Family Satisfaction

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There were three main goals for the family component of the Kingswood project: (1) to examine what family members consider important in the environmental design of nursing homes, (2) to assess family members' satisfaction with the Kingswood Health Center where their relatives lived, prior to versus after the design renovation, and (3) to explore the impact design interventions had on family members' feelings about and experiences with the Health Center.

Three types of data were collected to meet these goals. First, a mail survey was sent to persons who had a family member residing in the Health Center. The pre-renovation survey was done during March-April 1999, with the post-survey being completed in September 2000. The purpose of the survey was to gather family members' feelings of satisfaction with various dimensions of care and the environment at the Health Center, prior to versus after the design renovation. The survey used a validated tool from the field of nursing home research (The Family Perceptions of Care Tool) and obtained a highly acceptable response rates at both pre- (49 of 68= 72%) and post-renovation (49 of 81=60%). A subgroup of family members also was selected to complete personal interviews with the researchers at both pre and post-renovation. Of the 14 family members originally interviewed, approximately half had a resident family member with dementia, and the rest had relatively high-functioning resident family members. Post-renovation interviews were only repeated with 12 of these family members, as two were no longer available after the renovation.

The interviews focused on care and environment issues, giving family members a relatively unstructured format in which to share, in depth, their views about the facility. These interviews were designed to permit family members to raise the issues they considered most salient, rather than to assume that the environment would be important to them and therefore focus them on that issue. They were prompted for their views about the environment (e.g., things they liked, things they did not like) at the end of the interview if they had not already raised such issues earlier in the interview. Interviews lasted approximately
45-60 minutes at pre-renovation and about 30 minutes at post-renovation. They have been transcribed from tape and are currently being thematically coded. Finally, to consider whether design innovation altered the frequency of family visitation visitor sign-in data were collected from the visitor logs for approximately 6-7 weeks at both pre- and post-renovation. We consider the multiple sources of data we collected as valuable in strengthening the validity of our findings, as they include self-report as well as observational data, and data assessed both objectively through quantitative methods, as well as more subjectively through qualitative assessments of personal interviews.

To assess Goal 1 stated above, we used both the pre-renovation mail surveys and in-person interviews to explore what family members value and expect in a nursing home environment. Interestingly, the mail survey conducted prior to the Health Center renovation revealed that of four dimensions (Total care, Nursing care, Relationships of staff, residents & family, and Environment) assessed on the satisfaction tool, family members rated the environment the lowest (3.51 on a 5-point scale). To gain deeper understanding of their relative dissatisfaction with the pre-renovation environment, we combed through the qualitative data from the personal interviews and the main concerns that emerged were:

- **institutional feeling of the health center** (e.g., neutral colors, unattractive draperies & furnishings, hospital-like food). Some of those interviewed, however, expressed doubt that a nursing home can really feel "homelike."

- **lack of aesthetic appeal in the resident rooms** (in contrast to beautiful parlor and other parts of the CCRC)

- **privacy issues** (lack of privacy for visiting in rooms, problems keeping other residents out of one's room and things)

- **poorly matched roommate and dining assignments** (centered on mixing of residents with and without dementia)

While some of these issues can be addressed through physical renovation (e.g., the set-up of double rooms in a way to promote privacy, selection of wall-coverings, floorings), others require modifications in the social environment that may depend on policy and procedural changes initiated by administrative and nursing staff. For example, factors considered when pairing roommates for the double rooms, or policies involving privacy (keeping
doors open or shut) are not directly linked to physical environment changes. [A paper based on these findings was presented at the 1999 annual meeting of the Environmental Design Research Association, San Francisco.]

Once post-renovation survey data were in, we conducted analyses of the mail survey data to test for pre to post-renovation changes in family satisfaction. Surprisingly, significant changes were found on only 8 of 63 items on the Family Perceptions of Care tool, and nearly all of these changes were in the negative direction, with family being more satisfied at pre than post renovation. The only item pertaining to the environment that showed a significant change was that concerning "attractiveness of the décor" and this item did, however, change in the positive direction. When the four dimensions of the scale (noted above) were summed, only that related to Relationships between staff, residents, and family revealed significant pre- to post-renovation change, again in the negative direction.

Additional analyses showed no differences in ratings of the environment by family based on dementia status of their resident member. When we compared satisfaction ratings for families whose resident member moved to a newly constructed wing versus those who did not, more differences were revealed. Family members whose resident was residing on one of the new wings were less satisfied with activities provided for the resident, and their family member's use of self-care abilities. These families also reported more problems with odors than the other family members, but they had become more satisfied with their resident family members' ability to control the temperature in their own rooms. Relationships with staff, residents & family and physical care were less satisfying at post-renovation for families whose members had moved onto one of the newly built wings.

Our interpretation of these surprising findings is that there were possibly other changes occurring in the Health Center, at about the same time that the building was renovated, that may have altered care and staff-resident-family relationships. One change we are aware of involved a new director of nursing, who, according to comments from families, was less open and communicative with the resident families, and less responsive. Such a shift in personnel could have confounded our pre to post renovation comparisons. Another possibility, however, is that physical changes in the environment are not enough to provoke positive changes in care; that is, changes in the care situation may require accompanying modifications in policies and procedures aimed at altering the social environment. Finally, the fact that family with members on
the new wings felt less satisfied than other family members could be a response to adjusting to a new setting, or to the fact that many of the placements on the new wing were residents with more severe cognitive and functional impairments, which could create differences in the responses that families gave to these survey items. [These findings were reported at the annual meetings of the Gerontological Society of American, in Washington, D.C., in November, 2000.]

Currently, we are beginning the qualitative analyses of the post-renovation personal interviews that were conducted with 12 family members, all of whom had also been interviewed prior to renovation. Our focus in these analyses is the changes in the environment and delivery of care from pre-to-post renovation that family members identify and discuss. Please note that observations here are preliminary as the systematic coding of the interviews is not complete. For the most part, family members recognize the enhanced aesthetics of the facility and appreciate the more home-like, up-to-date, and cheerful physical environment. Such comments as:

"It's just more attractive. It's brighter, it's more colorful, it's newer. . .I just think it's more uplifting. . .I try to point those things out to my sister, who may not be as tuned in to that kind of thing. . ." [#40]

Yet, several still felt that it is impossible for the facility to feel home-like. As one family member said:

"I don't know if any place like this can really be homelike. Unless a person is able to take care of themselves and move themselves around, and really keep their room the way they want to, I think it becomes institutionalized." [#41]

When asked what their resident family members have said or thought about these changes, however, nearly all said that it means very little to them. According to one family member, her very alert sister doesn't have much reaction to the changes:

"when you're in a facility like this, and you're not able to get up and walk around, and you're old. What difference does it make?"[#35]

Not surprisingly, similar comments were more often given by those families whose resident member suffers from dementia. From the point of view of family members, they attribute essentially no effects of the environmental
changes on their experience with visiting (including frequency, how they spend their time, where they spend their time, or feelings about visiting). Several noted that the place doesn't have bad odors anymore and is more pleasant looking, but they still find the most discomfort and displeasure with visiting to be centered on seeing older persons who are physically challenged and cognitively disoriented.

Some of the concerns family had with the renovations focused on increased costs for the rooms and their perceptions that physical appearance of the facility may have taken priority over the quality of care delivered to residents. The Health Center, like many facilities, deals almost constantly with high staff turnover and understaffing due to currently low unemployment rates. Some family members see this as the major challenge to their resident member getting consistent, high quality care:

"the people who actually give the care--there's just not quite enough of them, ever. Nor are they as well trained as they ought to be. . . you're paying minimum wage, and for most of them. . . that leaves a little to be desired." [#10]

With high turnover they worry that staff don't know the unique needs of their family members or have time to develop a real concern for their personal well-being. More than one family member who was interviewed expressed the desire that some of the money used for renovation could have alternatively been used to increase staff salaries and staffing in general, thereby hopefully reducing turnover:

"(it's) fine to have a fabulous facility, but there needs to be a balance with staff salaries and upgrading positions." [#26]

The belief is that this will have a greater impact on care than changes in the physical environment.

Finally, a few family members discussed the idea of changing the social environment. They discussed how the administration had planned for these physical renovations to be accompanied by an Edenization approach that emphasizes a more personal, social approach to resident care. This social part of the plan had not yet been implemented to the degree that family members desired, which led some to conclude that any goals that had been set had not yet materialized:
"when the remodeling was finished we were supposed to transition to a new plan for dementia patients--Edenizing... (but) they weren't ready to go into it because staff wasn't ready. . . I was expecting a greater number of hours per patient ratio and therefore more attention. . . and a better trained staff in dementia treatment and that just wasn't pushed!"

Later in the interview this same family member added that the resident can come first in any environment--you don't need to change the setting for that!

We still have to analyze visitation data, but at least from the perspective of these twelve family members, we don't anticipate significant changes in the level of visiting in response to the environmental renovation. [These current analyses will become part of a paper submitted for presentation at the 2001 Gerontological Society of America meetings to be held in Chicago in November.]

In sum, our exploration of how family members view the physical environment of nursing home facilities and respond to changes in the environment reveals mixed findings. Although family members appreciate efforts to enhance the physical features and design of nursing home facilities, they do not appear to consider physical environment as the top priority in their rating a facility's quality or in what they look for in a facility. Not surprisingly, family members concentrate first and foremost on staffing and care issues that are going to impinge more directly on the treatment of their resident relative. When family members perceive environmental upgrades as a trade-off to maintaining or obtaining quality care, they seem less positive about effort to enhance physical space. As more than one family member noted, while a beautiful facility may sell more beds initially, that is not what will keep families satisfied with the facility over the long-term. Finally, these results suggest that environmental renovation has to include modification to the social setting, as well as the physical setting, if care is to be positively affected and nursing home settings are to become less institutional and more home-like and personalized.