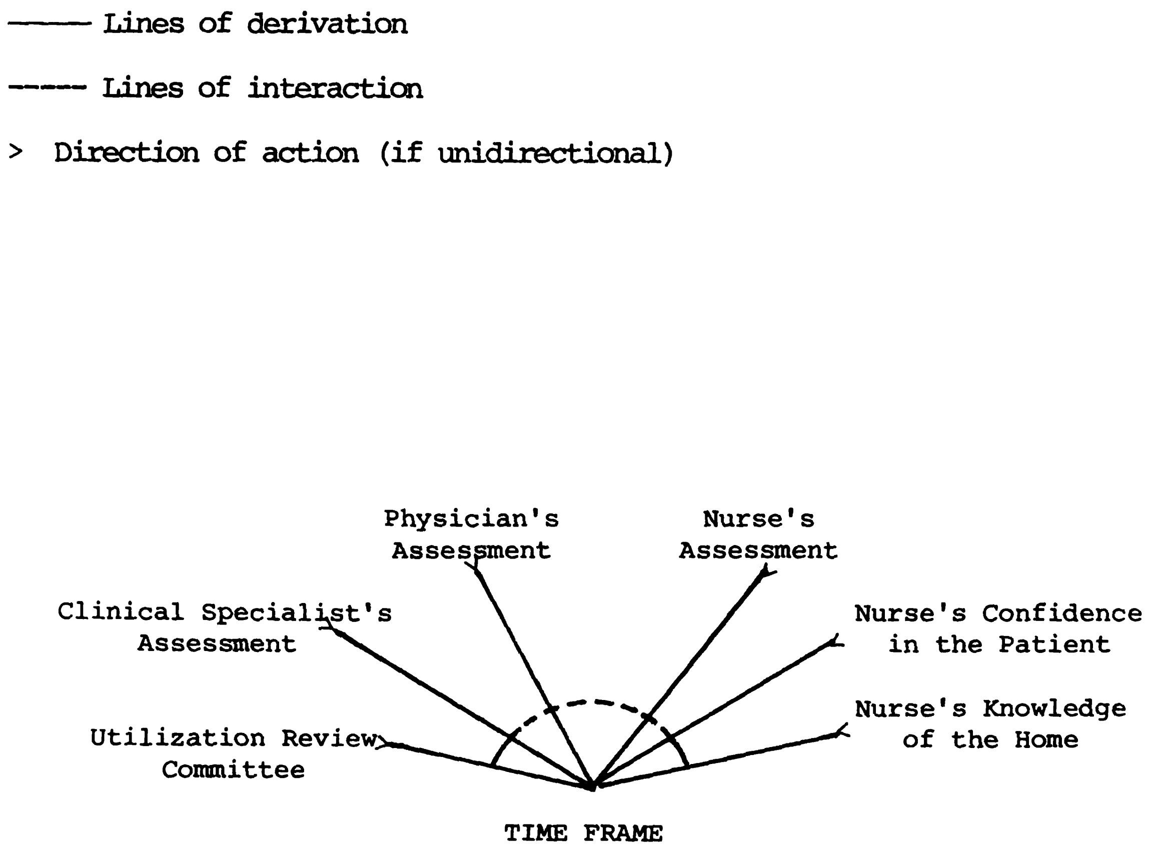

Fig. 7. Derivation of the temporal component of the Nursing Staff Benchmarks

The general expectations regarding the time of the patient's stay were set by the extended care facility staff upon admission of the patient. Changes in these expectations resulted in frustrations to the attainment of the nursing goal. If the patient left sooner than was expected, the staff was unable to complete the projected regimen. If the patient's progress slowed so much as to suggest the need for prolonged rehabilitative treatment, the patient became a candidate for a different level of care, and so was discharged to an intermediate or long-term care facility prior to the attainment of the nursing goal.

In this unit, where the nursing goal was common to all the patients, the disease entity did not provide a significant reference for the temporal aspect of the status passage. One nurse stated: "Many times I don't know what is wrong with the patients, just what has to be done for them."

Implications for Nursing

Benchmarks are indicators of progress. They are selected subjectively and as such offer insight into the events that are important to the individual, and the factors that influence him during the selection of these events. The setting of goals, and the progress toward these goals are influenced by this selection process. It is fairly obvious that attainment of a goal is more likely if those persons working toward it have a shared definition, or at least a complementary definition of that goal. In this study, the goals were not always complementary, and they definitely were not shared, creating the potential for blocking patient progress.

The patient benchmarks were derived from three major areas of influence: the home area, the life area, and the hospital area, suggesting a need for the nurse to be aware of the total patient context, rather than focusing on the illness context. The extended care facility, in part, provides the link between the acute, or illness-oriented, phase and the home, or life-oriented, phase. The nurse's benchmarks were derived mainly from the illness phase, and in part from the home area, suggesting that her role in providing the link to the home was minimal.

The time frame of the patient's hospitalization and recovery also has implications for the extended care facility nurse. The patients, quite obviously, were trying to construct a time frame. They had, however, little on which to base their definition. This resulted in inaccurate expectations or an inability to set time expectations. The patient required valid cues upon which to base a time frame that allowed realistic planning for both short- and long-term goals.

The importance and meaning of aspects of the recovery process to the patient or the nurse resulted in opposing views of the same event. For example, walking with a wider stance was reported as a step backwards by Anne Coolidge; to the staff it was a step ahead. Oscar French related each esophageal dilatation as a step backward, for he lost weight and his eating did not improve. The nurse stated these treatments indicated progress, for his eating did improve. These opposing views point out the need for further assessment of the patient and understanding the patient's perspective.

To the patient the nurse represented the "audience reference group" described by Kemper, for it was through the assessments made by the nurse and the other health care team members that the patient was allowed to go home, the reward for appropriate achievement.[1] The nurse on this unit perceived her role to be that of providing a guide to action, or at least that of encouraging the desire for action by the patient, rather than that of providing the audience and the reward, the role assigned to her by the patient. Such differences could be minimized or avoided through improved patient-staff and health care team communications and assessment, as was called for in Muriel Skeet's study of the needs of discharged patients.[2] Such communication would reduce

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[1] Kemper, "Reference Groups, Socialization and Achievement," p. 32.

[2] Skeet, Home from Hospital.

misunderstandings, promote complementary goal setting and clarify the role of the nurse and the patient. The staff, of course, must be concerned that the patient acquire the basic skills for independent functioning, just as a teacher is concerned that her pupils learn the basics of a subject. That material can often be molded into a different and more meaningful context if the needs, interests, and goals of the student are known and considered. So it can be for the extended care facility patient.

Such assessments and communication can also result in a more efficient course of action. For example, the goal of Greta Queen, R.N., the staff nurse interviewed in relation to Oscar French, was for this diabetic patient to do his own urine testing and insulin administration, and to understand his diabetes. Mr. French, a highly intelligent man, had been a diabetic for twenty-eight years. He was quite knowledgeable about his disease, as the nurse had reported. He was concerned with gaining weight and developing a positive weight gain trajectory, not with reviewing the basic diabetic instruction. Mr. French was undergoing esophageal dilatations, procedures he understood but did not find at all pleasant. He did not see a positive result from the treatments as he usually lost weight following each dilatation. The nurse may well have approached this aspect of his hospitalization, dealt with his concerns, and related this to his diabetic regime, thus including both her teaching goal and the patient's concern with the surgical procedure in the one teaching plan.

The patient's knowledge of the purpose of his treatment and of the plan of care was limited. This, again, may form a block in the progress toward the goal. None of the patients connected the accomplishment of one exercise with development of further skills, suggesting their rehabilitation tasks were being done without a purpose or context. A patient care plan that is developed and shared with the patient would promote a better understanding by the patient of his rehabilitation tasks. In an article on the necessity of nursing care plans, Marlene Kramer suggests ways to make nursing care plans realistic, viable, and powerful tools.[1] Among these suggestions is the idea of leaving the care plan at the bedside so that the patient and the family are involved in, and knowledgeable about, the plan of care.

Congruence of goal definition by the patient and nurse is not the only significant aspect of nursing care in the extended care facility, although admittedly a major one. The sources of information available to the patient provide him with the basis for his self-assessment. Such sources are not necessarily accurate, creating misunderstandings and

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[1] Marlene Kramer, "Nursing Care Plans--Power to the Patient," a mimeographed paper, p. 15.

poor planning by the patient and his family. The nurse is in a position to share her goals with the patient and to clarify or reinforce the information that the patient has obtained. To do this, the nurse needs to be aware of the information the patient does have, emphasizing the need for open nurse-patient communication as well as intra-health care team communication.

The focus of care in the extended care facility is on rehabilitation of the patient. Such a focus requires that the patient be ready, psychologically as well as physically, to approach the rehabilitation tasks. Some of the patients interviewed in this research were not ready to do this, for their energy was still being directed toward the survival aspect of their illness. One assumption upon which this study was based was that the extended care facility patient would no longer be concerned with survival. This assumption was shown to be not always a valid assumption. Some patients were indeed focusing on the rehabilitation tasks; some were not. The concern with survival, rather than rehabilitation, was an unexpected one. Some patients' concern was with non-illness-related tasks, again drawing their energy away from the rehabilitation tasks.

For the patient to benefit from the nursing and rehabilitative care, the nurse must be aware of the patient's focus. She can detect clues in the patient's behavior or conversation that suggest he has other than illness concerns. The patient can then be assisted in his efforts to resolve these concerns. It was obvious that the patient used the hospital personnel as he saw appropriate, based on his own definition of the role of that health care worker. The nurse, in an extended care facility, is in a position to alter the patient's definition of her role through her own actions or communications.

The importance placed on the home by each of the patients offers considerable thought for nursing. The patient set his goals and some of his time expectations with reference to that perception of home. The tasks the patient selected were related to his perception of home and the goals he set. While other factors did influence the tasks selected by the patient, they were frequently modified by the goals or the perception of home, suggesting this triad of home-goals-tasks was the focal point of the patient benchmarking process. For this reason it is worthwhile to focus on this relationship.

The interrelatedness of the patient's goal and his perception of home on the benchmarking process is probably best demonstrated when the patient has either no goal or no perception of home. For example, Mrs. Thomas knew what her home was like, but she had no specific goals; all she knew was that she wanted to go home. When asked what she felt were the requirements for going home, she replied, "I think the doctor wants me to get rid of the shortness of breath. . . . But if it doesn't go, then I'll have to have the oxygen at home." She was unable to identify few benchmarks. Frances Crown also lacked the functional goal orientation of most of the patients. She wanted to go home, but had no goal beyond that. She also used a physician-initiated requirement to go home, that of getting a live-in housekeeper.

The patient's perception of the home influences how he views his progress. If a patient has determined his goal to be that of going home to garden, then he sets the tasks for that end; he may also set a time frame for his preparatory period. If the nursing goal for this patient is also his return home, then the patient progressed, at least ideationally, toward that goal. That is, he anticipates and rehearses for living at home. If the nursing and medical goal for this patient changes because his physical or mental progress does not proceed as anticipated, he may be discharged to an intermediate care facility. The patient's ability to handle this change of plans is based on the preparation he is able to make. The patient faced with a sudden change in plans must change his preparatory perspective, yet he may not have the references to make this change. He then is likely to be unable to set new or modified goals and time references. It is here that the nurse can assist the patient by providing the patient with these new references or by facilitating their provision by other persons.

The patient who is going home is probably the most independent patient in the extended care facility, and so requires less physical care from the nurse. This patient, however, does require the support and assistance of the nursing staff to successfully anticipate and plan for his return home, as was demonstrated by the patient interview data.

The data from this study have implications for fields other than nursing. The use of the theory of status passage as the basis for this study provided the researcher the opportunity to validate, modify, or expand that theory. The movement from illness to wellness is a transitional status, marked officially by discharge from the hospital. This physical movement is obvious and well delineated. The patient defined the end of institutionalized status as his arrival at home, also a well delineated occurrence. The change in the conceptualization of the patient, however, was not well delineated; in fact, it was important that the patient retain a transitional status in respect to his illness disabilities so that he might continue to pursue his rehabilitation program once out of the institution. This suggests that while a rather artificial status passage, that of leaving the hospital, is operant, the predominant status passage must be kept in a transitional phase. The desirability of this passage is due to the very nature of its transitional properties and the effects that anticipation of an improved functional status has on the patient.

The movement out of the hospital, while an arbitrary status passage, defines the spheres of major responsibility for the passagee (patient) and the passage controller (health care giver). This raises questions as to the mechanisms of control relinquishment. Who assumes the responsibility for maintaining the patient in the transitional status once he leaves the extended care facility? Does anyone assume this responsibility? Once the official passage to non-institutionalized status is made, does the patient maintain a transitional philosophy, or does he accept the new status as non-patient and so assume a relatively static position? It must be remembered that no status is truly static; however, the end point of some passages indicates a level of achievement that is definable; for example, graduation from high school, or achievement of inactive tuberculosis. Discharge from the extended care facility does not indicate such a level of achievement, although it marks the termination of a controlled patient care situation. These questions suggest the need for further close examination and application of the theory of status passage, that this theory may be further developed and validated.

Suggestions for Further Research

As with any research study, many new questions were raised. Several of these have implications for nursing and so warrant further research by nurses.

1. The use and meanings of the nebulous terms used by the health care personnel created problems as well as having value for the patient and the nurse; for example, the words "soon," "stable," and "doing well." What are the meanings, uses and values of these words to the patient, his family, and the nursing staff?

2. The effect of a change in anticipated outcome of hospitalization was suggested as an occurrence that may be difficult for a patient to handle. What are the reference points for a patient who has such a change in plans? How does he handle this transition?

3. The actual role, or roles, of the nurse in the extended care setting has not been well delinated. The nurse in this study suggested she was a facilitator of the patient's desire to progress; the patient suggested a variety of roles, such as the controller of progress, or as the helper. A question in this area may be valuable to those preparing nurses to deliver and manage patient care in the extended care facility; for example, What are some of the potential and actual roles of the nurse in the extended care facility?

4. The sample selected for this study represented a variety of socio-cultural backgrounds. There was no apparent differentiation between these groups. A study designed to accent such differences may indeed demonstrate this to be a factor in benchmark determination.

5. The patients in this study represented one homogeneous age group, seventy to seventy-nine years of age. Would a change in the age group of the patient-subjects studied result in different benchmark content and timing?

6. The data in the study reported here indicated that there were distinct patient rehabilitation styles. A study designed to assess this factor would provide a more complete answer to this question.

7. The theories of the content and timing derivation of the benchmarking process, as suggested in this paper, need to be tested for further validation and refinement.

Summary

The factors influencing the benchmarking process of the patient were divided into three major areas: the home area, the life area, and the hospital area. These three areas interacted to determine the tasks the patient saw as necessary for his discharge. Benchmarks were derived directly from the tasks selected. The staff benchmarks were similarly derived from the tasks to be accomplished by the patient. These tasks, however, related to the staff goal for the patient. It was the goal that was then modified by the major areas, rather than the tasks. The nursing goal was greatly influenced by the professional goal and philosophy of the nursing unit.

The temporal aspect of the patient benchmarking process was derived from a number of sources, the most common being the comments of the health care team, that is, the hospital area. Each patient constructed his own time frame. The nursing staff assessed the patients against a preset continuum, but did not have a time frame for this continuum.

Implications for nursing included the need for communication between the health care team and the patient to produce more congruent and related goals, which involve both the patient and his family. In order to achieve the stated goals, a shared plan of action is necessary. An understanding of the patient's perception of the home situation is vital to the nurse, for the patient sets his goals and tasks in reference to this perception.

Suggestions were made for further nursing research.

CHAPTER VIII

SUMMARY

Following the passage of Medicare legislation, the health care field focused on the extended care facility, a new level of care created by this legislation. Extended care refers to an extension of the services of the hospital, centered around the need for skilled nursing care, rather than an extended time period of receiving care. Research focusing on the extended care facility has, to date, dealt with the fiscal and managerial aspects of this facility. The patient in this facility is there becuase he requires continued skilled nursing care, thus the nurse can be a vital and influential part of the extended care facility.

The patient in an extended care facility tends to be an elderly person for a number of reasons: (1) the extended care facility was introduced as a part of Medicare, health insurance for the elderly; (2) the elderly have decreased healing abilities and so often require extended hospital care for illnesses or surgical procedures that would be short-term illnesses for younger persons; and (3) illnesses that are common to the aged are frequently chronic, or long-term, illnesses.

The patient moves from this facility to other health care facilities or to his home, as fits his needs. Terminal patients may stay on the unit until their death. For the elderly person in the extended care facility, movement home may necessitate a change in life style. It will necessitate a movement to a new status, that of non-institutionalized or non-hospitalized status. To explore the anticipation of this status passage, the following research question was developed: What are the similarities and dissimilarities in the content and timing of the status passage benchmarks, in the passage from institutionalized to non-institutionalized status, as reported by the nursing staff and the older patients on one extended care facility? Content was defined as the event that was perceived and reported or identified as a benchmark by the interviewee. Timing was defined as the point at which the subject perceived the stated benchmark.

To gain the answers to the research question, the field method of study was selected. Elderly patients and the nursing staff of the participating facility were interviewed using a semi-structured interview guide. The interviews were tape-recorded. The interview guide was modified during the course of the data collection as new areas of concern surfaced, or previous areas proved irrelevant. The patient was interviewed several times during his stay on the extended care facility. These frequent interviews allowed the interviewer to maintain continuity with the patient as well as to encourage some of the more reticent patients to share their experiences. Each patient was asked to designate a nurse who would be interviewed about the same topics as was the patient. The nurse was interviewed after the patient had been discharged. A total of twelve patient-nurse interview sequences were completed.

The interview data were examined for the timing and content aspects of the benchmarks; these properties were then categorized. Data collection was terminated when new categories ceased to appear with any regularity.

The content categories that developed were: mobility, progress toward normalcy, reduction of pain, eating, sleeping, change of interest, change of attitude, development of confidence in the patient, and indicators of regression. These benchmarks were related to the tasks the patient, or nurse, felt were necessary to the patient's discharge. The patient related goals that were functional in nature; the nursing staff related goals that reflected the professional goal of the extended care facility, rehabilitation of the patient. The category of benchmarks most frequently reported by both the patient and the nurse dealt with mobility of the patient. Not all the benchmarks indicated progression; both the patient and the nurse reported regressive benchmarks. These were a source of frustration to the nurse; for the patient they were only a delay in the path toward his goal.

The patient reported benchmarks occurring in both the acute care and the extended care setting. Those occurring in the acute care setting tended to be dramatic physiological changes which were associated with a specific time reference. The benchmarks occurring in the exteded care facility came from a variety of content categories, and were seldom associated with a specific timing. Progress in the extended care setting was gradual, the steps overlapping.

A factor that appeared to be influential in the selection of benchmarks by both the patient and the staff member was the individual's perception of the home situation. The patient perceived the home to be a positive, supportive environment. It represented financial security, personal security, individuality, and hope. The nursing staff perceived the home to be a dubious resource. The physical setting and the family relationships were important factors in the staff assessment of the home as a resource. The staff did not always have adequate information on which to base this assessment for information was normally obtained from the patient and his family, who shared a biased home perspective.

A second important factor was the patient's rehabilitative style, that is, the way in which he approached the tasks related to his illness. Three distinct styles were noted: (1) the initiator--the patient who set his own goals and initiated tasks to achieve these goals; (2) the assumer--

the patient who did not initiate such goals and tasks, but who did assume the responsibility for his own progress when such an action was suggested by a member of the health care team; and (3) the acceptor--the patient who accepted the goals and tasks set by the health care team. A low level of available energy and preoccupation with concerns other than illness tasks led some patients to accept criteria for the patient's discharge set by the health care team instead of setting his own criteria.

Two general themes emerged from the benchmarks reported by the patient. These were survival and mastery. These two major categories of benchmarks could then be subdivided into biological and personal survival and mastery. Survival benchmarks did not always relate to the presenting illness, mastery ones did. The nursing staff benchmarks related to biological mastery. The patient derived his benchmarks from a variety of sources. These sources were grouped into three interacting dyads: (1) other concerns--illness concerns (the life area); (2) goals--home (the home area); and (3) rehabilitation style--health care team (the hospital area). The product of each of the dyads then combined with those of the other dyads to determine the tasks to be accomplished prior to discharge. The patient's goals were but one of the influencing factors.

The nursing staff derived their benchmarks from the tasks to be accomplished; however, these tasks were drawn directly from the goals for the patient. The goals were derived from a number of sources, the primary influence being the professional goal of the nursing unit.

The time perspective for the rehabilitative process was, for most of the patients, an indiscrete open-ended frame. Time cues were derived mainly from the health care team's statements, although some patients did incorporate parts of previous experiences into their scheme. The time frame constructed by the patient was generally inaccurate. The nurse developed her time perspective from the health care team and her previous experience, rather than from the patient's experience. The nurse's temporal perspective, as with the benchmarking perspective, was drawn from the hospital area; the patient's was drawn from all three areas: hospital, home, and life.

These patients were going home, and so were comparatively independent; they did express needs other than the need for physical care. These needs could have been assessed and/or met by the nursing staff. The patient who had concerns other than his illness, or who was struggling with survival-oriented tasks, needed assistance to resolve these concerns before he could turn to the mastery concerns that formed the basis for the nurse's goals. If the nurse was able to assess this, she could then have assisted the patient to complete his survival-oriented tasks and progress to those tasks that dealt with mastery of his illness.

Finally, suggestions for further research were made, based on the findings of this study, and new questions that arose during the course of the study.

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APPENDIX A

CONSENT FORMS

Consent to act as a subject for research and investigations - Patient.

Consent to act as a subject for research and investigations - Staff

CONSENT TO ACT AS A SUBJECT FOR RESEARCH AND INVESTIGATIONS
(Patient)

Subject's Name______________________________ Date__________

1) I hereby authorize Elizabeth Nichols to conduct the following investigation:

   A minimum of two tape-recorded interviews to discuss the experiences I have had in the hospital, or outside of the hospital, that relate to my preparation for discharge from this extended care facility.
   A similar interview will be performed with a member of the nursing staff. This person is to be designated by me (the subject).

2) The investigation has been explained to me by Elizabeth Nichols.

3) I understand that the investigation described in Paragraph 1 involves the following possible risks and discomforts:

   > Introduction of a topic that is difficult, or uncomfortable for me to talk about;

   and that the following benefits of the investigation are:

   > a greater knowledge of the patient experiences in the extended care facility. This is not a direct benefit to me, but may have implications for the care of other patients.

4) I understand that Elizabeth Nichols will answer any inquiries I may have at any time concerning the investigation.

5) I understand that I may terminate my participation in the study at any time, and that, owing to the scientific nature of the study, the investigator may in his absolute discretion terminate my participation at any time.

6) I understand that I will not be reimbursed for my participation in this study.

Subject's Signature____________________

Witness:______________________________

CONSENT TO ACT AS A SUBJECT FOR RESEARCH AND INVESTIGATIONS
(Staff)

Subject's Name________________________________ Date__________

1) I hereby authorize Elizabeth Nichols to conduct the following investigation:

A tape-recorded interview to explore the basis by which I assess a specific patient's progress toward discharge to his home. A similar interview was held with the patient.

2) The investigation has been explained to me by Elizabeth Nichols.

3) I understand that the investigation described in Paragraph 1 involves the following possible risks and discomforts:

None anticipated;

and that the following benefits of the investigation are:

a better understanding of the basis of patient assessment.

4) I understand that Elizabeth Nichols will answer any inquiries I may have at any time concerning the investigation.

5) I understand that I may terminate my participation in the study at any time, and that, owing to the scientific nature of the study, the investigator may in his absolute discretion terminate my participation at any time.

6) I understand that I will not be reimbursed for my participation in the study.

Subject's Signature_______________

Witness:__________________________

APPENDIX B

INTERVIEW GUIDES

Patient interview - initial interviews

Patient interview - pre-discharge interview

Staff interview

PATIENT INTERVIEW - INITIAL INTERVIEWS

1. Introduction of investigator.
2. Purpose of interview, sequencing of interviews.
3. Patient's consent.
4. Collect orientation data:
   a. What is patient's name?
   b. Location of the patient.
   c. Length of hospital stay.
5. When does the patient anticipate going home?
6. When did he first determine he would return home?
7. What event is associated with this determination?
8. Can you tell me something about hour home?
   a. Who do you live with?
   b. Did they in any way affect your self-assessment?
   c. What sort of accommodation do you have?
   d. Has this affected your consideration of going home?
9. What sorts of plans have you made for your discharge, if any?
10. On what have you based these plans? Who has assisted you, if anyone?
11. If plans are made at first interview, do you assess your progress against these plans?
12. What do you see as the requisites for you to return to your home? Is there a sequence to these? How do you determine if you have met these?
13. What tells you that you are getting better?

PATIENT INTERVIEW - PRE-DISCHARGE INTERVIEW

1. When will you be going home?
   a. When was this decided?
   b. Who decided this?
   c. What was the basis for this decision?

2. Have you noticed any changes in yourself since you arrived on the extended care facility?
   a. What are they?
   b. When did they occur?

3. Are you ready to go home?
   a. What tells you this?

4. Name a nurse for interview.

STAFF INTERVIEW

1. Introduction of investigator.
2. Purpose of interview.
3. Obtain consent.
4. What were the goals for the patient?
    a. Were they your goals? If not, whose were they?
    b. How were these goals set?
5. Were these goals attained?

    Clarify.
6. What indicated this accomplishment?
7. Were there other goals? What?
8. Were they attained?
9. How could you tell?
10. What indicated that the patient was ready to go home?
11. What indicated that the patient was getting better (or not)?
12. Were the patient's accomplishments associated with a time (or an event)?

COPY 1