THE EFFECTS OF EMPLOYEE MORALE ON NURSING HOME RESIDENT SATISFACTION

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CHAPTER I

STATEMENT OF RESEARCH PROBLEM

It is a fact of life that as people age, they may require nursing home placement at some point in their lives. As society continues to grow, the number of elderly individuals requiring long-term care will also grow.

Currently, many nursing homes have waiting lists for potential residents. While the frequency of need for placement increases, state and federal funding continues to decrease. This forces nursing homes to expand their occupancy.

Increasing the number of beds available to potential residents allows for shorter waiting periods for admittance and also increases the funding received through state and federal programming. Therefore, increasing the number of beds in existing nursing homes seems to alleviate the problem of a population boom of elderly requiring long-term placement.

Although the stress of placement is no longer existent, now the stress falls on the care providers. Decreased funding has also led to decreased staffing. Staff that were once accustomed to caring for 120 residents are now trying to care for 140 residents. Nurse aides now have 7 or 8 residents to bathe and dress, rather than the 5 or 6 that they were comfortable with. Unfortunately, this means that each resident only receives 20 minutes of care every morning, rather than the half hour that they have been receiving for the past year.

The burden also falls on the nurses, who are now responsible for passing more medications and giving more treatments. Their time for documentation has been cut by 25%. But, everyone is expected to keep doing their jobs.

That is exactly what it becomes, a job. Nurse aides rush form resident to resident, there's no longer any time to curl Mrs. Jones hair or read mail to Mr.

Brown. Everyone has a job to do, and the residents are paying the price.

The way the nurses and nurse aides treat the residents effects every aspect of the residents care. If for example, the nurse aide yells at the resident because he/she is taking too long eating their meals, the resident is going to find mealtime an unenjoyable experience. The resident may cease eating altogether.

Another example of how nurses and nurse aides effect the residents care is with physician services. If the nurses or nurse aides fail to document that the resident needs or has requested physician services, the resident won't receive any. The resident may believe that the physician has given up on them.

It isn't only the nurses and nurse aides, the rest of the staff feels the burden of 20 new residents as well. Accounting has 20 new accounts to keep track of. Dietary has to prepare 20 more meals. Physical Therapy is evaluating and admitting more residents into their program. But, nobody feels the strain more than the nursing staff. Nurse Aides feel over worked and under appreciated. The physical stress alone has led to increased illness and sick time.

Now, there is a perpetual cycle, the increased work load has led to increased sick time, which has now multiplied the work load for everyone else. Obviously, this has taken a toll on everyone. The residents are dissatisfied with their care and employee morale is extremely low.

The research question to be answered in this paper is whether or not resident satisfaction is directly linked to employee morale. Do nursing homes with a higher percentage of employees with high morale produce higher levels of

satisfaction among their residents? More specifically, does the morale of nurses and nurse aides, being primary care givers, have a direct effect on the satisfaction of the residents?

CHAPTER II

REVIEW OF THE LITERATURE

A. The aging of America

The growth of the oldest age groups will have a major impact on long-term care facilities, therefore, it is essential to understand how the population is changing. In 1993, the 50+ adult population was 34 percent (63 million) of the total population, and is continuing to grow, with an expected 80 million by the year 2000 and 97 million by 2010 (Gilmartin, 1993). The number of individuals over the age of 65 is expected to increase to 52 million by the year 2020 and 68 million by the year 2040 (Schneider and Guralnik, 1990). James Fries (1990) disagrees with Schneider and Guralnik based on his understanding that trends in life expectancy will alter this figure.

Life expectancy of the elderly population is extremely important, especially when it is combined with the expected increase in the number of elderly. According to Schneider and Guralnik (1990), the average life expectancy for women in the year 2020 will be 82 years and 74.2 years for men. The implications of this are enormous. For example, individuals with lifelong disabling conditions are also living longer than ever before. Those with developmental disabilities are outliving their parents who have traditionally provided the majority of their care (Ansello, 1988).

Therefore, long-term care facilities will be faced with an increasing number of elderly individuals requiring placement as well as individuals with developmental disabilities. Along with the crisis of an increase in need for long-term care placement, nursing home staff will need to learn how to care for individuals with developmental disabilities, such as mental retardation, downs

syndrome, multiple sclerosis, and other childhood disabilities.

B. Cost of health care

With an increasing number of individuals requiring placement, it is essential to focus some attention on the cost of providing long-term care. The cost of providing this care has become an increasing concern to lawmakers, administrators, and health care providers.

In 1985, the average cost for providing care in a nursing home averaged $23,600 per resident. This totaled $31.1 billion for the 1.3 million nursing home residents, with 40% of this cost reimbursed by the government through Medicaid. (Schneider and Guralnik, 1990).

After adjusting for inflation and discounting to age 65, using constant 1990 dollars, the cost of nursing home care averages to be an expected discounted cost of $27,600. Using data reported by Kemper and Murtaugh (1991) that 43% of persons aged 65 and older can expect to enter a nursing home at some point in their lives, this would generate a long-term care spending cost of $60 billion (Kemper, Spillman, and Murtaugh, 1991).

The $60 billion figure doesn't even include the population that is stuck in the Medicaid gap. These are individuals that don't qualify for Medicaid, but can't afford to pay for long-term care on their own. They are ineligible for Medicaid because their monthly income exceeds the maximum allowable, but doesn't cover nursing home expenses. These people are dependent on families and friends for care (Quadagno, Harrington, and Turner, 1991).

"Between 1960 and 1982, nursing home expenditures grew faster than

any other component of health care costs, with annual increases averaging 18 percent" (Coburn, Fortinsky, McGuire, and McDonald, 1993, pg 46). It was during this period of substantial growth that the states set up prospective payment systems. Prospective rates were established using base year cost projections and an inflation index (Coburn et al., 1993). Therefore, nursing homes that kept costs at or below the prospective rates were much better off than homes that exceed the rates. This would be a wonderful incentive for administration to keep expenses down by limiting the number of staffed care givers.

Now that estimated long-term care costs are $60 billion, can the state continue to cover 40%? They have already made severe cut backs that effect both staff and residents. Robert J. Myers, chief actuary of the Social Security Administration, stated that "due to low reimbursements, the nursing homes aren't operated as well as they could be, and the residents are treated less well than they should be" (Butler, Brame, Kahn, McConnell, Myers, Pollack, and Rowland, 1992). Most long-term care facilities cannot reduce staffing any further. They have already decreased the amount of nurses and nurse aides to the point where many facilities are having to deal with staff burnout.

C. How morale effects staff

1. Positive effects

Employee morale increases job satisfaction immensely. Not only are the employees more satisfied, they are less stressed and are more likely to do their jobs well and accurately, and involve teamwork into their work situations

(Lictenberg, Strzepek, and Zeiss, 1990).

Jon R. Zemans, president and CEO of the Wesley Group, has taken steps toward increasing employee morale in his nursing home by providing employee opinion surveys. Mr. Zemans strongly believes that his effort has paid off and is quoted commenting on this payoff, "Our work force can take credit for clean health department surveys, increased resident satisfaction, designation as an EAGLE facility by the United Methodist Association and accreditation with commendation by the Joint Commission of Accreditation of Health care Organizations" (Zemans, 1995, pg 11).

In a health care setting, it is critical not only to staff, but also to the residents that there is high employee morale. When employees are not content with their job situation, the residents are going to suffer. Therefore, the goal of administrators should be satisfied employees. When employees are satisfied, they are free to focus their energy on the needs of their residents (Carey & Drachman, 1988). It would be an ideal situation if nurse aides had the opportunity to spend as much time as the residents need when providing their care.

2. Negative effects of low morale

One of the largest outcomes of low morale is a high turnover rate of nurse aides. As of 1992, information suggests that an annual turnover rate in excess of 50% exists for nurse aides (Monahan & McCarthy, 1992). The excessive rates in turnover can cost the facility anywhere from $8,886 to $15,152 annually (Klemm & Schreiber, 1992). The money that is being lost in employee turnover

could have been put toward hiring an extra aide to help with patient care. This could ultimately help to increase morale and eventually decrease turnover rates.

Staff turnover seems to be a perpetual cycle. The higher the turnover, the greater the workload for the remaining nurse aides. As this workload increases, performance and morale decrease.

The lack of morale also stimulates feelings of low self worth among the nurse aides. Quite often, in facilities that lack standards in employee satisfaction, the care that is given by the aides is perceived to be custodial. Their job performance is evaluated on a quantitative rather than qualitative basis. Administration is more concerned with getting many residents bathed in little time than they are with the residents quality of life. Therefore, the aides are forced to compromise their humanness in order to satisfy the system (Chartock, Nevins, Rzetelny, & Gilberto, 1988).

The combination of high turnover rates and feelings of low self worth can undoubtedly foster stress among the health care providers. "A useful operational definition of stress is the negative forces exerted on persons when their perception of demands from the environment leads them to believe that they cannot do their job adequately" (Johnson, 1991, pg 57). Johnson suggests that individuals working with older patients are more susceptible to being exposed to stress. Caring for individuals at the last stages of their lives is often a difficult process. Loss of the individual is inevitable, therefore the working environment is sometimes tense and overwhelming.

D. How employee morale effects the resident

1. Effects of high employee morale

Teresi, Holmes, Benenson, Monaco, Barrett, and Koren (1993) studied how employee satisfaction toward care was effected when employee morale increased. They used one upstate facility and one downstate facility as their sample. In both instances the residents satisfaction with care was increased.

As stated earlier, when morale increases, turnover rates will usually decrease. Therefore, the residents will have a greater opportunity to get to know their care givers on a personal basis. This personal relationship may result in enhanced communication and greater satisfaction with the residents.

The residents will also experience greater satisfaction with other aspects of their care when employee morale is increased. For example, they will find mealtimes more enjoyable because the nurse aides aren't rushing them through their meals. Their overall satisfaction with care and services will most likely increase as a result of increased employee morale.

2. Negative effects of low employee morale

Stein, Linn, and Stein (1986), in a three year study, found that in nursing homes where aides had poor morale, the quality of care suffered dramatically. In the homes with poorer morale, the staff was less satisfied with their work and acted to suppress the patient's open communication. Such attitudes can promote social isolation among the residents.

As increased morale of staff leads to increased communication with the residents, decreased morale may disrupt social relationships and reduce the

quality of physical care received (Brennan & Moos, 1990). Brennan and Moos (1990) also suggest that "residents exposed to the most staff turnover are those with the fewest resources to adapt to disrupted social ties and altered care regimens" (pg 26). Quite often, these residents are in need of a permanent care giver. Permanent care givers are more in tune with the needs of their assigned residents.

The stress that occurs as the result of staff turnover and caring for the older ill patient can lead to abuse of nursing home residents. Pillemer and Moore (1989) conducted a survey of 577 nurses and nurse aides from 31 long-term care facilities. The staff was questioned over the telephone about abusive actions taken both by themselves and by other staff members. Physical abuse was defined as "an act carried out with the intention, or perceived intention, of causing physical pain or injury to another person" (pg 315). Psychological abuse was defined as "an act carried out with the intention, or perceived intention, of causing emotional pain to another person (e.g., threats or insults)" (Pillemer & Moore, 1989, pg 315).

Pillemer and Moore (1989) used the following items as indicators of physical abuse: "excessive use of restraints; pushed, grabbed, shoved, or pinched a patient; kicked a patient or hit with a fist; and hit or tried to hit a patient with an object" (pg 315-316). The items used to measure psychological abuse were: "isolated a patient beyond what was needed to control him or her; insulted or swore at a patient; yelled at a patient in anger; denied a patient food or privileges as part of a punishment; and threatened to hit or throw something

at a patient (Pillemer & Moore, 1989, pg 315-316).

The results reported by the staff members of abuse by others are the following: "36% of the sample had seen at least one incident of physical abuse in the preceding year. A total of 81% of respondents had observed at least one psychologically abusive incident in the preceding year" (pg 316-317). The results gathered here may be somewhat subjective, as it is difficult to state whether or not abuses carried out by others are intentional. "Fully 10% of the respondents reported that they had themselves committed one or more physically abusive acts. 40% of the respondents reported that they had committed at least one psychologically abusive act within the preceding year" (Pillemer & Moore, 1989, pg 316-317).

"Investigating Security" (1981) directly linked lack of employee morale to patient abuse. It was found that "in addition to the lack of patient attention and unauthorized absences of employees, the basic attitude of many staff members was that they did not want to be bothered by the residents and refused to perform their prescribed duties, often in defiance of supervisors' requests" (pg 41). This suggests lack of communication and teamwork among the staff.

Patient abuse is a frightening reality that health care providers must deal with. Although it may not currently be an issue, it shouldn't be ignored. Inservices and training on patients' rights and how to cope with stress should be available to employees.

E. Techniques to improve employee morale

Because employee morale is so vital to the quality of care that residents

receive, it is important that facilities lacking in morale find ways to increase it. It is equally important that what management views as being effective for increasing morale is equivalent to the staff's views of the same. According to Carey and Drachman (1988), "the value of benefits depends largely on the employees' perceptions of these benefits, rather than on any intrinsic value the benefits have. If employees do not value a benefit highly, the hospital is spending money on employees without receiving commensurate returns in the form of employee satisfaction. The money spent may actually be money lost" (pg 68). It is equally important that all parties are involved in the decision making process. Carol Benson (personal communication, Jan 11-14, 1996) stated "people like change, people don't like to be changed".

This section of the paper will explain some programs that have previously worked to increase morale in other facilities.

1. Interdisciplinary Team Training in Geriatrics (ITTG)

Interdisciplinary Team Training in Geriatrics (ITTG) was created for and used by Veteran Administration hospitals. The idea of ITTG is to provide knowledge and skill in a team work setting. It stresses the importance of everyone's roles in the group and how all contributions influence both the delivery and outcome of patient care (Lichtenberg et al., 1990). ITTG emphasizes the following topics in it's educational approach:

> "team theory, particularly the distinction between multidisciplinary and interdisciplinary teams; understanding the skills and training of each profession on the team; increasing knowledge about the special problems of geriatric patients and the need for diverse skills to address them; developing a model of constructive disagreement among team members; developing skills for clarifying areas of disagreement; developing skills for negotiation resolution when there is disagreement; and utilizing all of these skills to improve interdisciplinary team treatment planning and service delivery" (Lichtenberg, Strzepek, and Zeiss, 1990 pg 66).

Lictenberg et al. (1990) suggest bringing psychiatric aides into the treatment team of a psychiatric hospital to improve morale. The hospital that was used for the study was the Shenandoah Geriatric Treatment Care Center, a 130 bed Intermediate Care Facility located in a state psychiatric hospital.

Initially, the aides in this hospital were viewed as invaluable. They were rarely included in decisions regarding patient care and were discouraged from verbalizing their opinions about the care. This caused the aides to experience feelings of low self worth.

Results of the training showed that: "75% of the staff rated the training as very useful, 50% said it greatly improved their morale, and 100% said the training was good or excellent" (Lictenberg et al., 1990 pg 70). These results support a training affect on the staff, but they do not show how the training may have impacted on the residents. Having the aides directly involved in decisions regarding patient care can have a very dramatic effect on the care that the resident receives. For example, because the aide works with the resident on a daily basis, they are often the first to notice resident changes as they occur. If the resident's health is improving and they now not only clean their hands, they also can wash their arms and upper extremities, it is important for other staff to know that, Physical Therapy for example. Klemm and Schreiber (1992) suggest that treating nurses as professionals is critical to effective patient care and successful business operations.

The use of teams in a health care setting will most likely prove effective. Not only will the teams produce higher quality decisions, they will increase their

communication skills with one another. In a health care setting, communication literally can be the difference between life and death.

2. Primary care

According to Teresi et al. (1993), bringing primary care nursing into a longterm care facility will increase staff satisfaction and attitudes. Primary care nursing includes permanent assignment of residents and increased team participation.

Teresi et al. (1993) researched tow long-term care facilities, one upstate and one downstate. They had hoped that the outcome of the primary care in these facilities would be:

> " greater knowledge of each resident's preference for clothing and mode of being cared for; better recall of the individual's family history; more intimate knowledge of resident's level of function; more aware of incipient decubiti; more team participation; and better able coordinate care among assigned residents because of knowledge of the time requirements for each individual resident with respect to each task" (pg 418).

The results of the experiment found in both cases the above to be true. The biggest problem found was that the nurse aides found it difficult to care for patients with behavior problems on a permanent basis. No impact of the intervention of morale was observed. This could be because they did not use any behaviorally anchored measures to study this with.

3. Increased job training

Much of the work done in a long-term care facility is done by paraprofessionals, is viewed as custodial and is not recognized as having therapeutic value for the residents. The result often leads to decreased staff functioning and morale.

Chartock et al. (1988) recognized this as an issue and with the support of

the Brookdale Center on Aging of Hunter College and a consortium of New York State agencies, developed a program to assist nursing home staff in understanding the behavior of the mentally impaired and to develop effective intervention skills.

The pilot training population for the program consisted of 350 professional and paraprofessional staff who had regular interaction with the residents. The group represented individuals from: social work, physical therapy, occupational therapy, activities, pharmacy, dietary, housekeeping, maintenance, clerical staff, and chaplains. Everyone had various backgrounds with respect to education and number of years on the job. Evaluation of the training program was based on increased participant knowledge. Pre and post tests were distributed to the participants in the form of multiple choice questions. Supervisors also rated the participants on job performance 2 months after the end of the program.

The reaction to the training was quite positive. 45% rated the training as excellent, 48% rated it as good, and only 6% would not recommend the training to others. The supervisors reports were also conclusive that the training was successful:

> "supervisors reported that 93% of the program graduates they supervised showed improved communication skills with residents; 86% were perceived to improve their handling of mentally impaired residents; and over one-half showed improved morale and willingness to take on extra responsibility" (506).

4. Adding humor to the nursing facility

Lila Green (1990) wrote a brief article titled "Feeling Good: Humor In The Facility, How to Use Humor to Boost Staff and Resident Morale, and Improve the Quality of Care in Your Facility". In this article, Green states that "employees

who have fun at work are less likely to be late or absent, or to quit their jobs" (pg 6). Ms. Green also noted that residents benefit a great deal from humor. "Patients who often could not remember the names of their spouses and children could tell a joke, recite an amusing story, or sing a long, funny song from beginning to end" (pg 6).

5. Recognizing the employee

One of the quickest and most personal ways to increase employee morale is through employee recognition. There are many ways in which employees can be recognized. Management can recognize staff at awards ceremonies or staff luncheons. This singles out the employees and lets them know they are important and their work is appreciated.

Another direct morale booster is monetary gifts. Money represents appreciation as well as an incentive to "keep up the good work".

The employees benefits plan can also help to boost morale. Offering a flexible benefit plan can increase employee satisfaction and save the facility as much as $92 per employee compared to facilities without the plan (Gardner, 1987).

A flexible benefits plan allows the employee to select which benefit plan best suits their needs. The employer then deposits a set amount of money into that spending account for the employee (Gardner, 1987).

Recognizing employees can be very beneficial to the organization. It produces greater productivity, a positive mind-set, and lower turnover rates (Klubnik, 1995).

Most importantly, it is essential to use the works "thank you" when recognizing employees. The staff might forget about the monogrammed pen that was given to them at the last employee luncheon, but they won't forget about management thanking them for all of the hours of hard work and dedication.

Rewarding and recognizing employees is vital to the success of the organization. In a health care setting, employee appreciation can increase the quality of care that the patients receive. If the employees are satisfied, they will be more likely to increase their job performance (Lichtenberg et al., 1990).

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

A research design to measure the effects of employee morale on nursing home resident satisfaction will obviously take place in nursing homes. Three not for profit nursing homes in upstate NY have been selected as the research settings. When discussing the data in section IV, these nursing homes will be referred to as nursing homes #1, #2, and #3, to ensure confidentiality.

A. Measuring resident satisfaction

The nursing home resident satisfaction scale was used to measure the residents' level of satisfaction (see Appendix A). This is a ten item survey that was developed by Jacqueline Zinn, Risa Lavizzo-Mourey, and Lynne Taylor to measure nursing home residents' satisfaction with their care. The survey takes approximately 15 minutes to complete.

The survey was scored along a four point Likert scale, ranging from 'not so good' (1) to 'very good' (4). Residents that couldn't, or chose not to respond to a question were assigned a score of (5) 'not applicable' for that particular question. Questions that were not answered were assigned a missing value (9).

The survey was conducted orally with complete assurance of confidentiality. Everyone was interviewed in a private location.

The nursing facility was asked to generate a list of residents that were competent enough to do the survey prior to my arrival. Competency of the residents was decided upon by the professional opinion of the nursing homes social worker. The residents had the opportunity to decline taking the survey if they so desired.

As with any research, there was always the possibility of receiving

inaccurate test results. Three threats to the validity of this research design have been identified as the following:

1. Due to the fact that the survey was only issued one day, it was difficult to determine whether or not the residents satisfaction was actually correlated with employee morale. It is possible that the resident(s) could just have had a bad day.

2. Oral questionnaires sometimes don't allow the participants to be as honest as they might be if they were filling out the survey themselves.

3. It is also a possibility that the list provided by the nursing facility social worker may be biased. The nursing homes social worker is responsible for generating the list, and therefore has the power to choose which residents to place on it. They could choose to put only residents who seem to be satisfied with their care on the list.

B. Measuring employee morale

A staff morale survey developed by Jeanne Teresi, Douglas Holmes, Esther Benenson, Charlene Monaco, Virginia Barrett, and Mary Jane Koren was used to measure employee morale in the participating facilities (see Appendix A). This survey measures attitudes toward the job, working environment, supervisors, and feelings of self-worth on the job.

The morale survey was distributed to nurses and nurse aides during afternoon change of shift, for the purpose of being able to catch the day shift when they were leaving and the evening shift when they were reporting for work. The employees were then instructed to drop off their surveys in a drop box that

was located in the cafeteria. Extra surveys were also located in the cafeteria for the night shift. The nurses and nurse aides were not required to put their names on the survey. They were also provided with an envelope that was attached to their survey to ensure confidentiality.

The surveys and drop boxes were distributed to participating facilities prior to the scheduled date of resident interviews. After the interviews were concluded, the drop boxes were collected.

The survey was scored along a four point Likert scale ranging from (4) strongly disagree to (1) strongly agree. Questions that were not answered were assigned a missing value (9).

Once again, the threat of the research not being valid is a possibility. This time, 2 threats have been identified as the following:

1. The fact that the survey was only distributed at one time could cause the research to be invalid. It is also possible that the employee could have had a bad day or an unusually good day the day the surveys were distributed.

2. Due to the fact that the employees were not supervised while they completed the surveys, it is possible that they could have collaborated. This could have contaminated the research.

C. Hypothesis

> Hypothesis: Nursing homes with higher percentages of employees with high morale will produce higher levels of satisfaction among their residents.

By requesting that both the nurse/nurse aides and residents participate in completing surveys, comparisons can be made with the data. If the hypothesis

is accurate, nursing homes with a higher percentage of employee morale statements answered 'strongly agree' will also have a higher percentage of resident satisfaction questions answered 'very good'. Therefore, nursing homes that have more employee morale statements closer to a mean score of (1) will also have more resident satisfaction statements with a mean score closer to (4).

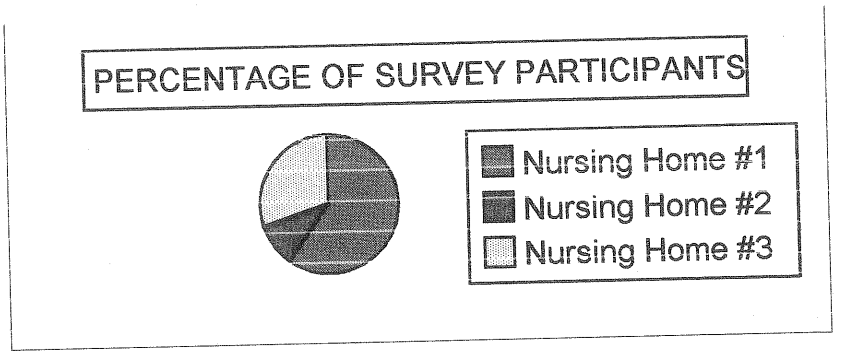
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

A. Nursing Home Resident Satisfaction

Of the 392 residents within the three nursing facilities, 83 completed the survey. Only 5 of the residents that were asked to participate in the study declined. 50 (60%) of the residents that completed the survey were from facility #1, 9 (10%) were from facility #2, and 25 (30%) were from facility #3. Although 60% of the residents were from nursing home #1, they actually only represent 18.5% of that homes resident population. The other two participating facilities represent 21.4% and 31.2% of their resident population, respectively. Therefore, nursing home #1 is actually under-represented in regards to percentage of resident population.

Table #1: Percentage of nursing home participants



1. Data analysis of the nursing home resident satisfaction scale

The data received from the three nursing homes is based on a four point Likert scale ranging from (1) not so good to (4) very good. The data is

separated into four groups: physician services; nursing services; environment; and global satisfaction. Due to the fact that (4) represents 'very good', the best score that each category within the group can receive is a 4. Scores of each category are based upon the mean of each of the three facilities. Although the mean does not accurately represent the data obtained from each individual, it does give a fair representation of the population.

Table #2 presents the data received from nursing home #1. As indicated in the table, the mean of each of the categories never went below 2.5. This suggests that most of the residents were somewhat satisfied with the care that they were receiving. The lowest mean score recorded was for reliability of physician services. Residents at this nursing home stated that they rarely ever see a doctor, even when they request one.

The highest score is recorded in the interpersonal skills of the nursing staff. This is interpreted to mean that the nursing staff is kind to the residents.

Table #2: Nursing home #1 means and standard deviations

Item	Cases Responding (n=50)	Mean	SD
PHYSICIAN SERVICES			
Interpersonal skills	46	2.93	1.02
Reliability	30	2.57	1.01
Technical Skills	44	3.00	1.03
NURSING SERVICES			
Interpersonal skills	49	3.36	.91
Reliability	44	2.77	.99
Technical Skills	50	3.18	.92
ENVIRONMENT			
Meals	50	2.68	1.13
Physical Surroundings	50	3.22	.97
Privacy	49	3.08	.99
GLOBAL SATISFACTION	50	3.14	.99

Data received at nursing home #2 is presented in table #3. Once again, the lowest mean score was recorded for physician services. Residents that completed this survey stated that they only see their physician once per month. A few of the residents couldn't remember ever being seen by a physician at all.

Meals were also scored fairly low, in comparison to the other categories. No specific answers were given to indicate why the participants disliked their meals. It could be in the dietitians best interest to look into this issue further.

Once again, the highest score was interpersonal skills of the nursing staff. As a whole, nursing home #2 scored all categories under nursing services quite high.

Table #3: Nursing home #2 means and standard deviations

Item	Cases Responding (n=9)	Mean	SD
PHYSICIAN SERVICES			
Interpersonal skills	8	3.38	.92
Reliability	3	2.33	1.15
Technical Skills	8	3.37	.52
NURSING SERVICES			
Interpersonal skills	9	3.67	.50
Reliability	9	3.22	.67
Technical Skills	9	3.44	.53
ENVIRONMENT			
Meals	9	2.44	1.01
Physical Surroundings	9	3.44	.73
Privacy	9	3.33	.71
GLOBAL SATISFACTION	9	3.33	.50

Table #4 represents data gathered at nursing home #3. Unfortunately for the physicians, physician reliability received the lowest score out of all of the categories. This nursing home has just recently expanded and many of the residents that were interviewed were fairly new and hadn't had the opportunity to get to know the nursing homes physicians.

Oddly enough, the highest score was recorded in the category of interpersonal skills for physicians. Apparently the doctors are kind, but not very reliable.

Table #4: Nursing home #3 means and standard deviations

Item	Cases Responding (n=24)	Mean	SD
PHYSICIAN SERVICES			
Interpersonal skills	24	3.67	.64
Reliability	13	2.92	1.12
Technical Skills	22	3.13	.94
NURSING SERVICES			
Interpersonal skills	23	3.52	.67
Reliability	22	3.36	.73
Technical Skills	23	3.35	.78
ENVIRONMENT			
Meals	24	3.42	.65
Physical Surroundings	24	3.33	.92
Privacy	24	3.04	.95
GLOBAL SATISFACTION	24	3.50	.66

Table #5: Means of nursing homes #1, #2, and #3

Item	Nursing Home #1	Nursing Home #2	Nursing Home #3
PHYSICIAN SERVICES			
Interpersonal skills	2.93	3.38	**3.67**
Reliability	2.57	2.33	**2.92**
Technical Skills	3.00	**3.37**	3.13
NURSING SERVICES			
Interpersonal skills	3.36	**3.67**	3.52
Reliability	2.77	3.22	**3.36**
Technical Skills	3.18	**3.44**	3.35
ENVIRONMENT			
Meals	2.68	2.44	**3.42**
Physical Surroundings	3.22	**3.44**	3.33
Privacy	3.08	**3.33**	3.04
GLOBAL SATISFACTION	3.14	3.33	**3.50**

In respect to percentages of means, nursing homes #2 and #3 rated highest in 50% of the categories. Nursing home #3 rated highest in global satisfaction, which is extremely relevant, as it assess' general satisfaction with all aspects of care in the nursing home.

Nursing home #1 failed to rate highest in any of the categories. This could have been caused by the fact that the majority of participants were from this nursing home. Therefore, because there was a larger pool of participants, residents that were dissatisfied with their care would have had more of an opportunity to be chosen to participate in the survey.

Another reason that nursing home #1 could have for not scoring highest is that the residents may actually be less satisfied than the residents at the other two nursing homes. That would explain why their global satisfaction score was only a 3.14, which is closer to good than very good.

Table #6: Frequency distribution of responses (in percentages)

			Domains		
	Total Score	Global Satisfaction Item	Physician	Nurse	Environment
Not so good	8.0	6.0	8.2	5.7	8.5
OK	18.2	9.6	19.5	15.1	19.8
Good	31.7	36.1	30.3	26.0	27.0
Very good	42.1	48.2	42.0	53.2	44.7
Total Respondents	100.0	100.0	100.0	100.0	100.0

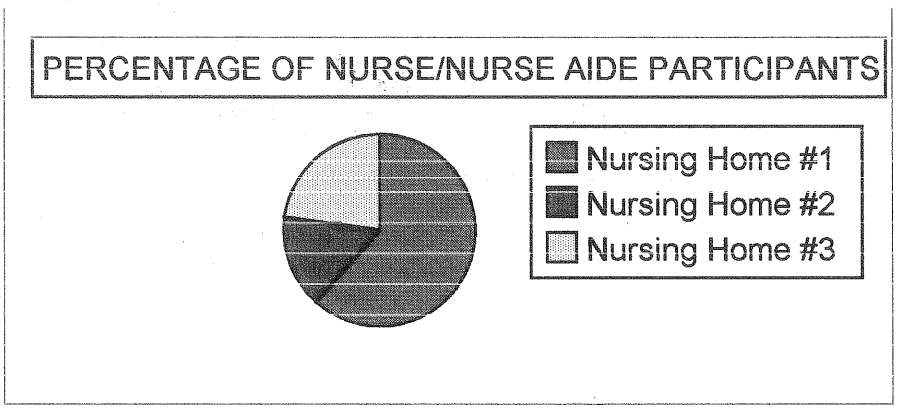
As evidenced by table #6, the frequency distribution of resident scores for the total instrument, the global satisfaction item and the three domains all

indicate very good response variability. These scores are actually much higher than in past documented studies.

B. Employee Morale

Of the 250 possible nurse and nurse aides employed by the three nursing homes, 114 completed the survey. 70 (61.4%) of the employees that completed the survey were from facility #1, 18 (15.8%) were from facility #2, and 26 (22.8%) were from facility #3. Once again, nursing home #1 comprises the largest amount of participants. Although nursing home #1 has 61.4% of the employees involved in the survey, they only represent 50% of that homes nurse and nurse aide population. 64.3% of nursing home #2's nurse and nurse aides completed the survey, while only 31.7% of nursing home #3's nurse and nurse aides filled out the survey.

Table #7: Percentage of nurse and nurse aide participants



1. Data analysis of the employee morale survey

The data received from the three nursing homes is based on a four point Likert scale ranging from (1) strongly agree to (4) strongly disagree. Due to the fact that (1) is strongly agree, the mean scores that are closest to one are most favorable. The original survey has been reworded to make all of the sentences positive. This made it possible to recode the data so that a (4) strongly disagree answer could be changed to a (1) strongly agree. For example, statement #2 was worded on the original survey: "I sometimes don't know just what is expected of me". If an individual strongly disagreed with the statement, it was assigned a score of 4. Rewording the statement to say "I know what is expected of me" made it possible to recode the scale so that the original (4) strongly disagree would be given a score of (1) strongly agree.

Once again, the scores of each category are based upon the mean of each of the three facilities. The mean does give a fair representation of the nurse and nurse aide population.

The data collected at nursing home #1 is presented in Table #8. Most of the statements were scored below 2.5, which represents the half-way mark between 'strongly agree' and 'strongly disagree'. Only four of the statements received scores above a 2.5. The most obvious statement that scored above a 2.5 is statement #24, "there's not enough to do and enough time to do it". Turning the sentence around, to say "there's too much to do and too little time to do it" makes more sense. This statement received a mean score of 3.62, meaning that many of the nurses and nurse aides don't feel that they have

enough time to do all of the work they have. This question is not surprising, as financial cutbacks and staff turnover have left staff members with large work loads.

The statement that came closest to a score of 1 was statement #17, "I am able to spot patients' problems before they become serious". It is surprising to see this statement score so well when the statement regarding time did so poorly. With so little time to get work done, it is difficult to believe that patients' problems are discovered in the early stages.

Table #8: Nursing home #1 means and standard deviations

Item	Cases Responding (n=70)	Mean	SD
The people I work w/ are friendly.	70	1.84	.86
Know what is expected of me.	70	2.41	1.12
Get to do a variety of things on the job.	70	1.56	.83
The pay is good.	70	1.61	.82
Given a lot of freedom to decide how to do my work.	69	2.78	1.08
Get a chance to follow through on tasks.	69	2.29	89
Don't feel trapped in tasks.	70	2.61	1.07
Get a feeling of accomplishment from what I'm doing.	70	1.74	.83
Don't have to do things against my better judgment.	69	2.71	1.05
Job security is good.	69	1.51	.78
Supervisor lets me know how well I take care of patients.	68	2.38	1.12
Don't have to work overtime when I don't want to.	70	1.70	.95
Patients accept and trust me.	68	1.49	.76
Not expected to do things that aren't part of my job.	70	2.47	1.16
Patients don't threaten to complain about me.	69	2.49	1.09
Families don't threaten to report me.	68	2.29	1.20
Able to spot patients' problems before they're serious.	68	1.41	.60
Patients make me feel needed.	69	1.52	.80
Supervisor listens to my suggestions.	69	1.86	.96
Not too much to do and enough time to do it.	69	3.62	.69
Can see the results of my work.	70	1.79	.90

Table #9 represents data received at nursing home #2. As indicated in the table, the mean of each statement only went above 2.5 two times. Once again, the statement regarding how much time there is to do work is an issue.

"The pay is good" received the same score as the statement regarding time. It is not surprising to see money as an issue, as many nurses and nurse aides are not paid for the hard work they do.

Table #9: Nursing home #2 means and standard deviations

Item	Cases Responding (n=18)	Mean	SD
The people I work w/ are friendly.	18	1.38	.50
Know what is expected of me.	18	2.11	.96
Get to do a variety of things on the job.	18	1.61	.85
The pay is good.	18	2.94	1.00
Given a lot of freedom to decide how to do my work.	18	2.50	.99
Get a chance to follow through on tasks.	18	1.67	.68
Don't feel trapped in tasks.	18	2.17	1.10
Get a feeling of accomplishment from what I'm doing.	18	1.39	.78
Don't have to do things against my better judgment.	18	1.89	.96
Job security is good.	18	2.27	1.13
Supervisor lets me know how well I take care of patients.	18	2.22	1.00
Don't have to work overtime when I don't want to.	18	1.83	.99
Patients accept and trust me.	18	1.22	.43
Not expected to do things that aren't part of my job.	18	2.06	1.00
Patients don't threaten to complain about me.	18	1.50	.92
Families don't threaten to report me.	18	1.11	.47
Able to spot patients' problems before they're serious.	18	1.56	.51
Patients make me feel needed.	18	1.22	.43
Supervisor listens to my suggestions.	18	2.11	.96
Not too much to do and enough time to do it.	18	2.94	.87
Can see the results of my work.	18	1.39	.70

Data received at nursing home #3 is presented in table #10. Four of the statements went above 2.5. For the third time, the statement regarding amount of time in which to do things received a score of 3.44. Apparently most everyone feels stressed for time.

The lowest recorded score for nursing home #3 is statement #18, "My patients make me feel needed". It is wonderful to see this statement score so well when the staff is feeling so over worked. Feeling needed by the residents can help to outweigh the stress of not having enough time to do work.

Table #10: Nursing home #3 means and standard deviations

Item	Cases Responding (n=26)	Mean	SD
The people I work w/ are friendly.	26	1.92	.80
Know what is expected of me.	26	2.46	1.14
Get to do a variety of things on the job.	26	1.65	.75
The pay is good.	23	2.89	.92
Given a lot of freedom to decide how to do my work.	25	2.48	.87
Get a chance to follow through on tasks.	25	1.96	.84
Don't feel trapped in tasks.	26	2.69	1.16
Get a feeling of accomplishment from what I'm doing.	26	1.69	.88
Don't have to do things against my better judgment.	26	1.77	1.03
Job security is good.	24	2.17	1.17
Supervisor lets me know how well I take care of patients.	26	2.46	1.14
Don't have to work overtime when I don't want to.	26	2.08	1.20
Patients accept and trust me.	25	1.48	.71
Not expected to do things that aren't part of my job.	23	2.61	1.16
Patients don't threaten to complain about me.	26	1.88	1.03
Families don't threaten to report me.	25	1.60	1.00
Able to spot patients' problems before they're serious.	26	1.58	.58
Patients make me feel needed.	26	1.31	.47
Supervisor listens to my suggestions.	26	2.31	1.09
Not too much to do and enough time to do it.	26	3.44	.65
Can see the results of my work.	26	1.46	.65

Table #11 Compared means of all 3 nursing homes

Item	Nursing Home #1	Nursing Home #2	Nursing Home #3
The people I work w/ are friendly.	1.84	**1.38**	1.92
Know what is expected of me.	2.41	**2.11**	2.46
Get to do a variety of things on the job.	**1.56**	1.61	1.65
The pay is good.	**1.61**	2.94	2.89
Given a lot of freedom to decide how to do my work.	2.78	2.50	**2.48**
Get a chance to follow through on tasks.	2.29	**1.67**	1.96
Don't feel trapped in tasks.	2.61	**2.17**	2.69
Get a feeling of accomplishment from what I'm doing.	1.74	**1.39**	1.69
Don't have to do things against my better judgment.	2.71	1.89	**1.77**
Job security is good.	**1.51**	2.27	2.17
Supervisor lets me know how well I take care of patients.	2.38	**2.22**	2.46
Don't have to work overtime when I don't want to.	**1.70**	1.83	2.08
Patients accept and trust me.	1.49	**1.22**	1.48
Not expected to do things that aren't part of my job.	2.47	**2.06**	2.61
Patients don't threaten to complain about me.	2.49	**1.50**	1.88
Families don't threaten to report me.	2.29	**1.11**	1.60
Able to spot patients' problems before they're serious.	**1.41**	1.56	1.58
Patients make me feel needed.	1.52	**1.22**	1.31
Supervisor listens to my suggestions.	**1.86**	2.11	2.31
Not too much to do and enough time to do it.	3.62	**2.94**	3.44
Can see the results of my work.	1.79	**1.39**	1.46

Nursing home #1 scored closest to (1) 28% of the time, nursing home #2 62% of the time, and nursing home #3 10% of the time.

C. Analyzing the hypothesis

Hypothesis: Nursing homes with higher percentages of employees with high morale will produce higher levels of satisfaction among their residents.

Table #12: Compared percentages of resident satisfaction & employee morale

	Nursing Home #1	Nursing Home #2	Nursing Home #3
Employee Morale	28%	62%	10%
Resident Satisfaction	0%	50%	50%

Nursing home #2 validates the hypothesis, with percentages of employee morale being higher that the other two nursing homes 62% of the time and resident satisfaction scoring higher than the other two nursing homes 50% of the time. Employee morale scored highest in 62% of the statements, this was much higher than the other two nursing homes. The other nursing homes scored higher than nursing home #2 a total of 38%, this is an obvious difference. With a difference in percentages being so obvious, it was not surprising to see resident satisfaction also rate high for this nursing home.

Nursing homes #1 and #3 do not prove the hypothesis. They do not necessarily disprove the hypothesis, they just don't present a good argument for it. Nursing home #1 scored higher in employee morale 28% of the time, while nursing home #3 scored higher 10% of the time. The mean scores for employee

morale in nursing home #1 and #3 are extremely close 28% of the time. Therefore, the high rate of resident satisfaction at nursing home #3 is not unexpected. Overall, nursing home #3 scored under 2.5 80% of the time in employee morale. This explains why 50% of the resident satisfaction scores were highest at this nursing home.

Nursing home #1 scored above a 2.5 in resident satisfaction 80% of the time also, but didn't score highest in any of the categories. As a matter of fact, they only scored second highest in all of the categories 30% of the time. Resident satisfaction was fairly low at this nursing home, but so was employee morale.

While nursing home #2 supports the hypothesis, nursing home #1 and #3 do not offer conclusive evidence in favor of the hypothesis. Perhaps the results would have been more conclusive if there were more nursing homes involved in the study. It would also have helped to have similar size nursing homes, as the same number of surveys could be distributed at all nursing homes, offering more consistency.

With similar sized staff and resident populations, it is believed that the survey tools used are useful in determining the effects that employee morale have on resident satisfaction.

CHAPTER V

SUMMARY AND CONCLUSIONS

A. Summary

It is obvious that with an increasing number of our baby boomers reaching retirement age, we are going to need to increase the number of available nursing home beds. State and federal cutbacks have already made it impossible to run a nursing home efficiently and properly. Increasing the number of beds will just add to the stress that is already so much a part of being a nursing home employee.

The main issue considered throughout this paper was how employee morale effects nursing home resident satisfaction. It would be almost impossible for the employees to shield the residents from the pressures that they are receiving from their jobs. In fact, they probably hear about the nurses and nurse aides problems at least once per day. The nurses and nurse aides sometimes forget why they are there.

Three nursing homes in upstate NY were studied to determine how employee morale effects resident satisfaction. Employees were instructed to fill out a 21 item survey measuring their satisfaction with their employment. Residents were approached and asked to participate in an oral questionnaire that would measure their satisfaction with care.

Only one of the nursing homes involved in the research proved the hypothesis to be accurate, that employee morale does effect resident satisfaction. The other two provided essential information, but were not consistent in proving the hypothesis.

B. Conclusion

From this study, it can be concluded that the data collected is inconclusive. The nursing home that proved employee morale effects resident satisfaction was extremely small, which may have had a direct effect on both employee morale as well as resident satisfaction. A smaller nursing home would allow for the residents to have more one on one communication with all of the staff. For example, there would be less residents for the social worker to deal with, therefore, they would be more accessible to the residents that need them.

C. Recommendations

Information regarding data collected at the three nursing homes has been offered to the administrators at each of these facilities. It is highly recommended that these individuals accept the information and put it to some use. The information made available to the administrators could be very useful when making quality improvement decisions. For example, because the residents at nursing home #1 scored nursing reliability so low, inservices could be offered to the nursing staff on how to answer call bells in a more efficient manner.

Other recommendations to improve employee morale are the following:

1. Make employees feel as though they are a team by implementing ITTG training methods.
2. Consider primary care as a method for permanent assignment of residents and increased team participation.
3. Increase job training and inservices.
4. Add humor to the nursing facility.

5. Offer recognition to each and every employee.

Although this paper only identifies with long-term care facilities, the underlying concept is identifiable in most all circumstances. Take for instance a line worker for Ford Motor Company. If that line worker feels undervalued he is going to slack off and perhaps one mini-van might not receive the spring that holds the seat belt in place. In this example, it is essential that management understands the magnitude of this problem. With the suggested recommendations, it is possible for management to provide an environment for their employees that is satisfying as well as enjoyable, hence, improving morale.

APPENDIX A

The Nursing Home Resident Satisfaction Scale

Using a scale from 1 (not so good) to 4 (very good), please rate your stay in the nursing home on the following questions. Feel free to make any comments or suggestions.

1	2	3	4	5
Not So Good	OK	Good	Very Good	N/A

Physician Services

1. Do the doctors treat you well? 1 = yes 2 = no _____
   How well do they treat you? (1,2,3,4,5) _____
2. Do the doctors come quickly when you ask to see them? _____
   1 = yes 2 = no
   How would you rate the time it takes to come see you? _____
   (1,2,3,4,5)
3. Do you have confidence in the doctors' abilities? 1 = yes 2 = no _____
   How would you rate your confidence? (1,2,3,4,5) _____

Nursing Services

1. Do the nurses treat you well? 1 = yes 2 = no _____
   How well do they treat you? (1,2,3,4,5) _____
2. Do the nurses come quickly when you call them? 1 = yes 2 = no _____
   How would you rate the time it takes to come to you? (1,2,3,4,5) _____
3. Do you have confidence in the nurses' abilities? 1 = yes 2 = no _____
   How would you rate your confidence? (1,2,3,4,5) _____

Other Services

1. Do you enjoy mealtime? 1 = yes 2 = no _____
   (presentation, service, choices, taste)
   How would you rate mealtime? (1,2,3,4,5) _____
2. Do you like your room? 1 = yes 2 = no _____
   (cleanliness, roommate, space, temperature)
   How would you rate your room? (1,2,3,4,5) _____
3. Do you get enough quiet and privacy? 1 = yes 2 = no _____
   How would you rate the amount of quiet and privacy? (1,2,3,4,5) _____

General Services

1. Considering everything how would you rate your overall satisfaction (doctor, nursing care facilities, etc.) (1,2,3,4,5) _____

Courtesy of Zinn, Lavizzo, Risa, and Taylor (1993)

Nursing Home:

Shift: (1) Day (2) Evening (3) Night

INSTRUCTIONS

Please indicate how much you agree or disagree with each of the following statements about your job, by circling one of the numbers for each statement: "Strongly Agree", "Somewhat Agree", "Somewhat Disagree", and "Strongly Disagree".

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
The people I work with are friendly.	4	3	2	1
I sometimes don't know just what is expected of me.	4	3	2	1
I get to do a variety of things on the job.	4	3	2	1
The pay is good.	4	3	2	1
I am given a lot of freedom to decide how I want to do my work.	4	3	2	1
I get a chance to follow through on a task I start.	4	3	2	1
I sometimes feel trapped in a task I can't get out of.	4	3	2	1
I get a feeling of accomplishment from what I'm doing.	4	3	2	1
I feel that I have to do things that are against my better judgement.	4	3	2	1
The job security is good.	4	3	2	1
My supervisor lets me know how well I am taking care of my patients.	4	3	2	1
I have to work overtime when I don't want to.	4	3	2	1
My patients accept and trust me.	4	3	2	1
I'm expected to do things that are not part of the job.	4	3	2	1
Patients threaten to complain if I don't do what they want.	4	3	2	1
Families threaten to report me if I don't do what they want.	4	3	2	1
I am able to spot patients' problems before they become serious.	4	3	2	1
My patients make me feel needed.	4	3	2	1
My supervisor listens to my suggestions.	4	3	2	1
There's too much to do and too little time to do it.	4	3	2	1
I feel that I can see the results of my work.	4	3	2	1

Courtesy of: Teresi, Holmes, Benenson, Monaco, Barrett, and Koren (1993)

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