DOCUMENT RESUME

ED 307 565 CG 021 735

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TITLE An Evaluation of the Training Program: "The Alzheimer's Disease Afflicted: Understanding the Disease and the Resident."
INSTITUTION Illinois State Dept. of Public Aid, Springfield.
PUB DATE 87
NOTE 59p.; One of a series of reports issued under the the heading: "1987 Long Term Care Research and Demonstration Projects. Final Reports. New Horizons in Long Term Care." (see CG 021 733, 734).
PUB TYPE Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Alzheimers Disease; *Caregivers; Employee Attitudes; Employees; *Nursing Homes; *Program Effectiveness; *Staff Development; *Training Methods

ABSTRACT

This study was undertaken to evaluate a training program on understanding Alzheimer's disease for nursing home caregivers of those with the disease. A pretest/posttest design control group methodology was used to evaluate 81 staff members. Results of the study showed that: (1) staff satisfaction with working with mentally impaired and demented residents improved significantly after training; (2) the kind of knowledge required to care for Alzheimer's disease afflicted persons also increased; (3) proper knowledge of various tasks and positive attitudes toward the patients increased; and (4) the training group showed improved self-esteem after the training. Limits of the study were the voluntary participation of the staff and the smaller than desirable sample size; lack of participation in all training sessions; and the lack of multivariate analysis instead of the pretest/posttest strategy which was used. Despite limitations, overall results suggest that a training program such as this one is worth repeating and replicating in view of the urgent needs of persons afflicted with Alzheimer's disease residing in nursing homes. (ABL)

AN EVALUATION OF THE TRAINING PROGRAM:

"THE ALZHEIMER'S DISEASE AFFLICTED: UNDERSTANDING THE DISEASE AND THE RESIDENT"

by
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Illinois Department of Public Aid

Edward T. Duffy, Director

1987 LONG TERM CARE RESEARCH AND DEMONSTRATION PROJECTS

FINAL REPORTS

NEW HORIZONS IN LONG TERM CARE

Edward T. Duffy
Director

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Funds for collaborative research in long term care were appropriated in the Department of Public Aid's budget in Fiscal Years 1986 and 1987 to find new ways to treat long term care patients in Illinois nursing homes. The $2.5 million appropriation over the two years enabled the State, academic institutions, and providers of long term care to pool their talents for the first time. In all, there were 17 projects funded in Fiscal Year 1986 and 14 projects funded in Fiscal Year 1987, the final year of the Long Term Care Research and Demonstrations projects. The attached document is the final report from one of the 1987 projects.

The Department of Public Aid expects the ideas generated by these projects to be put into reality. There are, in fact, training programs already being disseminated as a result of the research.

This report is one of a series of reports that comprise the long term care projects funded during 1987. Copies of the other reports are available from the Department of Public Aid by writing to Jo Ann Day, Ph.D., Long Term Care Research and Demonstration Project Director, Office for Employment and Social Services.

Sincerely,

Edward T. Duffy
enc.

ETD:JD:gt

A C K N O W L E D G M E N T S

A project of this importance and magnitude required a commitment from many individuals. Among those are Richard A. Ligon, Administrator, whose support at the onset of the idea's inception to its closure must be credited. His support among the caregiving staff enlisted the participation of the personnel in the facility. He kept abreast of the projects's activities by participating himself.

Bill Krzykowski, Business Office Manager, is credited too for his apt handling of the financial procedures with the nursing home as contractor with the University. Marge Eisenhauer, R.N., Director of Nursing Services, was most instrumental as she lent the power of her office to encourage personnel to participate. In her absence, Stephanie Green, R.N., Associate Director of Nursing Services, kept the momentum going. There were others whose ancillary activities and support contributed. Dan Marsh, Geriatric Counselor, Jackson County Community Mental Health promoted the project among family members of Alzheimer residents at the support groups he conducts. Connie J. Armstrong directed support group of Jackson County Nursing Home personnel most ably. Then there were collectivities of other persons from the nursing home. Most notably the Employees Relations Council whose interest was displayed in many different and effective ways. And of course, the affable Andrew R. Esposito, M. D., Medical Director for the nursing home, was as he always is, a positive force of encouragement.

Externally, Dr. Jo Ann Day, Project Manager, Long Term Care Research and Development Projects, was so helpful in evaluating constructively and in a gentle manner the Project's proceedings. Special kudos to this lady for her guidance.

On the outside too were those wonderful people from the Randolph County Nursing Home, Sparta, Illinois who functioned as the control group. Our thanks to Jeannette Buch, Administrator, and to Janice Mergelkamp, R.N., Director of Nursing Services, who solicited such a fine turnout of caregivers to take the pre and post test instrument measures.

John M. Ross, the administrator of the River Bluff Nursing Home, Rockford, Illinois gets credit for designing the incentive patch given to the staff who achieved the project's goals for attendance and participation.

A debit of gratitude to the principals to the project who grew personnally and professionally with each phase and who worked so well together as a team. Those persons are:

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I. INTRODUCTION

The major objective of the project, "The Alzheimer's Disease Afflicted: Understanding The Disease and the Resident," was to make the allied health personnel more sensitive to the special needs and treatment of the aged suffering from Alzheimer's Disease (AD). It was assumed that incumbent practitioners do not have the special skills and knowledge that will allow them to appropriately treat the Alzheimer's resident. Similar concern was also expressed by Dietsch and Pollman (1982) who observed that in basic nursing education, training and education regarding Alzheimer's disease and related disorders are at best minimal. Our training program was designed to address such needs in one of the nursing homes in Southern Illinois, namely, the Jackson County Nursing Home (JCNH). In all, seven training sessions were organized for its staff members who are directly or indirectly involved in Alzheimer's resident care. A brief description of the training sessions by date follows:

December 12, 1986: The first training session took place with Mary Barringer, R.N., the presenter. She spoke on what the participants would learn over the next few months, and outlined what Alzheimer's Disease is.

January 29, 1987: The second training session, "Communication Skills," was presented by Mary Barringer, R.N., and Nelly Ryan, M.S.W. This in-service session dealt with communication skills which aid in caring for AD residents.

February 25, 1987: A training tool called "Communication Exercise" was given to staff on a voluntary basis. This was designed to re-enforce what was taught at the first and second training session.

March 3, 1987: The third training session, "Understanding the Family's Burden," was presented by Nelly Ryan, M.S.W. This in-service described what the families of residents have gone through prior to admission of their afflicted family member to the nursing home.

April 2, 1987: Training session four took place in the form of an event outside the nursing home. The project sponsored a live broadcast of an AD teleconference out of Nashville, Tennessee. The conference was directed towards family members of AD victims but was applicable for nursing home staff as well.

April 16, 1987: The fifth training session, presented by Mary Barringer, was "Care Strategies." After a video tape was shown there was a discussion with the staff concerning how to care for confused residents in various situations.

May 22, 1987: The sixth training session, "Sensory Loss," was presented by Catharine Kopac, R.N., Ph.D. This in-service was meant to teach the staff what it is like to experience the loss of the ability to touch, see, and hear. The staff wore rubber gloves, blindfolds, and earplugs.

June 9, 1987: The seventh and final training session, "Dying and Bereavement," was presented by Betty J. Walston, R.N., Ph.D. This in-service talk dealt with the grief which comes when a resident the staff has cared for dies.

This report contains an evaluation of outcomes of this training program, its strengths and weaknesses, and its implications for future training programs.

II. METHODS

A quasi-experimental pre- and post-test[1] control group design (see Campbell and Stanley, 1963, for detail on this design) was used for the evaluation of the training program. Jackson County Nursing Home (JCNH), whose staff participated in the training program, was the experimental group. Another county nursing home, the Randolph County Nursing Home (RCNH), served as a control group.[2]

Questionnaires

Two separate self-administered questionnaires were used once during pre-test and once during post-test for both experimental and control groups.

Questionnaire I and Measures:

This assessment tool (see Appendix 1) was originally developed by Springer and Brubaker (1984) and was used successfully by the Department of Medical Social Work, University of Illinois at Chicago, in their assessment of the caregivers training program at the Alzheimer's Disease Training Center, Chicago, Illinois. Questionnaire I contained four specific dimensions that were used to gather the data for this evalua-

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[1] Pre-test in this report refers to measures taken in the pre-training phase of the study, and post-test refers to measures taken after the training programs were over. Thus, the terms pre-test and pre-training, and post-test and post-training are used interchangeably throughout this report.

[2] Originally one more nursing home, the River Bluff Nursing Home, Rockford, Illinois, agreed to serve as a second control group. But, since the post-test evaluation results could not be obtained from them, the final report excludes this nursing home from the analysis.

tion study. These were: (1) Knowledge of Dementia; (2) Understanding about Responsibility for Tasks regarding resident care; (3) Degree of Work Satisfaction feelings in the current job; and (4) Attitude toward working with cognitively impaired residents.

Measures for Knowledge dimension included 20 items having 'true' or 'false' response types (see section B, items 1 through 20 in Appendix 1) derived from information about aging and dementia by Brubaker for family caregivers (Springer and Brubaker, 1984). The Knowledge test had one correct response for each item and a respondent could get zero to 20 points on this dimension (all wrong = 0; all correct = 20).

The second dimension, "Responsibility for Tasks," included 16 items that measured respondents' understanding about who they think should be responsible for various tasks regarding Alzheimer's care (see items 21 through 36 in Appendix 1). There could be three possible responses to each item such as, (1) Only nursing home is responsible for tasks; (2) Both nursing home and family are responsible for tasks (joint); and (3) Only family is responsible for tasks. From the training point of view, each item on this dimension also had one correct answer. Thus, a respondent could receive a total of 16 points, if all correct, or zero point, if all wrong.

The third dimension, "Work Satisfaction," (see items 37 through 45 in Appendix 1) measured the degree of satisfaction staff members presently have with various aspects of their job regarding Alzheimer's resident care.[3] This dimension included nine Likert-type five-point response categories ranging from Very Dissatisfied (=1) to Very

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[3] Items on this dimension have been adopted from Shuttlesworth and Rubin (1983) Task Inventory (see Shuttlesworth and Rubin, 1983, for detail).

Satisfied (=5). A summative "Work Satisfaction Scale" was developed after proper item analysis. The internal consistency of the scale (Cronbach's alpha) for the experimental group (JCNH) in the pre-test and post-test was .75 and .74 respectively. For the control group (RCNH) Cronbach's alpha in the pre- and post-tests were .78 and .75 respectively. Scores of individual respondents on this scale could vary from a low of nine to a high of 45 points, provided one has responded to all of the items. A higher score on the scale means higher work satisfaction, and a lower score, lower work satisfaction.

The fourth dimension measured the staff members' attitude toward working with confused residents and their families on 15 unidimensional items (see items 46 through 60). The response categories for the items were also 5-point Likert-type that ranged from Disagree Strongly (= 1) to Agree Strongly (= 5). Like the "Work Satisfaction Scale," an additive "Attitude Scale" was developed after similar item analyses following Statistical Packages for the Social Sciences (SPSS-X, SPSS Inc., 1986) procedures. However, since some of the items were negatively worded (see Questionnaire I, item numbers 46, 61-64, 66, 68-70 and 72), before the item analysis they were reverse coded and made comparable with other items. For the **Jackson County Nursing Home**, the pre-test and the post-test alpha coefficients were .61 and .66 respectively. These coefficients for the **Randolph County Nursing Home** were .60 and .67 respectively. The scale scores for a respondent on this dimension could yield a maximum of 75 points and a minimum of 15 points depending on one's patterns of responses. A higher score on this scale would indicate a strong positive attitude, and a lower score a strong negative

attitude about working with confused Alzheimer's residents at the nursing home. Additionally, Questionnaire I also included demographic variables, like sex, education, work experience, and job position, that provided background information for each of the respondents.

Questionnaire II and Measures:

The second questionnaire "Sliding Person Measure" (see Appendix 2) has also been self-administered by the respondents (SPM). The "Sliding Person Measure" assessed the Self-Esteem of the nursing home staff. This instrument is a rating scale and includes ten equivalent item statements. Respondents were asked to indicate how they feel about each of the ten statements by placing an 'X' on a horizontal line. Each line is 100 millimeters in length. The further to the right the 'X' is placed, the higher the respondents' Self-Esteem as measured by individual statements. Each of the instruments' ten statements has been scored by measuring how far from the left the 'X' has been placed on the line using a metric ruler. An 'X' placed all the way to the left yielded a score of '000,' and all the way to the right yielded '100' points for each respondent. No response for each item was coded as '999'.

This scale was developed by Andrew Marcec and was used in a past research project in the health field with an acceptable degree of reliability (alpha coefficients were .79 and .81 in pre-and- post tests respectively). In the present study the results of item analysis were quite satisfactory. For the **Jackson County Nursing Home,** alpha coefficients for pre-test and post-test were .91 and .89 respectively. The internal consistency of the scale for the **Randolph County Nursing Home** in the pre-test was .83 and the post-test was .87. When used as a

composite Self-Esteem scale in the analysis, a respondent's total score on this scale could vary from '0000' to '1000'; the higher score indicating higher Self-Esteem and the lower score indicating lower Self-Esteem.

Sample

A total of 65 staff members from JCNH completed the pre-test Questionnaire I as compared to 85 from RCNH. Questionnaire II in this phase was completed by only 46 respondents in JCNH and 65 in RCNH. In the post-test phase 36 JCNH staff completed both questionnaires, I and II, whereas 45 RCNH staff completed both questionnaires in this phase. Since we had to measure the effect of training, matched respondents for both phases, responding to both questionnaire instruments, were needed. Therefore, this evaluation report includes only the analysis of results for 36 JCNH staff and 45 RCNH staff who completed the questionnaires in both pre- and post-test phases.

Procedures

Pre-test data from the JCNH staff and RCNH staff were collected through both questionnaires in January 1987. The post-test data for JCNH and RCNH were collected in July 1987. Both pre- and post-test questionnaires at JCNH were distributed and collected by the project staff. The pre-test questionnaires for RCNH were delivered by the project staff to the JCNH supervisor, who then distributed them among the nursing home staff. The post-test questionnaires were mailed to

RCNH for distribution. A Project staff member picked up the post-test questionnaires from RCNH.

Analysis Strategy

Se eral analytical techniques were used in this evaluation study for both the experimental (JCNH) and control groups (RCNH). First, a univariate analysis (involving frequency and percent distributions) of respondents' background variables; Knowledge score; Responsibility for Tasks; Work Satisfaction; Attitude toward Alzheimer's Resident Care; and Self-Esteem was performed. This first level analysis also included item-wise descriptive statistics on each of the dimensions of Questionnaire I and Questionnaire II. Second, internal consis'ency reliability, which measures the degree to which each item in the scale relates to the others, was measured separately for the three proposed scales through the use of Cronbach's alpha (Cronbach, 1951). Third, summary statistics such as mean and standard deviation were calculated by nursing homes involving the respondents' Knowledge, Task, Work Satisfaction, Attitude, and Self-Esteem scale scores.[4] Finally, both independent and dependent t-tests were performed for the two groups (JCNH and RCNH) to measure the significance of differences between pre- and post-test mean scores on all four dimensions included in Questionnaire I, and Self-Esteem mean scores in Questionnaire II.

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[4] Several bivariate analyses between respondents' background variables and each scale scores were performed for the two Nursing Homes separately. These results were statistically non-significant and therefore, not presented in this report.

Dependent t-tests were used to test the significance of mean score changes between pre- and post-test measures for the experimental and control group separately. Independent t-tests were used to compare both the experimental and control groups' mean scores on all measured dimensions once at the pre-test phase and again at the post-test phase. The Statistical Packages For the Social Sciences procedures FREQUENCIES, CONDESCRIPTIVE, and BREAKDOWN were used for obtaining summary statistics (See SPSS-X User's Guide, 1986). The procedure RELIABILITY was used for internal-consistency estimates. For independent t-tests, procedures GROUPS specification was used, whereas, for dependent t-tests, PAIRS specification was used.

III. FINDINGS

Demographic Characteristics

Age: Table 1 shows the age distribution of the respondents for both training and control group. The modal category of age for JCNH is 25 and below; a little less than one-third of the respondents in JCNH are in this age category. Whereas, the modal category of age for RCNH is 31 - 35; about 27 percent of the respondents in this Nursing Home are within 31 - 35 years of age. Although both the groups have similar amount of dispersion in age distribution around the mean (standard deviation of 10.63 for JCNH and 10.22 for RCNH), a greater proportion (15.5 percent) of RCNH staff is in the '51 and above' age category as compared to only 5.6 percent of the staff in JCNH. The mean age of RCNH respondents is 36.2 and JCNH respondents is 33.9.

TABLE 1

Frequency, Percentage and Mean Distribution of Age of the Respondents for JCNH (N=36) and RCNH (N=45)

	JCNH		RCNH		Total	
Age group	Freq.	Percent	Freq.	Percent	Freq.	Percent
25 and below	11	30.6	7	15.6	18	22.2
26 - 30	7	19.4	4	8.9	11	13.6
31 - 35	3	8.3	12	26.7	15	18.5
36 - 40	3	8.3	6	13.3	9	11.1
41 - 45	5	13.9	6	13.3	11	13.6
46 - 50	5	13.9	3	6.7	8	9.9
51 and above	2	5.6	7	15.5	9	11.1
Total:	36	100.0	45	100.0		100.0
Mean:		33.9		36.2		
Standard Deviation:		10.63		10.22		

Table 2 shows other characteristics of the respondents that include variables such as sex, educational levels, years of experience in the current job, and whether the respondents' position involves direct or indirect resident care.

Sex: An overwhelming majority of the respondents (89%) in both nursing homes were females. In JCNH, out of 36 total respondents, 32 were females. In RCNH, 40 out of 45 respondents were females.

Education: The modal category of education for both groups was high school completed and some college; 59 percent (N = 20) of the sample in JCNH and 67 percent of the sample in RCNH (N = 30) were in this category. Thirty-two percent of the respondents in JCNH, and 18 percent in RCNH had less than a high school education. Very few of the respondents in either group had 'college graduation and above' education. However, the proportion of respondents having college graduation were almost double in RCNH compared to JCNH; 16 percent in RCNH compared to 9 percent in JCNH.

Work Experience: An overwhelming majority of the respondents have been employed in their respective nursing homes for more than one year. However, this proportion is slightly higher for JCNH staff (about 88%) compared to the RCNH staff (80%). In fact, the mean years of work experience for JCNH staff is 3.8 and RCNH is 3.6.

Job Position: The available responses on this variable (12 respondents did not answer this question), show that a majority, but similar proportion (71 percent in each nursing home), of respondents have positions that involve direct Alzheimer's resident care[5] in their facility.

[5] Positions involving direct resident care include Certified Nurse Assistant, Rehabilitation Aide, Charge Nurse, Supervising Nurse, and Dietary Aide. Whereas, indirect resident care positions (cont.)

TABLE 2**

Frequency Distribution of Respondents' Sex, Education, Work Experience, and Position by Nursing Home

Variables	JCNH		RCNH		Row Total	
Sex						
Male	4	(11.4%)	5	(11.1%)	9	(11.3%)
Female	31	(88.6%)	40	(88.9%)	71	(38.8%)
Column Total	35*	(43.8%)	45	(56.3%)	80	(100%)
* missing observation = 1						
Education						
< High School	11	(32.4%)	8	(17.8%)	19	(24.1%)
H.S. completed & some College	20	(58.8%)	30	(66.7%)	50	(63.3%)
College Grad & more	3	(8.8%)	7	(15.6%)	10	(12.7%)
Column Total	34*	(43.0%)	45	(57.0%)	79	(100%)
* number of missing observations = 2						
Work Experience						
Employed < 1 yr	4	(12.1%)	9	(20.0%)	13	(16.7%)
Employed > 1 yr	29	(87.7%)	36	(80.0%)	65	(83.3%)
Column Total	33*	(42.3%)	45	(57.7%)	78	(100%)
Mean	3.8 yrs		3.6 yrs			
* number of missing observations = 3						
Job						
Direct Patient Care	20	(71.4%)	29	(70.7%)	49	(71.0%)
Indirect Patient Care	8	(28.6%)	12	(29.3%)	20	(29.0%)
Column Total	28*	(40.6%)	41	(59.4%)	69	(100%)
* number of missing observations = 12						

** Percentage included in parenthesis

(cont.) include Bookkeeper, Activity Aide, Housekeeper, Social Service Assistant, Laundry Aide, Administrative Clerk, Receptionist, and Maintenance persons. This variable was recoded.

KNOWLEDGE OF DEMENTIA

Table 3 shows the pre-test and post-test results of the 20 Knowledge items for JCNH and RCNH. An increased percentage of JCNH staff gave correct answers in the post-test phase on 12 items. Their percentage of correct answers remained the same for both tests on 3 items. The percentage of correct answers declined in the post-test for 5 items in this group. In contrast, the percent of correct answers declined for the control group (RCNH) on 9 items and increased on the other 11 items.

TABLE 3

Pre- and Post-test Results Reflecting
Percent of Correct Responses to 20 "Knowledge" Items
by Nursing Home

Knowledge Items*	Percent of Correct Responses JCNH (N=36) Pre-test	JCNH (N=36) Post-test	RCNH (N=45) Pre-test	RCNH (N=45) Post-test
1. DEM (F)	50%	49%	60%	49%
2. LIFE (F)	92	81	80	84
3. SOME (T)	89	89	89	80
4. DEPEND (F)	72	69	76	78
5. COPE (T)	75	86	78	82
6. STRESS (T)	78	80	84	73
7. CGSTR (F)	64	64	76	80
8. DEC (F)	97	100	98	87
9. QUAL (T)	69	71	73	69
10. HIDE (F)	44	46	49	44
11. GDREL (T)	97	100	93	89
12. SELF (F)	75	86	76	87
13. GUILT (T)	58	71	44	47
14. RAPID (T)	78	81	84	91
15. RESHAP (F)	94	92	91	96
16. NOTALK (F)	97	97	98	91
17. CGILL (T)	53	58	51	64
18. FRSP (F)	42	37	52	42
19. CGSUP (F)	22	37	33	47
20. RESPON (T)	56	74	69	71

* Correct answer is shown within parenthesis and a full description of the items is shown in Appendix 3.

When the summative scores for all 20 knowledge items are considered for comparison, the picture becomes more clear (see Table 4 below).

TABLE 4

Pre- and Post-Test Mean and Standard Deviation (SD) for the 20 Knowledge Items by Nursing Home

	Pre-Test		Post-Test		
Nursing Home	Mean	SD	Mean	SD	Mean Differences
JCNH (N=36)	14.00	2.32	14.50	3.14	(+.50)
RCNH (N=45)	14.53	3.12	14.49	3.42	(-.04)
For Entire Population	14.29	2.78	14.48	3.28	(+.19)

Table 4 shows that for the Jackson County Nursing Home, the average number of correct answers in the pre-test was 14.0, which increased in the post-test to 14.5. The respondents in JCNH thus have experienced an average Knowledge increase of .50 after the training. On the other hand, RCNH respondents started off with a higher average Knowledge (mean = 14.53) compared to the JCNH staff at the pre-test phase but have experienced an average decline of .04 at the post-test phase. Their post-test mean Knowledge score was 14.49, which was slightly lower than that of JCNH staff at post-test.

RESPONSIBILITY FOR TASKS REGARDING ALZHEIMER'S RESIDENT CARE

On the question of who the staff think is responsible for each of the 16-Tasks items, the percentage of correct answers increased in the post-test on most of the items for JCNH respondents. In this group, the percentage of correct answers went up for 11 out of 16 items as compared to only 8 items in RCNH (see Table 5). In other words, the control

group, which did not go through the training experience, showed a declining percentage of correct answers on almost 50% of the items (on one item the percentage of correct answers for this group remained the same in both tests). Whereas, the training group showed a decreased percent of correct answers in less than one-third of the items (in 5 out of 16). The lowest percentage of correct answers was recorded for item number one, for both of the groups in pre- and post-tests.

TABLE 5

Pre- and Post-Test Results for Percent of Correct Answers on the 16 "Responsibility for Tasks" Items by Nursing Home

	Percent of Correct Answers			
	JCNH		RCNH	
Task Items*	Pre-test	Post-test	Pre-test	Post-test
1. XFOOD (NH)**	14%	12%	18%	13%
2. ROOM (Joint)***	53	68	64	71
3. BPARTY (Joint)	77	72	73	89
4. REPORT (Joint)	72	78	84	84
5. DRUGS (NH)	69	56	58	44
6. PHONE (NH)	46	41	78	71
7. CLAIMS (Joint)	33	34	58	62
8. TRANS (Joint)	51	65	64	71
9. SUPP (Joint)	42	54	49	67
10. WASH (Joint)	39	51	33	36
11. MARK (Joint)	22	39	44	42
12. CLOTH (Joint)	33	36	44	58
13. CLIP (Joint)	83	79	84	82
14. HAIR (Joint)	44	58	51	67
15. NEWS (Joint)	36	55	40	36
16. READ (Joint)	39	53	56	44

* Correct answers are shown within parenthesis and a full description of the variables is shown in Appendix 4.
** NH = Nursing home responsible for specific tasks.
*** Joint = Nursing home and family (both) responsible for specific tasks.

The results of the additive Task scores (see Table 6) for all 16 items show that JCNH respondents received a mean score of 7.47 in the pre-test and 8.28 in the post-test. RCNH staff's mean scores in the pre- and post-tests were 8.97 and 9.47 respectively. A comparison of pre- and post-test mean score differences show that both groups gained in Task Scale scores but this gain was higher for JCNH (+.89) as compared to RCNH (+.50).

TABLE 6

Pre- and Post-Test Mean and Standard Deviation (SD) for the 16 "Responsibility for Task" Items by Nursing Home

	Pre-Test		Post-Test		Mean
Nursing Home	Mean	SD	Mean	SD	Differences
JCNH (N =36)	7.47	2.91	8.28	2.83	(+.89)
RCNH (N =45)	8.97	2.65	9.47	2.93	(+.50)
For Entire Population	8.31	2.85	8.94	2.93	(+.53)

WORK SATISFACTION AT THE NURSING HOME

Table 7 shows the mean and standard deviation for each of the 9 items used to measure the degree of Work Satisfaction of the respondents on a 5-point scale for both nursing homes.

TABLE 7

Pre- and Post-Test Mean and Standard Deviation (SD)
for the 9 "Work Satisfaction" Items for JCNH and RCNH

Work Satisfaction Items*	JCNH Pre-test Mean	JCNH Pre-test SD	JCNH Post-test Mean	JCNH Post-test SD	RCNH Pre-test Mean	RCNH Pre-test SD	RCNH Post-test Mean	RCNH Post-test SD
1. PAY	3.36	1.05	3.61	.93	2.44	.99	2.44	.94
2. PRAISE	2.86	1.22	3.31	1.09	2.56	1.16	2.78	1.36
3. POLICY	3.17	.88	3.03	.77	2.60	.78	2.49	1.01
4. WKCOND	3.19	.71	3.36	.76	2.89	1.09	2.73	1.14
5. COWK	2.78	1.04	2.86	1.02	3.29	.99	2.98	1.05
6. WKSAT	3.94	.98	4.03	.61	3.60	1.07	3.51	1.08
7. WKVAR	3.50	.88	3.61	.69	3.11	.93	3.42	.89
8. OTHERS	4.17	.56	4.00	.59	3.60	1.03	3.91	.82
9. CONFUS	3.89	.78	3.71	.75	3.20	.73	3.44	.66

* A full description of the items is shown in Appendix 5.

It can be seen from the table that, to begin with, JCNH staff showed a higher level of satisfaction for getting a chance to do things for others (item no. 8; mean = 4.17). In the pre-test, their mean score was slightly higher than the 'satisfaction' (code = 4) point in the 5-point scale on 1 out of 9 items. The staff were less satisfied with regard to 'praise' (item no. 2) for doing a good job (mean = 2.86) and the way their "coworkers get along with each other" (item no. 5; mean = 2.78). The post-test results showed that the respondents' level of satisfaction increased on both of these items. In addition, they showed increasing satisfaction on four other items that include their pay (item no. 1), working conditions (item no. 4), feelings of accomplishment (item no. 6), and the chance to do different things from time to time (item no. 7) On three other items such as "the way nursing home policies are put into practice" (item no. 3), "the chance to do things for

others" (item no. 8) and, "the chance to work with confused residents" (item no. 9), although the JCNH staffs' satisfaction level went down a little in the post-test, their mean level of satisfaction on each item was still reasonably higher than that of RCNH.

In contrast, the Randolph County Nursing Home staff showed lower than average (neutral position) satisfaction on 4 out of 9 items in the pre-test. In the post-test, their satisfaction level remained lower than 3.0 on 5 items. These items include their 'pay', the 'praise they get for doing a good job', "the way nursing home policies are put into practice," their "working conditions," and the way their "coworkers get along with each other." Their average (mean) satisfaction level, however, increased in the post-test with regard to variables measuring their "chance to do different things from time to time" (3.42), "chance to do things for other people" (3.91) and "chance to work with confused residents" (3.44).

When the overall Work Satisfaction scale scores were compared (see Table 8), the post-test results indicated that, on the average, the JCNH staff have experienced a .56 increase in their satisfaction level as compared to a .42 increase for that of RCNH. The pre- and post-test mean scores for JCNH were 30.86 and 31.42 respectively (maximum possible score being 45). While the comparable mean scores for RCNH were 27.29 and 27.71 respectively.

TABLE 8

Mean and Standard Deviation for the "Work Satisfaction" Scale by Nursing Home and by Pre- and Post-Test Measures

	Pre-test		Post-test		
Nursing Home	Mean	SD	Mean	SD	Differences of Mean
JCNH (N =36)	30.86	4.81	31.42	4.25	(+.56)
RCNH (N =45)	27.29	5.35	27.71	5.25	(+.42)
Differences of Mean For Entire Population	(3.57)*		(3.71)**		
	28.88	5.39	29.36	5.15	(+.48)

* Mean difference between JCNH and RCNH at the pre-test.
** Mean difference between JCNH and RCNH at the post-test.

It should be noted here that the difference in the pre-test Work Satisfaction scale score between JCNH and RCNH was 3.57. In the post-test this difference increased to 3.71, JCNH having a higher average scale score in both the phases.

ATTITUDES TOWARDS ALZHEIMER'S RESIDENTS

From Table 9 it can be discerned that on most of the 15 items dealing with measuring the attitudes toward Alzheimer's residents, staff members in both nursing homes maintained a positive attitude. This was true both for pre- and post-tests. It should be noted that for each item, a mean score below 2 indicates a negative, 2 to 3 a neutral, and above 3 a positive attitude. It should also be mentioned that item numbers 1, 4-7, 9, 11-13, and 15 have been reverse coded to make them equivalent with other item scale points.

On three items, both groups have maintained a consistent neutral position across the tests. These items are:

1. "I prefer working with residents who know what they want and can tell me their needs" (item no. 1; question no. 46, in Questionnaire I; variable name = NOCONF);
2. "I would rather do things myself than wait for help" (item no. 8; question no. 50, in Questionnaire I; variable name = IHELP);
3. "I don't feel that my work is appreciated as much as it should be" (item no. 12; question no. 57, in Questionnaire I; variable name = APPR).

TABLE 9

Mean and Standard Deviation for the 15 Items on Attitudes Towards the Alzheimer's Residents by Nursing Home and Pre- and Post-Test Measures.

Attitude Items*	JCNH (N =36) Pre-test Mean	SD	Post-test Mean	SD	RCNH (N =45) Pre-test Mean	SD	Post-test Mean	SD
1. NOCONF	2.89	.78	3.05	.92	2.84	.99	2.86	.92
2. OKCONF	3.86	.99	3.66	.90	3.27	.96	3.44	.75
3. OKMNTL	3.67	.92	3.58	.99	3.47	.94	3.47	.62
4. OTHELP	3.57	1.00	3.78	.95	3.69	.97	4.02	.75
5. MYSELF	2.97	1.03	2.98	1.05	2.53	1.06	2.67	1.02
6. FAM	3.61	.80	3.31	.95	3.23	1.00	3.04	.93
7. TRBL	3.19	1.06	3.33	1.01	3.39	.89	3.28	.97
8. IHELP	3.54	1.01	3.61	1.04	3.63	.86	3.67	.67
9. FORGET	4.17	.97	4.36	.59	4.32	.86	4.16	.98
10. STAFF	3.92	.99	4.06	.67	4.00	.61	3.98	.72
11. HEAR	3.67	1.09	3.75	.81	3.75	.87	3.89	.98
12. APPR	3.00	1.26	2.83	1.05	2.61	1.01	2.67	1.15
13. LVCOND	4.17	.86	4.22	.83	4.23	.83	4.27	.91
14. TREAT	4.57	.37	4.44	.65	4.59	.35	4.49	.89
15. RESRCH	4.06	.95	4.33	.76	3.90	1.05	4.09	.97

* A full description of the items is given in Appendix 6.

Overall, post-test results showed that the JCNH staff have indicated change toward a more positive attitude on ten items out of 15, while similar change was noted for RCNH on nine items. RCNH staff, however, maintained the same attitude over the tests (mean =3.47 for both tests) on the item, "I think it's rewarding working with mentally and memory impaired residents." However, since the index of internal consistency showed an acceptable level of alpha coefficients in all the tests, for both experimental and control groups (see Measures section, page 6), we developed a summative 'Attitude Scale' combining item scores. Both groups' pre- and post-test results on this scale are presented in Table 10.

TABLE 10

Pre- and Post-Test Mean and Standard Deviation (SD) for Attitude Scale by Nursing Home

Nursing Home	Pre-Test Mean	Pre-Test SD	Post-Test Mean	Post-Test SD	Difference of Mean
JCNH (N =36)	54.31	5.95	55.14	5.68	(+ .83)
RCNH (N =45)	52.63	7.85	54.00	5.64	(+1.37)
	(1.68)*		(1.14)**		
For Entire Population	53.37	7.08	54.51	5.65	(+1.14)

* Pre-test mean difference between JCNH and RCNH.
** Post-test mean difference between JCNH and RCNH.

It can be seen from this table that the Jackson County Nursing Home staff had a higher pre-test mean score (54.31) on this attitude scale[6]

[6] Maximum possible score for this scale is 75; a score of over 45 indicating a positive, 30-45 indicating a neutral, and below 30 indicating a negative attitude. An individual's mean item score of 2.0 and below indicates negative attitude; 2.1 to 3.0 indicates neutral attitude; and 3.1 to 5.0 indicates positive attitude.

than that of RCNH (52.63). In addition, the Standard Deviation at pre-test indicated that JCNH staff's scale score had a lower spread around the mean (5.95 as compared to 7.85 for RCNH). Also, JCNH staff's average post-test scale score was higher (mean = 55.14) than that of RCNH (mean = 54.00). However, the difference of mean score between pre- and post-test for each group suggested that RCNH had an increase of 1.37, while this difference was .83 for JCNH. The reasons and implications of this difference will be addressed later in the discussion section of this report.

SELF-ESTEEM OF THE STAFF: SLIDING PERSON MEASURE

Table 11 shows the pre- and post-test mean and standard deviation for all ten items included in the Self-Esteem scale by the name of the nursing homes. On a zero to 100-point scale for each item, the results show that both groups recorded the highest Self-Esteem for item number two (variable name = RESP) in both tests. This item measured how the respondents view themselves, concerning how responsible they are when caring for Alzheimer's residents. The pre-test Self-Esteem mean score on this variable for JCNH was 88.30 and for RCNH was 90.10. The post-test results showed an increase of Self-Esteem for both groups (88.97 and 90.57 respectively). Again, in both the pre- and post-tests the groups noted lower Self-Esteem for item number five (variable name = KNOW). This item asked, "When you give care to residents, you feel that you know all you need to know." The post-test mean score on this item decreased a little for JCNH (mean = 61.84), while the RCNH staff experienced a slight increase (mean = 64.25).

TABLE 11

Mean and Standard Deviation (SD) for the 10-Item "Sliding Person Measure" (SPM) by Nursing Home

	JCNH (N =36)				RCNH (N =45)			
	Pre-test		Post-test		Pre-test		Post-test	
SPM Items*	Mean	SD	Mean	SD	Mean	SD	Mean	SD
1. CARE	85.27	16.44	86.11	12.12	88.54	14.95	88.70	10.77
2. RESP	88.32	13.72	88.97	10.27	90.15	11.15	90.57	8.90
3. FELLOW	78.38	17.98	74.86	17.60	77.77	21.89	82.41	15.11
4. YRSELF	86.94	14.08	86.78	12.65	85.56	14.02	87.95	11.09
5. KNOW	62.24	25.64	61.84	20.37	58.91	22.22	64.25	16.78
6. BHRS	80.19	16.39	79.62	16.34	73.63	19.28	74.72	16.40
7. EMG	72.36	19.59	75.46	20.41	66.23	21.20	67.18	20.27
8. NEW	69.95	23.97	76.40	17.03	69.84	24.81	73.73	19.42
9. DIRECT	78.53	21.25	76.81	20.79	75.07	17.79	78.28	2[illegible]43
10. ADMIN	71.56	27.66	71.46	24.95	70.23	24.38	74.06	23.25

* A full description of the items is given in Appendix 7.

The second highest Self-Esteem score was also noted for the same variable (CARE) for both groups in the pre- and post-tests. This item asked the question: "When working with residents, show how you view yourself concerning the care you give." The observed pre-test mean score on this item for JCNH was 85.27, and for RCNH 88.54. In the post-test, both groups recorded an increase which was 86.11 for JCNH, and 88.70 for RCNH.

The overall summative Self-Esteem scale results, as reflected in Table 12, showed that JCNH staff had higher mean scores on both the pre-test (769.14) and post-test (785.89) when compared to RCNH. The respondents in the latter nursing home recorded a pre-test mean score of 755.07 and post-test mean score of 780.02.

TABLE 12

Pre- and Post-Test Mean and Standard Deviation for "Sliding Person" Scale by Nursing Home

Nursing Home	Pre-test Mean	Pre-test SD	Post-test Mean	Post-test SD	Difference of Mean Score
JCNH	769.14	152.55	785.89	121.03	(+16.75)
RCNH	755.07	126.20	780.02	117.38	(+24.95)
Difference of Mean Score	(14.07)		(5.87)		

When the pre- and post-test Self-Esteem scale scores were compared separately across the group, JCNH had about a 14.07 higher average Self-Esteem score than that of RCNH in the pre-test. In the post-test this difference decreased to 5.87, JCNH still having a higher average scale score. From the pre- to post-test, both groups recorded an increase of scores; the mean increase of JCNH was 16.75, while it was 24.95 for RCNH.

Tests of Significance for Differences in Knowledge Score, Task Score, and Work Satisfaction Scale Scores Between JCNH and RCNH

In the previous section, we have discussed the findings on the differences of mean score between two samples relating to their mean scores on Knowledge, Responsibilities for Tasks, Work Satisfaction, Attitude toward Alzheimer's Residents, and Self-Esteem scales. Since the training group (JCNH) is assumed to have significantly higher scores on all measured scales, further analysis of data involved several one-tailed t-tests. The results of independent t-tests (differences in

scale scores between JCNH and RCNH at pre-test, and at post-test) are presented in Table 13.

TABLE 13

Independent T-Test Results on Knowledge (KNSCOR), Tasks (TASKSCOR), Work Satisfaction (WSSCOR), Attitude (ATTSCOR), and Self-Esteem (SPSCOR) Scale Scores By JCNH (N=36) and RCNH (N=45)

Variable	t-value	1-tail prob.	Nursing Home	Mean	Standard Deviation
KNSCOR1**	-0.88	0.190	JCNH	14.0000	2.318
			RCNH	14.5333	3.116
KNSCOR2***	-0.02	0.491	JCNH	14.4722	3.149
			RCNH	14.4889	3.422
TASKSCOR1**	-2.41	0.019*	JCNH	7.4722	2.913
			RCNH	8.9778	2.650
TSKSCOR2***	-1.85	0.068	JCNH	8.2778	2.835
			RCNH	9.4773	2.929
WKSCOR1**	3.16	0.001*	JCNH	30.8611	4.806
			RCNH	27.2889	5.350
WKSCOR2***	3.51	0.001*	JCNH	31.4167	4.245
			RCNH	27.7111	5.251
ATTSCOR1**	1.10	0.140	JCNH	54.3056	5.951
			RCNH	52.6222	7.852
ATTSCOR2***	0.90	0.185	JCNH	55.1389	5.683
			RCNH	54.0000	5.637
SPSCOR1**	0.44	0.333	JCNH	769.1429	152.553
			RCNH	755.0714	126.204
SPSCOR2***	0.22	0.415	JCNH	785.8889	121.038
			RCNH	780.0238	117.385

* Significant t-values.
** Pre-test.
*** Post-test.

Table 13 shows that the training group (JCNH) had significantly higher average scores on the Work Satisfaction scale at the pre- and post-tests (t-value = 3.16, P = .001 and t = 3.5, P = .001, respectively). These results were in the expected direction. RCNH, on the other hand, had significantly higher average scores on Responsibility for Tasks scale on the pre-test (t = -2.41, P =.01), but statistically non-significant results on the post-test = -1.85, P = .06). The t-tests measuring differences between the two groups in the Knowledge scale and Attitude scale were not statistically significant at the pre- or post-test. Moreover, though the training group (JCNH) recorded higher average scores than the control group (RCNH) on the Self-Esteem scale at the pre- and post-tests, both t-tests yielded statistically non-significant results.

The results of paired t-tests related to each nursing home's pre-test and post-test average scores -- for Knowledge, Tasks, Work Satisfaction, Attitude, and Self-Esteem scales -- were all statistically non-significant and, therefore, not presented in this report.

IV. DISCUSSION

A comparison of background characteristics of the respondents show that both sample groups have similar characteristics with regard to sex ratios and the nature of the job. Most of the respondents who completed our questionnaires were females and were involved in direct resident care. But the two samples differed to some extent with regard to age, education, and work experience. The mean educational level and age of the control group (RCNH) were higher than the experimental group. For example, a majority of the respondents in RCNH had greater than a high school education as compared to the JCNH staff. Also, the mean age of the former group was higher (36.2 years) than that of JCNH (33.9 years). These background differences, apart from training, could perhaps have an effect on some of the measured dimensions. In terms of duration of job, the training group, on the average, was employed for a slightly longer period of time (3.8 years) as compared to the control group (3.6 years).

The question of whether or not the training contributed to the Knowledge, Tasks, Work Satisfaction, Attitude and Self-Esteem scores of the experimental group could be answered in two ways: First, through the comparison of pre-test and post-test mean scores for all these dimensions across the groups; Second, an examination of independent t-test values for the significance of results.

With regard to the first point, it was demonstrated that the training group had consistently increased scores from pre-test to post-test on all five measured scales. On the additive Knowledge scores, JCNH had an average increase of .50 whereas, RCNH had experienced a decrease of

.04 at the post-test measure. The absence of training for the latter group thus accounts for the inconsistency of results from the pre-test to the post-test.

Similarly, a comparison of mean differences between the two tests for Work Satisfaction and Responsibility for Task scores shows a marked effect of training on the JCNH staff. This group's average gain for Task scores was +.89 and for Work Satisfaction scores was +.56 as compared to that of RCNH, which was +.50 and +.42 respectively.

On the other hand, although the RCNH staff showed a higher average increase on Attitude scale (+1.37 as compared to +.83 for JCNH) and Self-Esteem scale (+24.95 as compared to +16.75 for JCNH), their pre- and post-test mean scores on both these scales were still lower than that of the JCNH staff. The lower net gains for the JCNH staff could be a function of the 'regression to the mean' (See Babbie, 1986:191, and Atherton and Klemmack, 1982:44 for this argument). Since the RCNH staff had lower scores on both these scales, their net gain could always be higher than that of JCNH staff because both of these were fixed-point scales. These results are, therefore, not surprising or even contrary to our expectations. As such this does not minimize the positive effect of training on the experimental group whose post-test results on both of these scales were reasonably substantial.

With regard to our second point, the significance of t-tests, the JCNH staff showed significantly higher Work Satisfaction at the end of training. For the control group, the significant t-value at the pre-test level (P = .01) and the lack of significant t-value at the post-test level once again proves their inconsistent results. It is

possible that the lack of training for this group contributed to such results.

The lack of significant t-test results for other scale scores is not unexperted. This could be due to the small size of our samples. As such, our failure to detect statistically significant results for other scale scores does not prove that the observed differences between pre- and post-test results of the training group were unimportant for practical purposes (See Norusis, 1986:226-227 for this argument). It has been observed that the training did make a differential between the experimental and control groups' mean scores on all measured dimensions.

V. CONCLUSION

Given the extent and nature of Alzheimer's Disease today the importance of training programs in preparing staff members for providing more efficient care to AD Afflicted residents in a nursing home setting can hardly be exaggerated. The training program organized for the JCNH staff had several desirable effects. First, their satisfaction for working with mentally impaired and demented residents improved significantly after training. Secondly, the kind of knowledge required to care for AD afflicted persons also increased. Before training, although most of the participants from JCNH showed a considerable amount of knowledge about AD, after training their knowledge level increased further. Thirdly, the proper knowledge of various Tasks and positive Attitudes toward AD afflicted residents are important prerequisites for satisfactory care. On both of these dimensions, the training group showed substantial improvement after training. Finally, an efficient caregiver must essentially have a high positive Self-Esteem. In this regard, the training group also showed improved Self-Esteem after the training.

This training program was not, however, without limitations. One of the limitations pertains to the voluntary participation in the training by the JCNH staff. For the purpose of this evaluation, this was acceptable, yet it lowered the sample size substantially. This factor also precluded the possibility of random selection of the subjects for this research. From the training point of view, all staff members involved with AD residents care should have participated in the training program without any exception. Future training programs should address

this problem and seek more cooperation from the nursing home staff. Thus, better coordination between the group responsible for training and the nursing home administrators will be essential.

A second problem essentially follows from the first one. That is, there had been some variations in the attendance of the training sessions. Some of the staff members participated in all of the sessions, but in most cases the attendance varied from one to six sessions. Since we have compared only the mean differences of pre- and post-tests related to various scale scores, the overall result might have been affected by the nature of participation. Attendance in all sessions by the training group as compared to no participation by the control group could have shown more striking differences between the two group's post-test results. Once again, future training programs' better coordination with the nursing home administrators might help solve such problems.

Finally, the question of whether or not training contributed to the observed increase in the post-test average scale scores of the JCNH staff could be more conclusively answered through a multivariate form of analysis, taking into consideration all the background (independent) variables along with training as a key independent variable. The non-random nature and small size of the sample, however, precluded any such analysis for the present study. The expansion and replication of this training program in more nursing homes may open up possibilities for more sophisticated analysis through random selection of subjects for evaluation purposes.

Despite these limitations, the overall results suggest that a training program such as this one is worth repeating and replicating in view of the urgent needs of Alzheimer's Disease afflicted persons currently residing in various nursing homes in Illinois and throughout the United States.

APPENDICES

APPENDIX 1

ALZHEIMER'S DISEASE RESEARCH DESIGN PROJECT

Jackson County Nursing Home and Southern Illinois University

KICK-OFF EXERCISE

The "Kick-Off" exercise will help our research demonstration and evaluation of the training program you will be an important part of during the next nine months. Responses are anonymous. Nowhere on the answer sheet will your name appear. However, so that we may match-up your responses today with the responses on an "Exit Replay" questionnaire at the completion of training, please write the last four (4) digits of your social security number in the space requested both on this form and on the answer sheet. The score you receive will allow you to compare your responses to the others who have participated. Please hand in both the questionnaire and the answer sheet.

Please use a soft lead pencil when marking your answer, and heavily color in the circle on the answer sheet. Your answers will be machine scored.

ID number: _ _ _ _

Sex: Female _ _ _
Male _ _ _

A. WORK AND EDUCATIONAL EXPERIENCE

1. What is your education level?

One through eight years	1
Incomplete High School	2
High school completed	3
Some college (1-3 years)	4
College graduate	5
Post-graduate study	6

2. How long have you worked at Jackson County Nursing Home?

Less than three months	1
3-6 months	2
7-12 months	3
Over one year	4

3. How long have you worked in your present position?

Less than three months	1
3-6 months	2
7-12 months	3
Over one year	4

4. What is your position?

CNA	1
Rehabilitation Aide	2
Bookkeeper	3
Activity Aide	4
Housekeeper	5
Social Service Assistant	6
Laundry Aide	7
Administrative Clerk	8
Charge Nurse	9
Supervising Nurse	10
Dietary Aide	11
Receptionist	12
Maintenance	13

5. What shift do you usually work?

Day shift	1
Evening shift	2
Night shift	3

B. KNOWLEDGE EXERCISE

The following questions review your knowledge of the aging process and experiences of caregivers. Answers will be discussed in class.

Please circle True or False for each answer.

1. Senile dementia is a normal age-related change. T F

2. A person's environment and lifestyle do not affect the speed of his/her aging process. T F

3. Some age-related changes occur in some people but not in others. T F

4. The majority of persons 65 and over do not have adequate health to live independently. T F

5. Even though there are physical changes accompanying old age, most older people are able to cope well because the changes are gradual enough that they are able to make the necessary psychological and emotional changes. T F

6. Caregiving stresses are interrelated. The effects of one stress may directly or indirectly influence all of the caregivers functioning. T F

7. The stresses of caregiving seldom cause increased health problems for the caregiver. T F

8. It is usually best to make decisions for residents without consulting them. T F

9. A caregiver's feeling about his/her own aging do determine the quality of care he/she gives to the resident. T F

10. Even though a caregiver may resent having to take care of a resident, he/she can usually hide those feelings from the resident if he/she tried hard enough. T F

11. A good relationship between an older family member and his/her caregiver can become even closer if healthy patterns of relating together are continued. T F

12. A caregiver should not try to find time for himself/herself if the residents seem to need constant attention. T F

13. It is common for caregivers to feel guilty during their caregiving experiences. T F

14. A person may age more rapidly if he/she does not have opportunities to communicate with others. T F

15. Residents will feel more secure and happier if family members or staff take complete control of their lives. T F

16. When a stroke victim cannot speak, this is usually an indication that he/she cannot understand what others say to him/her.

17. A person involved in caregiving runs a higher risk of illness unless he/she has a planned support system to fill the gaps. T F

18. Continued friendships seem to promote higher morale among persons than do ongoing family relationships. T F

19. A caregiver can give ongoing support to residents even if he/she does not receive any support. T F

20. Caregivers sometimes feel guilty about transferring certain responsibilities to family members. T F

C. RESPONSIBILITY FOR TASKS

Who do you think should be responsible for the following tasks--nursing home staff, resident's family and staff jointly, or the resident's family.

	Nursing Home	Joint	Family
21. Provide special foods (extras)	1	2	3
22. Make sure resident's room is attractive	1	2	3
23. Give birthday party for resident	1	2	3
24. Report any abuse or neglect to authorities	1	2	3

25.	Ensure that drugs/medication not covered by Medicare/medicaid are ordered	1	2	3
26.	Make a telephone accessible to resident	1	2	3
27.	File claims for resident benefits	1	2	3
28.	Transport resident to doctor	1	2	3
29.	Provide adequate supplies (kleenex, etc.)	1	2	3
30.	Launder resident's personal clothing	1	2	3
31.	Mark resident's personal clothing	1	2	3
32.	Keep resident's clothing inventory up-to-date	1	2	3
33.	Clip finger and toe nails	1	2	3
34.	Arrange for hair grooming	1	2	3
35.	Make current newspaper available	1	2	3
36.	Keep books, magazines available	1	2	3

D. WORK SATISFACTION

Please indicate the number representing the degree of satisfaction you have with the following aspects of your job. The scale is:

1= Very dissatisfied
2= Dissatisfied
3= Neutral
4= Satisfied
5= Very satisfied

37.	My pay and the amount of work I do	1	2	3	4	5
38.	The praise I get for doing a good job	1	2	3	4	5
39.	The way nursing home policies are put into practice	1	2	3	4	5
40.	The working conditions	1	2	3	4	5
41.	The way my co-workers get along with each other	1	2	3	4	5
42.	The feelings of accomplishment I get from the job	1	2	3	4	5

43. The chance to do different things from time to time 1 2 3 4 5

44. The chance to do things for other people 1 2 3 4 5

45. The chance to work with confused residents 1 2 3 4 5

Please indicate the extent to which you agree or disagree with each of the following statements. The scale is:

1= Disagree strongly
2= Disagree
3= Neutral
4= Agree
5= Agree strongly

46. I prefer working with residents who know what they want and can tell me their needs 1 2 3 4 5

47. I feel comfortable around confused residents 1 2 3 4 5

48. I think it's fun working with mentally and memory impaired residents 1 2 3 4 5

49. I don't think most of the residents can do much for themselves 1 2 3 4 5

50. I would rather do things myself than wait for help 1 2 3 4 5

51. I don't think that the resident's families want to do very much for them 1 2 3 4 5

52. I think that the resident's families are usually more trouble than help 1 2 3 4 5

53. I believe that I can influence the way residents behave 1 2 3 4 5

54. The residents are so confused that it really doesn't matter what you say because they will forget it anyway 1 2 3 4 5

55. I think it's possible to coordinate staff to work with residents in a planned way 1 2 3 4 5

56. I think it's best to tell the residents what they want to hear, even if it's not the truth 1 2 3 4 5

57. I don't feel that my work is appreciated as much as it should be 1 2 3 4 5

58.	I don't think that improvements can be made to improve residents living condition	1	2	3	4	5
59.	I think that it is important to treat the residents as individuals	1	2	3	4	5
60.	I think the research belongs in schoolbooks, not in the workplace	1	2	3	4	5

Thank you very much for your cooperation.

APPENDIX 2

SOCIAL SECURITY#_ _ _ _
(LAST 4 DIGITS)

SLIDING PERSON MEASURE

SAMPLE EXERCISE

Look at the line below. Think of yourself as person A. Pretend the line below is a scale from 0 to 10. The ☆ is zero or poor, and the person figure is 10 or perfect.

Now put your pencil at the ☆ and move it along just above the line. Stop at the point which shows how close you are now to being Person A. Mark that point on your line with an X.

Go ahead. Draw your ine and mark an "X" on the line below it.

☆ _____

Now try this example. When I wake from sleep in the morning, it helps me to get my day started right if I have a cup of coffee.

☆ _____

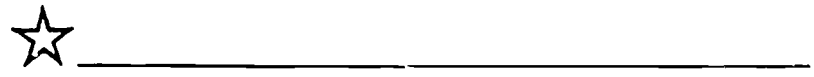
Produced for the Alzheimer's Disease Afflicted Project with the Jackson County Nursing Home and the Division of Continuing Education, Southern Illinois University at Carbondale.

Please answer all of the following items in the same way as you did on the other page. That is, for each statement, draw a line, starting at the star and stopping at the point which shows how close you are to being as you would like to be for that statement. Mark with an "X" the end point of each line that you draw.

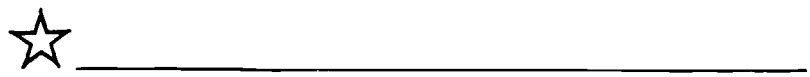
When working with residents, show how you view yourself concerning the <u>care</u> you give.

When caring for residents, show how you view yourself concerning how <u>responsible</u> you are.

Show your view of yourself when you think of how your <u>fellow workers</u> regard the <u>quality</u> of your work.

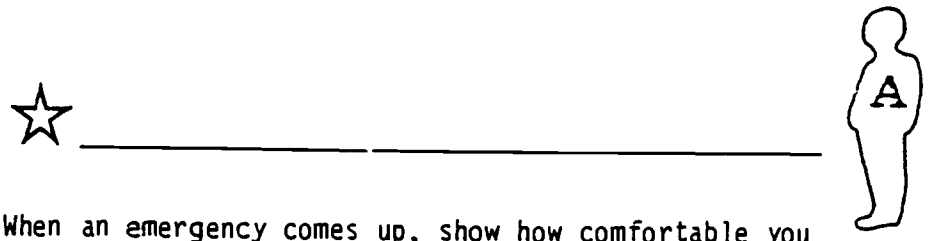


When you work with residents, show your view of yourself concerning how <u>good</u> of a <u>job</u> you are doing.

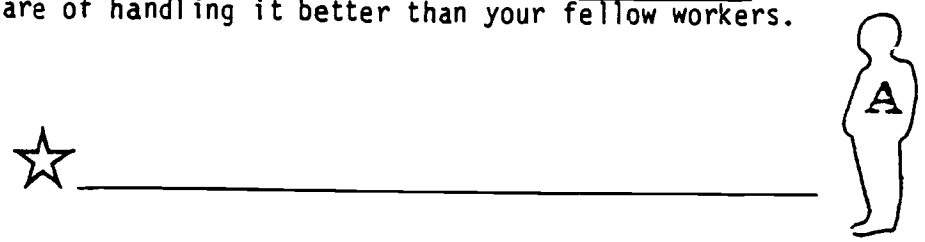


When you give care to residents, you <u>feel</u> that you know all that you need to know.

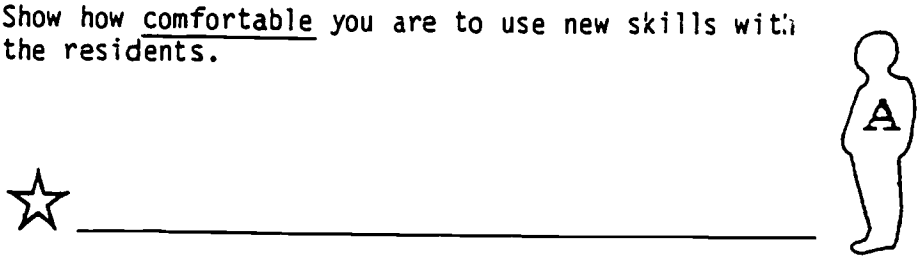
When residents have needs and show unusual behavior, show how you <u>feel</u> about handling the situation effectively.



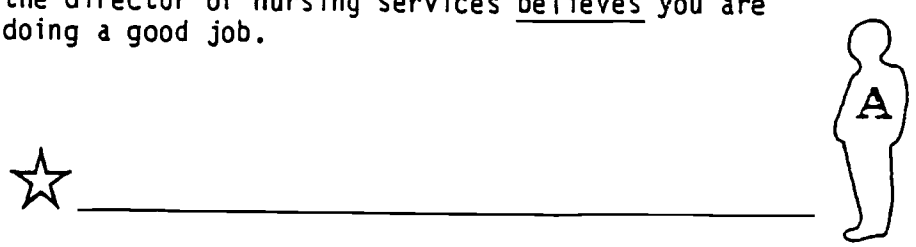
When an emergency comes up, show how <u>comfortable</u> you are of handling it better than your <u>fellow workers</u>.



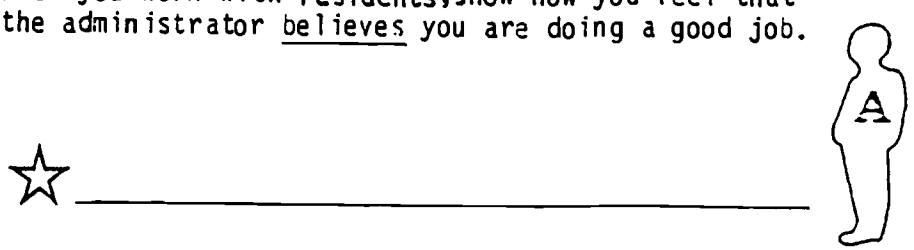
Show how <u>comfortable</u> you are to use new skills with the residents.



When you work with residents, show how you feel that the director of nursing services <u>believes</u> you are doing a good job.



When you work with residents, show how you feel that the administrator <u>believes</u> you are doing a good job.



What is your job title? _____

How long have you worked on this job? _____

Your age? _____

Sex F___ M ___

APPENDIX 3

(abbreviated names are shown in the left column for each item)

DEM =Senile dementia is a normal age-related change.

LIFE =A person's environment and lifestyle do not affect the speed of his/her aging process.

SOME =Some age-related changes occur in some people but not in others.

DEP =The majority of persons 65 and over do not have adequate health to live independently.

COPE =Even though there are physical changes accompanying old age, most older people are able to cope well because the changes are gradual enough that they are able to make the necessary psychological and emotional changes.

STRESS=Caregiving stresses are interrelated. The effects of one stress may directly or indirectly influence all of the caregivers functioning.

CGSTR =The stresses of caregiving seldom cause increased health problems for the caregiver.

DEC =It is usually best to make decisions for residents without consulting them.

QUAL =A caregiver's feelings about his/her own aging do determine the quality of care he/she gives to the resident.

HIDE =Even though a caregiver may resent having to take care of a resident, he/she can usually hide those feelings from the resident of he/she tries hard enough.

GDREL =A good relationship between an older family member and his/her caregiver can become even closer if healthy patterns of relating together are continued.

SELF =A caregiver should not try to find time for himself/herself if the residents seem to need constant attention.

GUILT =It is common for caregivers to feel guilty during their caregiving experiences.

RAPID =A person may age more rapidly of he/she does not have opportunities to communicate with others.

RESHAP=Residents will feel more secure and happier if family members or staff take complete control of their lives.

NOTALK=When a stroke victim cannot speak, this is usually an indication that he/she cannot understand what others say to him/her.

CGILL = A person involved in caregiving runs a higher risk of illness unless he/she has a planned support system to fill the gaps.

FRSP = Continued friendship seem to promote higher morale among persons than do ongoing family relationships.

CGSUP = A caregiver can give ongoing support to residents even if he/she does not receive any support.

RESPON = Caregivers sometimes feel guilty about transferring certain responsibilities to family members.

APPENDIX 4

RESPONSIBILITY FOR TASKS

(Abbreviated variable names are shown in left column for each item)

XFOOD = Provide special foods (extras)

ROOM = Make sure resident's room is attractive

BPARTY = Give birthday party for resident

REPORT = Report any abuse or neglect to authorities

DRUGS = Ensure that drugs/medication not covered by Medicare/medicaid are ordered

PHONE = Make a telephone accessible to resident

CLAIMS = File claims for resident to doctor

TRANS = Transport resident to doctor

SUPP = Provide adequate supplies (kleenex, etc.)

WASH = Launder resider 's personal clothing

MARK = Mark resident's personal clothing

CLOTH = Keep resident's clothing inventory up-to-date

CLIP = Clip finger and toe nails

HAIR = Arrange for hair grooming

NEWS = Make current newspaper available

READ = Keep books, magazines available

APPENDIX 5

WORK SATISFACTION

(abbreviated variable names are shown in left column for each item)

PAY = My pay and the amount of work I do

PRAISE = The praise I get for doing a good job

POLICY = The way nursing home policies are put into practice

WKCONO = The working conditions

COWK = The way my co-worker get along with each other

WKSAT = The feelings of accomplishment I get from the job

WKVAR = The chance to do different things from time to time

OTHERS = The chance to do things for other people

CONFUS = The chance to work with confused residents

APPENOIX 6

ATTITUDE TOWARDS ALZHEIMER'S RESIDENTS

(abbrc iated variable names are shown in left column for each item)

NOCONF = I prefer working with residents who know what they want and can tell me their needs.

OKCONF = I feel comfortable around confused residents.

OKMNTL = I think it's rewarding working with mentally and memory impaired residents.

OTHLP = I don't think most of the residents can do much for themselves.

MYSELF = I would rather do things myself than wait for help.

FAM = I don't think that the resident's families want to do very much for them.

TRBL = I think that the resident's families are usually more trouble than help.

IHELP = I believe that I can influence the way residents behave.

FORGET = The residents are so confused that it really doesn't matter what you say because they will forget it anyway.

STAFF = I think it's possible to coordinate staff to work with resident's in a planned way.

HEAR = I think it's best to tell the residents what they want to hear, even if it's not the truth.

APPR = I don't feel that my work is appreciated as much as it should be.

LVCOND = I don't think that improvements can be made to improve residents living condition.

TREAT = I think that it is important to treat the residents as individuals.

RESRCH = I think the research belongs in schoolbooks, not in the workplace.

SLIDING PERSON MEASURE

(abbreviated variable names are shown in left column for each item)

CARE = When working with residents, show how you view yourself concerning the care you give.

RESP = When caring for residents, show how you view yourself concerning how responsible you are.

FELLOW = Show your view of yourself when you think of how your fellow workers regard the quality of your work.

YRSELF = When you work with residents, show your view of yourself concerning how good of a job you are doing.

KNOW = When you give care to residents, you feel that you know all that you need to know.

BHRS = When residents have needs and show unusual behavior, show how you feel about handling the situation effectively.

EMG = When ar emergency comes up, show how comfortable you are of handling it better than your fellow workers.

NEW = Show how comfortable you are to use new skills with the residents.

DIRECT = When you work with residents, show how you feel that the director of nursing services believes you are doing a good job.

ADMIN = When you work with patients, show how you feel that the administrator believes you are doing a good job.

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