

QUALITY NURSING CARE RELATED TO THE PRIMARY
NURSE'S LEVEL OF EDUCATION

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BY
LINDA DIANE UNGVARSKY

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We hereby recommend that the thesis prepared under
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Master of Science

Committee:

Betty Henderson
Chairman
William F. Dyer
Mary Elizabeth Benedict

Accepted:

Margaret J. Ferrell
Dean of The Graduate School

DEDICATION

This thesis is dedicated to my late father,
Andrew Julius Ungvarsky, Captain, United States Army,
and my mother, Eleanor Anne Portasik Ungvarsky.

Influenced by their belief that

tedi treba strom zohnúts kim je mladý,

(the tree must be bent while it is still young)

they taught me to value education, a lesson which continues
to influence me today.

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CHAPTER 1

INTRODUCTION

Quality health care has been declared a right for all citizens; however, it has not been consistently evidenced throughout our health care system. Therefore, health care consumers have flexed their political muscle and demanded that they be guaranteed quality health care when hospitalized. In 1972, Public Law 92-603 amended Title XI of the Social Security Act to include Section 249 F which requires that Professional Standards Review of physicians' services for Medicare and Medicaid patients be conducted. In addition, the Joint Commission on Accreditation of Hospitals (JCAH) extends the requirement of peer review to all hospitals and practices which seek accreditation. Peer Review, as described in the Performance Evaluation Procedure (PEP) Manual for health care institutions, identifies physician behaviors that are evaluated to determine the quality of medical care delivered. Section 730 of the PEP Manual also describes the equally important, but not yet required, evaluation of nonphysician health care professional behaviors. Of particular interest is the reference made to professional nursing's accountability for the delivery of quality nursing care.

Professional nursing should be held accountable for the quality of nursing care regardless of whether the accountability is mandated by law or not. Personal accountability for one's practice is one of the hallmarks of a profession; that is, each practicing nurse should ensure that quality nursing care is received by the patient. Many factors influence the quality of this care rendered by the professional nurse. However, the nurse's knowledge and skill derived from educational programs have been identified as one factor which can influence quality health care.

In many health care settings, professional nursing is being practiced by individuals with wide differences in their level of educational preparation. In addition, educational preparation seems not to influence the hiring criteria for most staff nurse positions. This situation is unlike that found among physicians who share a common minimum level of educational preparation. The question then arises concerning the possible effect differences in the level of educational preparation in nursing may have on the quality of nursing care as measured by Standards of Quality Nursing Care.

Statement of Problem

The specific question identified for study was: How does the level of educational preparation in nursing relate

to the quality of nursing care, in a primary nursing setting, as determined by Standards of Quality Nursing Care?

Statement of Purpose

The purposes of this study were:

1. To identify the highest level of educational preparation of nurses who care for patients in a primary nursing setting.
2. To determine the quality of nursing care delivered within a primary nursing setting.
3. To relate the highest level of educational preparation of nurses with the quality of nursing care delivered in a primary nursing setting.

Background and Significance

The Professional Standards Review Organizations (PSROs), mandated by Public Law 92-603, provide for the establishment of a national system of medical peer review (Hegyvary & Haussmann, 1976b). One component of this review is medical care evaluation. The Joint Commission on Accreditation of Hospitals also includes the component of medical care evaluation (Hegyvary & Haussmann, 1976b). While neither the PSROs nor the JCAH require that professional nursing conducts nursing care evaluation, the JCAH does define five Standards for Nursing Services (JCAH, 1970). Of these five Standards, four relate to nursing service

organization, policies, and structural attributes, and one relates to the need for documentation of the Nursing Process. Presently then, professional nursing only is required to provide evidence for satisfactory fulfillment of documentation of patient care in institutions which seek JCAH accreditation. It is anticipated, however, that peer review for nonphysician health care professionals, which would include evaluation of care delivered, will be mandated by Public Law in the future (Hauser, 1975; Hegyvary & Haussmann, 1976b).

In view of this likelihood, professional nursing has laid the foundation for holding its practitioners accountable for their delivery of care. In 1974, the American Nurses' Association, at its convention, issued resolutions which emphasized the need for identifying standards of care (Hauser, 1975). This has since been done, and a variety of efforts have been made to measure the quality of nursing care according to these standards. Some approaches have been structurally based and focus on the organization of the patient care system. Some have been process based and focus on the actual performance of care; and, some have been outcome oriented, and focus on the patient's welfare (Haussmann, Hegyvary & Newman, 1976). Hegyvary and Haussmann (1976d) contend that, although the complete model of patient care includes all three components (structure for delivery, actual performance or process, and outcome), the most valid

measure of the quality of nursing care of the patient is the Nursing Process itself. The Nursing Process is defined as "the comprehensive set of nursing activities performed in the delivery of a patient's care" and includes four phases: "assessing the problems or needs of the patient; planning for care; implementing the plan of care; and evaluating and updating the plan of care by evaluating the patient's response" (Hausmann et al., 1976, p. 6).

As professional nursing is currently practiced in the United States, individuals with varying degrees of educational preparation are employed by hospitals and other health care agencies. Most aspects of employment include the individual's responsibility for carrying out the Nursing Process. There are indications that the employing agencies assume that all professional nurses, regardless of their level of educational preparation, are capable of assuming complete responsibility for the Nursing Process (Abdellah, Beland, Martin, & Matheney, 1973; Boyd, 1975; DeChow, Malstrom, & Ogden, 1968; Forest, 1968; Hausmann et al., 1976; Moore, 1967). The literature, however, provided evidence that the different types of nursing education endow their graduates with varying abilities and capabilities in utilizing the Nursing Process (Benner & Kramer, 1972; Boyd, 1975; Francis, 1972; Meyer, 1958; National League for Nursing, 1966, 1968, 1973; Waters, Chater, Vivier, Urrea & Wilson, 1972).

Yet, literature is limited in studies which investigate the effect that the level of educational preparation has on quality of nursing care.

Education was one of the correlates of quality nursing care that was identified in the development of "Monitoring Quality of Nursing Care" by Haussmann et al. (1976). As they conducted large scale testing of their instrument, they concluded that the nurse's education had a possible latent effect on the quality of nursing care; however, they could not discount the effect that organizational realities might have on the educational ideals. They recommended controlling for nursing unit organizational structure in future studies which focused on influence of the nurse's education on the quality of nursing care delivered. Specifically, they believed that a study that included an organizational structure that was predisposed to high quality care could possibly identify the nurse's education as a significant influence.

Primary nursing has been identified as an organizational structure that promotes a high quality of nursing care (Leninger, Little & Carnevali, 1972; Logsdon, 1973; Manthey, Ciske, Robertson, & Harris, 1970; Marram, Schlegel, & Bevis, 1974; Smith, 1977). In addition, in a primary nursing setting, one nurse is held responsible for the total care of the patient during his hospitalization. This focus of

responsibility allows for the review of one particular nurse's performance in rendering quality care based on an evaluation of the Nursing Process.

In a primary nursing setting then, a study of the effect that level of educational preparation may have on quality of nursing care would contribute to the body of nursing knowledge that seeks to identify variables which influence quality care. A study of this nature is vital as professional nursing assumes accountability for its practice.

Conceptual Framework

Standards of quality nursing care are based on structure, process, and outcome of the care providing system. Process standards are descriptions of behaviors of nurses at the desired level of performance (Nicholls, 1977a). The standards of the Nursing Process include: assessment of the problems or needs of the patient; planning for care; implementing the plan of care; and evaluating the plan of care.

Hypothesis

The study hypothesis was: To determine if a difference exists in the quality of nursing care rendered in a primary nursing setting as related to the nurse's highest level of educational preparation in nursing.

Definition of Terms

For the purposes of this study, the following terms were defined:

Level of Educational Preparation: the highest degree obtained in formal academic preparation in nursing. This would include: an Associate Degree in Nursing, a Nursing Diploma, a Baccalaureate Degree in Nursing, Post Baccalaureate studies in Nursing, and a Master's Degree in Nursing.

Nursing Process: "the comprehensive set of nursing activities performed in the delivery of a patient's care" including "assessing the problems or needs of the patient, planning for care, implementing the plan of care, and evaluating and updating the plan of care by evaluating the patient's responses" (Hausmann et al., 1976, p. 6).

Primary Nursing: "the distribution of nursing so that the total care of the individual patient is the responsibility of one nurse, not many nurses" (Marram et al., 1974, p. 1). This approach to nursing includes a primary nurse providing initial patient assessment, assuming accountability for planning comprehensive round-the-clock care for the patient both during and immediately following hospital stay, and providing nursing care services to that patient while coordinating care with associate (other) nurses (Marram et al., 1974).

Quality of Nursing Care: the numerical value obtained from the systematic analysis of selected components of the Nursing Process derived from the Criteria Master List for Quality of Nursing Care (Haussmann et al., 1976).

Limitations

For the purposes of this study, the following limitations were considered:

1. The quality of nursing care was measured using a Nursing Process instrument which is limited to only one criterion.
2. The concept of primary nursing was limited to that which is practiced within one institution whose philosophy of the concept may vary from the pure or ideal form.
3. The level of educational preparation indicated only the highest level of nursing achieved and did not attempt to identify the effects that previous educational achievements may have had on the practitioner's orientation to nursing care.
4. The level of educational preparation did not take into account the differences that a school's philosophy and curriculum may have had on their graduates' orientation to the Nursing Process.
5. The investigator did not consciously seek to obtain an evenly dispersed number of varied educational levels in nursing.

Assumptions

For the purposes of this study the following assumptions were identified:

1. The Nursing Process was a significant variable in evaluating the quality of nursing care.
2. The individual nurse's highest level of educational preparation had much more relevance than the basic level of educational preparation on the quality of care delivered. This greater effect occurred since the individual's orientation was most significantly influenced by the latest and presumably highest academic exposure.

Summary

The health care system has as its mandate the delivery of quality health care to all who seek it. Professional nursing, a vital component of the health care system, is accountable for delivery of quality nursing care. One aspect of this accountability is the identification of those variables which influence the quality of nursing care rendered.

Primary nursing has been identified as an organizational variable that promotes a high quality of nursing care. The professional nurse's level of educational preparation in nursing also may be a significant correlate of quality nursing care. However the literature was limited in studies

which investigated this variable. By use of the Criteria Master List, this investigation proposed to determine if the primary nurse's level of educational preparation in nursing significantly affected the quality of nursing care delivered within the framework of the Nursing Process. The succeeding chapters present the investigation of this problem.

Chapter 2, the Review of Literature, presents an overview of quality nursing care related to the primary nurse's level of education. The principal topics incorporated in this chapter include: Quality Assurance, Quality Nursing Care, Nursing Practice and the Educational Preparation of Nurses, and Primary Nursing. The methodology utilized in this investigation is discussed in Chapter 3. The setting, population, sample selection, instrument, and method and treatment of the data collected are presented. Chapter 4, Analysis of Data, presents the results and provides an interpretation of the findings and statistics. In Chapter 5, Summary, Conclusions, Implications, and Recommendations are derived and presented based on the findings of this investigation.

CHAPTER 2

REVIEW OF LITERATURE

Within the health care system, more emphasis is being placed on the provision of quality care and the establishment of measures necessary to assure quality. Professional nursing, as a vital component of the health care system, has a great interest in establishing evidence for and maintaining control over, the quality of care provided by its practitioners. Presently, nursing's stimulus, as it progresses along the path of maturity leading to full recognition as an intellectual profession and an academic discipline, is the need to demonstrate accountability and responsibility among its practitioners for the quality of care provided. The future may alter this stimulus by adding the mandatory legal requirement of Professional Standards Review (PSR) of services for patients who participate in Medicare, Medicaid, and Maternal-Child Health programs, or for all patients should National Health Insurance become a reality. Therefore, nursing must invest tremendous interest in the area of evaluating the quality of nursing care presently delivered to identify those variables which promote high quality care. This investment is imperative if nursing does not wish to abdicate self-control of its practice. A review of the

literature will be presented to document the current body of knowledge pertaining to quality assurance and to quality nursing care. A discussion of the educational preparation of the nurse providing the care, and one organizational structure, primary nursing, also will be included.

Quality Assurance

The health care system exists to provide care to members of society who are in need of reestablishing or who wish to maintain the integrity of their health. The professions of medicine and nursing are but two of the several health care professions which are included in this system. As such, medicine and nursing "exist at the will of society and are influenced by the changes in the society they serve" (Nicholls, 1977a, p. 42). Society, at large, has taken a greater interest in the health care system within the last decade. This interest has been generated, most probably, by advancing scientific technology which has brought expanded knowledge and awareness to the attention of the general public. Included in this increased awareness is the greater emphasis placed on the expense associated with the health care system. Today, men and women live longer, and presumably healthier, lives due to medical and scientific advances in the treatment and prevention of disease and disability and in health promotion. Individuals have

come to expect health care services to be available and to be assured of high quality care at a reasonable cost (Sward, 1975).

In October 1972, the United States Congress passed and the President signed Public Law 92-603, an amendment to Title XI of the Social Security Act to "promote effective, efficient, and economical delivery" of health services (U.S. Congress, 1972, p. 1). Section 249F of this law established Professional Standards Review Organizations (PSROs) as a prerequisite for institutional (hospital and other health care agency) participation in the federally financed programs of Medicare (Title 18), Medicaid (Title 19), and Maternal-Child Health (Title 5). The PSROs comprise a national system of medical peer review which is regionally based and conducted. The Secretary, Department of Health, Education, and Welfare has designated 203 regional PSROs in the United States. Within each regional PSRO, continual review of health care services provided to patients whose care is financed through Medicare, Medicaid, and Maternal Child-Health programs is mandated. Included in this review are the areas of: (1) determining whether admission of the patient to an institution is medically necessary; (2) determining whether the length of stay in the institution is consistent with reasonable professional judgment; (3) determining whether the services could be

provided effectively and more economically by ambulatory care or by inpatient care in a different type of facility; and (4) determining whether the quality of the services to the patient conforms to appropriate professional standards (Geoffrey, 1977). It can be seen, therefore, that in addition to the emphasis placed on the proper utilization of hospitals and alternative health care agencies, emphasis is placed also on an evaluation of the medical care the patient receives (Hegyvary & Haussmann, 1976a).

The concept of medical care evaluation was addressed by the Joint Commission on Accreditation of Hospitals (JCAH) (1970). All hospitals seeking JCAH accreditation after July 1, 1975 must provide evidence that medical care evaluation, in the form of peer review, is conducted. Peer review was defined for nurses by the American Nurses' Association (ANA) as the:

. . . process by which registered nurses, actively engaged in the practice of nursing, appraise the quality of nursing care in a given situation in accordance with the established standards of practice. (ANA, 1973, p. 1)

Peer review for physicians would be conducted in a similar fashion. The significance of the JCAH directive stems from its applicability to all patients cared for in institutions seeking JCAH accreditation as opposed to the PSROs concern with only those patients involved in federally financed programs. The JCAH developed the Performance Evaluation

Procedure (PEP) Manual to facilitate the evaluation of the medical care provided. This manual provides a methodology to "effectively assess the quality of patient care on the basis of patient outcome data and retrospect chart review" (Christoffel & Jacobs, 1974, p. 34). Physicians who provide care for patients in institutions which participate in federally financed programs and/or which seek JCAH accreditation can generally satisfy both the PSRO and the JCAH medical care evaluation requirements with the PEP Manual.

While both the PSROs and the JCAH are concerned with documentation of quality health care, their requirements legally extend only to the medical care the patient receives. However, both do address the concept of quality nursing care. In the PSRO manual, reference is made to nonphysician health care practitioners. These practitioners are defined as:

. . . those health care professionals who do not have a Doctor of Medicine or a Doctor of Osteopathy degree, but who deliver direct patient care which is directly or indirectly reimbursed by Medicare, Medicaid, and/or Maternal-Child Programs. These nonphysician health care practitioners must be qualified by education, experience, and/or licensure to practice their profession. (U.S. Dept. of Health, Education, & Welfare, 1975, p. 21)

This reference to the nonphysician health care practitioner has come to be accepted as the reference with specific applicability to the professional nurse. Davidson, Burleson, Crawford, and Christofferson (1977) have interpreted this

reference to indicate that nurses must provide evidence that they are involved in the activities of: (1) developing and continually modifying norms, criteria, and standards for their area of practice; (2) developing review mechanisms to be used for peer assessment of nurses' performance; (3) conducting health care review of nurses by their peers; (4) working to establish continuing education programs to assure the utilization of the results of the review; and (5) where appropriate, participating with physicians in review committees. Geoffrey (1977) contended that nursing performance will soon come under particular scrutiny as nurses are the "most numerous of the nonphysician health care practitioners" (p. 30). As such, he contended, the professional nurse has an important role in decision-making regarding quality of health care. Horswell (1975) noted that the logical evolvement of the PSRO authority will be the demand that the nonphysician health care practitioner evaluate and monitor the care provided. Nicholls and Wessells (1977) sensed an urgent pressure on nursing to develop more precise standards for nursing care, and to devise effective means to measure the degree of achievement of these standards as a result of the Public Law which established PSROs. Furthermore, Nicholls (1977a) believed that with the passage of some form of National Health Insurance, all health care professionals will be

expected to evolve practice standards and monitor adherence to them. Hegyvary and Haussmann (1976b) contended that the intent of PL 92-603 will be extended to include the professional nurse.

So definite is the assumption that professional nurses will be legally included in PSROs in the immediate future, a contract was established between the Department of Health, Education, and Welfare, Health Services Administration, Office of Professional Standards Review, Bureau of Quality Assurance and the American Nurses' Association. The stated purpose of this contract (HSA NO 105-74-207) was to "develop model sets of criteria for screening quality, appropriateness, and necessity of nursing care in settings for which PSROs have responsibility" (American Nurses' Association, 1975b, p. v). The result has been the preparation of a manual to serve as an educational tool to aid in the development of a system for evaluation of quality nursing care (American Nurses' Association, 1976).

The JCAH also addressed the concept of the role of professional nursing in assuring quality of care. Section 730 of the PEP Manual describes the importance of the evaluation of nonphysician health care practitioners. In this reference, professional nursing is held accountable for the delivery of quality nursing care. In addition, the JCAH, in its Accreditation Manual for Hospitals, defined five

Standards for Nursing Services, four of which relate to nursing service organization, policies, and structural attributes, and one which relates to professional nursing activities (JCAH, 1970). This Standard stated "there shall be evidence that the Nursing Service provides safe, efficient, and therapeutically effective nursing care through the planning of each patient's care and the effective implementation of the plans" (JCAH, 1970, p. 10).

Professional Standards Review Organizations and the Joint Commission on Accreditation of Hospitals are two examples of forces outside a profession which demand quality assurance. Another source of external control is the American Hospital Association. In 1971, the Association issued a Policy Statement on the Provision of Health Services which focused on the individuals providing health care.

The system must support only those providers that meet standards of effectiveness, quality, and efficiency. Providers rendering good quality care in the most economic manner must be continued and developed, providers not providing such care must be assisted to do so, and providers unwilling or incapable of providing such care must not be supported. (American Hospital Association, 1971, p. 1)

The PSROs, American Hospital Association, JCAH, and other similar structures rely on the law, public concern, economic circumstances, and institutional policy. The strength of these forces has been evidenced only recently, and with respect to professional nursing, is only in its gestational

period. There are other forces, within the profession, however, which have influenced professional nursing for decades.

The basis for these internal forces was summarized in Donabedian's commentary on social contracts between society and a profession.

There is a social contract between society and the professions. Under its terms, society grants the profession authority over functions vital to itself, and permits them considerable autonomy in the conduct of their own affairs. In return, the professionals are expected to act responsibly, always mindful of the public trust. Self regulation to assure quality performance is at the heart of this relationship. It is the authentic hallmark of a mature profession. (Donabedian, 1972, p. xi)

Quality Nursing Care

The concept of quality nursing care was first addressed by Florence Nightingale in Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army (1858). Nightingale emphasized the structural conditions (clean air, sunlight, adequate diet, and so forth) that she had observed as necessary for patient recovery. Sward (1975) noted that a "moral commitment to the concept of quality nursing care was made almost 80 years ago by the organization that later became the American Nurses' Association" (p. 29). Adda Eldredge indicated her concern for quality nursing care in 1932 when she identified many of the factors which comprise the major dimensions

of quality today (Hegyvary, Gortner, & Haussmann, 1975). This commitment to quality nursing has been and is the major thrust of the American Nurses' Association. In 1972, the ANA set, as one of its priorities, the promotion of peer review as a means of maintaining standards of care. In 1973, the American Nurses' Association Congress for Nursing Practice issued Guidelines for Peer Review, and, at the convention, resolutions were made to again emphasize standards of care. From these resolutions emerged two major steps directed towards professional and public assurance of quality of nursing care: development of generic and specialty Standards of Nursing Practice; and, programming for national implementation of these Standards (Phaneuf, 1975). Phaneuf (1975) directed attention to these American Nurses' Association actions which are "bold and courageous" as "no other health profession has moved in this dynamic way under voluntary national organizational leadership" (p. 138).

The Standards of Nursing Practice, of which Phaneuf spoke, were developed through the efforts of the Congress for Nursing Practice and the Division on Nursing Practice of the American Nurses' Association (ANA). The need for their identification and implementation was based on the premise that as "nursing care is a major component of health care, quality assurance in nursing is essential to

guarantee the overall quality of health care" (ANA, 1975b, p. v). The Standards that emerged are "based on the premise that the individual nurse is responsible and accountable to the client for the quality of nursing care the client receives" and are to be "considered baseline for determining quality of care" (ANA, 1975b, p. 2). These Standards require that all clients have nursing diagnoses derived from the health status data collected; that the data be collected systematically and continuously; that the plan of nursing care include goals derived from the nursing diagnosis, identification of priorities, and prescription of nursing approaches to achieve the goals; that client orientation to the plan of care, in addition to client collaboration in goal determination and progress evaluation, be included; and, that reassessment, reordering of priorities, new goal setting, and revision of the plan of nursing care accompany any failure to achieve progress towards goal attainment (ANA, 1975b). The ANA underscored the need for implementation of Standards of Practice based on its contention that:

. . . nursing's concern for the quality of its services constitutes the heart of its responsibilities to the public. The more expertise required to perform the service, the greater is society's dependence on those who carry it out. Nursing must control its practice in order to guarantee the quality of its services to the public. Behind that guarantee are the standards of the profession which provide assurance that service of a high quality will be provided. This is essential

both for the protection of the public and the profession itself. A profession which does not maintain the confidence of the public will soon cease to be a social force. (ANA, 1975b, p. 1)

The confidence of the public will be maintained only if continuous measurement of the quality of nursing care based on these Standards is undertaken. Approaches for measuring the quality of care generally have followed the framework identified by Donabedian, "one of the foremost authorities on evaluation of (medical) care" (Block, 1975, p. 189). Donabedian (1966) rejected the traditional indices of quality of hospital care (morbidity and mortality rates) as of little use due to the many factors which can contribute to producing these phenomena. From the approaches identified by Sheps in 1955 (examination of the prerequisites for adequate care, indices of elements of performance, indices of the effects of care, and qualitative clinical evaluations), Donabedian (1966) derived the classification system of structure, process and outcome. Structurally based approaches focus on the organization of the patient care system; process based approaches focus on the actual performance of care; and, outcome based approaches focus on the patient's welfare (Hausmann et al., 1976).

Donabedian emphasized the importance of process based approaches in the evaluation of the quality of care. He stated:

. . . in the particular context of evaluating the performance of practitioners in caring for individual patients, I have felt it more reasonable to give primacy to the process of care and to consider structural attributes and outcomes as indirect measure, or evidence of the quality of the process, on the assumption that certain attributes of structure are conducive to the achievement of certain states of the patient. (Donabedian, 1975, p. 8)

He cited the advantage of immediate or early feedback concerning quality of care as an inherent characteristic of process based approaches. Additional support for this viewpoint of "primacy to the process of care" is abundant in the literature. Hegyvary and Haussmann (1976c) contended that, although the complete model of patient care includes all three components (structure for delivery, actual performance or process, and outcome), the most valid measure of the quality of nursing care of the patient is the Nursing Process itself. Schlotfeldt (1977) concurred with the focus on the actual practice of performance of care, i.e.,

. . . on assessing the people's health status, assets, and deviations from health and on helping sick people to regain health and the well or near well to maintain or attain health through selective application of nursing science and the use of available nursing strategies. (p. 11)

The American Nurses' Association (1975b) recognized the Nursing Process as the model of practice and affirmed its utilization as the model of quality appraisal in the examination of the roles of assessment, goal-setting, planning, and evaluation. Block (1974) identified the Nursing Process as

a construct of basic importance in nursing, as it embodies such activities as assessment, planning, implementation or intervention, and evaluation. She referred to the fact that these activities or principles are incorporated into the generic Standards of Practice promulgated by the ANA; and, therefore, evaluating them involves examination and judgment regarding the nurse's adherence to these principles. Block (1975) cited the advantage of process approaches as "giving clues to corrective action" because "after all, in efforts at improvement of the quality of care, it is not the outcome which can be manipulated; rather, it is the professional practice which must be changed in the hope and with the expectation that outcomes will change as a result" (p. 262). Nicholls (1977c) supported process based approaches with her observation that the "actual activities involved in providing care are crucial in determining the quality of care" (p. 34). Phaneuf (1975) offered the view that "in quality assurance, substantial attention must be given to the quality assurance methods that center on the Nursing Process" which is "nursing's prerogative and responsibility and under nursing control" (p. 146). Stevens (1977) believed that the "process format offers the most realistic area in which to locate quality control" (p. 78). Sward (1975) reminded nursing that the ANA's Standards of Nursing Practice address themselves to the concept of quality in

nursing care and affirm the Nursing Process as a systematic approach to the delivery and evaluation of quality care.

A review of the literature further revealed that process based approaches, because they can be limited to nursing activities, have special relevance for professional nursing as it seeks to identify correlates of quality nursing care. Admittedly, there are limitations inherent in this approach, some of which are fulfilled in outcome based approaches. Donabedian (1972) identified some of the advantages of outcome based evaluations. This format, he stated, satisfies the "eminently reasonable argument that all the health care in the world is for naught unless it makes some impact on health" (Donabedian, 1972, p. 8). It also is characterized by much agreement on the identification of desired health outcomes. Finally, outcome based evaluations possess integrative health care properties, i.e., "at the level of the individual patient, they represent the result of the efforts of all those involved in the patient's care, and at the population level, they represent the operationalization of the health care system as a whole" (Donabedian, 1972, p. 8). However, as global as these advantages appear, their very all-inclusiveness acts as a potent factor in eliminating them from usefulness in identifying the actual correlates of quality nursing care.

A select review, from a large body of current literature on outcome based evaluations, emphasized this problem of attribution of place and degree of responsibility for outcomes. Donabedian (1972) contended that a multiplicity of factors can influence health, and, at our present state of knowledge, it is not possible to separate the contributions of medicine from nursing or from other health care professions. Furthermore, it is not possible to identify the subtle effects that psychological, sociological, and emotional components inherent in the nature of the individual patient may have had on the outcome of the patient's health state. Bellinger (1975) made reference to the great many non-nursing factors which contribute to a patient's health status, as well as to the many outcomes which are difficult to evaluate (i.e., satisfaction with care, compliance, and so forth). Block (1975) observed that a patient's knowledge, behavior, and health state are influenced by many factors besides nursing care, and indicated that it is extremely difficult to define outcome criteria which can be solely attributed to nursing care.

Hilger (1974) defined an outcome as "an alteration in the health status of the consumer" and a criterion as "an established objective" which is "written for a very specific population of consumers" (Hilger, 1974, pp. 323, 329). The emphasis on patient outcome criteria is based on the

"probable relationship between the quality of patient care and the outcome that the patient experiences as a result of interventions by physicians and other health care professionals" (JCAH, 1978, p. 143). Some of the patient outcomes evaluated have been identified as health status at time of discharge, presence of complications, morbidity and mortality rates, and patients' demonstrated knowledge concerning health status, level of functioning, and self-care activities (JCAH, 1978). Haussmann and Hegyvary (1976c) noted that the primary purpose in screening patients' nursing outcomes according to established criteria is to identify those situations in which the nursing care had been inadequate. A secondary purpose in screening nursing outcome criteria is the identification of those nursing interventions that positively altered the health status of the patient (Haussmann & Hegyvary, 1976c). Hagen (1972) observed that one advantage of a quality care evaluation based on outcome criteria is measuring the extent to which the nursing care objectives have been achieved. Outcome criteria "focus attention on the consequences of care . . . measuring not what a nurse taught, but what a patient learned" (Horn & Swain, 1975, p. 74). This orientation has the additional advantages of recognizing that alternate ways of achieving the same goal may exist and allowing for the possibility

that the same treatment may yield different results (Horn & Swain, 1975).

There are, however, problems inherent in the use of outcome criteria. Block (1975) noted that although she espoused the basic tenets of outcome criteria ("philosophically, it is the outcome of his total care which matters to the patient" (p. 262), she affirmed the need for each category of care provider evaluating his/her own process of care. Zimmer (1974b), a major proponent of outcome criteria, conceded that overlapping of care responsibilities among all health care professionals makes outcome criteria for any one health care group difficult to identify. Horn and Swain (1975) referred to the "multiply determined nature of health status precluding direct ties between specific scores on outcome measures and inferences about the quality of care delivered by specific individuals, such as nurses" (p. 81). Finally, Lang (1975) conceptualized a major limitation inherent in the use of outcome criteria as the acknowledgment that medical and nursing interventions may not be the most important variables affecting health status.

Structurally based approaches, while important attributes of quality care, are of limited value in determining the correlates of quality nursing care. Stevens (1977) contended that this format "gives conditions under

which it is likely that good nursing care could take place," but it does not "assure that the good care does in fact take place" (p. 78). In addition, structurally based approaches cannot provide an evaluation of the quality of care rendered by an individual practitioner, nor can they be used to promote a greater sense of accountability and responsibility among professional nurses (Froebe & Bain, 1976). In summary, while approaches to determine the quality of nursing care may be structural, process, or outcome based, the process format, which is based on Standards of Practice, presently allows for the most valid measure of the quality of the patient's nursing care.

Quality monitoring. Within the framework of a process based approach to evaluating quality of care, a variety of methods have been developed. Foremost among these has been the Nursing Audit. Froebe and Bain (1976) contended that the "major purpose of any nursing audit program is to measure the nursing care received by the client and to compare that care to predetermined standards" (p. 74). The value of the audit stems from the "clarification of values" which "leads to increased observance of them" (Phaneuf, 1972, p. 3). A value was defined as an "affective disposition towards a person, object, or idea" (Steele & Harmon, 1979, p. 1). An individual's life and activities derive

their directions from the values held by that individual. If the "goal of values clarification is to facilitate self-understanding," it can be inferred that the use of the nursing audit format promotes a greater professional awareness of the quality of nursing care delivered (Steele & Harmon, 1979, p. 1).

The JCAH developed an audit as a review means of examining the charts of discharged patients to determine the type of care they had received. Six points are included in the audit plan: (1) the establishment of patient care criteria; (2) a comparison of the actual practice with the established criteria; (3) an analysis of the actual practice findings; (4) the institution of corrective action; (5) a determination of the degree of the corrective action's effectiveness by means of a follow-up study; and (6) a report of the results of the audit activity (JCAH, 1970). The net effect of the audit plan, however, is more a retrospective review of care processes as Froebe and Bain (1976), documented in their example of the assessment of the diabetic patients' ability to self-administer insulin following hospitalization.

Instruction giving during the period of hospitalization would be considered essential to this behavioral outcome. In this instance, checking diabetics' charts is desirable to determine if the patients went to classes for diabetics, received bedside instruction, and indicated to teaching personnel whether they understand the teaching. Understanding might be recorded in terms of

demonstration by the patients or administration of their own insulin during the period of hospitalization after the instruction. (Froebe & Bain, 1976, p. 76)

Phaneuf's audit also is a retrospective, process based approach. It includes 50 items which measure the quality of care a patient received during a particular phase of care delivery. The process or actual performance of care which is evaluated is not, however, the Nursing Process of assessment, planning, implementation, and evaluation, but rather it is the seven nursing functions which Phaneuf contended are contained in statutes of licensure for nurses. The conceptual framework utilized is: (1) application and execution of the physician's legal orders; (2) observation of symptoms and reactions; (3) supervision of those participating in care, except for the physician; (4) supervision of the patient; (5) reporting and recording; (6) application and execution of nursing procedures and techniques; and (7) promotion of physical and emotional health by direction and teaching (Phaneuf, 1972). Numerical scores are obtained for each subsection, while the total evaluation is the sum of all the subsection scores translated into words (excellent; good; incomplete i.e., good as far as it goes; poor; and unsafe) that describe the quality of care (Phaneuf, 1972). Critics point to the functional orientation Phaneuf had chosen as a limiting factor in the usefulness of the audit as a monitoring agent of the Nursing

Process (Froebe & Bain, 1976). Therefore, while existing audits attempt to focus attention on the actual performance of nursing care, their format does not accomplish this goal within the framework of the Nursing Process.

Numerous other attempts to measure the quality of nursing care based on actual performance have been undertaken. The Nursing Problems Priority Inventory (NPPI) was developed and based upon Abdellah's scheme of 21 nursing problems (Ayers, 1972). Brodt and Anderson (1967) developed a Patient Welfare Evaluation instrument based on 11 components of patient welfare which they contended are attributable to nursing practice. The authors claimed that these components "possessed a high degree of relevance to nursing intervention" and were "derived from the Synergistic Theory of Nursing" (Brodt & Anderson, 1967, p. 167). Included as components are skin integrity, mobility, nutrition-hydration, bladder function, anatomical alignment, pulmonary function, independence, mental attitude, personal appearance, and interaction. Each component is evaluated individually and a numerical score is assigned to indicate the degree of effectiveness in achieving optimal welfare within that component. Total patient welfare scores then are derived by summing the individual scores, and the results provide ordinal data to evaluate the patient's progress and the effects of the medical and nursing process

(Brodt & Anderson, 1967). Castles (1972) and Carter, Hilliard, Castles, Slothl, and Cowan (1976) all reported on Matheney's four categories of patient problems as presented in Patient Centered Approaches to Nursing (Abdellah, Beland, Martin, & Matheney, 1960). Problems in Group I represent the nursing measures to maintain hygiene, personal comfort, activity, rest and sleep, and safety and body mechanics. Group II includes the nursing measures to maintain an adequate oxygen supply, nutrition, fluid and electrolyte balance, regulatory mechanisms, and sensory function. Group III has the nursing measures identified as helpful to the patient and family during their emotional reactions to the patient's illness. In Group IV, the nursing measures that will assist the patient and family to cope with the patient's illness and the net life adjustment are discussed. In this evaluation indices of quality nursing care are derived from three sources of information which incorporate the groups of patient problems: the nursing care plan, the nursing record, and an audit of the patient and his environment.

Dunn (1970) approached the measurement of nursing performance using a method of observation of behavior associated with a nursing task. The instrument was developed to aid the nursing supervisor in an objective assessment of the knowledge and skills of staff nurses. Dunn selected the five procedures of tracheal suctioning,

administration of tube feedings, administration of oral medications, administration of intravenous solutions, and administration of intramuscular medications and performed a task analysis study of the nurse's behavior in performing the procedures. The author claimed that the tasks are couched in the scientific principles of physiology, pharmacology, microbiology, the behavioral sciences, and physics, all of which constitute the framework of quality nursing practice.

The Slater Nursing Competencies Rating Scale is yet another instrument which purports to measure the quality of nursing care based on a process approach. The Scale, developed by Doris Slater Stewart in 1964, is composed of 84 items which "identify actions performed by nursing personnel as they provide care for patients" (Wandelt & Stewart, 1975, p. xiii). The items are arranged into six subsections "according to the primary science and cultural basis for the nursing care actions to be rated" (Wandelt & Stewart, 1975, p. xiii). The subsections are: psychosocial with an emphasis on the individual; psychosocial with an emphasis on the group; physical; general; communication; and professional implications. The categories of nursing competencies are identified as best nurse, between best and average nurse, average nurse, between average and poorest nurse, poorest nurse, not applicable, and not observed.

The standard of measurement is the "quality of performance of care expected of a first-level staff nurse" who is defined as a "nurse who, traditionally is charged with responsibility for providing nursing care that is safe, adequate, therapeutic, and supportive in meeting the needs of patients" (Wandelt & Stewart, 1975, pp. xiii, 50). The authors claimed that although "each rater develops her own individual frame of reference to serve as a concrete yardstick against which to measure competence displayed by a nurse performing nursing care activities," the findings from tests of the Slater Scale "reveal that variations in adjectives which hold generally common meanings for raters do not yield differences in ratings" (Wandelt & Stewart, 1975, pp. 35-36). Slater conceptualized that the value of the Scale emanates from the emphasis on clinical competence which incorporates the elements of nursing care planning, problem-solving, and evaluating the plans of care. The measurements derived from the Scale, she believed, can be used to evaluate the overall competency level of a first-level staff nurse and the levels of care displayed in particular areas of care.

A modification of the Slater Scale is the Quality Patient Care Scale (QUALPACS) developed by Wandelt and Ager in 1969. QUALPACS consists of 68 items which are based on actions performed by nursing personnel as they

care for individual patients. The items are arranged into the same six subsections that are characteristic of the Slater Scale and are essentially the same items rewritten in a fashion that focuses attention on the nature of the care given (rated as best care, between best and average care, and so forth) rather than on the competencies demonstrated by the nurse performing the care. The standard of measurement remains the same, i.e., the care expected of a first-level staff nurse, and the measuring device remains the same, i.e., the rater's own frame of reference.

Other formats based to some degree on the process or actual performance of care are "A Quality Control Plan for Nursing Services" promulgated by the Commission for Administrative Services in Hospitals (CASH) in 1965, and the Nursing Care Quality Evaluation developed by the Veterans Administration (Jelinek, Haussmann, Hegyvary & Newman, 1974).

A methodology that focuses on the Nursing Process as the modality of nursing practice and that reflects the generic Standards of Practice advanced by the American Nurses' Association is the quality monitoring methodology developed by Haussmann, Hegyvary and Newman (1976). Their work constituted a contract (Public Health Services Contract NO NU-24299) given by the Division of Nursing, Health Resources Administration, United States Department of Health, Education, and Welfare to the Rush-Presbyterian-St. Luke's

Medical Center (Chicago) and through them, to the Medicus Corporation. From a massive two phase project emerged an evaluative instrument which delineates each of the dimensions of the Nursing Process. Each area is operationally defined: the plan of care is formulated after the assessment is made; the physical needs of the patient are attended; the nonphysical needs of the patient are attended; and, achievement of nursing care objectives is evaluated.

Specific indicators of quality for each of the dimensions contained in the areas are identified. To comply with the operational definition of the Nursing Process, the identified specific indicators or criteria fulfill certain qualifications: a relationship to nursing; an authoritative documentation; a predicted reliability; and, a specific Nursing Process dimension relationship. Also included in the instrument developed by Haussmann et al. is a portion which evaluates some of the structural attributes (unit management and support services) of the nursing care delivery system.

The complete instrument, the Criteria Master List, consists of 257 criteria for quality nursing care. The authors claimed its outstanding feature is its level of detail: "no other existing methodology for monitoring quality of nursing is based on an operational definition of the Nursing Process to the same degree of specificity and

discreteness" (Hausmann et al., 1976, p. 7). Block (1975) concurred with this observation and stated that "although this method may not solve all problems of process measurement in nursing, it is the result of a major effort in the area, and it should prove highly useful to those in nursing wishing to evaluate quality of nursing care in institutions" (p. 260).

In summary, many instruments that purport to measure the quality of nursing care exist. Of these, the Criteria Master List, developed by Hausmann et al., more effectively measures the quality of nursing care delivered under the aegis of the Nursing Process than do any other presently existing instruments. The Nursing Process provides an operational approach to the Standards of Practice advanced by the ANA. The conformity of a professional nurse's practice to the standards embodied in the Nursing Process can serve as a measurement of the quality of nursing care rendered. When effective monitoring devices exist, the professional nurse can become more accountable to self, the profession, and the public for the quality of nursing care provided.

Nursing Practice and the Educational Preparation of Nurses

As professional nursing is currently practiced in the United States, individuals with varying degrees of educational preparation are employed by hospitals and other

health care agencies. The most recent data indicate that in 1974, of the estimated 857,000 registered nurses practicing in the United States, 28,000 (3.3%) were prepared on the master's or doctorate level, 130,400 (15.2%) on the baccalaureate level, 647,000 (75.5%) on the diploma level, and 51,600 (6.0%) on the associate degree level (United States Department of Health, Education, & Welfare, 1974). Within the hospital and related institution category, master's or doctorate prepared nurses constituted 1.3% of the staff, baccalaureate prepared nurses, 12.2%, diploma prepared nurses, 81.3%, and, associate degree nurses, 5.4% (United States Department of Health, Education, & Welfare, 1974). Earlier data indicated that in 1972, doctorally prepared nurses nationally totaled 1,106 (0.2%) of the entire registered nurse population, while those employed in hospitals totaled 261 (0.1%) (ANA, 1977). The continued trend towards a predominance of nonbaccalaureate prepared nurses remains despite the 14 years that have passed since the ANA published its statement entitled Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper. At that time, the ANA "affirmed its belief that unless all nursing education is upgraded, nurses will be handicapped in efforts to provide patient care encompassing advances made possible by the explosion of scientific knowledge" (ANA, 1965, p. 1). The position regarding this

upgrading of nursing education was one which placed the education in "institutions of higher learning" (ANA, 1965, p. 1). Distinctions were made regarding minimum preparation for beginning professional nursing (a baccalaureate education in nursing) and for beginning technical nursing (an associate degree education in nursing).

The authors of the Position Paper conceptualized that care, cure, and coordination are the essential components of professional nursing. Constant evaluation of nursing practice constitutes a hallmark of professionalism. Identifying nursing problems, generating possible solutions, and conducting research in the quest to improve the quality of nursing care add to the body of theoretical nursing knowledge. These abilities, they noted, require "education which can only be obtained through a rigorous course of study in colleges and universities" (ANA, 1965, p. 6).

In contrast, technical nursing practice is "unlimited in depth, but limited in scope" (ANA, 1965, p. 8). The same essential components of practice, care, cure, and coordination, are reflected in technical nursing practice, but they are carried out under the direction and supervision of professional nurse practitioners. Preparation for these activities is obtained in an educational program which is "technically oriented and scientifically founded, but not primarily concerned with evolving theory" (ANA, 1965, p. 8).

The authors concluded that the environment for technical education "remains the responsibility of junior and senior colleges" as opposed to the "nondegree granting technical institute" (ANA, 1965, p. 8).

Nursing Practice Responsibilities and Scope of Preparation

The focus of nursing practice was identified by Florence Nightingale in Notes on Nursing--What It Is and What It Is Not in 1859 as "putting the patient in the best condition for nature to act upon him" (Henderson, 1966, p. 1). Orlando (1961) noted that continuous observation and interpretation of the patient's behavior, patient validation of the nurse's interpretation, and nursing action based on the validated inference constituted the responsibilities inherent in effective nursing practice. Henderson (1966) conceptualized the practice of nursing as "assisting the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge" (p. 15). The American Nurses' Association (1975b) recognized the Nursing Process as the framework in which the responsibilities of nursing practice are discharged. Carlson (1972) provided support for the ANA's position on the Nursing Process: "the philosophical and theoretical acceptance of the nursing process is

evidenced by the growing number of books and articles on the subject in general, as well as on its component parts: the nursing history, nursing diagnosis, and nursing care plan" (p. 1589). She further conceptualized the Nursing Process as the totality of a three part problem-solving approach (assessment, including the nursing history and nursing diagnosis; intervention, including the nursing orders and nursing care plan; and evaluation, including the nursing prognosis, jointly undertaken by the nurse and patient. Roy (1971) noted that two factors which are necessary for optimal nursing care are included in the Nursing Process: assessment and intervention. The activities of the Nursing Process are accomplished through using judgments in the assessment phase, establishing realistic health goals, planning and implementing goal directed nursing strategies, using the referral system, employing judgment and decision-making skills in the evaluation process, collaborating with other health professionals, and leading and managing assistant nursing personnel (Schlotfeldt, 1977). The individual nurse's ability to effectively carry out the phases of the Nursing Process can be related to the scope of the nurse's educational preparation. Areas in which differences in abilities among graduates of the various types of programs have been documented include: the nature of the problem the practitioner solves and the characteristics

of the decision-making process; the scope of practice; and the attitude towards practice (Waters, Vivier, Chater, Urrea, & Wilson, 1972).

Baccalaureate and higher education. Benner and Kramer (1972) contended that the baccalaureate program emphasizes educational socialization which promotes the development of and adherence to standards of practice, and provides in-depth familiarity with decision-making and problem-solving approaches. The extensive body of theoretical and empirical knowledge to which the baccalaureate graduate has been exposed extends beyond the practical and established nursing knowledge, and includes a large selection of problem-solving approaches (Waters et al., 1972). This varied background enables the baccalaureate practitioner to identify a wide range of nursing problems, including those which are both abstract and/or complex (Nicholls, 1977a). The skills and knowledge needed for assessment, goal setting, and planning are derived from a balanced general and professional theoretical background (DeChow, Malmstrom, & Ogden, 1968). Nursing strategies that are selected often are innovative (Waters et al., 1972).

Anderson (1972) noted that this wider range of judgment and problem-solving abilities enables the baccalaureate nurse to respond to less prescribed situations. In the face

of uncertainty, she continued, this nurse utilizes deliberative approaches in the selection of appropriate strategies. Nursing strategies often are extremely modified for use with particular patients, families, and/or communities. These strategies also incorporate the concept of collaboration with members of other health care disciplines (Waters et al., 1972). Leadership and management theories endow the practitioner with the ability to direct and guide others in nursing care activities (Boyd, 1975). The baccalaureate graduate, by virtue of the educational program, also is prepared for operational autonomy and demonstrates an expressive functional ability (Benner & Kramer, 1972). This expressive function often is characterized by an interest in the scientific gathering of data to refine and extend the scope of nursing practice (Waters et al., 1972). Gray et al. (1977) noted that the baccalaureate graduate is not satisfied with mere problem identification, but often demonstrates concern for determining causes and possible preventive/corrective measures.

Graduate education in nursing has been identified as a process which develops the baccalaureate graduate more fully (McGivern, 1974). Exposure to graduate education provides the nurse with the "complex theoretical base and advanced clinical practice necessary to prepare a responsible professional" (McGivern, 1974, p. 77). The nurse,

executing the various phases of the Nursing Process, does so guided by standards of practice that have been internalized. Nicholls (1977a) contended that there may be considerable differences in the standards set by the nurse who is pursuing or who has completed graduate education and the nurse who has remained at the baccalaureate level. This nurse, who has remained at the basic level of baccalaureate preparation, may be influenced by standards of practice which "may have crystallized at the level achieved at graduation" (Nicholls, 1977a, p. 53). This level would not include the maturing process that supports highly critical judgment and greater leadership skills that are catalyzed by exposure to graduate nursing education (McGivern, 1974).

Associate degree education. References to the characteristics of the associate degree (and diploma programs) maintain an emphasis on technical orientation to the Nursing Process. Nicholls (1977a) contended that a limited theoretical foundation inhibits the associate degree nurse's independent problem-solving and decision-making activities. The lack of a firm scientific and theoretical base impairs the associate degree graduate's ability to assess, plan, implement, and evaluate care in a manner reflecting a highly intellectual process (Rotkovitch, 1976). The nursing science base which this practitioner possesses

is delimited to predictable, recurrent nurse-client and nurse-group interactions (Anderson, 1972). This level of abstraction provides the knowledge and skills necessary to select those nursing strategies which are mainly physical measures requiring competencies of manual dexterity (Waters et al., 1972).

The scope of the associate degree nurse's practice is characterized by the nursing care of patients with clearly defined nursing problems, in the areas of physical comfort and safety, and physiological malfunctions, under the supervision of a professional nurse (Waters et al., 1972; Matheney, 1975; Gray et al., 1977). Whereas the baccalaureate prepared nurse may be thought of as "care oriented," the associate degree practitioner is "cure oriented" (Bullough & Sparks, 1975). The technically (associate degree) prepared nurse focuses on the accepted way to perform tasks in order to achieve clearly defined nursing goals (Schlotfeldt, 1977). Collaboration with other health care providers is characterized by coordination and/or supervision of technical functions under the leadership of a professional nurse (Gray et al., 1977). Research information, derived from professional (baccalaureate prepared) nurses' studies, is analyzed and interpreted by the technical nurse for the identification of those practice

innovations which may be incorporated into the existing body of technical nursing knowledge (Waters et al., 1972).

Diploma education. The technical nurse prepared at the diploma level relies on others to develop and refine the body of nursing knowledge which underlies clinical competencies similarly to the associate degree practitioner. Again, the emphasis is placed on the identification of nursing problems which are recurrent in nature and common to a specific target population (DeChow et al., 1968). The problems identified by the diploma nurse generally are more likely to be medical in lieu of nursing, and physical or physiological in lieu of social or psychological than are those defined by the baccalaureate nurse (Waters et al., 1972). The process of decision-making is accomplished through a reliance on general knowledge gained in secondary school study (Schlotfeldt, 1977).

The practice of the nurse prepared at the diploma level generally focuses on the instrumental role (Benner & Kramer, 1972). These graduates have "learned how to do tasks almost to perfection" (Nicholls, 1977a, p. 52). The focus on the mastery of particular skills is based on the mastery of selected essential concepts that either rationalize or explain the skills (Schlotfeldt, 1977). The diploma graduate implements these skills relatively free of supervision,

but is not prepared to assume a leadership role (Boyd, 1975). Furthermore, similar to the associate degree nurse, the diploma graduate must rely on the research information gathered, analyzed, and often interpreted by others (Waters et al., 1972).

Comparison of Nursing Practice Competencies

That inconsistencies exist among the various competencies of nurses prepared at different levels of education is thereby concluded from a review of the literature. However, additional support for the contention that nurses prepared at different levels of education function differently in a practice setting is found in a review of selected studies.

Waters et al. (1972) conducted an exploratory study to determine if actual performance differences between technically and professionally prepared nurses could be validated systematically. Their findings indicated that differences existed in some aspects of nursing practice. The baccalaureate graduate was more oriented than the associate degree graduate to comprehensive care which included: identification of problems that were psychological and/or sociological as well as physical; collaboration and consultation with other health care providers; and independent inquiry. In contrast, the associate degree graduate was

identified as being hospital oriented and more concerned with the mechanical performance of routine tasks than the baccalaureate graduate.

Gray et al. (1977) reported the results of their study of the performance of associate degree and baccalaureate students in the areas of technical skills, teaching, leadership, providing support to the patient and the patient's family, interviewing skills utilized in the assessment phase, and nursing strategies chosen in both predictable and unpredictable situations. These areas were identified by the authors as reflective of the differences in the philosophy and terminal objectives of the two different educational programs. The study indicated a performance difference in the areas of primary concerns of the respective students. Whereas both groups indicated a concern for meeting the physical needs of the patient, the baccalaureate student indicated a concern also for the psychological needs as well as for determining the cause of the identified problem and possible preventive measures. Differences in role function also were identified: the associate degree student was found to be management oriented, i.e., providing for equipment and supplies; whereas, the baccalaureate student was leadership oriented, i.e., teaching staff and initiating patient education programs. One interesting conclusion drawn by Gray et al. was their observation that

many nursing actions specifically undertaken by the baccalaureate nurse are not readily visible, i.e., involving the use of knowledge in assessment prior to action, and planning for and carrying out preventive nursing actions. They contend that this characteristic might explain "why the general public, and indeed, nurses themselves, have difficulty describing the differences in the function of technically and professionally prepared nurses" (Gray et al., 1977, p. 373). This area of projected difference has been identified as the focus for potential research by Anderson (1972). As Dean of the School of Nursing, University of Hawaii, she has indicated a concern for establishing the reliability of a computer based test of the decision-making process utilized in nursing situations by graduates of both associate degree and baccalaureate programs.

Differences in the level of educational preparation was an area that was studied by Haussmann et al. (1976). Their focus was on the quality of the Nursing Process and attempts were made to identify the various correlates of quality care, reflected in the execution of the Nursing Process. The level of educational preparation of the nurse carrying out the Nursing Process was identified as having a possible latent effect on the quality of nursing care.

Nursing Education and Nursing Employment

The literature supported the contention that nurses prepared at various educational levels possess different abilities and capabilities in carrying out the Nursing Process. Yet, the literature indicated that rarely do staff nurse hiring criteria reflect this difference. As long ago as 1967, Moore noted that upon licensure, few Directors of Nursing Services made any distinction between professional and technical nurses once they were employed. One year later, DeChow et al. (1968) admonished nursing service administrators to "recognize that jobs and registered nurses are seldom tailor-made and that some alterations will be needed" (p. 149). Francis (1972) noted that all nurses continue to assume the same set of responsibilities, regardless of level of educational preparation and Boyd (1975) concluded that differences in skill, preparation, and potential for growth are not considered in most nursing employment situations. As Haussmann et al. (1976) were identifying possible correlates of quality nursing care, they also noted that provisions for variations in educational preparation were not made for most staff nurse positions. Waters et al. (1972) have referred to this situation as one which perpetuates the old cliché of "a nurse is a nurse is a nurse" and blame it for impeding nursing's goal of improving the care of patients through the best use of

resources and background in the health care setting. Christman (1971) contended that "care is delivered at the level of preparation of the person giving the care" (p. 23). Nicholls (1977a) expanded this theme with her observation that as "it is the practicing nurse who, in the final analysis, determines the quality of care received by the patient, emphasis must be placed on those factors which influence the individual nurse" (p. 51). A principle factor, she noted, is the level of educational preparation of the nurse.

In summary, nurses practicing in health care agencies in the United States today are prepared at various levels of formal academic education in nursing. The various educational programs endow their graduates with varying abilities and capabilities in carrying out the Nursing Process. These differences have been shown in a discussion of the various types of nursing programs and selected research studies. Yet, most employing agencies make no distinction in the hiring criteria for staff nurse positions.

Primary Nursing

Nursing's ability to provide quality care is influenced by a multitude of variables. Another important variable, noted in the quest for quality assurance, is the identification of the organizational structure which supports the

delivery of high quality nursing care. Nicholls (1977b) observed that the organization of nursing care must be based on the maximum utilization and development of nurses. Primary nursing is an organizational modality that meets this structural requirement.

Primary Nursing Philosophy

Within primary nursing, the fragmentation of patient care is at a minimum, and patients are directly cared for by professional nurses (Manthey, 1973). The focus of nursing activities is the individual patient (Leninger, Little, & Carnevalli, 1972). Marram et al. (1974) contended that primary nursing supports the philosophy of patient centered nursing. Also inherent in this structure is the accountability of nurses for the quality of care provided. The Nursing Process is the conceptual framework utilized by the primary nurse in the delivery of nursing care (Mundinger, 1977). The phases of the Nursing Process are carried out with the active participation of the patient (Logsdon, 1973). Marram et al. (1974) contended that the primary nurse, then, is accountable for all decision-making regarding the patients within the nurse's caseload, although collaboration with other (associate) nurses and with other health care providers is permitted. Collaboration with others does not however, relieve the primary nurse of the central focus of responsibility.

The definition of primary nursing reported by Dickerson (1978) provides a succinct summary:

. . . primary nursing is a philosophy and a modality of humanistic health care delivery in which the client becomes a contributor to as well as recipient of his plan of care. The client is assigned to a professional nurse who cares for him utilizing the nursing process and scientific inquiry. The Primary Nurse has authority, autonomy, and is accountable and directly available to the client. (p. 1)

Primary Nursing Studies

Smith (1977) noted that, as the same nurse delivers care from the time of admission to the time of discharge, the care is comprehensive and continuous. As the focus remains on the needs of the individual patient, the result, Smith continued, is quality and individualized care. Numerous systematic investigations provide support for this contention.

Most studies have concentrated on a comparison of the effects of the structures of primary and team nursing on the quality of care provided to patients. Jones (1975) reported the results of a study in which renal transplant patients cared for on a primary nursing unit recovered more rapidly and with fewer complications than those patients on a team nursing unit. Felton (1975) and Williams (1975) both independently reported on the quality of care scores measured by the Slater Scale, QUALPACS, and Phaneuf Audit, utilizing pediatric units where team or functional nursing (control

unit) and primary nursing (experimental unit) were practiced. The mean scores for the primary nursing unit were higher on all three quality monitoring devices and statistical significance was achieved with QUALPACS and the Phaneuf Audit. Daeffler (1977) studied patients' perceptions of their care on both primary and team nursing units. Their perceptions were based on their ability to identify omissions in the care they received. Patient responses from the team nursing unit indicated a much higher rate of omissions in care than did those from the primary nursing unit. Furthermore, patient responses regarding their satisfaction with their care were consistently higher on the primary nursing unit.

In 1974, Ciske administered a questionnaire to patients discharged from primary and team nursing units. She also sampled the patients' perceptions of their nursing care. Statistical significance was achieved on one item, with six other items approaching statistical significance. The results of this study indicated that patients cared for on primary nursing units identified a quality of care higher than those on the team units. Ciske (1977) also offered her nonsystematic observations of primary nursing based on her experience as a nurse clinician in an institution that utilized both the team and primary organizational structures. She noted that whereas kardexes on the team units lacked

evidence of care plans, those on the primary units indicated clearly defined nursing orders. Furthermore, informal positive reports of the quality of the nursing care from nurses "floated" to the primary nursing units, strengthened her conclusions regarding primary nursing.

Marram et al.'s (1973, 1977) extensive studies of primary and team nursing have focused on patient satisfaction, staff satisfaction, and cost effectiveness. Patient satisfaction was explored both informally and formally. Under both circumstances, patients on the primary nursing units described a higher quality of individualized and personalized care and related their greater satisfaction with their care. Marram et al. (1973) contended that the patient's perceptions of how well his/her needs are met is a vital criterion for quality evaluation because "nursing is primarily an interactional process through which the nurse and patient work together in mastering health needs and adjustment to the hospital" (p. 815). Additional support for the contention that the patients on primary units were more satisfied with their care because it was more individualized and personalized, comes from Marram's (1977) examination of the differences in the nursing assessment on the units. The primary nursing assessments, she noted, often incorporated the patient's perceptions of his/her illness and

his/her nursing needs, a characteristic frequently lacking on the team units.

Informal data on nursing satisfaction indicated that new graduate nurses on primary units maintained a higher level of commitment to professional ideals and became more idealistic in outlook over time than those new graduate nurses on team units (Marram et al., 1973). Formal data, in the form of questionnaire responses, yielded similar results. Finally, formal data also indicated that a primary nursing unit costs less to operate than a team nursing unit, especially when the cost of sick-hours and other absences is calculated (Marram, 1977). Marram (1977) concluded that the "primary nursing unit not only appears to be providing more individualized patient-centered care, but it is also cost-effective, providing both higher quality care and reduced expense" (p. 25).

Kramer (1970) relied on her observations and data from committee meetings, patient records, kardex care plans, and semi-structured interviews of primary, associate, and supervisory nurses, physicians, patients, and patients' families, to draw her conclusions regarding primary nursing. Data, from the use of a modified United States Public Health Services time-sampling technique, indicated that the primary nurse was almost always observed to be providing direct patient care. Other conclusions included validation of

primary nurses assuming responsibility for coordination of patient care activities with other health professionals, for providing clear and explicit plans of nursing care, for functioning as role models for student nurses, and for utilizing other primary nurses for nursing consultations (Kramer, 1970). An interesting aspect of primary nursing that Kramer (1970) noted was the greater ease of identifying different levels of nursing competence with respect to the ability to deliver quality nursing care on primary nursing units as opposed to team and/or functional nursing units.

Accountability and Responsibility

Ciske (1977) stated that the concept of shared responsibility and accountability in team nursing often becomes no responsibility and accountability. "The team leader's goals of assessing each patient on her team and supervising the planning, implementing, and evaluating of care plans for ten to twenty patients were unmet" in her study (Ciske, 1977, p. 6). In contrast, Christman (1978) contended that primary nurses develop a sense of accountability and responsibility for the process and outcome of their nursing activities undertaken on behalf of their caseload of patients. It is this sense of personal accountability and responsibility for quality of services

that is consistent with the hallmarks of full professionalism that nursing is seeking to attain.

Summary

In conclusion, a review of the literature has indicated that much emphasis is being placed on the measurement of the quality of care provided within the health care system. Professional nursing is pursuing voluntarily the goals of identifying the correlates of quality of care delivered by its practitioners. A quality monitoring methodology which is based on the conceptual framework of the Nursing Process appears to be the most useful means of evaluation. This instrument, the Criteria Master List, can be used to evaluate individual nurses' abilities to carry out the Nursing Process. Within the organizational structure of primary nursing, where accountability and responsibility of the primary nurse for the individual patient's care is the underlying philosophy, individual characteristics of nurses can be examined to learn if they contribute to quality assurance. The nurse's level of educational preparation in nursing may be one of these correlates of quality nursing care. Further research focused on quality nursing care as related to the nurse's level of educational preparation is needed.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Introduction

This study was a nonexperimental research study. Abedllah and Levine (1965) stated that, in nonexperimental research, all elements of the research are not under the control of the researcher. In addition, it is conducted in a natural setting. They further cite the following advantages of nonexperimental research: it is less expensive to conduct than the experimental one, and it is the method of choice where there is a time lag between the application of the independent variable and the appearance of a response in the dependent variable. Further advantages that are noted are: if it involves human studies, it can often attain a greater reality in relation to the total content of the research than experimental research can; and, in general, its findings are more broadly representative of a larger target population than are the findings from experimental research.

Abdellah and Levine (1965) also identified certain drawbacks to the use of a nonexperimental research design: it cannot establish causal relationships with the same

degree of confidence as the experimental design, and, it cannot be easily applied to test out a newly developed product, plan, or program. In addition, it is usually not useful in the development of new theories, ideas, or principles, and it is not considered to be true research by some people.

Setting for the Study

The setting for the study was a 374 bed teaching hospital in a large medical center in the Southwest United States. The hospital is a corporation-owned, nonsectarian, general hospital which provides care for only private patients. The hospital's nursing service is organized around the primary nursing model. This organizational structure is the only one the nursing service has ever utilized.

Population and Sample

The target population from which the total sample was drawn consisted of all adults (defined as 18 years or older) who were classified as in-patients on all the medical and surgical units. Three patient units were randomly selected using the fishbowl technique. The process of sampling with replacement was utilized.

The units selected were all designated primarily as surgical units, although medical patients were occasionally

placed on these units as a result of "overflow" from the medical units. For purposes of this study, each patient unit was structurally and functionally subdivided to yield three subsections or "pods." The total patient capacity for each unit was 54, with 18 patients located on each "pod."

Patients, whose quality of nursing care was measured, were randomly selected, according to a numerical method of selection (every third patient). Patients included in the sample were hospitalized for a time period greater than 72 hours to allow time for implementing those aspects of the Nursing Process that were monitored. Subjects were eliminated from the sample if they did not have a registered nurse identified as a primary nurse. This elimination was necessary as the institution under study also utilized licensed vocational nurses as primary nurses. Patients also were eliminated as subjects if their primary nurse was one whose nursing care had been previously evaluated. The total patient sample consisted of 31 subjects, all of whom were classified as surgical patients.

The required consent was obtained from the appropriate sources prior to conducting the study (Appendix A). Written consent was obtained from each patient for a review of his/her chart and for direct interview if necessary (Appendix B). Written consent was obtained from all of the available

full-time registered nurses who provided primary nursing care on the three units prior to data collection (Appendix C). The nurses, however, were informed that their patients might not necessarily be selected as subjects for participation in the study. An explanation of the investigation was provided to the day shift nurses in unit meetings and to the evening and night nurses on an individual basis. All participation was strictly voluntary and anonymous.

Description of Instrument

The instrument that was used to measure the quality of nursing care was the Criteria Master List derived from the quality-monitoring methodology devised by Jelinek, Haussmann, and Hegyvary (1974) and Newman (1976) under a grant from the United States Department of Health, Education, and Welfare (Appendix D). The instrument has been shown to have content, construct, concurrent, and predictive validity (Haussmann et al., 1976). The instrument also has been analyzed for systems reliability by its developers on two occasions. The first evidence for its reliability was based on data from two pilot hospitals. The second format for reliability was based on data from 19 hospitals. In both situations, distribution, correlation, cluster, and variance analyses were performed to assess the criteria and structural performance on the instrument. The developers claim the

validity and reliability of the methodology were confirmed to the extent that corroborative measures of quality do exist.

The instrument developed by Haussmann et al. includes an extensive set of 257 criteria which are grouped under six main objectives. Four of the objectives form the framework of the Nursing Process and are identified as follows: the plan of nursing care is formulated after the assessment is made; the physical needs of the patient are attended; the nonphysical needs (psychological, emotional, mental, and social) are attended; and achievement of nursing care objectives is evaluated. The remaining two objectives reflect the influence that indirect or support components of the health care agency have on the ability of the nurse to utilize the Nursing Process. These objectives are identified as follows: unit procedures are followed for the protection of all patients; and the delivery of nursing care is facilitated by administrative and managerial services.

The criteria are grouped within 28 subobjectives of nursing care. Each criterion, grouped under a subobjective, is coded to indicate the patient type and patient unit type for whom and for which it is applicable. This coding for patient type includes the patient care classification systems of 1, 2, 3, and 4, as well as the nursery patient and

the recovery room patient. The patient unit coding includes the general unit, the nursery unit, and the recovery unit.

The instrument's developers have identified the process of scoring as being accomplished by means of computing quality indexes for each of the 28 subobjectives.

Each index is the average of the criterion scores within the subobjective. Each criterion score is the ratio of positive responses to the maximum possible positive responses based on the number of valid observations for the criterion Indexes for objectives are computed as average values of the subobjective scores within a given objective. (Hausmann et al., 1976, p. 11)

This format of scoring makes it possible to develop comparative analyses for groups.

Data Collection

Different worksheets were generated from the Criteria Master List by means of a computer (Texas Instruments Model 51-A), which randomized the criteria (by number) for quality nursing care measured. The developers of the instrument have established that random selection of the criteria is consistent with the identified validity and reliability. This is possible because the criteria are grouped in such a way that those "within any one set relate both substantively and statistically to one another and together provide a consistent measure of quality for that subobjective" (Hausmann et al., 1976, p. 7). The Criteria Master List used in the study consisted of those criteria which pertained to the

medical-surgical patient. The revised list consisted of 201 criteria. Of these, the computer was directed to select 56 criteria per worksheet, two from each subobjective. Each worksheet was identified by a code (Worksheet A, B, C, D, E, and F), which was arbitrarily assigned. On each unit, the worksheet selected for use was a different one. The nursing staff was not informed of the identity of the particular worksheet, nor of its inclusive criteria. To prevent influencing the nursing staff from ascertaining which aspects of the Nursing Process were monitored during the week long observation period, different worksheets were used on additional visits to the patient units. Each unit was visited twice. The researcher administered all the worksheets and interviewed the patients according to the criteria on a particular worksheet, as necessary. This insured that observer reliability was consistent.

Each worksheet was coded with the primary nurse's code number. Each participating primary nurse was assigned an identification number that was double-blind coded.

Treatment of Data

The nonexperimental research design lends itself to an analysis of the relationship between independent and dependent variables. In this study, the dependent variable was the quality of nursing care measured against selected

Nursing Process criteria. The independent variable was the level of educational preparation, identified as the highest degree obtained in formal academic preparation in nursing, of the primary nurse who is responsible for the nursing care of the patient. Classification of the independent variable was: an Associate Degree in Nursing, a Nursing Diploma, a Baccalaureate Degree in Nursing, and Post Baccalaureate studies in Nursing.

The statistical treatment included a One-Way Analysis of Variance. This test is a parametric statistical test of significance for quantitative variables (Abdellah & Levine, 1965). It is useful for a comparison of the values of quantitative criteria measures for more than two groups. In the study, the different levels of educational preparation of the primary nurses yielded multiple groups (Associate Degree in Nursing, Nursing Diploma, Baccalaureate Degree in Nursing, and Post Baccalaureate studies in Nursing). None of the nurse subjects had masters' or doctoral degrees. The numerical values or scores of the quality of nursing care delivered by each primary nurse yielded the mean for the group. From this, the standard deviation and the variance for each group were calculated. Then, the variance of the measurements within each of the alternative groups was computed. The first procedure reflected the effects of chance variation attributable to randomization.

The second procedure reflected the effect of the independent variable, the primary nurse's level of educational preparation. The F-test of significance was calculated as the ratio of the variance among groups to the variance within groups. The quotient then was referred to the appropriate entry in a table of the F distribution to discover if there was statistical significance. The selected acceptable level of significance was $p \leq .05$. This procedure was conducted for each of the six objectives contained in the Criteria Master List as well as for the overall total score.

On the basis of these results, the study was designed to indicate if there was a statistically significant difference in the quality of nursing care delivered by primary nurses with different levels of educational preparation in nursing.

Summary

The investigation was a nonexperimental research study. The setting was identified and the target population was described. The method of random sample selection was discussed. Evidence of informed consent was presented. The instrument utilized in the study was identified as the Criteria Master List derived from the quality-monitoring methodology devised by Haussmann, Hegyvary, and Newman. A discussion of the instrument also was included. The method

of data collection, including the generation of multiple random worksheets was described. The method in which the data were treated statistically was presented and was related to the problem identified for study.

CHAPTER 4

ANALYSIS OF THE DATA

Introduction

A nonexperimental study was conducted to determine if a relationship existed between the quality of nursing care delivered and the educational preparation of the primary nurse responsible for the care. Data collection was accomplished by utilizing worksheets derived from the Criteria Master List (Hausmann, Hegyvary, & Newman, 1976). These worksheets, which contained 56 items or criteria, were administered to 31 randomly selected patients whose quality of nursing care was measured. Demographic information was obtained from the primary nurses responsible for the care of these patients (Appendix E). This chapter presents an analysis of the data collected. An interpretation of the statistical evaluation also is presented, followed by a summary of the findings.

Description of the Sample

The study sample of primary nurses included 31 full-time registered nurses who were identified as the primary nurses responsible for a specific patient caseload. Data were collected including the basic educational preparation in

nursing, years of experience in nursing, and years of experience in the study institution; however, data related to the years of nursing experience and of institutional experience were not related to the quality of nursing care score. Of the 31 nurse subjects included in the study, nine (29%) were identified as having an associate degree in nursing, seven (23%), a nursing diploma, 14 (45%), a baccalaureate degree in nursing, and one (3%), as pursuing post baccalaureate studies in nursing (Table 1). In contrast to the general population of nurses employed in hospital settings, the educational proportion emphasizes a predominance of diploma level nurses (United States Department of Health, Education, & Welfare, 1974).

Of the 31 nurses, only three were found to have progressed beyond their basic level of educational preparation in nursing. One nurse acquired a baccalaureate degree in nursing following a basic preparation at the diploma level; a second also acquired a baccalaureate degree following a basic preparation at the associate degree level; and, the third is pursuing post baccalaureate studies in nursing.

Presentation of the Findings

The worksheets were individually scored to yield total quality scores and subtotal quality scores for the six objectives. Thus, scores were derived for the quality of

Table 1

Summary of the Basic and the Highest Levels of Educational
Preparation and Mean Years of Nursing and Institutional
Experience of the 31 Primary Nurses Included
in the Study

Educational Level	Subjects				Mean Years of Experience	
	Basic Level		Highest Level		Nursing	Institu- tional
	Number	Percent	Number	Percent		
Associate Degree	10	32	9	29	5.44	1.88
Nursing Diploma	8	26	7	23	19.14	1.15
Baccalaureate Degree	13	42	14	45	2.96	1.05
Post Baccalaureate	0	0	1	3	2.58	1.51
Total	31	100	31	100		

the nursing care delivered during the assessment and planning phase (Objective 1.0), the implementation phase which included meeting both physical (Objective 2.0) and nonphysical needs (Objective 3.0), and the care evaluation phase (Objective 4.0). In addition, scores were obtained for unit management ability (Objective 5.0) and utilization of support services (Objective 6.0) (Appendix F).

To determine if a relationship existed between the quality score and the level of educational preparation of the primary nurse, the data were analyzed utilizing the highest level of educational preparation. Mean scores were derived for the overall quality measurement and for the objective subtotals of quality measurement for each group.

Quality Care Scores Related to the Highest Level of Educational Preparation

An analysis of the data according to the highest level of educational preparation is presented in Table 2. One subject, who was identified as pursuing post baccalaureate studies in nursing, was grouped with the baccalaureate nurses due to the absence of any other subjects pursuing post baccalaureate studies. As the data were analyzed, a discernable pattern of mean quality care scores based on educational level emerged.

Table 2

Mean Quality Care Scores for the 31 Primary Nurses Studied According
to the Highest Level of Educational Preparation

Educational Preparation by Highest Level	Subjects by Educational Level		Mean Overall Total Score	Mean Subtotal Score					
	Number	Percent		Objectives					
				1.0	2.0	3.0	4.0	5.0	6.0
Associate Degree	9	29	0.68	0.56	0.81	0.55	0.72	0.89	0.80
Nursing Diploma	7	23	0.73	0.62	0.86	0.61	0.77	0.81	0.82
Baccalaureate Degree	15	48	0.74	0.68	0.81	0.68	0.75	0.90	0.77
Total	31	100							

Baccalaureate nurses. Those subjects in the baccalaureate group rated the highest in the overall quality mean score as well as in the quality mean scores for the phases of assessment and plan of care formulation (Objective 1.0) and implementation of the plan for non-physical needs (Objective 3.0). These results are consistent with the literature and related research studies which emphasized the baccalaureate graduate's exposure to a body of theoretical and empirical knowledge associated with decision-making, problem solving, and the provision of psychological care. The highest score in unit management (Objective 5.0) was surprising as the literature and related research studies identified this area to be more within the practice domain of the diploma and the associate degree nurses than that of the baccalaureate nurses. Much more unexpected was the baccalaureate nurses' mean score of 0.75 for Objective 4.0 as compared to the 0.77 mean score for the diploma group. This result may be attributed to the greater ease of evaluating nursing care activities aimed at clearly identifiable problems, i.e., physical, as opposed to those nursing activities associated with primary prevention and/or nonphysical problems (Gray et al., 1977). The lowest score, the utilization of support services' category, for the baccalaureate nurses was not surprising as this focus of

attention had not been found to be consistent with the preparation of baccalaureate nurses (Gray et al., 1977).

Diploma nurses. The highest scores attained by the diploma nurses were as expected, Objectives 2.0 (attending the physical needs of the patient) and 6.0 (utilization of support services). The literature review emphasized this group's expertise in caring for physical needs and its focus on structural aspects of the nursing care delivery system. However, the unexpected results of the diploma nurses scoring lowest in Objective 5.0 (unit management ability) is difficult, if not impossible, to explain at this time. The literature had indicated that diploma nurses were more task oriented than associate degree and baccalaureate degree nurses.

Associate degree nurses. The mean scores attained on Objectives 1.0 (assessment and care plan formulation) and 3.0 (attending nonphysical needs) by the associate degree nurses were both consistent with the expected results and surprising when compared with the diploma nurses. The lack of a firm scientific and theoretical base can impair the ability to assess needs and plan care (Rotkovitch, 1976). Furthermore, a nursing science base which is delimited to predictable nurse-client interactions can limit the repertoire of nursing strategies to those which are mainly

physical measures (Anderson, 1972; Waters et al., 1972). The low scores attained by the associate degree sample in the phases of assessment and formulation of the plan of care, and attending the nonphysical needs of the patient are consistent with the literature. However, as diploma preparation supposedly shares these characteristics, the higher scores attained by diploma nurses in Objectives 1.0 and 3.0, as compared to the scores attained by the associate degree nurses, are surprising. No reason for this unexpected result can be identified.

Statistical Analysis

To determine if a statistically significant difference existed between the quality of nursing care and the level of educational preparation of the primary nurses responsible for that care, statistical testing was performed utilizing the Veldman (1967) format of computer analysis. A one-way analysis of variance was conducted to compare the overall mean quality care scores among the three preparation groups, associate degree, diploma, and baccalaureate degree. In addition, a one-way analysis of variance was determined also for each of the six objectives. The results indicate no significant difference in the overall score or in the objective subtotal scores for the quality of nursing care provided by nurses prepared at different levels of education

in nursing (Table 3). This conclusion is based on the failure to achieve a level of significance in which $p \leq .05$. No attempt was made to assign an absolute value reflecting good or bad nursing care. The different levels were compared relatively. (See also Appendix F.)

Based on the results obtained from the one-way analysis of variance, the study hypothesis is interpreted to conclude that differences in the quality of nursing care failed to be significantly related to the highest level of educational preparation in nursing of primary nurses who provide nursing care in one institution.

Table 3

F-Ratios and Levels of Significance for the
Mean Quality Care Scores

Mean Score Source	<u>F</u> -Ratio	Level of Significance
Overall	1.59	.22
<u>Objective</u>		
1.0	1.94	.16
2.0	0.56	.58
3.0	1.37	.27
4.0	0.13	.88
5.0	0.52	.61
6.0	0.38	.70

Additional Findings

As the data were analyzed, it was noted that the two subjects who progressed from a basic educational level (diploma and associate degree) to a higher level (baccalaureate), affected the mean score of the baccalaureate nurses. Table 4 shows the differences in the overall mean score and the six objective mean scores. These subjects lowered the mean scores in those areas (assessment and planning, meeting nonphysical needs, and evaluating nursing care objectives) that had been identified as receiving less emphasis in nonbaccalaureate programs. This difference may reflect these subjects' proclivity to identify with the characteristics of their former educational programs. In contrast, when these subjects were included with the basic baccalaureate level, the mean score for Objective 6.0 (utilization of support services) was lowered. This result is surprising as the task oriented focus of this objective is more consistent with diploma and associate degree preparation than with baccalaureate preparation. No reason for this result can be identified.

Summary

This chapter presented an analysis of the data collected to determine if a relationship existed between the quality of nursing care delivered and the educational preparation

Table 4

Mean Quality Care Scores for the Baccalaureate
Nurses With and Without Two Subjects

Score Source	Baccalaureate With All Subjects	Baccalaureate Without Two Subjects
Overall	0.74	0.75
<u>Objective</u>		
1.0	0.68	0.69
2.0	0.81	0.81
3.0	0.68	0.69
4.0	0.75	0.76
5.0	0.89	0.89
6.0	0.77	0.78

of the primary nurse responsible for the care. The sample of 31 primary nurses was described. A summary of the mean quality care scores was presented and discussed according to the level of educational preparation of the nurses. The method and results of the statistical treatment of the data were presented. Based on the results of the one-way analysis of variance, the study hypothesis was interpreted to conclude that differences in the quality of nursing care failed to be related to the highest level of educational preparation in nursing of the primary nurses who provide nursing care in the study institution.

CHAPTER 5

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

This chapter is concerned with a summary of the study including the purpose and research problem, the setting, data collection, and means of analysis of the data. Conclusions drawn from the study are detailed. Implications derived from the results of the study are directed to nurses in practice, administration, education, and research. Recommendations for further research are offered.

Summary

This nonexperimental study was conducted to determine if a relationship existed between the quality of nursing care delivered and the highest educational preparation of the primary nurse responsible for the care. Systematic evaluation of this problem had not been thoroughly reported in the literature. To determine if a statistically significant relationship existed, the study was undertaken, utilizing quality-monitoring worksheets derived from the Criteria Master List developed by Haussmann, Hegyvary, and Newman (1976).

The target population was identified as all adults (defined as 18 years or older) who were classified as in-patients on all the medical-surgical units in a 374 bed teaching hospital. Three patient care units, designated primarily as surgical units, were randomly selected by fishbowl technique, using sampling with replacement. On the units, patients were randomly selected using a numerical method of selection (every third patient). The study sample of patients consisted of those who had been hospitalized for a time period greater than 72 hours, had given informed consent, and had a registered nurse identified as the primary nurse who was willing to participate in the study and whose nursing care had not previously been evaluated. The study sample of nurses totaled 31: nine (29%) of whom had an associate degree in nursing; seven (23%), a nursing diploma; and 15 (48%), a baccalaureate degree in nursing. One nurse was identified as pursuing post baccalaureate studies in nursing, and two were identified as having progressed from their basic level of educational preparation in nursing, associate degree and diploma respectively, to a higher level (baccalaureate degree).

Data were collected using 56-item worksheets randomly generated by computer from the 257-item Criteria Master List (Haussmann et al., 1976). The items or criteria were

arranged in six major subsections which represented aspects of the Nursing Process and structural attributes of the nursing care delivery system. The four aspects of the Nursing Process were as follows: (1) the plan of care is formulated after the assessment is made; (2) the physical needs of the patient are attended; (3) the nonphysical needs of the patient are attended; and (4) achievement of nursing care objectives is evaluated. The two structural aspects of the nursing care delivery system were: (1) unit procedures are followed for the protection of all patients; and (2) the delivery of nursing care is facilitated by administrative and managerial services.

The data were analyzed according to mean scores for overall quality nursing care and for quality of care relevant to each of the six objectives. These mean scores were computed for each of the three educational levels of nurses studied. Baccalaureate nurses were noted to have attained the highest overall mean quality care score as well as the highest mean quality care scores for Objectives 1.0 (formulating the plan of care), 3.0 (implementing plans for meeting nonphysical needs), and 5.0 (unit management ability). Diploma nurses were noted to have attained the highest mean quality care scores for Objectives 2.0 (implementing plans for meeting physical needs), 4.0 (evaluating plans of care), and 6.0 (utilizing support

services). Associate degree nurses were found to attain the lowest mean quality care score for the overall mean quality care score as well as the lowest mean quality care scores for Objectives 1.0 (formulating the plan of care), 3.0 (implementing plans for meeting nonphysical needs), and 4.0 (evaluating plans of care). These findings were detailed in terms of the literature and related research studies and both consistencies and inconsistencies were identified and discussed.

Tests of significance were employed to relate the mean overall score and the mean objective scores to the different levels of educational preparation of the primary nurses. The use of the one-way analysis of variance indicated that there was no statistically significant difference in any of the mean quality scores among the three different nursing groups. Based on the results of the statistical treatment, the study hypothesis was interpreted to conclude that differences in the quality of nursing care failed to be related to the highest level of educational preparation in nursing of primary nurses who provide care in the study institution.

Conclusions

Based on the findings of this study, the following conclusions are drawn:

1. Within one institution whose nursing service is organized around the primary nursing model, differences in the quality of the nursing care cannot be related to the highest level of educational preparation in nursing of those nurses who provide the nursing care.
2. The overall quality of the nursing care in the institution cannot be evaluated as no attempt was made to assign an absolute value reflecting good or bad nursing care.
3. Although not statistically significant, some differences were noted in the strengths and weaknesses of the nurses prepared at different levels which were consistent with the literature and related research studies:
 - a. Baccalaureate nurses focused more on the phases of assessment, formulation of the plan of care, and implementation of the plans for meeting nonphysical needs than did diploma and associate degree nurses.
 - b. Diploma nurses emphasized implementation of the plans for meeting physical needs more than baccalaureate and associate degree nurses emphasized them.
 - c. Associate degree nurses focused less on assessment, formulation of the plan of care, and implementation of the plans for meeting nonphysical needs than did the baccalaureate and diploma nurses.

4. Inconsistencies with the literature and related research studies were noted in some differences in the strengths and weaknesses of the nurses prepared at the different levels. These differences, although not statistically significant were:
 - a. Baccalaureate nurses placed greater emphasis on the task oriented functions of unit management ability than did diploma and associate degree nurses.
 - b. Diploma nurses focused more on evaluating nursing care activities than did baccalaureate and associate degree nurses.
 - c. Diploma nurses emphasized assessment, care plan formulation, and implementation of the plans for meeting nonphysical needs more than associate degree nurses.

Possible factors which could have affected the study and thereby influenced the results have been identified as follows: the nurse sample size was small; the patient sample consisted of only surgical patients; the nursing care delivery system had always been structured around the primary nursing model; nursing administration as well as the individual nurse practitioners were all enthusiastic about the concept of primary nursing; and, nursing administration actively and consistently pursued quality assurance monitoring.

Implications

Based on the findings of the study, implications were derived and were directed to nurses in nursing practice, nursing administration, nursing education, and nursing research.

Nursing Practice

Although no statistically significant difference was found in the quality of nursing care provided by primary nurses prepared at different educational levels in nursing, some common differences were noted among the baccalaureate, diploma, and associate degree nurses. Within the various phases of the Nursing Process, some fairly common strengths and weaknesses among the different graduates were noted. Nurses prepared at different levels should be aware that their individual educational programs may have provided them with greater skill and knowledge in certain facets of the Nursing Process as opposed to other facets in which the educational emphasis had been less. Nurse-practitioners, cognizant of these likely strengths and weaknesses, can concentrate on improving their weaker areas and can share their expertise in their strengths with those nurses who express a desire to improve their practice. New graduates, who are seeking employment, might consider those areas in which their educational programs placed less emphasis and explore, with

the employing agency, the possibility of providing additional exposure to these areas in the orientation program. New graduates also should consider continuing education courses as a means of overcoming basic educational deficits.

Nursing Administration

Enthusiasm for the concepts of primary nursing and quality assurance in nursing can positively affect the individual nurse-practitioner's attitude towards quality care. The underlying theme of "my patient" inherent in primary nursing seemed to promote a sense of accountability and responsibility for the quality of the nursing care provided. Active and consistent quality monitoring appeared to convey to the nurse-practitioners the necessity of assuring that quality of services provided is the goal of nursing service.

Nursing administrators also should consider offering orientation programs which focus on those aspects of the Nursing Process in which the particular graduate needs to strengthen his/her skills.

Nursing Education

Nurse educators should emphasize to their particular student body those areas in which the student will continue to need guidance and direction upon graduation. These

students should be encouraged to become familiar with the nature of the orientation programs of the various hospitals and health care agencies for new graduates. Nurse educators also should emphasize to their students the importance of their evaluating the climate and commitment of the nursing administration to quality assurance when they are seeking staff nurse positions.

Nursing Research

Nurse researchers should continue to explore possible variables that affect the quality of nursing care provided. Structural variables such as the modality of nursing care delivery (i.e., team, functional, primary, and so forth), the characteristics of individual nurse-practitioners (i.e., age, education, experience, degree of professionalism, all R.N. staff, and so forth), and the nursing administrative climate (i.e., centralization and decentralization, authoritative and democratic leadership, and so forth) should be critically and systematically examined. Existing process criteria for quality care should be examined and refined, as necessary. Additional emphasis should be placed on the identification of outcome criteria. Continued research should be conducted in the area of developing process-outcome criteria.

Recommendations

Based on the findings of this study, the following research recommendations are offered:

1. A similar study should be conducted using a larger nurse sample and a mixture of medical and surgical patients whose quality of nursing care is monitored.
2. A similar study should be conducted in a number of hospitals and health care agencies whose nursing care delivery systems vary, i.e., functional nursing, team nursing, primary nursing, and so forth.
3. A similar study should be conducted using two groups of nurses: one group basically prepared at the baccalaureate level; and the other, basically prepared at the associate degree or diploma level, who progressed to the higher level of baccalaureate preparation.
4. A related study should be conducted using an instrument based on Nursing Process and related nursing outcome criteria to monitor the quality of nursing care delivered by various educational levels of nurses.

APPENDIX A

PERMISSION FORMS

TEXAS WOMAN'S UNIVERSITY

HOUSTON CAMPUS

HUMAN RESEARCH REVIEW COMMITTEE REPORT

93

IDENT'S NAME Linda Ann Ungersky

PROPOSAL TITLE ~~Adult~~ Level of Literacy Reading Case Related
to the Primary Reading Level of Education

REMARKS:

DATE: 3-9-79

Jane Robertson
~~Disapprove~~ Approve

W. H. Davis
~~Disapprove~~ Approve

Don Harty
~~Disapprove~~ Approve

James M. Soler
~~Disapprove~~ Approve

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

94

ELLAS CENTER
310 INWOOD ROAD
ELLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

IE PARIC PLAZA Hospital

WANTS TO LINDA DIANE UNGVARSKY

student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

How does the level of educational preparation in nursing relate to the quality of nursing care, in a primary nursing setting, as determined by Standards of Quality Nursing Care?, within the context of a thesis entitled QUALITY NURSING CARE RELATED TO THE PRIMARY NURSE'S LEVEL OF EDUCATION.

the conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: 3-26-79

Linda D. Ungvarsky
Signature of Student

Brian Rogers
Signature of Agency Personnel

Betty Henderson
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

APPENDIX B

PATIENT CONSENT

CONSENT TO ACT AS A SUBJECT FOR RESEARCH AND INVESTIGATION
(PATIENT)

1. I hereby authorize Linda D. Ungvarsky to perform the following investigation: measure the quality of the nursing care I am receiving based on 56 criteria derived from the Criteria Master List. The nature of the evaluation may include any or all of the following: a review of my chart; personal observation; and interview.
2. The procedure listed in Paragraph 1 has been explained to me by Linda D. Ungvarsky.

3. (a) I understand that the investigation described in Paragraph 1 involves the following possible risks or discomforts:

The researcher (Linda D. Ungvarsky) will have access to the information contained within my chart; and the researcher may need to interview me to ascertain some aspects of the quality of my nursing care.

(b) I understand that the investigation described in Paragraph 1 has the following potential benefits to myself and/or others:

The researcher may identify some factors which promote a high quality of nursing care.

4. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

Subject's Signature

Date

APPENDIX C

NURSE CONSENT

CONSENT TO ACT AS A SUBJECT FOR RESEARCH AND INVESTIGATION
(NURSE)

1. I hereby authorize Linda D. Ungvarsky to perform the following investigations:

Identify my highest level of formal educational preparation in nursing;

Measure the quality of the nursing care I provide a patient based on the 56 criteria derived from the Criteria Master List; and

Correlate the two items to ascertain if my level of educational preparation is significantly related to the quality of nursing care.

2. The investigations listed in Paragraph 1 have been explained to my by Linda D. Ungvarsky.
3. (a) I understand that the investigations described in Paragraph 1 involve the following possible risks or discomforts: The possible disclosure of individual quality of care scores. However, anonymity and double blind coding of nurse subjects will virtually eliminate this potential risk.
(b) I understand that the investigations described in Paragraph 1 have the following potential benefits to myself and/or others: the researcher may identify a significant correlate of quality nursing care in a Primary nursing setting; and the researcher may identify common strengths and weaknesses of particular nursing programs which may be of value to the Nursing Staff Development Department as it plans for the orientation needs of nurses from different program levels.
4. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

Subject's Signature

Date

APPENDIX D

CRITERIA MASTER LIST

INSTRUCTIONS

The Criteria Master List--Quality Study that follows consists of 257 criteria for quality that were identified and verified in extensive testing by Haussmann, Hegyvary, and Newmann (1976) in a joint undertaking by the Rush-Presbyterian-St. Luke's Medical Center (Chicago) and the Medicus Systems Corporation. The research was performed under Public Health Service Contract N01 NU-24299 from the Division of Nursing, Health Resources Administration.

For purposes of this study, only those criteria that pertain to the Medical-Surgical patient (Patient types 1, 2, 3, and 4) on a General Unit (5) will be included in the present study. The Criterion Applicability column (far right on page) will indicate the areas covered by each criterion. Of interest to this study are only those patient types 1, 2, 3, and 4, and General Unit 5. Therefore, the Criteria Master List to be utilized in this study will consist of 201 criteria for quality.

NOTES

Within a subobjective, criterion numbering is not always consecutive, i.e., some numbers in sequence are skipped, indicating that criteria have been moved or dropped in the course of analysis.

Key to criterion applicability codes:

- | | |
|------------------|-------------------------|
| 1—Patient type 1 | 6—Nursery patient |
| 2—Patient type 2 | 7—Recovery room patient |
| 3—Patient type 3 | 8—Nursery unit |
| 4—Patient type 4 | 9—Recovery room |
| 5—General unit | |

Key to source of information codes:

- | | |
|--------------------------------|------------------------------------|
| 01—Patient record | 05—Nursing personnel observation |
| 02—Patient observation | 06—Patient environment observation |
| 03—Patient interview | 07—Observer inference |
| 04—Nursing personnel interview | 08—Unit management observation |

Source of
Information

Criterion
Applicability

1.0 THE PLAN OF NURSING CARE IS FORMULATED

1.1 The Condition of the Patient Is Assessed on Admission

01	02. If the patient has physical disabilities, e.g., sensory or motor impairment such as impaired hearing, vision, speech, etc., are they recorded within the first 24 hours of admission to this unit?	No	1	2, 3
		Yes	2	
		Not Applicable	3	
01	03. Is there a statement about allergies written at the time of admission to this unit? (Refers to statement of presence or absence of allergies. Code NA if information recorded on admission to another unit.)	No	1	1, 2, 3, 4
		Yes	2	
01	04. If the patient depends on prosthetic devices for ADL, is this recorded within the first 24 hours of admission to this unit? (Depends means that the patient uses or has prosthetic devices for ADL. Prosthetic devices refer to any device used for ADL, e.g., dentures, glasses or contact lenses, hearing aids, orthopedic shoes or braces, artificial limbs or eyes. May include devices such as wigs. ADL means minimal activities required for daily personal care, e.g., eating, toilet, dressing, ambulation. Code NA if patient initially admitted to another unit.)	No	1	1, 2, 3, 4
		Yes	2	
		Not Applicable	3	

Source of Information				Criterion Applicability
01	05. Are patient's elimination patterns recorded within the first 24 hours of admission to this unit? (Applies to patterns prior to hospital stay. Code NA only if information recorded on admission to another unit. Patterns refers to information about regularity/irregularity of bowel or bladder.)	No Yes	1 2	1, 2, 3, 4
01	06. Are behaviors indicative of mental-emotional state recorded at the time of admission to this unit? (Do not code NA for adults or children; may code NA for infants. Applies to statements of behavior. e.g., alert, talkative, anxious, depressed, mentally retarded, etc.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4
01	07. Is there a statement written within the first 24 hours of admission to this unit about the condition of the skin? (Refers to dryness, turgor-hydration, absence or presence of skin lesions, localized skin color, warmth, etc. Do not accept general description such as "pale." Do not code NA. Applies to all patients on this unit.)	No Yes	1 2	1, 2, 3, 4
1.2 Data Relevant to Hospital Care Are Ascertained on Admission				
01	01. Is the general physical appearance of the patient recorded within the first 24 hours of admission to this unit? (Accept any description of physical appearance, e.g., pale, emaciated, obese. Do not accept reference to age, sex, race, marital status. Does not include behavioral description. Do not accept general description such as "in acute distress." Do not code NA. Applies to all patients on the unit.)	No Yes	1 2	1, 2, 3, 4, 6
01	02. Is the patient's understanding of his illness recorded within the first 24 hours of admission to this unit? (Refers to responses probably elicited by question: "Can you tell me something about your illness?" or "What is the reason you are in the hospital?" Refer to answer format for definition of level of understanding. Do not code NA for responsive adults or children; may code NA for small children, infants, or patients unresponsive on admission.)	No Yes, includes name of diagnosis, surgery, tests, or symptoms Yes, understanding of illness and prognosis stated Not Applicable	1 2 3 4	1, 2, 3, 4
01	04. Is height recorded on admission to this unit? (Code NA if information recorded on admission to another unit.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4
01	05. Is weight recorded on admission to this unit? (Code NA if information recorded on admission to another unit.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4
01	06. Is there a statement written at the time of admission to this unit about whether the patient is taking medications? (Accept any description of or reference to the fact that the patient is or is not taking medication. Code NA if information recorded on admission to another unit. Do not code NA if patient initially admitted to this unit.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4
01	07. Are either the diet or the food preferences of the patient recorded within the first 24 hours of admission to this unit? (Code NA if information recorded on admission to another unit. Do not code NA if patient initially admitted to this unit. Includes reference to dietary considerations based on religious beliefs or customs.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4

CRITERIA MASTER LIST

<i>Source of Information</i>				<i>Criterion Applicability</i>
01	09. Are the measurements of the head and chest circumferences of the baby recorded? (Should be taken shortly after birth. Both are necessary for Yes answer.)	No Yes	1 2	6
01	11. Are any injuries or malformations of the child noted? (Check baby to see if any injuries or malformations present.)	No Yes	1 2	6
1.3 The Current Condition of the Patient Is Assessed				
01	01. Is there a written statement about the current condition of the skin? (Relates to dryness, turgor-hydration, absence or presence of skin lesions, localized skin color, warmth, etc. Do not accept general description such as "pale." Should apply to present status or within past 48 hours.)	No Yes	1 2	3, 4, 6, 7
01	02. Are respiratory rate and quality recorded? (Quality refers to descriptions such as shallow, labored, grunting, Cheyne-Stokes, retracting, etc. Applies to patients with respiratory conditions, conditions in which respiratory involvement is anticipated, or when otherwise necessary, e.g., stroke patient, patient on respirator, hyperglycemic patient, etc. Must be recorded within past 48 hours. Both rate and quality necessary for Yes answer.)	No Yes	1 2	3, 4, 6, 7
01	03. Are behaviors indicative of the current emotional state recorded? (Applies to statements such as alert, talkative, anxious, depressed, etc. May not be applicable for infants. Applies to 48 hours prior to time of observation.)	No Yes	1 2	1, 2, 3, 4, 7
01	04. Is the patient's level of consciousness indicated on the record? (Should be recorded before patient leaves recovery room.)	No Yes Not Applicable	1 2 3	7
01	05. Is the patient's orientation to time, place, and person indicated on the nursing record? (Should be recorded before patient leaves recovery room.)	No Yes Not Applicable	1 2 3	7
01	06. Is the baby's activity noted at least once each shift? (Lethargic, floppy, irritable, tremors, etc.)	No Yes	1 2	6
01	07. Is the baby's color noted at least once each shift? (E.g., color normal for race, unusual color such as pallor, jaundice, cyanotic, plethora, mottling, etc.)	No Yes	1 2	6
01	08. Are temperatures recorded every shift up to the day of this observation? (Axillary, rectal, or electronic readings acceptable.)	No Yes	1 2	6
01	10. Is there a written statement about the relation between family or mother and baby? (Implies attitudes or feelings mother or family have toward the baby, e.g., mother awkward in caring for baby, parents don't want child, mother and father accept responsibility for care of child, etc.)	No Yes Not Applicable	1 2 3	6
01	11. Is there a written statement about the baby's response to his environment? (Wakes easily, cries when disturbed, responds to fondling.)	No Yes	1 2	6

Source of Information				Criterion Applicability
01	12. Is there a written statement about the baby's reflexes:			6
	A. The moro reflex?	No	1	
		Yes	2	
	B. The suck reflex?	No	1	
		Yes	2	
01	13. Is there a written statement about the baby's cry (i.e., pitch or tone)?	No	1	6
		Yes	2	
	1.4 The Written Plan of Nursing Care Is Formulated			
01	01. Are goals of care written?	No	1	1, 2, 3, 4, 6
		Yes	2	
01	02. Do nursing orders specify times and methods for carrying out medical and nursing therapeutic or diagnostic measures?	No	1	1, 2, 3, 4, 6
	(For Complete, each order should indicate specific time activity is to be done and method of performing activity. For diagnostic procedure, acceptable if reference made to use of file or Rolodex. Does not refer to instruction of patient. Code NA only if there are no medical or nursing orders. Statements such as BID, QID, etc. are not acceptable as times unless specific hours stated in hospital policy.)	Yes, incomplete	2	
		Yes, complete	3	
		Not Applicable	4	
01	03. Are nursing therapeutic measures to be given in regard to patient condition or symptoms in writing?	No	1	1, 2, 3, 4, 6
	(E.g., elevation of head for shortness of breath, measures for decubitus care, exercises for immobile patients, etc. Does not apply to medical orders. Observer must identify therapeutic nursing measures that should be specified for this patient, then check nursing plan, e.g., Kardex, care plan, etc. to see if measures are listed. Record as Incomplete if any significant therapeutic measures are not written.)	Yes, incomplete	2	
		Yes, complete	3	
		Not Applicable	4	
01	04. Are activities the patient is expected to do for himself and activities the nursing staff should perform for the patient stated in writing (e.g., in the nursing care plan, Kardex, etc.)?	No	1	1, 2, 3
	(Refers to all ADL, e.g., eating, toilet, dressing, walking, and other types of participation in care.)	Yes	2	
01	05. Do the nursing records indicate that consideration has been given to discharge teaching?	No	1	1, 2, 3
	(May include referral to special teaching teams or individuals, either nursing or nonnursing.)	Yes	2	
		Not Applicable	3	
01	06. Is the desired extent of ambulation stated in writing, e.g., in the nursing care plan, Kardex, etc.?	No	1	2, 3
	(Refers to distance patient is expected to walk or length of time out of bed; includes up to bathroom if patient walks to bathroom. Does not apply to patients up ad lib or patients on bed rest.)	Yes	2	
		Not Applicable	3	
01	07. Is the time and type of care related to presence of tubes (e.g., catheters, trach tubes, etc.) stated in writing, e.g., in the nursing plan, Kardex, etc?	No	1	3, 4, 6
	(E.g., cleaning around tube, irrigation, etc. Does not refer to IVs. Code Complete only if both time and type of care are recorded for each type of tube present.)	Yes, incomplete	2	
		Yes, complete	3	
		Not Applicable	4	

CRITERIA MASTER LIST

Source of Information			Criterion Applicability	
01	08. Is the plan for turning and positioning the patient stated in writing, e.g., in the nursing care plan, Kardex, etc? (If not stated in writing, to see if applicable may ask nurse: "Is Mr. X able to turn and position himself?" Check NA only if patient does not need to be turned or positioned. Accept only written plan.)	No Yes Not Applicable	1 2 3	3, 4
01	09. Is there a plan for providing frequent observation of patient with threatening conditions, such as bleeding, respiratory distress, or psychiatric disorders? (Frequent observation implies approximately every 30 minutes or more often. To see if applicable, may ask nurse: "Does Mr. X need any frequent observation? How do you arrange for observation?")	No Yes, oral only Yes, written only Not Applicable	1 2 3 4	3, 4, 6
01	10. Is there a plan for systematically increasing the patient's independence or restoring him to a higher level of function, e.g., increasing self-help or increasing activity? (Applies only if patient needs attention to such care. Applies to care not included in the medical regimen.)	No Yes Not Applicable	1 2 3	2, 3
07	11. If the patient should do deep breathing exercises, is there a written statement in the nursing plan (Kardex, care plan, etc.) that they should be done? (Applicable for patients who have respiratory conditions, are immobile, are in the first two postoperative days, etc.)	No Yes Not Applicable	1 2 3	3, 4
01	12. Is the baby's feeding schedule in writing in the nursing plan (Kardex, care plan, etc.)?	No Yes	1 2	6
1.5 The Plan of Nursing Care Is Coordinated with the Medical Plan of Care				
01	01. Are medically prescribed treatments included in the nursing care records? (Check nursing record of treatments with current medical orders for this patient.)	No Yes, incomplete Yes, complete Not Applicable	1 2 3 4	1, 2, 3, 4, 6
01	02. Is there a plan for making observations of signs or symptoms in regard to medical treatment, medications, disease process, or possible complications? (Refers to major signs and symptoms in regard to this patient's present condition. Does not apply to observations indicated in physician's orders. Observer must determine if patient condition indicates need for specific observation.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4, 6
04	04. Do the physician and nurse in charge of the patient discuss current plans for the patient daily? (To the nurse in charge: "How often do you and the physician responsible for Mr. X discuss the patient's current orders or plans together? Were you able to do this today or the last day you worked?" Nurse in charge refers to primary nurse, team leader, charge nurse, or equivalent.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4, 6
04	06. Has the nurse discussed plans for the patient with other disciplines (besides medicine) who are also working with the patient? (Determine whether other disciplines are working with the patient. If so: to nurse: "Have you had a chance to discuss Mr. X's care with other disciplines such as PT, OT, etc who are working with him?")	No Yes	1 2	1, 2, 3, 4

Source of
InformationCriterion
Applicability

2.0 THE PHYSICAL NEEDS OF THE PATIENT ARE ATTENDED

2.1 The Patient Is Protected from Accident and Injury

02	01. Is the patient wearing an identification bracelet or tag? (Patient must be wearing some form of identification bracelet or tag, even if not required by hospital policy. Do not answer NA.)	No	1	1, 2, 3, 4, 6, 7
		Yes	2	
02	02. Is the patient in a position of optimal body alignment? (Observe position of feet, legs, knees, trunk, shoulders, arms, and head. Answer No if any part of body not properly aligned.)	No	1	3, 4, 7
		Yes	2	
		Not Applicable	3	
02	03. Is the IV needle adequately secured in place? (Observe to see if IV needle adequately taped, with armboard if appropriate.)	No	1	3, 4, 7
		Yes	2	
		Not Applicable	3	
03	04. If specific precautions are required when the patient gets into or out of bed (e.g., patients with IVs, tubing, dressings, incisions, crutches, muscle weakness, etc.), are appropriate instructions given? (Observer must determine whether special precautions are necessary. If they are, ask patient: "Did someone tell you how to be careful with (tubes, weakness, or special condition) when you get up?" If no special precautions are necessary for this patient, code NA.)	No	1	2, 3
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
04	05. Are assigned nursing staff informed of the patient's present status? (To nurse: "What is his condition today, or what is his present status?" Observer must know patient's present status. If nurse answers incorrectly, record No.)	No	1	1, 2, 3, 6
		Yes	2	
06	07. Are medications for self-administration labeled with patient's name and name and dosage of drug? (To patient: "Are there any medicines you are supposed to take by yourself while in the hospital?" If Yes, "Could I please see them?")	No	1	1, 2
		Yes	2	
		Not Applicable	3	
06	08. Are the bedside table and other self-care equipment positioned within the patient's reach?	No	1	2, 3
		Yes	2	
06	09. In rooms where oxygen is in use, is smoking prohibited by posted sign? (Code No if no sign posted or if anyone is seen smoking in room.)	No	1	5, 9
		Yes	2	
		Not Applicable	3	
07	10. Are siderails up if the condition of the patient warrants? (Observer must determine if patient's condition warrants having siderails up, e.g., patients who are restless, disoriented, on seizure precautions, have received narcotics or sedatives, etc.)	No	1	3, 4, 7
		Yes	2	
		Not Applicable	3	
07	12. Are all nursing procedures currently done for this patient specifically ordered in writing by either physician or nurse? (Answer No if any procedures are not specifically ordered, e.g., a catheter irrigation done when it is not ordered, etc.)	No	1	1, 2, 3, 4, 6
		Yes	2	
06	13. Are all wheels locked when patient is assisted into or out of bed and/or wheelchair? (All wheels must be locked for Yes answer.)	No	1	1, 2, 3
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	

		CRITERIA MASTER LIST		
Source of Information			Criterion Applicability	
06	15. Is bed in lowest position except when treatments are being done?	No	1	1, 2, 3
		Yes	2	
		Not Applicable	3	
06	16. Is the patient protected from electrical injury:			1,2,3,4,5,6,7
	A. Is all electric equipment grounded (i.e., each piece has a 3-prong plug)?	No	1	
		Yes	2	
	(Refers to all electric equipment in the patient's room, whether hospital- or patient-owned. Includes equipment not currently being used.)	Not Applicable	3	
	B. Is the bed at least 6 inches from the electric outlet?	No	1	
		Yes	2	
		Not Applicable	3	
	C. Is all electric equipment at least 6 inches from the bedframe?	No	1	
		Yes	2	
		Not Applicable	3	
	D. Are all electric cords smooth, with no frayed ends or exposed wires?	No	1	
		Yes	2	
		Not Applicable	3	
02	17. If protective or supportive devices (e.g., restraints, donut rings, heel guards, footboards, sandbags, pillows, etc.) are being used, are they used properly to provide support or prevent injury? (Check position of protective or supportive device in relation to body area.)	No	1	3, 4
		Yes	2	
		Not Applicable	3	
08	18. Is there a list of patient's allergies on the front of the chart?	No	1	1, 2, 3, 4
		Yes	2	
		Not Applicable	3	
02	19. If the Bili light is being used:			8
	A. Are the baby's eyes covered?	No	1	
		Yes	2	
		Not Applicable	3	
	B. Is the position of the baby changed every 4 hours?	No	1	
		Yes	2	
		Not Applicable	3	
	C. Is the temperature of the baby taken every 4 hours?	No	1	
		Yes	2	
		Not Applicable	3	
06	20. Is the baby checked for proper identification with mother each time he is brought to her for feeding?	No	1	6
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
06	22. When the baby is transferred from the delivery room to the nursery, is a check for identification and sex made between the nursery and the delivery room personnel? (Answer Yes if both checks made.)	No	1	8
		Yes	2	
		Information Not Available	3	
02	25. Is the baby correctly positioned? (Applies to time of observation only. Observer must determine if current position is appropriate for current condition, e.g., if baby was just fed or gavaged, is he toward or on his right side with head elevated, etc. Unacceptable if baby left on back unattended.)	No	1	8
		Yes	2	
		Not Applicable	3	

Source of
InformationCriterion
Applicability

06	* 26. Is the baby protected from injury by:			8
	A. Holding properly with support to all body parts?	No	1	
		Yes	2	
		Information		
		Not Available	3	
	B. Protection from falling when on scales, counter, etc., e.g., the nurse's hand on baby?	No	1	
		Yes	2	
		Information		
		Not Available	3	
04	27. Do the nursing personnel use a cross-checking system to assure that each baby gets his correct formula?	No	1	8
	(To nurse: "In the past 2 days, did you cross-check to see that each baby gets the correct formula?" If no indication of a cross-checking system, answer No.)	Yes	2	
	2.2 The Need for Physical Comfort and Rest Is Attended			
02	01. Is the patient able to reach the water glass and pitcher?	No	1	2, 3
	(Does not apply to infants and small children. Always applies to adults unless NPO. If patient does not have both water glass and pitcher within reach, code No.)	Yes	2	
		Not Applicable	3	
03	02. Was the patient's hair combed today?	No	1	3, 4
	(To patient: "Was your hair combed today?")	Yes	2	
		Not Applicable	3	
03	03. Has the patient received attention to complaints of pain, nausea, or vomiting?	No	1	2, 3, 4, 7
	(To patient: "Have you had any pain or have you been sick to your stomach?" If No to either, code NA. If Yes: "Was something done to help you feel better?")	Yes	2	
		Not Applicable	3	
		Information		
		Not available	4	
06	04. Is the bed clear of extraneous items?	No	1	1, 2, 3, 4, 6, 7
	(E.g., supply wrappers, syringes, etc. Does not refer to personal items apparently put there by patient.)	Yes	2	
02	05. Is the call light within the patient's reach?	No	1	2, 3
	(Observe whether light is within patient's reach. Code NA only for infants and small children.)	Yes	2	
		Not Applicable	3	
02	07. Is lighting controllable for the patient?	No	1	2, 3
	(Observe to determine if patient can turn light on and off. May be NA for small children and infants.)	Yes	2	
		Not Applicable	3	
03	08. Are measures for relief of pain provided by the nursing staff (e.g., changing patient's position, splinting incision or painful area, or giving medication)?	No	1	2, 3, 4
	(To patient: "Have you been troubled with pain in the past two days?" or "You mentioned that you've had some pain." If No, code NA. If Yes: "Did you ask a nurse for any help?" If No, code NA. If Yes, "What was done for you to relieve the pain?")	Yes, sometimes	2	
		Yes, always	3	
		Not Applicable	4	
		Information		
		Not Available	5	
03	09. Does the patient receive pain medication promptly after requesting it, or an explanation as to why pain medication cannot be given promptly?	No	1	2, 3, 4, 7
	(To patient: "In the past 2 days did you usually receive pain medication promptly after you asked for it?" If the answer is No, ask the patient: "Did the nurse explain why the medication was not given promptly?")	Yes	2	
		Not Applicable	3	

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03	10. Is the patient free of disturbing noise from the hospital environment? (To patient: "In the past 2 days have you been undisturbed by noise from hospital equipment or from people talking in the corridors?" Does not refer to noise external to hospital, such as street noise. If patient undisturbed by hospital noise, code Yes.)	No Yes Not Applicable	1 2 3	1, 2, 3, 4
03	11. Does the patient have uninterrupted periods of sleep and rest? (To patient: "For the past 2 nights, have you been able to sleep or rest without interruption for at least several hours?" Accept patient's definition of several hours.)	No Yes Not Applicable	1 2 3	1, 2, 3
03	12. Is the patient offered a backrub daily? (To patient: "Do the nurses offer you a backrub each day?" To answer Yes, must be offered at least once in 24-hour period. May be NA only if patient's condition contraindicates backrub, e.g., burn patient, etc.)	No Yes	1 2	2, 3, 4
06	13. Are the halls and patient rooms (or nursery) quiet and free of boisterous behavior?	No Yes	1 2	5, 8, 9
03	14. Is the patient's call light answered promptly? (To patient: "In the past 2 days, when you called for assistance, did someone come to your room promptly?" NA only if patient in room without call light or if patient has not called for nurse in past 2 days.)	No Yes, some of the time Yes, most of the time Yes, all of the time Not Applicable Information Not Available	1 2 3 4 5 6	2, 3, 4
03	15. Is the male patient shaved each day? (To patient: "Did someone shave you today or help you to shave yourself today?")	No Yes Not Applicable	1 2 3	3, 4
03	16. Is the patient in an appropriate position for meals or tube feedings? (To patient: "What position were you in for your last meal or tube feeding?" Observer must determine if position was appropriate for patient's condition.)	No Yes Not Applicable	1 2 3	3, 4
06	17. Is there a rocking chair in the nursery?	No Yes	1 2	8
04	18. Are babies permitted at least 30 minutes per feeding? (Ask nurse: "In the past two days, how much time was spent feeding baby at each feeding?" Code Yes if babies permitted at least 20-30 minutes per feeding. Includes gavage feeding.)	No Yes	1 2	6
2.3 The Need for Physical Hygiene Is Attended				
02	01. Are the patient's nails clean?	No Yes	1 2	2, 3, 4
03	02. Are the patient's hands washed before meals? (To patient: "In the past 2 days, did someone assist you to wash your hands or were you able to wash yourself before your meals?" Probe: "Would you say your hands were washed sometimes, most of the time, or all of the time in these 2 days before meals?")	No Yes, some of the time Yes, most of the time Yes, all of the time Information Not Available	1 2 3 4 5	3, 4

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06	03. Is equipment available at patient's bedside for bathing? (Check to see that towels, washcloth, basin, and soap are in the patient's room.)	No Yes	1 2	1, 2, 3, 4, 6
06	04. Is adequate equipment for oral hygiene available? (Check to see that all necessary equipment is present: toothbrush, toothpaste and mouthwash or swab, solution, and denture cup if indicated.)	No Yes	1 2	1, 2, 3, 4
06	05. Are the bedpan and/or urinal clean and stored in bedside table or bathroom? (Code No if placed on overbed table, on floor, on windowsill, etc. Must be both clean and stored for Yes answer.)	No Yes	1 2	2, 3, 4
01	07. Is the baby given at least minimal cleansing care daily? (Must be cleansing of at least face and diaper area.)	No Yes	1 2	6
05	08. Does cleansing care proceed from clean to less clean areas of baby?	No Yes Not Applicable	1 2 3	6
02	09. Is the baby protected from chilling during bath or cleansing care?	No Yes Not Applicable	1 2 3	8
2.4 The Need for a Supply of Oxygen Is Attended				
02	01. Is the patient in a position for maximal lung expansion? (Observe elevation of bed, use of pillows, and position of head, neck, and chest. Answer Yes only if all indicators good.)	No Yes Not Applicable	1 2 3	3, 4, 7
04	02. A. Does the patient take deep breaths after suctioning, or if patient is unconscious, does nurse ambu patient after suctioning? (To nurse: "Does Mr. X take deep breaths after being suctioned?" or, if patient is unconscious: "Do you ambu after suctioning?" Code NA only if patient is not suctioned.) B. Is the patient suctioned correctly? (Observe suctioning technique. Check for rotation of catheter, intermittent use of suction, proper depth of catheter insertion, and slow insertion and removal of catheter. If any part not correct, code No.) C. Is the tracheostomy suctioned when needed? (Observe patient for airway patency. Check records to see when trach was last suctioned. Make inference as to whether frequency of suctioning is adequate.)	No Yes Not Applicable No Yes Not Applicable No Yes Not Applicable	1 2 3 1 2 3 1 2 3	5
06	03. Is equipment necessary for maintaining a clear airway at the bedside? (E.g., ambu, airway, suction equipment, tongue blade, etc. Does not apply to turning or use of humidification.)	No Yes Not Applicable	1 2 3	3, 4, 7
02	04. Is equipment for supplying supplementary oxygen and/or humidification properly used? (Check oxygen flow rate, tubing, position of face mask or other means of giving oxygen, all equipment and connections. If any part not right, answer No. Equipment for humidification applies to any kind of humidification, e.g., trach, O2, aerosols, isolettes, etc. Check presence of water, all tubing and connections. If any part not right, code No. If patient has both oxygen and humidification, all parts must be right for Yes answer.)	No Yes Not Applicable	1 2 3	3, 4, 7

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04	09. Does the nurse check for respiratory adequacy after the airway is removed? (Includes checking for laryngospasm, listening to breath sounds, telling patient to take breaths, etc.)	No Yes	1 2	7
2.5 The Need for Activity Is Attended				
01	01. Is the patient out of bed the number of times ordered? (Check records for previous day only. May be NA only for patients up ad lib, patients on bedrest, or infants and small children.)	No Yes Not Applicable	1 2 3	2, 3
03	02. Is the patient assisted with ADL (eating, toilet, dressing, walking, etc.) as needed? (To patient: "In the past 2 days, when you needed some help in your daily activities, such as bathing or doing things for yourself, did someone assist you within a reasonable amount of time?" Needed and reasonable amount of time as defined by patient.)	No Yes, some of the time Yes, most of the time Yes, all of the time Not Applicable Information Not Available	1 2 3 4 5 6	2, 3
01	03. If the patient should have range-of-motion exercises performed, either active or passive, are they done? (If no medical or nursing orders for exercises written, observer must determine whether exercises should be done. Code NA if patient does not need exercises. May include leg exercises in the immediate postoperative period.)	No Yes, off schedule Yes, on schedule Not Applicable	1 2 3 4	3, 4
03	04. Unless contraindicated, do the nursing staff inform the patient to do (or assist the patient with) leg exercises in bed? (Observer should first determine if leg exercises should be done. If so, ask patient: "Does anyone from the nursing staff give you any leg exercises or move your legs much while you're in bed?" Applies to knee flexion and ankle rotation, e.g., for patient in immediate postoperative period, bedfast patient, etc. Does not apply to turning or to range-of-motion exercises.)	No Yes Not Applicable Information Not Available	1 2 3 4	3, 4
04	05. Is the patient stimulated to respond (e.g., by talking or touching)?	No Yes	1 2	7
2.6 The Need for Nutrition and Fluid Balance Is Attended				
03	01. Are nursing personnel accessible to patient during meals? (To patient: "In the past 2 days, if you needed or requested some help with your meal tray, was there someone from the nursing staff to help you within a reasonable amount of time?" Patient defines reasonable amount of time.)	No Yes, some of the time Yes, most of the time Yes, all of the time Not Applicable Information Not Available	1 2 3 4 5 6	1, 2, 3
03	02. Is the diet served at appropriate time after patient's admission to this unit? (To patient: "When you were admitted to this unit, do you remember if you were served your first meal or snack within a reasonable amount of time?" Patient defines reasonable amount of time. NA only if patient NPO on admission to unit.)	No Yes Not Applicable Information Not Available	1 2 3 4	1, 2, 3

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01	04. If attention to the patient's oral fluid intake is indicated, e.g., encourage, force, or restrict fluids, are the following stated:			3, 4
	A. Time fluids are to be given?	No	1	
		Yes	2	
		Not Applicable	3	
	B. Kinds of fluids to be given?	No	1	
		Yes	2	
		Not Applicable	3	
	C. Amount of fluids to be given?	No	1	
		Yes	2	
		Not Applicable	3	
01	05. Is the amount of fluid intake and output recorded? (Applies if patient is on I&O, has special attention given to fluid intake and output, or is in the immediate postoperative period. Complete only if both intake and output recorded and totaled for each shift in past 2 days. If patient has been on this unit less than 2 days, answer only for time on this unit.)	No	1	2, 3, 4, 7
		Yes, incomplete	2	
		Yes, complete	3	
		Not Applicable	4	
06	06. Are bottles for intravenous therapy labeled with:			3, 4, 7
	A. Patient's name and room number?	No	1	
		Yes	2	
		Not Applicable	3	
	B. Kind of solution?	No	1	
		Yes	2	
		Not Applicable	3	
	C. Name and amount of additives?	No	1	
		Yes	2	
		Not Applicable	3	
	D. Date and time?	No	1	
		Yes	2	
		Not Applicable	3	
	E. Rate of flow, in drops or on time schedule label?	No	1	
		Yes	2	
		Not Applicable	3	
	F. Bottle number, if patient receives more than one bottle in 24-hour period?	No	1	
		Yes	2	
		Not Applicable	3	
06	07. Is IV fluid infusing at prescribed rate? (Get prescribed rate and check flow.)	No	1	3, 4, 7
		Yes	2	
		Not Applicable	3	
01	2.7 The Need for Elimination Is Attended			
01	01. Is bowel function recorded daily?	No	1	1, 2, 3, 4, 6
		Yes	2	
01	02. Are unusual bowel or urinary tract problems noted, e.g., passing blood, burning, frequency, incontinence, etc.? (To determine if applicable, ask patient: "In the past 2 days, have you noticed any unusual problems with your bowels or on urination?" Does not refer to daily recording of bowel movement or to amount of urinary output. Unusual problems are those defined as such by either the observer or the patient. Refers to all patients, including those with a urinary catheter or colostomy.)	No	1	1, 2, 3, 4, 6
		Yes	2	
		Not Applicable	3	
		Information		
		Not Available	4	

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03	03. Does the nursing staff assist the patient to the bathroom or with bedpan/urinal within a reasonable amount of time when requested? (To patient: "Have you requested assistance in going to the bathroom (or with the bedpan/urinal) within the past 2 days? Did the nursing staff give you the assistance you needed within a reasonable amount of time?" Patient defines reasonable amount of time. Code Yes only if help needed and given within reasonable time.)	No Yes Not Applicable Information Not Available	1 2 3 4	2, 3, 4
01	06. Is the frequency of the baby's voidings recorded each shift?	No Yes	1 2	6
01	07. Are stool descriptions recorded at least daily?	No Yes Not Applicable	1 2 3	6
01	08. Was the quality of the male babies' urinary stream noted? (NA for female babies.)	No Yes Not Applicable	1 2 3	6
01	09. Was the baby's first meconium noted?	No Yes Not Applicable	1 2 3	6
01	11. Is there a written statement about whether the patient has had any urinary output? (Applies to all patients, including those with urinary catheters. Not applicable if patient has been in recovery room a very short time.)	No Yes Not Applicable	1 2 3	7
2.3 The Need for Skin Care Is Attended				
01	01. Is there a written statement of the care given to pressure areas on the skin? (Refers to direct care of skin provided to prevent skin breakdown, such as massage. Does not refer to turning or to specific care given for decubitus.)	No Yes	1 2	3, 4, 6
01	02. Is the condition of the skin around the IV site recorded? (E.g., reddened, swollen, complaint of itching or pain, infiltration.)	No Yes Not Applicable	1 2 3	3, 4, 7
06	03. Are the undersheets clean, dry, and smooth? (Applies only to bedfast patients. Code NA for use of high humidity.)	No Yes Not Applicable	1 2 3	3, 4, 6, 7
01	05. Is care given to areas of skin breakdown as often as required? (Applicable to any areas of breakdown, such as decubitus, laceration, diaper rash, or sheet burn. Includes care of skin around ostomies. Check to see if special care is needed and whether plan indicates schedule for giving such care. If care should be given and is not, record No. If care is scheduled, note whether records indicate care is done as often as scheduled. If not, record Incomplete.)	No Yes, incomplete Yes, complete Not Applicable	1 2 3 4	3, 4, 7
2.9 The Patient Is Protected from Infection				
01	01. Is the IV bottle or bag changed every 24 hours? (Check records to see when last changed. Changing bottle or bag should follow CDC standards, not hospital policy if it differs from CDC standards.)	No Yes Not Applicable	1 2 3	3, 4, 6

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03	02. Is the IV tubing changed every 24 hours? (To nurse: "When was the IV tubing changed in Mr. X's IV?" If not changed within the past 24 hours, code No. This statement is based on CDC standards, not on hospital policy. Code NA only if patient has no IV.)	No Yes Not Applicable Information Not Available	1 2 3 4 4	3, 4
04	03. Is the IV site changed at least every 72 hours, unless contraindicated by patient's condition? (Sites should be changed to comply with CDC standards, not with hospital policy if it differs from CDC standards.) (To nurse: "When was Mr. X's IV site changed?")	No Yes Not Applicable Information Not Available	1 2 3 4 4	3, 4, 7
04	04. Does the patient do deep-breathing exercises at scheduled intervals? (Check records to determine if deep-breathing exercises should be done and at what intervals. If no plan for doing deep-breathing exercises, observer should determine whether they should be done, e.g., if patient is bedfast, is in the immediate postoperative period, has a respiratory infection, etc. To nurse: "Does Mr. X do his deep-breathing exercises? How often does he do them?" If exercises should be done and are not, record No. If exercises are scheduled, record whether nurse reports that they were done every time they were scheduled to be done. If not, record Incomplete. Applies to past 2 days.)	No Yes, incomplete Yes, complete Not Applicable	1 2 3 4	4
04	05. Is the patient turned as often as he should be turned? (To nurse: "How often is Mr. X turned?" Check records to determine if patient should be turned and when. If no plan for turning, observer should determine whether patient should be turned, e.g., if patient is bedfast, cannot turn self, immediate postoperative, etc. If patient should be turned and is not, record No. If turning is scheduled, record whether nurse reports that patient was turned every time scheduled. If not, record Incomplete. Applies to past 2 days.)	No Yes, incomplete Yes, complete Not Applicable	1 2 3 4	4
04	06. Do the nursing staff give or assist the patient who is NPO with mouth care? (Applies to patient who is NPO for at least 24 hours. NA for short specific NPO period, e.g., pre-diagnostic/presurgical. To nurse: "How often do you give mouth care to Mr. X?" Code Yes if done once on each shift for last 2 shifts.)	No Yes Not Applicable	1 2 3	3, 4
02	07. If the patient has a tracheostomy: A. Are the tracheostomy tubes clean? (Observe for presence of mucus or blood on tubes.) B. Are materials around the trach tube clean and properly in place? (E.g., neck strip and gauze, securely attached, plain gauze rather than filled. No accumulated dried mucus or blood on skin, gauze, and neck strip.) C. Are gloves worn or forceps used to suction trachs? (To nurse: "In the past 2 days, when suctioning Mr. X, did you always wear gloves or use forceps?" Code No if not always done.)	No Yes Not Applicable No Yes Not Applicable No Yes Not Applicable	1 2 3 1 2 3 1 2 3	5, 9
01	09. Does the record indicate that perineal/meatus care has been given at least twice daily to patients with indwelling catheters?	No Yes Not Applicable	1 2 3	3, 4

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05	11. Is aseptic technique carried out as necessary in preparing or giving injections, treatments, or special procedures, e.g., catheterizations, dressing changes, wound care, etc.? (May observe any of above items to answer question.)	No Yes Not Applicable Information Not Available	1 2 3 4	5, 9
02	14. Is the urinary catheter drainage system closed? (Refers to drainage system being used. There should be no opening through which dust particles can enter system. Check all connection points, especially where tubing is attached to bag.)	No Yes Not Applicable	1 2 3	3, 4, 7
02	15. Are the drainage tubing and bag patent, properly connected, and positioned for maximal drainage and prevention of stasis? (Applies to urinary or other tubes. Acceptable only if all of catheter and tubing placed for continuous downward drainage, not acceptable if catheter or tubing looped or slanted upward at any point. All parts must be right for Yes answer. May be NA in unusual cases, such as TUR or bladder retraining or when medical or nursing orders specify other than straight gravity drainage.)	No Yes Not Applicable	1 2 3	3, 4, 6, 7
06	16. Do the equipment and solutions for suctioning and irrigation meet requirements for asepsis? (E.g., sterile for urinary catheters, clean for G.I. tubes. For trach care, equipment and solutions must either be sterile or must be changed at least every 4 hours. Unacceptable if any solutions kept in uncovered container. All equipment and solutions must meet these standards for Yes answers.)	No Yes Not Applicable	1 2 3	3, 4, 6
01	17. Is there a statement about allergies written at the time of admission to this unit? (Refers to statement of presence or absence of allergies. Code NA if information recorded on admission to another unit.)	No Yes Not Applicable	1 2 3	3, 4
06	20. If cloth diapers are used are they rinsed elsewhere than the nursery? (To nurse: "In the past 2 days, have all cloth diapers been rinsed in places other than the nursery?" Code NA if disposable diapers are used.)	No Yes Not Applicable	1 2 3	8
06	25. Does each baby have his own thermometer or, if electronic thermometer used, does each baby have his own probe cover?	No Yes	1 2	8
3.0 THE NONPHYSICAL NEEDS (PSYCHOLOGICAL, EMOTIONAL, MENTAL, SOCIAL, SPIRITUAL) OF THE PATIENT ARE ATTENDED				
3.1 The Patient Is Oriented to Hospital Facilities on Admission				
03	01. Is patient contacted by the nursing staff 15 minutes after arrival on unit? (To patient: "When you first arrived on the unit, how long was it before someone on the nursing staff came to see you?" If patient cannot be questioned, ask family.)	No Yes Patient does not know Information Not Available	1 2 3 4	1, 2, 3
03	02. On admission to this unit, is patient informed how to call the nurse? (To patient: "Did someone tell you how to call the nursing staff or check to see if you already knew how to call?" If answer is Yes, ask: "When did you find out how to call someone?" If patient was not informed by the nursing staff within the first 24 hours of admission to this unit, code No, even if patient already knew from previous admission or from admission to another unit.)	No Yes Information Not Available	1 2 3	1, 2, 3

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03	03. Do the nursing staff inform the patient of hospital routines on admission? (To patient: "When you were admitted to this unit, did the nursing staff talk to you about hospital routines, such as when meals are served?" Probe if patient was given patient guide or information booklet: "Did someone explain to you what is included in the booklet or tell you why you should read it?" Acceptable if written patient guide is given to inform patient of routines and nursing staff inform patient this information is in the guide. Unacceptable if patient is only given the guide with no information as to why he or she should read it. Code No if patient knew information from previous admission but was not informed on admission to this unit.)	No Yes Information Not Available	1 2 3	1, 2, 3
03	06. Is the patient informed of visiting hours on admission to the unit? (To patient: "Did someone tell you what the visiting hours are for this unit?" If Yes, ask: "When did you find out?" If patient was not told when visiting hours were within the first 24 hours of admission, code No. Code NA if patient transferred to this unit from another unit with same visiting hours. Acceptable if patient was referred to patient guide or information booklet for visiting hours.)	No Yes Information Not Available	1 2 3	1, 2, 3, 4
03	06. Is the patient informed of availability of religious counselors and facilities on admission to the hospital? (To patient: "Most hospitals have a chapel or clergyman available to patients and families. Did someone tell you they are available to you here if you want them?" If answer is Yes, ask: "When did you find out about that?" If patient was not told whether a chapel or clergyman were available within the first 24 hours after admission, code No. Acceptable if patient informed by clergy or hospital brochures. Code NA if patient initially admitted to another unit.)	No Yes Information Not Available	1 2 3	1, 2, 3
03	07. Is the patient told how to use the telephone on admission? (To patient: "When you were first admitted to this unit, did someone tell you how to use the hospital telephone?" If patient was not told within 24 hours after admission, code No. Code NA if patient initially admitted to another unit. Acceptable if volunteer or other nonnursing personnel informed patient.)	No Yes Information Not Available	1 2 3	2, 3
03	08. Is the patient shown necessary facilities, such as the lavatory and bathroom, on admission? (To patient: "When you were admitted to this unit, did someone show you where the bathroom or place to wash your hands are located?" If patient was not shown within the first 24 hours of admission, code No. Code NA if patient initially admitted to another unit or if patient was not up to bathroom on admission.)	No Yes Information Not Available	1 2 3	2, 3
03	09. Are safety measures, such as smoking regulations, or precautions getting in and out of bed, explained on admission to the unit? (To patient: "When you arrived on this unit, were you told if there are any special safety measures for this unit, such as smoking regulations, precautions in getting in and out of bed, or any other precautions?" Acceptable if safety measures included in patient brochure and patient was referred to brochure for information. Code NA if patient initially admitted to another unit.)	No Yes Information Not Available	1 2 3	1, 2, 3

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03	10. Is the patient informed within the first 24 hours of the emergency call system in the bathroom? (Applies to situations in which the bathroom has emergency call system. To patient: "When you were first admitted to this unit, did someone tell you how to call for a nurse if you are in the bathroom?" If patient was not informed within the first 24 hours of admission, code No. Code NA if patient initially admitted to another unit.)	No Yes Not Applicable Information Not Available	1 2 3 4 4	1, 2, 3
3.2 The Patient Is Extended Social Courtesy by the Nursing Staff				
03	01. Do the nursing staff call patient and family by desired name? (To patient: "When speaking to you or your family in the past 2 days, have the nursing staff called you by the name you prefer?")	No Yes, some of the time Yes, most of the time Yes, all of the time Information Not Available	1 2 3 4 5 5	1, 2, 3, 4
03	02. Do nursing staff members introduce themselves to the patient? (To patient: "Do members of the nursing staff introduce themselves to you?")	No Yes, some of the time Yes, most of the time Yes, all of the time Information Not Available	1 2 3 4 5 5	1, 2, 3
03	04. Are nursing personnel courteous to patient and his family? (To patient: "During the past 2 days, have the nurses been satisfactorily courteous to you and your family?" Code All of the time only if always courteous to both patient and family, if family has been present. If family has not been present code for patient only.)	No Yes, some of the time Yes, all of the time Information Not Available	1 2 3 4 4	1, 2, 3, 7
03	05. Do staff elicit patient's participation during rounds? (To patient: "In the past 2 days, have any groups of staff, such as doctors and nurses making rounds, come into your room?" If Yes, "Did you feel that they adequately included you in their discussions and gave you a chance to ask questions?")	No Yes Information Not Available	1 2 3 3	1, 2, 3
3.3 The Patient's Privacy and Civil Rights Are Honored				
01	01. Is written consent secured prior to special procedures and/or studies? (Includes any procedure for which written consent must be given, e.g., surgery, lumbar puncture, etc. For last procedure only. For nursery or pediatrics, refers to written consent of parents.)	No Yes Not Applicable	1 2 3	1, 2, 3
04	02. Is the nurse aware of what the patient has been told about his condition? (To nurse: "Do you know what Mr. X has been told about his illness?" Code No if nurse is unsure or does not know.)	No Yes Information Not Available	1 2 3 3	1, 2, 3, 4
03	03. Do the nursing staff inform the patient of the plan for daily care of the patient? (To patient: "At the beginning of the day, say in the past 2 days, did the nurse tell you what your activities for the day would be?")	No Yes Information Not Available	1 2 3 3	1, 2, 3

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03	04. Are special procedures and studies explained to the patient? (To patient: "Have you had any special tests or procedures while you've been in the hospital? Were they explained to you before they were done?" Does not refer to routine treatments. Code NA if patient had no tests or special procedures. May record NA for infants.)	No Yes, sometimes Yes, always Not Applicable Information Not Available	1 2 3 4 5	1, 2, 3
03	05. Are curtains drawn or door closed for examinations, treatments, or privacy? (To patient: "When you have had an examination or treatment or when you just want privacy, were the curtains drawn around your bed or the door closed?")	No Yes Not Applicable	1 2 3	1, 2, 3
03	06. Do nursing staff knock before entering a patient's room? (To patient: "Do nursing staff knock before entering your room?")	No Yes, some of the time Yes, most of the time Yes, all of the time	1 2 3 4	1, 2, 3
05	08. Do nursing staff discuss the patient and his care either with the patient, as in nursing rounds, or in private places on the unit where other patients or visitors cannot hear the discussion? (Private place may refer to station, conference areas on unit, etc.)	No Yes Information Not Available	1 2 3	5
03	09. Do nursing staff discuss their personal problems in private, not with or in the presence of patients? (To patient: "Have any of the nursing staff discussed their personal problems with you or in your presence?" If patient reports that staff do discuss personal problems in his presence, record No.)	No Yes Information Not Available	1 2 3	1, 2, 3
3.4 The Need for Psychological-Emotional Well-Being Is Attended				
03	01. Is opportunity provided for patient to discuss fear and anxieties? (To patient or parents of children: "In the past 2 days, if there was something that concerned you, was there an opportunity to talk with someone on the nursing staff about it?")	No Yes Information Not Available	1 2 3	5
03	02. Do the nursing staff discuss the physical dependence-independence of the patient with the patient? (To patient: "Has your illness had much effect on what you can do for yourself, such as daily hygiene or eating, or taking care of yourself in general? Has anyone from the nursing staff talked in detail with you about how much you should do for yourself or how you can increase what you can do for yourself?" Code No if patient merely informed of activities but not engaged in discussion about the level of his/her involvement in care.)	No Yes Information Not Available	1 2 3	2, 3
03	03. Is the use of special equipment (e.g., inhalation equipment, suction, IV, gormco, and similar) explained to the patient? (To patient: "I notice that you have some special equipment. Has anyone told you how it works or why you need it?")	No Yes Not Applicable Information Not Available	1 2 3 4	3, 4
03	04. Do the nurse and patient discuss mode of living, living conditions, or occupational role in relation to his illness and restorative care? (To patient: "Have any of the nurses talked with you in detail about whether your illness might affect your home situation or your work?" If Yes, ask: "Did they help you think through or plan what to do about it?" Unacceptable if patient merely informed of activities.)	No Yes Not Applicable Information Not Available	1 2 3 4	1, 2, 3

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03	05. Is an opportunity provided for the patient or the family to evaluate the care given by the nursing staff? (To patient: "At any time in the past week, has anyone from the nursing staff asked you or your family what you think about the nursing care you've had here?")	No	1	1, 2, 3
		Yes	2	
		Information		
		Not Available	3	
03	06. Do the nursing staff inform the patients about activities before they are carried out? (Refers to routine care activities; does not refer to obtaining consent for special procedures. Information may be minimal about what nurse is going to do. Does not need to be extensive explanation. To patient: "Do the nurses tell you what they are going to do before they carry out some activity such as baths, injections, dressing changes, etc.?" If cannot interview severely ill patients, try to get information by observing nurses with patients.)	No	1	2, 3, 4
		Yes	2	
		Information		
		Not Available	3	
04	07. When the patient's condition warrants, does the nurse give attention to the patient's need for diversional activities? (To nurse: "If appropriate, have any of the nursing staff given attention to providing diversional activities for Mr. X, such as reading, getting the family or someone in the hospital to visit, talking to him or her, and so on?" If nurse says not appropriate, code NA.)	No	1	1, 2, 3
		Yes	2	
		Not Applicable	3	
		Information		
05	08. Is verbal communication directed toward the severely ill or unconscious patient or toward infants? (Observe nursing staff with patient to see whether they talk to patient.)	No	1	4, 6, 7
		Yes, not much at all	2	
		Yes, a great deal	3	
		Not Applicable	4	
05	09. Is there tactile communication with the severely ill or unconscious patient or with infants? (Observe nursing staff with patient to determine whether sense of touch is used as means of communication, e.g., use of touch in comforting way, aside from providing technical care.)	No	1	4, 6, 7
		Yes, not much at all	2	
		Yes, a great deal	3	
		Not Applicable	4	
03	11. Do nurses listen to the patient? (To patient: "When you ask questions or make comments, do you feel that the nurses listen to you and show an interest in what you say?")	No	1	1, 2, 3, 4
		Yes, some of the time	2	
		Yes, all of the time	3	
		Information		
03	13. Does the patient wear his own clothing (gown, pajamas, etc.) if desired? (To patient: "If you want to wear your own clothing, such as pajamas, while you're in the hospital, do you feel free to do so?" Code NA only if patient's condition or extensive treatments make it undesirable to wear own clothing.)	No	1	1, 2, 3
		Yes	2	
		Not Applicable	3	
		Information		
03	14. Can the patient identify a particular nurse as "his nurse"? (To patient: "Is there one particular nurse that is 'your nurse' while you are here?" Acceptable if patient indicates one nurse as his nurse.)	No	1	1, 2, 3, 4
		Yes	2	
		Information		
		Not Available	3	
05	15. Are babies held for feedings, if fed by staff? (Inapplicable for premature infants, special-type feedings. Answer No if any bottle propping.)	No	1	8
		Yes	2	
		Not Applicable	3	

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06	16. Is an area in the nursery provided for mothers to feed convalescent infants?	No	1	8
		Yes	2	
		Not Applicable	3	
3.5 The Patient Is Taught Measures of Health Maintenance and Illness Prevention				
03	01. Do the nursing staff inform the patient to report signs and symptoms related to his illness (e.g., rash, pain) to the nursing staff?	No	1	1, 2, 3
		Yes	2	
		Not Applicable	3	
	(Applicable if there are any signs or symptoms which patient should be aware of to report. To patient: "Did anyone from the nursing staff tell you if there are any signs or symptoms related to your illness that you should report to them?" In pediatrics, may ask parent if one is present.)	Information		
		Not Available	4	
04	02. Have instructions to be given to the patient been outlined, either verbally or in writing?	No	1	1, 2, 3
		Yes, oral only	2	
	(To nurse: "Are there any special instructions to be given to Mr. X?" If Yes, ask: "Are they in writing?" Applicable if any instructions are indicated, such as preoperative/prediagnostic testing, teaching patients to do own treatments, medications, etc. If teaching team is instructing patient, record Written only.)	Yes, written only	3	
		Not Applicable	4	
04	03. Is a specific member of the nursing staff designated for instructing the patient in his care?	No	1	1, 2, 3
		Yes	2	
	(To nurse: "Is any particular staff member assigned to give special instructions to Mr. X?")	Not Applicable	3	
		Information		
		Not Available	4	
03	04. Are the patient or family informed of or instructed in care that must be done at home?	No	1	1, 2, 3
	(To patient: "Has anyone from the nursing staff talked to you yet about anything you should not do when you go home?" Probe: "Such as activity limitations, climbing stairs, or other things?" Applicable as soon as it can be recognized that patient will need any kind of information about posthospital activities. Does not require specific referral or physician's orders regarding discharge date or activities.)	Yes, informed only	2	
		Yes, informed and instructed	3	
		Not Applicable	4	
		Information		
		Not Available	5	
03	05. Is the plan for oral fluids formulated by patient and nurse?	No	1	1, 2, 3
	(Applies to any patient with order such as "encourage fluids," "restrict fluids," "force fluids," or give specific amount of oral fluids per day. To patient: "Do you have a schedule that says when and what kind of liquids you're supposed to drink? Did you plan this together with the nurse?" If not formulated jointly by nurse and patient, answer is No.)	Yes	2	
		Not Applicable	3	
		Information		
		Not Available	4	
3.6 The Patient's Family Is Included in the Nursing Care Process				
01	01. Is there a written statement in regard to the family's level of understanding of the patient's condition?	No	1	1, 2, 3, 4
	(Refers to any time during hospitalization. Refers to responses probably elicited by question: "Can you tell me something about Mr. X's condition?" Level of understanding defined in answer codes.)	Yes, name of diagnosis, surgery, or test	2	
		Yes, understanding of illness stated	3	
		Not Applicable	4	
		Information		
		Not Available	5	

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03	02. Do the nurse, patient, and family discuss the family's participation in the care of the patient? (To patient: "Does your family come to visit you? In the past week have any of the nursing staff talked with you and your family about what things they might help you do?")	No	1	2, 3
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
04	03. Is opportunity provided for family to discuss fears and anxieties (past 2 days)? (To nurse: "Have Mr. X's family been in to visit him in the past 2 days?" If No, code NA. If Yes, ask nurse: "Have any of the nurses spent some time with them to see if they have any particular fears or problems related to Mr. X's illness?")	No	1	2, 3, 4
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
01	04. Is a description of care given by the family recorded? (Ask patient, to determine if applicable: "Do your family and/or friends visit you in the hospital? Are there any specific things they do for you while they are here? What do they do?")	No	1	2, 3
		Yes	2	
		Not Applicable	3	
07	05. Is the family notified when there are serious changes in the patient's condition? (Check progress notes to determine whether there were significant changes in the patient's condition. If there were, see whether family was notified.)	No	1	4
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
01	06. Is the name and phone number of family or friend to contact in case of emergency listed on the Kardex or other appropriate record?	No	1	1, 2, 3, 4
		Yes	2	
03	07. Did the nursing staff inform the family of visiting hours on the unit? (To patient: "Did anyone on the nursing staff inform your family of the visiting hours on this unit?" Acceptable if informed by staff or by brochure.)	No	1	1, 2, 3, 4
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
03	08. Is the family informed of the availability of religious counselors and facilities such as the chapel? (To patient: "Did anyone inform your family that there are chaplains available or that they may use the chapel if they so wish?" Acceptable if family informed by clergy or brochure. Code NA if family informed while patient was on another unit.)	No	1	1, 2, 3, 4
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
01	09. Is there a written statement that the baby was shown to at least one of his parents, if not being placed for adoption?	No	1	6
		Yes	2	
		Not Applicable	3	
04	10. Was the mother given instructions by the nurses with regard to feeding the baby: A. Times to feed the baby? B. The baby's formula, if indicated? C. How to burp the baby? D. How to feed the baby, including how to hold and how long to feed?	No	1	6
		Yes	2	
		Not Applicable	3	
		No	1	
		Yes	2	
		Not Applicable	3	
		No	1	
		Yes	2	
		Not Applicable	3	
		No	1	
		Yes	2	
		Not Applicable	3	
		No	1	
		Yes	2	
		Not Applicable	3	

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	E. Breast care, if breast feeding?	No	1	
	(To nurse: "Has Mrs. X been given instructions about each of the following items: (read the above list)?")	Yes	2	
		Not Applicable	3	
03	11. Is the mother given home-care instructions with regard to:			6
	A. Activity level of the baby?	No	1	
		Yes	2	
		Not Applicable	3	
	B. Circumcision care if indicated?	No	1	
		Yes	2	
		Not Applicable	3	
	C. How to take the baby's temperature?	No	1	
		Yes	2	
		Not Applicable	3	
	D. Kind of clothing appropriate for hospital discharge?	No	1	
		Yes	2	
		Not Applicable	3	
03	12. Was the mother given any information about the appearance or care of the cord?	No	1	6
	(To mother: "Did any of the nursery nurses give you any information about the appearance or care of the baby's cord?")	Yes	2	
		Not Applicable	3	
03	13. Was the mother given the opportunity to learn how to bathe her baby, at any time during her stay, if she desired?	No	1	6
	(To mother: "Were you given an opportunity to learn how to bathe your baby?")	Yes	2	
		Not Applicable	3	
03	14. Was the father given any information about the care of the baby, such as how to hold or feed the baby?	No	1	6
	(Ask father or mother: "Did the nursery nurse give you, or show your husband, any information about care of the baby, such as how to hold or feed the baby?")	Yes	2	
		Not Applicable	3	
		Information		
		Not Available	4	
03	15. Was the mother given instructions by the nursery personnel with regard to handwashing techniques in preparation for handling her baby?	No	1	6
	(Ask mother: "Did the nursery nurses tell you that you should wash your hands before you handle your baby?")	Yes	2	
		Not Applicable	3	
		Information		
		Not Available	4	
	4.0 ACHIEVEMENT OF NURSING CARE OBJECTIVES IS EVALUATED			
	4.1 Records Document the Care Provided for the Patient			
01	01. Do records document all treatments currently being performed?	No	1	1, 2, 3, 4, 6, 7
	(All written prescribed treatments, either by medicine or by nursing, e.g., dressings, irrigation, IPPB, etc.)	Yes, incomplete	2	
		Yes, complete	3	
		Not Applicable	4	
01	02. Do records document the vital signs and blood pressure as indicated in medical or nursing orders?	No	1	1, 2, 3, 4, 6, 7
	(On admission or as specified for the last two days.)	Yes, incomplete	2	
		Yes, complete	3	
01	03. Do records document the reasons for omission of medications?	No	1	1, 2, 3, 4, 6
	(Refers to past 7 days. If patient on unit less than 7 days, consider whatever time patient has been on this unit.)	Yes, some of the time	2	
		Yes, most of the time	3	
		Yes, all of the time	4	
		Not Applicable	5	

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01	04. Do records document the reason for administration of PRN medications? (Refers to past 7 days. If patient on unit less than 7 days, consider whatever time patient has been on this unit.)	No Yes, some of the time Yes, most of the time Yes, all of the time Not Applicable	1 2 3 4 5	1, 2, 3, 4, 6, 7
01	05. Do records document the effect of PRN medication? (Refers to past 7 days. If patient has been on unit less than 7 days, consider whatever time patient has been on unit.)	No Yes, some of the time Yes, most of the time Yes, all of the time Not Applicable	1 2 3 4 5	1, 2, 3, 4, 6, 7
01	06. Do records document the administration of medications on this unit including: A. Time given? B. Route of administration? C. Site of injection? D. Name of person who gave medication? E. Dosage? (Refers to past 7 days. If patient on unit less than 7 days, consider whatever time patient has been on this unit.)	No Yes Not Applicable No Yes Not Applicable No Yes Not Applicable No Yes Not Applicable	1 2 3 1 2 3 1 2 3 1 2 3	1, 2, 3, 4, 6
01	07. Is the time of admission to the unit recorded?	No Yes	1 2	7
01	08. Does the record indicate the type of feeding the baby is receiving?	No Yes	1 2	6
01	09. Are there daily written statements about the condition of the baby's eyes, mouth, and fontanel? (Applies to past 2 days. Code Complete only if observation of all three areas is recorded.)	No Yes, incomplete Yes, complete	1 2 3	6
01	10. Are daily weights recorded, up to the day of this observation?	No Yes	1 2	6
01	11. Is the amount of each feeding taken noted? (Amount may be in drops or ounces, or the weight difference of the baby pre- and postfeeding.)	No Yes Not Applicable	1 2 3	6
01	12. Does the record note if baby has been burped (bubbled) after each feeding given in the nursery? (NA if mother fed baby, except for mothers feeding convalescent babies.)	No Yes Not Applicable	1 2 3	6

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4.2 The Patient's Response to Therapy Is Evaluated

01	01. Are observations related to medical treatment, medications, disease process, or possible complications noted, e.g., changes in condition, observations to detect onset of complications, observations of newborn such as healing of circumcision, etc.? (Statement of observations may refer to either presence or absence of problems, includes any nursing observations not included in medical orders. Includes side or untoward effects of current therapy. Consider condition of patient and determine whether specific observations should be made. If not recorded, answer No. Refers to past 48 hours.)	No	1	1, 2, 3, 4, 6, 7
		Yes	2	
		Not Applicable	3	
01	03. Do records document the patient's response to explanations of care? (May include response to any type of informal or formal explanations or instructions given by nurse or other health personnel. To nurse: "Have any kind of explanations been given to Mr. X in regard to his condition or care?" If answer is No, code Not Applicable. Answer coded Yes refers to written statement about patient's response or apparent comprehension.)	No	1	1, 2, 3, 4
		Yes	2	
		Not Applicable	3	
01	04. Do records document the need for additional instruction? (To nurse: "Has any kind of explanation been given to Mr. X. in regard to his condition or care? Are any additional explanations needed?" Answer code Yes refers to written statement about what additional explanations are needed.)	No	1	1, 2, 3, 4
		Yes	2	
		Not Applicable	3	
01	05. Is the patient's performance of self-care activities, e.g., eating, toilet, walking, dressing, doing own treatments, etc., recorded? (Applies to hospital situation in past 48 hours.)	No	1	2, 3
		Yes	2	
01	06. Does the record note whether each feeding is retained or regurgitated?	No	1	6
		Yes	2	
		Not Applicable	3	

5.0 UNIT PROCEDURES ARE FOLLOWED FOR THE PROTECTION OF ALL PATIENTS

5.1 Isolation and Decontamination Procedures Are Followed

05	01. When a patient is isolated:			5
		A. Do the nursing staff follow the isolation procedure specified for the isolated patient?	No	
			Yes, all of the time	
			Not Applicable	
		B. Is contaminated linen, equipment, and waste removed from isolation rooms according to hospital policy?	No	
			Yes, all of the time	
			Not Applicable	
		C. Are isolation precautions (i.e., a sign to indicate what to wear: gloves, gown, mask) posted outside the patient's door?	No	
			Yes	
			Not Applicable	
		D. Are necessary supplies (e.g., gown, gloves, mask) immediately accessible, for example outside the door of the isolated patient's room or inside the nursery?	No	
			Yes, all of the time	
			Not Applicable	
		E. Do nonnursing personnel observe the isolation procedure specified outside the patient's door? (If procedure is not always followed, record No.) Refers to all nonnursing personnel.)	No	
			Yes, all of the time	
			Not Applicable	

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06	02. Is the procedure for disposal of dirty/used supplies and equipment followed? (Does not refer to isolation procedure. See hospital procedure.)	No Yes Information Not Available	1 2 3	5, 8, 9
06	03. Are precautions taken by nursing staff to protect patients from known respiratory infections and other communicable diseases? (To nurse in charge: "In the past 2 days, has there been any incidence of other communicable diseases on this unit?" If Yes: "Was anything done to prevent the spread of infection, such as putting patients in private rooms or requiring staff with respiratory conditions to stay at home?" Code Yes only if Nurse states specific precautions that were taken.)	Definitely No Probably No Probably Yes Definitely Yes Not Applicable Information Not Available	1 2 3 4 5 6	5, 8, 9
06	04. Do the staff wash their hands between patients? (Should be done after any direct care with direct contact of nurse with body or linens of the patient. If not always done, record No.) (Does not refer to isolation procedure. See hospital procedure.)	No Yes, all of the time Information Not Available	1 2 3	5, 8, 9
04	10. Are all bassinets cleaned and disinfected: A. When the baby is discharged? (To nurse in charge: "In the past 2 days, have any babies been discharged from the nursery? Were bassinets cleaned and disinfected?" B. If the baby has been in the nursery longer than 7 days? (To nurse in charge: "In the past 2 days, have there been any babies who have been in this nursery longer than 7 days?" If Yes: "Were their bassinets cleaned and disinfected or were they transferred to a clean bassinet at least every 7 days?")	No Yes Not Applicable Information Not Available No Yes Not Applicable Information Not Available	1 2 3 4 1 2 3 4	8
5.2 The Unit Is Prepared for Emergency Situations				
04	01. Are plans for intervention during a cardiac arrest known by the nursing staff? (To nurse: "What do the nursing staff do if there is a cardiac arrest on the unit?" Answer Complete includes clearing the airway, cardiopulmonary resuscitation, preparing medications, and notifying appropriate personnel. May code NA if nurse being interviewed has been asked this question within the past 7 days.)	No Yes, incomplete Yes, complete Information Not Available	1 2 3 4	5, 8, 9
04	02. Is the emergency cart checked daily for adequacy of supplies? (To nurse: "Do you know if the emergency cart was checked?" Not necessary to ask nurse, if record used to indicate that cart has been checked.)	No Yes Information Not Available	1 2 3	5, 8, 9
06	03. Is an emergency cart or tray stationed on the unit? (If only tray on the unit, it must include at least equipment and supplies for immediate resuscitation.)	No Yes	1 2	5, 8, 9
04	04. Are actions to be taken in case of fire known by the nursing staff? (To nurse: "What do the nursing staff do if a fire is discovered on the unit?" Answer Complete includes at least notifying appropriate persons for assistance, protecting patients from fire and smoke, e.g., by closing doors, removing patients from immediate area of fire, etc. May code NA if nurse being interviewed has been asked this question within the past 7 days.)	Definitely No Probably No Probably Yes Definitely Yes	1 2 3 4	5, 8, 9
06	05. Is there a standby heated incubator or radiant warmer for unexpected problems?	No Yes	1 2	8

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ADMINISTRATIVE AND MANAGERIAL SERVICES

6.1 Nursing Reporting Follows Prescribed Standards

03	01. Are nursing notes written about the patient as required by hospital policy? (If patient on this unit less than 48 hours, consider whatever time patient has been on this unit.)	No	1	1, 2, 3, 4, 6, 7
		Yes	2	
01	02. Are all nursing notes legible? (If patient has been on this unit less than 48 hours, consider whatever time patient has been on this unit.)	No	1	
		Yes	2	
01	03. Are nursing notes properly signed as required by hospital policy? (If patient has been on this unit less than 48 hours, consider whatever time patient has been on this unit.)	No	1	1, 2, 3, 4, 6, 7
		Yes, some of the time	2	
		Yes, all of the time	3	
01	04. If abbreviations are used in the nursing records, are they acceptable according to hospital policy? (If patient has been on this unit less than 48 hours, consider nursing records only for time patient has been on this unit.)	No	1	1, 2, 3, 4, 6, 7
		Yes	2	
04	05. Do nursing staff report to the nurse in charge at the end of the shift? (To nurse in charge: "Using yesterday or the last day you worked as an example, did you get a report from each person working with you at the end of the shift?" Nurse in charge refers to team leader, primary nurse, charge nurse, or equivalent. May code NA if nurse in charge worked alone yesterday as possible in modular setting.)	No	1	5, 8, 9
		Yes	2	
		Information Not Available	3	
04	06. Do private nurses give a verbal report to the nurse in charge? (To nurse in charge: "Have there been any private duty nurses on this unit in the past 2 days?" If Yes, ask: "Did they give you a verbal report at the end of the shift?")	No	1	5
		Yes	2	
		Not Applicable	3	
		Information Not Available	4	
04	07. Do the retiring and oncoming nurses in charge make walking rounds together? (To nurse in charge: "Were you and the retiring nurse in charge on the last shift able to make walking rounds together at the beginning of this shift?" Nurse in charge refers to team leader, charge nurse, or equivalent. Walking rounds refers to all patients for whom nurse in charge is responsible.)	No	1	5, 8
		Yes	2	
04	08. Do all nursing personnel on the oncoming shift receive a report on patients to whom they will give nursing care that shift? (To nurse in charge: "Using this shift as an example, did all nursing personnel receive a report on patients to whom they are now giving care?")	No	1	5, 8
		Yes	2	
01	09. Does the admitting record indicate: A. The sex of the baby? B. The date of birth?	No	1	6
		Yes	2	
		No	1	
		Yes	2	

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	C. The time of birth?	No	1	
		Yes	2	
	D. The birth weight?	No	1	
		Yes	2	
	E. The length at birth?	No	1	
		Yes	2	
	F. The birth position (ROA, LOA, breech, etc.)	No	1	
		Yes	2	
	G. The type of delivery (vaginal, Caesarian section, precipitous)?	No	1	
		Yes	2	
	H. The gestational age (calculated by LMP of mother or physician's estimate?)	No	1	
		Yes	2	
	(May apply to records from delivery room transferred to nursery.)			
	6.2 Nursing Management Is Provided			
07	01. Is a registered nurse in charge and present on the unit this shift?	No	1	5, 8, 9
	(Means RN on the unit. Not acceptable to have same RN cover more than one unit. Check staffing roster or by observation. For tour observed only.)	Yes	2	
04	03. Does the nurse in charge delegate tasks according to both patient needs and level of skill of personnel?	No	1	5, 8, 9
	(To nurse: "Using today as an example, how did you decide which activities to assign to other members of the nursing staff and which ones to perform yourself?" Answer No if tasks or patients assigned according to numbers of personnel. Answer Yes if assignment made in consideration of both different levels of skill of staff and severity of patients. May be NA only in primary or modular setting in which nurse works alone.)	Yes	2	
08	04. Are copies of the staffing schedule for the unit posted on the patient care unit?	No	1	5, 8, 9
	Refers to staffing schedule for 1 week or 1 month, etc. Code No if not present.)	Yes	2	
04	05. Does the nurse in charge see the patient at least twice during the shift?	No	1	1, 2, 3
	(To nurse in charge: "How many times would you say you were able to see Mr. X during the shift, using yesterday or the last day you worked as an example?" Nurse in charge refers to primary nurse, team leader, charge nurse, or equivalent.)	Yes	2	
04	06. Does the nurse in charge check to see that delegated tasks have been performed?	No	1	5, 8, 9
	(To nurse in charge: "Using yesterday as an example, how did you find out whether the work you had assigned to other personnel had been carried out?" Record Yes only if nurse reports direct personal observation for evidence that all specific tasks were performed—not necessary to have observed actual performance. Nurse in charge refers to team leader, charge nurse, or equivalent.)	Yes	2	

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04	07. Does the head nurse or equivalent in charge of the unit make rounds on all patients on the unit? (To head nurse or equivalent: "During the past 2 days did you make walking rounds on all patients on this unit?")	No Yes Information Not Available	1 2 3	5, 8
04	08. Are patient conferences conducted to plan and coordinate a specific patient's care? (To nurse in charge: "In the past week, have you had any patient care conferences?" Patient care conferences refer to any conferences held about a specific patient for the purpose of planning and coordinating his care. Not acceptable if the only conferences in the past week were rounds, in-service programs, or other meetings not related to a specific patient's care.)	No Yes, 1-3 times per week Yes, more than 3 times per week	1 2 3	5, 8
03	09. Have there been two or fewer nurses assigned to Mr. X during the day shift for the past 7 days? (To the patient: "Does the same nurse take care of you each day?" Probe: "In the past 7 days during the day shift, how many nurses would you say have been responsible for your care?" If there were one or two nurses responsible for patient's care, code Yes. If three or more, code No. If patient has been on this unit fewer than 7 days, consider whatever time patient has been on this unit.)	No Yes Information Not Available	1 2 3	1, 2, 3, 4
6.3 Clerical Services Are Provided				
01	01. Is the chart assembled in the correct order as specified by hospital procedure?	No Yes	1 2	1, 2, 3, 4, 6
01	02. Are transcribed medication and treatment orders dated? (From Kardex and/or med cards.)	No Yes, incomplete Yes, complete Not Applicable	1 2 3 4	1, 2, 3, 4, 6
04	03. Is there a list of nursing staff on duty for this shift kept at the desk or in a readily accessible place on the unit?	No Yes	1 2	5, 8, 9
04	04. Does the clerk transcribe the physician's orders within one hour of writing? (To nurse in charge: "Using yesterday or the last day you worked as an example, did a clerk transcribe the physician's orders within one hour after they were written?" For Yes answer, clerk must have transcribed all orders, and all must have been transcribed within one hour.)	No Yes	1 2	5, 8
04	05. Are orders reviewed daily to ensure that all transcriptions are accurate, current, and complete? (To nurse: "During the past 2 days, did someone review the orders to be sure transcriptions are complete? To check for automatic expiration of medication orders? To make sure they were transcribed correctly?" If review was not done for all 3, or according to hospital policy, code No.)	No Yes	1 2	5, 8
08	06. Does a clerk answer the unit telephone? (To nurse: "In the past 2 days, have clerks on duty always answered the phone at the desk?" If nurses have answered the phone, code No.)	No Yes	1 2	5, 8, 9

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04	07. Does the clerk handle communications with other departments unless direct communication by a nurse is required? (To nurse: "In the past 2 days, has a clerk taken care of all communications with other departments unless direct communication by a nurse is required?" Answer No if nurse took care of any routine requisitions. Code NA only if nurse is required, i.e., if specific nursing knowledge is needed. Does not refer to answering telephone.)	No Yes Not Applicable Information Not Available	1 2 3 4	5, 8, 9
01	08. Are all pages of the chart stamped with the addressograph correctly? (For Yes answer all pages must be stamped with the correct patient's addressograph plate.)	No Yes	1 2	1, 2, 3, 4, 6, 7
01	09. Are all routine forms included in the patient's chart? (Check to see that all routine pages are present.)	No Yes	1 2	1, 2, 3, 4, 6, 7
6.4 Environmental and Support Services Are Provided				
06	01. Is the patient's room clean? (Refers to cleanliness of floor, bed aside from linens, walls, major pieces of equipment, and bedside tables. All must be clean for Yes answer. Does not refer to trash cans.)	No Yes	1 2	1, 2, 3, 4, 6, 7
06	02. Is the sink in the patient's room or adjacent bathroom used by the patient clean?	No Yes	1 2	1, 2, 3, 4, 6, 7
06	03. Has waste been removed from the patient's room? (Check for emptied trash cans and for clutter in room. Does not apply to items left on patient's bed.)	No Yes	1 2	1, 2, 3, 4, 6, 7
06	04. Is all equipment in the room being: A. Used or on a standby basis? B. In its proper place? (Refers to any type of equipment currently used in treating patients, e.g., oxygen equipment, IPPB machine, suction equipment, etc. or equipment anticipated for immediate use because of patient's unstable condition.)	No Yes Not Applicable No Yes Not Applicable	1 2 3 1 2 3	1, 2, 3, 4, 6, 7
06	05. Is the patient's room free of smoke? (Not applicable only if patient is in private room and is smoking.)	No Yes	1 2	1, 2, 3
03	06. Is the room temperature comfortable for the patient? (To patient: "Is the temperature in your room comfortable for you now?")	No Yes Information Not Available	1 2 3	1, 2, 3
06	08. Is the corridor clear of all equipment? (Observe for stretchers and machines or any other equipment currently in corridor. If isolation or dietary equipment present, code as Various kinds of equipment.)	No, various kinds of equip- ment present No, emergency equipment present Yes, none present	1 2 3	5, 8, 9
04	09. Is there an adequate supply of linen provided? (To nurse: "In the past two days, have you had enough linen for all of your patients?")	No Yes	1 2	5, 8, 9

Sources of
InformationCriterion
Applicability

04	10. Are adequate supplies for routine treatments provided? (To nurse: "In the past 2 days, have you had enough supplies, other than linen, for treatments such as dressing changes whenever you needed them?")	No Yes	1 2	5, 8, 9
06	11. Are there handwashing facilities in or adjacent to each patient's room? (Refers to sink for use by either patients or staff: must be either in the room or not more than one room away from patient's room.)	No Yes	1 2	1, 2, 3, 4, 6, 7
03	12. Are supplies for handwashing (soap, water, towels) present at the sink used for handwashing by patients or staff?	No Yes	1 2	1, 2, 3, 4, 6, 7
04	13. Does the pharmacy deliver all routine and stat supplies to the unit? (To nurse in charge: "In the past 2 days, have pharmacy personnel delivered all routine and stat supplies to the unit within a reasonable time?" Applies to all shifts. Code Yes only if supplies both delivered by pharmacy personnel and within a reasonable time. Applies to any delivery system, e.g., dumbwaiter, etc.)	No Yes	1 2	5, 8, 9
04	14. Are supplies from central supply delivered to the unit? (To nurse: "During the past 2 days have central supply personnel delivered all supplies to the unit within a reasonable time?" Applies to all shifts. Code Yes only if supplies both delivered by central supply personnel and within a reasonable time. Applies to any delivery system, e.g., dumbwaiter, etc.)	No Yes	1 2	5, 8, 9
04	15. In the past 2 days, have housekeeping personnel done all cleaning in the following areas (ask nurse in charge):			5, 8, 9
	A. Cleaning corridors?	No Yes Information Not Available	1 2 3	
	B. Cleaning utility rooms?	No Yes Information Not Available	1 2 3	
	C. Cleaning patient beds, aside from changing linens?	No Yes Information Not Available	1 2 3	
	D. Cleaning patient unit on discharge? (Code No if any part done by nursing personnel.)	No Yes Information Not Available	1 2 3	
04	16. Do dietary personnel deliver all trays to patients? (To nurse: "In the past 2 days, have dietary personnel delivered all trays to nonisolated patients' bedsides, including late trays and snacks?" For nursery: "In the past 2 days, have dietary personnel delivered all formula to the unit for babies?" Code No if any trays or formula delivered by nurses.)	No Yes	1 2	5, 8
04	17. Do dietary personnel remove all trays from patients' rooms? (To nurse: "In the past 2 days, have dietary personnel removed all trays from nonisolated patients' rooms, including late trays and snacks?" For nursery: "In the past 2 days, have dietary personnel removed all formula materials from the nursery?" Code No if any trays or formula materials removed by nurses.)	No Yes Information Not Available	1 2 3	5, 8

CRITERIA MASTER LIST

Source of
InformationCriterion
Applicability

(A)

18. Does an escort service take patients to other areas of the hospital unless nursing supervision of the patient is required?

No	1	5, 8
Yes	2	
Information		
Not Available	3	

(To nurse: "In the past 2 days, has an escort service taken all patients to other areas of the hospital unless nursing supervision of the patient was required?" Nurse is necessary for babies. Escort service refers to personnel who are specifically responsible for transporting patients and do not have nursing care responsibilities. Code No if any nursing personnel who are providing nursing care on the unit are used for transport service, if nursing supervision of patient was not required.)

03

20. Do support service personnel, such as unit managers, admitting office, etc., explain care and use of personal property to the patient or family on admission to the hospital?

No	1	1, 2, 3
Yes	2	
Information		
Not Available	3	

(To patient: "When you entered the hospital, did someone tell you what to do with personal belongings, such as clothes or jewelry? Do you recall who explained it to you?" Yes only if explained by nonnursing personnel. Code NA if patient transferred from another unit.)

APPENDIX E

NURSE DEMOGRAPHIC INFORMATION

DEMOGRAPHIC INFORMATION

Nurse Code Number: _____

Basic educational preparation in nursing:

Associate Degree _____

Nursing Diploma _____

Baccalaureate Degree _____

Post Baccalaureate Studies in Nursing _____

Master's Degree _____

Present educational preparation in nursing:

Associate Degree _____

Nursing Diploma _____

Baccalaureate Degree _____

Post Baccalaureate Studies in Nursing _____

Master's Degree _____

Years of experience in nursing _____

Years of experience in present institution _____

APPENDIX F

TABLES--RAW SCORES AND F-RATIOS

Table 5

Raw Quality Care Scores for the 31 Primary Nurses Studied

Nurse	Highest Educational Level ^a	Overall Score	Subtotal Scores					
			Objective					
			1.0	2.0	3.0	4.0	5.0	6.0
01	A.D.	0.75	0.70	0.83	0.69	0.86	0.57	0.81
02	A.D.	0.83	0.78	0.85	0.71	1.00	1.00	0.81
03	N.D.	0.82	0.55	0.86	0.87	1.00	1.00	0.80
04	B.S.	0.71	0.62	0.87	0.74	0.55	1.00	0.71
05	B.S.	0.71	0.50	0.78	0.71	0.89	0.71	0.75
06	A.D.	0.58	0.30	0.91	0.50	0.57	0.57	0.61
07	N.D.	0.61	0.30	0.92	0.56	0.73	0.29	0.80
08	B.S.	0.82	0.67	0.92	0.79	0.79	1.00	0.78
09	N.D.	0.81	0.87	0.94	0.65	0.54	1.00	0.87
10	B.S.	0.77	0.67	0.91	0.70	0.73	1.00	0.67
11	B.S.	0.70	0.67	0.78	0.52	0.73	1.00	0.80
12	N.D.	0.63	0.52	0.78	0.38	0.57	1.00	0.87
14	A.D.	0.70	0.44	1.00	0.48	0.82	1.00	0.67
16	A.D.	0.79	0.61	0.73	0.73	1.00	1.00	1.00
17	N.D.	0.72	0.55	0.84	0.47	0.83	1.00	0.89
18	B.S.	0.68	0.63	0.76	0.48	0.74	0.86	0.82
19	A.D.	0.53	0.35	0.67	0.34	0.45	1.00	0.87
20	B.S.	0.88	0.67	1.00	0.94	0.86	1.00	1.00
21	B.S.	0.69	0.74	0.71	0.40	0.54	1.00	1.00
22	A.D.	0.55	0.59	0.67	0.34	0.20	1.00	0.82

Table 5 (Continued)

Nurse	Highest Educational Level ^a	Overall Score	Subtotal Scores					
			Objective					
			1.0	2.0	3.0	4.0	5.0	6.0
23	A.D.	0.61	0.57	0.67	0.52	0.67	0.86	0.82
24	A.D.	0.75	0.73	1.00	0.66	0.91	1.00	0.80
25	B.S.	0.58	0.62	0.52	0.31	0.78	1.00	0.75
26	B.S.	0.70	0.60	0.81	0.80	0.91	0.57	0.37
27	N.D.	0.78	0.78	0.86	0.63	0.90	0.75	0.82
28	B.S.	0.74	0.67	0.92	0.54	0.86	1.00	0.71
29	N.D.	0.74	0.76	0.83	0.73	0.80	0.62	0.71
30	B.S.	0.82	0.78	0.80	0.91	0.60	1.00	0.82
31	B.S.	0.88	0.94	0.77	1.00	0.90	0.62	0.94
32	P.B.S.	0.76	0.76	0.76	0.71	0.78	1.00	0.72
33	B.S.	0.72	0.70	0.83	0.60	0.57	0.71	0.78

^aA.D. = Associate Degree in Nursing

N.D. = Nursing Diploma

B.S. = Baccalaureate Degree in Nursing

P.B.S. = Post Baccalaureate Studies in Nursing

Table 6

Analysis of Variance of Overall and Objective Scores
Based on the Computer Analysis Utilizing the
Veldman (1967) Format

Source	Mean Square	<u>df</u>	<u>F</u> -Ratio	<u>p</u>
<u>Overall Mean Score</u>				
Total	.0086	30		
Groups	.0131	2	1.589	.2208
Error	.0082	28		
<u>Objective 1.0</u>				
Total	.0225	30		
Group	.0411	2	1.938	.1611
Error	.0212	28		
<u>Objective 2.0</u>				
Total	.0119	30		
Group	.0069	2	0.562	.5816
Error	.0123	28		
<u>Objective 3.0</u>				
Total	.0332	30		
Group	.0444	2	1.369	.2702
Error	.0324	28		
<u>Objective 4.0</u>				
Total	.0335	30		
Group	.0047	2	0.131	.8773
Error	.0355	28		
<u>Objective 5.0</u>				
Total	.0378	30		
Group	.0203	2	0.519	.6059
Error	.0391	28		
<u>Objective 6.0</u>				
Total	.0151	30		
Group	.0059	2	0.376	.6953
Error	.0158	28		

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QUALITY NURSING CARE RELATED TO THE PRIMARY NURSE'S
LEVEL OF EDUCATION

ABSTRACT

LINDA DIANE UNGVARSKY

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
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The identified problem was to determine if the level of nursing education could be related to quality of care in a primary nursing setting. Purposes were: (1) identification of highest educational level; (2) determination of quality of care provided; (3) relationship of educational level with quality of care. The conceptual framework was the Nursing Process.

The sample included 31 randomly selected patients, having 31 primary nurses, who were on medical-surgical units within a general hospital. Haussmann et al.'s Criteria Master List was utilized to collect data.

Mean scores showed some differences in the use of the Nursing Process among different educational levels of primary nurses. ANOVA was applied to data and indicated no significant difference in quality of care among educational levels.