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A COMPARISON OF NURSE AND PATIENT SATISFACTION WITH POSTPARTUM CARE IN THE TRADITIONAL MATERNITY SETTING VERSUS THE HOME CARE SETTING

by

Christine A. Donica

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Nursing
Madonna University
1996

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Approved for content by:

Mary Wawrzynski, Ph.D., RN
Thesis Advisor

April 26, 1996
date

Mary G. Mutsch
Second Reader

4/26/96
date

Approved for format by:

Edith A. Raleigh
Coordinator of Nursing Research

April 24, 1996
date

Abstract

A Comparison of Nurse and Patient Satisfaction with Postpartum Care in the Traditional Maternity Setting Versus the Home Care Setting

by

Christine A. Donica

The practice of early obstetrical discharge is being re-examined. Parents and pediatricians are asking the United States' Senate to consider the passage of a law for a minimum length of postpartum hospital stay. There is added pressure on the maternity nurse to provide quality care when a shorter length of stay is routine. The purpose of this study was to compare patient and nurse satisfaction between the traditional obstetrical setting versus the home care setting. The Rice model (1992) of dynamic self-determination was used as the conceptual model of home care for this nonexperimental descriptive study. Sixty obstetrical registered nurses and 124 postpartum patients were surveyed in the home care and traditional maternity care setting. Results indicate that there was no significant difference in satisfaction between nurses in either setting; however, home care patients were more satisfied than patients in a traditional setting. A professional standard of postpartum care should be considered.

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CHAPTER ONE

Statement of the Problem

General Background

Home care is today's fastest growing area of nursing and consumer health care service. Few predicted this trend; however, the increased emphasis on early discharge, cost containment issues, and the advances in technology have ignited this area of health care reform. In addition, consumers are demanding more knowledge about their care, are taking more responsibility for their care, and are insisting on improvements in delivery of health care services. One such area expected to expand is in maternal-child health.

In 1880, the first home care agencies were established. Home care can be defined as providing health services in the patients' place of residence for promoting client and family education. Home care is also given for preventing illness, restoring and treating disease, giving care to relieve or reduce discomfort, and for providing rehabilitative measures.

The most predominant of the professional home care services is nursing. Other services included are physical, occupational, speech, and respiratory therapy. Nutritional counseling, social work, and psychological support are other professional services included when needed. It is the nurse who coordinates the discharge plan. She/he identifies and arranges the support services and makes referrals as necessary, while keeping in touch with the physician

regarding the treatment plan.

Home care team members may also include home health aides, chore workers, sitters, and companions. They provide personal care and household support services that assist in preventing the need for costly hospitalization and/or nursing home placement.

The main focus of home care is to encourage client and family independence through teaching health education and self-care. Problems that need to be identified by the nurse may be related to life style, safety, environment, family dynamics, and health care practices (Potter & Perry, 1995).

In 1963, according to National Association for Home Care (NAHC) there were some 1,100 home care agencies in the United States. By 1993, the number grew to 13,951 (Andreola & O'Neill, 1994). Two events accounted for the increase. The first was the enactment of Medicare in 1965, in which services were provided to the elderly and later, in 1973 younger patients with disabilities were added to the program. The second one was the establishment of the Diagnosis-Related Group(DRG) system (Andreola & O'Neill, 1994).

Third party payers are attempting to reduce their costs by reducing time spent in the hospital. The DRG system provides hospitals with an incentive to control costs. If hospitals can provide the needed services for less than the predetermined rate, they get to keep the difference. If the actual costs exceed the average allowed amount it also puts the health care facility at risk, they have to absorb the

difference (Cohen, Kenner, & Hollingsworth, 1991).

According to Goodwin (1994), health care reform in the United States identifies home care as a cost-effective alternative to hospitalization and proposes full payment or 80% insurance coverage for all individuals. Reasons for the reform surge are new legislation, an increase in Medicaid and Medicare reimbursement, HMOs, recognition of cost benefits, more availability of services, advances in technology, and a preference for home care by the consumer (patient), as an alternative to hospital admission (Humphrey, 1988).

Since the early 1990s, the number of home care agencies has grown rapidly. The elderly make up about half of the home care patient population. Patients with AIDS also comprise a large number of the home care clientele. This trend is expected to increase dramatically for other patients in the near future. Growth and expansion will be especially evident in the perinatal nursing specialty which includes both the antepartum and postpartum periods of the maternity cycle.

Specific Background

Since 1950, early discharge (short stay) obstetrical programs were developed in response to hospital bed and staff shortages. Several other benefits have been realized as a result of this trend. Consumers applied pressure for an alternative service. Some families did not have health insurance and requested this choice because they could save

money. Fathers wanted to be more involved in infant care with their babies. It was an alternative to home birth. In addition, early discharge could lessen exposure to pathogens (Rush & Valaitis, 1992). There was also a renewed belief in the value of breastfeeding and early discharge reduced the incidence of imposed artificial schedules of feeding. Lastly, this was a way to decrease disruption to the family. There is decreased stress placed on the family system when a woman and her newborn are able to remain at home, rather than be separated from their support system because of hospitalization (DeVore, 1990).

Today, giving birth is viewed as a normal, healthy process; therefore, early discharge from the hospital is the norm, ranging from 12 to 48 hours postpartum for uncomplicated vaginal deliveries and healthy newborns. New mothers are expected to leave the hospital, take care of themselves, take care of their babies, and assume household responsibilities earlier than ever before (Ruchola & Halstead, 1994). The practice of early discharge of mothers and babies has demonstrated not only cost savings and improved outcomes, but has enhanced the support and educational needs of new families through nurses visiting in the patient's home (Evans, 1991).

Early discharge of uncomplicated vaginal delivery patients has been shown to be successful and not to increase the hospital re-admission rate of mother and/or baby (Williams, 1989; Berryman & Rhodes, 1991; Gonzalves & Hardin,

1993; Frank, 1994). Now, the focus is to increase and expand home care to patients to prevent preterm labor and low-risk and low-birth weight infants and to manage pregnancy induced hypertension (PIH) and expectant mothers with diabetes.

Because these patients may have significant risks or complications, nurses must have experience in perinatal nursing and be able to function independently. They need excellent clinical judgement and technical skills. In the area of women's health and childbearing, especially with high-risk child-bearing families, this is important because undergraduate curricula cover very little of this content (Sherwen, 1995). In fact, Brooten et al. (1988) recommend a model using a masters-prepared nurse specialist for reasons of both quality and cost since it decreases the variability in preparation (Diploma, A.D.N., B.S.N.) of the nurse generalist.

The acuity level of the client's condition is increasing and the role of the home-care nurse is expanding (Dineen, 1992). The home health nurse administrator must be aware of several factors in order to provide safe and quality health care to new mothers and their infants. First, referrals and follow-up home visits need to be established soon after discharge from the hospital because early contact of the nurse with the new mother and baby is essential for successful home care visits.

Second, specialized reimbursement functions must be understood. Each third party payer will have its own rules,

exceptions, qualifiers, and exclusions (Goodwin, 1994). Currently, many HMOs and other managed care plans are paying for only 24 hours in the hospital after a routine vaginal birth and 72 hours after a Cesarean, according to the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics (ACOG, 1994; AAP, 1995).

Recently, early postpartum discharge has renewed the debate regarding length of maternity stay across the United States between physicians, parents, and insurance companies. Three states, New Jersey, Maryland, and North Carolina passed laws in 1995 which require health care plans to cover minimum stays in the hospital. Women who have had a vaginal birth would stay two nights and women who have had a Cesarean would stay four nights (Smock, 1995). Eleven other states have similar laws pending. Currently, Michigan has not passed such a law. The United States' Senate is basing a postpartum hospital stay law on joint recommendations by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. Health care plans that would allow women to go home earlier with permission of their doctor and at their own request would be exempt from the mandatory length of stay law if their health care programs provided home nursing visits for mothers and their newborns (Smock, 1995).

Third, the nurse administrator should be aware that the "scope of practice" must be agreed on by the supervisor, employee, and patient. Home health care nurses may find

themselves in situations where the patient or family may request assistance or services beyond the defined nursing responsibility of taking care of the mother and her newborn.

Fourth, because one third of the home health nurses' time is spent in documentation of care given and recording of supplies used, streamlining this area is important to improve nurse satisfaction and efficiency. Ways of improving this process may include using standardized forms and the use of portable computers. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) approves credentialing through the home care documentation process. They do not accompany nurses on their home visits.

Fifth, continuous quality patient outcomes is the overall goal of home health care services. According to Buck (1988), these outcome criteria need to evaluate three things. First, can the client understand and follow through with the nurse's teaching? Next, does the client comply with the nurse's teaching? Lastly, has the change in her behavior improved her health status and that of her infant? Care needs to be evaluated, deficiencies identified and corrected, and competence rewarded. Documentation of what nurses accomplish rather than simply what they can do is important since home care consists of nursing care.

Statement of Purpose

The purpose of this study was to assess nurse and patient satisfaction in perinatal home health nursing

compared with the traditional hospital delivery care system in obstetrics.

The specific research questions investigated by this study are:

1) Are there differences in levels of job satisfaction between nurses working in perinatal home health care and those of the traditional hospital setting in obstetrics?

2) Are there differences in levels of care satisfaction between patients receiving perinatal home health care nursing and those in the traditional hospital care system in obstetrics?

CHAPTER TWO

Literature Review

A review of the literature begins with the changing role that the hospital maternity nurse has undergone. Next, a new mother's ability to absorb information about her own care and that of her infant will be reviewed. In addition, nurses are trying to achieve in a few hours or in a day the amount of care and education given years ago which generates implications for the caregiver now that a shorter length of stay is routine. This places added pressure on the nurse who is responsible and accountable for maternity nursing care. The effects of job stress/satisfaction on the maternity nurse needs to be studied. A few studies have been done on job satisfaction of home care nurses. If home care of the perinatal patient is the future, then nurse job satisfaction for this group needs to be studied.

Finally, the practice of early obstetrical discharge is being re-examined. In the United States, 24% of infants are discharged within 24 hours of birth (Sinai, Kim, Casey, & Pinto-Martin, 1995). Health care providers, who are not always comfortable with the short stay protocol, have labeled it "drive through deliveries." The United States' Senate is considering the passage of a law which would require a 48 hour postpartum hospital stay for mothers who had an uncomplicated vaginal delivery. An alternative to the practice of early discharge would be to provide all mothers

with home nursing visits. The visits would provide the medical follow-up, psychological support, and the teaching needs of the client with her infant at home. Patient satisfaction in the hospital, with early discharge, and with postpartum home care, needs to be studied. The purpose of this study is to assess patient and nurse satisfaction between the traditional obstetrical setting and the home health care setting.

Changing Role of the Maternity Nurse

In the 1960s the postpartum nurse's job was considered custodial (Lukacs, 1991). Reva Rubin changed that thinking by describing the phases of maternal role development (Ament, 1990). She helped to expand the maternity nurse's body of knowledge. The postpartum period includes not only physiologic changes but emotional ones as well.

Beginning in the 1960s various childbirth preparation methods evolved. Dick-Read (1959) emphasized relaxation and breathing exercises as the main focus of the natural childbirth movement. Nurses needed to become familiar with these techniques in order to assist the laboring mother.

During the 1970s a new philosophy of maternity care emphasized a family-centered environment. This philosophy of care emphasized more patient freedom and placed less emphasis on structure and routine. Dr. Robert Bradley (1981), further assisted the childbirth preparation method. He included coaches, mostly fathers, to be involved with the mother

during the labor and delivery. Touch was an important aspect of support. A recent study by Weaver (1990) concluded that touch conveyed sensitivity to the client's needs for comfort, pain relief, and alleviation of fear and anxiety. The nurse assesses the mother's behavior by examining her responses to the coach's suggestions.

When the same nurse became responsible for both the mother and the baby, that is, couplet care, the maternity nursing role expanded care and made it more family centered. Teaching during the postpartum period became an important part of nursing care (Lukacs, 1991). More emphasis was placed on the mother's self-care and overall care of her newborn. Later, the importance of breastfeeding and its benefits to the infant began re-emerging. Awareness of parental attachment development was also part of the nurse's assessment.

In the 1980s another type of maternity service was offered. Labor, delivery, recovery, and postpartum (LDRP) rooms emerged (Lukacs, 1991). Nurses became responsible to the family during the labor and delivery plus postpartum. The nurse was well educated in all aspects of the childbearing year and used nursing diagnosis to provide care during the intrapartum, postpartum, and newborn stage. In many hospitals the nurse began to have earlier contact with the expectant parents in an educational setting teaching childbirth preparation classes.

With the decreased length of stay of the 1990s and

additional accountability, the nurse has a limited amount of time to carry out the responsibilities that he/she must be prepared to perform. The low risk pregnant, laboring, and postpartum mother is usually considered well and does not have the more involved problems of today's hospital patients; however, the nurse realizes that the woman's needs have important implications for individual and family development (Lukacs, 1991).

Cognitive Deficits and Readiness to Learn

In 1967, nurse researcher, Reva Rubin, published her classic study on the phases that new mothers experience during the postpartum period. This research is still applicable today; however, women go through these stages at a slightly faster rate due to their age and parity (Ament, 1990). The taking-in phase (passive and dependent) during the first 24 hours after birth, is not a time period that is conducive to learning (Ament, 1990). Nursing activities need to be planned around the woman's need for rest and physiologic recovery. The taking-hold phase (independent and autonomous) that follows is a better time to teach (Ament, 1990).

A recent study by Eidelamn, Hoffmann, and Kaitz (1993) was conducted to examine cognitive function of postpartum mothers on the days following delivery. One hundred mothers who had an uncomplicated pregnancy, labor, and delivery, and who delivered normal full-term infants participated. The new

mothers were tested with standardized neuropsychological tests, the Wechsler Logical Memory Test and the Wechsler Visual Reproduction Test. Reliability and validity information on these instruments was not given. The new mothers' results were compared with those of nonpregnant childless women, third trimester high-risk pregnant women, and fathers of newborns. Exclusion criteria included use of any anesthesia during childbirth or sedative or analgesic medication after the delivery.

Postpartum women scored significantly lower than nonpregnant women on both tests on the first postpartum day. The deficit was temporary and not present on the second or third postpartum day. Interestingly, the use of intrapartum analgesia lessened the cognitive deficit. A study by Robin (1962) indicated poor cognitive functioning on the eighth postpartum day. Treadway, Kane, Jarrahi-Zadeh, and Lipton, (1969) noted poor cognitive thought processes on the third day. In contrast, four other studies (Freedman, Redlich, Eron, & Jackson, 1952; Jarrahi-Zadeh, Kane, Van Decastif, Lachenbruch, & Ewing 1969; Yalom, Lunde, Moos, & Nambur 1968; Rofe & Algom, 1985) failed to document any changes in cognitive function despite subjective reports of mothers and reports of medical caregivers.

According to Eidelman, Hoffman, and Kaitz (1993), results of this study strongly support that the observed cognitive effect is not a side effect of the narcotic medication but rather it is due to the stress of labor and

delivery. The stress effect results from the combination of physical exertion, fatigue, physiological changes, and emotional responses. This results in the cognitive deficit.

Job Stress of the Maternity Nurse

A small pilot study done by Lukacs (1991) using telephone interviews was conducted with 12 postpartum nurses and nurse managers to determine how decreased length of stay (LOS) influenced postpartum nursing. This group represented a variety of maternity services from birth centers to traditional facilities. They ranged from 600 deliveries a year to 10,000 deliveries per year. They included a variety of geographic areas including Minnesota, southern Florida, Pennsylvania, Massachusetts, New Jersey, Delaware, and Rhode Island. Five questions were asked of each participant. First, how do you feel about decreased length of stay? The nurses and managers responded that they felt frustrated in trying to provide the care patients need. Second, has the patient's plan of care been altered due to the decreased length of stay? Most of the nurses and managers stated that they continued with the plan of care, a few deleted some interventions. Third, what is the cause of the decreased length of stay? All of the nurses and managers believed that insurance companies were responsible for this. Fourth, are new mothers ready to go when discharged? They responded no, citing the mothers' fatigue level. The nurses also reported that they felt like "villains." Finally, what solutions do

you have for the future? The suggestions were to improve prenatal education programs, develop written instructions for mothers to take home, establish a home health visiting program, do follow-up phone calls, and have support groups for patients.

In an Australian study by Cross and Fallon (1985) a range of personal and professional stressors across four nursing specialty groups (critical care, surgical, medical, and obstetric) were investigated. The obstetric group was comprised of a total of 25 nurses; one neonatal intensive care nurse, eight from labor and delivery, four from the antepartum unit, nine from postpartum, and three from the nursery. The instrument, developed by Bailey (1980) identified seven main categories. A total of 44 different items described a range of stress situations that could occur for the nurse. For example, the categories were management of the unit, interpersonal relationships, patient care, knowledge and skills, work environment, life events, and administrative rewards. One additional item was added under the patient care category dealing with the patient's relatives. MANCOVA analyses indicated significant differences among the four nursing groups. The four more frequent professional stressors reported for all the groups, including the obstetric area, were inadequate staffing, interruptions, paperwork, and dealing with uncooperative patients. The personal stress for the obstetric nurse that was the hardest to deal with was the death of a patient

and/or her infant.

Studies of Nurse Satisfaction in Home Health Care

An ethnographic research study (data were gathered by participant observation) was conducted by Chubon (1991). The author spent 300 hours observing and interviewing 25 home care nurses while on home visits and in the office. There was no reliability and validity information given. Some worked for a hospital-based home care program and some worked for a statewide home care agency. The author reported that nurses liked the independence and autonomy of their practice. Another source of satisfaction was the rapport they developed with the patients and their families. In describing their job stress, the nurses talked about the frustration of dealing with a health care system that was inflexible, inadequate to meet patient's needs and sometimes erratic. Peer support was also important to them.

Research done by Shuster (1992) examined job satisfaction in home health care using the Atwood and Hinshaw Nursing Job Satisfaction Scale (NJS). This too is intended for use with professional nurses in both inpatient and outpatient settings. In this study, a nonexperimental, cross-sectional design was used to collect information from a sample of 129 nurses drawn from the staffs of 24 urban and rural home health care agencies in a southwestern state. Internal reliability (Cronbach's alpha) was .85. The results of this study indicated that the amount of direct patient

care during the clinical day is the most important source of job satisfaction for home health care nurses, whether the agency was profit or nonprofit. Paperwork was cited as a source of frustration for home health care nurses. Follow-up visits were related to increased job satisfaction, whereas initial home visits were related to decreased job satisfaction because of the additional paperwork to open a case. Home health care nurses liked the autonomy and a practice setting that encouraged teaching and positive interaction, not only with the patient, but with his or her family.

In another study Riordan (1991) conducted research that examined dimensions of job satisfaction of community-based nurses (community health, school health, and home health nurses). The sample consisted of 104 staff nurses from three midwestern cities in the United States. Names were randomly selected from State Board of Nursing computer lists of registered nurses. Two survey instruments with a Likert scale of five categories of agreement or disagreement were used to measure dimensions of job satisfaction. The Index of Job Satisfaction (IJS) by Brayfield and Rothe (1951) is a self-report scale of 18 items that measure overall aspects of job satisfaction. The reliability coefficient of this scale using the Spearman-Brown technique was reported as .87. The Staff Satisfaction Scale (SSS) by Hall, VonEndt, and Parker (1970) was developed specifically for measuring nurse job satisfaction with 41 items under six subscales. The

subscales were as follows: task requirements, organizational requirements, social interaction, pay, autonomy, and prestige. The authors reported a strong positive relationship between job satisfaction and prestige (perception of overall importance of one's position). Three other factors (autonomy, organizational requirements, and social interaction) resulted in moderately positive relationships. This finding is consistent with several studies (Blegan & Mueller, 1987; Cronin-Stubbs, 1977; Munro, 1983; Slavitt, Stamps, Piedmeont, & Haase, 1978) that suggest that status and recognition by supervisors and/or nursing administration lead to nurse's work satisfaction.

Women's Satisfaction with Hospital Maternity Care

Sequin, Therrien, Champagne, and Larouche (1989) conducted a large study in Montreal, Canada with 938 women. The new mothers were mailed a questionnaire 4 to 6 months after they delivered. Using factor analysis, five dimensions of women's satisfaction were studied: the delivery itself, medical care, nursing care, information received and participation in the decision-making process, and physical aspects of the labor and delivery rooms. Items related to the delivery process such as pain intensity, complications, and length of labor were the most important aspects of the delivery experience itself. Delivery is a personal experience the evaluation of which is related to the women's individual expectations. Reliability of each scale was

assessed with Cronbach's alpha except in the case of one scale having two items, then Kendall's tau-B coefficient was used. There was a 68.2% satisfaction rate with the aspects of delivery. Participation in the decision-making process was the important component of satisfaction with medical care at 83.2%. Information received was the major component of satisfaction with nursing care at 90.1%. Participation and explanations rated 81.2%. Lastly, the physical environment did not affect women's satisfaction with obstetric care, at 87%, as much as the other factors.

Alexander, Sandridge, and Moore (1993) examined patient's satisfaction with aspects of their hospital experiences and maternal satisfaction with both newborn and postpartum care. They used a convenience sample of 152 subjects from The University of Texas Medical Branch. Three data collection instruments were used: Maternal Demographic and Background Data Record (MDR), Maternity Services Assessment Questionnaire (MSAQ), and Patient Satisfaction with Maternity Services Instrument (PSI). The clinical nurse specialist developed the 50-item MSAQ instrument. Cronbach's alpha coefficient of reliability was .99. The PSI was a 25-item instrument with a five-point Likert scale. Three subscales included technical-professional factors, the trusting relationship, and the education relationship. Alpha coefficients of reliability for each of the subscales averaged between .78 and .88.

The postpartum women indicated high satisfaction with

the nursing staff with respect to answering their questions, providing personalized care, and maintaining their privacy. They were highly satisfied that the nurses were pleasant and they understood their feelings, and provided information in preparing moms for hospital discharge with the baby. The areas representing levels of dissatisfaction among subjects were: the food, the tray being quickly taken away after a meal, not knowing the nurse's name, not allowing enough visiting time for family and friends, and the call light not being answered promptly. The mothers also thought the nurses could have given them more information about rooming-in options and how to use the emergency button in the bathroom.

A Study of Nursing Behaviors that Predict Patient Satisfaction

A study to understand the difference between consumer expectations and actual experiences was done by Bader (1988). A 250 bed nonprofit hospital was used. Data were collected by convenience sampling from 50 patients hospitalized on one of three medical-surgical units. The questionnaire used was The Patient Satisfaction Instrument by Risser (1975). It consisted of 25 items with three subscales, that measure the patient's attitude toward nursing care. A five-point Likert scale was used. The investigator added three items to the PSI: (a) how satisfied he/she was with the nursing care received during the current hospitalization; (b) if he/she would return to this hospital if it became necessary; and (c)

if he/she would recommend this hospital to family or friends.

The results suggested that as patients desire more information about themselves, they also want to take a more active role in their own care. This desire for information is congruent with findings by Mangen and Griffin (1982), Oberst (1984), Leke (1978), Gil (1984), and Shields (1978). Some studies support that the personal characteristics of the nurse, such as interpersonal skills, friendliness, and helpfulness, were important to patient satisfaction; however, according to findings by Leke (1978), Larson (1984), and Robinson (1978), when a patient was acutely ill, technical care was more important. The results of this study by Bader (1988) suggest satisfaction with nursing care would increase if emphasis were placed on satisfying emotional and psychological needs of patients.

The Largest and Most Current Study of Early Postpartum Discharge

In the early 1990s, pediatricians and parents had increasing concerns about the practice of early discharge. This led to the development of a study in New Hampshire (Frank, 1994). All 26 hospitals in the state participated which included 15,000 babies. Dr. Judith Frank, a neonatolgist from Dartmouth University, lead the research. Twenty-four percent of the babies born were qualified to be discharged early. There was a 50% increased risk rate of readmission (early discharge is considered a potential

complication) and a 70% increased risk rate in emergency room visits of the babies when discharged under 48 hours; however, the actual numbers demonstrated that 1.6% of the babies were readmitted and 2.04% were seen in the emergency room. These low numbers demonstrate the safety of the practice along with cost savings ($7.4 million a year) to third party payers (Frank, 1994).

Due to patient and doctor dissatisfaction with early discharge, United States Senators Bradley and Kassebaum have introduced a bill for consideration of a standardized postpartum plan (Smock, 1995). The bill calls for a minimum of a 48 hour stay for an uncomplicated vaginal delivery. The patient, family, and the doctor should decide when to be discharged not the insurance companies. The money spent ($183,000) during the study on readmission could support visiting nurse home care follow-up and should be supported by third party payers (Frank, 1994).

Studies of Early Postpartum Discharge and Follow-Up Home Care

Norr and Nacion (1987) reviewed all postpartum early discharge program outcomes in the United States published between 1960 and 1985. They concluded that discharge under 48 hours has generally been safe for mothers and infants. The types and levels of morbidity did not differ from those who experienced longer hospital stays. Infant readmissions were higher than maternal readmissions. The major infant morbidity was hyperbilirubinemia. Differences in the rate of

infant problems reported on this in the literature ranged from 7.8% to 41%. This difference is believed to be attributable to variations in the ranges or degrees of hyperbilirubinemia. Nearly all reported outcomes were for programs with extensive prenatal preparation and postpartum follow-up. These programs served the middle-class populations. Patient satisfaction with this philosophy of care was not studied.

A study by Jansson (1988) reported increased patient satisfaction with the early discharge programs. Decreased family disruption and the rapid return to a familiar environment were the two reasons most often given for increased patient satisfaction. Two military studies, Berryman and Rhodes (1991) and Gonzalves and Hardin (1993), reported that cost effectiveness, safety, and patient satisfaction were demonstrated with early discharge programs as long as patients had uncomplicated vaginal deliveries and attended the educational programs. The unexpected outcome was the increased availability of bed space for an increase in gynecological procedures and improved use of personnel. Carr and Walton (1982) and Hemmer (1987) emphasized that a strong patient education program must accompany an early discharge program.

In Vancouver, British Columbia a study of pregnant women was conducted by Carty and Bradley (1990). One hundred thirty one women at 37 weeks gestation who were expecting a vaginal birth were randomly assigned to one of three

postpartum hospital discharge times. Depending on the group assignment, the women received from one to five home visits by an experienced maternity nurse during the first 10 days postpartum. The group who were discharged the soonest received five postpartum visits on days 1,2,3,5, and 10. Those in the group who stayed in the hospital for 4 days received only one visit on day 10. Maternal and infant morbidity were low regardless of discharge time. Hellman, Kohl, and Palmer (1962) reported readmissions were higher in the early discharge group then in the control group. This contradicts a study by Jones, Miller, and Yanover (1976) who reported no hospitalizations. The results of the Canadian study indicated that women who were discharged earliest reported being more satisfied with nursing care than those who were discharged later. Other benefits from this study were that more early discharge mothers were breastfeeding without supplement than those mothers discharged later. Those hospitalized longer scored higher on measures of depression and lower on scores of confidence in their mothering skills.

This nurse researcher believes that nurse administrators need to develop policies/programs that will improve job satisfaction for the nurses and patient satisfaction for the consumers. Maternity nurses have expressed frustration about the practice of early discharge. They are not convinced that the literature supports that patients are satisfied with this practice. Fatigue is an important factor in not wanting to

go home. Having to be totally responsible for an infant's care can be anxiety producing without a knowledgeable support system. Since early discharge programs have been recognized as safe, they will continue to be a part of maternity care. Home visits are a way of accomplishing quality maternity care.

With the rapid growth in the number of home health care agencies, discovering the factors that will encourage and retain nurses is important. One major source of their satisfaction is autonomy and direct patient care. By improving job satisfaction, turnover will be reduced. This has important economic implications for nurse administrators of home health care agencies which have small nursing staffs.

Meeting customer expectations and providing quality care will continue to be important to any agency large or small in improving patient satisfaction. It is through improving satisfaction that progress of the organization can be measured.

Theoretical Framework

The Rice model (1992) of dynamic self-determination is used as a framework for the perinatal home health nursing care system. The goal of this model is for patients to manage their health care needs successfully in the home in order to achieve optimal health, or a state of well-being, and interpersonal harmony. Patients try to bridge the gap between need and attainment of a goal. The nurse-patient

relationship moves through stages of dependence, interdependence, and independence when achieving goals. The following major premises are part of this model:

1. The process of teaching and learning does not guarantee successful management of health care needs. The patient assumes responsibility for managing health care needs at home.

2. Successful management of health care needs depends on the patient's participation in the care plan.

3. Participation is collaborating with the other members of the health care team, the patient, and the nurse; therefore, the patient has an active role.

4. Participation is primarily achieved by rehabilitative, restorative, and or palliative actions.

5. Dynamic self-determination is an ongoing, reflective process and is necessary to achieve well-being or optimal health, and interpersonal harmony. It arises from motivation.

6. The role of home health nurses is that of a facilitator and they focus on the patient's social, interpersonal, spiritual, technological, environmental, and educational needs for goal attainment.

7. The caregiver is viewed as the extension of the patient and the patient's needs. The caregiver's role is to provide social and psychological support. They are a very important part of the care plan.

For home care to be a successful alternative, the mother

and/or her partner must be willing and able to take on the responsibility for the newborn's care. Parental needs are both physical and emotional. Nurses, during home visits, assess for these needs. The nurse helps to integrate the infant into the family by providing health education that promotes maternal and neonatal care. Maternal physical needs include relieving or minimizing fatigue, recovering from the birth (involution), healing of sutures if applicable, and preventing mastitis while breastfeeding. The psychological needs include healthy bonding, understanding of growth and development, and knowledge of infant care techniques (skin care, feeding concerns, comforting techniques, and safety). Among other concerns are the parent's stress level, financial concerns, if any, need for relief care givers, and role-change adaptation (Cohen, Kenner, & Hollingsworth, 1991).

This nurse researcher believes that since patients of today wish to become more involved in their health care, this model is appropriate for use in this study. Patients will have to take more responsibility for themselves because of limitations and requirements of their health insurance plans. More teaching will need to be done by the nurses because patients are going home earlier. They will have questions about taking care of themselves at home, recognizing signs and symptoms of problems that might arise, and how to use more advanced technology. They will be released sooner while not feeling physically or emotionally strong. When patient

care goals can be achieved, then both the nurse and patient should be more satisfied.

Definition of Terms

Home health nursing is the delivery of nursing care to patients in their home environment. It is provided on a part-time or intermittent basis. The care of the patient involves coordinating therapies, educating the patient, developing competence for independent management, fostering positive caregiver adjustment to the changes in life-style role and reintegrating the patient/caregiver back into the community.

Nursing job satisfaction. For this study, job satisfaction of nurses is the perception that the nurses are administering care in the best possible manner, are autonomous, are valued health care team members, and feel that they belong to a team that delivers quality home health nursing care.

Patient satisfaction. For this study, patient satisfaction is the perception by a patient that she was treated appropriately by the nurse, was offered explanations about her or her baby's condition, and felt that there was a nurse of whom she could ask questions and get satisfactory answers and emotional support.

Perinatal nurse is a nurse with experience in antepartum assessment, labor and delivery, postpartum and newborn care. He or she must have completed one or more years of full time

employment in obstetrics, and is currently employed part or full time.

Traditional obstetrical setting. For this study, this is a community hospital in which patients are educated clients who meet specific early discharge criteria, and have an easier access to medical care but do not receive postpartum home nursing visits.

Hypotheses

The review of the literature supports the development of two hypotheses. The hypotheses are:

1) $H_{(R)}1$: Nurse satisfaction will be higher in the perinatal home health care delivery system than in the traditional hospital setting in obstetrics.

2) $H_{(R)}2$: Patient satisfaction will be higher in the perinatal home health care delivery system than in the traditional hospital setting in obstetrics.

The independent variable is the type of nursing care delivery system, home health care or traditional hospital setting in obstetrics. The dependent variables are nurse satisfaction and satisfaction of patients who have recently used traditional maternity services and perinatal home health care services.

CHAPTER THREE

Methods and Procedures

Shorter postpartum hospital stays have increased the need for postpartum care. Home visits are a unique way to provide quality maternity care. The purpose of this study was to determine the level of nurse and patient satisfaction in two different settings, obstetrical departments of hospitals and in perinatal home health nursing services.

Research Design

The research design was a nonexperimental descriptive method which examined the relationships between the variables. This type of study has no control over the variables. The variables occur naturally rather than imposing any type of experimental manipulation; data are collected without introducing any new treatments or changes. There is no attempt to determine a cause and effect relationship among the variables. The goal of descriptive research is simply to describe the frequency with which the variables occur (Polit & Hungler, 1995).

Setting and Sample

Two agencies that provide postpartum home care were used in this study and were compared with a small suburban community hospital. A new community hospital in Novi, Michigan was used; it opened in 1994. By the end of 1995, it

has had over 100 deliveries. Their program was designed for pregnant women who are at low risk for medical or surgical complications. They have been prescreened by their physicians. This setting allowed for the mother and her baby to go home within one day after delivery. It provided a home-like atmosphere. The expectant mother/parents were required to attend two orientation classes taught by the hospital staff. The setting provided individualized nursing care for both mother and baby. Two follow-up home visits from a nurse were included. Ninety percent of the home visits were made by the same nurse who helped the patient during labor and delivery. The 10% exceptions occur when nurses are away on vacation, on weekends, and for the holidays. Then home care coverage is provided by a home care agency in Novi associated with the hospital. They have three nurses who make these visits.

The second home care agency is one of four associated with a large metropolitan hospital; their office is located in Southfield, Michigan. It serves Northwestern Wayne County and a part of Oakland County. It began in 1988 and was one of the first home care agencies to do two postpartum visits for patients who delivered at the main hospital. They follow approximately 80 maternal-child cases per month with 20 to 40 of those being uncomplicated, vaginally-delivered, first-time mothers. The program they developed is a comprehensive plan for educating their maternity patients. It starts with the first prenatal visit and continues into the first month

of the new baby's life. Topics covered under PIP (Partners in Parenting) range from correct nutrition and preterm labor, to feeding a newborn, and identifying health problems. Around 28 weeks into the pregnancy, a nurse conducts a psychological/social exam to determine whether the patient has the knowledge, skills, and support system necessary to care for an infant at home. When the baby is born, the mom has completed nine education modules. One more is conducted during the hospital stay for a vaginal birth and two more for a Cesarean delivery. After patients are discharged in 24 hours from the hospital, they receive two intensive home visits and at least one phone call from a nurse who is experienced in maternal and infant care.

A community hospital in Livonia, Michigan was used for the traditional obstetrical hospital setting. They deliver around 50 patients per month. They participate in early discharge, have a phone hotline for questions, but do not provide home nursing visits. They provide infant care classes which are recommended during the prenatal period. They also recommend one prenatal breastfeeding class for those mothers who wish to nurse their infants and suggest that they belong to a support group that meets once a month after delivery.

Nurses were obtained from these agencies by convenience sampling. They were eligible to complete the questionnaire if they had worked one or more years in hospital obstetrics, and were presently working full or part time in the hospital

or home health care agencies. All eligible nurses (all shifts) in both types of health care delivery systems were given questionnaires.

The female patients sampled were between 17 and 40 years of age and had their first uncomplicated vaginal birth and a normal infant. The subjects were also obtained by convenience sample and they had to meet the criteria for early discharge. The maternal criteria for early discharge are: the length of labor (not abnormally short or long), the blood pressure under 140/90, pulse below 110, the temperature below 100.4^{o} F, no prolonged rupture of the membranes, and an absence of fetal distress during labor. Other factors considered are: the fundus is firm with moderate bleeding after delivery, hemoglobin above 9mg./ml., vaginal delivery (not Cesearean), patient is able to ambulate well, able to void, the type of anesthesia or analgesia used, and has had Rhogam given, if indicated.

The following infant criteria are considered for early discharge: a gestational age of 38 to 42 weeks at birth, a birth weight of at least five and a half pounds or more, an Apgar score of at least 8 for one and five minutes, an axillary temperature below 99^{o} F, a heart rate above 110, and respirations between 30 to 60 per minute. Other factors also considered are: has passed the meconium stool, is able to suck and swallow (two feedings), there is no cyanosis or significant jaundice, has results of blood work within normal range (Coombs, dextrostic, hematocrit, & phenylketonuria

(PKU), is able to void, and if circumcised, has satisfactorily undergone observation for bleeding for two hours.

Instruments

This study examined three aspects of a nurse's satisfaction with the job in two different types of care delivery systems. The three aspects include the quality of care the nurse feels she/he is able to deliver, enjoyment of one's job, and the time to do one's job. The questionnaire completed by the nurses was the Nurse Job Satisfaction Scale adapted by Hinshaw and Atwood (1981) (see Appendix A) from the industrial Brayfield and Rothe Job Satisfaction Scale. The Nurse Job Satisfaction Scale was designed to measure the professional occupational aspects of nursing care performed for pay. The wording on item #6 was changed to read, "Many days I feel hassled," instead of "harassed," "because I don't have time to do all I want to do." Permission to modify and use the Nurse Job Satisfaction Scale was received from the authors (see Appendix C).

Additionally, three aspects of patient satisfaction were explored in patients who received nursing care in either the traditional obstetrical department of the hospital or later in the home health care setting. The three aspects include the professional-technical skills of the nurse, how the educational needs of the patient were met by the nurse, and the patient's trust in the nurse. Former obstetrical

department patients and perinatal home health care patients were asked to complete the Risser Patient Satisfaction Instrument (Risser, 1975) (see Appendix B). This scale was developed over a period of 8 years in five clinical and administrative studies. The wording on two items was altered to make it more appropriate for traditional and home care. Originally, Item #10 was worded, "the nurse is too busy at the desk to spend time with me." For this study it was changed to, "the nurse is too busy at the desk, on the phone, or doing paperwork to spend time with me." Also, the wording on item #25 originally was, "the nurse is skillful in assisting the doctor with procedures." For this study it was changed to, "the nurse is skillful in doing procedures herself or assisting the doctor with them." Permission to modify and use the Risser Patient Satisfaction Instrument was received (see Appendix D).

Validity/Reliability

The Nurse Job Satisfaction Scale evolved from the work done by Hinshaw and Atwood (1980) to develop a scale specifically suited to a health care setting. Three of the six subscales were eliminated based on item analysis. The final scale has as identifiable factors: enjoyment in one's job, quality of care, and time to do one's job. A five-point Likert scale rates the three dimensions of nurse satisfaction. Enjoyment of one's job was assessed with eleven questions, and quality of care was assessed with seven

questions. Ten questions evaluated time to do one's job. The questionnaire contains 15 positive statements and 13 negative statements.

Construct validity of the Nurse Job Satisfaction Scale is estimated in three ways, which are described in the information provided by the authors. Factor analysis yields average subscale factor loadings of .63. Convergent and discriminate estimates meet all predictions for both rank and direction. Predictive modeling supports the predicted directions and magnitudes of relationships. In the Anticipated Turnover Study (Hinshaw, Atwood, Gerber, & Erickson, 1987) significant predictions were supported; that is, that job satisfaction is a buffer for job stress. The alpha coefficient reliability of the three subscales was .90 (Hinshaw, Scofield, & Atwood, 1981; Atwood & Hinshaw, 1987).

The Patient Satisfaction Instrument was developed over a period of 8 years by Nancy J. Risser (1975). Originally used for outpatients in ambulatory care settings, it was later used for inpatients. Five clinical and administrative studies were completed with a total of 600 medical-surgical outpatients. This process replicated the study several times to achieve measurement precision. The Patient Satisfaction Instrument is a Likert-type scale which rates three dimensions of patient satisfaction in 11 negative statements and 14 positive statements. Seven questions focus on technical-professional care, which is the patient's perception of the competency of the nurse who delivered the

care. Trust was assessed by 11 questions. Trust is the feeling by the patient of having to rely on the judgment of the nursing staff and a sense that the nurse was sympathetic toward her problems. The third section of the scale is the patients' assessment of how their educational needs of being informed about their condition or that of their baby were met by the nurse. This subscale consists of seven statements. Respondents were asked to circle the appropriate responses. The Patient Satisfaction Scale requires 10 to 15 minutes to complete and a fifth grade reading level ability.

Validity and reliability information was provided by Hinshaw (1977), who helped adapt the scale for use by inpatients. Internal consistency estimates appeared satisfactory and stable in the subscales. Alpha coefficients for the Technical-Professional subscale averaged .786. Education coefficients were made by factor analysis which shows stable loadings above .500 criterion level across the studies. Empirical correlations moderately substantiated the multiple, convergent/discriminate predictions. Discriminance was strongly documented for all except the education subscale which had modest support. Predictive modeling had moderate to strong validity estimates.

Data Collection

An expedited review from the Human Subjects Review Board of Madonna University was granted on July 10, 1995 (see Appendix G). Permission of the hospital review board was

obtained on August 7, 1995 (see Appendix H). Permission of the two home health care agencies was obtained on July 14, 1995 and on August 2, 1995 respectively (see Appendix I & J). Nurses received the Nursing Job Satisfaction Scale through the mail during the month of July, 1995. Sixty registered nurses from the different patient care settings received the mailings. A cover letter (see Appendix K) was enclosed explaining the purpose of the study and informing them that by returning the study they were granting permission to have the data used in the study. A demographic data sheet was enclosed along with a stamped envelope addressed to the researcher. They were requested not to put their return address on them. The respondents were asked to return the questionnaire within two weeks. Follow-up post cards were sent to the nurses approximately two weeks after the initial mailing in order to increase the response rate (see Appendix M). The results of the study were sent to the agency nurse managers. This was done to assure anonymity of the responses.

The Patient Satisfaction Instrument was mailed to 124 postpartum patients during the months of July through October, 1995. A cover letter (see Appendix L) explained the purpose of the study and informed the patients that, by returning the completed questionnaire, they were consenting to the use of the information in the study. A stamped self-addressed envelope was included. They were requested not to put their return address on them. Follow-up post

cards (see Appendix N) were sent to the patients approximately two weeks after the initial mailing in order to increase the response rate. Different colored paper was used to identify the nurses and patients from each agency and hospital.

Demographic data sheets were included with the questionnaires. Nurses were asked their age, sex, type of nursing education, years as a nurse, years as an obstetrical nurse, shift normally worked, and whether currently employed as a part time or full time staff member (see Appendix E). Patients were asked to indicate their age, years of school completed, and current employment status. They also were asked the time of day admitted to the maternity department, approximate length of stay in that department, existence of social support at home, and whether childbirth preparation, breastfeeding, or infant care classes were attended. Patients were asked if they had used the telephone hotline and how many home visits by a nurse they received (see Appendix F).

Data Analysis

Statements on each of the scales were worded so that some indicated satisfaction while others indicated dissatisfaction. Items which indicated satisfaction were scored 1 (low) to 5 (high). The scoring was reversed on those items which indicated dissatisfaction. The statistical significance for each hypothesis was set at $p<.05$. The t

test was used to analyze the variables of nurse job satisfaction between the obstetrical department and the two home health care agencies. It was also used for patient satisfaction in the obstetrical department and the two home health care agencies.

CHAPTER FOUR

Findings

Demographics

Forty nurses responded to the nurse job satisfaction survey. Twenty of these nurses worked in the traditional postpartum setting and twenty worked in the home care settings. Thirty-three were mailed to the traditional hospital setting nurses with a response rate of 60%. Thirty were mailed to the nurses working in the home care settings, eleven to the Northwest Detroit location and nineteen to the Novi location with a 73% return rate and a 63% return rate respectively. All of the nurse surveys were usable.

Sixty-two patients responded to the patient satisfaction questionnaire; however, only fifty-nine were usable. Three were received too late for the numbers to be included in the analysis. Thirty-two patients were in the traditional setting and 27 were from the home care settings. Fifty-eight were mailed to the traditional setting patients with a response rate of 62%. Forty-eight were mailed to patients in the home care setting of the Northwest Detroit location and 18 to the patients from the Novi location with a return rate of 44% and 33% respectively.

Thirty-nine nurse respondents were female, one did not answer the question. Table 1 shows that the home care nurses were younger than the traditional setting nurses. This difference was statistically significant (t=-3.79, df=35,

p=.001).

Table 1

Summary of Age (in years) of Nurses

Variable	n	Mean	SD	SE of Mean
Home Care	20	37.6	7.3	1.6
Traditional	17	48.5	10.2	2.4

Number of Missing Observations: 3

The home care nurses worked slightly longer hours per week (36.5 hours) than the traditional setting nurses (35.9 hours), but this difference was not significant (t=0.35, df=37, p=.732). There was no significant difference in the number of years nurses had worked in maternal/newborn nursing; home care setting nurses averaged 12.2 years while traditional setting nurses averaged 12.4 years (t=-.07, df=36, p=.946).

Table 2 demonstrates that there was no relationship between setting in which nurses worked and their nursing education background (X^2=2.88, df=3, p=.409). In the home care setting, the largest group of nurses held a bachelor degree. In the traditional setting, the distribution of educational levels was nearly equal with the exception of one master's degree.

Table 2

Demographic Profile of Nursing Education

Group	Home Care		Traditional	
	n	%	n	%
Diploma	4	20	7	36.8
A.D.N.	6	30	5	26.3
B.S.N.	10	50	6	31.5
M.S.N.	0	0	1	5.3
Totals	20	100	19	100.0

Number of Missing Observations: 1

There was no relationship between the setting in which the nurses worked and the shift they worked (X^2=2.31, df=2, p=.315). In the home care setting, 13 nurses reported that they worked days, five worked nights and two indicated other shift arrangements. In the traditional setting, eight worked days, nine worked nights, and two indicated other shift arrangements.

Demographic information for the patients consisted of eleven questions: age, work status, educational level, time admitted to the hospital, length of stay, and attendance at childbirth education classes. Additionally, items evaluated were presence of a support person at home, telephone hot line use, home visitation, and attendance at breastfeeding and/or newborn care classes.

Twenty-seven patients were in the home care setting and

32 were in the traditional setting. There was no statistically significant difference in age between the two groups of patients (t=-0.87, df=47.83, p=.387 using separate estimates). The mean age for home care patients was 28.0 years while traditional patients had a mean age of 29.1 years.

There was no relationship between setting and work status for patients (X^2=6.31, df=5, p=.277). In the home care setting, four were on maternity leave, six worked part time, nine worked full time, two were unemployed, five worked "at home", and one marked "other." In the traditional setting, one patient was on maternity leave, 15 worked part time, 11 worked full time, one was unemployed, three reported working "at home," and one marked "other."

Table 3 shows that there was no relationship between setting and educational level for patients (X^2=7.94, df=4, p=.093). In the home care setting, five patients had completed high school, three had some college, four held associate degrees, nine had bachelor's degrees, and six had graduate school training. In the traditional setting, five had completed high school, thirteen had some college, four held associate degrees, eight had bachelor's degrees, and two had graduate school training.

Table 3

Demographic Profile of Patients Educational Level

Group	Home Care		Traditional	
	n	%	n	%
High School	5	18.5	5	15.6
Some College	3	11.1	13	40.6
Associate Degree	4	14.8	4	12.5
Bachelor Degree	9	33.3	8	25.0
Graduate School	6	22.2	2	6.3
Totals	27	100.0	32	100.0

There was no relationship between setting and the time patients came to the hospital (X^2=37.61, df=38, p=.487). Sixteen home care setting patients came to the hospital before noon and 11 came in the afternoon. Fifteen patients in the traditional setting came to the hospital before noon and 15 came in the afternoon.

Traditional setting patients had longer stays on average (38.4 hours) in the maternity department than home care patients (25.9). This difference was statistically significant (t=-2.07, df=45.83, p=.044 using separate estimates). Table 4 demonstrates that patients in the traditional setting also had longer hospital stays after their baby's birth (36.7 hours) than home care setting patients (24.2 hours). This difference was also statistically significant (t=-5.35, df=41.64,p<.001 using

separate estimates).

Table 4

Length of Stay (in hours) after Birth of Baby

Length of Stay in Hours	Home Care		Traditional	
	n	%	n	%
0-4	-	0.0	-	0.0
5-8	1	3.6	-	0.0
9-12	-	0.0	-	0.0
13-16	-	0.0	-	0.0
17-20	3	10.7	1	3.3
21-24	15	53.6	6	20.0
25-30	6	21.4	1	3.3
31-34	2	7.1	3	10.0
35-40	1	3.6	8	26.6
41-44	-	0.0	4	13.3
45-50	-	0.0	4	13.3
51-54	-	0.0	-	0.0
55-58	-	0.0	2	6.6
59-62	-	0.0	-	0.0
67-70	-	0.0	-	0.0
71-74	-	0.0	1	3.3
Totals	28	100.0	30	99.7

Number of Missing Observations: 1

Table 5 demonstrates that patients in the home care setting attended slightly more childbirth education classes (mean of 3.2) than patients in the traditional setting (mean of 2.3), but this difference was not statistically significant (t=1.33, df=53, p=.188).

Table 5

Childbirth Classes Attended by Patients

Number of Classes Attended	Home Care		Traditional	
	n	%	n	%
None	4	14.8	10	31.2
One	6	22.2	4	12.5
Two	1	3.7	3	9.3
Three	4	14.8	1	3.1
Four	1	3.7	3	9.3
Five	4	14.8	1	3.1
Six	5	18.5	10	31.2
Seven	2	7.4	0	0.0
Totals	27	99.9	32	99.7

Median 2.0 Maximum 7.0 SD 2.45

There was no statistically significant relationship between patient setting and support person available at home (X^2 =4.87, df=4, p=.300). For home care patients, one had a parent, 17 had a spouse or boyfriend, seven had multiple support persons, and two indicated others. For the

traditional setting patients, two had no support, one had a parent, 24 had a spouse or boyfriend, three had multiple support persons, and one indicated other.

Home care patients used the telephone hot line slightly more often (an average of 1.3 times) than traditional patients (an average of 1 time), but this difference was not statistically significant (t=0.49, df=55, p=.624).

As expected, home care patients received more home visits (mean of 2.07) than traditional patients (mean of 0.29). This difference was statistically significant (t=7.30, df=56, p<.001).

There was no relationship between current breastfeeding and patient setting (X^2=.99, df=1, p=.317). Seventeen of the home care patients and 16 of the traditional patients were currently breastfeeding their infants.

Table 6 shows that there was no relationship between patient setting and child care classes attended (X^2=5.52, df=3, p=.137). Thirteen home care setting patients indicated that they had attended no classes, six attended breastfeeding class, and eight attended both breastfeeding and infant care. Twenty traditional setting mothers indicated that they had attended no classes, five attended breastfeeding, three attended infant care, and four attended both classes.

Table 6

Child Care Classes Attended By Patients

Group	Home Care		Traditional	
	n	%	n	%
None	13	48.1	20	62.5
Breastfeeding	6	22.2	5	15.6
Infant Care	0	0.0	3	9.3
Both	8	29.6	4	12.5
Totals	27	99.9	32	99.9

Results

The purpose of this study was to determine if there were a significant difference in satisfaction for nurses and for patients between home care and traditional settings. After scoring the instruments, a reliability analysis was conducted on each of the instruments. Cronbach's alpha was computed for each of the two scales. For the nurse satisfaction scale, the obtained reliability coefficient, based upon the 28 items and data from 40 respondents, was .93, indicating a high degree of internal consistency. For the patient satisfaction scale, the obtained reliability coefficient, based upon 25 items and data from 59 respondents, was .96, representing a high degree of internal consistency. Scores from the nurse and patient satisfaction scales were compared using *t* tests for independent groups. The results of these tests are presented in Tables 7 and 8.

Table 7

Descriptive Statistics for Nurse and Patient Satisfaction Scales

Group	n	Mean	SD
		Nurses	
Home Care	20	104.35	14.73
Traditional	20	106.40	16.65
		Patients	
Home Care	27	106.04	10.25
Traditional	32	97.19	17.53

Although traditional setting nurses had a slightly higher satisfaction mean score (106.40) than home care nurses (104.35), this difference was not satistically significant (t=0.41, df=38, p=.628). Thus, there was no significant difference in satisfaction between nurses in the traditional setting and those in the home care setting.

Table 8

T-test Results for Nurse and Patient Satisfaction Scales

Group	t	df	p
Nurses			
	-0.41	38	.682
Patients			
	2.41	51.2	.020

For patients, the difference in means was substantial and statistically significant (t=2.41, df=51.20, p=.020 using separate estimates). Home care patients had a mean satisfaction score of 106.04 while traditional setting patients had a mean satisfaction score of 97.19. Thus, home care settings patients were significantly more satisfied than traditional setting patients.

CHAPTER FIVE

Conclusion

In response to cost containment issues, advances in technology, and increased emphasis on early discharge, home care is expanding at a rapid rate. Home care is popular because it takes place in the patient's own setting, to promote client and family independence through health teaching and increased confidence in self-care. The future will see an increase in maternal-child home care services.

There are many reasons why early postpartum discharge gained popularity. It was a way to decrease disruption to the family, an alternative to home birth, encouraged more father involvement, decreased exposure to pathogens, and could save money if there were no health insurance. Early discharge is a safe, cost-saving practice that is here to stay (Berryman & Rhodes, 1991; Gonzalves & Hardin, 1993; Frank, 1994).

Discharging the mother and baby early without follow-up nursing support either through phone follow-up, postpartum clinics, support groups or home nursing visits can be very stressful. The literature supports the notion that patients are satisfied with early postpartum discharge when home nursing visits are included (Jansson, 1988; Berryman & Rhodes, 1991; Gonzalves & Hardin, 1993; Carty & Bradley, 1990).

In contrast, some parents, nurses, and pediatricians

have expressed frustration with early discharge (Frank, 1994). They do not want insurance companies dictating to them when new mothers and babies should go home. The U.S. Senate is considering a law which would require a minimum hospitalization of 48 hours. The patient's physician and nurses are better judges of the patient's health status and home situation better than the insurance company. It should be up to the patient and doctor when to go home (Frank, 1994). Maternity nurses know that certain information and repeat demonstrations regarding the mother's care and that of her infant need to be given and understood (Lukacs, 1991). If the length of stay could be 48 hours, the nurse would be able to provide appropriate care, especially on the second postpartum day (Ament, 1990; Eidleman, Hoffman, & Kaitz, 1993).

Combs-Orme, Reis, and Ward (1985) reviewed studies between 1960 and 1984 regarding the value of perinatal home health nursing and its impact of health behaviors (maternal attitudes and parenting practices). Many of these studies have dealt with programs serving favorable, selective groups that have had strict selection criteria.

The following recommendations need to be considered. Nurses need to be involved in the legislative process and help to apply pressure on insurance companies for a longer stay. Also, they need to put pressure on their state board of nursing for a standard of care related to postpartum care and how it is provided. A position paper published by the

Northeast Ohio March of Dimes (1987) suggested an earlier effort to recognize the need for a professional standard of care. Postpartum home nursing visits are one way to provide such care. The literature supports that there are many fine quality postpartum home care programs to select from which could serve as models (Evans, 1991; Lemmer, 1987; Norr & Nacion, 1987; Williams & Cooper, 1992).

This study was designed to see if differences with satisfaction existed for the nurses and patients between the two different types of obstetrical care settings. Patient satisfaction is of concern to the quality assurance department of hospitals and home care agencies. The two most common accreditation models which monitor quality of care are the Joint Commission on the Accreditation of Healthcare Organizations and the Community Health Accreditation Program, Inc.

Commitment to quality is important in dealing with the competitive market and ensuring future economic survival. Total quality management (TQM) is an approach toward long-term success through customer and staff satisfaction. It is meant to be a way to accomplish things, not another thing to have to do. Nurse administrators need to be familiar with the TQM philosophy and adopt it.

Many times the first hospital experience that a woman or young family has is the birth of a baby. Their satisfaction with this experience can influence whether or not they would use that hospital or health care agency again in the future.

Nurse administrators need to remember this when developing programs and policies. Dearing (1993) claims that 58% of pregnant women choose a hospital first and the doctors who practice there second. When there is a successfully managed birth and postpartum experience, health care consumers are more likely to return there for future care in illness or emergency situations.

Nurse researcher, Reva Rubin (1967), recognized the stages of maternal change during the postpartum period. In these stages the mother moves from taking care of herself to taking care of herself and the new baby. The Rice model of self-determination was used in this study. It is a conceptual model for home care nursing.

The instruments used in this study were adapted by the investigator with permission. They were the Nurse Job Satisfaction Scale by Hinshaw and Atwood, and the Patient Satisfaction Instrument by Nancy J. Risser.

Interpretations

The results related to the hypotheses are:

$H_{(R)}1$: Nurse satisfaction will be higher in the perinatal home health care delivery system then in the traditional hospital setting in obstetrics. This hypothesis was unsupported. There was no statistically significant difference in satisfaction between nurses in the traditional setting and those in the home care setting. These findings are in contrast to those reported by Chubon, (1991), Shuster,

(1992), and Riordan, (1991); however, these studies did not specifically focus on nurses doing postpartum home care.

$H_{(R)}2$: Patient satisfaction will be higher in the perinatal home health delivery system than in the traditional hospital setting in obstetrics. This hypothesis was supported. Home care patients were more satisfied than traditional setting patients. These findings are consistent with those of Jansson, (1988) and Bradley and Carty, (1990). Several studies support the idea that patients desire information and that this was the important aspect in their increased patient satisfaction (Bader, 1988; Sequin, Therrien, Champagne, & Larouche, 1989; Alexander, Sandridge, & Moore, 1993).

Limitations

There were several limitations to this research study. First, the study was restricted to a smaller hospital. A larger hospital that delivers a couple hundred mothers and babies a month may have given different results because in such a larger setting nurses may feel increased frustration related to increased workload and less time for individual patient care. Also, patients in such a large setting may feel they are on a production line.

Second, the number of subjects was small. A larger sample of postpartum home care nurses from the same larger hospital may have given different findings. Studying postpartum nurses from other home care agencies also could

affect the results.

Third, additional questions for patients could have yielded interesting related data. This nurse researcher would have liked to have included three more specific questions to the patients. First, "how long (in hours) does your insurance company allow you to stay after the birth of your baby?" Second, "would you have liked to have stayed longer in the hospital?" Third, "on a scale of 1 to 10, 1 being the lowest and 10 the highest, rate your level of fatigue after three days home from the hospital."

Fourth, additional questions for the nurses may have yielded interesting related results. This nurse researcher would have liked to have asked the nurses two more specific questions. First, "do you feel the patients were ready to go home after 24 hours in the hospital?" Second, "what in your opinion, is the mother's biggest concern about going home?"

Fifth, the survey instruments were not specific to obstetric and postpartum care. Using a tool more specific to evaluating obstetrics and postpartum care would be more appropriate.

Implications for Research

According to Williams (1989) the necessity of postpartum home care needs to be validated through research on the types and frequency of nursing diagnosis. A larger study in Michigan may yield interesting results. Michigan is unique with its upper and lower peninsulas and population groups.

There is a need to compare the United States with other countries on nurse and patient satisfaction. In Australia, mothers stay from four to six days (McMillen, 1995). Canada allows mothers and babies to stay two and a half days (McMillen, 1995). In France, five days to two weeks is the norm (McMillen, 1995). Lastly in Sweden, when using a midwife, they are allowed one to three days (McMillen, 1995). Costs of postpartum home care nursing programs and actual costs of readmission rates of mothers and babies needs to be studied.

Implications for Nurse Administrators

Since patients desire more information, written instructions need to be given to mothers about caring for themselves and their infants. This is a way of reinforcing what they may have been taught while in the hospital. Patients can go back to this resource when questions arise at home. They will know when to seek health care.

In the past, the factors that attracted nurses to home care were autonomy, better working hours, teaching opportunities, and more direct contact with patients and/or their families. Today, nurse administrators need to also consider the increased acuity level of the patients and the increased paperwork and documentation requirements. Also, decreased patient satisfaction due to the shorter length of stay on service and restrictive reimbursement requirements needs to be considered when developing policies and

procedures. Important issues for the staff include salary, the opportunity to participate in policy and procedure development, recognition of personal achievement and growth, peer support, opportunities to attain personal and professional goals. Administrative support and encouragement are essential to employee satisfaction and retention.

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Appendix A

Nurse Job Satisfaction Scale

I: NURSE JOB SATISFACTION QUESTIONNAIRE

The following questions are designed to measure your satisfaction with your job in the obstetrical department or home health care agency. Please respond by circling the appropriate letter.

SA - Strongly Agree
A - Agree
U - Undecided
D - Disagree
SD - Strongly Disagree

You may choose not to answer some of the items in the questionnaire but please return the incomplete or completed form in the envelope provided.

Thank you.

1. Most days I have time to provide hygiene measures for my patient.
   SA A U D SD

2. I consider my job rather unpleasant.
   SA A U D SD

3. Usually I have enough time to do a good job of patient care.
   SA A U D SD

4. I enjoy my work more than my leisure time.
   SA A U D SD

5. Many days I would have to stay overtime to get all my paperwork done.
   SA A U D SD

6. Many days I feel hassled because I don't have time to do all I want to do.
   SA A U D SD

7. I feel fairly well satisfied with my present job.
   SA A U D SD

8. I am not satisfied with the level of individualized care I am giving now.
SA A U D SD

9. Most of the time I have to force myself to go to work.
SA A U D SD

10. Under the circumstances, it is difficult to provide high quality care.
SA A U D SD

11. I am satisfied with my job for the time being.
SA A U D SD

12. I definitely dislike my work.
SA A U D SD

13. I feel that I am happier than most other people.
SA A U D SD

14. Most of the time I am satisfied with patient care that I give.
SA A U D SD

15. Most days I am enthusiastic about my work.
SA A U D SD

16. It is hard for me to give patient care which meets my standards.
SA A U D SD

17. I like my job better than the average worker does.
SA A U D SD

18. I find real enjoyment in my work.
SA A U D SD

19. I am disappointed that I ever took this job.
SA A U D SD

20. There are some conditions concerning my job that could be improved.
SA A U D SD

21. I feel I have time to do both the paper work and my patient care.

SA A U D SD

22. I feel satisfied with the technical care I give.

SA A U D SD

23. I am able to keep my patients comfortable.

SA A U D SD

24. I could deliver much better care if I had more time with each patient.

SA A U D SD

25. I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.

SA A U D SD

26. The amount of time I must spend on administration ("paper") work on my service is reasonable, and I am sure that patients do not suffer because of it.

SA A U D SD

27. I do not spend as much time as I would like to taking care of patients directly.

SA A U D SD

28. I think I could do a better job if I did not have so much to do all the time.

SA A U D SD

Appendix B

Risser Patient Satisfaction Questionnaire

II: PATIENT SATISFACTION QUESTIONNAIRE

The purpose of this questionnaire is to find out how you feel about the nursing care you received (the nurse who spent the most time with you after the birth of your baby) while you were a patient in the maternity department or the nurse from the home care agency. You are being asked to voluntarily give your opinion. Read each statement and circle the appropriate answer to indicate whether you strongly agree, agree, are uncertain, disagree, or strongly disagree. You may choose not to answer some of the questions but please return the partly finished or completed questionnaire in the envelope provided.

Thank you

1. The nurse should be more attentive than he/she is.

   STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
   AGREE DISAGREE

2. Too often the nurse thinks I can't understand the medical explanation of my condition/illness, so he/she just doesn't bother to explain.

   STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
   AGREE DISAGREE

3. The nurse is pleasant to be around.

   STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
   AGREE DISAGREE

4. A person feels free to ask the nurse questions.

   STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
   AGREE DISAGREE

5. The nurse should be more friendly than he/she is.

   STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
   AGREE DISAGREE

6. The nurse is a person who can understand how I feel.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

7. The nurse explains things in simple language.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

8. The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

9. When I need to talk to someone, I can go to the nurse with my problems.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

10. The nurse is too busy at the desk, on the phone, or doing paperwork to spend time talking with me.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

11. I wish the nurse would tell me about the results of my test/s more than he/she does.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

12. The nurse makes it a point to show me how to carry out the doctor's orders.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

13. The nurse is often too disorganized to appear calm.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

14. The nurse is understanding in listening to a patient's problems.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

15. The nurse gives good advice.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

16. The nurse really knows what he/she is talking about.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

17. It is always easy to understand what the nurse is talking about.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

18. The nurse is too slow to do things for me.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

19. The nurse is just not patient enough.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

20. The nurse is not precise in doing his/her work.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

21. The nurse gives directions at just the right speed.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

22. I'm tired of the nurse talking down to me.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

23. Just talking to the nurse makes me feel better.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

24. The nurse always gives complete enough explanations of why tests are ordered.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

25. The nurse is skillful in doing procedures herself or assisting the doctor with them.

STRONGLY AGREE UNCERTAIN DISAGREE STRONGLY
AGREE DISAGREE

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

School of Public Health
Curriculum in Public Health Nursing
(919) 966-1030, 966-1069
FAX# (919) 966-7141

The University of North Carolina at Chapel Hill
Campus Box 7400, 263 Rosenau Hall
Chapel Hill, N.C. 27599-7400

April 13, 1995

Ms. Christine A. Donica
43121 Arlington
Canton, MI 48187

Dear Ms. Donica:

Thank you for your recent request for information about instruments in the Anticipated Turnover Among Nursing Staff study (#R01 NU00908). We are pleased to be able to share this information with you.

Enclosed you will find the **Nursing Job Satisfaction Scale**, along with the scoring key, validity and reliability estimates obtained on our sample. You have permission for use, and we trust this information will be helpful.

To defray my personal costs of xeroxing and postage, please return $1.77 in **STAMPS, NOT CASH OR CHECK,** to me. If we can be of any other assistance to you, please let us know: (919) 966-6879. Also, we would request that you share any information regarding the process of using the instrument and the results or outcomes of its use. We wish you much success in your research.

Sincerely,

Jan R. Atwood, Ph.D., F.A.A.N., Professor
Curriculum in Public Health Nursing and
Health Behavior/Health Education Dept.
Internet # JATWOOD@SOPHIA.SPH.UNC.EDU

c.c. A.S. Hinshaw, Ph.D., F.A.A.N., Co-Principal Investigator

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Appendix D

15 Knollcroft Rd
Basking Ridge, NJ 07920-1912
June 26, 1995

Dear Ms Donica

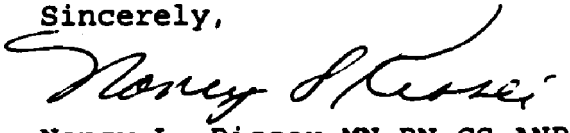
I received your letter in which you requested permission to use my Patient Satisfaction Scale in your thesis which will study nurse and patient satisfaction with perinatal home health nursing. My tool is not copyrighted so you are welcome to use it. You may also modify the wording of item #10 to make it more valid in your setting.

A copy of the tool as I originally administered it is in Volume 2 of Mary Ward and Carol Lindeman's Instruments for Measuring Nursing Practice and other Health Care Variables, Western Interstate Commission for Higher Education, Boulder, Colorado, 1978, pp. 673-678. After my second administration 3 items were eliminated to make the final 25 item scale. Table 1 in the January-February issue of Nursing Research (24(1):45-52) lists the final 25 items, their theoretical subscale content areas, and their directions.

You may want to review Elaine L. La Monica's article "Development of a Patient Satisfaction Scale," in Research in Nursing and Health, 1986, 9:43-50 for additonal background for your study and your use of my tool. Work by Hinshaw and Atwood published in Nursing Research in 1982 did some initial validation of the tool in inpatient settings. Ventura et al (Nursing Research, July/August 1982) used it in an inpatient setting, but found it somewhat insensitive in discriminating between degrees of patient satisfaction.

I wish you success in your study. I would appreciate it if you would share an abstract of the results of your thesis when completed if you do use part or all of my tool.

Sincerely,



Nancy L. Risser MN,RN,CS,ANP

Appendix E

I: Nurses' Demographic Data

By answering the following items you will assist me to further analyze the information in the questionnaire. Please place an X or fill in the space.

Thank you!

Sex: Female _____ Your age: _____
Male _____

What type of nursing education do you have?

Associate Degree _____
Diploma _____
B.S.N. _____
M.S.N. _____

How many years have you been a maternal- newborn nurse? _____

What shift do you spend most of your work hours on? _____

On average, how many hours do you work? _____

Appendix F

II: Patients' Demographic Data

By answering the following items you will assist me to further assess the information on the questionnaire. Please place an X or fill in the space.

Thank you!

Your age: _____

Are you working or planning to return to work?

- Maternity Leave _____
- Part-time _____
- Full-time _____
- Unemployed _____
- Working "at Home" _____
- Other _____

What is your highest level of school completed?

- Grade school _____
- Middle-Junior High school _____
- High-school _____
- Some college courses _____
- Associate Degree _____
- Bachelor's Degree _____
- Graduate school _____

What time did you come to the hospital? _____

How many hours were you a patient in the maternity department? (includes the labor and delivery time) _____

After the birth of your baby how many hours did you stay in the hospital before you were discharged home? _____

How many childbirth education classes did you attend? _____

Who was your support person at home? _____

How often did you use the telephone hotline? _____

How many home visits by a nurse did you receive? _____

Are you currently breastfeeding? _____

Which of these classes did you attend?

Breastfeeding _____

Infant Care(Newborn) _____

neither _____

MADONNA UNIVERSITY

APPROVAL FOR USE OF HUMAN SUBJECTS

TO: Christine Donica
Graduate Student

FROM: **Dr. Paul Stemmer, Jr., Pro tem**
Dr. L. Levitt, Chair
Human Subjects Review Committee (HSRC)

RE: **Use of Human Subjects**

DATE: July 10, 1995

TITLE: A Comparison of Patient and Nurse Satisfaction with Postpartum Care in the Traditional Maternity Setting Versus the Home Care Setting

_____ **I have reviewed your application for use of human subjects which you submitted to be reviewed by the HSRC. I have found your research to be exempt as identified by the Madonna University Guidelines for Review of Research Involving Human Subjects. You may now initiate research with human subjects.**

✓ **Your research has been approved by expedited review procedures. You may now initiate research with human subjects,** pending permission letter.

_____ **Your research has been approved by a full committee review. You may now initiate research with human subjects.**

IMPORTANT: **No student investigator may initiate research with human subjects without prior written approval of Chair of HSRC. Compliance with approved plan of approach is required to obtain acceptance of completed thesis as a partial requirement for the masters degree.**

Comments:

Paul M. Stemmer

St. Mary Hospital
Family-Centered Care

August 7, 1995

Christine A. Donica, R.N.
43121 Arlington
Canton, MI 48187

Dear Christine,

As discussed in our brief meeting, this letter serves as your formal approval to conduct your research at St. Mary Hospital, Livonia, Michigan.

In our meeting I did express the necessity of changing the word "harassed" in the nurse questionnaire. Additionally, the definition of the hospital as "traditional" will need clarification.

Upon completion of your research, the Executive Team is requesting a copy of your final thesis. At that point of time we will also approve the use of the hospital's name, should you publish your research.

Please feel free to contact me during your research. And as promised we will prepare the staff address labels and mailing for you.

Thank you for selecting St. Mary Hospital as one of your research sites.

Sincerely,

Carol A. Lewandowski
Senior Director, Nursing Operations

MISSION HEALTH

Providence Hospital and Medical Centers

16001 West Nine Mile Road
P.O. Box 2043
Southfield, Michigan 48037
Phone: (810) 424-3000

PROVIDENCE HOSPITAL
Southfield, Michigan

MEMORANDUM

TO: Christine A. Donica, R.N., B.S.N.

FROM: DAVID PIEPER, Ph.D.
Chairman, Institutional Review Board

DATE: August 2, 1995

SUBJECT: PROJECT # 768- A Comparison of Patient and Nurse Satisfaction with Postpartum Care in the Traditional Maternity Setting Vs. The Home Care Setting.

This project was reviewed by the Research Committee and Institutional Review Board on August 2, 1995. The protocol and with revised informed consent were unanimously approved contingent on the following changes being made and submitted to the Physiology department:

Appendix L, Cover Letter to Patients, change the sentence "in your studying" to "in studying your".

The hospital requires that the principal investigator submit a status report for all approved projects at least annually. It is the right of the hospital to request a status report at any time. If unanticipated problems are encountered on this project (i.e., untoward side effects) they must be reported to the IRB (Physiology Department, phone number 810/424-3326) within five days. Changes in the protocol should not be initiated without prior approval.

Thank you.

dmc 8/7/95

a:approval

Appendix J

Henry Ford Hospital

Home Health Care Division

2921 West Grand Boulevard
NCP 809
Detroit, Michigan 48202
(313) 972-1640

July 14, 1995

Christine A. Donica
43121 Arlington
Canton, MI 48187

Dear Christine,

Thank you for your interest in our Maternal Child postpartal program.

I have reviewed your proposal and I am in agreement for you to use our facility. As always, if there are to be publications of information regarding the study, I ask that we be allowed to review the information.

As in all research, there are a couple of limitations, one being the questionnaires are trying to address both in-hospital and home care at the same time for both patient and nurse. The other limitation is that the sample seems to include only one home care facility.

As a former Madonna graduate myself, I wish you luck and look forward to reading your thesis.

Sincerely,

Jeanette Gronda

Jeanette Gronda, RN, BSN, MSA
Clinical Director

JG/sj

Appendix K

Cover Letter to Nurses

Dear Maternal-Newborn Nurse:

I am a graduate student at Madonna University interested in evaluating nurses' job satisfaction in the obstetrical department and in the home care setting. This study is part of a thesis requirement for my Master's Degree in Nursing Administration.

As an obstetrical nurse with one or more years of perinatal experience, you are being asked to complete the Job Satisfaction questionnaire enclosed. This should take approximately 10 minutes of your time. Participation is entirely voluntary and responses will be anonymous. The only identifiable feature will be different color paper (blue/pink/green) for the questionnaire which will indicate by which hospital or home care agency the responder is employed.

Returning the completed questionnaire will serve as your consent to use your responses in the study. You may choose to withdraw from the study at any time and may return the incomplete questionnaire in the envelope provided. Please do not put your return address on the envelope. The only minimal risk in answering the questionnaire is that you may consider it an invasion of your privacy, although you will be unable to be identified.

The completed study will be made available to your nurse manager by the end of October, 1995. Only aggregate group data will be reported in the study.

If you decide to participate, please return the enclosed questionnaire within 2 weeks in the stamped self-addressed envelope. Thank you for taking the time to read this letter, if you have any questions please contact me at (313) 455-9014 in the evenings.

Sincerely,

Christine A. Donica, R.N.

Appendix L

Cover Letter to Patients

Dear Patient:

I am a nursing administration graduate student at Madonna University interested in studying your feelings about the nursing care you recently received while you were a patient in the Maternity Department of the hospital or during your home nursing visit/s.

You have been randomly selected to be asked to fill out the enclosed questionnaire. The questions are designed to measure your satisfaction with the nursing care that you received. It should take about 10 minutes for you to complete.

Your participation in this survey is entirely voluntary and you may choose not to finish the questionnaire at any time and return the incomplete form in the enclosed envelope. Your response will be anonymous and the only identifiable feature will be the color of the paper (pink/blue/green) to inform me which of the facilities being studied is referred to in the responses.

Returning the completed questionnaire will serve as your consent to use your responses in the study. Since this is a written survey, there is no risk to you. The results of the study will be sent to the nurse manager of the agency or hospital by the end of October, 1995.

If you decide to participate in this study, please return the completed form in the self-addressed stamped envelope within 2 weeks. Do not include your return address on the envelope. Thank you for taking the time to read this letter, if you have any questions please contact me at (313) 455-9014 in the evenings

Sincerely,

Christine A. Donica, R.N.

Appendix M

Follow-up Post Card to Nurses

Dear Maternal-Newborn Nurse:

Recently you received a questionnaire asking you to rate your perception of satisfaction with your job. Since I have no way of knowing who has responded and who has not, I am sending this post card as a thank you to those of you that have done so.

I would also like to remind those of you that have not yet responded that your feelings are very important. It is only by these types of surveys that we can improve the work environment in order to provide quality patient care. I hope that you will take a few minutes to complete the questionnaire and return it.

Thank you for taking the time to read this.

Sincerely,

Christine A. Donica

Appendix N

Follow-up Post Card to Patients

Dear Maternity Patient:

Recently you received a questionnaire asking you to rate the nursing care you received while you were a patient in the hospital or receiving home care visits after the birth of your baby. Since I have no way of knowing who has responded and who has not, I am sending this post card as a thank you to those of you who have done so.

I would also like to remind those of you who have not yet responded that your feelings are very important. It is only by these types of surveys that we can determine what it is about our nursing care that you like. Perhaps, there are parts of the care that may need some improvement. I hope that you will take a few minutes to complete the questionnaire and return it.

Thank you for taking the time to read this.

Sincerely,

Christine A. Donica