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Life satisfaction as perceived by the elderly home care client

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Life satisfaction as perceived by the elderly home care client

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San Jose State University, 1992

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LIFE SATISFACTION AS PERCEIVED BY THE
ELDERLY HOME CARE CLIENT

A Thesis
Presented to
The Faculty of the Department of Nursing
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

by
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August, 1992

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ABSTRACT

LIFE SATISFACTION AS PERCEIVED BY THE ELDERLY HOME CARE CLIENT

by Carolyn Parsons

The purpose of this study was to examine whether there was a change in life satisfaction after the initiation of home care in the chronically ill elderly client. The conceptual framework for the study was developed from concepts from Erickson, Tomlin, and Swain's Modeling and Role-Modeling theory (1983) combined with Donabedian's Health Potential Model (1972).

A convenience sample of elderly home care patients, ($N=20$), living independently in their own homes were surveyed pre- and post-home care intervention, by interview, with the Quality of Life Index (Ferrans & Powers, 1985). Although not statistically significant, results showed a minimal increase in total life satisfaction scores, and in all subscales except family following a 6 weeks period of home care. Data indicate that the use of a life satisfaction assessment tool during home care intake visits can be useful for the Registered Nurse casemanager for planning of patient care. Life satisfaction assessment at the time of discharge from home care can be useful as an outcome measure of care.

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Chapter 1

INTRODUCTION

The growing number of elderly persons in the population is necessitating extensive changes in the type and extent of services necessary to support this group and their families. Of the current 26 million elderly, it is estimated that one-third, or approximately 8 million persons, need some assistance with the tasks of daily living (Cantor, 1989).

Results of the 1990 National Health Interview (U. S. Bureau of Census, 1991) state that 28% of Americans over age 65, living alone, assess themselves to be in poor health. The old-old population, comprised of those over 85 years, is the fastest growing segment of the group. This group, requiring the most extensive support, comprises about 5.2 million people (U. S. Bureau of Census, 1991). In the current decade, the number of individuals between 75 and 84 years and older is expected to increase by 20% (Green, 1989).

Given a choice, when health care and personal assistance are needed, most elderly people elect to remain in their own homes. Although the frail elderly in the community are most often cared for by kin (Cantor, 1989), there are times when the burden of care becomes too great for family members, or no family member is available. Agencies are hired to provide caregivers, nursing support, and other services as determined by the needs and wishes of the client. These

arrangements may remain in place for a limited amount of time, until a specific medical problem is resolved, or may be carried out for the remainder of the life of the recipient (Blanchard, Guenveur, & Ryan, 1988; Green, 1989). Approximately 25% of disabled elderly living within the community receive some type of in-home service (Cantor, 1989).

Although surveys have shown that elders in need of care prefer to remain in their own homes, elders have not been questioned as to the problems inherent in the actual situation of having unfamiliar, paid, care providers intermittently entering their homes and taking charge of some aspects of their lives. The elder in need of assistance is forced to make choices and decisions concerning his or her life, often while in a crisis situation. Elders may be torn between their desire to be independent and their need to be dependent upon others.

In the early 1970's, researchers began questioning the appropriateness of institutionalization of the elderly (Bell, 1973; Kaplan, 1972; Shanas, 1971). Bell argued that a comprehensive long-term health care policy was indicated to include service delivery approaches aimed at maintaining dependent older people in their homes. Palley and Oktay (1989) stressed the need for a national family policy to provide a variety of community and social services for the

chronically ill, older population on a systematic basis. The purpose of such services would be to assist families to care for elderly family members within their own homes.

Community based, home care has been investigated in a number of studies (Kane & Kane, 1980). However, little is known about the effect that home care has on the quality of life of the elderly. Studies have focused mainly on the cost-effectiveness of community care as an alternative to institutionalization. Although, in long term care, it was found that it is more costly for the elderly to be cared for in their homes, studies have demonstrated some improvement in quality of life in those that remained at home (Green, 1989). Quality of life was identified as a favorable client outcome in an evaluation study of community based, long-term demonstration projects (Berkeley Planning Associates, 1987). The "Black Box" of Home Care Quality (Sabatino, 1987) report issued by the American Bar Association Commission on Legal Problems of the Elderly, was presented to the U.S. House of Representatives. One conclusion drawn in the report was that quality of life, while different from quality of care, is fundamental to a patient's well-being and to the philosophy of in-home care.

If it is to be meaningful, service must not only be available, but also of satisfactory quality to those receiving it. Recently, research agendas have been published

calling for development and adaptation of methods for assessing quality of home care and the identification of applicable outcome measures (Green, 1989). One of the identified outcome measures (Katz, 1987; Ware, 1987) for assessing quality, in need of further research and development, is general well-being as a component of a multidimensional definition of health (Ware, 1987).

Quality of life is an organizing concept for all those who work toward improving conditions of life and for practitioners who work to provide service programs (George & Bearon, 1980). Home care nursing organizations are now attempting to develop methods to evaluate life satisfaction as an outcome measure of nursing care (Green, 1989). Knowledge of areas of life satisfaction affected by the initiation of care can provide the nurse with guidelines for easing the transition from independent to assisted living. Use of these guidelines could prove to be very beneficial to the client, the family, and the caregiver.

The Problem

The growing number of elderly people in the population is bringing about the need for changes in the type and extent of services necessary to support this group and their families. Given a choice, most elders elect to remain in their own homes when assistance is needed.

It is commonly known that a significant group of the elderly population reject all or some services that are offered to them, even when there is no charge for those services (Haug & Ory, 1987). Reasons for refusal or cancellation of services are often not discussed by the elder or explored by the nurse. Little research has been done concerning the relationship of acceptance of health care to the perceived life satisfaction of the elderly client. It is not known whether the initiation of home care changes life satisfaction in the elder, and if so, what the nature and direction of that change might be. It is also unknown whether some domains of life satisfaction might be affected more strongly than others at the time that home care is initiated.

If it is to be meaningful, home health care of the elderly must include more than provision for physical needs. Nursing is now mandated by current demographics and research agendas to research life satisfaction and to establish methods which can be used to evaluate life satisfaction as an outcome of home nursing care.

Purpose of the Study

The purpose of this study was to investigate the effect of the initiation of home care on life satisfaction of the elderly client, and to determine if there are common areas of life satisfaction which are altered as independent living

is interrupted and often terminated. The following questions were investigated:

1. What is the impact of the initiation of home care on life satisfaction as determined by The Quality of Life Index (Ferrans & Powers 1985), upon the elderly?
2. Are there common areas of satisfaction, as determined by The Quality of Life Index, which increase or decrease as independent living is interrupted or terminated?
3. Is the Quality of Life Index useful to nursing as a tool to measure life satisfaction outcome of home care of the elderly?

Definitions

For the purpose of this study, the following definitions were applied:

1. Elderly includes those adults age 65 and older (Christ & Hohloch, 1988).
 2. Initiation of home care is the instigation of a complex and interrelated array of health, health-related, and social services designed to provide preventive, therapeutic, rehabilitative, supportive, and maintenance care for individuals who have chronic physical or mental conditions. These chronic conditions impair the individual's ability to function at his or her own optimum level of mental, physical and social functioning (Blanchard, Guenveur, & Ryan, 1988).
-

3. Life satisfaction as measured by the Quality of Life Index is a person's sense of well-being that stems from satisfaction or dissatisfaction with the areas of life that are important to him/her (Ferrans & Powers, 1985).

4. Outcomes represent the results of efforts of all those who have been involved in the patient's care. Evaluation of outcomes is based on the physiological, psychological, and social functioning of the patient (Donabedian, 1987).

Summary

There is an assumption within society in general, among adult children of elders and in the nursing profession, that elders will be happier in life if some of the burdens of their existence are lifted from them and are assumed by others who care for them. The nurse operates under the premise that quality of care is better for all patients when the nursing process is employed. This process includes the identification of patient problems and needs and provision of the necessary interventions to assist with resolution of those circumstances if possible. If resolution is not possible, interventions are aimed at enhancing patient adaptation to their situation and providing needed support. Not all nursing theories include as part of the nursing process, consultation with the patient to identify his or her perception of the problem and his or her priorities and

concerns. This study assists clarification of what values constitute the elder's sense of well-being and provides information on one means of assessing the state of life satisfaction of elderly home care clients.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

This section presents an overview of two conceptual models: Erickson, Tomlin, and Swain's Modeling and Role-Modeling (Erickson, Tomlin, & Swain (1983) and Donabedian's Health Potential Model (Donabedian, 1987). Concepts used to guide this study will be discussed to address life satisfaction as a component of nursing assessment and intervention and as an outcome measure of home nursing care.

Related literature on both the subjective and objective components of life satisfaction will be reviewed. Although several studies have focused on the elderly, few have addressed life satisfaction as an outcome measure of home care.

Conceptual Framework

Erickson, Tomlin, and Swain's Modeling and Role-Modeling

Erickson, Tomlin, and Swain (1983) link basic need satisfaction to completion of developmental tasks and object attainment and loss. These authors state that an individual's potential for mobilizing coping resources is directly associated with the person's need satisfaction level. Adaptation occurs as the individual responds to internal and external stressors in a health directed manner. The nurse is seen as a facilitator in assisting the client to

identify, mobilize, and develop his or her own strengths, resources and growth to facilitate adaptation.

Three major concepts of Erickson, Tomlin, and Swain's theory are applicable to this conceptual framework. They include the nurses' tasks: (a) to seek to know and understand the client's personal model of his or her world, (b) to appreciate the personal model's value and significance for that client from the client's perspective, and (c) to plan and implement interventions which encourage and facilitate growth and development at the patient's own pace and within his or her own perception of the world.

Modeling and Role-Modeling theory as developed by Erickson, et al., 1983) supports Campbell and Converse's (1976) concept that life satisfaction is a subjective factor, necessarily related to the quantifiable conditions of a person's life. The theory presents a model to assist nurses in understanding the individual's perceptions and to assist clients in coping with life's changes.

In addition to the need to administer care from a perspective of priority of what is important to the client the quality of that care, from a patient perspective must also be evaluated. Donabedian (1987) provides a model which recognizes the importance of consideration of quality of life as a component to the provision of health care.

Donabedian's Health Potential Model

Donabedian's (1987) concept of outcome evaluation includes the assertion that it is necessary to measure quality of life during the years that ministrations by health professionals occur. To determine the weaknesses and strengths of a health care system at the individual level, the patient-practitioner transaction must include the recognition that each person decides what is worthwhile in life, and at what point mere survival has ceased to be meaningful. At the collective level, the determinates of quality of care are dependent on what constitutes quality of life, and should be a determining factor in planning for the client's care. Measures of standards of care should embody the general values of society. Donabedian (1987) states that "research that would result in a better understanding of the professional-client relationship and the values attached to specified aspects of it" (p. 4) is needed.

Application of Erickson, Tomlin, and Swain's Modeling and Role-Modeling and Donabedian's Health Potential

The components and concepts making up life satisfaction vary, and are both individually and collectively determined. Although perception of life satisfaction may be unique to each individual, some components may be common to a majority of the nurse's elderly clients, since those clients share some common life experiences. Knowledge of what constitutes

Figure 1. Life Satisfaction Perceptions of the Home Care Client

these components, and familiarity with tools which can be used to elicit information on life satisfaction from clients, will prove helpful to the nurse as care is provided to the geriatric patient. Figure 1 indicates the progression of the home care client from a state of stress towards equilibrium and life satisfaction enhancing outcomes. This progression is facilitated by the registered nurse's intervention which has been planned with the patient and takes into account his level of development, his strengths and his resources.

Literature Review

The importance of life satisfaction as it relates to well-being of persons of all ages has been acknowledged by many writers and researchers. There is a wide range of opinion as to what factors in a person's life determine perceived satisfaction, or the lack of, and how to measure that level of satisfaction. Little has been written as to the effect of the influence of nursing care on the life satisfaction of elders.

Life Satisfaction

Campbell and Converse (1976) define life satisfaction in terms of satisfaction of needs, and states that "satisfaction is a psychological experience, and the quality of this experience may not correspond very closely to these external conditions of life" (p. 18). They state that life

satisfaction is a fluctuating determination made by the individual. Campbell and Converse identified self-esteem and a feeling of control as critical components of life satisfaction, and state that in any situation, the direction of satisfaction cannot be predicted. They conceptualized an "accommodation affect" (p. 209) to explain their finding that perceived satisfaction increases as one becomes increasingly accommodated to a situation, even though the gross features of the situation remain the same. They found there was a decline in reported global happiness with advancing years, but increased satisfaction in all domains of life, with the exception of health. They theorized that satisfactions are tied to expectations, and although aspirations decline slightly with age, at about 85 to 90 years, aspirations intersect with ratings of the current situation, producing perceptions of satisfaction (p. 53).

Campbell and Converse (1976) state it may be necessary to distinguish between a satisfaction which is associated with an experience of rising expectations and one which is associated with declining expectations. Feelings of satisfaction may be of success or of resignation (p. 56).

Satisfaction with a domain of life as expressed by an individual is seen by Campbell and Converse as dependent on his or her evaluations or assessments of various attributes of that domain. How a person assesses a particular attribute

of a specific domain is considered to be dependent on two things: how he or she perceives the attribute and the standard against which he or she judges that attribute. The person's assessment may derive from the following basis: aspiration levels, expectation levels, equity levels, reference group levels, personal needs, and personal values. People encountering events which change their life situations in a particular domain are more likely to show change in that specific domain and in their global reports than those people whose situations have remained stable. However, the direction of satisfaction cannot be predicted.

The concept of internal locus of control as a determining factor in well-being has been substantiated by several researchers. Reid and Ziegler (1978) have carried out nine separate investigations in which they obtained positive correlations ranging from .32 to .54 between locus of desired control and life satisfaction. Palmore and Lukart (1972) found belief in internal control to be the second best predictor of life satisfaction for 60 to 71 year olds, and the third best predictor for their total population. Wolk and Telleen (1976) found in a study of 129 ambulatory residents of two retirement settings, that life satisfaction was higher in low constraint, high autonomy settings than in high constrain settings. Burckhardt (1985) in a study of 94 patients with Melanoma identified the

variables of positive self-esteem, internal control over health, perceived support, and low negative self-attitude as contributing to higher life satisfaction.

Life Satisfaction in the Geriatric Population

Life satisfaction in the elderly has been widely researched, with low income, poor health, and lack of social interaction shown to be related to lower perceived quality of life (Kozma & Stones, 1978; Larson, 1978; Spreitzer & Snyder, 1974). The Life Satisfaction Index (Neugarten, Havighurst, & Tobin (1961) was one of the first instruments developed specifically for use on older populations. The index was refined in a later study (Wyllie, Wood, & Sheafor, 1970) and examined by Wyllie (1970) for use as a program impact criterion. The Wyllie study attempted to determine the impact of the program upon the morale of 131 elderly subjects who participated in a volunteer service program. Morale was found to increase from 18.92 to 20.65 in program participants and, within the same time period, to decrease from 18.58 to 16 in non-program participants. Both life satisfaction indexes are multidimensional and have been criticized for providing a single score which fails to distinguish the relationship between underlying dimensions, but have usually been tallied to indicate that a single score represents a single dimension. The single score fails to distinguish the relationship between underlying discrete

dimensions and independent variables (George & Bearon, 1980).

Chappell and Badger (1989) examined ten common indicators of social isolation and assessed which, if any, related to subjective well being in the elderly. They found in a sample of 743 individuals, that the single indicator of having no confidants, and the combined indicators of living alone and being unmarried, were related to both global happiness and quality of life. Reich and Zautra (1984) conducted a series of studies on events and life satisfaction and concluded that events over which people have personal control correlate positively with positive aspects of life satisfaction, and events which are out of a person's control correlate with negative aspects. They assert that the study of events and life satisfaction requires attention not only to the event itself, but to the responses people make to events and the degree of satisfaction felt with the outcome of those responses. Hulsman and Chubon (1989) compared the life satisfaction of 20 disabled clients in a community long-term care program with that of 20 clients residing in a nursing home. Mean scores were equal for the two groups, but the distribution of scores was different. The researchers recommend qualitative studies that elicit participants' definitions and descriptions of factors which enhance or detract from life satisfaction be carried out.

They state that the information obtained would be useful in planning nursing interventions. Parsons, Cox, and Kimboko (1989) examined the quality of the relationship between elder's satisfaction, elder and caregiver, and the objective level of the elder's functioning. They found the elder's level of satisfaction to be significantly correlated with the components of the quality of the relationship with the caregiver and not significantly correlated with the functional status of the elder.

Life Satisfaction of Patients

Life satisfaction, as it relates to patients, has been examined from both an objective and a subjective point of view. In the medical literature, the terms quality of life, health status, and functional status have often been used interchangeably. It is widely agreed that lack of a specific definition and disagreement over the desired components of life satisfaction measurement have hampered research and conclusions in this area (Bergner, 1989; Campbell & Converse, 1967; Ferrans & Powers, 1985; Grossman & Weinger, 1988).

The proportional contribution of the specific dimensions contributing to life satisfaction has not been widely investigated. Addition of satisfaction scores produces an inaccurate representation of total life satisfaction since values of individual domains differ from one individual to

another (Campbell & Converse, 1976; Ferrans & Powers, 1985). In assessing satisfaction with life, Ferrans and Powers recommend the use of a measurement tool which includes a mechanism for the adjustment of scores so that importance of each item can be taken into account.

Researchers assessing life satisfaction of elders in long term care situations have examined a number of different dimensions, and defined life satisfaction in many different ways. However, an extensive literature search yielded few studies which specifically address care within the elder's own home.

Begge, Bloom, Blenknew, Downs, and Nielsen (1972) examined the effects of an organized program of home health aide services on 100 patients discharged from a geriatric rehabilitation hospital. Services of the home health aide were of both a personal and housekeeping nature. Pre- and post-testing on a 4 point Contentment Index, found a significant favorable change in contentment in the service sample compared to the control group. In a study of 124 elderly persons residing in board and care homes, Faulk (1988) found that once lower-level, material needs were met, satisfaction scores increased significantly as higher-level social integration needs were met. Pearlman and Uhlmann (1988) matched 47 community residents with 47 nursing home residents and found that self-perceived life satisfaction

ratings were similar between the two groups, although there were differences in which domains the two groups associated with life satisfaction. Nursing home residents perceived housing, finances, health, and interpersonal relationships to be associated with global life satisfaction. Global life satisfaction was defined as "their personal situation" (p. 319). Community residents perceived health, disability, finances, anxiety, and interpersonal relationships to be associated with life satisfaction. Hiner, Weinberger, and Darnell (1988) found, in a life satisfaction and health status study on 257 public housing residents living alone or with another person, that the poor elderly, living alone, are not at greater risk for negative health outcomes or diminished life satisfaction than those living with another person.

In a review of the literature on correlates and components of subjective well being in the elderly, Okun and Stock (1987) and Larson (1978) recommended that human service providers should use subjective well being scales such as the Life Satisfaction Index A (Neugarten, Havighurst, & Tobin, 1961), the Philadelphia Geriatric Center Morale Scale (Lawton, 1975), and the Bradburn Affect Balance Scale (Bradburn, 1969) to assess the effectiveness of interventions designed for older adults and also for program evaluation. Subjective well-being refers to the

affective reactions of individuals to their life experiences along a positive-negative continuum (Larson). Okun and Stock concluded that: (a) correlations between objective life conditions and subjective well being are weak, (b) that it is important to assess the older persons' expectations, and how they are derived, (c) that positive and negative reactions may be modified by promoting satisfying daily event transactions, through involvement in decision making, and (d) by reduction of unrealistically high expectations.

Life Satisfaction in Nursing Research

Nursing has also defined life satisfaction in a number of different ways. Laborde and Powers (1980) rated life satisfaction on the Cantril Self Actualizing Scale (1965) in relation to past, present, and future life satisfaction. Young and Longman (1983) defined life satisfaction as "the degree of satisfaction with perceived present life circumstances" (p. 219) as measured on a 6 point scale. Lewis (1982) defined life satisfaction as a "composite score of the degree to which one has self esteem, a purpose in life, and minimal anxiety" (p. 113). Burckhardt (1985) defined life satisfaction as a composite score of the degree to which one perceives that life's quality is good, life is satisfying, that the individual has physical and material well-being, good relations with others, the ability to participate in social and community activities, and has

personal development, fulfillment, and recreation" (p. 13). Ferrans and Powers (1985) define life satisfaction as "a person's sense of well-being that stems from satisfaction or dissatisfaction with the areas of life that are important to him/her" (p. 16).

In the 1970's the federal government awarded a contract to the American Nurses Association to develop models of screening criteria to measure the quality and effectiveness of nursing care (Bloch, 1975). Early efforts were focused on physical health, survival, and cost (Bloch, 1975; Macstravic, 1988). Donabedian (1987) developed a model which was originally limited to physical health. He later enlarged his concept of outcome evaluation to include psychological and social functioning. Donabedian defines patient outcomes as "the results of the efforts of all those who have been involved in the patient's care" (p. 9).

Few studies have been done on life satisfaction as an outcome of nursing care and none of these studies used samples of the elderly population. A pilot study on life satisfaction and persons with melanoma (Young & Longman, 1983) found symptom distress and social dependency to be negatively associated with life satisfaction scores, and behavior-morale to be positively associated. In a study of 135 cancer patients, Padilla and Grant (1985) found that satisfaction with nursing care was significantly and

positively correlated with psychological well-being. They claim that the mediating variable of a perceived caring attitude by the nurse is an antecedent to perceived positive life satisfaction. Other nursing studies have shown the correlation of personal control and self-esteem with positive life satisfaction (Burckhardt, 1985; Lewis, 1982). A convenience sample of 20 nursing home residents and 20 community participants in a long term care program was found to have equal life satisfaction mean scores as measured by the Life Satisfaction Survey (Chubon, 1987). However, the distribution of scores for each group was very different, with 2 nursing home residents scoring more than 2 standard deviations below the mean and 1 community resident scoring 2 standard deviations above the mean. The research questions regarding life satisfaction remained unanswered due to the skewed distribution. The researchers concluded from the data gathered that, rather than life satisfaction assessment being based solely on objective factors, part of one's judgment of life satisfaction may stem from comparison of one's self with one's peers. Hulsman and Chubon (1989) state that life satisfaction may be an important outcome measure of programs aimed at prevention of institutionalization as well as a predictor of patient's adherence to treatment regimens.

Summary

The current research agenda calls for development of criteria to measure the quality of nursing care. This agenda combined with the expanded quality concept to include psychological and social functioning of individuals indicates the validity of the inclusion of life satisfaction as one criteria of nursing quality and effectiveness.

Current demographics of the elderly population and documentation of the need for greater support for the elderly and their families, substantiate the need for research on life satisfaction in those elders who remain at home with home with assistance.

The recent development and refinement of life satisfaction measurement tools has made such research meaningful. Research should be able to provide specific and crucial information applicable to the development of governmental, social, and professional policies for care of the elderly. Findings should also be useful to nurses practicing both in clinical settings and in the home.

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

This section provides information on the design of the study, and the methods used to collect and analyze data. Subject characteristics and selection, consents obtained, maintenance of confidentiality, and instruments used will also be discussed.

Design

This research was designed as a one-group pretest-post-test study using questionnaires to collect data. Participants were interviewed 2 times. The first interview took place at the time of admission to home care service. The second interview was conducted 6 weeks after the first interview. The period of 6 weeks was determined for two reasons: (a) a relatively short time period between survey and resurvey was chosen to minimize mortality effect, a major concern due to possible discharge from home care or death of participants; and (b) to give elders the opportunity to make the adjustment to having new persons take part in the routines of their lives.

A sample size of 20 was selected. This number was determined to be adequate to provide meaningful statistical results (Scott & Wertheimer, 1962) and an obtainable goal which could be completed in a timely manner.

Measurement

Subjects were asked to respond to each item on the questionnaire by choosing from a 6 point Likert-like scale the answer that came closest to how they felt. Half of the questions were designed to collect information on how satisfied respondents were with different areas of their lives. The remainder of the questions were designed to collect information on how important the same areas of respondents lives were to them. The possible range of response was from (1) "very unsatisfied" to (6) "very satisfied" and from (1) "very unimportant" to (6) "very important."

Scores were obtained as follows: First scores of each participant for each subgroup were determined by summing numerical responses to each question designated as being part of that particular subgroup. Then, to obtain a total score, all subgroup scores for a participant were added together. Following these procedures, in order to determine if some areas of satisfaction were more important to participants than others, importance of the various subscales of satisfaction were calculated according to the specifications of Ferrans and Powers (1985). The steps are as follows: (a) satisfaction responses were recoded to center the scale on 0 by subtracting 3.5 from the satisfaction response for each item, (b) item scores were adjusted by multiplying the recoded satisfaction score by the importance

score, item by item, (c) overall adjusted scores were obtained by summing all adjusted item scores. To prevent bias due to missing scores, the sum of the items were divided by the number of items answered. To eliminate negative values, 15 was added to every score to get the final score. The range possible for final overall quality of life score is 0 to 30.

The rationale behind this adjustment is that great dissatisfaction with an area of great importance would have a greater impact on total life satisfaction than great satisfaction with a very unimportant area. For example an elder who chooses a "very dissatisfied" (1) when asked "How satisfied are you with your family relationships?" and a "very important" (6) when asked "How important are family relationships to you?", would obtain an adjusted score of 3.5. An elder who chooses "very dissatisfied" (1) and "very unimportant" in response to the same questions would obtain an adjusted score of 2.5 for that item.

Subjects/Setting

The study took place in northern California in a geographical area made up primarily of small towns and rural agricultural areas. Although patients of record at the agency are reported to be about 5% non-Caucasian, all participants qualifying for participation in the study were Caucasian.

Participants were clients of a home health agency. In addition to receiving regular visits from registered nurses, some receive additional service from home health aides, social workers, and physical, occupational or speech therapists.

Clients of the agency were self, family, hospital, and physician referred. They were living at home and managing their activities of daily living and their health needs with the assistance of registered nurses and home health aides. Nursing visits varied in frequency from daily to once a month. Home health aide visit frequency varied from daily to twice a week. Each visit by registered nurse or home health aide was no more than two hours in length. The client's plan of treatment was developed and supervised by a casemanager who was a Registered Nurse.

A convenience sample of 20 elderly clients was used. A review of new admissions was done every 48 hours. Possible participation was limited to new clients, age 65 and over, living alone and having at least one chronic illness. Sample eligibility within this selected group was limited to those scoring at least 7 out of 10 correct answers of the Short Portable Mental Status Questionnaire (Pfeiffer, 1975; Appendix A). This eligibility was established to control

for the possibility of incorrect answers to the Quality of Life Life Index (Ferrans & Powers, 1985) from disoriented participants.

Consent/Confidentiality

Institutional Review Board, Human Subjects at San Jose State University approval was granted on April 9, 1991 (Appendix B). In addition, the investigator obtained a written consent from the General Manager of the agency (Appendix C) and each study participant (Appendix D). Consents were also obtained to use the Short Portable Mental Status Questionnaire (Appendix E) and the Quality of Life Index (Appendix F).

Confidentiality was maintained by several means. Each participant was interviewed without the presence of anyone else. Questionnaires were not marked with subjects' names. They were coded by number so that only the researcher was able to identify them by use of a master list. The list was kept in a separate locked file from the questionnaires. Collected data were kept in a locked file drawer in the researcher's home. The researcher coded the collected scores for the statistical analysis and gave numerical scores and assigned numerical subject codes only to the statistician. No information from the questionnaires was shared with

employees of the home health agency. Following completion of the study questionnaires were burned in the researcher's fireplace.

Data Collection

The questionnaire was administered by interview in the patient's home, on a day and time of his or her selection. An effort was made to assure that the participant was comfortable both physically and with the interviewer before proceeding with the questionnaire. In an effort to reduce participant stress and anxiety, and to enhance accuracy of response, participants were provided with a large print, visual representation of answer choices. The Likert-type scale answer choices of the Quality of Life Index (Appendix G) was duplicated on a 3 by 4 foot white poster board in 3 inch dark blue lettering. The poster was displayed at eye level for each participant and he or she was asked to read the responses prior to the start of the administration of the questionnaire. During the administration of the questionnaire, after asking the question, the interviewer pointed to each potential answer while reading the choices aloud. The participants responded verbally with the selected answer and the interviewer recorded his or her selection on the questionnaire. Since each of the elderly participants was able to read the large print, and had a visual reminder of the answer choices, possible error

due to poor eyesight, poor hearing, or poor memory for verbally stated choices was controlled.

Instruments

Two instruments were used to carry out the study. The Short Portable Mental Status Examination (Pfeiffer, 1975) was administered as a screening tool to determine mental ability of potential participants to comprehend and respond reliably to the survey instrument. This questionnaire was selected from a group of several potential mental status exams. Because it is included in the Older Americans' Resources and Services Multidimensional Functional Assessment Questionnaire (Duke University, 1978) it has been used effectively on a large number of elderly persons. It has sensitivity of 95% and a specificity of 88% for patients older than 60 years used as a screen for dementia (Pfeiffer, 1975). Validity testing done on community, clinic, and institutionalized elderly patients has shown correlation of the number of errors with years of education completed, as well as a high correlation with epidemiological survey data that no more than 10% of the elderly community resident population has organic brain disease. Findings of maximum numbers of errors were: (a) community residents 1.5 for approximately 28% of the population; (b) clinic patients 3 errors for 15% of the population; (c) institutionalized patients 9 errors for 12% of the population. Comparison of

data results with clinical psychiatric diagnoses of 133 patients showed a 92% agreement when scores indicated impairment and a 82% agreement when scores indicated either no or only mild impairment. Reliability studies performed upon 59 subjects showed test-retest correlations of 0.82 when carried out at four week intervals (Pfeiffer, 1975).

The scoring scale for the Short Portable Mental Status Exam goes from 0 to 10 errors. Scores are ranked in the following manner: (a) 0-2 errors Intact Intellectual Functioning, (b) 3-4 errors Mild Intellectual Impairment, (c) 5-7 errors Moderate Intellectual Impairment, (d) 8-10 errors Severe Intellectual Impairment.

The Quality of Life Index (Ferrans & Powers, 1985) (Appendix G) was selected for assessment of life satisfaction of study participants. The instrument was developed to "measure the quality of life of healthy as well as ill individuals" (p. 15). Two sections make up the questionnaire; one measures satisfaction with various domains of life, and the other measures the importance of the domain to the subject. Each section has 32 items which assess health care, physical health and functioning, marriage, family, friends, stress, standard of living, occupation, education, leisure, future retirement, peace of mind, personal faith, life goals, personal appearance, general happiness, and general satisfaction. The first

group of questions ask "How satisfied are you with....?". The second ask "How important is.....to you?". Subjects respond to each item on a six-point Likert-like scale ranging from "very satisfied" to "very dissatisfied" for satisfaction items, and from "very important" to "very unimportant" for the importance items.

Life satisfaction scores are determined by adjusting satisfaction responses for the importance responses. As a result, the adjusted quality of life score reflects not only satisfaction, but also how much an individual values each domain making up life satisfaction. The adjustment is accomplished by recoding satisfaction responses by subtracting 3.5 from the response and then multiplying the recoded satisfaction score by the importance score, item by item. This calculation reflects the value of each domain to the individual (Ferrans & Powers, 1985).

Validity has been established for the instrument through testing on graduate students ages 23 to 35 and dialysis patients ages 24 to 75. A total of 88 persons have been tested in these two groups. Content validity has been varied in both written and interview form. Criterion-related validity of 0.61, while acceptable, indicated some instability in the instrument. Test-retest reliability was tested at 2 week and 1 month intervals. Stability reliability was supported by test-retest correlations of 0.87 with a 2

week interval and 0.81 with a 1 month interval. Internal consistency was 0.93 with graduate students and 0.90 with dialysis patients (Ferrans & Powers, 1985). At the time of the index's use in this study, no research had been published using it with a sample which was exclusively geriatric.

Analysis Procedures

The variables analyzed included life satisfaction as an independent self-caring elder and life satisfaction as an elder with nursing assistance in the home. The variables controlled for by the selection and screening processes, included age, living with another party, and mental status.

Scores for each subscale included in the questionnaire and an overall life satisfaction score both pre- and post-survey were computed. Scores for mean overall life satisfaction scores, and mean scores for each subscale were then calculated and t-tests were performed to compare pre- and post-survey scores.

In order to determine if a change in life satisfaction occurred upon the initiation of home care, and the direction of that change, t-tests were performed on pre- and post care interview scores. These tests were then compared to each other.

The provision of a readable visual representation of answer choices, and the weighting of domains of greater

importance to participants helped to produce accurate, meaningful data for this study. The selection between a relatively large number of possible answers may have also contributed to accuracy by forcing the participants to consider their answers carefully and to distinguish between relatively subtle choices as they examined their lives.

Chapter 4

DATA ANALYSIS AND INTERPRETATION

This section provides a discussion and interpretation of data used in this study. After data were examined, life satisfaction scores were calculated pre- and post-home care intervention. The purpose of the study was to investigate the following research questions:

1. What is the impact of the initiation of home care on life satisfaction as determined by The Quality of Life Index (Ferrans & Powers, 1985), upon the elderly?
2. Are there common areas of satisfaction, as determined by the Quality of Life Index (Ferrans & Powers, 1985) which increase or decrease as independent living is interrupted or terminated?
3. Is the Quality of Life Index useful to nursing as a tool to measure life satisfaction outcome of home care?

Two questionnaires making up the Quality of Life Index [QLI] (Ferrans & Powers, 1985) were administered to persons over 65 years of age upon the initiation of home care and again in 6 weeks. Scores were analyzed to determine if perception of life satisfaction changed between the time home care was initiated and six weeks into home care.

All admission charts were screened by the researcher within 48 hours of intake to the agency. Potential

participants were identified as those who met the criteria of 65 years of age or older, had at least one chronic illness, lived alone and were assessed by the agency intake nurse with the use of the Short Portable Mental Status Exam (Pfeiffer, 1975) to be alert and oriented.

Subject Characteristics

Twenty-five potential participants were approached by telephone. Four refused to participate. Three of the group stated they did not feel well enough to take part. One stated that she was "a very private person." Those elders who consented were visited in their homes for further explanation of the study. If consent was given, the participants were then screened with the Short Portable Mental Status Exam [SPMSE] (Pfeiffer, 1975) before administration of the Quality of Life Index [QLI] (Ferrans & Powers, 1985). If the participant scored at least 7 out of 10 correct answers on the SPMSE the QLI was administered. Twenty-one participants were pre-tested with the QLI. One participant died prior to the post test. A total of 20 participants produced useable data for the study.

Although a formal demographic instrument was not used, information is provided in this discussion on the age, sex, and marital status of participants. This information was obtained from the home health agency's intake form and verified with participants. Participants ranged in age from 68

to 90 years with an average age of 80. Two males and 18 females made up the sample. The males had never been married. All the females were widowed.

Participants' scores on the SPMSE ranged from 1 to 2 incorrect answers, on a scale of 10. This placed all of them in the category of "Intact Intellectual Functioning" (Pfeiffer, 1975).

Response to several of the QLI questions provided further information of a demographic nature. When asked the question "How satisfied are you with your children?", 6 participants responded that they were childless. When asked the questions "How satisfied are you with your relationship with your spouse/significant other?" and "How satisfied are you with your sex life?", every participant denied having a significant relationship or a sex life. When asked "How satisfied are you with your job?", during the pre-test two participants considered themselves employed. The first working participant was employed part time at home at the time of the first interview, but had given up working due to declining health at the time of the second interview. The second participant was on disability due to an injury at the time of the first interview, and remained disabled, but improving, at the time of the second interview.

The majority of the participants completed the interview in 20 to 30 minutes. Use of a poster board with choice of answers kept participants focused on the task.

The 32 items comprising both the satisfaction and importance sections of the QLI are divided into 4 subscales. These include: Health and functioning, socioeconomic, family, and psychological/spiritual. The total life satisfaction score is the total of the scores of each subscale. Mean overall life satisfaction scores ranged from 21.3 pre-home care to 21.8 post-home care. Scores for the 4 component subscales making up the total included: (a) health and functioning 18.2 pre-home care and 18.9 post-home care, (b) socioeconomic 22.6 pre-home care and 23.1 post home care, (c) psychological/spiritual 22.2 pre-home care and 23.1 post-home care, and (d) family 27.7 pre-home care and 26.1 post-home care.

Mean scores pre- and post- home care did not differ significantly. With the exception of the family subscale, which decreased from 27.74 to 26.14 the measures reflected only a minimal increase in perceived life satisfaction. Health and functioning increased from 18.24 to 18.94. Socioeconomic increased from 22.59 to 23.07. Psychological/spiritual increased from 22.16 to 22.98. Overall combined mean score of perceived life satisfaction increased from 21.27 to 21.79. There were no statistically significant

results with values ranging from $-.86$ for overall score to 2.11 for the family subscale.

Results of total life satisfaction mean scores were midway between those of other studies. Mean life satisfaction scores were higher than those in early life satisfaction studies. Mean scores of those studies ranged from 11.6 to 14.1 (Campbell & Converse, 1976; Neugarten, Havighurst, & Tobin, 1961; Wood, Wylie, & Sheafar, 1969). Mean scores were lower than some recent studies, for example Padilla and Grant's mean life satisfaction scores (1985) ranged from 69 to 52 .

Compared to other studies which used the Quality of Life Index (Ferrans & Powers, 1985) the overall mean score of 21.3 was lower than Ferrans and Powers scores of 21.9 for a healthy group but higher than 20.7 scored by dialysis patients. Ferrans and Powers subscale scores for dialysis patients were: health and functioning 18.6 , socioeconomic 21.3 , family 25.3 , and psychological/spiritual 21.6 . Findings of the importance ranking of subscales in this study were comparable to findings of Ferrans and Powers (1985), with the exception of socioeconomic versus psychological/spiritual. Socioeconomic, with a score of 22.6 pre-home care and 23.1 post-home care was ranked slightly higher in importance by the elderly participants of this study. The dialysis patients studied by Ferrans and

Powers (1985) ranked psychological/spiritual at 21.6 slightly higher than socioeconomic at 21.3. Findings in this study indicating that the most influential component of life satisfaction was family, were consistent with findings of Ferrans and Powers (1985).

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

The study surveyed life satisfaction of chronically ill, homebound elders, at the time when home health nursing was initiated and again after 6 weeks. Most of the participants had friends, neighbors, or relatives providing some support services, such as shopping, transportation to medical appointments, etc. None had anyone living with them and assisting with their care on a 24 hour basis.

Conclusions

Data from the study indicate only a modest, but not statistically significant impact on life satisfaction as home care intervention occurred. However, of interest, the participants' mean score was the highest in life satisfaction in areas relating to family and relationships. While the change was not statistically significant, satisfaction scores in this domain were the only ones to decrease following home care intervention. Participants of this study scored lower in total life satisfaction than in some studies, and yet higher than in others.

Scores of study participants using the QLI were, for the most part in very similar ranges to those of other, dissimilar groups tested by Ferrans and Powers (1985). Although there were some differences, this indicates that the

questionnaire could be valuable in assessing life satisfaction as an outcome measure of home health nursing of the elderly.

Although the reason for the variation in total life satisfaction scores of this study compared to findings of other studies is unknown, a number of possibilities exist. First, little or nothing is known about the effect on the outcome of life satisfaction scores, of using one method of data collection versus another, or one setting versus another (Bergner, 1989). Second, the variation in measurement tools, domains measured and interchange of the concepts of happiness and life satisfaction by researchers and writers make direct comparisons difficult. Third, the concept of the influence of autonomy or locus of control may have contributed to results of the study (Palmore & Lukart, 1972; Wolk & Tellen, 1976).

Elderly participants in the study may either have perceived their autonomy as being decreased with the addition to their lives of home care nursing, or as enhanced by a perceived decrease in the likelihood that they would soon be threatened with having to give up the independence of living on their own. While participants were not formally surveyed as to their attitudes and feelings regarding autonomy, in conversation each portrayed him/herself as a survivor of life's vicissitudes. Each expressed pride in independence

and satisfaction with living independently. Most credited their well-being to their own determination, the assistance of families and friends, and a strong faith in God. Several practiced and advised positive thinking and stated they actively avoid negative input and influences.

The majority of participants took the opportunity to reminisce and to share their philosophy of life after responding to the questions. Many talked about accomplishments of children, and the pride they have in them. Some spoke of regrets concerning relationships, education, and goals. Two stated they were ready to die. Although the interviewer made every attempt to keep participant's conversation limited to answering the survey, until completed, the fact that the questions brought up certain thoughts and memories for participants may have influenced responses. At this time no data have been collected on a similar population using the QLI. It is possible, in an age group whose developmental task is to reminisce and perform life review (Butler & Lewis, 1982), that the QLI may prove to be a sensitive and effective measure of life as a sum of a person's life experiences, as well as of their satisfaction with their current situation.

The fact that total life satisfaction scores did not decrease during the time of home care intervention could possibly be significant. A chart review done at the

completion of the study indicated that the majority of participants had little positive change in their health status and that 3 actually had a definite worsening of their physical condition between the time of the pre- and post-surveys. It seems possible that without home care intervention, mean life satisfaction scores might have shown a decrease, rather than an insignificant rise.

The reason for the modest decrease in perceived satisfaction in the family domain at the time of post-test is unknown. One possible explanation could be that family support lessened as nurses took over some duties previously assumed by family, and patients felt less satisfied as family members became less involved. Another possible explanation could be that family members felt the stress of an ongoing situation and reacted in ways which left the patient feeling less supported and satisfied than he had at the beginning of his illness. Some elders may have felt that the nurse's role was one which should be assumed by family members only and were less satisfied with the family allowing others to perform the necessary care.

It seems significant that at the pre-test interview, 4 participants (1/5 of the study) refused to respond to the question on the QLI scale "How satisfied are you with your potential to live a long life?" At the post-test interview only one respondent refused to respond. Apparently, despite

the fact that most participants claimed to be mostly satisfied and happy with their lives, a significant group were either uncertain how much longer their lives would last or uncomfortable discussing the matter. As a slight, although not significant improvement in their perceived health status occurred over the 6 week period, the group felt more comfortable choosing an answer to this question.

Several characteristics of the sample could have influenced the trend of response. First, participants were self-selecting. They had the option to refuse to participate. Although few meeting the screening criteria did refuse, it is possible that those who did refuse may have differed in their outlook on life compared to those who did participate. They may have been more ill, withdrawn, or apathetic than the general population of elders and might therefore have scored lower on both sets of questionnaires. Health status has been shown to be an important determinant of life satisfaction (Burckhardt, 1985; Katz, 1987; Larson, 1978). It is also possible that others might have felt themselves to be too busy to participate (although this reason was not given), or more involved and supported by friends and family than those who did participate. It is impossible to predict whether home care would have had a greater or lesser effect on these non-participating groups, as compared to those who took part in the survey.

A preliminary study of this type raises as many questions, or more, than it answers. Some of these include:

(a) Would life satisfaction have remained constant, or would it have decreased in a comparable group of elders who did not have home care? (b) Would more or different nursing interventions have made a difference in post-test scores? (c) What was the cause of the relatively high mean life satisfaction scores in the study group and would they be duplicated in another sample? (d) Did nursing intervention influence the decrease in post-test satisfaction with family relationships? The results are not significant but can provide insight into the lives of elders and guides for future studies.

Elders surveyed at the time home care was initiated were not necessarily comparable in life satisfaction to elders in the general population due to the fact that a crisis, or near crisis situation may have been the factor necessitating the initiation of home care. The crisis, or the elder's reaction to it, may have been influential at the time the pre-test interview was administered. The elder's situation could contribute to his or her perceived life satisfaction and could affect the scores in a negative manner. The fact that the addition of home care did not significantly raise life satisfaction scores may have been influenced by perceived loss of autonomy and/or family support. The

choice of a 6 week time period between pre- and post-survey may also have affected satisfaction scores. Perhaps a longer period of time between surveys would produce different data.

The modest changes in life satisfaction scores, pre- and post-home care could have occurred for any number of reasons. It is impossible to determine the cause of these insignificant increases. Change over the time that home care was in place may have been due to improvement, resolution of, or the elder's adjustment to, an actual critical situation, or one perceived as such by the elder. Change could also occur as a result of an improvement in the elder's level of socialization due to introduction of home care personnel. Increased frequency of interaction with other persons, even though those visits were for a specific reason and for a predictable and temporary period of time, might have been an independent factor slightly enhancing the elder's life satisfaction, even if his health condition did not improve.

Recommendations

In future studies, a control group of homebound elders with chronic illnesses, but with no home care intervention should be surveyed to ascertain baseline comparison to those of a group receiving home care. Use of such a group would clarify the influence of a post survey on study

participants. It would also determine the influence on change in life satisfaction due to the development of a relationship with the home care nurse.

Secondly, research should be done using a longer time period between pre- and post-survey. Results would indicate whether the time interval between surveys was an influential factor in determining the outcome of the study.

Third, interventions could be designed which focus on the specific domains of satisfaction measured in this study. Life satisfaction could then be pre- and post-tested to determine the effectiveness of interventions and to develop outcome standards for geriatric home care patients.

The QLI could also be tested for use as an assessment tool for home care nurses. It was found to be useful in the study in establishing rapport with patients. The researcher was able to quickly identify areas of concern and importance to the client, in both the physical and emotional areas of their lives. This researcher will incorporate questions from the index into clinical practice when appropriate.

Although results were not significant, the study can provide insight into the lives of elders and guides for future studies. Findings in research concerning life satisfaction and home care, should be taken into account by those engaging in policy development of care of elders. In an atmosphere of limited resources and an increasing population

of elders, difficult decisions will have to be made concerning the importance of various aspects of care. Information regarding how the life satisfaction of elders is impacted upon by services should help make those decisions appropriate to the needs and desires of the group those decisions will effect.

This study will add to the body of knowledge of both nursing care outcomes and life satisfaction as it relates to home care. It is a beginning investigation of life satisfaction in the elderly which can be used as a basis for further research.

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APPENDIX A
The Short Portable Mental Status
Questionnaire

SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

Eric Pfeiffer, M.D.

Instructions: Ask questions 1-10 in this list and record all answers. Ask question 4A only if patient does not have a telephone. Record total number of errors based on ten questions.

1. What is the date today? _____
Month Day Year
2. What day of the week is it? _____
3. What is the name of this place? _____
4. What is your telephone number? _____
- 4A. What is your street address? _____
5. How old are you? _____
6. When were you born? _____
7. Who is the President of the U.S. now? _____
8. What was President just before him? _____
9. What was your mother's maiden name? _____
10. Subtract 3 from 20, and keep subtracting 3 from each new number, all the way down.

_____ Total number of errors

To be Completed by Interviewer

Patient's name: _____ Date _____

Sex: 1. Male
2. Female

Race: 1. White
2. Black
3. Other

Years of Education: _____
1. Grade School
2. High School
3. Beyond High School

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APPENDIX B
Institutional Review Board, Human
Subjects Approval

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

To: Carolyn Parsons, Nursing
657 Spazier Avenue
Pacific Grove, CA 93940

From: Charles R. Bolz
Office of Graduate Studies and Research

Date: April 9, 1991

Charles R. Bolz

The Human Subjects Institutional Review Board has approved your request to use human subjects in the study entitled:

"Life Satisfaction as Perceived by the Home Care Client"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact Dr. Stanford or me at (408) 924-2480.

cc: Jean M. Sullivan, D.N.Sc.

APPENDIX C
Consent From Home Health Agency

July 1, 1991

To Whom It May Concern:

Carolyn Parsons has my permission to interview the patients of Home Health Plus, Monterey, for her Master's thesis.

Sincerely,

General Manager

/kk

APPENDIX D
Participant Consent Form

A CAMPUS OF THE CALIFORNIA STATE UNIVERSITY

School of Applied Arts and Sciences • Department of Nursing • Graduate Program
One Washington Square • San Jose, California 95192-0057 • 408/924-3134

INFORMED PARTICIPATION STATEMENT
SAN JOSE STATE UNIVERSITY

RESPONSIBLE INVESTIGATOR: Carolyn Parsons, R.N.

TITLE OF PROTOCOL: Life Satisfaction in Long Term Home Care

I have been asked to participate in a research study that is investigating quality of life in the elderly. The results of this study should further our understanding of factors which affect the elders being cared for in their homes.

I understand that

- 1) I will be asked to be interviewed two times for approximately 30 minutes each time.
- 2) the possible risks of this study are: fatigue from the interview.
- 3) the possible benefits of this study to me are: possible suggestions at the conclusion of the study as to ways my situation might be improved.
- 4) alternative procedures include: None
- 5) the results from this study may be published, but any information from this study that can be identified with me will remain confidential and will be disclosed only with my permission or as required by law.
- 6) any questions about my participation in this study will be answered by Carolyn Parsons, R.N. 375-1995. Complaints about the procedures may be presented to Bobbye Gorenberg, R.N., DSc. 924-3134; Department Chair for Nursing. For questions or complaints about research subject's rights, or in the event of research-related injury, contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies & Research) at 924-2480.
- 7) My consent is given voluntarily without being coerced; I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with SJSU or Home Caremanagers.
- 9) I have received a copy of this consent for for my file.

I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY
SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED
ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.

Date

Subject's Signature

Investigator's Signature

APPENDIX E

Consent To Use The Short Portable
Mental Status Questionnaire

**American Geriatrics Society
Permission to Reprint**

Requestee: Carolyn Parsons, PHN
Company/
Institution: San Jose State University
Purpose: Educational

Publication: The Journal of the American Geriatrics Society

Issue: 1975, 23, (10) 433-441

Title: "A Short Portable Mental Status Questionnaire of the Assessment of Organic Brain Deficit in Elderly Patients"

Author(s): Eric Pfeiffer

The American Geriatrics Society hereby grants the above mentioned permission to reprint the requested article. The primary author's permission should also be obtained for permission to reprint. Permission to use this materials is contingent upon proper credit being given to the *Journal of the American Geriatrics Society*. The credit line should read: "Reprinted with permission of the American Geriatrics Society, (Title of Article), by (Author), *Journal of the American Geriatrics Society*, (Vol. No.), (pp.), (year)."

The above request is approved on the conditions specified above and on the understanding that full credit will be given to the source.

Approved by:

Title:

Date:

Melissa Librestri Communications 2/13/92
Assistant

APPENDIX F

Consent To Use The Quality of
Life Index

UIC

The University of Illinois at Chicago

Department of Medical-Surgical Nursing (M/C 802)
College of Nursing
845 South Damen Avenue, 7th Floor
Box 6998, Chicago, Illinois 60680
(312) 996-7900

April 24, 1990

Ms. Carolyn Parsons
657 Spazier Avenue
Pacific Grove, CA

Dear Ms. Parsons:

Thank you for your interest in the Quality of Life Index (QLI). I have enclosed the generic version of the QLI and the computer program for calculating scores. I also have included a list of the weighted items that are used for each of four subscales: health and functioning, socioeconomic, psychological/spiritual, and family, as well as the computer commands used to calculate the subscale scores. The same steps are used to calculate subscale scores and overall scores.

There is no charge for use of the QLI. However, in return for my permission to use the QLI, I would appreciate it if you would send me the raw data from the QLI and sociodemographic information on your sample. This data will be combined with other data and used for further reliability and validity assessments. The results of these assessments then will be made available to researchers like yourself.

If you do use the QLI for your research and publish an article(s) reporting the findings, I would be very grateful if you would send me a copy. If I can be of further assistance, please do not hesitate to contact me. I wish you much success with your research.

Sincerely,

Carol Estwing Ferrans, PhD, RN
Assistant Professor

APPENDIX G
The Quality of Life Index

DOMAIN SATISFACTION

People differ in how they look at their lives. What is satisfying to one person may not be satisfying to another.

For each of the following, please choose the answer that best describes how satisfied you are with your life. If none of the answers fit exactly, pick the answer that comes closest to how you feel. Please mark your answer by circling the number.

If some questions do not apply to you, please leave them blank. For example, one question asks about your job. If you are unemployed, leave the question blank. Please try to answer all the question that apply to you. There are no right or wrong answers.

	<u>Very Dissatisfied</u>	<u>Moderately Dissatisfied</u>	<u>Slightly Dissatisfied</u>	<u>Slightly Satisfied</u>	<u>Moderately Satisfied</u>	<u>Very Satisfied</u>
1. How satisfied are you with your health?	1	2	3	4	5	6
2. How satisfied are you with the health care you are receiving?	1	2	3	4	5	6
3. How satisfied are you with your physical independence (ability to do things for yourself, get around) to you?	1	2	3	4	5	6
4. How satisfied are you with your potential to live a long life?	1	2	3	4	5	6
5. How satisfied are you with your family's health?	1	2	3	4	5	6

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	<u>Very Dissatisfied</u>	<u>Moderately Dissatisfied</u>	<u>Slightly Dissatisfied</u>	<u>Slightly Satisfied</u>	<u>Moderately Satisfied</u>	<u>Very Satisfied</u>
6. How satisfied are you with your children?	1	2	3	4	5	6
7. How satisfied are you with your family's happiness ?	1	2	3	4	5	6
8. How satisfied are you with your relationship spouse/significant other?	1	2	3	4	5	6
9. How satisfied are you with your sex life ?	1	2	3	4	5	6
10. How satisfied are you with your friends?	1	2	3	4	5	6
11. How satisfied are you with the emotional support you get from others?	1	2	3	4	5	6
12. How satisfied are you with your ability to meet family responsibilities (things you have to do for your family) ?	1	2	3	4	5	6
13. How satisfied are you with your usefulness to others?	1	2	3	4	5	6
14. How satisfied are you with the amount of stress or worries in your life?	1	2	3	4	5	6

	<u>Very Dissatisfied</u>	<u>Moderately Dissatisfied</u>	<u>Slightly Dissatisfied</u>	<u>Slightly Satisfied</u>	<u>Moderately Satisfied</u>	<u>Very Satisfied</u>
15. How satisfied are you with your home (furniture, house or apartment)?	1	2	3	4	5	6
16. How satisfied are you with your neighborhood ?	1	2	3	4	5	6
17. How satisfied are you with your standard of living?	1	2	3	4	5	6
18. How satisfied are you with the overall conditions in the United States?	1	2	3	4	5	6
19. (If employed) how satisfied are you with your job?	1	2	3	4	5	6
20. (If unemployed, retired, or disabled) how satisfied are you with not having a job?	1	2	3	4	5	6
21. How satisfied are you with your education?	1	2	3	4	5	6
22. How satisfied are you with your financial independence?	1	2	3	4	5	6

	<u>Very Dissatisfied</u>	<u>Moderately Dissatisfied</u>	<u>Slightly Dissatisfied</u>	<u>Slightly Satisfied</u>	<u>Moderately Satisfied</u>	<u>Very Satisfied</u>
23. How satisfied are you with your leisure time activities ?	1	2	3	4	5	6
24. How satisfied are you with your ability to travel on vacations?	1	2	3	4	5	6
25. How satisfied are you with your potential for a happy old age/retirement ?	1	2	3	4	5	6
26. How satisfied are you with your peace of mind?	1	2	3	4	5	6
27. How satisfied are you with your personal faith in God?	1	2	3	4	5	6
28. How satisfied are you with your achievement of personal goals ?	1	2	3	4	5	6
30. How satisfied are you with your life in general?	1	2	3	4	5	6
31. How satisfied are you with your personal appearance?	1	2	3	4	5	6
32. How satisfied are you with yourself in general?	1	2	3	4	5	6

DOMAIN IMPORTANCE

People differ in how they look at their lives. What is important to one person may not be important to another.

For each of the following, please choose the answer that best describes how important that area of your life is to you. If none of the answers fit exactly, pick the answer that comes closest to how you feel. Please mark your answer by circling the number.

If some questions do not apply to you, please leave them blank. For example, one question asks about your job. If you are unemployed, leave the question blank. Please try to answer all the questions that apply to you. There are no right or wrong answers.

	Very Unimportant	Moderately Unimportant	Slightly Unimportant	Slightly Important	Moderately Important	Very Important
1. How important is your health to you?	1	2	3	4	5	6
2. How important is health care to you?	1	2	3	4	5	6
3. How important is your physical independence (ability to do things for yourself, get around) to you?	1	2	3	4	5	6
4. How important is living a long time to you?	1	2	3	4	5	6
5. How important is your family's health to you?	1	2	3	4	5	6

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	<u>Very Unimportant</u>	<u>Moderately Unimportant</u>	<u>Slightly Unimportant</u>	<u>Slightly Important</u>	<u>Moderately Important</u>	<u>Very Important</u>
6. How important are your children to you?	1	2	3	4	5	6
7. How important is your family's happiness to you?	1	2	3	4	5	6
8. How important is your relationship with your spouse/significant other to you?	1	2	3	4	5	6
9. How important is your sex life to you?	1	2	3	4	5	6
10. How important are your friends to you?	1	2	3	4	5	6
11. How important is emotional support to you?	1	2	3	4	5	6
12. How important is meeting family responsibilities to you (things you have to do for your family) ?	1	2	3	4	5	6
13. How important is being useful to others to you?	1	2	3	4	5	6
14. How important is it to you to have a reasonable amount of stress or worries?	1	2	3	4	5	6

	<u>Very</u> <u>Unimportant</u>	<u>Moderately</u> <u>Unimportant</u>	<u>Slightly</u> <u>Unimportant</u>	<u>Slightly</u> <u>Important</u>	<u>Moderately</u> <u>Important</u>	<u>Very</u> <u>Important</u>
15. How important is your home to you (furniture, house or apartment)?	1	2	3	4	5	6
16. How important is your neighborhood to you?	1	2	3	4	5	6
17. How important is your standard of living to you?	1	2	3	4	5	6
18. How important are the overall conditions in the United States to you?	1	2	3	4	5	6
19. (If employed) how important is your job (or working) to you?	1	2	3	4	5	6
20. (If unemployed, retired, or disabled) how would it be to you to have a job?	1	2	3	4	5	6
21. How important is your education to you?	1	2	3	4	5	6
22. How important is your financial independence to you?	1	2	3	4	5	6
23. How important are leisure time activities to you?	1	2	3	4	5	6

	Very Unimportant	Moderately Unimportant	Slightly Unimportant	Slightly Important	Moderately Important	Very Important
24. How important is the ability to travel on vacations?	1	2	3	4	5	6
25. How important is having a happy old age/retirement ?	1	2	3	4	5	6
26. How important is peace of mind to you?	1	2	3	4	5	6
27. How important is your personal faith in God to you?	1	2	3	4	5	6
28. How important is achieving your personal goals to you?	1	2	3	4	5	6
30. How important is it to you to be satisfied with life?	1	2	3	4	5	6
32. How important are you to yourself?	1	2	3	4	5	6

APPENDIX H

t Test Data Summary Table

t Tests For Pre and Post Quality of Life (QLI) Indices
of Elderly Home Care Clients (N=20)

p = .05